

Child Death Review Board

Queensland **Family & Child** Commission

IN PLAIN SIGHT

Review into System Responses
to Child Sexual Abuse

2025

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Acknowledgements

The Queensland Child Death Review Board acknowledges Aboriginal and Torres Strait Islander peoples as the Traditional Custodians across the lands, seas and skies where we walk, live and work. We recognise Aboriginal and Torres Strait Islander people as two unique peoples, with their own rich and distinct cultures, strengths and knowledge. We celebrate the diversity of Aboriginal and Torres Strait Islander cultures across Queensland and pay our respects to Elders past, present and emerging.

We acknowledge the important role played by Aboriginal and Torres Strait Islander communities and recognise their right to self-determination, and the need for community-led approaches to support healing and strengthen resilience.

Warning

This report may cause distress for some people.

It contains information relating to the incidence and prevalence of child sexual abuse, the motivations and behaviours of people who sexually abuse children, and outlines specific incidences of child sexual abuse.

Discussions of child sexual abuse are necessary to increase awareness, build community understanding, and drive reform. At the same time, the subject matter can be distressing and carries a risk of retraumatisation for victim-survivors, families, and professionals.

In producing this report, we have sought to balance the need for openness and transparency with a commitment to safety and care. We have aimed to:

- present information in clear and respectful language that does not minimise the harm experienced, sensationalise events, or retraumatise those with lived experience
- focus on systemic lessons and institutional accountability, rather than on unnecessary detail of individual cases
- recognise and uphold the dignity of victim-survivors by using survivor-centred language and framing
- acknowledge the diversity of experiences across cultures, genders, and communities
- provide pathways to support for those who may be affected by engaging with this material.

This approach reflects our belief that child sexual abuse can and must be spoken about in ways that both reveal uncomfortable truths and contribute to safer, more responsive systems for children, families, and communities.

Note: Pseudonyms have been used throughout this report in reference to the early childhood education and care centres relevant to this review.

A note on language

Victim-survivor

People who have experienced child sexual abuse reflect on and identify with this experience in individualised ways. No one person is the same. In understanding this, the Board has chosen to use the term 'victim-survivor' to describe those who have experienced child sexual abuse. The use of the combined term is an attempt to capture a wider range of people's preference. As outlined by the National Centre for Action on Child Sexual Abuse's Child sexual abuse language guide:

We recognise that some people prefer the term "survivor" because of its association with resilience and empowerment. We also recognise many have lost their lives as a direct result of abuse, or do not feel they have "survived" the abuse and its impacts. In these cases the term "victim" may be more appropriate. We recognise that some people do not identify with either of these terms.¹

The term 'victim' may be used throughout the report in the context of a defined legal meaning.

The offender

On 29 November 2024, Ashley Paul Griffith was sentenced to life imprisonment in Queensland for 307 offences related to the sexual abuse of 69 children in early education and care services over a period of around 20 years. His offences have caused significant harm to the victim-survivors, and their families. The Board seeks to focus on whether there are systemic issues which contributed to the offender's ability to avoid detection, and in doing so emphasise the experiences of the victim-survivors of his abuse. For this reason, and due to his name itself possibly causing further trauma, in this paper he is referred to as 'the offender'.

Media guidelines

For media guidelines about reporting on child sexual abuse, including correct language and terminology, please visit www.childsafety.gov.au/what-we-do/reporting-child-sexual-abuse-guidance-media-and-victims-and-survivors

**If you need help or support,
please contact any of these
services:**

Lifeline:
13 11 14

Beyond Blue:
1300 22 4636

Kids Helpline (for 5- to 25-year-olds):
1800 55 1800

Sexual Assault Helpline:
1800 010 120

Bravehearts:
1800 272 831

13YARN:
13 92 76

QLife:
1800 184 527

The Honourable Deb Frecklington MP
Attorney-General and Minister for Justice and Minister for Integrity
Department of Justice GPO Box 149
BRISBANE QLD 4001

Dear Attorney-General

On 4 December 2024, you requested that the Child Death Review Board (the Board) undertake a review under section 29I of the *Queensland Family and Child Commission Act 2014* (Qld). The request was initiated in response to the case of Ashley Paul Griffith and asked the Board to examine systemic issues across the early childhood education and care sector, police services, and the blue card system. This report is the result of that review.

Using the Griffith matter as a case study, the Board has undertaken a detailed examination of how our systems functioned. The Board has approached this work with a deep sense of responsibility to the children and families affected, and with a strong commitment to identifying opportunities to strengthen the prevention, detection, and response to child sexual abuse in Queensland.

In alignment with our terms of reference this report:

1. Establishes the timeline of conduct by Ashley Paul Griffith to understand what laws, policies, procedures and practices could or should have enabled earlier identification, investigation and prosecution. This includes documenting his history of employment, residential movements, and complaints or reports about him or his conduct.
2. Examines how the legislative framework, policies and practices of the early childhood education and care, police (state and federal) and blue card systems operated during the time of Griffith's offending, to identify necessary systems improvements to better protect children from sexual abuse and other harm.
3. Identifies the context of child sexual offending in Queensland, including changes in the legislative and policy framework, historical and current rates of extra-familial offending and changes in our understanding of the nature of extra-familial offending.
4. Identifies best practice across Australia and internationally for: protecting children from sexual abuse; identifying perpetrators and children at risk; and responding to allegations.

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5. Considers and presents the views of impacted parties to identify the lessons arising from their experience.
6. Analyses the legislative and policy framework in place today to protect children from child sexual abuse in Queensland and identify any gaps and areas for improvement. This includes assessing how the timeline of offending and action taken may have changed if the protections in place today had existed earlier.
7. Examines how the early childhood education and care, police and blue card systems have responded to the Ashley Paul Griffith case to review and implement improved protections and responses.

Throughout the review, the Board has been mindful of the ongoing court processes and taken every precaution to ensure that our work does not hinder or jeopardise these proceedings. At the same time, we have exercised the full extent of our legislative powers to obtain and analyse relevant information, and to ensure those affected had a safe and supported pathway to contribute their experiences.

The report reflects what we have learned. It outlines how existing systems operated, what risks were visible but not acted upon, and what legislative, policy and practice changes are needed to better protect children in Queensland today and into the future. It includes a suite of practical, evidence-informed recommendations, each designed to reduce systemic blind spots, improve coordination, and rebuild community trust in the institutions that exist to keep children safe.

On behalf of the Board, I want to acknowledge the courage of those who shared their experiences, the dedication of the professionals who supported this review, and the commitment of the agencies who are already acting to improve their systems in response to this case. The lessons are difficult, but essential. If fully acted upon, they offer an opportunity to build a stronger, more responsive child safeguarding system in Queensland.

Yours sincerely



Luke Twyford
Chairperson,
Child Death Review Board
November 2025

An open letter to children and parents harmed by sexual abuse in early childhood and care centres

To the children and parents whose lives have been forever altered by abuse in early childhood education and care centres.

I want to speak to you directly, not as a representative of government or an institution, but as a person who has listened to your lived experiences, studied the failures, and carried the responsibility of reviewing how and why these terrible things were allowed to happen.

Through my work, I have come to understand the depth of the betrayal that you and your families have endured: the deception, the silence, the failure of people and systems that should have protected you. I have reviewed the records, met with victim-survivors and parents, attended the places where abuse occurred, and witnessed the weight of harm that has been caused and carried for too long.

I cannot undo what was done. I cannot take away the pain, nor fill the spaces left by broken trust, broken relationships, or hopes that feel lost, but I can say this plainly: I believe you. I see the cost that has been borne not just by those who suffered abuse, but by parents who placed their trust in systems that utterly failed them. You deserved care, protection, and honesty. Instead, you were met with betrayal and harm. And while I cannot speak for any government or for the community, I can speak for myself: I am committed to pursuing the changes needed to ensure that no parent or child experiences this kind of harm again.

The work of reviewing these events is not just about documenting failure. It is about making sure we learn from it and drive real change in law, in practice, and in culture. I will continue to push for those changes: for stronger safeguards, for greater transparency, for systems that listen to children and parents rather than dismiss them. And for real accountability for those who abuse trust.

Your courage in telling your stories, whether publicly or quietly, has shaped my work and my resolve. To those who have not yet spoken, I want you to know your silence does not make your experience any less real. Your suffering is seen and acknowledged.

I carry the weight of what I have learnt during this review, and I will carry it forward until the work is done: until every child is safe, and every parent can trust without fear.

With sincerity and respect,



Luke Twyford
Chairperson,
Child Death Review Board
November 2025

An open letter to acknowledge those that review sexual abuse cases

To my colleagues, those I've worked alongside of during this review, and to all of you across organisations dedicated to reviewing and responding to child sexual abuse cases, I want to pause and speak directly to you.

This is difficult work. It is work that asks us to carry the heaviest truths: stories of harm, betrayal, and loss that no child or family should ever experience.

We undertake this grim work because we believe that through it, children can be safer, and systems can be stronger.

To those who worked on this review—Anne, Erin, Susan, Sanja, Caitlin, Angus, Elizabeth, Abbie, Kirstine, and Michael, Board members, expert advisors and everyone who serves in oversight bodies, commissions, inquiry teams, support services, and frontline agencies across the country—I want to acknowledge both your commitment and the personal toll that this work takes. You sit with difficult material. You listen carefully to people's pain and witness the long shadows cast by abuse. You weigh each decision knowing that behind every page, every photo, every file, there are real lives. You do this because you care. Because you know that while no review can undo the past, our collective effort can prevent future harm.

There is still much work to do. We know that. But I want to say clearly: what you do matters. The hours spent reviewing files, sitting with families, drafting recommendations, shaping better systems—it all makes a difference. You may not always see it in the moment, but it builds over time. The facts, the evidence, and the lessons build and grow, until they transform into real change. Please do not lose sight of that, especially on the harder days.

To all of you who hold these responsibilities: thank you. For your skill, your diligence, and most of all, for your care.

You carry stories that are hard to hold, so that others might be safer in the future. That deserves respect and gratitude.

Thank you,



Luke Twyford
Chairperson,
Child Death Review Board
November 2025

Terms of Reference

System responses to child sexual abuse

Review purpose

On 4 December 2024 the Attorney General referred a matter to the Child Death Review Board (the Board) and requested a review under section 29I of the *Family and Child Commission Act 2014* (Qld). In response the Board has approved these Terms of Reference for a review into the system responses to child sexual abuse. The system responses to child sexual abuse review (the Review) will use the Ashley Paul Griffith matter as a case study to review system responses to child sexual abuse and make recommendations for any necessary improvements to the laws, policies, procedures and practices across the early childhood education and care, police and the blue card systems.

Terms of reference

1. Establish the timeline of conduct by Ashley Paul Griffith to understand what laws, policies, procedures and practices could or should have enabled earlier identification, investigation and prosecution. This should include documenting his history of employment, residential movements, and complaints or reports about him or his conduct.
2. Examine how the legislative framework, policies and practices of the early childhood education and care, police (State and Federal) and blue card systems operated during the time of Griffith's offending, to identify necessary systems improvements to better protect children from sexual abuse and other harm.
3. Identify the context of child sexual offending in Queensland, including changes in the legislative and policy framework, historical and current rates of extra-familial offending and changes in our understanding of the nature of extra-familial offending.
4. Identify best practice across Australian and internationally for: protecting children from sexual abuse; identifying perpetrators and children at risk; and responding to allegations.
5. Seek and consider the views of impacted parties to identify the lessons arising from their experience.
6. Analyse the legislative and policy framework in place today to protect children from child sexual abuse in Queensland and identify any gaps and areas for improvement. This will include assessing how the timeline of offending and action taken may have changed if the protections in place today had existed earlier.
7. Examine how the early childhood education and care, police and blue card systems have responded to the Ashley Paul Griffith case to review and implement improved protections and responses.

In undertaking this review, the Board will:

- ensure all remaining court actions against the offender are not hindered or jeopardised;
- utilise all powers provided to it including the information access powers under s29P of the *Family and Child Commission Act 2014* (Qld) and provide the Minister with advice on the extent to which the powers and processes are enabling the Review to identify key facts or learnings;
- seek and incorporate the advice of relevant experts;
- seek and incorporate submissions from those directly impacted by the Ashley Paul Griffith matter and provide them with appropriate support to contribute; and
- keep the public informed on the status and progress of the Review.

Out of scope

The Review will not consider the prosecution case and court-related processes, the legal accountability of individuals and will only consider matters occurring outside Queensland to the extent legally possible.

Timeframe

The Review's final report will be delivered in 2025.

The Board

The Child Death Review Board is comprised of the following members:

Luke Twyford in his position of Principal Commissioner of the Queensland Family and Child Commission, was appointed as the Chairperson of the Child Death Review Board on 17 March 2022.

Sharon Cavanagh-Luskin is a First Nations Kuuku Ya'u, Irukandji and Wonnarua woman, she is Illuminate-FNQ First Nations Chief Scientist.

Carly Jacobitz is a registered psychologist and is the Deputy Chief Executive, Child, Youth and Family at Life Without Barriers.

Beth McNamara lives and works on beautiful Gubbi Gubbi/Kabi Kabi and Jinibara Country and is the National Education Manager at the Daniel Morcombe Foundation.

Dr Marlene Longbottom is a Yuin woman, from Roseby Park mission (Jerrinja) on the South Coast of New South Wales and is an Associate Professor with the Indigenous Education and Research Centre at James Cook University.

Victoria van Houdt is the Chief Practitioner for the Department of Families, Seniors, Disability Services and Child Safety.

Dr Divna Haslam is a registered clinical psychologist with a doctorate in the field of parenting. She is an Associate Professor and Senior Principal Research Fellow with the School of Public Health, University of Queensland.

Darren Hegarty is the Assistant Chief Operating Officer Department of Youth Justice and Victim Support representative on the Board.

Dr Stephen Stathis obtained a dual fellowship in paediatrics and psychiatry, with certificates in Child and Adolescent Psychiatry and Forensic Psychiatry. He is currently the Medical Director of Child and Youth Mental Health Services, Children's Health Queensland.

Murray Benton is a proud Aboriginal Barkindji Koori man from Central West New South Wales. He is the Deputy Chief Executive Officer for Youth Justice with the Queensland Aboriginal and Torres Strait Islander Child Protection Peak.

Hayley Stevenson is the Assistant Director-General, Strategic Engagement at the Department of Education.

Detective Superintendent Denzil Clark commenced with the Queensland Police Service in January 1988 and has served the past 33 years as a detective in various positions across the service.

Expert Panel

To support the Review the Chair appointed an expert panel in child safeguarding, victim engagement, policing and child sexual exploitation policy. Members were:

- **Bob Atkinson AO APM** is a former Queensland Police Commissioner (2000–12) and was a Commissioner on the *Royal Commission into Institutional Responses to Child Sexual Abuse*. He has contributed extensively to criminal justice reform, policing practice, and child protection policy, particularly around systemic responses to abuse. His career is marked by efforts to modernise policing, improve investigative standards, and advocate for better interagency collaboration to protect vulnerable children.
- **Jon Rouse APM** is a retired Detective Inspector of the Queensland Police Service and internationally recognised expert in the investigation of child sexual exploitation. He established and led the Argos Taskforce, a world-leading unit combating online child sexual abuse and exploitation networks. Mr Rouse has worked closely with international law enforcement partners and non-government organisations to rescue victims and dismantle offender networks, and he continues to advocate for stronger global action against child exploitation through advisory and ambassadorial roles.
- **Hetty Johnston AM** is the founder of Bravehearts, one of Australia's leading child protection advocacy organisations. For decades she has been a prominent national voice campaigning for stronger laws, policies, and community awareness to prevent child sexual abuse. Hetty has advised governments, served on multiple inquiries, and her advocacy has led to significant legislative reforms and increased public recognition of the rights of children to be safe.
- **Conrad Townson** is currently Principal Advisor on Child Sexual Exploitation with Integrated Family and Youth Service and oversees Project Paradigm, a national programme aimed at addressing child sexual exploitation in Australia. He sits on the board of the Australian Community Workers Association, is chair of the National Strategic Partnership on Child Sexual Exploitation, a member of the National Working Group on Responses to Victims of Child Sexual Abuse Material, and is a member of the National Stakeholder Working Group for the Australian Centre to Counter Child Exploitation.
- **Alison Geale** has served as the Chief Executive Officer of Bravehearts, one of Australia's foremost child protection organisations, since 2019. She first joined the organisation in 2018 as General Manager and quickly moved into the Chief Executive Officer role in the same year. Prior to her leadership in the child protection sector, Alison spent over 20 years in senior management roles across major Australian media networks—a foundation that informs her strategic acumen and media-savvy advocacy.



Foreword - Chair of the Board

This review has been one of the most profound responsibilities I have carried. From the moment it was commissioned, I have been acutely aware that the work is not abstract, nor simply administrative. It concerns real children, real families, and real harm. Every page of evidence, every conversation, and every finding has carried with it the weight of lives altered, and trust broken.

The Review's report is called *In Plain Sight* because too often those who harm children are operating openly in our community, visible to systems, neighbours, and institutions, yet unseen for who they truly are. Their actions are not hidden in the shadows—they are in schools, in early childhood education and care centres, in sporting clubs, and online. Their danger lies not only in their cruelty, but in our inability to see them clearly and act decisively.

This review has sought to sharpen that sight: to reveal the blind spots in our laws, our systems, and our cultures that have allowed offending to continue when it could, and should, have been stopped.

I have approached this task conscious of the dual responsibility it carries. First, to those who have been harmed—children and parents who placed their trust in others and were betrayed in ways that should never be borne. Their voices, their courage, and their losses are at the heart of this report. And second, to the broader Queensland community who must be able to trust that the systems charged with protecting children are capable, vigilant, and relentless in their duty.

Working on this review has continually asked me to step between two worlds, not just once, but across many different dimensions. Each perspective has required me to hold the tension between them, and to consider what is gained and what is lost when we move from one world to the other. These shifts are rarely comfortable, but they are essential for seeing the whole picture of how children are kept safe, and how they are sometimes let down.

There is the contrast between the *real world* and the *online world*: people who seek to harm children are operating both in our community and online. They operate across both worlds with cruel intent. The spaces where harm occurs may be different in form, but the consequences are equally real. Online spaces blur borders and jurisdictions, yet the harm still lands in the lives of children, families and communities. The digital world does not lessen the damage, it amplifies reach, conceals perpetrators, and challenges our capacity to respond. The real and online worlds cannot be separated: both must be confronted with equal determination.

There is also contrast between the *world of the criminal justice system* and the *world of children*. One speaks in the language of evidence, rules, and thresholds, the other in feelings, trust, and everyday experiences. The legal system is transactional, reducing lives to cases and files; the world of children is experiential and holistic, lived in moments of safety or fear, stability or uncertainty. These worlds rarely meet on equal terms, and too often the experience of children is diminished by the structures of the legal system designed to protect them. The justice system asks, "Can this be proven?" while children ask, "Am I believed? Am I safe?" The gap between those questions remains one of the hardest to bridge.

Similarly, I have had to consider the *world of federal government* and the *world of local communities*. One operates at scale, shaping policy and legislation from afar, the other lives the impact of these decisions in daily realities. Local communities are where the safety of children is determined. It is the neighbour, the friend, the childcare worker who notices, acts, and protects. Federal parliament and the debates about safeguarding are not unimportant, but the distance between these two worlds can create a gap in understanding that leads to policies and laws that communities must carry. Without careful attention, the voices of those closest to children can be drowned out by the machinery of governance.

Finally, there is the *world of organisations* and the *world of families*. Organisations are governed by boards, shareholders, profit and loss statements, and corporate accountability mechanisms. The world of families is led by relationships, care, and the messy complexities of love and survival. When these worlds intersect, the question is always about whose priorities take precedence—compliance or compassion, profit or care. Where organisations see liability, families see their children's futures. When corporate systems and families clash, it is too often families, and children, who bear the cost.

Reflecting on these divides has reminded me that our work must be to bridge these worlds, not to choose one over the other. The task is to listen deeply, to carry insight from one world into the other, and to insist on responses that honour both. The safety of children lies not in the dominance of one world over another, but in our ability to hold them together with humility, with courage, and with a relentless focus on the child at the centre.

This report does not only catalogue failure, it also maps a path forward. It examines where risk was visible but ignored, where processes existed but were too weak, and where opportunities to act were missed.

It identifies how systems must be reformed, not in fragments, but holistically across government portfolios, institutions, and communities. Because the truth is stark: governments alone cannot keep children safe. Protection requires accountability, vigilance, and action across our communities and organisations, and in every space where children live and grow.

This work has been sobering. It has required the Board members and I to sit between worlds that do not always align—the legal and the human, the national and the local, the organisational and the familial. Bridging these divides is difficult, but it is where the safety of children will ultimately be secured. If we are to succeed, we must refuse to look away. We must act as if every child matters, because every child does.

This report is a call to see what is too often hidden in plain sight. And it is an appeal for—deliberate, urgent, and collective, so that our children are afforded the safety, trust, and care that should be their birthright.



Luke Twyford
Chairperson,
Child Death Review Board
November 2025

Expert Advice to the Board

- Mr Bob Atkinson, OAM

Responding to Child Abuse in Australia: Five Timeframes

The history of child sexual abuse in Australia is a painful story. It is a history marked by suffering, silence, and institutional failure, but also a history of courage, awakening, and reform. Understanding this journey is essential—not only to acknowledge past wrongs but to ensure that we continue to implement our promise to never return to them. To understand our progress—and the work still ahead—it is useful to consider this history across five overlapping timeframes.

- 1. The Dark Ages:** The time up to and from the 1950s to the 1990s was marked by widespread institutional sexual abuse of children across schools, churches, sports clubs, and other community organisations. Institutions prioritised their reputation, the protection of colleagues, and financial interests over the welfare of children. Societal deference to authority—particularly clergy—meant that those in positions of power were rarely questioned. Children were seen and not heard; their complaints were often dismissed as imaginative or unreliable. Adults who had been abused as children faced compounded prejudice, their credibility questioned due to the very trauma they endured. Courts were reluctant to admit evidence of similar acts, meaning offenders frequently faced isolated trials despite multiple victims. Institutions could move offenders elsewhere with minimal community awareness, perpetuating cycles of abuse.
- 2. The Lead-Up to the Royal Commission:** In the 1990s awareness of the significance of the issue began to grow. Dedicated organisations emerged, including Bravehearts, Act for Kids, and the Daniel Morcombe Foundation. Public inquiries, such as the Forde Inquiry, highlighted systemic failures, while investigative journalism—most notably Joanne McCarthy of the Newcastle Herald—brought cases into the public consciousness. Books such as Louise Milligan's *Cardinal* further exposed the failures of institutions. These efforts laid the groundwork for national action, but progress was uneven, and many survivors still struggled for recognition and justice.
- 3. The Royal Commission into Institutional Responses to Child Sexual Abuse:** Announced by Prime Minister Julia Gillard in November 2012, the Royal Commission became a watershed in Australia's reckoning with and awareness of child abuse. While there was initial trepidation about whether Australians would come forward and tell their story the commission needed to be extended to five years due to the sheer number of survivors coming forward. The Commission's work covered three pillars including research, private hearings and public hearings. That work included:
 - 57 public hearings
 - 8,013 private sessions with survivors
 - 59 research reports
 - 2,562 police referrals.

The Commission produced three reports with recommendations as it progressed.

The final report of 17 volumes was delivered to the Governor-General in December 2017. The reports and their 409 recommendations laid bare the scale of abuse, it also established a blueprint for reform. Yet even with this enormous body of work, implementing meaningful change would take time, and in some areas, progress has been slower than survivors and advocates had hoped for.

4. **Post-Royal Commission:** The period from the Royal Commission to today has seen the establishment of the National Office for Child Safety, the Redress Scheme, and adoption of Child Safe Standards across jurisdictions. Reportable Conduct Schemes have been introduced, the first five years of annual status reporting has provided transparency on government actions. National discussions on working with children checks continue, alongside ongoing work by the eSafety Commissioner, the Australian Centre for Child Exploitation, and other child safety organisations. Despite these advances, implementation gaps remain. Prosecutions and civil claims have increased, yet full compliance with Royal Commission recommendations is incomplete.

The pace of reform can frustrate those who have fought for decades to see tangible protection for children. Within the final report the Royal Commission recommended that there be a comprehensive review after 10 years. That will be in December 2027. It is vitally important that this review occurs.

5. **The Next Phase:** Looking forward there are ongoing opportunities, including the 10-year review and this Systemic Review by the Child Death Review Board to embed prevention and protection into the very fabric of our national institutions. The work ahead requires not only commitment but vigilance. Without ongoing leadership, accountability, and systemic coordination, the progress we have made risks being undermined. It is essential that governments, organisations, and communities maintain a shared focus: protecting children first, and ensuring that when abuse occurs, the response is swift, transparent, and survivor-focused.

As someone who has witnessed these five timeframes unfold—from the darkest days of institutional silence to the national reckoning of the Royal Commission, it is encouraging to see what has been achieved but it is also concerning to see the slow rate of progress in significant areas.

The history of child sexual abuse in Australia teaches us that vigilance, leadership, and action are not optional. They are essential. Only by recognising our past failures and steadfastly committing to systemic reform can we truly protect children now and into the future.

Bob Atkinson, OAM
November 2025

Executive Summary

On 4 December 2024, the Attorney-General requested the Child Death Review Board (the Board) conduct a review under section 29I of the *Queensland Family and Child Commission Act 2014* (Qld) into system responses to child sexual abuse. The matter was referred in light of the serious and sustained offending by Ashley Paul Griffith, a case that revealed critical questions about how Queensland's systems identify, prevent and respond to child sexual abuse, particularly in institutional and extra-familial contexts.

This report presents the findings of that review. It uses the Griffith matter as a case study to examine how the early childhood education and care (ECEC), policing, and blue card systems operated at the time of his offending. In doing so, this review identified the cultural, legislative, procedural and oversight issues that contributed to a failure to detect and respond earlier. It asks whether the laws and safeguards in place today would be sufficient to prevent similar harm and explores how these systems have since responded.

The Child Death Review Board

The Board was asked to complete this review, given it holds the necessary powers under the law and because its membership has extensive experience, knowledge and skills in child safety, child abuse prevention and investigations.

The Board is an independent statutory body established under the *Family and Child Commission Act 2014* (Qld). It has an established role to conduct *independent, systemic reviews* that look for patterns, recurring issues, and systemic weaknesses across agencies. These reviews seek to improve systems and practices so that children are kept safer. The Board is chaired by an independent statutory chair and comprises experts in law, health, child protection, policing, education, and community services.

The Board completed this review under section 29I of the *Queensland Family and Child Commission Act 2014* (Qld) which applies when the Attorney-General considers that an exceptional circumstance exists.

The Terms of Reference

The terms of reference were released in January 2025. They required the Board to:

1. establish a timeline of conduct by the offender
2. examine the legislative framework, policies and procedures that operated during the time of offending
3. identify the context of child sexual offending in Queensland
4. identify best practice for protecting children from sexual abuse
5. seek and consider the views of people directly impacted by the offender's behaviour
6. analyse the legislative and policy framework in place to protect children from child sexual abuse
7. examine the responses of the early childhood education and care, police and blue card systems.

Based on these terms of reference this review looked beyond the individual case. Drawing on expert advice, impacted party input, data analysis, media assessment, and jurisdictional comparisons, the report examines the broader context of child sexual offending in Queensland—how offenders operate, how children are targeted, how risks present, and how our systems must evolve to meet this challenge.

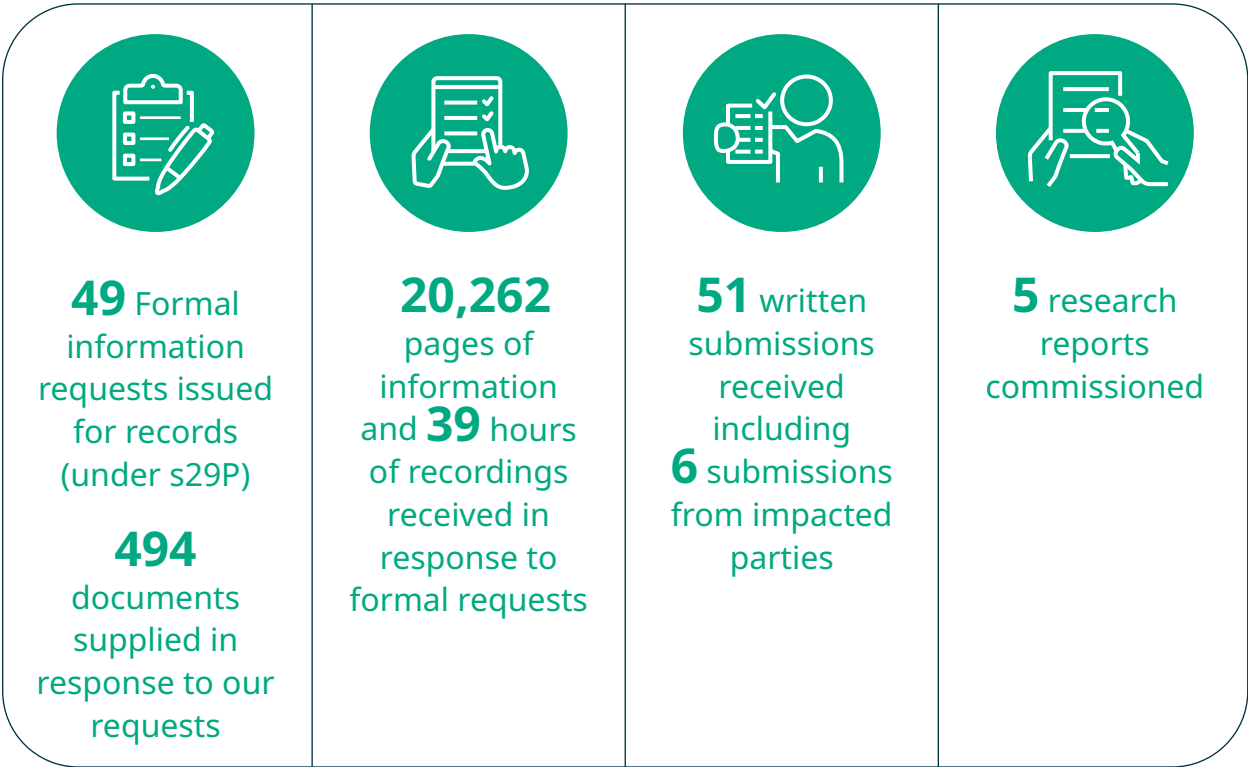
This report seeks to understand not only what went wrong in the past, but what should be done now and into the future to better protect children.

Conduct of the Review

To conduct this review the Board:

- established a dedicated team within the Queensland Family and Child Commission
- issued 49 information requests to a range of commonwealth and state government agencies, non-government organisations and private companies, using the Board’s information access powers under s29P of the *Family and Child Commission Act 2014* (Qld)
- received 494 documents in response to the information requests
- commissioned research to identify best-practice approaches for protecting children from sexual abuse, identifying perpetrators and children at risk of abuse, and responding to allegations of abuse
- mapped different pieces of legislation to help understand the legislative framework operating during and subsequent to the time of offending, focusing on three key domains: sexual offending against children, ECEC, and working with children checks
- approached several leading experts to assist, guide, and inform the Review, including attending expert roundtable meetings
- invited 51 organisations with a role in child sexual abuse prevention to contribute submissions
- sought advice from Australia’s children’s commissioners, advocates and guardians on best-practice initiatives underway in their jurisdictions
- documented the detailed chronology of the offender’s movements based on court and public records, as well as information gathered under the Board’s information access powers
- engaged with victim-survivors and their families and supported them to make submissions to the review to ensure that their perspectives and experiences were central to the Board’s understanding of the case
- issued a call for public submissions on improvements needed in policies and practices in the ECEC, police and blue card systems to better protect children from sexual abuse.

The Board is grateful to the victim-survivors, families and professionals who shared their experiences, and to the agencies who have cooperated with this review. The recommendations that follow were made with a single intent: to build a stronger, safer and more responsive child safeguarding system in Queensland.



Structure of this report

The structure of this report reflects the breadth of our ambition to understand child sexual abuse, determine contemporary best practice and form recommendations to better protect children. The chapters are informed by multiple methods: document analysis, stakeholder interviews, targeted submissions, case file reviews, and expert consultation. Care was taken to ensure the report does not interfere with any outstanding court matters and that the voices of those directly impacted were heard and respected throughout the process.

A

This report begins with **Part A** which presents a detailed analysis of the context and nature of child sexual abuse in Australia and Queensland. It considers the contemporary experience of childhood and the changing social conditions against the history of past reviews into child sexual abuse. This section then explores the operations of the key systems where children are cared for and protected—the Blue Card Scheme, police and the early child education and care system. It concludes with an examination of what we know about people that sexually abuse children.

B

Part B traces the timeline of offending in the Griffith matter. It does so from three perspectives to understand how risks were missed and opportunities for intervention were lost. It presents information about the offending, the offender, the organisations where abuse occurred, and the victim-survivors and their families. It concludes with information on how the systems involved in the case study responded to the arrest of the offender, including the reviews they conducted and the improvements they implemented.

C

Part C examines how systems and organisations can more effectively detect risks, threats and harm to children. Drawing on our case study and research into best practice, it explores how abuse, grooming and concerning behaviours can be identified early, including within workplaces and institutions. The chapters highlight the importance of intelligence sharing and integration to recognise emerging threats and those who pose them.

D

Part D examines how systems respond when concerns, allegations or evidence of child sexual abuse emerge. Drawing on our case study, it considers the effectiveness of complaint and reporting mechanisms, investigative processes, and police responses to emerging threats and growing demand. The chapters analyse the structural and systemic barriers that continue to impede timely and effective safeguarding of children.

E

Part E turns to the experiences of victim-survivors and what is required for genuine recovery and healing. Using insights from the case study and broader evidence on effective support models, it explores how services can respond with compassion, continuity and expertise. The chapters look at how to expand access to specialist assistance and create systems that help restore safety, connection and hope.

F

Part F focuses on prevention of child sexual abuse. It discusses a whole of system approach to prevention, including education for children, parents and early childhood staff, and contextual prevention approaches to enhance the safety of early childhood education and care services. This part also canvasses the complex issue of prevention of child sexual abuse perpetration. A practical guide for parents about safeguarding in early childhood education and care services is also provided.

G

Finally, **Part G** paints a picture of the future of the early childhood education and care, policing and blue card systems. It defines a multi-layered approach to preventing, detecting and responding to child sexual abuse in Australia.

Findings

The Review has confirmed systemic failings in the safeguarding and response to child sexual abuse in this case, and that these raise concerns about the capability and capacity of our current systems.

The evidence gathered through this review confirms:

1. That the offending could—and should—have been detected and disrupted earlier. Across organisations and agencies, sufficient concerns were recorded to have enabled earlier intervention had they been consolidated and treated as part of a broader safeguarding picture. Instead, information remained siloed, and the warning signs were never fully connected.
2. The reality is stark: parents, children and staff repeatedly raised legitimate concerns, but no obvious resolution followed. Ultimately, the offender was only apprehended after uploading digital images—not because of any effective response to the concerns that adults and children legitimately expressed.
3. Our prioritisation of criminal justice responses means we are focused on detecting crimes rather than detecting safety threats to our children. Consequently opportunities to intervene are lost. Victim-survivors and their families were left with no pathway to resolve their concerns once police determined there was insufficient evidence to proceed.
4. Police thresholds for action, combined with resourcing limitations, further inhibited earlier detection and contributed to missed opportunities². This left children unprotected and families unsupported, effectively closing the door on concerns despite the potential for ongoing risks.
5. The blue card system functioned as intended, yet offered no meaningful protection to children. Its operation did not prevent the abuse, nor did it alert organisations to the pattern of risk. The gap between the legal operation of the blue card system and community expectations of its protective factors means that trust is mislaid.
6. At the organisational level, actions were taken in isolation often resulting in the offender being ‘moved on’ rather than the risks he posed being systematically addressed, recorded and communicated. Such responses delivered no strategic or holistic benefit to the community, and critically, did not safeguard children.
7. The legislative and policy framework is itself fragmented. There is no clear single owner of child safeguarding in Australia or Queensland, and the response remains overly dependent on the criminal justice system and child welfare system with a significant gap between the two.
8. Public submissions underscored the absence of a clear pathway to raise concerns and receive services for suspected child sexual abuse. This evidence made it clear that there is a clear gap when neither police nor the Department of Child Safety are involved. This vacuum leaves families and organisations without a protective mechanism, and children at continued risk.

These findings demonstrate systemic weaknesses: siloed information, fragmented responsibilities, insufficient thresholds for action, and a lack of coordinated safeguarding architecture. The effect is that risks are routinely identified but remain unmitigated, while families and victim-survivors are left without redress until catastrophic harm is undeniable.

These findings point to the need for a stronger whole-of-system approach, underpinned by proactive detection, coordinated responses, investment in prevention, and sustained recovery pathways. Only by strengthening each of these domains can we deliver on our responsibility to keep children safer and support them to thrive.

Recommendations

As a board with deep experience making and monitoring recommendations, we acknowledge our place and our role in systemic improvements, and the many other bodies that issue recommendations. We know many readers will go looking directly for the list of recommendations and that there will be pressure on political leaders to accept the recommendations before there is the opportunity to fully consider them. As is outlined in this report, the reactive, crisis-driven approach to social policy does not assist with building integrated, and holistic systems.

We wish to make clear that we want both the Australian and the Queensland governments to take their time to consider our report in full, to develop a strategic and funded response that includes the acceptance of future accountability.

It is not our intent that the recommendations we make become a transactional checklist.

We have carefully crafted recommendations that work together in an integrated and holistic way, and we want to encourage a government response that is equally holistic, integrated and instructive of the future systems they intend to build.

Our first recommendation is therefore:

Operational Recommendation 1: Produce a public response to this report

That the Australian and Queensland governments both separately produce a public statement outlining the strategic transformation it commits to leading. This public statement should directly respond to the future system presented in Part G of this report, and include information on the planned timing, accountability and resourcing allocated to improve the prevention, detection, response and recovery from child sexual abuse.

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Introduction

The importance of childhood

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The importance of childhood

Childhood is the foundation of human development. It is a period marked by rapid growth, learning, and socialisation, during which the experiences and environments surrounding a child profoundly shape their future health, wellbeing, and capacity to thrive. Developmental science consistently shows that the early years of life are critical: neural pathways are formed at a pace never replicated again, patterns of attachment influence future relationships, and the presence of safety, stability, and nurturing care establishes resilience that can endure across a lifetime.

The importance of childhood has been recognised across cultures and eras. From traditional communities that viewed children as the continuation of family lines, to modern states that enshrine children's rights in law, societies have long acknowledged that the way we treat our youngest members determines the strength and direction of the generations to come. Protecting and investing in children is not only a moral obligation but also a practical one, as their development underpins the social, economic, and cultural fabric of every community.

At the same time, childhood is defined by vulnerability. Children cannot independently provide for their own safety or needs. They rely on adults—especially parents—for protection, guidance, and love. Where this care is consistent and safe, children flourish. Where it is absent, interrupted, or undermined by harm, the effects can echo across their lives and into the broader society.

For these reasons, childhood has increasingly been recognised as a protected stage of life in both policy and law. International agreements such as the United Nations Convention on the Rights of the Child affirm that children, by virtue of their dependence and developing capacities, require special safeguards and care. National systems of health, education, and welfare reinforce this principle, recognising that secure, nurturing childhoods are the cornerstone of public health and social progress.

In short, childhood matters because it is both the most vulnerable and the most formative stage of human life. It is a time when love, protection, and opportunity make the greatest difference.

Ensuring that every child has the chance to grow safely, to be nurtured, and to reach their potential is not only an investment in individuals, but an investment in the future of societies themselves.

The changing context of childhood and communities

Over the past twenty years, the world we live in has changed in ways that would have been hard to imagine two decades ago. Technology has reshaped daily life—smartphones, social media, and instant global communication have transformed how we connect, learn, and play. Communities are more informed, more connected, and more vocal, demanding higher standards of accountability and safety for the most vulnerable. At the same time, new forms of risk have emerged, often hidden in digital spaces, testing our ability to respond quickly and effectively.

Society itself has transformed alongside these technological shifts. Attitudes toward child protection, workplace culture, and institutional accountability have evolved, reflecting broader social movements that prioritise transparency, inclusion, and the rights of individuals. The family, community, and education landscapes have shifted too with diverse family structures, changing patterns of work and care, and the globalisation of knowledge all shaping the environment in which children grow, and organisations operate.

At the same time, the rise of dual-income households and more diverse family structures has reinforced the need for flexible, reliable systems of care and a recognition that parenting is shared between families, funded services, and community supports.

One of the most striking social changes of the past two decades has been the growth of the digital world and its central role in everyday life. In the early 2000s, children's engagement with technology was largely limited to television, gaming consoles, and early internet use in supervised settings such as schools and libraries. Parents, too, were only beginning to adopt mobile phones and broadband internet. ***By 2025, this landscape has shifted dramatically. Children are now digital natives, engaging daily with smartphones, tablets, and online platforms, while parents manage their working and personal lives through constant online connectivity.*** Time spent online has become not only a leisure activity but also a defining element of education, social interaction, work, productivity, economic participation and identity formation.

This transformation has reshaped parenting models. Two decades ago, parenting advice emphasised balancing work and family time, with limited reference to digital environments. Today, parents are expected to navigate the complex task of supervising children's digital lives, protecting them from online risks such as grooming, bullying, or exploitation, while also recognising the educational and social benefits of digital engagement. Parenting has become increasingly 'mediated parenting', where digital tools, apps, and monitoring platforms form part of everyday care.

A parallel shift has taken place in how communities connect. Historically, neighbourhoods, schools, religious institutions, and local clubs provided the backbone of community life. While these still exist, many forms of social connection have migrated online. Digital platforms allow parents to build support networks across distances, and children to form peer communities in virtual spaces. Yet this has also led to the erosion of traditional forms of community trust and cohesion. Parents are now more likely to not know their neighbours and not let their children play in the street.

“

The local community is no longer the sole environment where children learn social norms or receive support; instead, global organisations and digital communities now compete with, and sometimes displace, local face-to-face interactions. This duality—greater access to networks, but thinner ties to local places—has become a defining characteristic of family and community life in the 2020s.

”

Changing context of families and child raising roles

Over the past 50 years, Australia has experienced a fundamental shift in family structures. Where once the norm was a single-income household, today the majority of families rely on the earnings of both parents. This transition has been driven by a combination of economic, social and cultural factors, including rising housing and living costs, a desire for greater financial security, and evolving norms about gender roles and career participation.

A major driver of the demand for early childhood care is the significant increase in female workforce participation, particularly among mothers of young children. Whereas in previous generations many women left the workforce permanently or for extended periods after the birth of a child, contemporary patterns show a stronger expectation, and economic necessity, for women to return to paid work sooner. Paid parental leave policies, flexible work arrangements and societal shifts have enabled this trend, but they also create a structural need for reliable, affordable and high-quality early childhood education and care (ECEC).

The cost of modern family life, particularly housing in metropolitan areas, has increased the reliance on dual incomes. For many families, returning to work is not a choice but an economic necessity. As a result, ECEC services have become a critical enabler of workforce participation. Without such services, many families would face the untenable choice between reduced income and inadequate child supervision.

Beyond financial necessity, many women seek to maintain career momentum, professional identity and long-term earning capacity. Access to early childcare therefore supports not only immediate workforce participation but also gender equity in long-term economic outcomes.

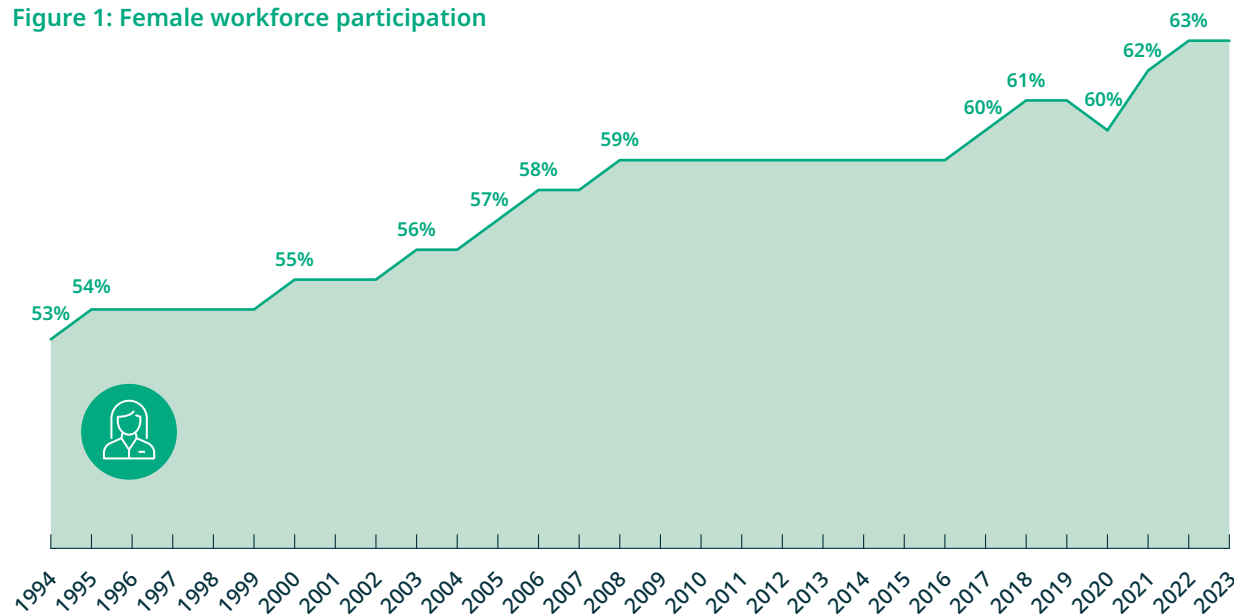
The increase in dual-earner households has created sustained pressure on governments and service systems to expand the availability, affordability and quality of ECEC. Demand now extends well beyond traditional preschool years, encompassing infant and toddler care to enable workforce participation from the earliest stages of parenthood. Public policy has responded with subsidies, regulation, and strategic workforce initiatives to ensure services meet both the developmental needs of children and the employment needs of parents.

The transition to two working parents and the rise of female workforce participation post-birth has fundamentally reshaped the demand for early childhood care. ECEC services are no longer a discretionary support but a central pillar of Australia's social and economic infrastructure. Their role in enabling parents, particularly mothers, to participate in the workforce underscores the interconnectedness of family wellbeing, gender equity, and national productivity.

The most reliable estimate of female work participation data is from the World Bank Group. This shows a 30-year change from close to one half (52%) of females being in the workforce in 1994 to two thirds (62.8%) participating in the workforce in 2023.

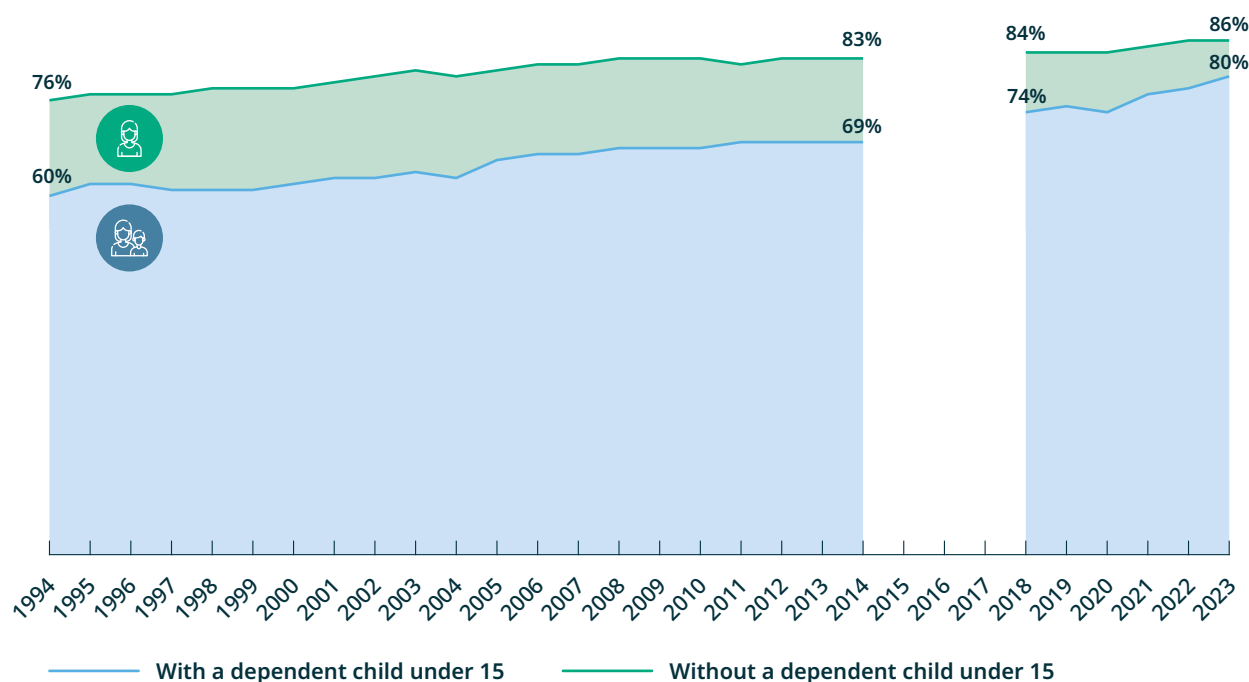
This is compounded by a steadily rising retirement age, which means that grandparents or older family members are also remaining in work longer.

Figure 1: Female workforce participation



The most consistently available data on workforce participation rates among mothers comes from a Productivity Commission inquiry report which uses Australian Bureau of Statistics (ABS) data. No data is available for 2015–17. This shows that over 30 years the number of mothers with a dependent child under 15 who participated in work rose from below 60 per cent to 80 per cent.

Figure 2: Workforce participation by motherhood status



Within this context of dual-income households and increasing female workforce participation, the use of ECEC has emerged as a new social norm. Whereas earlier generations often relied on extended family networks or one parent staying at home, today formal early childcare is a standard feature of family life for many Australians.

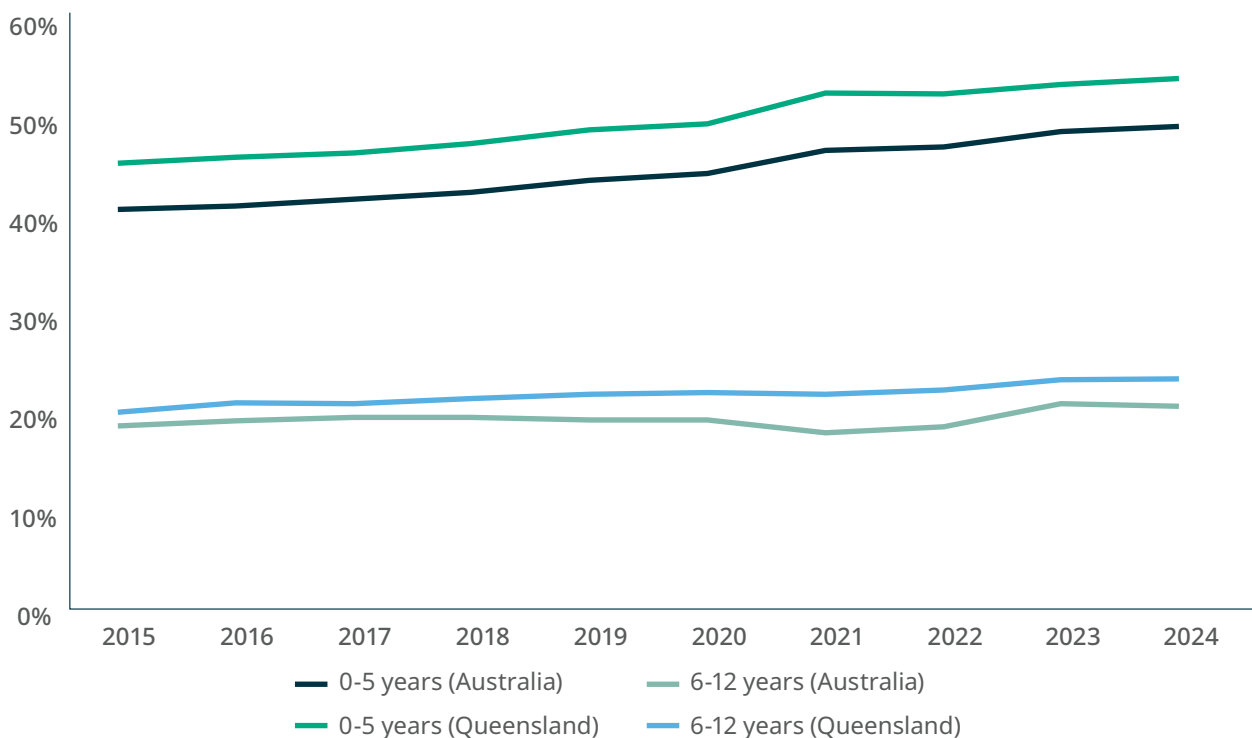
The normalisation of ECEC is evident in rising enrolment figures, with a majority of children now accessing some form of formal service before school age. Participation is not confined to preschool years; infants and toddlers are increasingly part of the early learning system. This reflects both necessity, driven by parents' return to the workforce, and a growing recognition of the developmental benefits of quality early learning environments.

The perception of childcare has also shifted. It is no longer seen solely as a custodial service enabling parents to work, but as a dual-purpose investment: supporting parental workforce participation while also laying foundations for children's cognitive, social and emotional development. This has reinforced its acceptance as a mainstream, and often expected part of family life.

Importantly, the normalisation of ECEC intersects with government policy settings. Subsidies, universal access initiatives, and national quality standards have entrenched its role as a structural support, rather than an optional or luxury service. The expectation that most families will use formal care during a child's early years is now embedded in both household decision-making and policy frameworks. As a result, ECEC has moved from being a supplementary option to a core institution within Australia's social and economic fabric integral to how families balance work, income, and child development.

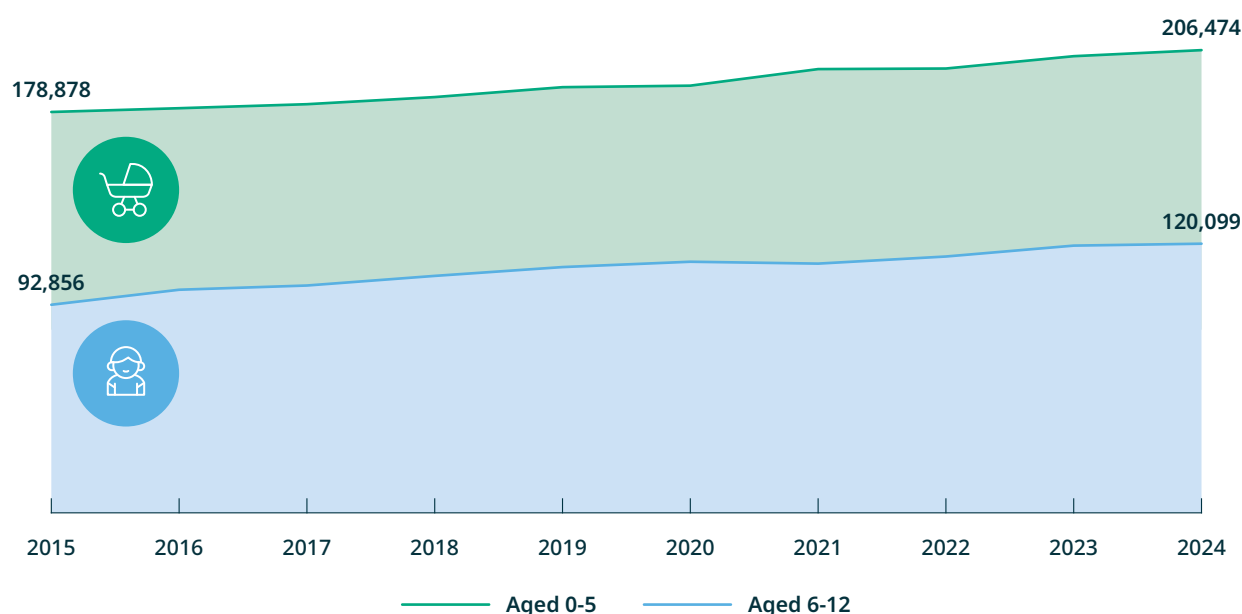
Data from the Productivity Commission shows the increasing number of Australian children attending ECEC services.

Figure 3: Proportion of Australian children attending ECEC, 2015 to 2024³



The most reliable data pertaining to the number of Queensland children attending ECEC is from the Productivity Commission. The data includes the proportion of all children attending government-approved childcare services in Queensland based on financial year.

Figure 4: Queensland children attending ECEC⁴



This growth of the ECEC sector is not unique as a social phenomena. Throughout the last 30 years the care industry has increasingly been privatised and professionalised, and similar trends in growth and use are visible in aged care, and disability care.

It should not be lost on us that as the modern family has increasingly outsourced care to private sector operators, the growth in concerns has grown with both the disability and aged care sectors subject to royal commissions regarding their safety and quality in the last 10 years.

Designing child-protection responses in today's context

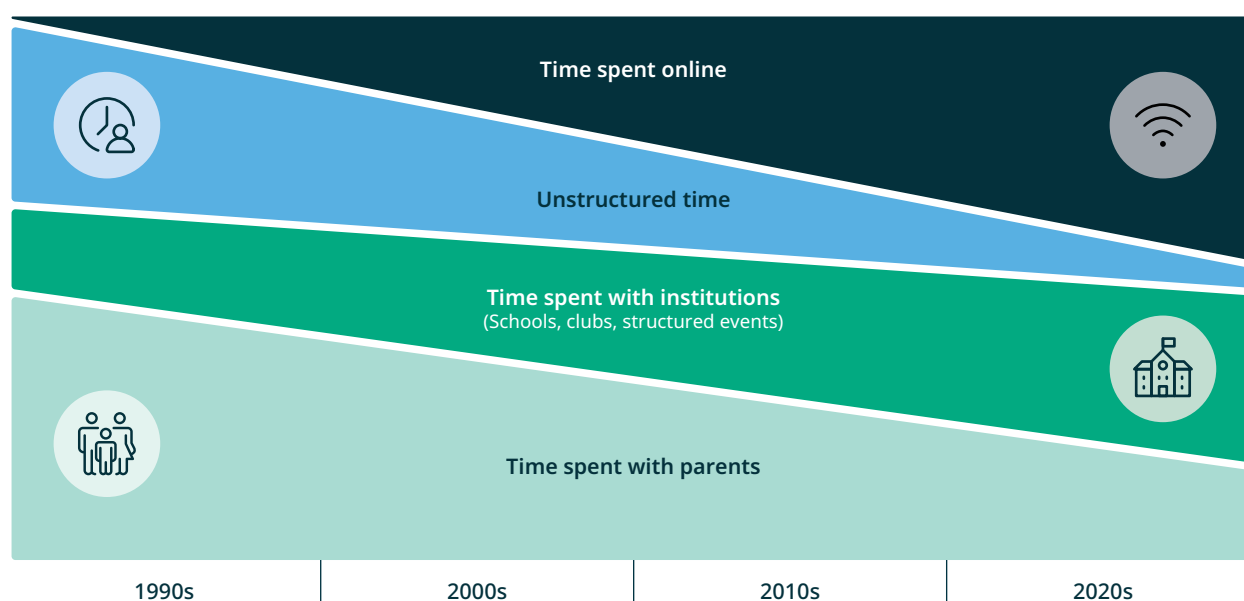
It is within this changing family and social context that our future plans to better protect children must be designed. While there is no single, universal dataset that captures every dimension of children's daily lives, a convergence of high-quality indicators—national time-use surveys, child-safety and digital-use research, early childhood participation statistics and international reviews—points to four intertwined shifts that are highly relevant for protection policy and practice. These shifts should be treated as working premises when designing prevention, supervision and safeguarding systems.⁵

- 1. Children are spending more time online:** Multiple Australian sources show growing online engagement among children, with recent national surveys documenting expanding use of internet-enabled devices and new patterns of digital interaction including social media, games with social functions, streaming and user-generated platforms. These patterns increase exposure to online harms, including cyberbullying, sexual exploitation, image-based abuse and algorithmic risks, while also changing where and how children socialise and learn. Policy responses therefore need to incorporate online safety as a core element of child protection—not an add-on—including proactive digital literacy, industry regulation, platform accountability and education for parents and carers.⁶

2. **Children are spending less time in local, unstructured community activities:** A growing body of research internationally and in Australia describes a decline in unstructured outdoor play and informal neighbourhood activity among children. Longitudinal studies link reductions in free, peer-led play to losses in self-regulation and social learning, while broader social trends, including urbanisation, parental work patterns, traffic and safety concerns, erode opportunities for spontaneous community interaction. Reduced presence in local, informal settings changes where protective observation and informal oversight typically happen, meaning fewer 'neighbourhood eyes' and fewer casual opportunities for concerns to be noticed and reported. Safeguarding strategies should therefore consider how to rebuild safe, accessible, informal spaces, and how to reach children whose lives are increasingly structured around formal care and online environments.⁷
3. **Children are spending less time with their parents in direct, day-to-day contact:** Time-use data shows that parents, especially mothers returning to paid work, are spending more hours in employment, and for many, less time available for day-long caregiving. The ABS Time Use Survey documents how parents' schedules have shifted, with implications for direct, informal supervision and opportunities for parent-child interaction during the working day. This shift does not imply lower parental care or concern; rather, it alters the contexts in which parenting occurs and places greater reliance on formal and substitute caregivers to meet children's day-to-day needs and to act as potential reporters or detectors of harm. Policy and practice must therefore strengthen partnerships between parents, employers and care providers to ensure continuity of protection across settings.⁸
4. **Children are spending more time in the care of institutions and companies:** Australian administrative data and national childcare reporting show that a large and growing share of children attend approved ECEC services for substantive portions of each week with average weekly attendance measured in many tens of hours for children aged zero to five. National program statistics and Organisation for Economic Co-operation and Development comparative work indicate that formal care is now a mainstream component of many families' daily rhythms. As a result, institutional settings, including long day care, outside-school hours care, and preschools, have become central arenas for both everyday child development and for the identification, reporting and prevention of harm. This trend makes the quality, regulation, and safeguarding practices of those services and the regulatory systems that oversee them a frontline child-protection concern.⁹

It is within this context that our future plans to better protect children must be designed.

Figure 5: Changing patterns in how children's time is spent, 1990 to 2020



Part

A

Examining the context

Are our children safe?

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Are our children safe?

Child sexual abuse in contemporary Australia

Despite increasing attention and investment by government, the media and the community more broadly, we still do not have a strong foundation to understand or respond to child sexual abuse.

Under the Review terms of reference, the Child Death Review Board (the Board) was tasked with identifying the context of child sexual offending in Queensland, including historical and current rates of extra-familial offending and changes in our understanding of the nature of this offending. This has not been an easy task.

There is no single dataset that provides a longitudinal view of child sexual offending at a state or national level. The data that is publicly available is high level and fragmented. While it tells us part of the story, it does not represent a complete picture of what is happening in Queensland.

Most available data is administrative and drawn from government systems. This means it is not always fit for purpose and can be difficult to extract and analyse. While some self-report surveys are available, these often provide us with a point in time snapshot. This limits the translatability of findings over time or with different cohorts.

Challenges also exist with the methods and quality of studies that attempt to generate reliable data on prevalence, including the use of instruments which do not have demonstrated validity and reliability, and the use of questions that are too vague, narrow or otherwise inappropriately constructed to capture nuanced and accurate data.¹⁰

Community understanding of child sexual abuse has changed over time. The Royal Commission into Institutional Responses to Child Sexual Abuse (the Royal Commission) of 2017 helped lift Australia's understanding of the historical risks and damage caused by abuse, and the landmark 2023 Australian Child Maltreatment Study (ACMS) shocked the community by confirming the ongoing rates and prevalence of child sexual abuse today.

During the conduct of this Review the community conversation was amplified because of similar high-profile matters occurring in other jurisdictions in early child education and care (ECEC) settings. This has resulted in urgent calls to act to tighten regulation and reduce vulnerabilities in this sector. While this report similarly considers these vulnerabilities it also addresses a confronting but critical truth that we must contend with and that this review has laid bare:

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Child sexual abuse is occurring at far higher rates, in more common places, and to children closer to us than the community expects.

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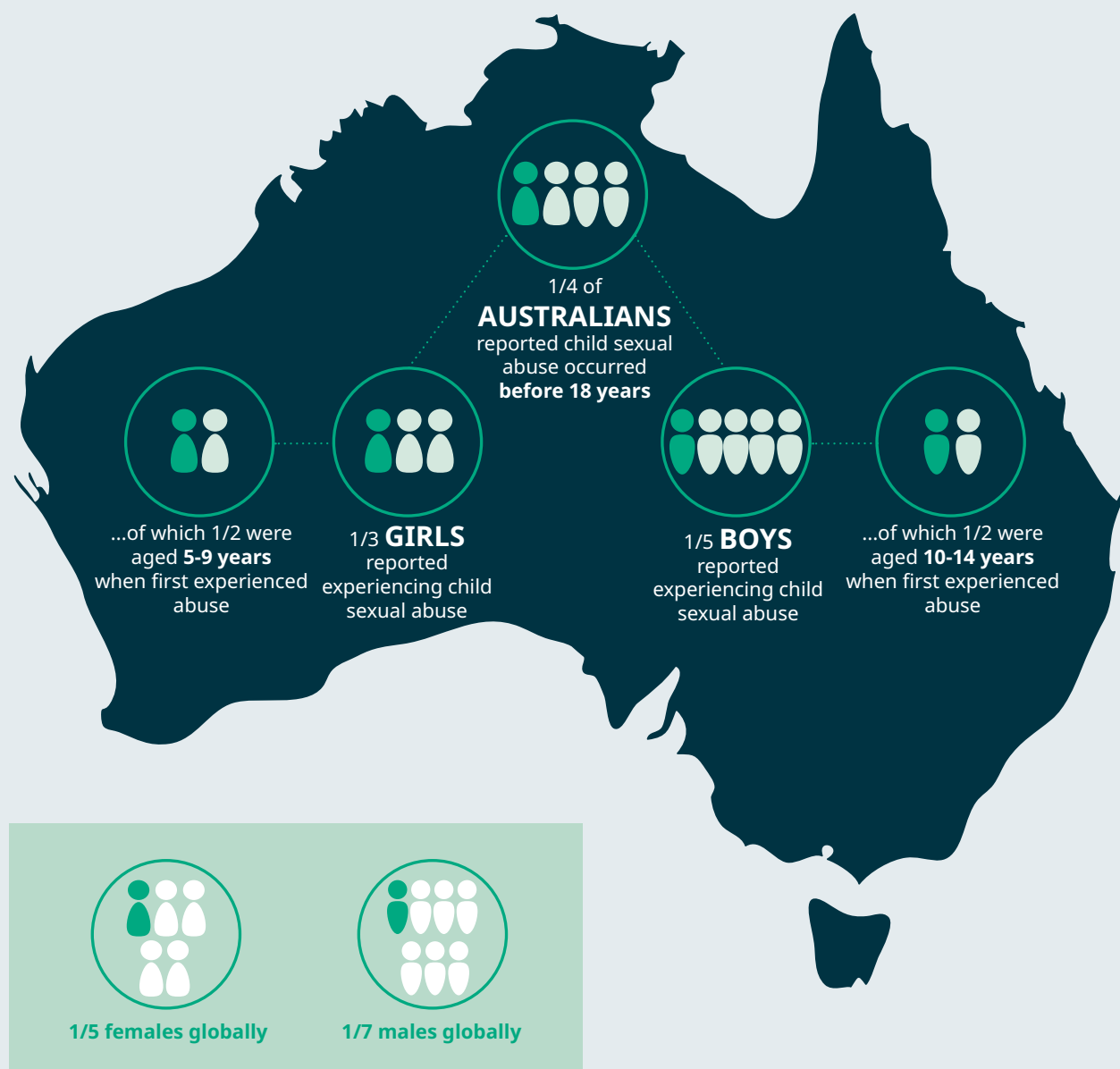
Prevalence of child sexual abuse

There is no single public source of data that shows the true prevalence of child sexual abuse in Queensland or Australia, the proportion of cases that come to police attention, or the number of matters that are prosecuted. Concerns with the lack of data have been raised previously, with the Royal Commission's Final Report stating:

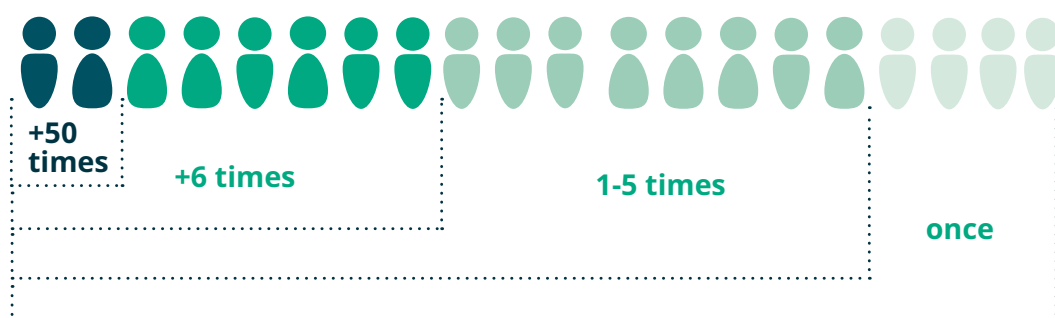
Without this data, policymakers and researchers are not able to measure the effectiveness of policy interventions designed to protect children. Without a nationally representative prevalence study, it will not be possible to determine how the extent of child sexual abuse in institutional contexts changes over time, or to compare the prevalence of child sexual abuse in Australia to other developed countries¹¹.

A desktop analysis of public data sources relating to child sexual abuse was completed to inform the Review, which was supported by engagement with Professor Ben Mathews from the Queensland University of Technology about the ACMS. Data was also requested from the Queensland Police Service (QPS), Queensland Courts and the Australian Centre to Counter Child Exploitation (ACCCE) to try and piece together a full picture of the prevalence of child sexual abuse in Queensland and nationally.

Reported experiences of child sexual abuse



Frequency of abuse



**Sourced from UNICEF, Australian Child Maltreatment Study and Australian Bureau of Statistics*

Reports, charges and prosecutions of child sexual abuse offences

We know that most child sexual abuse offences are never reported to formal services like police or courts. The Australian Institute of Family Studies told the Review that:

The sensitive nature of child sexual abuse means that victims and survivors may be reluctant to disclose their experiences. A recent study found that disclosure of child sexual abuse in Australia has been infrequent, with only 54.8% of all those who experienced [child sexual abuse] ever telling anyone anything about it.

There are a range of cultural, economic, societal, religious, familial and institutional factors, alongside recollection and detection challenges, that likely contribute to underreporting of child sexual abuse.

Underreporting is particularly likely for men and for victims and survivors who experienced child sexual abuse perpetrated by a parent or adult family member, a caregiver in an institutional setting, or a known adolescent they were romantically involved with.

There are multiple and intersecting barriers to reporting faced by victim-survivors. Reporting may be delayed, it may occur in a staged way, or victim-survivors may not feel safe to disclose a full account of the abuse they have experienced. Where a victim-survivor's initial disclosure is not believed or supported they are less likely to seek help or try to report the abuse in the future or to other people.

Of the offences that are reported to police, most will never proceed to the conviction of a perpetrator. An inability to meet the requisite threshold to prove an offence beyond a reasonable doubt is a key barrier in pursuing child sexual offences through the criminal justice system. This does not mean that the offence did not occur.

The threshold for pursuing matters through the criminal justice system is high. The result however is difficult to contend with, as the reality is that most perpetrators may never come to the attention of the law, or be held to account for the abuse they have committed.

It is impossible to piece together a full picture of how many instances of child sexual abuse are reported, charged and prosecuted when using publicly available data. Information provided by the QPS, Courts Services Queensland and the ACCCE has helped the Board develop an understanding of child sexual abuse reported to or detected by law enforcement entities or dealt with by the court system.

Prevalence of child sexual abuse in the public narrative

Most people do not directly observe the justice system and instead rely on the media to communicate about it. The media's reporting, including tone, framing and frequency, strongly influences how people perceive crime, and its severity.

As part of this review, we completed a desktop analysis of Queensland media reports relating to child abuse, including sexual, physical and online offences. This analysis provides insight into patterns of prevalence and information informing public awareness. Media coverage, while not a complete or definitive source of data, provides a valuable lens through which the scale and nature of child sexual abuse is discussed in the public domain and provides insight into the narrative built around child sexual abuse that feeds the public's understanding.

The aim of this methodology was twofold:

1. to identify the extent to which incidents of child sexual abuse are visible in the public sphere
2. to understand how media narratives shape perceptions of prevalence, accountability, and institutional responsibility.

While official statistics and administrative records remain the most reliable indicators of prevalence, they are often fragmented, delayed, or inaccessible. By contrast, media reporting reflects cases that penetrate the threshold of public attention, usually because of the seriousness of allegations, the involvement of institutions, or the criminal justice outcomes, and the emotive public response that cases can evoke.

Our analysis focused on Queensland-based offending, reported in Australian media outlets across print, online and broadcast platforms over the duration of the review period (1 January to 23 October 2025). Media items were identified through keyword searches (e.g. child sexual abuse, child exploitation) using a media monitoring database. While some cases were reported across multiple outlets, our analysis counted only the individual perpetrators involved. In this sense, our analysis represents not the volume of overall reporting, but the individual cases reported.



Data snapshot: Reports, Charges and Prosecution Data



Between 2015–16 and 2024–25, 43,812 child sexual abuse offences were reported to or identified by QPS. Of the offences that were reported to QPS, 80 percent did not proceed to an arrest, notice to appear, summons, or other criminal justice outcome.

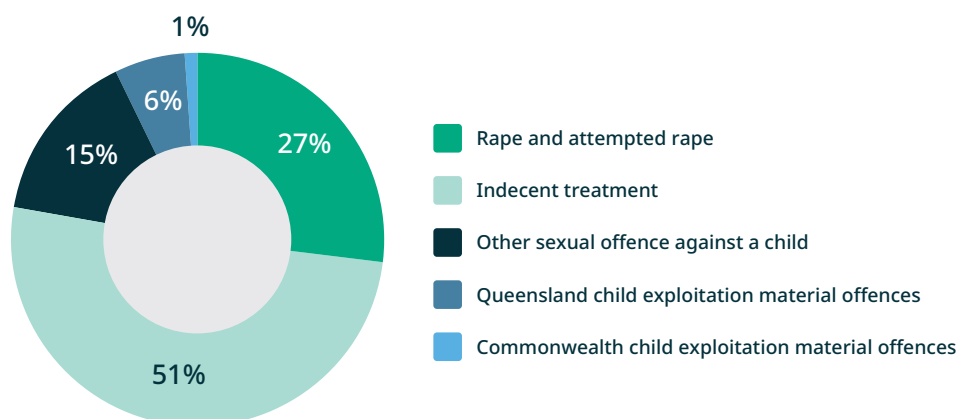


The majority of these offences (approximately 51%) were classified as indecent treatment offences.



15 per cent of sexual offences were not classified as rape, indecent treatment or child exploitation material (CEM) offences. These include offences against a child such as unlawful carnal knowledge, sexual assault, and certain offences involving the taking or distribution of intimate images.

Figure 6: Proportion of all child sexual abuse offences reported to QPS between 2015–16 and 2024–25 (n=43,812)



Between 2016 and 2025, approximately 82 per cent of victim-survivors were girls.



Between 2016 and 2025, nearly one in five victim-survivors were aged under five- years (14.7%). Nearly one in two were younger than 12-years (48.5%).



In 2024–25, ACCCE received 82,764 reports of online child sexual abuse.
 • 96.1 per cent of reports in 2024–25 were received from the National Center for Missing and Exploited Children (NCMEC).



In Queensland in 2024, ACCCE made 327 referrals to Queensland law enforcement. These included:

- 47 referrals for Joint Anti-Child Exploitation Team investigations
- 196 QPS Child Protection Investigation Unit referrals
- 84 requests to QPS for welfare checks.

Findings from the media analysis were not treated as a definitive prevalence measure but as an important supplementary source. They helped the Board to:

- illustrate the gap between actual prevalence (as indicated in research and administrative data) and what is visible to the public
- identify recurring institutional contexts where abuse was reported
- understand how public awareness of child sexual abuse is shaped by the media environment.

This approach allowed us to situate official data and stakeholder evidence within a broader societal context, acknowledging that media coverage plays a powerful role in defining public understanding of child sexual abuse.

The analysis recorded 129 events of child abuse reported in Queensland over the period of our review. This represents one case reported every two days. This is well below the actual number of offences that occur in Queensland, but remains shocking.

Of all child abuse cases, 114 related to child sexual abuse, and almost three-quarters of those involved online child sexual exploitation and CEM.

While the vast majority of child sexual abuse perpetrators were male (94%), other demographics were broad: ages ranged from between 19 and 98 years and professions spanned the employment spectrum, including volunteer, community, blue- and white-collar workers, public servants, and executives. Over the review period, cases we recorded included:

- **A 50-year-old senior banking executive** was charged with using electronic communication to procure an under-aged girl for sex in a Brisbane hotel room.
- **A 26-year-old surfing coach** from the Sunshine Coast was arrested on 33 charges including indecent treatment of children, wilful exposure, using a carriage service to access child abuse material, and grooming.
- **A 43-year-old former employee of Queensland's Department of Education and Corrective Services** was convicted of possessing more than 2000 CEM files, including hundreds of the worst category.
- **Four cases of police officers** possessing CEM. The offenders ranged in ages between 21 and 54 years.
- **A 50-year-old former sports coach** from Townsville filmed three children using a hidden mobile phone, with the intention to distribute to others.
- **A 21-year-old former Scouts Queensland leader** was arrested on suspicion of looking at children in a campground bathroom in Landsborough, north of Brisbane, and taking underwear from their tents. He was charged with 17 offences including unlawful entry, stalking, indecent treatment of children, and observations in breach of privacy.
- **A 30-year-old teacher** from Brisbane was charged with 25 offences against children interstate, including grooming, using the internet to procure children, and possessing CEM. Media reports indicate he was dismissed from his employment when the allegations came to light, and his teacher registration suspended two days later.
- **A 51-year-old journalist** from Brisbane was charged with more than 60 offences relating to CEM. He was also charged with three counts of failing to comply with reporting obligations and one count of giving false or misleading information. He was accused of allegedly failing to notify about a device, social networking site and carriage services.
- **A former youth worker in his 20s** was charged with possession of more than 2000 CEM files which the magistrate described as "some of the worst examples of this material" and which featured children from infancy upwards. He was also charged for filming himself molesting a four-year-old boy and sending the footage to an online contact. He received a nine-year jail term but is eligible for parole 10 months after sentencing, with two years spent in pre-trial custody considered time already served.
- **A 43-year-old Gladstone man** was charged with possessing CEM after police found images on his device while investigating him for strangulation (domestic violence offence). His previous criminal history included an assault occasioning bodily harm. While the judge described the CEM as "pretty sick stuff" the offender was sentenced to two and a half years' jail, suspended for five years, with 302 days' pre-sentence custody considered time already served.
- **21-year-old childcare worker** was charged with indecent treatment of a four-year-old child in a centre where he worked. He had a current and valid Working with Children Check. He was given conditional bail ahead of his court appearance.
- **A 51-year-old former swim coach** who pleaded guilty to eight sexual offences including trying to procure a 13-year-old for sex acts while already on bail, avoided a jail term and having any convictions recorded.

While the offences in these cases were not dissimilar, the coverage was hugely varied. The media tends to report on cases considered exceptional, rather than typical or common. While 114 reports of child sexual abuse were recorded across the period, our analysis found media coverage in most cases was limited to the local or regional area in which the case occurred. Generally, only high-profile cases—which are often characterised by a high number of victim-survivors or offences or by unusual demographics of the perpetrator—gain extensive state-wide or national attention across media outlets. This means the public is unlikely to appreciate the true prevalence of child sexual abuse, nor have an informed understanding of the circumstances in which it occurs. These high-profile cases are also likely to contribute to the public's misconception that child sexual abuse cases are extraordinary, misconstruing how common or statistically representative a case may be.

Very few cases of intra-familial child sexual abuse were reported over the period. This under-reporting may be due to sensitivity around these cases, or courts suppressing the release of details to media to protect the identities of victim-survivors and families involved. Evidence shows that most child sexual abuse is perpetrated by a family member or someone known to the child. The media under-reporting is likely to influence the public's understanding and awareness of the contexts and settings in which child sexual abuse commonly occurs.

Public perception about the severity of a crime can be influenced by media reports of sentencing. Around half the items recorded in our analysis reported on perpetrators' sentences. Most sentences included probation, suspended sentences, and imprisonment of between one and six years, although most jail sentences were reported to be suspended or perpetrators time awaiting sentencing was declared time served. The cases involving CEM were particularly insightful, particularly those where perpetrators were found guilty of possessing, creating and sharing hundreds of images and files, which extended into the thousands in some cases.

We recorded three cases of perpetrators possessing up to thousands of CEM files that were classified as the worst category:

- ***One perpetrator received no jail term and was released on a two-year probation order.***
- ***Another was sentenced to 18 months' jail, suspended after four months, receiving two years' probation and a three-year \$500 good behaviour bond.***
- ***The third was sentenced to five years' jail and eligible for parole within five months, after serving one-third of his sentence, with his pre-sentence custody declared as time already served.***
- ***A former sports coach was sentenced to four and a half years' jail, which was suspended, and he was given probation of two years. The judge recognised his pre-sentence custody as time already served, and he was returned to the community immediately.***

While sentencing is a matter for the courts, it's important to consider how this information contributes to the story told about the severity of child sexual abuse and the consequence for action, particularly those reported as extreme.

Finally, almost all reports we recorded were factual accounts of the criminal justice process and no reports featured perspectives from victim-survivors. While this is not always possible or appropriate in media reporting, the effects need to be highlighted. An absence of victim-survivors' perspectives can perpetuate the stigma known to exist around child sexual abuse. Victim-survivors are more likely to speak about their experiences if they see stories validating their experiences.

Media plays a critical role in shaping public opinion and its influence should be harnessed. Child sexual abuse is grossly under-reported in the media when compared with its actual occurrence, which can contribute to a distorted public perception of the facts. This includes the misplaced focus on stranger-danger or sensationalised stories that have greater news appeal, which can misrepresent the fact that most abuse is perpetrated by someone known to the child. Media can be a critical opportunity for public education about the warning signs of child sexual abuse, including grooming, as well as an opportunity to promote prevention strategies and reduce stigma for victim-survivors.

While the media plays a vital role in raising awareness of child sexual abuse and compelling institutional accountability, its coverage is often incomplete and sensationalised. This creates a significant gap between victims' experiences and what the public understands to be true — a gap that has real consequences for prevention, justice and healing.¹²

Australian's attitudes, knowledge and response to child sexual abuse

Although recent research and media reporting have heightened public awareness that child sexual abuse is prevalent in Australia, there remains a significant gap in understanding its impact. Many Australians accept that such abuse is not rare, yet the depth of its consequences on children's health, development, relationships, and long-term wellbeing remains less well appreciated. This is compounded by a striking dissonance in community attitudes. Most Australians (89%) agree there are many more victim-survivors in the community than people realise, and similarly high numbers (86%) acknowledge that child sexual abuse is more common than is generally understood¹³. A majority (62%) even recognise it is likely that someone they know has experienced abuse. Yet more than half (56%) do not believe child sexual abuse happens where they live¹⁴. This tendency to view the problem as distant—prevalent but not proximate—creates barriers to honest dialogue, limits community ownership of the issue, and risks reinforcing stigma and silence for those living with its effects.

“

Too often, child sexual abuse is viewed as rare, exceptional, or confined to particular settings, rather than recognised as a significant and systemic issue. This warped understanding has consequences: it dulls the urgency of reform, diminishes support for victim-survivors, and allows the conditions that enable abuse to remain insufficiently challenged.

”

Understanding of child sexual abuse

Child sexual abuse can occur in any institution where children are present, however, research indicates that certain factors can increase the likelihood of abuse occurring. While the presence of these risk factors does not guarantee that abuse will occur, early childhood education and care (ECEC) institutions and other organisations responsible for children should assess the risks relevant to their context and implement targeted strategies to mitigate them.

Research highlights how opportunity for abuse in ECEC settings and similar institutions is shaped by imbalances of power among children, parents, staff, the local community, and external regulators. Perpetrators often actively identify and exploit vulnerabilities in both children and their environments as part of their offending patterns.

While child sexual abuse reporting generally rises with age, with most reports received for children between the ages of eight and 15, preschool-aged children are particularly vulnerable to abuse due to their developmental stage, characterised by:

- emotional dependence
- need for personal/intimate care
- limited cognitive capacity
- physical vulnerability
- inability to recognise and report sexual abuse.

These factors contribute to a significant power imbalance between young children and perpetrators that is further amplified in contexts where situational and systemic factors reduce protection or increase access. Individual, situational and contextual risk factors intersect as perpetrators exploit specific characteristics or circumstances that facilitate abuse.



Data snapshot: Community awareness of child sexual abuse

The Australian child sexual abuse attitudes, knowledge and response study developed by the National Centre for Action on Child Sexual Abuse is the first of its kind in Australia. It investigated the knowledge, attitudes and responses of a community sample on child sexual abuse topics of 4,055 Australian adults including 601 Queenslanders. This survey, conducted in December 2023, found that the community recognises that child sexual abuse is a prevalent and current issue.

Survey participants reported a relatively accurate understanding of prevalence and reported that they believed that 21 per cent of boys and 33 per cent of girls experience child sexual abuse. For both boys and girls, most participants believed the main abusers were parents or stepparents (**43% for boys, 55% for girls**), or other relatives (**44% for boys, 51% for girls**), and that children were more at risk in their own home or in the homes of relatives or friends.

Key findings of the survey included:



Most participants (**89%**) agreed or strongly agreed there are more victim-survivors than people realise.

Similarly high numbers (**86%**) agreed or strongly agreed that child sexual abuse is more common than people realise.

Many people (**62%**) thought it was likely, very likely, or certain that someone they knew had experienced child sexual abuse.



Despite this, over half (**56%**) did not agree that child sexual abuse happens where they live.



Participants reported that their awareness of abuse most commonly came from the media (**81%**) or social media (**37%**).

Australians also reported wanting more action from government. 83 per cent of participants agreed that governments should do more to respond to the needs of victim-survivors.

There was evidence of victim-blaming or problematic attitudes towards victim-survivors, particularly teenagers. As an example, 40 per cent of participants believed that older children have a responsibility to actively resist adults' sexual advances.

Further analysis also showed that people who work with children scored higher on myths and harmful attitudes than those not working with children. Parents and carers, and victim-survivors of child sexual abuse held less harmful myths and attitudes than others.

While around half (48%) of participants agreed they know what to do to keep children safe, about 80 per cent agree there are things we can do as a community to reduce child sexual abuse. Most participants agreed it would be helpful to have greater community awareness about grooming indicators (81%) and more public awareness campaigns about how to prevent child sexual abuse (78%).

Most participants also agreed it would be helpful if:

The survey also showed that the community is unsure if perpetrators can be rehabilitated, however, about two-thirds believe that perpetrator focused services would be helpful in preventing child sexual abuse. This includes for **adults at risk of perpetrating child sexual abuse (68%)** and for **young people who display harmful sexual behaviour (77%)**.

Known risk factors for child sexual abuse

Research shows that there are a number of factors that may increase a child's risk of experiencing sexual abuse or increase the risk of child sexual abuse occurring. Many of these factors, especially individual and family factors, are characteristics or circumstances that cannot be or are not easily changed.

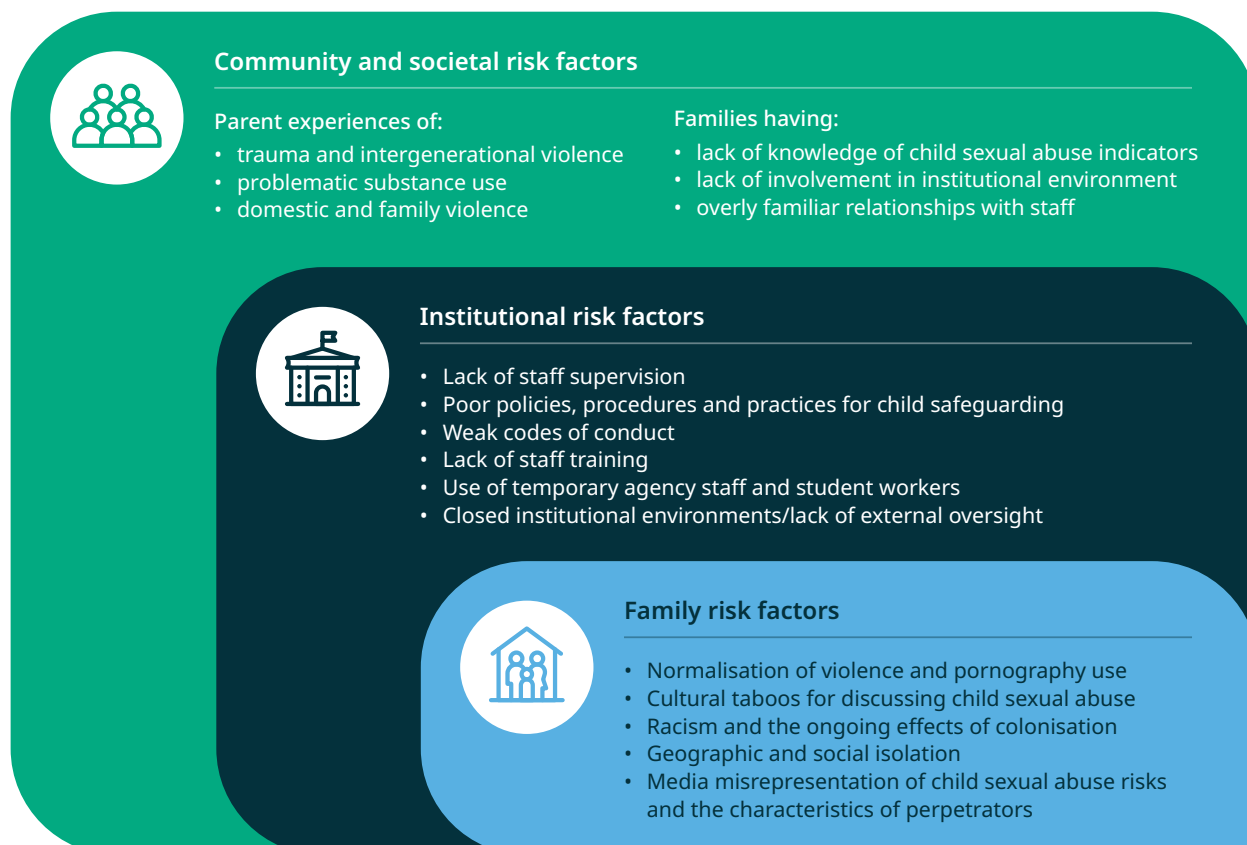
The sex of a child is a significant and consistent risk factor for child sexual abuse, with girls being up to three times more likely than boys to experience abuse. This disparity is evident even among preschool-aged children. A 1998 study found that, of 1,639 children sexually abused in daycare settings, 62 per cent were girls and 38 per cent were boys.¹⁵ Likewise, research from 2001 reported that 60 per cent of the 74 victims aged two to five were girls.¹⁶ The Royal Commission also found that the majority of survivors whose abuse began in childcare settings were female (62%).

Furthermore, children with a disability are 3.4 times more likely to be subjected to sexual abuse than their non-disabled peers, with preschool-aged children facing the highest rates of abuse among all age groups of these children.¹⁷ Perpetrators may deliberately target children with disability, as certain aspects of their support needs can make the abuse less likely to be detected. These factors include increased dependence on caregivers for personal care and greater difficulty in recognising and/or disclosing abuse, particularly among children with:

- visual impairment
- hearing impairment
- cognitive impairment
- behavioural disability.

It is important to understand that risk factors are not the cause of child sexual abuse. While a person may identify with or experience circumstances or characteristics that heighten their risk of experiencing child sexual abuse, the offender is always responsible for the abuse regardless of how many risk factors are present. Perpetrators target children with identified risk factors to increase their opportunity to offend and to remain undetected.

Figure 7: Risk factors for child sexual abuse



Online environments

Over the past 20 years, access to the online environment has increased for all Australians, including children. Between 2004–05 and 2016–17, the percentage of Australian households with access to the internet increased from 56 to 86 per cent. For households with children under the age of 15, 97.1 per cent have internet access. 98 per cent of 15- to 17-year-olds used the internet, compared to 55 per cent of those aged 65 and over.¹⁸

Increased access to social media, online games, chat rooms and forums and encrypted messaging apps has allowed children to communicate with known, unknown and anonymous people. This can occur with limited to no supervision or knowledge by parents and guardians. This provides a perfect opportunity for perpetrators to target children and create opportunities for abuse to occur through grooming, coercion and extortion.

“*Child sexual abuse has always been a complex, murky, widespread problem. Thanks to the unbridled technological evolution, the nature and scale is worsening by the minute.*¹⁹

”

There is a growing body of evidence suggesting a pathway between the consumption of particular types pornography and the escalation to CEM for some individuals. While not all people who view pornography progress to illegal behaviours, research indicates that regular consumption can desensitise individuals to extreme or violent sexual content. This desensitisation can create a tolerance effect, where increasingly explicit or taboo material is sought to achieve the same level of arousal. For a minority of users, this trajectory can extend into accessing CEM, representing a significant public safety risk. A study conducted by Childlight of approximately 4900 men across Australia, the United Kingdom and the United States of America found that as the frequency of pornography watching increased, the probability of child sexual offending also increased. It found men who watched rough or violent pornography were 4.91 times more likely to commit a child sexual abuse offence.

The accessibility of online pornography has amplified these risks. With vast volumes of content freely available and algorithms designed to encourage continued consumption, users may be inadvertently exposed to content that normalises harmful behaviours. This can foster distorted beliefs about sexuality, consent, and the acceptability of taboo material. In some cases, curiosity about 'forbidden' material, particularly when combined with pre-existing risk factors such as deviant sexual interests, trauma history, or social isolation, can lower inhibitions and act as a stepping stone to viewing CEM.

“*Prepubescent children represent the largest group depicted in [CEM]; however, determining the specific proportion of preschool-aged children is challenging due to variations in age categories and the different [CEM] detection methods employed across various reporting systems.*

”

A recent report by the New South Wales Parliamentary Standing Committee on Social Issues, *Impacts of harmful pornography on mental, emotional, and physical health*, found most boys by the age of 13 years have interacted with pornography in some way, and girls soon after. Pornography is considered harmful when problematic themes are normalised, such as violence, misogyny, a lack of consent, racism, and illegal activities such as child abuse and incest. Exposure to this content may lead to unhealthy social and intimate relationships, sexual objectification of women, and in some instances the exploitation of children.

Law enforcement agencies and child protection experts have repeatedly highlighted this progression. The QPS note that a proportion of offenders under investigation for CEM began with adult pornography use and escalated over time to illegal material. This is reinforced by international research showing that online forums and dark web communities actively encourage progression, with perpetrators often reporting that their first access to CEM followed a period of escalating pornography use.

Recognising this pathway is essential for prevention. Education about healthy sexual development, early intervention programs for individuals displaying concerning patterns of pornography use, and stronger regulation of online platforms are all critical steps. By addressing the risk factors that may drive escalation, from pornography to CEM, systems can reduce the likelihood of children being harmed and intervene earlier in the cycle of offending.

Reported child sexual abuse in the online environment



The Childlight - Global Child Safety Institute estimates that in the past year, **over 300 million children** were subject to abuse behaviours online.²⁰

eSafety reported that close to **half of young people aged 14–17** in Australia had received a sexual message from someone online in the past year.²¹

Conversations with children on social gaming platforms can escalate into high-risk grooming situations **within 19 seconds**, with an average grooming time of **just 45 minutes**.²²



According to the Internet Watch Foundation (IWF), the most severe category of CEM has **doubled since 2020**.²³

Quarterly sextortion reports to eSafety **increased from 600 in 2022 to 1700** in the same quarters of 2023.²⁴



In 2022, the IWF confirmed a total of **255,570 URLs** contained images or videos of children suffering abuse.²⁵



Available data indicates that reports of sextortion to the eSafety Commission have **increased 1,300 per cent** since 2018.²⁶

Harm in the digital world

1. **Exposure to harmful sexual content:** Widespread availability of violent and degrading pornography and CEM normalises harmful behaviours and distorts children's understanding of healthy sexuality and consent.
2. **Online grooming:** Among the most frequently reported harms, offenders use digital platforms to build trust with children to facilitate sexual exploitation, both online and offline.
3. **Self-generated sexual content:** Children are pressured, coerced, or encouraged to create explicit material, often believing they are in a relationship or under threat of exposure.
4. **Image-based abuse:** Non-consensual sharing of intimate or sexual images, or threats to share them, is a highly prevalent form of abuse with severe psychological and reputational impacts.
5. **Sexual extortion (sextortion):** Increasingly reported by AFP and eSafety, offenders blackmail children with threats to release explicit material unless further content, sexual acts, or money is provided.
6. **CEM:** The possession, sharing, or creation of CEM remains a core offence type, with large volumes distributed through the dark web and encrypted platforms.
7. **AI-generated abuse material:** An emerging harm, where artificial intelligence is used to create or "deepfake" images and videos of child sexual abuse, sometimes based on real children.
8. **Live-streamed abuse:** Real-time exploitation of children, frequently organised and paid for by offenders, though less prevalent than image-based or grooming offences.
9. **Sadistic or extreme exploitation:** A smaller but deeply harmful category, involving organised online communities coercing children into producing increasingly violent or degrading content.
10. **Peer-to-peer exploitation:** The trading of CEM across networks, sometimes involving young people themselves. While less visible, this reflects both offender activity and the complicity of peers.

A new and rapidly emerging risk in the online child abuse landscape is the creation of deepfake or AI-generated CEM. Using artificial intelligence, perpetrators can now produce realistic images, videos, or audio that appear to depict children in sexual contexts, even where no direct abuse of a child has occurred. This technology poses multiple dangers: it can be based on real children's likenesses, creating unique harms for victim-survivors whose images are manipulated; it lowers the barriers to offending by allowing individuals to create CEM without physical contact with a child; and it fuels demand within perpetrator communities for increasingly extreme or novel material. Law enforcement agencies and child protection experts warn that this development expands the scale of harmful content online, and risks normalising abusive behaviour in ways that can escalate to contact offending. In 2024 global reports of AI-generated CEM increased by 1325 per cent from the previous year²⁷.

“App stores are brimming with AI tools that enable instantaneous, prolific creation and distribution of increasingly realistic material. So-called “fake” content isn’t victimless; it is trained on images of real children — not to mention it also extends the limits of violence.”²⁸

An emerging concern in online child safety is the use of AI-powered chatbots and conversational tools by perpetrators to groom children. Perpetrators are increasingly experimenting with generative AI to simulate the tone, style, and interests of peers in order to build trust with young people. These tools can operate at scale, enabling an offender to engage with multiple children simultaneously, while also masking linguistic errors or behavioural cues that might otherwise raise suspicion. In some cases, chatbots can be customised to sustain long-term grooming conversations, reinforcing deception and emotional manipulation. The risk is heightened by the ability of AI systems to access, adapt, and respond instantly, making them powerful tools for social engineering. Experts warn that this technology could significantly expand the reach of grooming behaviour, increase children’s vulnerability in online spaces, and create new challenges for detection and law enforcement.

“Offenders are prompting software to automate grooming and advise them on how to avoid detection, and innovators are prioritising profit over protection as they rush to establish market dominance in a lawless, borderless domain. There is no ceiling for depravity.”²⁹

The Darknet

The darknet is the part of the internet that is intentionally hidden and cannot be accessed through standard web browsers or search engines. It exists on encrypted networks, most commonly accessed using specialised software such as Tor (The Onion Router) or I2P (Invisible Internet Project), which anonymise users’ identities and locations. Unlike the ‘surface web’ (websites indexed by Google and other search engines) and the ‘deep web’ (online content behind logins, databases, or paywalls), the darknet is designed to provide privacy, secrecy, and anonymity. While it has legitimate uses including protecting political dissidents, journalists, or whistleblowers from surveillance, it is also widely used for illegal activity. This includes black markets for drugs, weapons, and stolen data, as well as forums and marketplaces for CEM, grooming networks, and live-streamed abuse.

The anonymity offered by the darknet lowers the risk of detection, meaning perpetrators view it as a safer place to access CEM. The darknet also allows perpetrators to share information on offending methodologies and concealment. These communications can occur on online forums, which act not only as repositories of information but also as a place for pro-offending views to be propagated.³⁰

A recent survey of 1,546 CEM users on the darknet found 42 per cent had communicated with other CEM viewers³¹. It is therefore important to understand how child sexual abuse perpetrators engage with each other on the darknet, as this will help inform detection and intervention. Several studies have analysed darknet chat forums focused on child sexual offending, finding that users of such forums develop their own culture that can normalise, justify and endorse offending against children. In support of such findings, a survey of 459 individuals in the community found those who had visited online chat forums that discussed child sexual abuse were significantly more likely to report intentional viewing of CEM after first exposure than those who had not visited these online forums.³²

Technology itself has no moral compass; it is a tool that can be harnessed for immense social good or exploited for profound harm. The same digital innovations that connect communities, expand knowledge, and foster creativity can also be manipulated by those with criminal intent to exploit and abuse children. This reality demands that we remain vigilant, informed, and adaptive in our responses.

Safeguarding children in the digital world requires not only awareness of the evolving risks but also a commitment to innovation, developing smarter protections, stronger systems of accountability, and resilient support structures that ensure technology serves the best interests of children rather than those who would do them harm.

Conclusion

The evidence is clear: child sexual abuse in Australia is not rare or exceptional, it is widespread and persistent. Prevalence studies, administrative data, and victim-survivor accounts all converge on the sobering truth that many thousands of children experience sexual abuse, often at the hands of trusted adults or peers. While prevalence estimates vary depending on methodology, the weight of the evidence establishes that child sexual abuse is a common reality in the lives of Australian children.

Yet prevalence data only tells part of the story. Detecting and responding to child sexual abuse is uniquely complex. Victim-survivors may be too young to disclose, too fearful to speak, or too uncertain to be believed. Families, institutions, and authorities often struggle to interpret signs, while systemic barriers—stigma, inadequate training, fragmented information sharing, and legal thresholds—can delay or prevent protective action. As a result, the true scale of abuse is likely to remain under-reported and underestimated.

This reality underscores the need for a coordinated, whole-of-society response. Protecting children cannot rest solely with police or child protection agencies. It requires the active vigilance of families, communities, schools, religious institutions, sporting organisations, digital platforms, workplaces and governments. A shared recognition of prevalence, combined with collective responsibility for prevention, early detection and compassionate response, is essential if Australia is to reduce the burden of child sexual abuse.

Only through coordinated effort—cutting across sectors, systems and communities—can the widespread prevalence of child sexual abuse be addressed, its detection improved, and its devastating impacts mitigated.

“

Child sexual abuse is a common reality in the lives of Australian children.

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The systems that are meant to protect children

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The systems that are meant to protect children

The role of legislation, strategic frameworks, government agencies and programs

Child sexual abuse is a profound violation of children's rights and dignity, with lifelong consequences for victim-survivors and ripple effects across families, communities, and society as a whole. Preventing it is one of the most complex and urgent responsibilities that governments must shoulder.

For many decades, the response to child sexual abuse in Australia, as in most common law jurisdictions, was framed almost entirely through the lens of the criminal justice system. The process was conceived as a linear sequence: either a child disclosed abuse or an adult witnessed an incident, the disclosure was reported, police investigated, charges were laid, the matter went to court, and the offender was sentenced or found not guilty.

In theory, this pathway offered clarity and justice—an offender identified, a verdict reached, and punishment delivered. In practice, this traditional criminal justice approach has deep structural limitations, relying on a strictly legal approach to such complex and sensitive harm.

The traditional criminal justice model embodies society's clearest expression of condemnation, promising punishment for those found guilty. At the same time, it exposes the gulf between the lived experience of abuse and the demands of a legal process designed for adversarial testing of evidence.

For many victim-survivors, the lineal progression—disclosure, investigation, prosecution, trial, and sentencing—is less like a path to justice than a series of hurdles, each one higher than the last, with outcomes uncertain until the very end.

Australia has recognised that this approach alone, would not protect children, and prevention services and programs, safeguarding policies and practices, and protective awareness raising formed part of a broader response to the protection of children. To this end, legislatures across the country have enacted mandatory reporting laws for certain professionals, established working with children checks, and in some cases mandated that organisations implement child safe standards.

In Queensland this shift toward more complex and risk-focused child safeguarding can be seen in the findings and recommendations of major inquiries, including:

- the Commission of Inquiry into Abuse of Children in Queensland Institutions (Forde Inquiry) which delivered its report in 1999 focused on the incidence and impact of abuse of children in institutional care throughout Queensland's history
- the Queensland Child Protection Commission of Inquiry (Carmody Inquiry) which delivered its report in 2013 conducted a 'root and branch' review of the child protection system in Queensland
- the Royal Commission into Institutional Responses to Child Sexual Abuse (the Royal Commission) which considered what could be done to protect children against child sexual abuse in an institutional context, as well as how to alleviate or address the impact of past abuse (from 2013–17).

Our contemporary approach to protecting children from sexual abuse is now based on the acceptance that no single institution, professional, or level of government can bear this responsibility alone. Preventing child sexual abuse in Australia requires a whole-of-system, whole-of-society response. Legislation provides the legal framework, strategies chart the path, agencies deliver services and enforce standards, and programs engage directly with children and families. These elements are interdependent and must function coherently for protection to be effective.

An effective and coherent response depends on the alignment of multiple components: Legislation, strategic planning, government agencies, and programs across the three tiers of government are the building blocks of protection. When properly harmonised, they allow for a consistent and sustainable approach to protecting children, detecting threats and responding to harm.

Federalism

Australia's political and governmental landscape adds both richness and complexity to the task of protecting children. The nation's federal system features three tiers of government—federal, state, and local. This division of power and responsibility creates opportunities for tailored responses, innovation, and shared accountability, but also introduces difficulties in coordination, duplication, and inconsistency.

To effectively protect children, legislation, strategic plans, agencies, and programs must work in concert, guided by the lessons of inquiries such as the Royal Commission and Carmody Inquiry, and underpinned by national strategies and frameworks. Prevention efforts must be sustained beyond political cycles, embedded into the core business of governments and organisations, and be responsive to the diversity of Australian society.

Federalism, with its strengths and weaknesses, is central to how Australia organises its response to child protection and safeguarding. The law enforcement agencies and central and service delivery departments that administer laws and policies must be understood within their position within federalism as well as the social context of Australian society. Governments and agencies do not act in isolation: they are shaped by, and in turn shape, the cultural, political, and social norms of the community.

A homogeneous response to child sexual abuse does not mean uniformity in every detail; rather, it means coherence, collaboration, and shared commitment. Ideally it means no gaps between systems and no ending of responsibility for the primacy of protecting children simply because of boundaries and borders.

“

Borders don't stop paedophiles. I will keep saying this to whomever until we can get something done. Public submission

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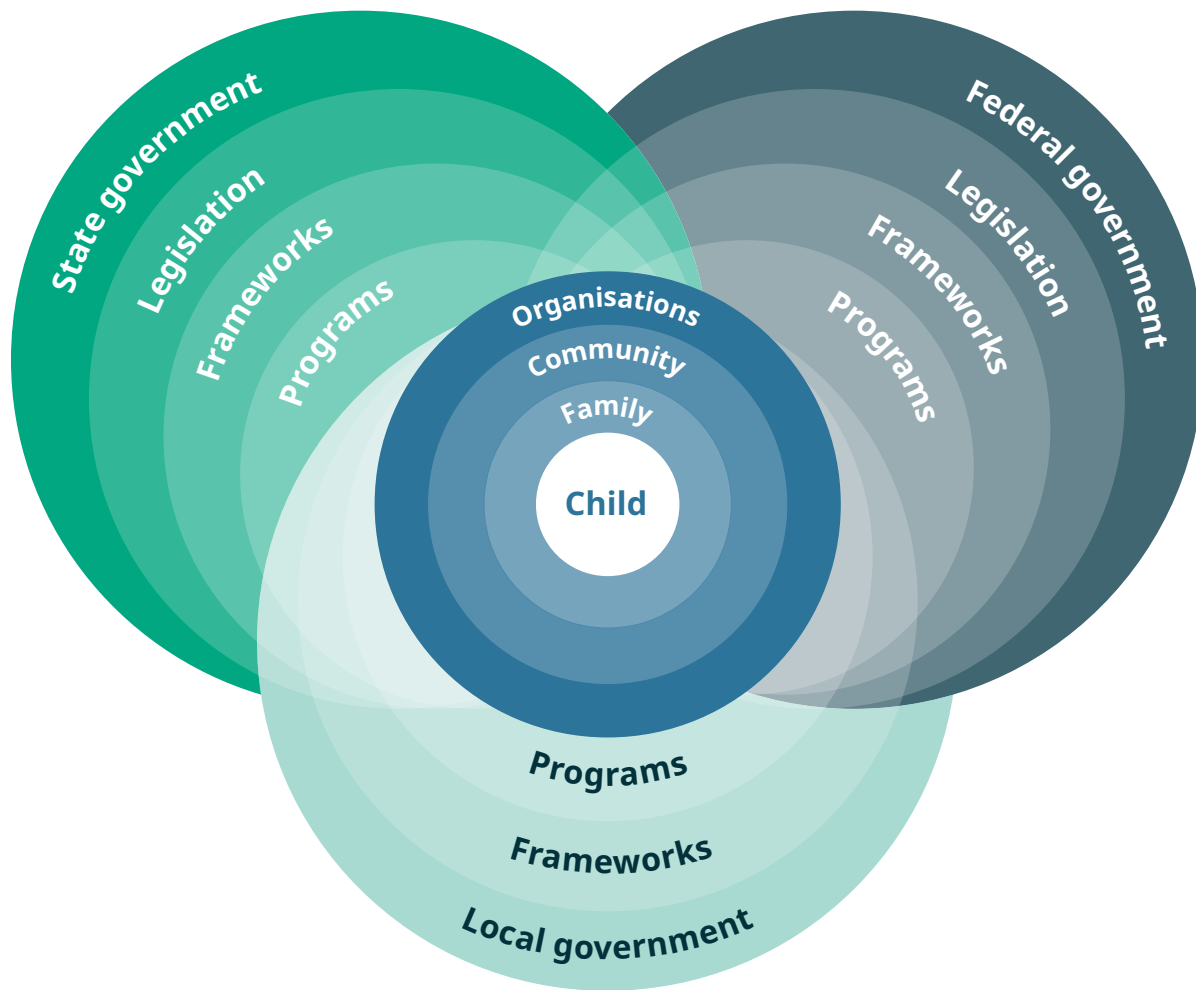
The central challenge in preventing child sexual abuse is to achieve coordination across Australia's three tiers of government. Each tier has a different role, and yet they are all implicated in the safety and wellbeing of children. The federal government leads on national policy, oversees matters of cross-border or international concern, and has a convening power to bring states and territories together. State and territory governments carry the primary responsibility for statutory child safeguarding, policing, courts, health, and education. Local governments, while not always formally recognised in child safeguarding frameworks, are critical actors because they are embedded in communities, operate services such as libraries, sports and recreation centres, and family support programs, and can foster safe environments in everyday spaces where children live and play.

The strength of this system is that it allows for diversity and local responsiveness. States and territories can design child protection systems that reflect their specific demographics, geographies, and communities. For example, remote communities in the Northern Territory require very different service models compared to metropolitan Sydney or Melbourne. Local councils in regional areas can design community programs that build on local strengths and partnerships. However, the weakness of this system is its fragmentation. A child living in one jurisdiction may experience very different protections and supports compared to a child living elsewhere.

Australia's federal structure provides both opportunities and obstacles to a homogeneous response. On the one hand, federalism encourages innovation, allows policies to be adapted to local contexts, and creates multiple avenues for accountability. On the other hand, it can foster fragmentation, duplication, and inequity.

The Royal Commission noted that inconsistencies between jurisdictions were a persistent challenge in areas such as criminal law, child protection systems, and regulatory regimes for institutions. Mechanisms for intergovernmental cooperation, such as the Council of Attorneys-General and the Council of Australian Governments (COAG), now replaced by National Cabinet processes, provide a means of coordination, yet success ultimately depends on political will, sustained investment, and a shared recognition that child safety must transcend partisan and jurisdictional divides.

Figure 8: Placing the safety of children within the context of Australian Federalism



The Royal Commission highlighted the challenges of federalism and the need for a coherent and nationally consistent approach. It found that institutional abuse had been facilitated by fragmented laws and uneven oversight, and it called for nationally consistent approaches in areas such as working with children checks, criminal laws, and child safe standards. Its recommendations were clear: prevention requires cooperation, harmonisation, and a shared vision that transcends state borders. The Royal Commission did not propose abolishing federalism, but rather urged that it be used more effectively, with the federal government providing leadership while respecting the responsibilities of states and territories.

In response, the Australian Government created the National Office for Child Safety (NOCS) in 2018, and tasked it with coordinating child safety initiatives across jurisdictions and leading national reforms. Importantly, it has an outward-facing role, engaging with communities, victim-survivors, and organisations to build trust and drive cultural change. This office symbolises the recognition that child safety requires national leadership, even in a federal system where most service delivery sits with states and territories.

One of the most significant legacies of the Royal Commission is the development of the *National Principles for Child Safe Organisations*. Endorsed by the COAG in 2019, these principles provide a nationally consistent approach for institutions working with children. They outline what organisations should do to create child safe cultures, including leadership, participation of children, staff training, and effective complaint processes. The principles are not legally binding in themselves but are being embedded through state and territory legislation and regulatory frameworks. For example, Victoria legislated mandatory compliance with child safe standards through the *Child Wellbeing and Safety Act 2005* (Vic), while New South Wales created a Child Safe Scheme under the *Children's Guardian Act 2019* (NSW). These examples show how federal leadership through shared principles can cascade down into local legislation and practice, gradually creating coherence across jurisdictions.

The federalist system brings complexity but also opportunity, as long as governments cooperate and share responsibility. Bureaucracies must be child-centred and accountable, and social norms must continue to shift towards openness and support for victim-survivors. A homogeneous response is not about rigid uniformity; it is about coherence, collaboration, and a shared national commitment to the safety and wellbeing of children. The lessons of the Royal Commission, the inquiries that preceded and proceeded it, and the policies now in place show that progress is possible. But the challenge is ongoing, and only a sustained and integrated, response will ensure that children in Australia are truly safe.

Role of the Australian Government

The Australian Government plays a central role in both the prevention of, and response to, child sexual abuse. While primary responsibility for child safeguarding sits with states and territories, the Commonwealth has enacted key measures that address child sexual abuse across different contexts. The Commonwealth Criminal Code contains offences that apply to abuse committed online, via postal services, and overseas where the alleged perpetrator is an Australian citizen. The growing incidence of such crimes heightens the federal responsibility to act decisively. Australia's national measures are framed within its international obligations. As a signatory to the United Nations Convention on the Rights of the Child and its Optional Protocol on the Sale of Children, Child Prostitution and Child Pornography, Australia has committed to upholding children's rights and to preventing and responding to child sexual abuse in line with international human rights standards. These frameworks reinforce the principle that child safeguarding is not only a national responsibility but a global imperative. In recognition of this responsibility, specialist agencies and initiatives have been established:

- The NOCS, created in 2018 following the Royal Commission, provides national leadership to strengthen child safety policies and reduce harm, with a particular focus on child sexual abuse. It oversees the implementation of the *National Strategy to Prevent and Respond to Child Sexual Abuse*.
- The Australian Federal Police (AFP) has a central role in responding to child sexual abuse, especially where cases cross state, territory, or international borders. The AFP investigates Commonwealth child sexual abuse offences, including crimes committed online, through the postal system, or overseas by Australian citizens.
- The Australian Centre to Counter Child Exploitation (ACCCE), established in 2018, drives a collaborative and connected national response to online child sexual abuse.
- The eSafety Commissioner promotes online safety, provides education to children, families, and educators, and offers complaint and reporting processes for serious cyberbullying and illegal online content.

Beyond these specialist entities, several Commonwealth departments contribute to child protection through broader portfolios. The Department of Social Services oversees national frameworks, including *Safe and Supported: The National Framework for Protecting Australia's Children*, the *National Plan to End Violence Against Women and Children*, and the *National Disability Strategy*. Other departments manage policies relating to Aboriginal and Torres Strait Islander peoples, family law, technology-facilitated crime, migration, workplace protections, and health. The National Children's Commissioner provides independent advocacy, research, and education, ensuring that children's voices are heard and that Commonwealth legislation, policies, and programs uphold children's rights.

Role of state and territory governments

State and territory governments are responsible for the direct protection of children who are experiencing, or at risk of, abuse and neglect. They hold legislative and service delivery responsibility for a wide range of child safety measures, including criminal offences relating to child sexual abuse, child protection systems, and courts with jurisdiction over crime, family and child matters.

State and territory police departments are the first agency expected to act once concerns are reported, carrying the dual responsibility of protecting children while gathering evidence strong enough to withstand the demands of the courtroom. Police decisions shape whether a case advances or stalls: they determine how a disclosure is recorded, whether witnesses are interviewed, what forensic or digital material is pursued, and ultimately whether a brief is sent to prosecutors. In this way, the pathway from an allegation to potential conviction rests heavily on the quality and focus of state and territory police work.

While the state's role in the protection of children is undisputed, a single point of responsibility for the safety of children is hard to find. It is shared across state government portfolios and is not the responsibility of one department but of many: police, health, education, justice, housing, and community services all play a part. Through these systems, states and territories maintain frontline responsibility for responding to allegations of child sexual abuse, supporting victim-survivors, and preventing harm. One of the most profound realisations is that each state's Department of Child Safety or Child Protection rarely serves their role, and is more often restricted to a limited focus on children who are not safe with their parents. Child protection departments do not hold responsibility for the overall safety of children. Effective prevention requires collaboration across silos. This is easier said than done, as bureaucracies often protect their own territories, funding, and priorities. Strategic reforms such as New South Wales' *Their Futures Matter* initiative or Queensland's *Supporting Families Changing Futures* demonstrated attempts to break down these silos through cross-agency collaboration. However, these initiatives also show how challenging it is to sustain such collaboration over time.

In Queensland, the Ministers with responsibility for administering these protective functions have shifted on numerous occasions during the last 25 years, specifically the early childhood education and care (ECEC), and blue card systems. The shifts acknowledge that while housed within one Minister's portfolio, these functions are inextricably linked with those of other agencies. Prior to their transition to the Department of Justice and Department of Education, blue cards and ECEC regulation were the responsibility of the Public Safety Business Agency and the Minister for the Department of Families, respectively.

Role of local governments

Local governments play an important role in promoting community safety, particularly in ways that affect children and young people. Their functions include the provision of services such as libraries, pools, childcare, holiday programs, and community facilities. These services can foster safe environments for children and provide opportunities to identify risks or concerns. Local governments also have the capacity to impact community safety through their role in planning and development. The design and evaluation of settings in which children are present becomes a critical component in preventing harm. In many regional and remote communities, local governments are the primary service providers and central points of contact for families, increasing their importance in ensuring protective environments for children.

The role of local government in building and sustaining strong communities should also be recognised. While not always formally part of child protection and safeguarding systems, local councils provide vital infrastructure for prevention. They operate libraries, sports facilities, community centres, and local networks that engage children and families. Councils often run programs for families, youth, and early childhood development. Because they are embedded in local communities, councils can respond to specific needs and build partnerships that make national strategies meaningful at the grassroots. This third tier of government is often overlooked but should be better integrated into national child safety efforts.

Legislation

Legislation is the cornerstone of protection efforts, setting out both the criminal prohibitions against child sexual abuse and the regulatory expectations placed on professionals, organisations and the community.

Legislation is often the most visible form of government action. It reflects society's values and sets the legal boundaries for behaviour. In Australia, responsibility for child sexual abuse offences is shared between state and territory governments on one hand, and the Commonwealth on the other. Each plays a distinct role in the broader legal framework.

At the state and territory level, criminal law sets out the main sexual offences against children, prescribes penalties, and defines the powers of police and child protection agencies. These laws also establish mandatory reporting requirements for professionals, regulate working with children checks, and shape the systems of child protection that operate on the ground. Because most child sexual abuse occurs within families, communities, or institutions located within a single jurisdiction, state and territory laws are the foundation of the response.

The Commonwealth's role is more targeted but increasingly important in the digital age. Under the *Criminal Code Act 1995* (Cth), the federal government legislates for offences with national or international dimensions. These include online grooming, child exploitation material (CEM), and extraterritorial offending. For example, offences committed overseas by Australian citizens or in cross-border digital environments are a Commonwealth responsibility. This reflects the reality that child sexual abuse is no longer confined by geography and requires national laws that can operate across jurisdictions and in cooperation with other countries.

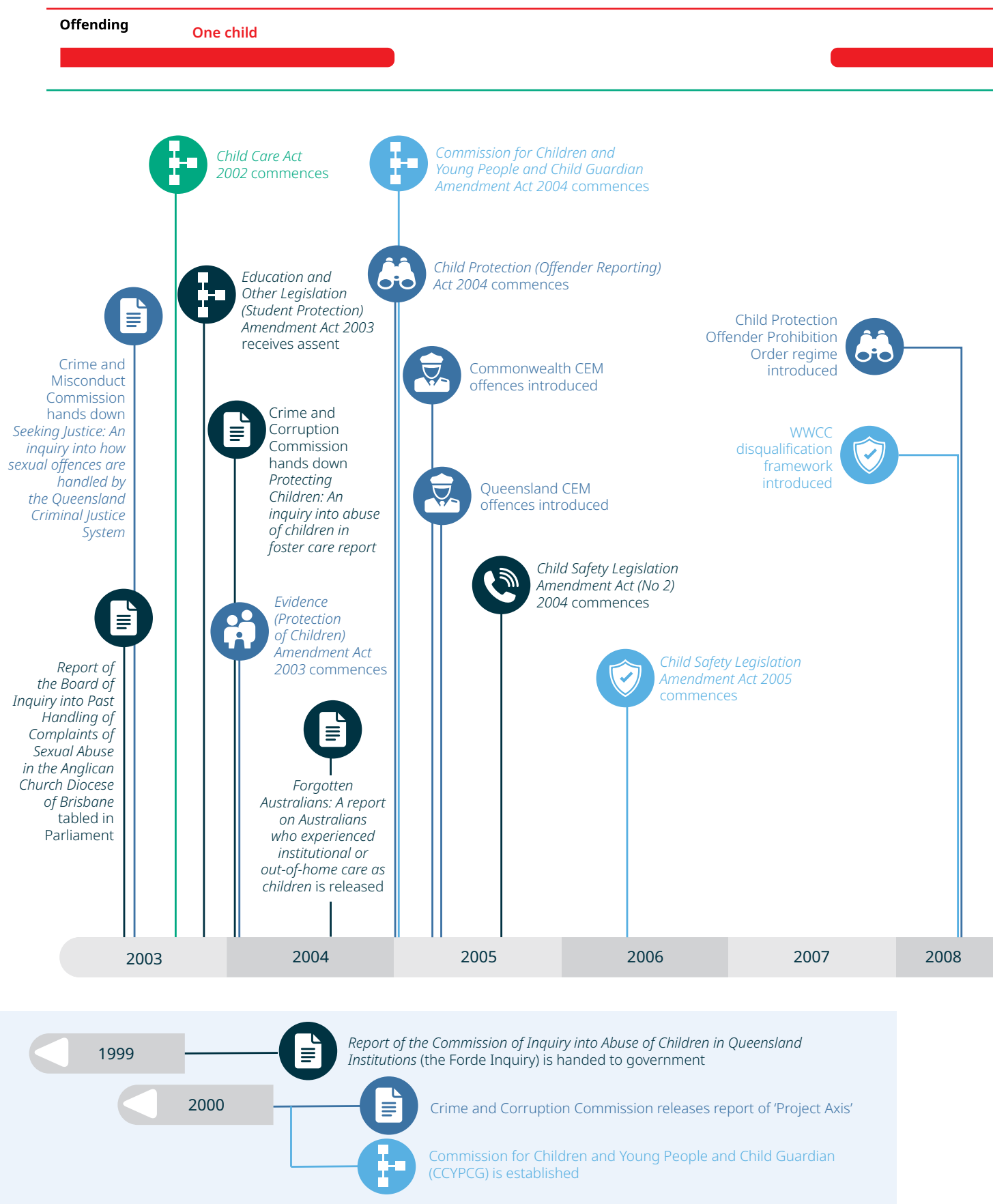
Legislation also extends beyond the criminal sphere. States and territories have developed civil and regulatory frameworks designed to create safer environments for children. Victoria's *Child Wellbeing and Safety Act 2005*, which mandates compliance with child safe standards, and New South Wales' *Children's Guardian Amendment (Child Safe Scheme) Act 2021*, which established a child safe scheme, are two examples. These reforms highlight a preventive focus, recognising that child safety requires not only criminal sanctions but also organisational responsibility. At the national level, the endorsement of the National Principles for Child Safe Organisations in 2019 sought to bring greater coherence to these state-based schemes and establish a common foundation for safeguarding across Australia.

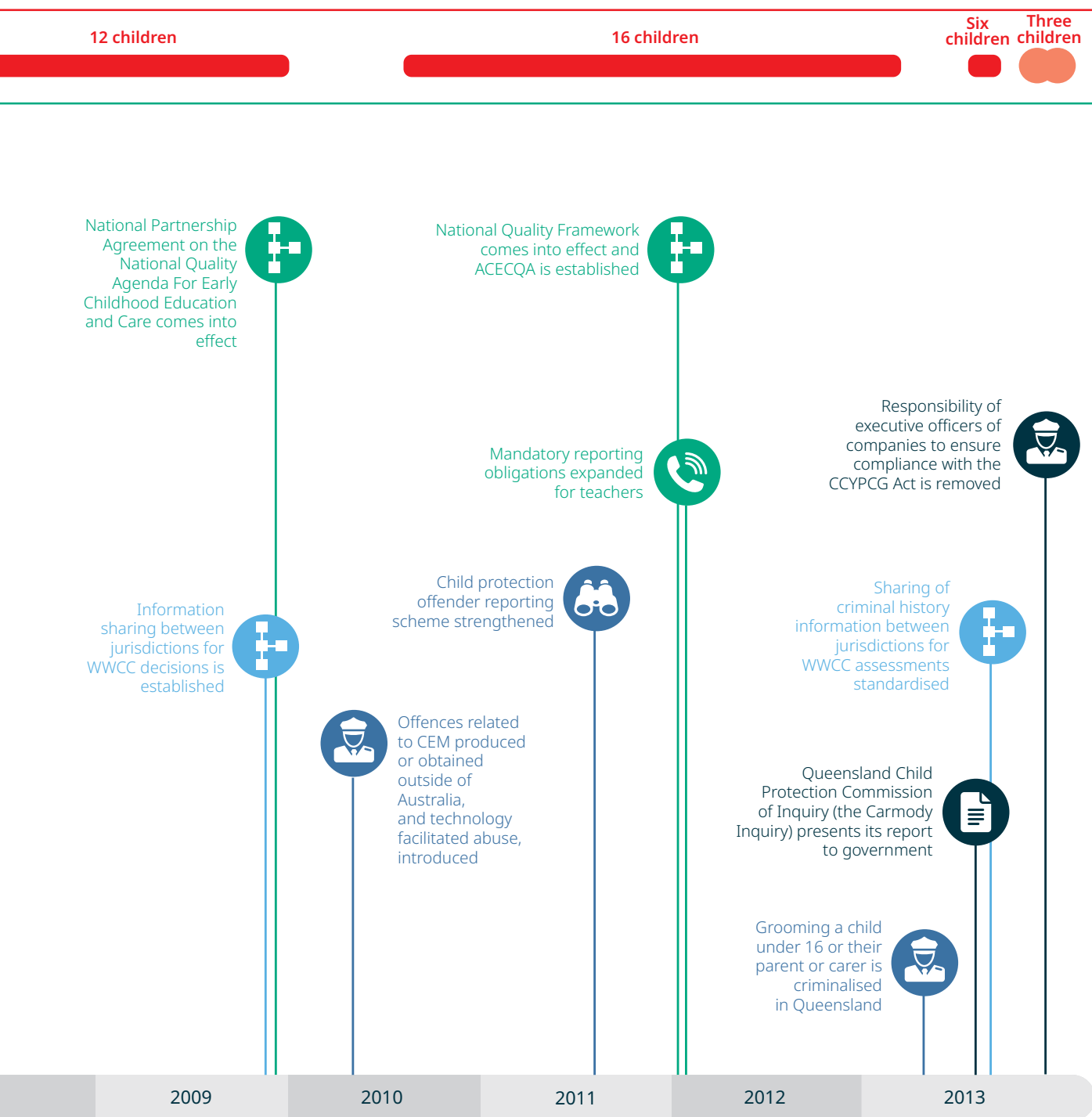
Despite these advances, inconsistency between jurisdictions remains a persistent challenge. Definitions of offences, reporting obligations, and regulatory regimes vary, as do the operation of working with children checks. The Royal Commission emphasised the risks this creates, both in confusing organisations and professionals and in leaving gaps in protection. While progress has been made, such as the intergovernmental agreement on nationally consistent working with children checks (WWCC), full harmonisation has yet to be achieved.

To aid our understanding the Board commissioned Queensland law firm Marrawah Law and Advisory to analyse the legal frameworks in place in Queensland that aim to protect children from sexual abuse across the ECEC, police and blue card systems. This review found that:

In the 25 years to 2025, more than 26 pieces of legislation have impacted Queensland safeguarding systems, including at least 12 entirely new principal Acts. In addition, during this time hundreds of amendments to relevant Acts, Regulations and other statutes were progressed.

Figure 9A: Timeline of legislative and policy changes, 1999–2013





Offending

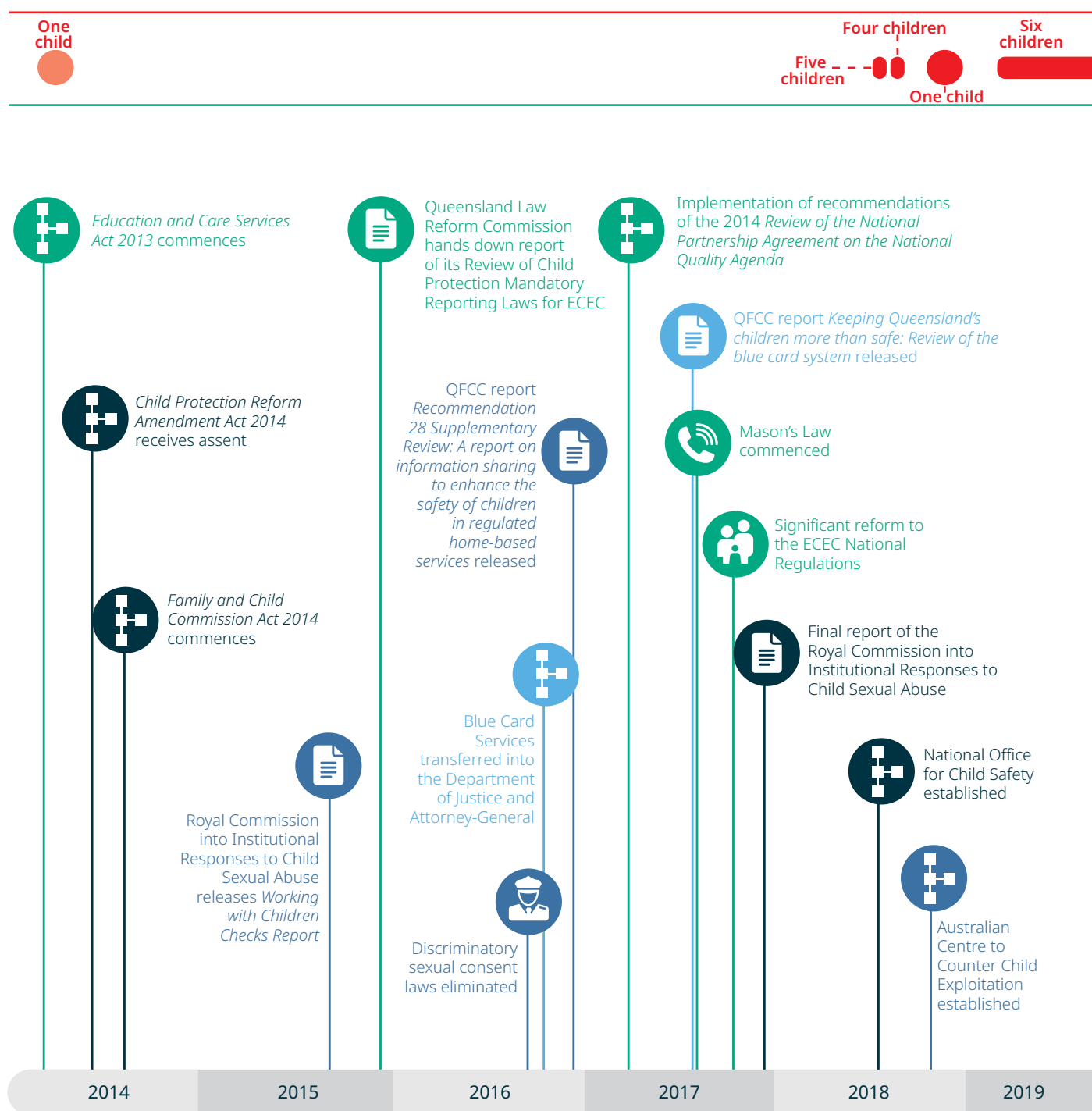
Offending event or period

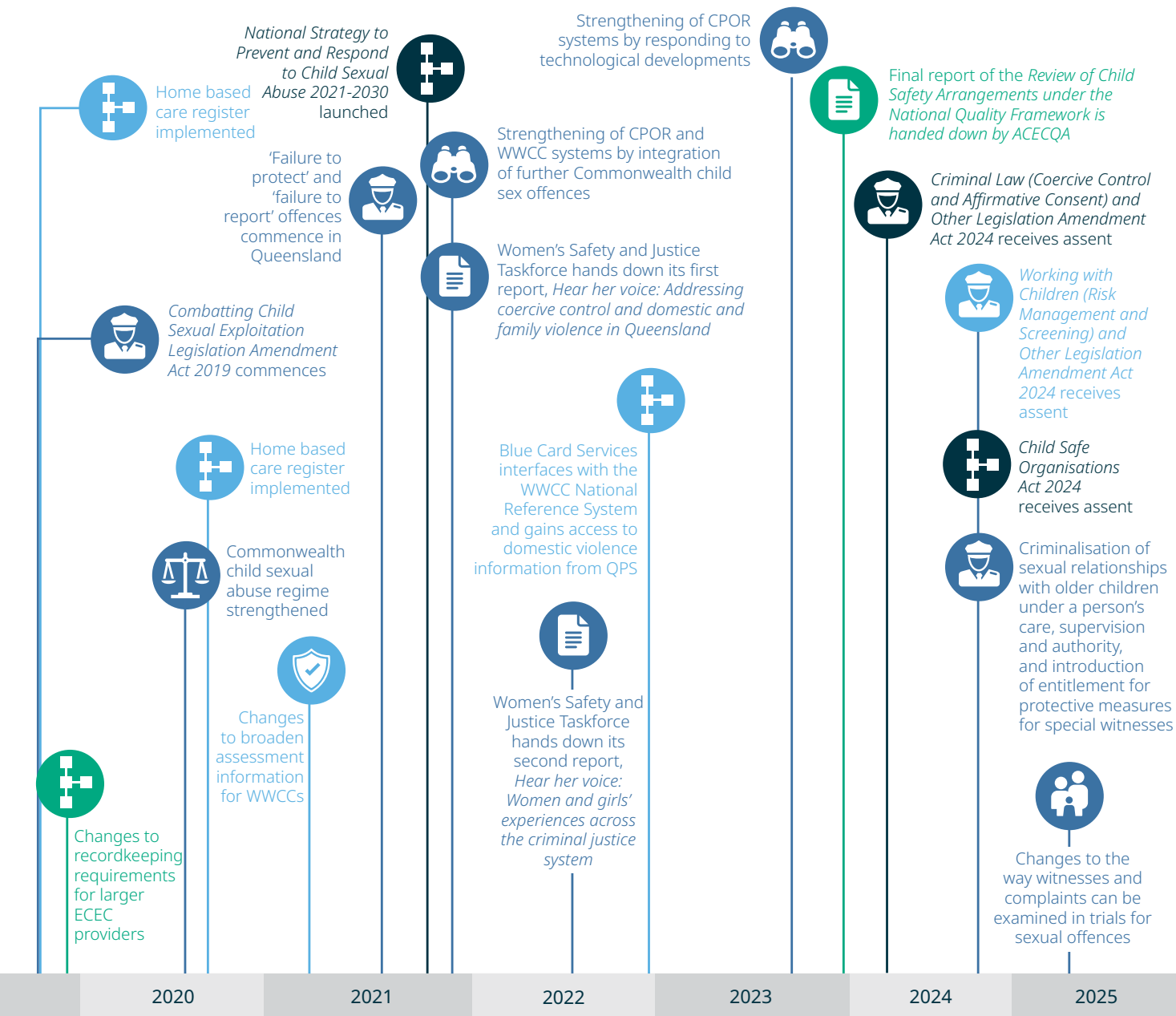
Legend

Early childhood
 Blue card
 Criminal justice
 Other / multiple

Screening Safeguarding Offences Sentencing Monitoring Systems Reviews Reporting

Figure 9B: Timeline of legislative and policy changes, 2014–25





Offending

Offending event or period

Police

Offender arrested

Legend

Early childhood
Blue card
Criminal justice
Other / multiple

Screening Safeguarding Offences Sentencing Monitoring Systems Reviews Reporting

Table 1: Key legislation in Queensland to protect and respond to child sexual abuse

Act (Year, Qld)	Focus / Key points
<i>Criminal Code Act 1899</i>	Core criminal law defining sexual offences against children (rape, indecent treatment, maintaining sexual relationships with a child). Sets penalties and aggravating circumstances.
<i>Evidence Act 1977</i>	Provides protections for child witnesses (e.g. video link, recorded statements, limits on cross-examination). Recognises children's vulnerability in court processes.
<i>Police Powers and Responsibilities Act 2000</i>	Framework for police powers in Queensland. Covers investigation processes, arrest, search, seizure, surveillance, and child interview procedures. Provides the authority underpinning police investigations of child sexual abuse.
<i>Child Protection Act 1999</i>	Establishes the child protection system. Allows investigation, removal, and intervention when children are at risk of harm (including sexual abuse). Defines 'best interests of the child' as paramount. Includes mandatory reporting obligations.
<i>Working with Children (Risk Management and Screening) Act 2000</i>	Creates the blue card system. Requires screening of people working with children. Disqualifies individuals with child sexual abuse offences. Aims to prevent unsuitable people from working with children.
<i>Child Protection (Offender Reporting and Offender Prohibition Order) Act 2004</i>	Establishes a child sex offender register. Imposes ongoing reporting obligations (addresses, travel, internet use). Allows prohibition orders to restrict high-risk offender behaviour.
<i>Child Protection (Offender Prohibition Order) Act 2008 (later incorporated into 2004 Act)</i>	Strengthens police ability to seek court orders restricting high-risk offender activities to prevent conduct that could lead to reoffending.
<i>Education (General Provisions) Act 2006</i>	Governs the safety of children in schools. Obligates teachers and staff to report suspicions of harm. Provides powers to exclude risky individuals from schools.
<i>Child Protection (Offender Reporting and Offender Prohibition Order) Amendment Act 2014</i>	Tightens offender reporting laws and expands police monitoring powers (travel, online accounts) to reflect digital risks and repeat offending.
<i>Child Safe Organisations Act 2024</i>	Introduces obligations for certain organisations to implement child safe standards and risk management strategies to reflect a preventative, systems-based approach to the safety of children.

Over 25 years the Queensland Government has made:



32 Amendments to Chapter 22 of Queensland's Criminal Code

33 Amendments to the *Child Protection (Offender Reporting and Offender Prohibition Order) Act 2004* (originally the *Child Protection (Offender Reporting) Act 2004*)

83 Amendments to the *Working with Children (Risk Management and Screening) Act 2000* (originally the *Commission for Children and Young People Act 2000*)

Changes to legislation in many cases reflected a move towards consistency across jurisdictions, acknowledging not only the shared responsibility framework but also the transiency of workers. While legislative change was motivated at least in part by this common goal, review of the legislative framework has found that it is expansive, complex, crowded and fragmented. Marrawah Law and Advisory advised the review that:

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Legislative changes to achieve various objectives related to children's safety over the study period have been numerous and frequent. In some cases, the frequency and volume of legislative change has added to the complexity of legislation.

- Marrawah Law and Advisory

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Recent alarming cases of child sexual abuse in ECEC are a critical reminder: the capacity of any one safeguarding mechanism or scheme to protect children in high-risk child-related settings is, in isolation, limited. Instead 'a more holistic and integrated, rather than piecemeal, reform approach will assist to minimise unnecessary regulatory duplication. More importantly, such an approach will assist to maximise the interoperability of laws for more effective safeguarding'.³³

Strategic frameworks

Legislation alone cannot drive reform or protect children. Strategic frameworks are essential for setting shared goals, aligning priorities, and ensuring that commitments are translated into practical action. They also provide continuity in a policy space where political leadership can shift quickly, bridging the gap between short electoral cycles and the long-term work of prevention. Yet strategies must be supported by resources and accountability if they are to move beyond rhetoric.

The first *National Framework for Protecting Australia's Children 2009–2020* was a landmark in uniting governments and the community sector around a common agenda. It introduced the principle that “protecting children is everyone's business” and promoted prevention, early intervention, and cross-sector partnerships. However, evaluations found progress uneven, limited by weak accountability and inconsistent implementation across jurisdictions.

Its successor, *Safe and Supported: The National Framework for Protecting Australia's Children 2021–2031*, seeks to overcome these shortcomings. It builds on the findings of the Royal Commission, sets clearer priorities, and emphasises joint accountability. Importantly, it has been co-designed with children, families, and the Aboriginal and Torres Strait Islander Leadership Group, reflecting the *National Agreement on Closing the Gap* and responding to past critiques that Aboriginal and Torres Strait Islander perspectives were marginalised.

The national strategy and related action plans

The *National Strategy to Prevent and Respond to Child Sexual Abuse 2021-2030* is a 10-year strategic framework based on a public health approach which responds to over 100 recommendations from the Royal Commission. It includes measures to better prevent, identify and respond to child sexual abuse and establishes a vision for all children and young people to be protected from sexual abuse and feel supported.

The national strategy has five themes:

1. Awareness raising, education and building child safe cultures
2. Supporting and empowering victims and survivors
3. Enhancing national approaches to children with harmful sexual behaviours
4. Offender prevention and intervention
5. Improving the evidence base.

These strategies have two related action plans: the *First National Action Plan* which includes Australia-wide actions and commitments that the Australian, state and territory governments will deliver together and the *First Commonwealth Action Plan* which includes specific measures for the Commonwealth to address. The national strategy is also supported by a monitoring and evaluation framework to ensure implementation is accountable and transparent, and to track progress against short, medium and long term outcomes.

These strategies are also aligned with the *National Framework for Protecting Australia's Children 2009-2020*, *Safe and Supported: the National Framework for Protecting Australia's Children 2021-2031*, and the associated action plans that sit under these.

The National Principles for Child Safe Organisations

Based on its findings about the risks of child sexual abuse in institutional settings, as well as the prevention, identification and response, the Royal Commission set out 10 child safe standards that were intended to be applied by all state and territory governments as mandatory minimum requirements for institutions that provide services to or care for children. The Australian Human Rights Commission formulated the National Principles for Child Safe Organisations (the National Principles) to give effect to the standards and these principles were endorsed by the Prime Minister in February 2019.

At the state and territory level, national objectives are interpreted through local reform programs. For example, Queensland's *Supporting Families Changing Futures* program emerged from the Carmody Inquiry and shifted the focus towards prevention and earlier intervention. Victoria's *Roadmap for Reform: Strong Families, Safe Children* emphasised integrated services and community-based supports, while New South Wales adopted *Their Futures Matter*, aimed at system redesign through cross-agency collaboration. These state strategies demonstrate how national and state inquiries drive localised reform agendas, while still contributing to a broader national direction. This jurisdictional-specific action can also create unevenness. A child's experience of support and protection can vary significantly depending on where they live, raising questions about equity and national responsibility.

Queensland's safeguarding strategies

Queensland has adopted a suite of strategies that, while distinct in scope and application, collectively seek to form a framework to prevent, detect, and respond to sexual violence and child sexual abuse. These strategies translate high-level policy commitments into practice, providing agencies and communities with structured approaches for protecting children and supporting victim-survivors. They include:

- **Prevent. Support. Believe. Queensland's framework to address sexual violence** - The *Prevent. Support. Believe.* framework represents Queensland's overarching whole-of-government strategy for responding to sexual violence. It sets out the vision of a society free from sexual violence in all its forms—spanning child sexual abuse, youth sexual violence, sexual harassment, and technology-facilitated abuse. The framework establishes strategic priorities and supports detailed action plans for the period 2023–28, ensuring a coordinated, system-wide response (Queensland Department of Families, Seniors, Disability Services, and Child Safety).
- **Interagency Guidelines for Responding to Sexual Assault or Child Sexual Abuse** - Updated in January 2024, these guidelines provide the foundational practice framework for agencies that respond to sexual assault and child sexual abuse. They articulate expectations for delivering trauma-informed, timely, and coordinated services, ensuring victim-survivors are met with consistent standards of care and support regardless of which agency they first engage with. These guidelines operationalise collaboration across government and non-government partners (Queensland Department of Families, Child Safety, Seniors and Disability Services).
- **Department of Education's "Aware. Protective. Safe." Strategy** - The Department of Education has developed the *Aware. Protective. Safe.* strategy as its core response to the findings of the Royal Commission. It aligns schools and early childhood services with national child safe principles, embedding a culture of safety through structured cycles of reflection, embedding, and continuous improvement. This strategy is tailored to ensure Queensland's education system proactively prevents and addresses risks to children (Queensland Department of Education).
- **Child and Youth Risk Management Strategies (blue card system)** - Operating under the Blue Card framework, Child and Youth Risk Management Strategies are mandatory for organisations working with children. They provide a practical safeguard by requiring organisations to establish commitments to child safety, codes of conduct, recruitment and training processes, and risk management plans. These strategies ensure frontline services working with children in Queensland maintain consistent, preventative safeguards (Queensland Department of Justice).
- **Our Way: A Generational Strategy for Aboriginal and Torres Strait Islander Children and Families** - Queensland has also adopted long-term strategies addressing the disproportionate representation of Aboriginal and Torres Strait Islander children in the child protection system. *Our Way* (2017–37), co-designed with Aboriginal and Torres Strait Islander communities, is a generational strategy that focuses on cultural responsiveness, self-determination, and community-led service design. It explicitly seeks to eliminate overrepresentation by addressing systemic drivers of risk and harm for Aboriginal and Torres Strait Islander children and families (Queensland Department of Families, Child Safety, Seniors and Disability Services).
- **Child Protection Framework (Family Support and Child Protection System)** - The state's Child Protection Framework establishes the practice continuum across early intervention, statutory child protection, and family support services. It defines stages, expectations, and outcomes for children at risk of or experiencing harm, aiming to build consistency in how the system supports families and protects children. This framework provides the operational backbone for frontline workers and agencies delivering child protection services (Queensland Government, *Our Performance*).

- **Queensland Police Service Sexual Violence Response Strategy 2025-29** - The QPS has also embedded an operational strategy to ensure victim-centred, trauma-informed policing in cases of sexual violence. The *Sexual Violence Response Strategy 2025-29* seeks to deliver effective policing responses and prevention approaches to sexual violence, ensuring victim survivors are safe and feel safe. The strategy commits to a range of actions under the four pillars of a healthy and engaged workforce, community safety, engaged and trusted relationships, and effective and efficient service delivery.

These frameworks collectively shape Queensland's strategic vision for preventing and responding to child sexual abuse through:

- whole-of-government coordination (e.g. *Prevent. Support. Believe.*)
- operational consistency across agencies (e.g. Interagency Guidelines)
- sector-specific safety strategies (Education Department's *Aware. Protective. Safe.*)
- cultural and community-led approaches (Our Way strategy)
- regulatory standards to prevent harm (blue card system)
- embedded system design in child protection services (Child Protection Framework)
- law enforcement commitments to trauma-informed practice (QPS Strategy).

Government departments and their programs

Government agencies are the machinery that turns law and strategy into practice. They are the operational arms of government.

State bureaucracies balance legal requirements, resource limitations, and public expectations. They operate within broader cultural and social contexts, reflecting prevailing attitudes towards children, families, and abuse. Community expectations are also central. Within this context, challenges remain in sustaining protection initiatives beyond political cycles. Governments change, budgets are reallocated, and priorities shift. This is a recurring problem in social policy: programs that are effective in the long term may be vulnerable to short-term funding decisions. For example, evaluations of the first *National Framework for Protecting Australia's Children* showed that many successful programs were unable to be scaled or sustained due to funding uncertainty. Ensuring long-term investment requires embedding the safety of children into the core business of government, rather than treating it as a temporary priority.

The question of bureaucracy and culture is important. Bureaucracies are often structured to minimise risk and comply with rules, but this can sometimes lead to rigidity and a failure to respond flexibly to children's needs. Families often describe systems as intimidating, confusing, or unresponsive. The Royal Commission highlighted how institutional cultures that prioritised reputation over children's safety enabled abuse to persist.

Independent oversight bodies provide a counterbalance to bureaucracies, ensuring that systems remain accountable and responsive. State children's commissioners and guardians, such as the Queensland Family and Child Commission and the Victorian Commissioner for Children and Young People, monitor system performance, advocate for children's rights, and conduct systemic inquiries. The Commonwealth has established a National Children's Commissioner within the Australian Human Rights Commission, giving children representation at the national level. Oversight bodies such as ombudsmen and child death review boards contribute by investigating complaints, identifying systemic issues, and recommending reforms. These mechanisms reflect the Royal Commission's emphasis on transparency and accountability as foundations for restoring trust.

At the federal level, agencies such as the AFP, the eSafety Commissioner, and the ACCCE focus on areas of national concern for children, particularly online safety and offences that cross borders. The NOCS provides leadership, coordination, and oversight, aiming to ensure that the Royal Commission's recommendations are implemented consistently. At the state and territory level, child protection departments, police, and education and health agencies are frontline actors. They respond to reports, investigate concerns, deliver services, and regulate compliance.

Commonwealth entities that protect children

Australian Federal Police

The AFP is established under the *Australian Federal Police Act 1979*, which sets out its structure, powers, and functions. It operates as the Commonwealth's principal federal law enforcement agency. Under section 8 of the Act, the AFP's functions include:

- providing police services in the Australian Capital Territory, Jervis Bay Territory, and to enforce Commonwealth laws, safeguard Commonwealth property, and protect Commonwealth interests
- investigating state offences with a federal aspect, administering witness protection under the *Witness Protection Act 1994*, and enforcing the *Proceeds of Crime Act 2002*
- performing protective and custodial roles as directed by the Minister
- cooperating with domestic and foreign law enforcement, intelligence, and regulatory agencies, and contributing to international peace, stability, and security, including overseas operations.

The National Office for Child Safety

The NOCS is a dedicated office within the federal Attorney-General's department which provides national leadership on child safety and works to implement the recommendations of the Royal Commission.

The key responsibilities of NOCS include:

- coordinating the implementation of the National Strategy and Monitoring and Evaluation Framework
- leading the National Principles for Child Safe Organisations
- engaging with stakeholder and advisory groups
- leading the Commonwealth Child Safe Framework
- reporting on the progress of implementation of recommendations from the Royal Commission
- guidance for media on reporting on child sexual abuse
- establishing Minimum Practice Standards for services responding to child sexual abuse.

The National Centre for Action on Child Sexual Abuse

Since its establishment in 2021, the non-government National Centre for Action on Child Sexual Abuse (National Centre) has laid solid foundations for an effective and innovative organisation. In 2025–26, the Board endorsed three strategic impact goals:

- Empower victims and survivors by embedding lived and living experience across all facets of its work—this includes a new framework, deeper community partnerships, and workforce capability-building.
- Build sector capability and responsiveness by translating research into practice and enabling professionals, organisations, and communities to deliver trauma-informed responses to child sexual abuse.
- Drive policy, systems and culture reform by mobilising its maturing research base to inform national policy, shape reform agendas, and support long-term cultural change.³⁴

Over the last four years the National Centre has:

- invested nearly \$3 million in research, commissioning over 40 projects
- delivered Australia's first Community Attitudes Study on child sexual abuse
- launched *The Change Academy*, a professional learning hub for practitioners and communities
- developed evidence-informed tools for trauma-aware practice
- engaged thousands through webinars, events, and campaigns, building a strong, connected community.

eSafety Commissioner

The Australian Government established the Office of the eSafety Commissioner (eSafety) in 2015 via the *Enhancing Online Safety Act 2015*. eSafety describes itself as the 'world's first government regulatory agency committed to keeping its citizens safer online.'³⁵ The powers and responsibility of the eSafety Commissioner as an independent statutory office holder were increased by the *Online Safety Act 2021* (Cth).

The *Online Safety Act 2021*, effective from 23 January 2022, established and consolidated the Commissioner's regulatory powers across three schemes: protecting children from cyberbullying, safeguarding adults from severe online abuse, and managing non-consensual intimate image sharing. Under this Act, the Commissioner is empowered to:

- issue takedown notices for harmful content, including child cyberbullying and severe abuse, across all relevant online services—not just social media
- enforce industry codes and standards, such as new codes addressing 'lawful but harmful' content and emerging technologies
- obtain necessary information, including subscriber data for investigations, and address image-based abuse through expanded information-gathering powers.

At the state and territory level the primary agencies that protect children are state and territory departments responsible for child safety. These departments receive notifications of suspected abuse, assess risks, intervene to protect children, and support families. They work closely with police, education, health, and non-government organisations. Historically, state child protection agencies in Australia have fluctuated in the scope of services they provide to protect children, balancing responsibilities between primary prevention—supporting all children and communities to prevent harm—and secondary or tertiary interventions, focused solely on responding when abuse or neglect by a parent or primary carer is identified. At various points, agencies have implemented programs aimed at strengthening parenting, early childhood wellbeing, and community capacity building, reflecting a broader protective role that extended beyond immediate parenting. These periods of expansive engagement often coincided with societal recognition of the value of upstream investment in child safety, where resources were allocated to support all children, not only those already at risk. Over time, however, contemporary legal interpretations and statutory frameworks have increasingly narrowed the operational remit of child protection agencies. The emphasis is now on protecting children from harm arising primarily within the parental or caregiver relationship, as enshrined in legislation such as the *Child Protection Act 1999* (Qld). This shift has reduced the scope for agencies to provide primary or universal preventive services, meaning that children's protection increasingly relies on the direct intervention of parents and families, rather than systemic supports provided by the state. As a result, while demand for services continues to grow—particularly in the context of complex social issues and heightened awareness of child abuse—statutory and legal parameters constrain agencies' capacity to address risk in the broader population or to proactively prevent harm in children who are not yet identified as at risk.

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It is a concerning truth that the Department of Child Safety has no role in protecting children from paedophiles that are not their parents.

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Other departments play a secondary role in child protection and safeguarding, often connected to their primary portfolio purpose. Police investigate crimes against children. Health services are often the first to identify concerns, providing not only medical treatment but also therapeutic supports. Education systems are critical because schools are one of the few universal services that reach almost all children. Teachers, counsellors, and principals are mandated reporters, and schools are vital sites for prevention education.

Queensland state entities that protect children

Queensland Police Service

The Queensland Police Service (QPS) is constituted under the *Police Service Administration Act 1990* (Qld) and guided by the *Police Powers and Responsibilities Act 2000* (Qld), which together provide the legal framework for policing functions across the state. Its remit spans crime prevention, community safety, criminal investigations, and law enforcement, alongside collaboration with other state, federal, and international agencies. The QPS Strategic Plan 2025–29 sets priorities to deliver rights-respecting, community-centred policing, build a capable and resilient workforce, and strengthen trust in policing institutions. Complementing this are dedicated strategies for domestic, family, and sexual violence that emphasise improved investigative capacity and enhanced victim support, including reforms to the way QPS disrupts sexual violence and related harms.

Queensland Department of Child Safety

The Department of Child Safety, Seniors and Disability Services derives its statutory mandate primarily from the *Child Protection Act 1999* (Qld), which establishes the legislative framework for protecting children who have been harmed or are at risk of harm from their parent or caregiver. The Act underpins the Department's legal responsibilities to investigate concerns, intervene where necessary, and ensure the safety and wellbeing of children in Queensland. Strategically, the Department's Strategic Plan 2024–28 sets a vision of ending violence against women and children and transforming the child protection system through prevention and early intervention. In the context of child sexual abuse, this means embedding trauma-informed practice, reducing over-representation of vulnerable groups, and implementing the Sexual Violence Prevention Framework, which coordinates whole-of-government action to strengthen prevention, reporting, and responses to child sexual abuse and sexual violence.

Queensland Department of Justice

The Queensland Department of Justice operates under a range of legislation, and provides legal, policy, and administrative support to the Attorney-General in discharging their statutory responsibilities. Its legal basis encompasses advising government on legislation, representing the state in civil and criminal matters, administering the justice system, and ensuring compliance with Queensland's laws and regulatory frameworks. Strategically, the Department prioritises maintaining access to justice, strengthening the integrity and efficiency of courts and tribunals, supporting victims of crime, and developing laws and policies that enhance public safety and protect vulnerable populations—including children at risk of abuse.

Queensland Health

Queensland Health operates under the *Hospital and Health Boards Act 2011* (Qld), which establishes the legal structure of the Department of Health and the system of independent Hospital and Health Services that deliver public healthcare across the state. The Act provides the statutory foundation for Queensland Health's role in service delivery, governance, accountability, and clinical safety. Within this framework, Queensland Health has a frontline role in responding to child sexual abuse: public hospitals and health services provide immediate medical care, forensic and sexual health services, and crisis support for victim-survivors. Its policies, including the "just-in-case" forensic examination directive, ensuring evidence can be preserved while safeguarding survivor choice.

Queensland Department of Education

The Queensland Department of Education operates primarily under the *Education (General Provisions) Act 2006* and the *Education (General Provisions) Regulation 2017* which outlines the management of educational facilities including compliance and regulation, the rights of students, and compulsory schooling requirements. The legislative framework for the Department of Education includes the requirement of staff to report child sexual abuse or suspected child sexual abuse. The *Aware. Protective. Safe. Strategy* established in 2020 and updated in 2021 sets out the department's commitment to the National Principles for Child Safe Organisations and to keeping children safe in educational environments. The Department of Education also incorporates regulatory bodies such as the Early Childhood Regulatory Authority, which provides oversight of ECEC services in Queensland, ensuring their compliance with the National Quality Standards.

Victims' Commissioner

The *Victims' Commissioner and Sexual Violence Review Board Act 2024* (Qld) establishes the independent statutory role of the Victims' Commissioner, tasked with advocating for victims of violent crime and overseeing systemic reviews of sexual violence through the Sexual Violence Review Board. In the context of child sexual abuse, the Commissioner's role is to ensure the justice system better reflects the dignity, safety, and evidence of victims, while amplifying victim-survivors voices in law reform and policy development. The Commissioner's Strategic Plan 2024–29 commits to a trauma-informed, rights-based, and person-centred approach, seeking to dismantle barriers to justice and ensure victims—including children—receive respectful and consistent support across police, health, legal, and social service systems.

Queensland Family and Child Commission

The *Queensland Family and Child Commission Act 2014* (Qld) establishes the Queensland Family and Child Commission as a statutory body with functions centred on systemic oversight, research, advocacy, and promoting the safety and wellbeing of children and young people. Importantly, the Act does not confer on the Commission any operational child safeguarding responsibilities. Its role is to monitor, advise, and support improvement across government and non-government systems rather than intervene directly in individual cases. This distinction will shift with the commencement of the *Child Safe Organisations Act 2024* (Qld), which introduces a new regulatory role for the Commission. Under this scheme, the Commission will be responsible for monitoring and enforcing compliance with legislated child safe standards across organisations that engage with children in Queensland, marking its first direct role in operational child safeguarding. Critically on 1 July 2026 the Commission will become responsible for operating a reportable conduct scheme in Queensland.

The effectiveness of government entities depends not only on structures but also on culture. The Royal Commission revealed that many institutions prioritised their reputations over children's safety. This culture of denial and defensiveness allowed abuse to persist and discouraged victims from coming forward. Transforming agencies requires cultural change as much as structural reform. Agencies must move from being compliance-driven and risk-averse to being genuinely child-centred, transparent, and accountable. This involves leadership, training, and engagement with children and victim-survivors.

Current programs that protect children

Programs bring all of these elements—laws, strategies, agencies—into the lives of children and families. Government programs are where children and families encounter the system most directly. They can empower children, support families, and reduce risk. Yet programs are vulnerable to funding cuts and political shifts. A program may be highly effective but discontinued when a government changes or budgets tighten. This instability undermines prevention and leaves communities without consistent support.

Prevention programs in schools, such as respectful relationships education and protective behaviours curricula, equip children with knowledge and skills to recognise unsafe situations. Community programs, often delivered by non-government organisations with government funding, support families to build resilience and reduce risk factors associated with abuse, such as social isolation, poverty, or parental mental health issues. The Bravehearts Ditto's Keep Safe Adventure Show, for example, delivers protective behaviours education to young children in schools and early learning centres across Australia. Australia's Biggest Child Safety Lesson, an annual initiative by the Daniel Morcombe Foundation, stands as a pivotal national effort in child safety education. This live-streamed event, conducted during National Child Protection Week, delivers age-appropriate safety messages to children aged 4 to 12 years. The lessons focus on empowering children to recognise, react to, and report unsafe situations, thereby promoting personal safety and consent. By engaging thousands of students across the country, it fosters a culture of awareness and proactive safety among young Australians. Through these efforts, the foundation has significantly contributed to raising awareness and providing resources that empower children to protect themselves, ensuring that Daniel's legacy continues to inspire and safeguard future generations.

Therapeutic programs for victim-survivors, such as those funded through the National Redress Scheme, provide counselling and support services.

Perpetrator-focused programs are another crucial component, though often less visible. Programs such as New South Wales' Cedar Cottage, which offered treatment for intrafamilial offenders as an alternative to incarceration under certain conditions, aim to prevent reoffending by addressing underlying behaviours. Similarly, the federal government has funded initiatives to prevent online child sexual exploitation, recognising the growing risks posed by digital environments. These programs show that prevention must operate on multiple fronts: reducing risks for children, supporting families, and intervening with those who pose threats.

Creating child safe bureaucracies requires more than compliance; it requires cultural change towards openness, listening, and accountability. Training, leadership, and survivor engagement are all necessary for shifting cultures from defensive to child-centred.

Role of community and private organisations

Both private and non-government organisations are critical to preventing and responding to child sexual abuse. They are often the first point of contact for children and families and therefore have a responsibility to operate in a child safe manner. Schools, ECEC services, sporting organisations, hospitals, disability services, and community health providers all occupy positions of trust that enable early identification of risks and direct support to children.

Organisations also have legal and ethical responsibilities, including mandatory reporting obligations in many jurisdictions and in many cases obligations under their relevant regulatory regime. More broadly, they are expected to implement the National Principles for Child Safe Organisations, embedding child safety into governance, culture, and practice. Organisations also contribute by raising awareness, conducting research, and providing direct services to victim-survivors and their families.

Communities

Finally, the broader social context cannot be overlooked. Governments and organisations operate within a society that holds certain beliefs, values, and attitudes about children, sexuality, authority, and institutions. Stigma, silence, and shame surrounding sexual abuse have historically discouraged disclosure and reporting. The Royal Commission found that many victim-survivors carried their experiences in silence for decades. Changing this culture is a long-term project, requiring public education, survivor advocacy, and community conversations. Government campaigns, non-government leadership, and media engagement all play roles in shaping a culture where abuse is no longer hidden but recognised and addressed.

The Australian community as a whole has a shared responsibility to promote child safety. Families, communities, and individuals play a crucial role in recognising signs of harm, understanding the risks and protective factors associated with child sexual abuse, and knowing how to respond to concerns.

Australians demand that governments protect children, yet also value family autonomy and privacy. Navigating these expectations requires careful policy design and clear communication.

Community awareness and vigilance underpin broader safeguarding and prevention strategies. By fostering safe and supportive environments, individuals and communities contribute to resilience and wellbeing, helping to prevent abuse before it occurs.

Trust is central. When communities trust government and institutions, they are more likely to report concerns, engage with services, and support prevention initiatives. When trust is broken, as it was in many institutions exposed by the Royal Commission, rebuilding it is a long and difficult process. Transparency, accountability, and meaningful engagement with victim-survivors are essential for restoring trust. The establishment of the National Redress Scheme was one attempt to provide recognition and support to victim-survivors, though it has faced criticism for complexity and delay. Nevertheless, it demonstrates a national acknowledgment of institutional failures and a commitment to providing some measure of justice. The role of trust cannot be overstated. When communities lack trust in government or institutions, they may hesitate to report abuse or engage with services.

Social features of the Australian community shape how governments and bureaucracies operate. Attitudes towards authority, children, and family influence both the demand for services and the willingness to engage with them. Historically, silence and stigma around sexual abuse meant that many victim-survivors did not disclose until decades later. The Royal Commission documented this in harrowing detail, showing how victim-survivors felt silenced by shame, disbelief, or fear of retribution. Public awareness campaigns and survivor advocacy have begun to shift this culture, but stigma and reluctance remain significant barriers. Government has a role to play in continuing to normalise conversations about the safety of children and in creating safe avenues for disclosure.

Conclusion

One of the most striking lessons from the Royal Commission is that failures were not confined to a single sector or type of organisation. Abuse occurred in churches, schools, sporting clubs, government institutions, foster care, and online environments. This finding reinforced the point that prevention must be systemic and societal.

“

No single set of laws, no single agency, and no single program can create safety alone. Instead, a whole system must work together, with each component reinforcing the others.

Legislation provides the binding framework, strategies give direction, agencies operationalise policy, and programs bring interventions into lived reality. When any of these components are weak or disconnected, the entire system is compromised.

”

Looking forward, achieving a homogeneous response to preventing child sexual abuse requires several key commitments. First, legislation must continue to evolve to close gaps and ensure consistency across jurisdictions. This includes harmonising definitions, strengthening mandatory reporting, and ensuring all organisations that engage with children adhere to child safe standards. Second, strategic plans must provide continuity and accountability, ensuring that prevention remains a national priority across political cycles. Third, agencies must pursue cultural change as well as structural reform.

Building genuinely child-centred bureaucracies requires leadership, training, and ongoing engagement with children and victim-survivors. Fourth, programs must be sustained and embedded, rather than subject to the vagaries of funding cycles. Prevention must be treated as core business, not as an optional or temporary initiative. Fifth, communities and local governments must be engaged as active partners. Prevention is most effective when it is grounded in local realities and supported by strong local networks.

Finally, the broader cultural shift towards openness, awareness, and accountability must continue. The Royal Commission changed the national conversation, but cultural change takes generations. Governments, institutions, communities, and families must continue to challenge stigma, break silences, and promote child safety as a shared responsibility.

Case study

Prevent. Support. Believe: Queensland's Framework to address sexual violence

Queensland's Framework sets a vision for everyone in Queensland to live free of the fear, threat or experience of sexual violence. The Framework's three priorities are:

1. **Prevention:** everyone works together to bring about cultural, behavioural and structural change to prevent sexual violence.
2. **Support and healing:** all people who are impacted by sexual violence are believed and supported to recover and heal.
3. **Accountability and justice:** the justice system is responsive to the needs of victims and survivors, and perpetrators are held to account for their actions.³⁶

The framework identifies priority areas for action and strategies to prevent and respond to all people who experience sexual violence, including children and young people. It also recognises that sexual violence is a gendered issue with the majority of victim-survivors being women and girls.

Implementation of the framework is being delivered through a series of whole-of-government Action Plans (2021–22, and 2023–24 to 2027–28). The current second Action Plan aims to progress measures to increase knowledge and understanding of the drivers of sexual violence, and challenge attitudes, practices and structures which enable violence to occur and prevent people from speaking out against it. The Department of Families, Seniors, Disability Services and Child Safety is responsible for the delivery of these action plans.

Actions currently being progressed include:

- Continuing to strengthen support for people who are impacted by sexual violence to navigate the criminal justice system and investigating the expansion of alternative justice responses by continuing the witness intermediary pilot program in relation to child sexual offence prosecutions, to assist witnesses and victim-survivors with communication difficulties to give their best evidence.
- Continuing to review and evaluate justice processes and relevant laws in Queensland to ensure that victim-survivors of sexual violence are supported and perpetrators are held accountable to ensure that the sexual abuse and exploitation of children is addressed in a way that is consistent with community standards.

Chapter

03

The systems under review: The Queensland early childhood education and care system

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The Queensland early childhood education and care system

Over the past 25 years, Australia's early childhood education and care (ECEC) sector has undergone a dramatic transformation. Shaped by policy changes, rising workforce participation, shifting social expectations, and significant investment, the ECEC sector has expanded in scale and seen major shifts in usage patterns.

Today ECEC is a foundational part of Australian social infrastructure. In 2025, approximately 1.44 million children from around 1.02 million families regularly access government-approved care,³⁷ up from about 1.27 million children and 874 000 families in 2016.³⁸

Australian Bureau of Statistics survey data shows that in 1999, 17 per cent of Australian children aged zero to 11 attended formal care, being either outside school hours care, long day care, family day care, occasional care or other formal care.³⁹ For children aged zero to four, this proportion was 27 per cent.⁴⁰ By 2017, the proportion of zero- to 12-year-olds who attended formal care had risen to 27.2 per cent, and to 42 per cent for zero- to four-year-olds.⁴¹ In 2025, the proportion of children aged zero to 12 years who attend a Child Care Subsidy approved service is 35 percent, and 50.8 per cent for zero- to five-year-olds⁴². This shift reflects parents' growing reliance on formal childcare to support workforce participation.

ECEC services, include:

- long day care
- family day care
- preschool/kindergarten
- outside school hours care (OSHC).⁴³

Most children attending these services are under the age of five, with long day care being the most common arrangement.

Nationally, there are more than 17,000 approved services.⁴⁴ Over half are operated by for-profit providers, including large corporate chains and private equity-backed operators.⁴⁵ The sector is supported by approximately \$15 billion in combined annual government subsidies and employs over 250,000 workers.⁴⁶ The workforce is overwhelmingly female, with only 7.6 per cent of employees being male.⁴⁷



Data snapshot – The ECEC system



3302 approved ECEC services operated in Queensland as of 31 December 2024.



54 per cent of the national ECEC market is run by for-profit providers, approaching **70 per cent** in centre-based services. The **majority** of OSHC and family day care services are operated by for-profit providers.



1 per cent of providers are considered large (operating 25+ services), yet they manage **36 per cent** of all services.

Since the introduction of the National Quality Framework (NQF) in 2012 the number of approved ECEC services across Australia has increased from just over 14,116 in 2013⁴⁸ to 17,842 in 2024.⁴⁹ The vast majority of these services are centre-based with family day care currently representing only two per cent of approved ECEC services.⁵⁰

Funding and profitability of the sector

IBISWorld Industry market research reports that Australia's ECEC services industry revenue is projected to reach \$22.3 billion in 2025–26, up from about \$21.4 billion in 2024.⁵¹ Forecasts show an expected continuation of this increase into the late 2020s, reaching around \$25.7 billion by 2030.⁵²

The childcare industry is heavily reliant on government funding and therefore changes in government policies can have a significant impact on the industry's performance. The impact of the government's 2023 Cheaper Child Care policy which sought to provide cost-of-living relief to Australian families by reducing the cost of ECEC services is an example of this. In 2023–24, total Australian, state and territory real government recurrent and capital expenditure on ECEC services was \$18.2 billion.⁵³ The expenditure on child care subsidies represented \$14.11 billion of this spending.⁵⁴ This represents a 26.0 per cent rise in funding of child care subsidies relative to the previous year.⁵⁵ More subdued growth of 4.4 per cent was foreshadowed in the 2024–25 Federal Budget.⁵⁶

Private for-profit providers hold the largest proportion of the sector, representing 54 per cent of services.⁵⁷ This proportion has risen slightly over the last ten years from 46 per cent.⁵⁸ While most approved providers only hold one service (79%), one per cent of approved providers hold more than 25 services each and as a result, this one per cent holds 36 per cent of approved services.⁵⁹

Of the top ten for-profit childcare providers four are owned by private equity companies, two are listed on the Australian Stock Exchange and two others are listed on foreign stock exchanges.⁶⁰

National workforce

Australia's ECEC workforce is made up of approximately 268,050 employees. Women make up the majority of the employees in all service types except OSHC. OSHC employees are also younger than the general labour force, with most other service types having a similar age profile to other sectors. Family day care employees have an older age profile.

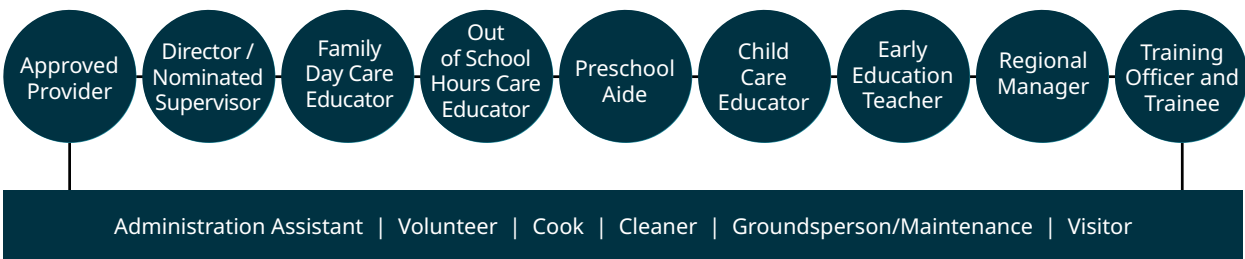
Aboriginal and Torres Strait Islander people make up a higher proportion of employees in ECEC than in other sectors, though they are not well represented in higher paying roles in the sector. The ECEC workforce also has a higher proportion of employees born overseas, with many temporary staff on study visas, and very few on temporary skilled visas.

When comparing the ECEC workforce with similar sectors such as aged care and disability care, ECEC staff on average work more hours but are paid at similar rates. Further, lower level ECEC staff have lower average weekly earnings than 'storepersons' and 'general clerks' despite requiring higher levels of education. Early childhood teachers are also paid significantly less than primary school teachers despite similar qualification requirements.⁶¹

In Queensland the ECEC workforce is similar demographically to the national workforce. Over 52,000 staff were employed across services in Queensland in 2024, more than 92 per cent of whom were women. The majority of workers are employed in long day care, kindergarten, and OSHC, with a smaller proportion in family day care and occasional care.

Workforce mobility is significant, with staff moving between services and jurisdictions, reflecting the national portability of qualifications and the relatively high turnover in the sector compared to other areas of education.

Figure 11: Scope of the ECEC Workforce



The qualification profile of the workforce reflects the requirements of the NQF, which mandates minimum educator-to-child ratios and qualification levels. Nationally, around 81 per cent of paid contact staff hold an ECEC-related qualification, ranging from a Certificate III to a bachelor's degree. Almost 15 per cent of the workforce hold a bachelor's degree or higher, often employed as Early Childhood Teachers (ECT). In Queensland, registration with the Queensland College of Teachers (QCT) is not required for ECTs in most services, though many voluntarily maintain their registration. Training requirements also include ongoing professional development, first aid, child protection awareness, and health and safety modules, which are embedded in service approval and staff obligations under the NQF.

Despite high levels of qualification, the workforce faces challenges of retention and tenure. Average tenure is relatively short, with a significant proportion of staff leaving within five years of entering the sector, citing workload pressures, limited pay progression, and the emotional demands of the work.

Recruitment and retention pressures are heightened in regional and remote areas, where services often experience chronic shortages of qualified educators. Workforce mobility—while offering flexibility and career progression—also impacts service continuity for children and families. These dynamics have led to calls for more structured career pathways, greater investment in professional development, and national strategies to stabilise and strengthen the workforce.

There are significant pressures on providers and government to ensure a sufficiently sized workforce. The *Future of the Early Childhood Education Profession* report by Skills Australia in 2024 found that:

Current workforce levels are not sustainable to even meet current levels of demand taking into account numerous factors including:

- *evidence of overtime being worked*
- *insufficient provision for ongoing professional development*
- *increasing reliance on trainees to meet workforce requirements, given their 20% allocation of paid work time for off-the-job learning*
- *time spent by more established staff recruiting and onboarding new staff and providing on the job supervision to trainees*
- *the high and increasing use of waivers by services not meeting National Regulations regarding staffing arrangements.*⁶²

It also found that:

In order to meet the various policies already committed to by Commonwealth, State and Territory governments, the ECEC workforce will likely need to increase by an annual average growth rate of 1.9 per cent per year overall and by 3.2 per cent per year for Early Childhood Teachers.⁶³

And:

When examined at the regional (SA4) level workforce shortages are apparent in most regions across major cities, regional and remote Australia and are forecast to persist over the next ten years.⁶⁴

Another key feature of the ECEC sector is the increased use of labour hire. A labour hire firm is a company that recruits and employs workers, then supplies them to client organisations on a temporary or contract basis. The workers are technically employees of the labour hire firm, but they perform work under the direction and supervision of the client organisation. Labour hire arrangements are common across sectors with fluctuating workforce needs, including healthcare, construction, hospitality, and early childhood education. These arrangements provide a flexible solution for organisations that face short-term surges in demand or skills shortages, without the administrative burden of direct employment.

The benefits of labour hire are particularly evident in sectors experiencing high workforce demand. For example, organisations can rapidly scale staffing levels to meet peaks in service delivery, access specialised skills that may be scarce locally, and reduce recruitment and training costs. Labour hire can also improve operational efficiency by allowing permanent staff to focus on core responsibilities while temporary staff cover gaps, and it can facilitate workforce diversity and mobility by introducing staff with varied experiences and expertise into the organisation.

However, labour hire arrangements also introduce risks and challenges. One of the most significant concerns is the dilution of worker–organisation accountability. Because the worker is formally employed by the labour hire firm, the client organisation may have less control over performance management, supervision, and compliance with organisational policies. This can be particularly problematic in sectors involving vulnerable populations, such as children or older people, where adherence to safeguarding protocols, mandatory reporting, and behavioural standards is critical. There is also the risk that organisations may rely too heavily on labour hire staff to fill gaps in permanent staffing, potentially undermining organisational culture, continuity of care, and systemic oversight.

Effective governance, clear contractual obligations, and strong induction and supervision processes are essential to mitigate these risks and ensure that labour hire staff uphold the same standards as permanent employees.

Data snapshot – ECEC Workforce

In Queensland **52,377** staff were employed across ECEC services in 2024. Over **40,000** (80%) worked in long day care, limited hours care, and occasional care

91.2% female

81% of paid contact staff nationally held an ECEC-related qualification (Certificate III to degree)

15% held a bachelor's degree or higher

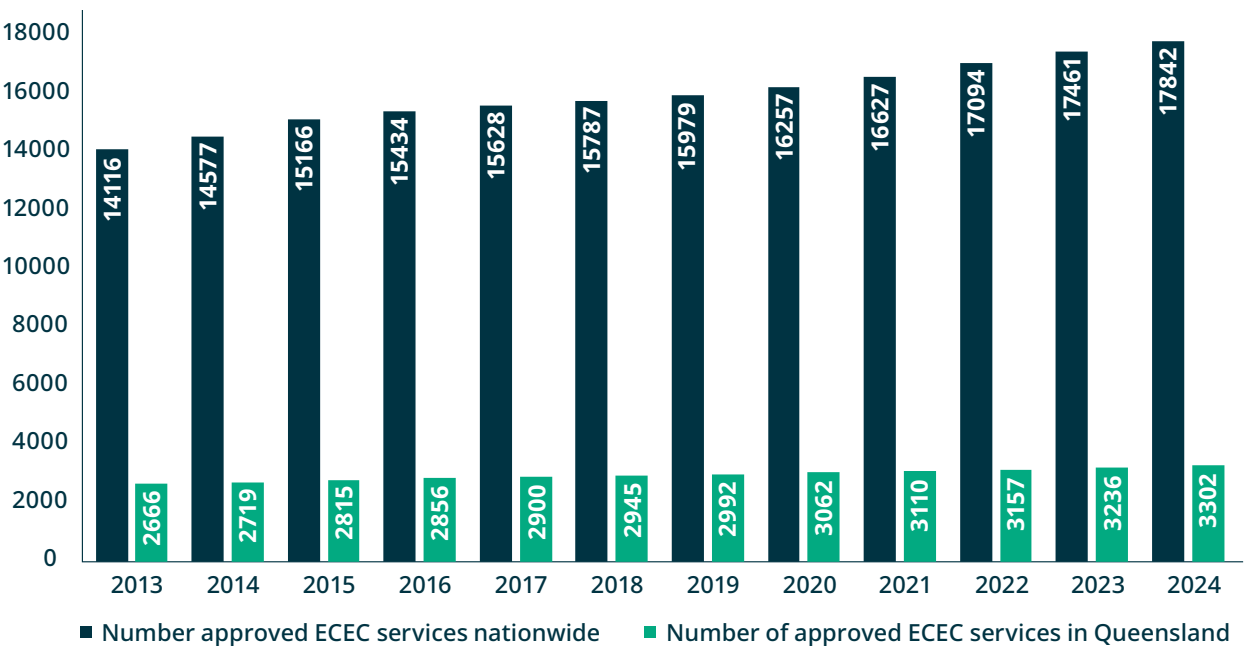
Queensland's ECEC system

Queensland's ECEC sector encompasses a range of service types, including family day care, long day care services, kindergarten, and OSHC. As of 31 March 2025, there were 3,355 approved ECEC services in Queensland, reflecting a diverse and growing sector.

Queensland represents just under 20 per cent of all ECEC services nationally.⁶⁵ Services are provided by a mix of for-profit and not-for-profit providers. While the number of not-for-profit providers has remained relatively stable over the past decade, their market share has declined, reflecting the expansion of for-profit operations, particularly in centre-based services.

Figure 12: Number of approved ECEC providers

Source: ACECQA NQF Snapshots 2013 to 2024



Legislative and regulatory framework for ECEC in Queensland

ECEC services in Queensland operate within a legislative and regulatory framework designed to ensure high-quality service delivery and safeguard the safety, health, and wellbeing of children. The sector is primarily regulated under the NQF, which provides a national approach to regulation, assessment, and continuous quality improvement across Australia. The NQF comprises three key elements:

1. *Education and Care Services National Law Act 2010* (National Law) – establishes the legal basis for the regulation of ECEC services.
2. Education and Care Services National Regulations (National Regulations) – details operational and compliance requirements for services.
3. National Quality Standard – sets benchmarks for service quality across seven quality areas, including educational programs and practice, health and safety, and governance and leadership.

While the NQF encompasses multiple domains of quality and compliance, child safeguarding and wellbeing remain central objectives.

The Early Childhood Regulatory Authority (ECRA) is the statutory authority responsible for administering the NQF in Queensland.

ECRA has a range of compliance and enforcement powers. For service providers, these include compliance directions or notices, enforceable undertakings, amendments, suspensions or cancellations of service approvals, and prosecution. Where offences are committed by individual educators, ECRA may issue enforceable undertakings, impose prohibitions, or initiate prosecution.

ECRA operates within the Queensland Department of Education. It is responsible for regulating ECEC services across the state, including those operating under the NQF and the *Education and Care Services Act 2013* (ECS Act). ECRA's primary functions encompass the following:

- **Regulation and compliance:** monitoring and enforcing compliance with the NQF and ECS Act, including service approvals, amendments, and waivers.
- **Assessment and rating:** evaluating services against the National Quality Standard and national regulations to determine service ratings.
- **Investigation and enforcement:** investigating complaints and incidents, and taking appropriate enforcement actions such as compliance notices, enforceable undertakings, and, where necessary, prosecution.
- **Support and guidance:** providing information, advice, and resources to service providers to support compliance and continuous improvement.

ECRA has narrow powers to share information with other government agencies but must share information in relation to prescribed statutory compliance action with Blue Card Services (BCS).⁶⁶ In exercising the functions of the regulatory authority, ECRA and its officers must have regard to the objectives and guiding principles of the National Law including that the rights and best interests of the child are paramount.

ECRA undertakes its regulatory role using the Regulating for Quality (R4Q) risk-based framework. The R4Q risk-based approach is aimed at identifying and assessing risks to the quality of ECEC services to ensure that ECRA focuses its efforts effectively on areas that present the greatest risk to the health, safety and wellbeing of children.⁶⁷

Striving for quality education in care

The NQF came into effect in Queensland and most other states and territories on 1 January 2012. It is a national approach to regulation, assessment and quality improvement which comprises the National Law, the National Regulations, and the National Quality Standard.

Prior to the commencement of the NQF in 2012, the ECEC sector operated under separate, state-based regulatory regimes. In Queensland, this was under the *Child Care Act 1991* and the *Child Care Act 2002* (the Child Care Acts). From 1 September 2003, the *Child Care Act 2002* replaced the 1991 Act for the regulation of ECEC in Queensland.

In 2009, the Council of Attorneys-General endorsed the *National partnership agreement on the National quality agenda for early childhood education and care* as the first step for a nationally harmonised system of regulating ECEC. This emerged from the *Early Childhood Development Strategy*, endorsed by the Council of Australian Governments (COAG) in 2009, which committed the Commonwealth, states and territories to standardised measures and outcomes for early years health, development, learning and wellbeing.

To coincide with this agreement, the responsibility for ECEC in most jurisdictions shifted to the Education Minister's portfolio. This was the case in Queensland with the responsibility for ECEC shifting to the Department of Education and Training (as it then was) in 2009. Prior to this, from the early 2000s until 2004, ECEC sat within the responsibilities of the Minister for Families at which point it shifted to the Minister for Communities.

The NQF and its administering authorities now operate within a legally defined structure that balances compliance, quality assurance, and improvement. This structure ensures:

- consistent standards across Queensland and Australia
- clear accountability for providers, educators, and regulatory bodies
- oversight mechanisms that prioritise child safety and wellbeing alongside service quality.

While the qualification requirements for educators and programming requirements were not substantially altered as part of the shift to the NQF, the introduction of the National Quality Standards (NQS) has seen a significant emphasis on the oversight of educational programming. The objectives of the National Law, as compared to the Child Care Acts also reflect this change.⁶⁸

The National Law and the National Regulations are Victorian and New South Wales legislation, respectively. The *Education and Care Services National Law (Queensland) Act 2011* applies both the National Law and National Regulations in Queensland. Unlike most subordinate legislation, the National Regulations are exempt from expiry. The National Regulations include exceptions for individual jurisdictions to accommodate differing state-based regulatory schemes, made as concessions during negotiations over the National Regulations in 2011.

On 1 October 2017, significant changes were made to the National Regulations.

- these changes included modified requirements for qualifications held by educators, extension of the complex rest period supervision ratios previously in the Child Care Act and provided exceptions to ratio and qualification requirements for rest pauses or other absences of less than ten or five minutes respectively
- these arrangements were intended to expire at the end of 2019; however, several continue to operate.

Together, ECRA and the Australian Children's Education and Care Quality Authority (ACECQA) provide an integrated system of state and national governance, ensuring ECEC services are safe, effective, and aligned with contemporary educational and care standards.

Services approved under the National Law are assessed and rated against the NQS. The rating report provides the service with a detailed assessment of its quality including strengths and areas for improvement, against each of the 15 standards within the NQS. It also provides a rating for each quality area and an overall rating for the service.

Publication of service ratings provides families objective information about service quality to inform their decisions about their children's education and care. These ratings must be displayed at the entrance of the service⁶⁹ and are published on the ACECQA website.⁷⁰ Services can receive a rating of Excellent (awarded by ACECQA), Exceeding, Meeting, Working Towards or Significant Improvement Required.



Data snapshot – The quality of ECEC sector as of 31 March 2025, in Queensland



94% of services have a quality rating



89% of services are rated exceeding or excellent⁷¹

The NQF sets no requirements regarding how often services must be visited. Under the ECS Act, services need to be visited by ECRA at least once every three years.⁷² In 2023–24, ECRA ensured that all approved ECEC services received at least one monitoring visit during the year.⁷³ ECRA receives intelligence regarding possible breaches of the legislation by way of prescribed notifications under the National Law and through direct complaints.

Where a breach of the National Law or National Regulations is substantiated, ECRA may take enforcement action. There are a range of compliance actions against a provider available to ECRA including compliance directions or notices, enforceable undertakings, amendments, suspensions or cancellations to service or provider approvals, or prosecution.⁷⁴

If an offence is committed by an educator, the compliance actions available to the ECRA are an enforceable undertaking, prohibition or prosecution.



Data snapshot – Compliance issues in Queensland ECEC services



620 breaches of the National Law and Regulations in Queensland involved inadequate supervision of children in 2023–24.



478 breaches involved failure to protect children from harm and hazards.



247 breaches involved failure to notify certain information to ECRA.

Table 2: Statutory enforcement actions undertaken by ECRA, 2023-24

Source: Department of Education (September 2024). Regulatory data: 2023–2024 FY summary.⁷⁵

Statutory enforcement actions	Number of actions
Compliance notice issued	681
Compliance direction issued	160
Emergency action notice issued	58
Enforceable undertaking accepted	20
Prohibition notice issued	13
Prosecution initiated	4
Condition imposed	2
Inappropriate person excluded	1
Notice of suspension	1
Total	940

Licensing

Operating an ECEC service under the NQF requires a provider approval and a service approval, both of which are assessed, granted and monitored by ECRA. ECRA also assesses a range of other applications including but not limited to amendments and internal reviews.

In the 2023–24 financial year, ECRA received 2079 applications with 190 being for provider approval and 130 for service approval.⁷⁶

The provider approval assessment considers the suitability of the persons in management or control of the service, including their Working with Children Check (WWCC) and their history of compliance with the National Law.⁷⁷ Under the NQF the provider of the service is legally responsible for the operation of the service. Therefore, the provider is accountable in some capacity for failures to comply with the legislation including notifying ECRA.

The service approval assessment considers the suitability of the service premises and the proposed policies and procedures of a service.⁷⁸

ECRA plays no role in the approval of other positions. When the National Quality Framework (NQF) commenced in 2012, approval from ECRA was required for a person to be placed in day-to-day charge of an education and care service through the issue of a supervisor certificate. This assessment considered an individual's fitness and propriety, as well as whether they met minimum qualification and experience requirements.

However, this provision was repealed on 1 October 2017 to reduce the administrative burden on services and regulatory authorities. The supervisor certificate was removed so service providers had more autonomy in deciding who could be the responsible person in each service. Under the current National Law and Regulations, approved providers are responsible for ensuring that:

- a nominated supervisor is appointed for each service
- the nominated supervisor and any person in day-to-day charge of the service are fit and proper, have suitable skills, experience, and knowledge of the service's operations, and can meet its obligations under the National Law
- the approved provider keeps records of the person's qualifications, experience, and evidence of their suitability for the role.

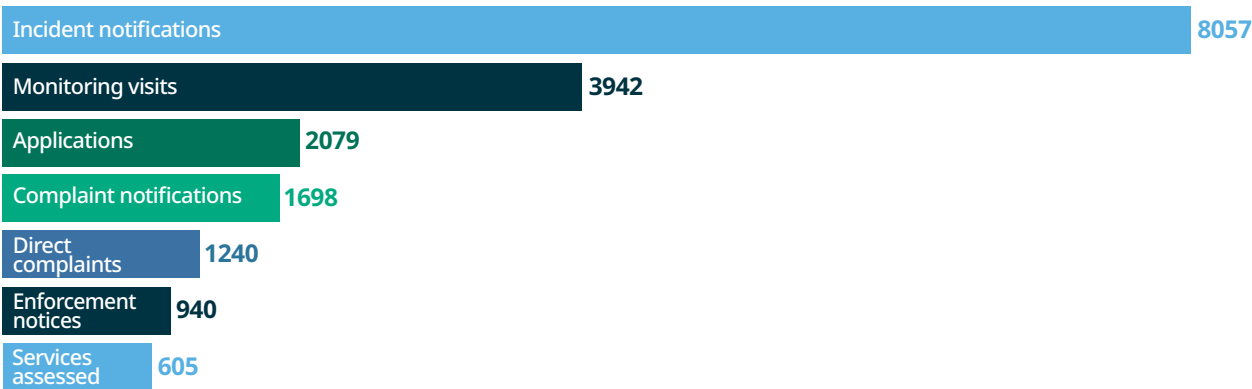
Ensuring the safety, health and wellbeing of children attending ECEC services is one of the objectives of the NQF. While the NQF sets out clear expectations for providers of services, both from a compliance and quality perspective, child safeguarding practice is just one of many areas of focus.

Authorised officers from ECRA visit services to assess their compliance with regulatory requirements. Visits may be announced or unannounced. They may be proactive and consider a range of compliance requirements or target a particular area of concern or risk in response to a notification or complaint. Entry powers coincide with both situations.⁷⁹ These visits also provide an opportunity for guidance to support compliance and promote improvement.

Current resourcing and workload

ECRA is supported by a dedicated workforce of over 250 staff within the Department of Education located across 13 regions in addition to the central office in Brisbane. In August 2025, the Queensland Government announced a \$12.7 million investment over four years to employ an additional 29 full-time early childhood regulatory officers. This initiative aims to enhance the capacity of ECRA to oversee the growing sector and ensure the safety of children.

Figure 13: ECRA workload 2023–2024 financial year⁸⁰



ECRA collaborates with various stakeholders, including approved providers, peak bodies, and ACECQA, to improve service quality and compliance.

Australian Children’s Education and Care Quality Authority

At a national level, ACECQA provides independent oversight and guidance. It is the statutory authority established by Australian governments in 2012 to oversee the implementation of the NQF. While each state and territory has its own regulatory authority for ECEC services, ACECQA provides national leadership and coordination, ensuring a consistent and high-quality approach across jurisdictions.

ACECQA is accountable to the nation’s education ministers, who collectively set strategic priorities through the Ministerial Council. It is governed by a nationally appointed board, which guides its strategic direction and ensures alignment with broader education and care policies. ACECQA’s core mandate is to support governments and the sector in delivering on the objectives of the NQF. Its functions extend across multiple areas, including:

- maintaining national registers of services and providers, enhancing transparency for families and regulators
- managing the National Quality Agenda IT System, a secure platform for information-sharing between providers and regulators
- providing resources, training and professional development to support regulatory officers and service providers
- conducting second-tier reviews of service quality ratings and awarding the prestigious ‘Excellent’ rating,
- publishing national data, research, and guidance materials, such as the NQF Snapshot, to monitor sector performance and inform policy development.

ACECQA also plays a crucial role in policy reform and capacity-building. It develops professional resources for both regulators and providers, supports family engagement through public-facing platforms such as StartingBlocks.gov.au, and advises governments on emerging priorities in quality, safety, and workforce development. Its recent work has focused on strengthening the child safety and safeguarding content in ECEC qualifications, ensuring the workforce is better equipped to respond to contemporary challenges.

Strategically, ACECQA positions itself as both a regulator and enabler of quality improvement. It applies child-centred principles, supports cultural inclusion, including recognition of Aboriginal and Torres Strait Islander perspectives, and promotes equity and access across the early learning sector. By working in partnership with state regulatory authorities, ACECQA ensures that while regulatory responsibilities remain decentralised, the standards and expectations applied to ECEC services remain consistent, transparent, and nationally coherent.

Response to child sexual abuse

Any adult, regardless of their position in an ECEC service, who reasonably believes that a child sexual offence is being or has been committed at the service must report the information to the police as soon as possible.

If an approved provider of an ECEC service reasonably believes that child sexual abuse is occurring or has occurred while a child is being educated and cared for by the ECEC service, they must notify ECRA within 24 hours of developing that belief.

If an approved provider of an ECEC service receives any allegations that child sexual abuse is occurring or has occurred while a child is being educated and cared for by the ECEC service, they must notify ECRA within 24 hours of receiving the allegation.

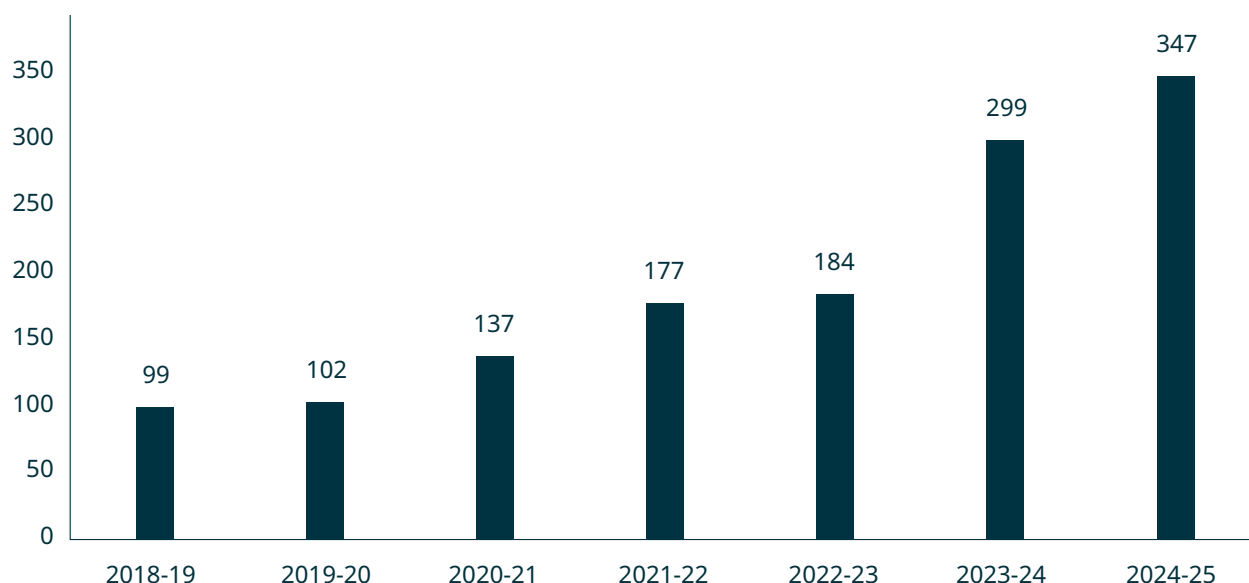
If an ECRA officer receives information that causes them to develop the reasonable belief that a child sexual offence is or has been committed at a service, they must report the information to police as soon as possible. If the ECRA officer believes that the offence has already been reported to police, for example if the approved provider has indicated that they have reported the matter to police, then they are excused from complying with this requirement. Compliance with this requirement would not give rise to a breach of the confidentiality provisions in the National Law.

If a notification regarding child sexual abuse is received by ECRA, a risk assessment is undertaken to determine what happens next. If more information is required an investigation may be conducted. If an investigation is conducted, the scope would be confined to determining whether an offence has been committed against the National Law or National Regulations.

If ECRA is satisfied that non-compliance is substantiated, a risk assessment is undertaken to determine an appropriate and proportionate regulatory response. This action can range from providing information and advice where non-compliance is low-risk and the approved provider is willing and able to address the non-compliance, to high level statutory sanctions when the non-compliance involves serious harm to children and/or significant negligence on the part of the approved provider. If ECRA takes prescribed statutory action such as amending, suspending or cancelling an approval or prohibiting a person involved in the provision of education and care, it must give written notice of this action to BCS.

Specific requirements to notify incidents and allegations of physical and sexual abuse came into effect from 1 October 2017, following the introduction of Regulations 175(2)d and 175(2)(e) of the National Regulations (Figure 14). Sexual abuse allegations and incidents notified include reports of both child sexual abuse and harmful sexual behaviours in children.

Figure 14: Notification of physical or sexual abuse occurring in ECEC services in Queensland



Reforms to the ECEC system

In 2023, ACECQA undertook a *Review of the Child Safety Arrangements under the NQF* (Child Safety Review). The Child Safety Review sought to identify new or refined systemic safeguards needed to support ECEC services to protect children, with a focus on reducing harm, abuse and neglect. It also extended to inter-related child safeguarding mechanisms such as WWCC and teacher registration.

The Child Safety Review found that while the NQF is a robust regulatory scheme, it exists in the context of a broad, interconnected child protection landscape, often at the jurisdictional level, which can be confusing to navigate and results in overlap. It also identified that many large providers operate across multiple states and territories and face ongoing challenges with high demand and a lack of educators and teachers.

Some recommendations from the Child Safety Review have been implemented, having taken effect from 1 September 2025. This includes a reduction in notification timeframes for reporting allegations or incidents of physical or sexual abuse from seven days to 24 hours. Stronger protections around digital technology use have also been implemented, with services required to have clear policies on taking photos and videos of children, including in obtaining parent consent, CCTV use and using service-issued devices.

The Australian Productivity Commission recently undertook an inquiry into the ECEC sector in Australia. The final report, *A path to universal early childhood education and care* highlighted the need for access to quality ECEC education for all children and a larger ECEC workforce. In its 2025–26 Budget, the Australian Government announced wage increases for ECEC educators and incentives to increase the supply of high-quality ECEC places, especially in priority and under-served markets.⁸¹ Implementation is also focused on strengthening integrity across the care economy, including greater powers to respond to providers who pose a potential integrity risk, persistently fail to meet minimum standards and/or who commit egregious or continued breaches.

As part of the current *Delivering quality care more efficiently inquiry*, the Productivity Commission is also considering reform of quality and safety regulation to support a more cohesive care economy through an examination of:

- ways to improve how regulators work together, including how they share information and recognise each other's decisions
- opportunities to streamline processes to reduce duplication across sectors
- how safety and quality regulations could be better aligned or made more consistent across the care economy to drive improvements in safety and quality.⁸²

The Productivity Commission is due to deliver its final report in December 2025.

Conclusion

While many children receive high-quality care, the ECEC system faces well-documented challenges, including high staff turnover and understaffing, inconsistent regulatory oversight, and limited mechanisms for identifying and escalating serious risks. The increasing commercialisation has also generated concerns about balancing financial objectives with child wellbeing.⁸³

These systemic pressures create an environment in which safeguarding failures can occur, including in relation to child sexual abuse. The risks are heightened by the fact that:

- signs of child sexual abuse in early childhood can be subtle
- victim-survivors are often too young to disclose
- institutional responses to concerns remain inconsistent.

Research commissioned by the Board for this Review found:

Barriers to reporting CSA [child sexual abuse] in ECEC are distinct from risk factors but often interact with them to delay detection and response, thereby enabling abuse to continue undetected. Barriers to CSA identification and response in ECEC also operate across multiple, interconnected ecological levels. These include:

- *Individual barriers: Young children, particularly those under five, can lack the verbal, cognitive, and emotional capacity to recognise or disclose abuse. Feelings of shame, fear, and trauma related dissociation can further inhibit purposeful disclosure.*
- *Relationship-level barriers: Children may be silenced by the grooming behaviours of offenders, feelings of loyalty or fear, or concerns that they will not be believed. Some parents may misinterpret or dismiss signs of abuse or lack the knowledge or confidence to act.*
- *Institutional barriers: Within ECEC settings, poor staff training, unclear reporting protocols, and fear of consequences can lead to missed signs and failures to act. Staff may lack the knowledge or confidence to escalate concerns or may be actively discouraged from doing so.*
- *Societal barriers: Cultural taboos, racism, and prejudicial beliefs about the credibility of very young children can prevent disclosure. Broader mistrust in institutions may also discourage reporting.*

These barriers do not simply delay disclosure, but they also create an environment in which abuse can continue without detection or accountability. ...these barriers manifest across ecological levels, reinforcing the need for system-wide reforms that address not only risk but also the conditions that allow harm to remain hidden.⁸⁴

The sexual abuse of children in ECEC settings is a crime that profoundly breaches community trust. These are environments where children are meant to be safe, nurtured, and supported. Exploitation of their vulnerability within such contexts stands in direct opposition to societal expectations of care and protection.

“*ECEC services play a vital role in the lives of Australian children and their families. While many children receive safe and nurturing care in ECEC, the sector faces several safeguarding complexities, including high staff turnover, inconsistent staff oversight, and limited pathways for identifying and escalating risks. These factors can interfere with the prevention, detection and responses to child sexual abuse.⁸⁵*

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The systems under review: The Queensland blue card system

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The Queensland blue card system

The Queensland blue card system is a statutory framework designed to promote safe environments for children and young people by regulating who may work or volunteer in child-related employment, or operate a regulated business involving children. It operates under the *Working with Children (Risk Management and Screening) Act 2000* (WWC Act) and is administered by Blue Card Services (BCS) within the Department of Justice.

Working with Children Checks (WWCCs) are undertaken to ensure people meet the eligibility requirements needed to participate in child-related work. If an applicant is assessed as eligible, they are issued a working with children clearance. In Queensland, this is referred to as a blue card.

The blue card system includes three key components:

- **Employment screening:** a point-in-time employment screening process which issues either a 'Working with Children Clearance' (previously known as a 'positive notice'), or a 'negative notice' barring the applicant from child-related work.
- **Daily monitoring:** daily ongoing monitoring by police of blue card holders for changes in their Queensland criminal history, and monitoring of changes in other information such as disciplinary information and adverse working with children decisions made in other states and territories.
- **Risk management:** a system of risk management by organisations undertaking regulated child-related employment, which is overseen by BCS.
- **Compliance:** auditing and monitoring of individual and employer compliance with blue card system requirements.

The blue card scheme requires that any individual undertaking *regulated employment* or operating a *regulated business* involving children must hold a working with children clearance. Regulated activities are prescribed in Schedule 1 of the WWC Act and include a wide range of settings where children are present, such as childcare, education, health services, residential facilities, sporting organisations, religious institutions, and cultural programs. The requirement applies to both paid workers and volunteers, with limited statutory exemptions (for example, some parent volunteers). The WWC Act lists categories of regulated employment, which includes educators and carers in early childhood education and care (ECEC). Police and registered teachers are not required to hold a blue card for their regular duties as Queensland Police Service (QPS) and the Queensland College of Teachers (QCT) conduct their own screening of prospective employees.

Decisions on whether to issue a clearance rest with the chief executive of the Department of Justice or their delegate. The governing test is whether, based on the information available, 'there is a real possibility that the person will pose a risk to the safety of children'. Arrangements are in place to provide for the exchange of information nationally when a person applies for a WWCC which ensures that relevant criminal history information from outside Queensland can be shared with BCS.⁸⁶ A person with an adverse interstate WWCC decision is unable to receive a blue card in Queensland. Some offences lead to automatic exclusion from eligibility. Persons convicted of *disqualifying offences* listed in Schedule 4, including child sexual offences, serious violent crimes, and offences involving child exploitation material (CEM), must be issued a negative notice which prohibits them from engaging in regulated child-related work or business.

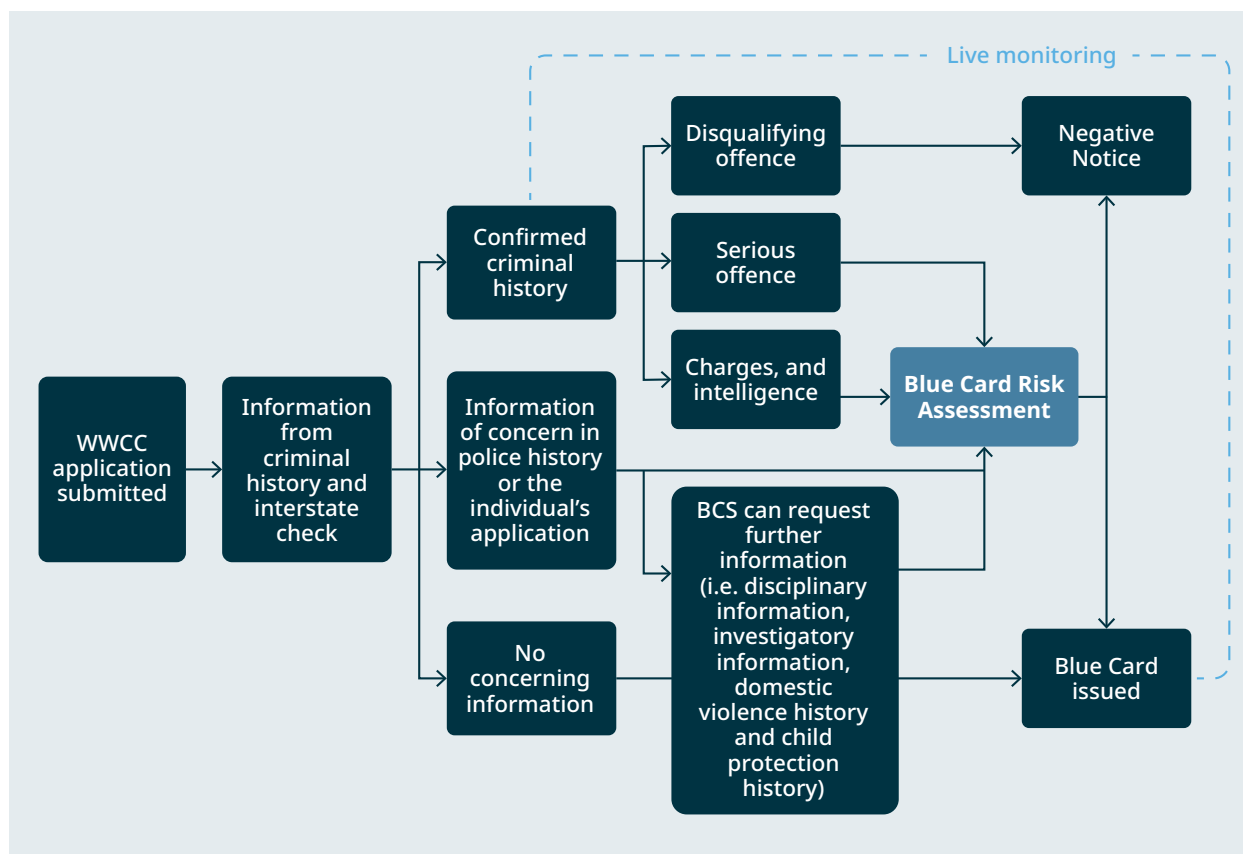
In other cases, the decision is discretionary. Where an applicant has been charged with or convicted of a *serious offence*, or where concerning information is provided by police or other relevant bodies (including charges, disciplinary information or investigatory information), the chief executive must conduct a risk assessment. This assessment balances protective factors, such as evidence of rehabilitation, against potential risk factors, with the welfare and safety of children as the overriding consideration. Affected individuals may seek merits review of the decision in the Queensland Civil and Administrative Tribunal (QCAT) under Chapter 9 of the WWC Act.

The scheme is not limited to a one-off application process. Cardholders are subject to continuous monitoring. The QPS provides BCS with daily updates on changes to a cardholder's Queensland police information. Where new information suggests a potential risk to children, the chief executive has powers under sections 294 to 304A of the WWC Act to suspend or cancel the clearance.

The scheme also places direct obligations on organisations that provide regulated services. Employers and volunteer coordinators must ensure that all personnel engaged in regulated activities hold a valid clearance (s 175). In addition, organisations are required to develop and implement a child and youth risk management strategy tailored to their operations (s 171). Engaging a person in regulated child-related work without a valid clearance is a criminal offence under section 175.

The WWC Act prescribes a range of offences and penalties for non-compliance. These include significant criminal sanctions for individuals who undertake regulated employment without a clearance, for organisations that allow this to occur, and for any misuse of information. Strong enforcement powers and a monitoring, audit and compliance function underpin the scheme to ensure its integrity and effectiveness in protecting children.

Figure 15: The Blue Card decision making process



The WWCC Act contains a dedicated set of information-sharing powers that support the blue card system. These provisions are designed to balance child safety with privacy protections and include powers to obtain and to disclose information. With respect to obtaining information:

- BCS can request and use information from QPS (including charges, convictions, investigative information, and spent convictions).⁸⁷ If interstate charges are disclosed as part of this request, BCS may request the information from an interstate police commissioner.⁸⁸ QPS and interstate police services are authorised to disclose this information.⁸⁹
- BCS can receive information about court outcomes (including findings of guilt, not guilty by reason of mental illness, and charges dismissed).⁹⁰
- BCS can request information regarding a person's mental health in certain circumstances.
- Regulators of education (including ECEC and schools) and disability services can provide disciplinary information.
- The WWCC Act authorises use of information about custodial status, parole, and certain child protection findings.

Other legislation, such as the *Education and Care Services National Law (Queensland) Act 2011* (National Law) also specifies the compulsive requirement to notify BCS regarding certain compliance activities.⁹¹

Eligibility assessment considers information collected about and from a blue card applicant, to assess their risk to children in regulated employment. Since 2021, BCS has been able to use 'other information about the person that the chief executive reasonably believes is relevant' to trigger an in-depth WWCC assessment or reassessment. Information currently able to be considered as part of an assessment of eligibility includes:

- police investigative information (where the Police Commissioner or their delegate has made a determination)
- disciplinary records from across the ECEC, education, child protection and health sectors
- domestic violence orders (since 2022)
- mental health reports
- adverse interstate WWCC decisions (since 2022).

While these changes were introduced to facilitate the use of information provided by disability services under the National Disability Insurance Scheme in assessing a person's eligibility, they also permit the consideration of reportable conduct matters provided to BCS under section 51 of the *Child Safe Organisations Act 2024* when it commences in Queensland in July 2026.



Data snapshot – the blue card system



In March 2025 over **one million Queenslanders**, or nearly **one in five** people in Queensland, held a blue card.³⁴



A total of **385,161** blue card applications were finalised during the 2024–25 financial year, including **3712** outcomes which prohibited the applicant from working with children.³⁵



Less than 1 per cent of applications are refused/not approved.



In 2024–25, BCS cancelled or suspended **758** blue cards as a result of their ongoing monitoring.



In 2024-25 **17.5 per cent** of negative notice decisions reviewed by QCAT were overturned.

BCS currently sits within Queensland Worker Screening Services, part of the Department of Justice's Harm Prevention and Regulation division.

Publicly available information about the exact staffing profile and dedicated budget for BCS is limited. Funding for the scheme is included within the broader departmental allocations, rather than reported as a discrete line item. However, past government announcements provide some insight. In 2018, \$17 million over three years was committed to support reforms, including the introduction of the No Card, No Start policy and improvements to the online application system. This indicates the scale of investment required to maintain and enhance the scheme's infrastructure.

BCS operates as a regulatory body rather than a frontline service, with its resources concentrated on the assessment of known relevant information (such as criminal history, disciplinary and domestic violence information), information gathering, compliance activities, and organisational support. The unit also plays a role in community education.

The operational volume of BCS is considerable. As of mid-2025, there were 1,029,960 current blue card holders in Queensland and a further 12,493 applicants being actively monitored. The system also tracks 1,000,924 live links between card holders and employers or volunteer organisations, ensuring that clearance information is tied to specific roles so that updates about a person's blue card status can be provided to employers and action can be taken to ensure compliance.

In a recent reporting period, 758 cards were suspended or cancelled due to new police or disciplinary information, as part of its continuous monitoring capabilities demonstrating the responsiveness of the system to emerging risks.

The scale of this workload highlights both the protective value of the scheme and the significant administrative and investigative capacity required to sustain it. The ongoing challenge for BCS is to balance timely processing of applications with rigorous risk assessment, ensuring that decisions remain firmly grounded in the best interests of children.

Reviews of Blue Card Services decisions

If a person is issued a negative notice (i.e. they are refused a blue card) by BCS, they may have an opportunity to seek an administrative review of the decision at the QCAT. In making a decision, QCAT reconsiders whether the WWCC Act was applied correctly given the facts and evidence available and may confirm, set aside, or vary the original decision, substitute its own decision, or return it to BCS to reconsider.⁹²

Not all adverse decisions made by BCS are reviewable by QCAT. For example, a disqualified person does not have the right to seek a review of a decision to issue them a negative notice, or refusal to cancel a negative notice, made by BCS.⁹³

Blue card matters make up a small fraction of QCAT's workload, which also includes a range of other administrative reviews and minor dispute resolution matters. The five years to 30 June 2024 saw a decrease in the number of appeals lodged for blue card decisions (from 310 to 160), however the number of matters pending have increased as a proportion of total active matters and received each year (from 52.89% to 62.53%).⁹⁴

The Queensland Family and Child Commission's 2017 review of the blue card system found that between 2011–12 and 2015–16, 25 per cent of negative notices were overturned by QCAT on review.⁹⁵ In 2024–25, of the BCS matters before QCAT, 17.5 per cent of reviews were successful, 16.5 per cent were unsuccessful, one per cent were referred back to BCS for reassessment and 65 per cent were withdrawn. The reasons for negative notices being overturned by QCAT vary significantly and were not considered by the Review. The Commission suggested that a contributing factor to the relatively large proportion of cases overturned on review may have been that important mitigating evidence is often not provided to BCS because of the opaqueness of the WWCC process. The Commission recommended that BCS implement an internal merits review process to reduce the number of matters which proceed to QCAT and are overturned. To date this recommendation has not been completed.⁹⁶

A history of evolution

During the 1990s, Queensland and other Australian jurisdictions faced heightened community concern about child sexual abuse in institutions, sporting clubs, churches, and community organisations. Reviews and inquiries emphasised the need for preventative measures, not just reactive responses. In September 1998, the Queensland Government commissioned an independent review of the *Children's Commissioner and Children's Services Appeals Tribunals Act 1996* (Qld). The review was completed, and a report and recommendations were submitted to government in April 1999. At the same time, the Commission of Inquiry into the Abuse of Children in Queensland Institutions (the Forde Inquiry) was established to report on the care and treatment of children in out-of-home residential facilities and juvenile detention centres.

The recommendations of these reports were largely accepted by the Queensland Government and reflected in the introduction of the *Commission for Children and Young People Act 2000* (now known as the WWCC Act). This legislation also saw the establishment of the Commission for Children and Young People. Its mandate included developing a screening system for child-related employment.

Since its inception in 2001, the blue card has become a fundamental component of seeking child-related employment or volunteering in Queensland.

WWCCs are administered separately in every state and territory. The Royal Commission found that the various schemes, including Queensland's, were inconsistent and did not regularly share information. Individual jurisdictions also apply different standards to the types of criminal history and other information considered in assessments.

As such, the Royal Commission made multiple recommendations to strengthen WWCCs and move towards national coordination of systems, facilitated by the Commonwealth.

In its *Working with Children Checks Report* published in 2015, the Royal Commission made the 36 recommendations in relation to WWCCs, some of which were jurisdictionally specific. The general recommendations (one to four) were given an implementation window of 12–18 months. Despite these implementation timeframes, many of the Royal Commission's recommendations are still in the process of being implemented. A summary of status of implementation of these recommendations in Queensland is outlined in Table 3.

The Royal Commission made multiple recommendations to strengthen WWCCs and move towards national coordination of systems, facilitated by the Commonwealth. To further prevent people who present a risk of harm to children from moving between jurisdictions without scrutiny, the Royal Commission recommended that WWCC decisions should be shared between jurisdictions.

The *Intergovernmental Agreement on National Exchange of Criminal History Information for People Working with Children* was made permanent by Council of Australian Governments (COAG) in 2013. It provides for the exchange of information on a national basis when a person applies for a WWCC. This ensures that relevant criminal history information from outside an applicant's jurisdiction can be shared with the administering body.

Queensland has responded to the Royal Commission recommendation to prevent people who present a risk of harm to children from moving between jurisdictions by implementing mutual recognition of adverse outcomes from other states and territories. This was operationalised in December 2022.

Table 3: Royal Commission recommendations about WWCCs and their implementation status

No	Recommendation summary	Queensland implementation status
1	State and Territory governments should amend laws to implement national standards for WWCCs and enable the recognition of decisions from other jurisdictions.	The Standing Council of Attorneys-General (SCAG) is overseeing reforms to WWCCs through a working group. On 15 August 2025, the SCAG agreed to: • work towards mutual recognition of negative notices between jurisdictions by the end of 2025, noting that this requires full integration of all jurisdictions into the National Reference System (NRS) • remove barriers to information sharing including in relation to the National Redress Scheme • assess the technical requirements for the establishment of a National Continuous Checking Capability (NCCC), leveraging existing systems where possible.⁹⁷ <i>The National Standards for Working with Children Checks</i> were agreed upon in 2019. <i>The Working with Children (Risk Management and Screening) and Other Legislation Amendment Act 2024</i> has brought Queensland broadly into line with the National Standards.
3	The Commonwealth should: • establish a centralised WWCC decision database • develop consistent terminology with the States and Territories • enhance the monitoring of national criminal histories of WWCC cardholders • explore making international criminal records more accessible.	From December 2022 the Australian Criminal Intelligence Commission (ACIC) commenced operation of the NRS, which gives BCS and other bodies administering WWCCs access to the decisions made in other jurisdictions. <i>The Child Protection Reform and Other Legislation Amendment Act 2022</i> amended the WWC Act to allow BCS to take information from the NRS into account in employment screening.
4	Governments should review the terminology in the National Exchange of Criminal History Information for People Working with Children to ensure that information sharing is consistent across jurisdictions.	Queensland participated in a review of, and was satisfied with, the use of the terms used.

No	Recommendation summary	Queensland implementation status
5-14	Governments should amend WWCC legislation to: • incorporate a nationally-consistent definition of child-related work • provide that contact with children is required for the definition of child-related work • define contact broadly and standardise this definition • define child-related work regardless of capacity and rewards, and standardise the categories of work • define exemptions for WWCCs and ensure those denied a WWCC cannot rely on exemptions.	The Department of Justice reports that implementation is complete as part of the delivery of recommendations from the Queensland Family and Child Commission's (the Commission's) blue card review, including through the <i>Working with Children (Risk Management and Screening) and Other Legislation Amendment Act 2019</i>.
15	Governments should standardise exemption categories.	The <i>National Standards for Working with Children Checks</i> were agreed upon in 2019 and include definitions for exemptions. The <i>Working with Children (Risk Management and Screening) and Other Legislation Amendment Act 2024</i> has brought Queensland broadly into line with the National Standards.
16	Governments should amend WWCC legislation to include a consistent list of offences relates to breaches of the employment screening system.	Offences in Queensland's WWC Act already exceeded national requirements.
17-18	Governments should amend WWCC legislation to include a standard definition of criminal history including charges and convictions, and facilitate police sharing criminal history and other information with administering agencies.	This was already part of the WWC Act in Queensland
19	Governments should amend WWCC legislation to include and standardise the reporting and consideration of disciplinary and misconduct information in WWCC, including where this arises from a reportable conduct scheme.	Departmental advice indicates that implementation is complete as part of the delivery of recommendations from the Commission's Blue Card review, and the commencement of the <i>Child Safe Organisations Act 2024</i> .
20	Governments should amend WWCC legislation to implement consistency in how WWCCs respond to criminal history and other information.	The Department of Justice has advised that implementation is complete.
21	Governments should amend WWCC legislation to implement consistency in what criminal information will be considered in a WWCC assessment.	This was already enacted in the WWCC Act in Queensland.

No	Recommendation summary	Queensland implementation status
22	The Commonwealth should lead the identification of what offences should be included in the consideration of an applicant's criminal history.	The <i>National Standards for Working with Children Checks</i> were agreed on in 2019. The <i>Working with Children (Risk Management and Screening) and Other Legislation Amendment Act 2024</i> has brought Queensland broadly into line with the National Standards.
23	Governments should amend WWCC legislation to standardise the criteria for assessing risk to children when considering a criminal history.	The <i>Working with Children (Risk Management and Screening) and Other Legislation Amendment Act 2024</i> , has brought Queensland broadly into line with the National Standards.
24	Governments should amend WWCC legislation to ensure the best interests of children are paramount to a WWC decision.	This was already part of the WWC Act in Queensland.
25	Governments should amend WWCC legislation to permit an applicant to begin child-related work while their application is being progressed, as long as certain safeguards are met.	The <i>Working with Children (Risk Management and Screening) and Other Legislation Amendment Act 2019</i> established the 'No Card, No Start' requirement which exceeds the protection provided by this recommendation.
26	WWCC applications should be processed online.	This has been implemented.
27	WWCC applications should be processed within specified timeframes.	This has been implemented.
28	Governments should amend WWCC legislation to ensure WWC decisions are made on the basis of the individual and not on their employment, and there should be no conditional clearances.	This was already part of the WWC Act in Queensland.
29	Governments should amend WWCC legislation to ensure applicants have an avenue for appeal to an independent body, except in cases where the person has a conviction for a particularly severe child-related offence.	This was already a part of the WWC Act in Queensland.
30	Governments should amend WWCC legislation to recognise a WWCC in another jurisdiction.	The <i>Child Protection Reform and Other Legislation Amendment Act 2022</i> amended the WWC Act to allow BCS to take information from the NRS into account.
31	Governments should amend WWCC legislation to ensure consistency in the length of a WWC clearance, and responsibilities of employers, cardholders, and the administering body to share information on employment and WWC status.	The Department of Justice reports that implementation is complete as part of the delivery of recommendations from the Commission's Blue Card Review.
32-33	Governments should amend WWCC legislation to ensure administering bodies have powers to monitor WWCC compliance and compel the production of information.	The Department of Justice reports that implementation is complete as part of the delivery of recommendations from the Commission's Blue Card Review.

NOCS initially led the implementation of many of the Royal Commission's recommendations and has developed National Standards for WWCCs. The National Standards seek to 'establish nationally consistent parameters for the screening of persons who propose to engage in child-related work'. In 2019, state and territory ministers endorsed the National Standards and committed to working toward its implementation in their respective jurisdictions. The Commonwealth Attorney-General's Department now leads the implementation of outstanding recommendations, coordinating via the Standing Council of Attorneys-General.

In practice, Queensland already exceeds some of these standards. For example, amendments to the WWC Act in 2019 established the 'No Card, No Start' requirement. This means that individuals cannot work with children or young people until their blue card application has been approved. Prior to the No Card No Start amendments in 2019 people could start working in regulated employment without a blue card, provided they had applied for one.

Amendments to the WWC Act in 2019 and 2024 were intended to bring Queensland broadly into line with the National Standards and implement recommendations from the Commission, particularly in relation to:

- preventing organisations from allowing employees to work with children in regulated activities without a blue card ('No Card, No Start')
- removing the eligibility declaration regime, which provided disqualified persons the opportunity to work in regulated employment in certain circumstances
- decoupling the current 'risk management' in the WWC Act from the child safe standards under a new regulator
- introducing obligations for applicants to disclose child-protection, domestic violence, and adverse interstate WWCC decision information.

These amendments made significant changes to the capacity and capability of the system and brought it into alignment with the other states and territories, however, there is currently no system for the mutual recognition of positive WWC clearances between jurisdictions. From December 2022 the ACIC commenced operation of the NRS which allows regulators to access decisions made in other jurisdictions to refuse a WWCC.⁹⁸ The WWC Act was amended in 2022 to allow BCS to take information from the NRS into account.⁹⁹ If an adverse WWCC decision is recorded from another state or territory, applications are refused, and the applicant is prohibited from working with children unless and until the bar is resolved.

Initially narrow in scope, Queensland's blue card system has expanded over the past 25 years to cover more employment types, use broader categories of risk-related information, and include stricter exclusion criteria, however, 10 years on from the publication of its *Working with Children Checks* report in 2015, recommendations from the Royal Commission have not yet fully been enacted.¹⁰⁰

Delayed action on Recommendation 3

National WWCC system

In 2017, the Royal Commission recommended that within 12 months of the publication of the report, the Australian Government should facilitate a model for National WWCCs. Despite this, the development of a national system has been slow and piecemeal.

To meet the intent of the recommendation, the Commonwealth Government established the WWCC NRS, a centralised database housed and operated by the ACIC. The NRS for WWCC was established in July 2019 following a joint project by the Commonwealth Department of Human Services and the ACIC.

During this period, the Queensland Government participated in discussion regarding the integration with the WWCC NRS at a national working group, chaired by the federal Department of Home Affairs.

Once established, jurisdictions were required to undertake necessary development work to integrate their WWCC systems with the NRS, including both internal operation processes and legislative amendments to enable the sharing of information between jurisdictions. While relevant amendments to Queensland's WWCC legislation commenced on 2 December 2022, as of mid-2025 not all jurisdictions have made the necessary statutory or policy changes to access and contribute to the NRS. However, in August 2025 the Australian Government committed to ensuring that all jurisdictions' WWCC systems were integrated with the NRS by the end of 2025. No information available to the Board provides insight regarding the protracted timeline for the implementation of this element of the recommendation.

The NRS however has limitations as it is a barring system not a proactive intelligence system. While it shares decisions such as a determination to suspend or cancel a current working with children clearance or to impose a temporary bar on a person from holding a clearance it does not share other intelligence that may have informed these decisions for example, the criminal history check. This must be gathered manually via the interstate agreement. National Continuous Checking Capability of WWCC cardholders' records will ideally fill this void.

National continuous checking capability (NCCC) of WWCC cardholders' records: Systematising national criminal history sharing

Currently, the daily QPS monitoring of blue card holders will not alert BCS to a charge or conviction for an offence—even a disqualifying offence—if it occurs outside Queensland. If the person attempts to renew their blue card upon expiry, the automated criminal history check will reveal such criminal history information.

This is despite the Royal Commission's recommendation for the continuous monitoring of WWCC cardholders. Relevant WWCC reforms are currently being considered by NOCS under Measure 3 of the First National Action Plan of the *National Strategy to Prevent and Respond to Child Sexual Abuse 2021–2030*.

As part of this, the Australian Attorney-General gave ACIC funding in November 2023 to scope design and pilot a NCCC. It was announced on 13 November 2025 that the pilot will receive \$37 million from the federal government over five years, with the NCCC to be ready for states and territories to join by the end of 2025¹⁰¹.

This mechanism is intended to ultimately fulfill the intent of recommendation 3 of the Royal Commission WWCC report, by facilitating real-time monitoring of the national criminal histories of WWCC cardholders throughout Australia.

The Council of Attorneys-General, met in August 2025 and agreed to accelerate the development of the NCCC with a view to the Council considering a technical assessment of the requirements for the proposed system in late-2025.

In 2016, the Commission was asked to undertake a review into information sharing to protect children in regulated service environments. The *Recommendation 28 Supplementary regulated Commission service* made multiple findings and recommendations primarily in relation to family day care services. Key changes for the blue card system included:

- legislative changes to establish a register of home-based carers, hosted by BCS
- BCS and QPS reaching an agreement to support automatic sharing of any international criminal history information held by police for assessments
- family day care educators and carers, and all adult household members and regular visitors to such centres, are required to hold to the same eligibility screening and monitoring standards as foster carers.

The preference for a stronger screening system has led to unintended consequences. For example, responsibility for screening of foster and kinship carers was transferred to the WWCC system in 2006. In 2023, a Commission report recommended that Aboriginal and Torres Strait Islander kinship carers be excluded from the requirement to hold a blue card. This is because the existing system was unfairly and unreasonably limiting the ability of kin to care for children under the supervision of Child Safety authorities.

The *Child Safe Organisations Act 2024* came into effect on 1 October 2025. With all Child Safe Organisations required to comply with the Child Safe Standards by 1 April 2026. Queensland is one of the last jurisdictions in Australia to implement a Reportable Conduct Scheme, as recommended by the Royal Commission. This scheme aims to improve the way institutions manage complaints about child sexual abuse and encourage improvements in:

- institutional complaint handling policies and procedures
- investigation standards
- reporting where abuse is known or suspected.

The Reportable Conduct Scheme commences from 1 July 2026. While the CSO Act as passed incorporated a staged rollout of the scheme, on 17 October 2025 amendments were made to commence the entire scheme early, in response to the increased urgency of addressing child sexual abuse which emerged from several highly-publicised instances of abuse, including those in ECEC.

Australia's child safeguarding framework has several robust elements, and Queensland's blue card system is widely regarded as one of the strongest in Australia. Several features underpin its effectiveness:

- **'No Card, No Start' Requirement:** Applicants, whether in paid or volunteer roles, are prohibited from commencing child-related work until a clearance has been issued. This ensures that all individuals are screened before contact with children occurs.
- **Comprehensive Information Consideration:** Queensland's assessment process draws on a broad range of information. This includes criminal history and police records (charges and convictions), disciplinary information from sector regulators, offender monitoring data, domestic violence information, adverse WWCC decisions in other jurisdictions and other relevant information (such as child protection information and information of concern from members of the public or employers).
- **NRS Integration:** The system incorporates information from other participating states and territories via the National Reference System, capturing any adverse WWCC decisions made elsewhere.
- **Consideration of Domestic Violence and Investigatory Information:** Queensland is unique in explicitly allowing the inclusion of domestic violence histories and other police investigative information in risk assessments, providing a more nuanced and protective assessment.
- **Organisational Safeguards:** Beyond individual screening, Queensland requires organisations that employ blue card holders to implement child and youth risk management strategies. This adds an additional layer of prevention and embeds safeguarding within the organisational culture.
- **Risk-based escalating compliance model:** BCS supports voluntary community compliance with blue card system requirements through extensive engagement and education activities, and undertakes reactive and proactive audits of high risk organisations, industries and individuals, using a range of information and data sources to assign resources to compliance activities according to risk identified.

Collectively, these features make Queensland's blue card system a comprehensive and proactive model of child protection, combining rigorous individual assessment with organisational accountability.

Inconsistencies in Working with Children Checks

Reviews and inquiries have consistently highlighted the critical importance of strong information sharing practices across WWCC schemes to prevent abuse and respond to harm. All jurisdictions have processes in place to share information, including with other states and territories, however, they are often governed by complex legislative and procedural requirements. In practice these requirements act to inhibit, not facilitate, effective information sharing processes.

Australia does not have a nationally consistent or harmonised WWCC system. While some information is exchanged between jurisdictions, the criteria for assessment and the thresholds applied vary considerably. In practice, this means that a person who is denied a clearance in one state may not be automatically prevented from obtaining one elsewhere.

Several specific weaknesses flow from this fragmentation:

- **Delayed information sharing:** Police information is not exchanged in real time across jurisdictions. As a result, relevant information may not come to light until a clearance is due for renewal.
- **No mutual recognition:** Positive WWCC clearances are not consistently recognised across jurisdictions, requiring separate applications when people move interstate.
- **Variation in assessment processes:** The categories of information considered during screening, and the manner in which risk assessments are conducted, differ between states and territories.

The Royal Commission recommended the development of National Standards for Working with Children Checks to address these gaps. All governments agreed to these standards in 2019, but implementation has been uneven and incomplete.

In Queensland, legislative amendments were passed in 2024 to bring the state's WWCC system into closer alignment with the National Standards. These amendments have now commenced, though the lack of nationally consistent implementation continues to present risks. As of November 2025, Queensland, New South Wales, Victoria, South Australia and Tasmania all recognise interstate decisions and prevent people from working with children if they have been denied a clearance in another state or territory. The Australian Capital Territory, Northern Territory and Western Australia have committed to introducing bills to align with the other states by the end of 2025.¹⁰²

In August 2025, the Standing Council of Attorneys-General agreed to strengthen and improve consistency for a national approach to WWCCs, based on mutual recognition, including removing barriers to information sharing and establishing consistent risk assessment frameworks and exclusion criteria. It was also agreed to work towards implementing, by the end of 2025, mutual recognition of negative notices across all Australian jurisdictions. The Standing Council of Attorneys-General met again in November 2025, confirming the readiness of the NCCC by the end of 2025.¹⁰³

Expectation and design misalignment

At its simplest form, a person who wants to work in child-related 'regulated employment' is required to hold a blue card. While WWCCs are a key part of a child safeguarding system, they can only screen out people who have previously been charged or convicted of a criminal offence, or where other relevant matters which raise concerns have been provided to the regulator.

On this basis, the blue card system is fundamentally a mechanism for assessing a person's *past conduct* to determine their eligibility under the legislation to work with children. While reforms to the legislation have introduced a more sophisticated risk assessment framework, the decision-making process remains anchored in an evaluation of historical information.

A perpetrator who avoids detection, who has never been charged for an offence, will not come to the attention of employment screening authorities like BCS.

The starting point for every application is a person's criminal history and other recorded interactions with regulatory and enforcement bodies. Automatic exclusions are triggered by past convictions for certain *disqualifying offences*, regardless of any subsequent rehabilitation or current circumstances. Where discretion is available, the risk assessment still relies heavily on past events—such as criminal, disciplinary, domestic violence and child protection information—to form a view of future risk.

Even the continuous monitoring element of the scheme is retrospective in nature. Police notifications to BCS are based on new charges or convictions which then feed into an assessment of whether the person's past conduct signals a present or future risk. The protective intent of the scheme is forward-looking, but its evidentiary foundation is necessarily backward-looking. In this way, the blue card system reflects a broader principle of child safeguarding regulation: the most reliable indicator of future behaviour is past behaviour.

This misalignment between name and function can generate unrealistic expectations among parents, organisations, and the wider community. Many assume that a person with a blue card has been actively 'checked' in their day-to-day interactions with children, or that the clearance signifies an endorsement of character. The scheme does not—and cannot—guarantee that a person poses no risk. It simply means that, on the basis of available historical information, no real and appreciable risk to children has been identified.

Both the Royal Commission and the Queensland Family and Child Commission have highlighted the risks of over-reliance on a WWCC as a guarantee of ongoing safety by parents and carers, employers and co-workers, and by society more broadly. The blue card system is an important part of safeguarding children across child-related industries and activities however, it is not a substitute for effectively creating a child safe environment, and for ongoing diligence in the activities of employees who hold a blue card.

As was so aptly highlighted in the 2016 South Australian Royal Commission report, *The Life They Deserve*, pre-employment screening is not intended to be a fail-safe measure in its own right. That report said:

“*Gaining clearance does not mean that a person has been deemed safe or suitable to work with children. It simply means there is no available history to suggest they pose a threat.*”

The risk of false confidence is well recognised in child safeguarding policy. When organisations or parents rely too heavily on a clearance, they may under-invest in broader protective strategies such as supervision, child-safe cultures, and active risk management. Clearer communication about what the blue card represents—and, importantly, what it does not—would help recalibrate community understanding. The name 'Working with Children Check' has utility as a simple and accessible label, but it inadvertently obscures the scheme's limits as a backward-looking assessment of eligibility rather than an ongoing guarantee of suitability and safety.

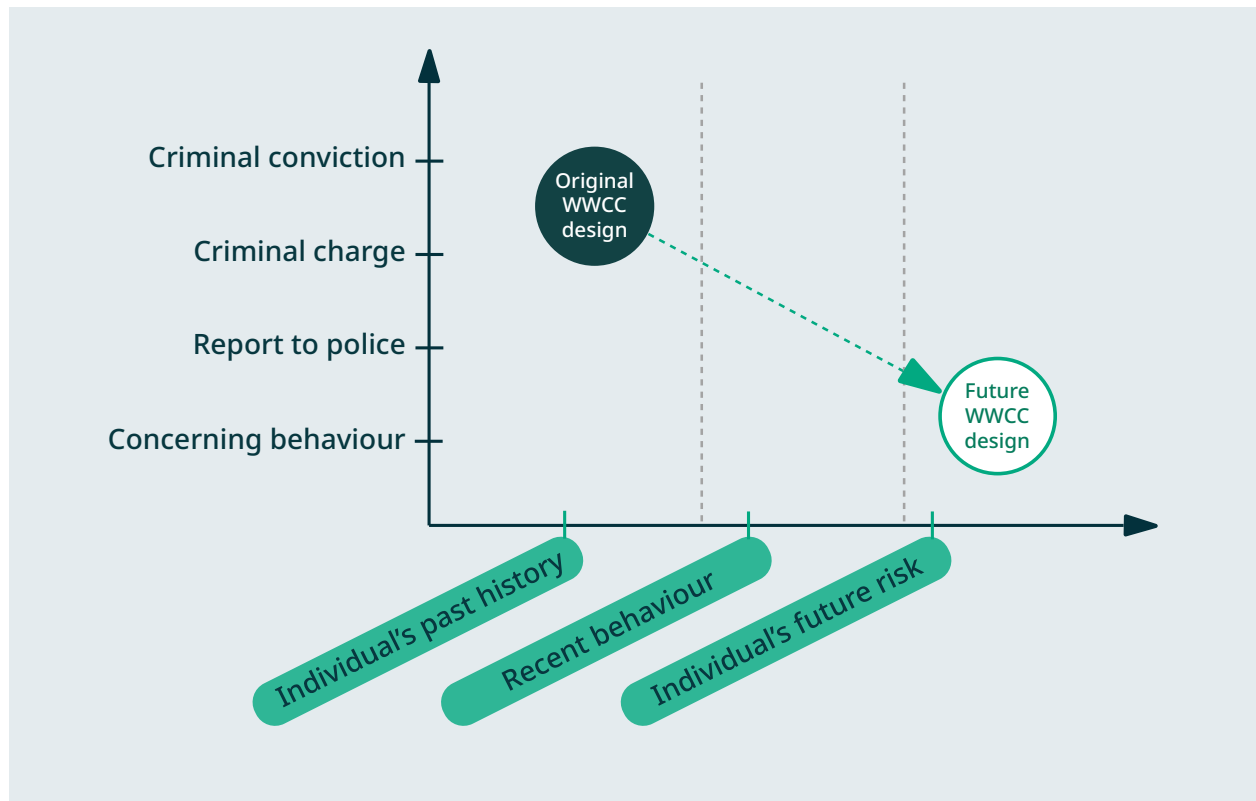
“*While an important tool, WWCCs – in the absence of broader child-safe strategies – do not make organisations safe for children. In fact, an over-reliance on WWCCs can be detrimental to children's safety. They can provide a false sense of comfort to parents and communities, and may cause organisations to become complacent due to the belief that people who have undergone WWCCs do not pose any risks to children – this is not the case.*¹⁰⁴”

The system can only screen out individuals who are assessed to be a risk because they have previously been charged or convicted for an offence, or where other information exists which raises concerns. Community education is necessary to ensure an appropriate weight is placed on WWCCs as one element of a safeguarding system.

“*Working with children checks and employment screening are a necessary part of institutional safeguarding, but we cannot rely on them.*¹⁰⁵”

In 2024, Queensland legislation was amended to improve the ability of BCS to undertake risk assessments. This amendment acknowledged the issues with arbitrary consideration of past charges. Into the future the Queensland blue card scheme must become better enabled to make predictive risk assessments.

Figure 16: Strengthening our blue card system



“

The working with children check is not a guarantee of a person's suitability to work with children, proof of good character, or confirmation that they do not pose any risk. It is one tool in a broader system to promote child-safe environments and works alongside other government agencies, such as the Queensland Police Service, Department of Education, Early Childhood Regulatory Authority, and Child Safety, as well as child-related organisations and people who run child-related businesses, to protect the safety and wellbeing of children. – Department of Justice

”

The systems under review: The Queensland police system

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The Queensland police system

Police officers are agents of the law, charged with the responsibility of upholding and enforcing legislative requirements. Their role necessitates a strictly legalistic approach, where compliance with statutory provisions is paramount and discretion is exercised within tightly defined parameters. Accordingly, police processes are highly procedural, reflecting the structured nature of the legislation they administer and enforce.

This procedural orientation is critical to ensuring consistency, accountability, and fairness in the enforcement of laws. By operating within clear legislative frameworks, police minimise the risk of arbitrary decision-making and provide transparency in the exercise of state authority. These processes also serve an evidentiary function, ensuring that investigative steps are properly documented and capable of scrutiny in judicial proceedings.

However, the structured nature of policing has important implications for the delivery of justice. On one hand, it promotes the rule of law by applying the same standards to all individuals, regardless of circumstance. On the other hand, the emphasis on procedural compliance can create tensions in contexts where the complexities of human behaviour, vulnerability, or trauma require more nuanced responses. For example, in cases of child sexual abuse, rigid adherence to procedure may safeguard due process but can risk overlooking broader welfare or safeguarding considerations.

In this way, policing forms a foundational but not exhaustive component of justice delivery. The justice system relies not only on procedural enforcement but also on the interpretative and discretionary roles of prosecutors, courts, and support services. While the police ensure that the law is applied consistently, the broader justice system must reconcile procedural integrity with the substantive goal of achieving fair and just outcomes for individuals and communities.

This strong relationship with the crafting and wording of law is important in the context of child sexual abuse. The detection and enforcement of child sexual abuse related offences including child exploitation material (CEM) shifted and changed in line with the digital world and societies deeper understanding of child abuse. Over the last 25 years:

- there has been an increase in the specificity and volume of criminal offences
- this includes multiple new principal Acts and amendments to existing laws, significantly expanding the legislative framework since 2000
- offences against children have become more detailed, including new offences relating to grooming, coercive control, and online abuse
- federal reforms introduced a broader range of offences related to overseas child sexual exploitation, and the number and scope of relevant offence provisions, especially in the Criminal Code of Queensland and Commonwealth law, have increased dramatically.

Frequent changes have been made since 2000 to increase the number of offences related to child abuse and the penalties for this offending. For example:

- Possessing, distributing, accessing and producing CEM was only made an explicit criminal offence in 2005.
- Further changes were made over the 2010s to Commonwealth legislation relating to CEM, sex trafficking, and sex tourism.

This reflects:

- an increasing community awareness of the harms associated with child sexual abuse
- attempts to improve perpetrator accountability
- increased complexity in offending associated with online child sexual exploitation and associated enforcement across state, national and international borders
- relevant recommendations from major inquiries and reviews.

Coordinated law enforcement response to child sexual abuse in Australia

The response to child sexual abuse in Australia involves multiple agencies operating at both federal and state levels, each with distinct but complementary roles. Together, these entities form an interconnected system of prevention, investigation, enforcement, and victim-survivor protection.

The interaction between federal and state authorities is critical. The Australian Federal Police (AFP) and Australian Centre to Counter Child Exploitation (ACCCE) provide national coordination, specialist intelligence, and global links, while the Queensland Police Service (QPS) and other state police services maintain operational primacy for most investigations under state criminal law. The co-location of QPS Argos officers and victim identification experts within the ACCCE, the operation of Joint Anti-Child Exploitation Teams (JACETs), and shared intelligence platforms all ensure that investigations can move seamlessly across jurisdictional boundaries.

This integrated framework enables Australia to respond effectively to both traditional forms of child sexual abuse and emerging threats, particularly those facilitated by technology, organised networks, and transnational offending.

Table 4: Police organisational roles and interactions

Entity	Role in child sexual abuse response
AFP	Coordination of multi-jurisdictional investigations; investigation of Commonwealth offences
ACCCE	National hub for strategic coordination, embedding a range of government and law enforcement agencies, victim-survivor identification, cross-sector collaboration including housing specialist capabilities
JACETs	Investigative task teams combining AFP and state/territory police expertise
State/Territory Police	Primary investigation and enforcement authority within jurisdiction
International Bodies	Global collaboration through AFP and state and territory police including links to National Center for Missing and Exploited Children (NCMEC) INTERPOL, Europol and other foreign law enforcement agencies.

This collaborative framework brings together investigative capacity, strategic oversight, intelligence sharing, and public engagement to confront and disrupt all forms of child sexual abuse, particularly in the digital domain.

Joint teams – where Federalism works

ACCCE performs the role of national coordination of operations and targeting opportunities, and receives and processes information from foreign law enforcement agencies, NCMEC and others on behalf of Australian law enforcement. JACETs (or the Child Protection Operations team in NSW) are located in each state and territory and include members of AFP and the state/territory police of that jurisdiction. JACETs ensure that intelligence and operational responses are integrated across jurisdictions.

Queensland Police Service

At the state and territory level, police services hold statutory responsibility for investigating sexual assault and child sexual abuse offences under state criminal laws.

In Queensland, QPS is responsible for:

- investigating complaints of sexual assault or sexual abuse and establishing whether an offence has been committed
- protecting victim-survivors of sexual assault or sexual abuse from further victimisation
- identifying, apprehending, and charging perpetrators.

All QPS officers share a duty to respond to reports of child sexual abuse, but specialist units have dedicated responsibilities:

- **Child Protection Investigation Units (CPIUs):** Local CPIUs are the primary units for investigating reports of child sexual abuse, alongside other crimes related to children. Where no CPIU is available, investigations are undertaken by the Criminal Investigation Bureau or by first response officers with remote support until specialist investigators arrive.

- **Argos – Child Abuse and Sexual Crime Group:** Formerly Taskforce Argos, this specialist unit investigates organised child sexual abuse, including technology-facilitated offending. Argos targets online platforms, networks, and offenders, focusing both on the identification of victim-survivors and the disruption of organised abuse. Members of Argos are co-located at the ACCCE, ensuring close operational ties between QPS and AFP efforts.
- **Child Protection Offender Registry (CPOR) - Child Abuse and Sexual Crime Group:** QPS manages Queensland's contribution to the Australian Child Protection Offender Reporting Scheme, established under the *Child Protection (Offender Reporting and Offender Prohibition Order) Act 2004*. The scheme requires reportable offenders to notify police of personal details and their movements for a defined period following conviction and release. The scheme aims to reduce reoffending and support the investigation and prosecution of any future crimes. Local police manage registered offenders within communities, balancing monitoring obligations with broader community safety objectives.

While individual investigations vary, police take a number of steps after they receive a complaint of child sexual abuse.

1. **Complaint received:** QPS general duties officers or Policelink staff receive a complaint from an individual or organisation. The unit responsible for investigating (typically CPIU) is notified.
2. **Assessment:** Investigating officers consider the report to determine what steps should be taken. This may include interviewing a child victim-survivor, a suspect and/or witnesses, or contacting other agencies for information relating to the report of sexual abuse.
3. **Charge and prosecution:** To arrest and charge a suspect, the investigating officer must be satisfied that certain conditions are met. This includes:
 - that an offence has been committed (and each element of an offence has been satisfied) and
 - there is sufficient and admissible evidence to prove the offence.

Evidence can be collected through interviews, statements, collection of any physical evidence and possibly medical examinations.

QPS and the Office of the Director of Public Prosecutions (ODPP) share the role of prosecuting perpetrators. The nature and complexity of the offending, and the court in which the matter is heard, will determine which agency undertakes the prosecution.

4. **Discontinuance:** If investigating officers are not satisfied sufficient and admissible evidence can be obtained to prove an offence beyond reasonable doubt, QPS must inform the child's parents/guardians of this outcome as soon as practicable.

As a law enforcement agency, QPS must operate in the bounds of the criminal justice system and cooperate with other entities such as the ODPP, Queensland Court Services and Queensland Corrective Services.

“*The role of QPS as investigators is to build a case against a suspect, which is sufficient to be able to determine that the offence occurred beyond a reasonable doubt.*”

The rules of evidence, including what can and cannot be brought before a court in a prosecution, are complex and governed by legislation including the *Evidence Act 1977* and common law. In addition, QPS must operate within relevant legislation and policy, such as the Criminal Code of Queensland, *Police Powers and Responsibilities Act 2000* (the PPRA) and the QPS Operational Procedures Manual (OPM).

As part of an investigation, officers may interview child victim-survivors. The purpose of this interview is to not only uncover facts, but to test their veracity and reliability. Consequently officers are required to ask questions to test the sufficiency of the child's evidence as it relates to the complaint. These interviews, and any statements made, may be recorded and used in court instead of the child having to testify. This is permitted under section 93A of the Evidence Act, with the statements referred to as '93A statements'. Although this often provides an alternative to having a child witness give testimony in court, the Evidence Act requires that if a 93A statement is tendered as evidence the child must also be available to testify.

Judges retain a broad discretion to exclude statements from juries, and they are mostly subject to the same rules of evidence as other testimony. 93A statements are intended to protect the integrity of evidence.

The OPM requires that where possible, a support person should **not** be present during an interview with a child unless this is unavoidable, in which case there are strict rules about a support person's conduct.

Parents and guardians, who the child has made a disclosure to, cannot act as a support person. In practice this means that children may find themselves in police stations with adults that they have just met, without any other supports. Regardless of the skills and capacity of the investigating officer, this is not an ideal environment to facilitate a disclosure, particularly when having regard to what is known about how, why and when victim-survivors, particularly children may choose to disclose their experiences of abuse.

While the OPM requires officers to interview child victim-survivors in a way that ensures the trauma to a child is minimised, no further guidance is provided about how to do so. Guidance is instead provided through operational training such as Interviewing Children and Recording Evidence (ICARE). This guide steps through:

- **Risk assessment framework:** How to apply professional judgment to analyse individual and environmental factors to assess the impact and potential impact of harm on a child.
- **Standard of proof:** How to gather enough evidence to have the best opportunity of satisfying the elements of a criminal charge beyond reasonable doubt.
- **Legalities:** Overview of the relevant legislation, gathering evidence such as s93A and witness statements, particularising events and competency of children to give evidence.
- **Understanding children:** Overview of how children recall events and how factors such as memory, conceptual development, suggestibility and language formation can impact this.
- **Interviewing model:** Identifying the major steps of the interview model and making links between them.
- **Pre-interview planning, opening and preparation:** Identifying the key tasks and pieces of information required before interviewing a child, such as appropriate questions and designing the interview in a way that minimises trauma, and how to successfully open an interview with a child by way of introduction, setting ground rules and building rapport.
- **Questioning during interview:** Identify legal issues such as leading questions and suggestive statements and develop knowledge of appropriate questioning techniques.
- **Interviewing framework:** This incorporates effective interviewing, free narrative, introducing the topic of concern, questioning techniques, barriers to disclosure, and interview strategies.
- **Interview closure:** This covers the importance of closing an interview in a positive manner and ensuring protective strategies are implemented and key concepts of safety and networks have been identified.

Australian Federal Police

At the federal level, the AFP holds responsibility for investigating Commonwealth child exploitation offences, particularly those involving online environments, cross-border offending, or matters that require national and international coordination.

The AFP leads the ACCCE, a national hub based in Brisbane that brings together law enforcement agencies, intelligence bodies, government departments, and non-government partners. The ACCCE focuses on coordination, intelligence sharing, victim identification, community engagement, and international collaboration. It does not generally lay charges but enables and enhances the investigative work of the AFP and state and territory police.

The ACCCE is a national hub for receiving and triaging reports of online child sexual exploitation, many of which come from overseas partners such as the National Center for Missing and Exploited Children (NCMEC)

Currently, ACCCE also collaborates with organisations like AUSTRAC to target financial technology-related exploitation. For example, on 1 July 2022, the ACCCE in partnership with AUSTRAC announced the national operational strategy, Operation HUNSTMAN, to counter the dramatic increase in online sexual extortion of Australian children. Phase 1 was a financial disruption strategy enacted against over 1,500 Australians, to prevent offshore offenders being able to access any funds garnered from the online sexual exploitation of Australian children.

The AFP has a central role in responding to online child sexual abuse, especially where cases cross state, territory, or international borders. The AFP investigates Commonwealth child sexual abuse offences, including crimes committed online, through the postal system, or overseas by Australian citizens. These investigations often involve serious and organised offending that cannot be managed by state and territory agencies alone. In Queensland, JACETs, bring the AFP and QPS together in coordinated responses to address child sexual abuse.

The AFP also works closely with international partners through agencies such as INTERPOL and Europol to track offenders across borders. It uses prevention and disruption strategies, to stop abuse before it escalates.

Alongside enforcement, the AFP contributes to education and awareness through programs like ThinkUKnow, which provides online safety education to children, parents, and educators. In short, the AFP provides national leadership in tackling online exploitation and other child sexual abuse offences under Commonwealth law, while working with states, territories, and international partners to protect children and prevent harm.

The AFP is responsible for 14 measures under the *National Strategy to Prevent and Respond to Child Sexual Abuse*.



Data snapshot – the police system



Most cases of child sexual abuse never come to the attention of police. Indeed, the Australian Bureau of Statistics found that **84 per cent** of women and **99 per cent** of men never reported their experiences of sexual abuse as children to police.¹⁰⁶ Of those that are reported to police, a substantial proportion do not proceed to the investigation or prosecution stages.



In 2023–24 approximately **34 per cent** of sexual assault and related charges against adults (for both child and adult victim-survivors) did not proceed to trial or sentencing.¹⁰⁷ Of those that did proceed to trial or sentencing, **80 per cent** resulted in a conviction.¹⁰⁸

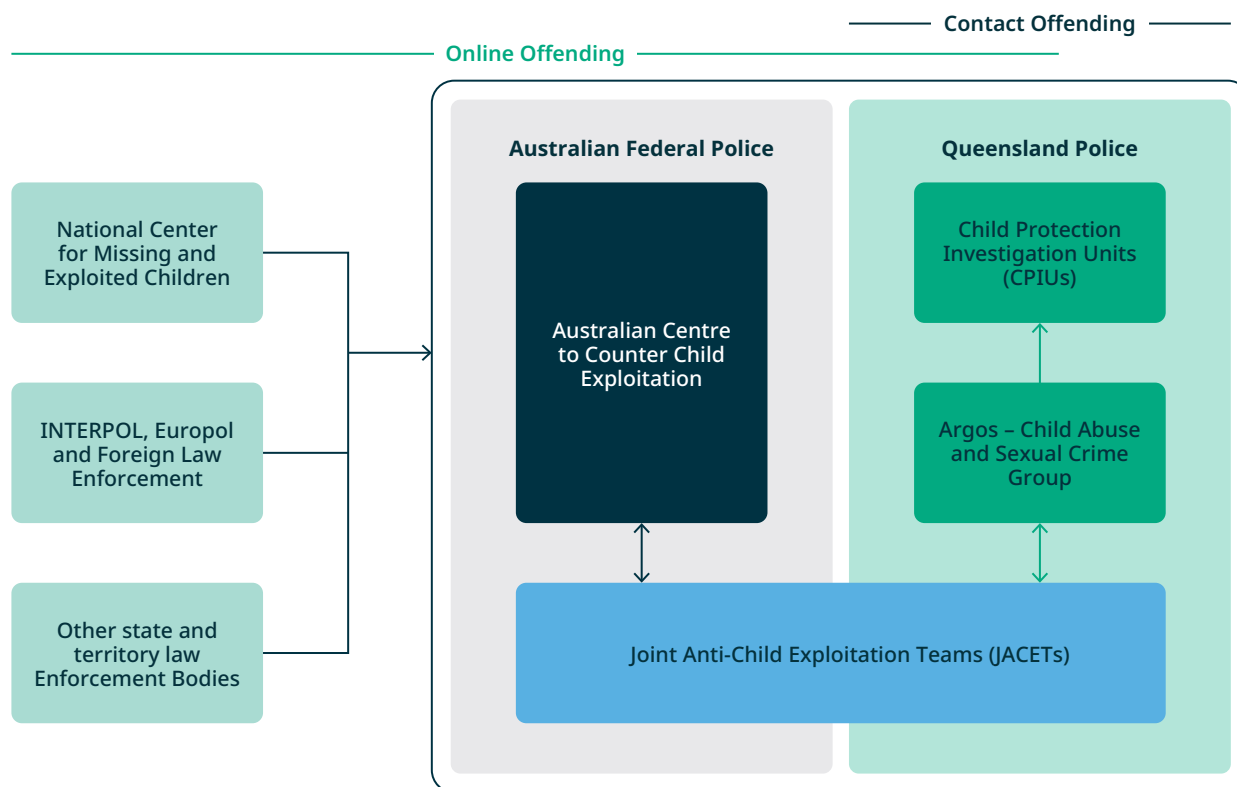


Between 2015–25, approximately **52 per cent** of child sexual abuse offences reported to or identified by QPS did not proceed to any criminal justice outcome.



Of the QPS cases that proceed to court, **51 per cent** of CEM offences, **60 per cent** of contact offences and **62 per cent** of grooming-related offences resulted in conviction.

Figure 17: The structure of policing



Recent reforms to the police system

The Royal Commission into Institutional Responses to Child Sexual Abuse (the Royal Commission) released its *Criminal justice* report in August 2017, which made 19 recommendations focused on improving police responses which sought to:

- encourage reporting by victim-survivors
- improve police investigative interviewing techniques and training
- address identified issues with the response by police to reports of historical child sexual abuse and reports of child sexual abuse made by people with disability.

The Queensland Government accepted or accepted in principle all recommendations made relevant to the police, with 14 of these being recorded as complete as of 2022. Although not directly targeted towards the police, the Royal Commission made other recommendations which were intended to also influence police practice, by making the criminal justice system more accessible and responsive to victim-survivors of child sexual abuse.

The Women's Safety and Justice Taskforce (the Taskforce) released its second report in 2022, which considered the experiences of women and girls across the criminal justice system in Queensland, including their experiences as victim-survivors of sexual violence. The report highlighted the high number of women and girls who experience child sexual abuse, and the low percentage of reports that make it through each stage of the criminal justice process.⁵⁴

The Taskforce found that the current system and related processes are difficult to navigate, retraumatising for victim-survivors and lacking in adequate and appropriate support. Many factors which discourage and prevent victim-survivors from reporting sexual violence were identified, including:

- myths and stigma about sexual violence
- overlapping structural inequality within the police and criminal justice system
- outdated legislation
- lack of support
- difficulty navigating the system.

The Taskforce made multiple recommendations to improve policing responses including by:

- developing a collaborative model across agencies to respond to sexual violence

- improving practice to deliver victim-centric and trauma-informed responses to victim-survivors
- continuing to implement evidence-based and trauma-informed training for all staff, and ensuring only specialist trained officers interview victim-survivors.

The Queensland Government supported or supported in principle nearly all Taskforce recommendations directed at the QPS.

In 2024 the Australian Law Reform Commission (ALRC) undertook a review of *Justice Responses to Sexual Violence* in Australia to identify what was needed to improve justice system responses to sexual violence. The ALRC found similar themes to the other reviews and inquiries discussed above, including:

- few victim-survivors engage with the criminal justice system due to significant barriers to engagement
- victim-survivors who do engage with the criminal justice system are not engaged in a safe, informed and supported way and often encounter myths and stigma about sexual violence
- people who use sexual violence often face no consequence for their actions.

The ALRC review resulted in 64 recommendations to various agencies, mostly the federal, state and territory governments. Again, most recommendations, if implemented, seek to influence police practice to improve processes and outcomes for both adult and child victim-survivors. Six recommendations were made directly to state and territory police services including:

- improving education and training to ensure police practice is trauma-informed, culturally safe and evidence-based, with specialist staff receiving tailored training
- reviewing and updating guidelines and processes for responding to sexual violence, including timeframes, interviewing, record-keeping, communication throughout the process, accessibility and complaints processes
- ensuring information about sexual violence criminal justice processes is accessible and publicly available
- involvement in a national taskforce for quality assurance of police interviewing for sexual violence victim-survivors
- ensuring interview spaces are safe and appropriate for all victim-survivors.

Recommendations from the ALRC review align closely with those made by the Royal Commission and the Taskforce, highlighting ongoing national issues in police responses to child sexual abuse and adult sexual violence.

National registration and monitoring of child offenders

Australia operates a system of national registration and monitoring for individuals convicted of serious offences against children. Although each state and territory is responsible for implementing the relevant legislation within its jurisdiction, the system is coordinated centrally through the Australian Criminal Intelligence Commission. This centralised administration enables information to be shared across borders, ensuring that offenders remain subject to monitoring even if they move between jurisdictions.

The purpose of the scheme is to support law enforcement agencies in managing risk. The scheme requires child sex offenders to keep police informed of their whereabouts. It provides police with a legal framework to monitor known offenders. By requiring offenders to remain visible to authorities, the scheme seeks to reduce opportunities for reoffending and enhance community protection.

In Queensland, the *Child Protection (Offender Reporting and Offender Prohibition Order) Act 2004* establishes the state's Child Protection Offender Reporting Scheme. Under this legislation, convicted child sex offenders and other categories of serious offenders against children are legally required to keep police informed of their whereabouts and certain personal information, such as changes of address, employment, or travel plans. The QPS manages the scheme, which forms part of its broader child protection responsibilities. Its central aim is to safeguard children by ensuring that high-risk individuals are subject to ongoing oversight and accountability.

Monitoring of released offenders who are considered as presenting a significant and ongoing risk to the community has increased. Legislation such as the *Dangerous Prisoners (Sexual Offenders) Act 2003* and the *Child Protection (Offender Reporting and Offender Prohibition Order) Act 2004* enabled extended detention, supervision and mandatory reporting for offenders. Over time, judicial discretion has been replaced or constrained by statutory obligations. The introduction of monitoring legislation, including the offender prohibition orders through the *Child Protection (Offender Prohibition) Act 2008* has strengthened the controls placed on released offenders and enabled critical information sharing between the child protection and blue card systems.

People that abuse children

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People that abuse children

“

Every society tells itself comforting lies about child abuse. That it is rare. That it is perpetrated only by monsters lurking in dark alleys. That the danger exists “out there”, beyond the family home, beyond the school gates, beyond the places we attend and consider safe. These lies, though soothing, are deadly. They obscure the truth: that those who abuse children are often ordinary in appearance, adept at camouflage, and deeply strategic in the way they infiltrate families, institutions, and communities.

”

When confronted with the horror of child sexual abuse, our instinct is often to look away. We prefer to focus on the bravery of victim-survivors, the resilience of families, or the systems that failed to protect. These are important, vital stories, but they are only a part of the story. To stop abuse before it begins, we must confront the other half: the perpetrators themselves. It is a dark and uncomfortable undertaking. To step into the mind of someone who manipulates, grooms, and exploits children is to look into areas that most people would rather never approach. Yet if we are serious about prevention, we must resist the temptation to avert our eyes. We must ask, relentlessly and without sentimentality: *who are these people, how do they think, and why do they do it?*

This is not morbid curiosity. It is necessity. The safety of children depends on our willingness to understand the people who seek to harm them.

The scale of child sexual abuse is staggering. In every jurisdiction, in every decade, child sexual abuse has been more widespread than authorities dared to admit. Inquiries around the world—from Ireland to Canada, from the United Kingdom to Australia—have peeled back the veneer of denial, exposing how institutions, governments, and communities consistently underestimated the prevalence of abuse and the cunning of those who perpetrated it. Why do these failures keep happening? Because systems are not built with a deep understanding of perpetrator behaviour at their core.

Children pay the price for adult discomfort. Each time a warning sign is dismissed, each time a disclosure is disbelieved, each time a complaint was smothered by organisational bureaucracy, another child is delivered into the hands of a perpetrator who has mastered the art of appearing trustworthy.

Risk assessments often rely on crude stereotypes: the 'dangerous stranger', the 'loner', the 'monster'. In reality, many perpetrators are skilled social operators. They cultivate reputations as helpers, carers, coaches, teachers, mentors, positions that disarm suspicion and provide legitimate access to children. They learn the weaknesses of organisations: the overburdened supervisor, the undertrained volunteer coordinator, the fragmented lines of accountability, and they exploit them with surgical precision.

When law enforcement, child protection agencies, or community leaders fail to integrate knowledge of these perpetrator characteristics into their strategies, children remain exposed. It is like trying to cure a disease without studying the virus.

“

*If you want to protect children more globally in this ECEC space, you're going to have to start asking some of these more difficult questions. We're so embarrassed to ask these questions. We've got to get over our embarrassment about this.*¹⁰⁹

”

One of the greatest barriers to progress is our collective reliance on caricature. We imagine child abusers as a separate species, inhuman, visibly deviant, incapable of blending into society. This caricature comforts us because it draws a neat line: they are 'other', and therefore easy to spot, easy to exclude, easy to contain. But research and lived experience tell us otherwise. Many perpetrators are outwardly ordinary. They are neighbours, colleagues, relatives, faith leaders and police officers. They sit on boards, lead scout groups,

volunteer at schools, or work in childcare centres. They often present as generous with their time, patient with children, reliable in moments of crisis. Some cultivate reputations of near saintliness, knowing that the more trusted they appear, the less likely anyone will suspect their darker motives.

By understanding this duality—the respectable façade and the predatory core—we begin to unravel the central paradox of child sexual abuse: that harm often comes not from those society teaches us to fear, but from those it teaches us to trust.

To stop child abuse, we must ask one of the hardest questions imaginable: *why would anyone choose to harm a child in this way?* Motivations vary. For some perpetrators, the drive is sexual gratification, entangled with distorted beliefs about children's capacity to consent. For others, it is about power and control, a sadistic assertion of dominance over the most vulnerable. What unites them is not a single motivation but a pattern of method. Perpetrators are strategists. They invest time and energy into breaking down barriers of suspicion, both around the child and around the child's ecosystem of protection. They groom not just victim-survivors but also parents, colleagues, and organisations, carefully crafting an environment in which abuse can occur unnoticed or unchallenged. This manipulation of context, the weaponising of trust, is what makes child sexual abuse uniquely difficult to detect and prevent. And it is precisely why studying offender behaviour is indispensable.

Every perpetrator leaves a trace. They may test boundaries with inappropriate jokes, or manufacture opportunities for one-on-one contact with children. They may volunteer for roles that give them unsupervised access, or cultivate relationships with families under the guise of mentorship or support. These patterns, when understood and recognised, become warning signs. But without a framework for analysis, signals are easily dismissed as quirks, eccentricities, or harmless enthusiasm. Too often, the pieces of the puzzle are scattered across different agencies, different contexts, different timeframes, never assembled into a coherent picture until it is far too late.

To analyse perpetrators is not to sympathise with them. It is to strip them of the shadows in which they thrive. Each insight into how they think and operate becomes a tool of prevention. A rigorous study of perpetrator pathways allows us to connect these fragments, to see the architecture of abuse before it is fully constructed. It empowers professionals, institutions, and communities to act earlier, with greater confidence, and with a clearer sense of what they are confronting.

To look directly at perpetrators—coldly, rigorously, without flinching—is to arm ourselves with the knowledge necessary to protect.

The bias of basing studies only on who you catch

Our understanding of people that abuse children is largely drawn from administrative criminal justice data. This means that we mostly know about perpetrators who have been caught.

When studies of child sexual abuse rely only on detected perpetrators, those who are charged, convicted, or otherwise caught, we risk a fundamental methodological bias. This is akin to the problem identified during World War II, when analysts initially proposed reinforcing the areas of returning aircraft that showed the most bullet holes. The statistician Abraham Wald famously pointed out the flaw: the bullet holes were on the planes that made it home. The critical areas were the ones with no damage on returning planes, because aircraft hit there had not survived to be counted. In the same way, if we build our understanding of child sexual abuse solely on perpetrators who are caught, prosecuted, or publicly exposed, we are studying the 'planes that made it home'. These individuals represent only a subset of all abusers, often those who were less skilled at concealing their actions, those who made mistakes, those who offended in ways that left clearer evidence, or who operated in contexts where detection was more likely.

This creates several distortions:

- **Over-representation of certain perpetrator types:** Opportunistic or less sophisticated perpetrators may be caught more often, skewing data away from highly organised, manipulative perpetrators who evade detection.
- **Underestimation of institutional grooming:** Perpetrators who succeed in embedding themselves in institutions, cultivating trust, and silencing victim-survivors may remain hidden for years or decades.
- **Misleading risk profiles:** By studying only those apprehended, we risk drawing conclusions about 'what perpetrators look like' that reflect detection bias, not the full spectrum of perpetrator behaviour.
- **System blindness:** Reliance on known cases hides the far larger number of undetected perpetrators, which research suggests is substantial. This limits the ability to design systemic safeguards that address the full risk environment.

Perpetrators are also unlikely to provide an accurate recall of their criminal histories particularly when it involves the sexual abuse of children. Criminal justice data and forensic studies have been critical in shaping our understanding of known perpetrators, including their motivations, methods, and risk factors. The true challenge however is not only to analyse those we catch, but to recognise the biases in that sample and to seek evidence, from victim-survivor disclosures, research, and systemic reviews, about those who remain undetected.

Much of what we know about child sexual abuse perpetrators is derived from clinical or forensic samples, individuals who have been charged, convicted, or treated in therapeutic settings, however this is a clear risk that such samples represent only a fraction of those who offend.

Most perpetrators will pass criminal history background checks, including WWCC, as they do not have prior criminal records. While they are an important part of a child safeguarding system, WWCC assume that risk is correlated with known histories of offending, but emerging research challenges that assumption. Most motivated child sexual abuse perpetrators, particularly those who operate online, those in positions of authority, and those who have adapted their offending to avoid detection, will pass these checks with ease.

Background checks such as WWCC are only effective when the individual in question has a known criminal history. This fact alone requires a paradigm shift in how we conceptualise risk and prevention. It calls for robust safeguarding systems that are proactive and informed by broader behavioural and environmental indicators, rather than being narrowly reactive to prior convictions or substantiated reports.

Based on population level surveys, and research, we also know that:

- there are people with a sexual interest in children who have yet to and may not commit offences
- there are people who have committed or continue to commit sexual offences against children who have yet to be detected for their offending
- there are people who have been convicted for sexual offences against children whose risk of reoffending can be managed, when they have access to an appropriate mix of interventions, ongoing monitoring and rehabilitation support.

While this is an uncomfortable conversation, by focusing on abusers, we seek to make the invisible visible, to better understand how to protect children and prevent future abuse.

Types of offenders

There is a community perception that every person who sexually abuses a child is a paedophile. This is not correct. Not all child sexual offenders are paedophiles. Rather paedophiles are a sub-set of child sexual offenders.¹¹⁰ Most child sexual offenders who come to police attention are opportunistic or situational perpetrators who do not meet the clinical diagnostic criteria for paedophilia. Opportunistic or situational perpetrators often do not have a sexual interest in children and engage in child sexual abuse when an opportunity arises and/or due to the circumstances they are in.¹¹¹ They are more likely to lack appropriate personal controls and be impulsive.¹¹²

The Royal Commission into Institutional Responses to Child Sexual Abuse (the Royal Commission) noted some key differences between the two. They considered that:

- Opportunistic perpetrators may be more likely to be involved in general offending other than child sexual abuse, they are less likely to intentionally create situations where abuse occurs and be less likely to use grooming strategies.¹¹³ They will abuse children where there is an opportunity to do so.
- Situational perpetrators tend to abuse children in response to things that are occurring in their own life.¹¹⁴ This might include a lack of positive adult relationships, low self-esteem or social isolation.¹¹⁵

The Diagnostic and Statistical Manual of Mental Disorders (5th edition) describes a person as having Paedophilic Disorder when they have intense and recurrent sexual urges towards, and fantasies about, prepubescent children that have either been acted upon or which cause the person distress or interpersonal difficulties.¹¹⁶ They can also be referred to as fixed or persistent perpetrators.¹¹⁷

Put simply, paedophilia is a sexual preference for prepubescent children.¹¹⁸ The person can be either attracted specifically to males or females, or both.¹¹⁹ One indicator of paedophilic disorder is the extensive use of child exploitation material (CEM) given individuals usually choose the kind of pornography that resembles their sexual interests.¹²⁰

People usually become aware of their sexual interest in children around the time of puberty and it appears to be a lifelong condition.¹²¹ Most of what we know about paedophiles comes from clinical or criminal justice samples, from men who have already committed sexual offences against children.¹²² Given the known underreporting of child sexual abuse, the prevalence of paedophilia in the general population is largely unknown with the highest possible reported prevalence in the male population being approximately three to five per cent.¹²³

Paedophiles have a higher recidivism rate compared to opportunistic or situational offenders due to their sexual preference towards children.¹²⁴ However, if a perpetrator is ready, willing and able to engage in sexual offender programs they can learn to manage their thoughts, feelings and behaviours towards children and lead a healthy lifestyle. There are significant challenges to building our understanding of how to intervene or work with people that abuse children.¹²⁵ This is impacted by inaccurate self-reporting by perpetrators who have been caught, including about other abuse they may have previously committed which has not been disclosed or detected.¹²⁶ This has serious implications for approaches to risk assessment, treatment planning, sentencing decisions and supervisory conditions.¹²⁷

Women who sexually abuse children

Most research in this area has predominately focused on men who sexually abuse children. There is little research about women who sexually abuse children. QPS data indicates that of all reported sexual offences alleged to have been committed against children in Queensland between 2015–25, only 8 per cent involved a female perpetrator. Women who sexually abuse children are a heterogeneous group and given the limited research, and comparatively lower rates of detected offending, caution is required when interpreting any female offenders profile.¹²⁸ The true prevalence of female-perpetrated sexual abuse is unknown, possibly due to under reporting. Some recent studies indicate between 5 per cent and 21 per cent of child sexual abuse is perpetrated by female offenders.^{129 130} Little is also known about the characteristics of women who sexually abuse children, such as their motivations, psychopathology, risk factors and treatment needs.¹³¹ One recent study found that female perpetrators engage in grooming behaviours similar to male perpetrators, however the sexual grooming model used for this study is validated only for use with men.¹³² The community is less likely to recognise women as sexual offenders and instead sees them as caregivers, nurturers or victims. This means that child sexual offences committed by women may be minimised or go undetected.¹³³ Further, victim-survivors who do come forward to report abuse by a female offender may be met by disbelief by family, professionals and police.

Research on hidden perpetrators

A study by Professor Michael Salter in 2023 offers valuable insight into a hidden population of perpetrators. The research focused on child sexual exploitation and abuse across three countries, with a particular emphasis on Australia. This large-scale survey explored the characteristics, motivations, online behaviours, and social environments of men who have sexually abused or exploited children, or who have a sexual interest in doing so, despite not necessarily having been detected or charged by authorities.

Within the Australian component of the study, a nationally representative sample of 1939 adult men was surveyed. The findings revealed approximately five per cent of survey respondents admitted to having a sexual interest in, feelings for, or motivation to offend against children. While not all people with a sexual interest in children go on to offend, the data indicated a significant population of motivated offenders operating outside the reach of the criminal justice system.

This data highlights the extent to which these individuals were present in child-related occupations. Of the surveyed sample, 16.3 per cent reported that their current employment involved working with children.

Furthermore, those who were identified as motivated offenders were found to be 3.17 times more likely to be employed in roles that involved direct access to children. This overrepresentation of motivated offenders in child-related roles challenges many foundational assumptions within safeguarding frameworks. It raises critical questions about how people may intentionally seek out employment or volunteer roles that provide both access to children and the necessary authority to deflect suspicion.

These types of roles also provide perpetrators with opportunities to build trust with children, families, and communities. Trust that can be strategically exploited to enable offending and reduce the likelihood of detection.

The findings reveal a pattern of risk among motivated offenders working with children, including demographic, behavioural, psychosocial, and attitudinal domains. These men were more likely to be older, married or cohabiting, living with children, and earning higher incomes. They also demonstrated frequent

use of encrypted digital platforms, daily consumption of pornography (including violent or illegal content), and engagement with offender networks. Psychosocial vulnerabilities, including anxiety, depression, and adverse childhood experiences, were significantly elevated. Importantly, many held beliefs that minimised the harms of CSA [child sexual abuse] and reported peer associations with offenders that further increased risk.

This profile underscores how risk may be concealed beneath outwardly stable life circumstances and professional roles.¹³⁴

The study also identified a distinct demographic and behavioural profile of motivated offenders who work with children. They were statistically more likely to:

- be aged 55 years or older
- live in metropolitan areas
- have a high annual household income
- be heterosexual
- be married or cohabitating with a partner
- have at least one child living in their household.

This demographic profile is notable for several reasons. First, it contrasts with the commonly held stereotype of the socially isolated or obviously deviant perpetrator. Instead, these individuals present as socially integrated, economically stable, and domestically situated, features that may actively obscure suspicion or complaints. Their apparent 'normality' and seniority in both professional and community settings can act as powerful camouflage. It enables them to deflect scrutiny and manipulate institutional cultures that are reluctant to suspect or accuse those in positions of trust.

These individuals also demonstrate particular behavioural patterns that enhance their capacity to offend covertly. They are more likely to:

- use social media platforms frequently
- engage in online gaming and online dating
- use anonymity-preserving technologies such as The Onion Router (TOR), virtual private networks (VPNs), and encrypted dark web forums like Hive
- have social networks that include others who engage in some form of child sexual exploitation or abuse
- report poorer mental health outcomes.

The intersections between these factors indicates that many motivated offenders are not isolated or operating independently. They are part of broader digital or social communities in which offending behaviours are normalised, encouraged, or concealed. The use of sophisticated digital technologies allows for both anonymity and connectivity. It creates an environment in which perpetrators can exchange material, reinforce distorted beliefs, and learn tactics to avoid detection.

Poor mental health, while not a cause of offending, may reflect the internal conflict, risk-taking behaviours, or emotional dysregulation associated with such individuals.

The 'typical' indicators of risk such as prior convictions, social deviance, or overt grooming behaviours do not apply to many of the individuals identified in this study. These motivated offenders are older, better resourced, more socially integrated, and more strategic in their offending. They may be senior educators, respected professionals, long-standing volunteers, or community leaders. Their offences are likely to be hidden, opportunistic, and methodically planned to avoid raising concern.

These findings highlight a fundamental weakness in many child safeguarding systems: the tendency to rely on visible warning signs or past criminal behaviour as the primary basis for risk assessment.

In environments where perpetrators are strategically 'normal' in their appearance and behaviour, and where they are embedded in protective institutional cultures, traditional mechanisms of prevention and detection are unlikely to be effective. This underscores the need for more dynamic and context-aware safeguarding frameworks, those that take account of:

- power dynamics
- access to children
- patterns of behaviour within organisations and over time
- the broader environments that facilitate grooming and concealment.

The findings also point to institutional blind spots that can be actively exploited by perpetrators.

Organisations that serve children, particularly large, hierarchical ones—may have cultures that prioritise loyalty, reputation, or procedural compliance over the safety of children. In such environments, perpetrators may thrive, using their seniority and perceived trustworthiness to silence concerns, discredit complainants, and manipulate reporting processes.

Where motivated offenders are embedded within these organisations, they can become 'untouchable', surrounded by structural and cultural safeguards that serve to protect them rather than the children in their care.

Staff may also be reluctant to raise concerns about respected colleagues, and children may not be believed. Even where reports are made, weak investigative responses, poor record-keeping, or inter-agency gaps can result in missed opportunities to intervene.

The implications of these findings are profound. If five per cent of adult men report a motivation to sexually abuse or exploit children, and if those with such motivations are statistically more likely to be working with children, then current child safeguarding systems may be significantly underestimating the scope and proximity of risk.

The findings presented in this study force a critical re-evaluation of how we identify, understand and respond to people with a sexual interest in, or who abuse children. It:

- challenges longstanding assumptions about risk
- reveals the inadequacy of current prevention mechanisms
- highlights the presence of motivated offenders operating undetected in our communities and institutions.

The fact that many of these individuals are older, wealthier, socially embedded and professionally respected makes them particularly difficult to detect and also particularly dangerous. Systems built around the identification of 'problem individuals' through criminal histories or visible red flags are insufficient.

We must build safeguarding environments that anticipate deception, embed protective culture, and actively question assumptions of safety based on social status or familiarity. Only by recognising the full scale and shape of the threat can we design a response that is truly fit for purpose.

This research is also consistent with other representative population samples and surveys. For example:

- A systematic review which critically evaluated 30 studies found the mean prevalence rate of sexual interest in children was between two per cent and 24 per cent. These findings were dependant on the population and there were several inconsistencies across the studies in terms of methodology and the definition of sexual interest in children.¹³⁵
- A 2013 survey conducted on 1978 male third-year high school students in Sweden found 4.2 per cent of the participants had viewed CEM indicating a potential sexual interest in children.¹³⁶
- An online survey of 8718 German men found 4.1 per cent reported sexual fantasies involving prepubescent children, 3.2 per cent reported sexual offending against prepubescent children, and 0.1 per cent reported a paedophilic sexual preference.¹³⁷

Understanding the preconditions for child sexual abuse: a critical analysis of Finkelhor's four-factor model

If identifying the people who may seek to sexually abuse children remains difficult, our focus can instead shift to observing and understanding the behaviours and actions through which abuse occurs. While predicting who will offend is challenging, analysing how abuse is perpetrated provides a more practical and evidence-informed pathway to prevention. To effectively safeguard children, it is essential to examine the behavioural patterns, social contexts, and situational circumstances that facilitate offending.

Understanding the mechanisms of abuse requires looking beyond perpetrator characteristics to consider the ways in which perpetrators interact with children, exploit environments, and leverage opportunities to commit abuse. By focusing on behaviours rather than traits, we can move from acknowledging that abuse occurs to a deeper understanding of the conditions and methods that make offending possible. This perspective naturally leads into the theory of offending circumstances, which examines how personal motivations, opportunity structures, and environmental factors converge to enable abuse. One of the most enduring and influential theoretical frameworks in this field is David Finkelhor's Four Preconditions Model. This model offers a structured psychological explanation of how and why child sexual abuse occurs.

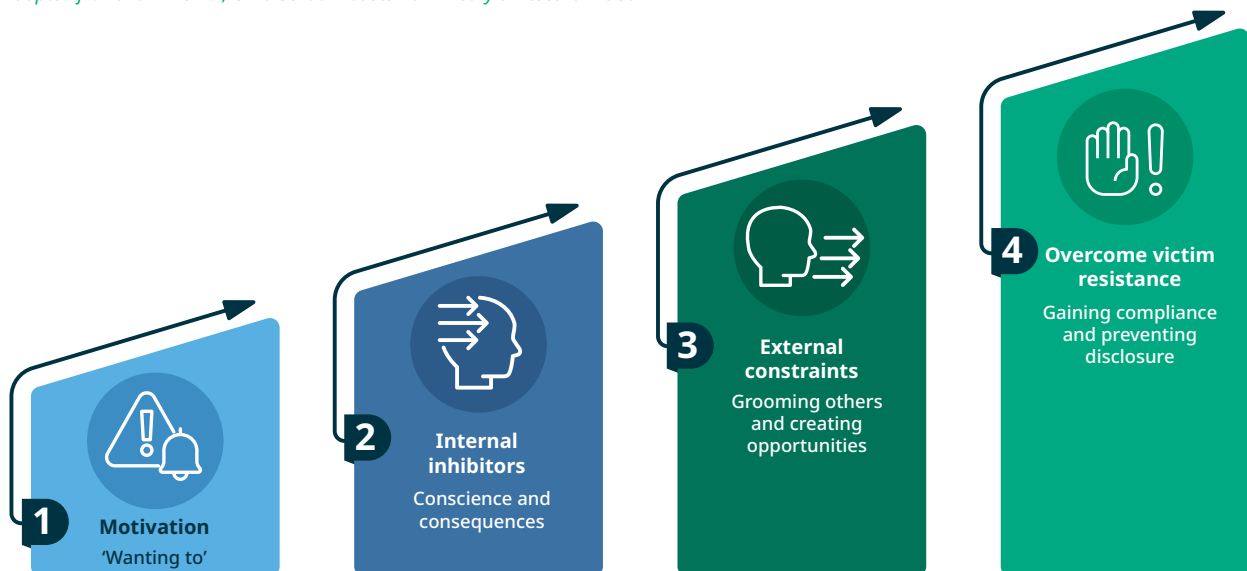
For an incident of child sexual abuse to occur, Finkelhor asserts that four preconditions need to be met.

1. **The offender needs to be motivated to sexually abuse a child.**
2. **The offender would have to overcome internal inhibitions to sexually abuse a child.**
3. **The offender would have to overcome external obstacles to sexually abuse a child.**
4. **The offender would have to overcome victim resistance to the sexual abuse.**

This model moves away from simple notions of 'evil' or criminality. It instead examines the interplay of individual, relational, and environmental factors that enable abuse to occur.

Figure 18: Four Pre-conditions to child sexual abuse

Adapted from: D. Finkelhor, Child Sexual Abuse: New Theory & Research 1986



1. The offender must be motivated to sexually abuse a child

The first precondition in Finkelhor's model is the presence of a motivated offender. This is often founded in three interrelated psychological dynamics:

- emotional congruence
- sexual arousal to children
- blockage of alternative sexual outlets.

Emotional congruence refers to the psychological identification of the perpetrator with the emotional world of the child.

Sometimes perpetrators may feel more comfortable or accepted in 'relationships' with children than with adults due to unresolved childhood trauma, social isolation, or low self-esteem. These perpetrators may seek out children not solely for sexual gratification, but also for emotional connection, validation, or control, blurring lines between emotional and sexual motivation in their own minds.

Sexual arousal to children is another critical factor. While not all people who have a sexual interest in children will offend, those who do are more likely to have persistent and intense patterns of arousal to prepubescent children. This may be compounded by the presence of deviant sexual fantasies, compulsive pornography use (including CEM), or participation in networks that normalise these desires.

Blockage refers to the idea that some perpetrators may lack appropriate or satisfying sexual relationships with adults due to psychological, relational, or situational issues. This 'blockage' of normative outlets may increase the likelihood that motivated offenders turn to children as accessible or less threatening targets.

While this concept has been criticised for implying a level of inevitability, it remains an important lens for examining how certain internal pressures may influence behaviour.

Motivation alone, however, is insufficient. Many people with a sexual interest in children do not offend. What distinguishes those who act is their ability or failure to manage and contain their desires, leading to the second precondition.

2. The offender must overcome internal inhibitions

The second precondition requires the motivated offender to overcome internal inhibitions—psychological and moral barriers that typically prevent individuals from harming others, particularly children. These inhibitions may stem from a person's conscience, empathy, fear or guilt, moral beliefs, or personal values. Perpetrators must neutralise or circumvent these barriers to act on their motivations.

Cognitive distortions are one of the most documented mechanisms by which perpetrators overcome internal inhibitions. They are used by perpetrators to rationalise and justify their harmful sexual behaviours towards children (and sometimes adults).¹³⁸ This includes personal thoughts, beliefs, perceptions, and attitudes which minimise the nature of the abuse and diminish a person's responsibility for the abuse.¹³⁹ The distorted views of victim-survivors, the world and the perpetrator themselves free them from guilt,¹⁴⁰ acting as a self-protective defence mechanism.¹⁴¹

Cognitive distortions could include statements relating to how children are capable of 'seducing' men, or sexual activity between adults and children being seen as 'healthy'.¹⁴² These are self-serving beliefs and rationalisations that allow the perpetrator to reinterpret their actions as non-harmful, justified, or even loving.¹⁴³ Common distortions include beliefs such as 'children are sexual beings,' 'I'm teaching them about sex,' or 'they wanted it.'¹⁴⁴ These distortions reduce moral dissonance and allow a perpetrator to view their behaviour as acceptable or excusable.¹⁴⁵ They can be further reinforced by socialising with others with a sexual interest in children, including in online environments.¹⁴⁶

Substance use can also serve to lower inhibitions. While alcohol and other drug use is not a causative factor, it is commonly associated with the perpetration of incidents of child sexual abuse, particularly those involving opportunistic or situational perpetrators. Alcohol and other drug use may reduce anxiety, impair judgment, and provide a psychological justification for behaviour the individual knows is wrong. In some cases, it may also be used intentionally by a perpetrator to lower their own inhibitions or those of the child.

Lack of impulse control or the presence of personality disorders can further reduce a perpetrator's capacity to resist acting on deviant urges. Perpetrators with antisocial, narcissistic, or psychopathic traits may lack empathy, remorse, or concern for the consequences of their actions. These individuals are more likely to engage in manipulative, coercive, or violent offending, and may reoffend even after detection.

Critically, many internal inhibition-lowering mechanisms are reinforced through repeated offending. The more times an individual offends without consequences, the more entrenched their cognitive distortions become, and the easier it becomes for them to justify ongoing abuse.

3. The offender must overcome external obstacles

The third precondition is the need to overcome external obstacles—physical, relational, or institutional barriers that might otherwise prevent access to a child or reduce opportunities to offend. These can include adult supervision, organisational safeguards, or social and environmental factors that create visibility and accountability.

Finkelhor's model underscores the importance of opportunity in enabling abuse. Even a motivated offender with low inhibitions is less likely to be able to offend if they are never alone with a child, or if they are closely monitored. Conversely, when external barriers are weak, absent, or can be easily bypassed, opportunities for abuse increase dramatically.

Access to children is a central enabling factor. Perpetrators are often in roles that provide both access and authority such as older family members (including uncles, siblings, fathers), neighbours, babysitters, teachers, coaches, youth workers, or clergy. These positions also afford trust, which can be used to manipulate both children and the adults around them. Research consistently finds that most child sexual abuse is perpetrated by someone known to the child who is often trusted by their family or community.

Institutional failings can also create environments in which perpetrators are shielded or enabled. This may include poor recruitment screening, inadequate supervision, fragmented reporting pathways, or cultures of silence and deference to authority. Organisational blind spots and failures to act on suspicions or allegations can contribute to environments which sustain offending. Some perpetrators become adept at identifying and exploiting these system weaknesses. This includes reluctance of institutions to damage their reputations or proactively act on ambiguous concerns.

Technological enablers also play a growing role in lowering external barriers. Perpetrators may groom children online, communicate in private or through encrypted channels, and exchange abuse material without ever being physically present. The internet also allows perpetrators to connect with like-minded individuals, further normalising their behaviour and reducing perceived risks. Preventing child sexual abuse, therefore, requires strengthening external barriers. This includes by:

- ensuring appropriate supervisory safeguards are in place
- embedding safeguarding culture in organisations
- disrupting digital environments where exploitation can thrive.

4. The offender must overcome victim resistance

The fourth and final precondition is the offender's need to overcome resistance from the child. This may be done through physical force, threats, coercion, manipulation, grooming, or abuse of authority. Importantly, Finkelhor acknowledges that many child victim-survivors are not capable of resisting the abuse, due to their age, size, developmental capacity, trust in the adult, or lack of understanding that the behaviour is abusive.

Grooming is one of the most common strategies perpetrators use to reduce resistance.

Grooming involves establishing a relationship of trust with a child, and often their caregivers including parents or other staff, to create opportunities for abuse to occur. This includes by normalising problematic behaviours and desensitising a child to physical contact, secrecy, or inappropriate attention. Perpetrators may provide gifts, affection, or special privileges, while simultaneously isolating the child from others and instilling confusion or guilt.

In some cases, force or threats may be used to ensure compliance and silence. This may include threats to harm the child or their loved ones, to expose them to shame or blame, or that they will not be believed if they were to disclose. The fear induced by such threats can be particularly powerful in keeping children compliant and preventing disclosure, including after the abuse has occurred.

Children may also be targeted when they are asleep, distracted, or otherwise unable to resist.

Vulnerable children—including very young children, those with disabilities, those in care, or those who have experienced previous trauma—are often at greater risk due to their reduced ability to resist or report the abuse, or to be believed when they do tell others.

Understanding how perpetrators manipulate and control children and their caregivers, including parents and staff, to create opportunities for abuse to occur and avoid detection is essential to improving the prevention and identification of, and response to, this type of abuse. It also challenges simplistic community myths and reinforces the need for trauma-informed, child-centred responses to all disclosures or suspicions of abuse.

Implications for prevention and systemic response

Finkelhor's model shows that abuse is rarely the result of a single failing. Rather, it is enabled by a combination of factors, internal and external, individual and systemic.

Primary prevention must target each of these four preconditions. This includes through:

- education to challenge cognitive distortions and promote healthy sexuality
- interventions for people with a sexual interest in children to seek help before offending
- strong cultural and legal norms that reinforce internal inhibitions
- robust safeguarding environments that minimise opportunities for abuse to occur and increase the likelihood of detection.

Secondary and tertiary prevention which focus on early intervention or responding after abuse has occurred, can also benefit from this type of framing. By understanding how grooming, coercion, and manipulation operate, professionals can better detect risk, assess disclosures, and respond sensitively. By recognising the organisational and systemic factors that reduce external obstacles, institutions can implement changes to close gaps and enhance organisational accountability.

Additionally, Finkelhor's model encourages a shared responsibility approach. Preventing child sexual abuse is not just the responsibility of police or child protection agencies. It is the role of schools, sporting clubs, religious institutions, health services, and every adult who interacts with children. Systems must be designed to detect not only clear signs of abuse, but also the situational or environmental conditions that make abuse possible.

Finkelhor's Four Preconditions Model reinforces that abuse is not an isolated or random event, but the result of multiple converging factors that must each be addressed if we are to truly protect children.

The model offers a comprehensive framework for prevention by improving understanding of the motivations of offenders by:

- the way in which they overcome their own inhibitions
- the environmental and institutional vulnerabilities they exploit, and
- the ways they seek to suppress victim resistance.

As systems evolve and perpetrators adapt, this model continues to provide essential insight. It reinforces the need for vigilance, for systemic reform, and for a comprehensive, evidence-informed understanding of how child sexual abuse occurs—and how it can be stopped.

Routine Activity Theory

***Environment is the invisible hand that shapes human behaviour.*¹⁴⁷**

Routine Activity Theory was introduced by Cohen and Felson and relates crime closely to the environment.¹⁴⁸ It is suggested many normal day-to-day activities bring adults and children into contact with each other. These routines can provide the opportunity for harmful offences to occur.¹⁴⁹ Prevention strategies related to environmental factors attempt to alter the opportunity to offend.¹⁵⁰

Routine Activity Theory asserts that for an offence to occur there needs to be the presence of a motivated offender, potential victim and the absence of a capable guardian.¹⁵¹

Figure 19: Routine Activity Theory



(Lawrence Cohen and Marcus Felson, 1979)

Motivated offenders are persons who have a desire to commit an offence and are capable.¹⁵² They may be driven by various factors such as financial need or social pressure, or for a person with a sexual interest in children potentially to meet a sexual need.¹⁵³

A suitable target/potential victim is a person who the motivated offender perceives to meet their personal preferences and is vulnerable.¹⁵⁴ The opportunity to commit a crime may influence which victim the motivated offender identifies and chooses to engage.¹⁵⁵

A capable guardian means anyone or anything that can effectively deter or prevent an offence.¹⁵⁶ For instance, a capable guardian can be a childcare educator who is going about their routine work and is able to keep both children and other educators in their line of sight (supervision) in order to prevent and/or identify an offence. Further, the choice of architecture of environments can reduce potential for offending by decreasing hiding places.

A likely time to commit harmful offences is when a motivated offender has unsupervised, or minimally supervised, access to children. This includes when no one is watching over them, or people are oblivious to the offending behaviour. It might also include when children are taken behind a closed door or into another area out of sight of other educators and/or CCTV.

If everyone is thinking about guardianship, then all forms of abuse to children committed by both men and women can be better prevented, identified and responded to.

...you need to look very simply at Routine Activity Theory. Particularly if you're dealing with very young, pre-verbal children. The notion of capable guardianship is absolutely critical. [ECEC employees] need to internalise the notion that in order to keep these kids safe, all of us here need to be capable and responsible guardians.¹⁵⁷

Policies and procedures can be implemented to increase guardianship or supervision and decrease opportunities for perpetrators to have unsupervised access to children.¹⁵⁸ Other institutional safeguards, such as contextual prevention and environmental design, can also be established to help further reduce opportunities for abuse to occur. This could include:

- controlling the number of children per educator
- strengthening regulatory controls, such as through the *Child Safe Organisations Act 2024*
- improving physical spaces by creating open spaces to ensure line of sight
- addressing the organisational culture to allow for better identification of offending behaviours and reporting processes.

Navigating online offending

Increased access to the internet and technological advances have created new ways for children to be sexually victimised by diverse motivated offenders.¹⁵⁹ Perpetrators may be known or unknown to a child victim-survivor and can include both young people and adults.¹⁶⁰ The online environment not only provides easy access to unsupervised children but is also an unchecked environment to commit child sexual abuse offences.¹⁶¹

The production, possession and distribution of CEM, either online or in person, presents unique challenges and opportunities for law enforcement and other entities. CEM is defined under the *Criminal Code Act 1899* s207A as follows:

“child exploitation material” means material that, in a way likely to cause offence to a reasonable adult, describes or depicts a person, or a representation of a person, who is, or apparently is, a child under 16 years –

- (a) in a sexual context, including for example, engaging in sexual activity; or*
- (b) in an offensive or demeaning context; or*
- (c) being subjected to abuse, cruelty or torture.*

Responding to the sheer volume of CEM available online is challenging. The volume of online CEM content is impossible for any police agency to remove or investigate efficiently.¹⁶² Police must find ways to triage cases and prioritise the most immediate and serious threats first.¹⁶³

Technology companies have knowledge of their platform's limitations, vulnerabilities and population demographics. Police rely on them to comply with subpoenas and requests to take down information.¹⁶⁴ The technology industry plays an important role in limiting the availability of CEM.

Collaborations and partnerships exist that demonstrate tech companies' strategic efforts to reduce CEM, such as the implementation of scanning tools against websites to proactively identify CEM.¹⁶⁵

Technology platforms and pornography providers should do more to disrupt the availability of illegal and seriously harmful content, including child sexual abuse material, and prevent children's access to pornographic content altogether.

Positively, identifying individuals with CEM can result in victim-survivors, and other perpetrators, being identified.¹⁶⁶ Online perpetrators often engage with communities of like-minded persons which can normalise abusive beliefs and behaviours and give the sense that it is more common than it actually is.¹⁶⁷ These darknet communities are literally on the dark side of our society. They provide anonymity and are challenging for law enforcement to detect and infiltrate.¹⁶⁸

Darknet communities can fill both an emotional and social need for a perpetrator through shared interests.¹⁶⁹ Perpetrators are in an online space to socialise with their like-minded peers. This is something which they often cannot do in real life due to a fear of being caught.¹⁷⁰

The extensive use of CEM indicates a person has a sexual interest in children given people usually choose the kind of pornography that resembles their sexual interests.¹⁷¹ When a perpetrator is caught with CEM it is often thought they will go onto contact offend when it is most likely they already have.¹⁷²

A recent study found 60 per cent of CEM offenders had committed contact sexual offences against children which had not been identified at the time of their arrest.¹⁷³

Recent research published in August 2025 by the Australian Institute of Criminology studied posts from a darknet child sexual abuse forum and found darknet users discussed a range of desistance strategies. Some of these included using CEM to avoid contact offending, reducing access to children, reducing access to the internet, and adjusting their lifestyle. A few darknet users had positive attitudes towards utilising professional psychosocial services however expressed concerns about risk of detection while seeking intervention. The results of the study indicate those with a sexual interest in children do want information and support but would prefer anonymity and online services to decrease the risk of detection.¹⁷⁴

It is clear that prevention strategies must move beyond criminal history checks and reactive reporting systems. A more sophisticated approach is needed. One that incorporates strong intelligence capabilities, behavioural monitoring, environmental risk assessments, and proactive culture-building within child-serving organisations.

Safeguarding cannot be reduced to compliance. It must be embedded in everyday practices, leadership expectations, and staff training, underpinned by a belief that child safeguarding is everyone's responsibility.

There is also a need for greater public and professional awareness of how grooming and offending can be hidden in plain sight. Normality should never be mistaken for safety. Systems must develop tools for identifying subtle patterns of risk and grooming that do not rely on criminal histories.

Technology-based responses must also evolve. The widespread use of encryption, anonymising software, and dark web platforms by perpetrators requires investment in digital forensics, inter-jurisdictional cooperation, and the development of tools to track and prevent online exploitation.

Prevention in the digital age is not only about content moderation or parental controls; it must include law enforcement capability, platform accountability, and education targeted at both children and adults.



Case studies

This section outlines a series of national and international case studies involving child sexual abuse in early childhood education and care (ECEC) settings. Each case highlights risk factors, systemic failures, barriers to detection, and post-case measures. Together, these cases provide critical insights into vulnerabilities within systems, and how perpetrators have committed serious abuse and damage.

Case Study One

R.M. (Netherlands, 2010) - At least 87 children, all under the age of four. Most of the victim-survivors were male.

R.M., a 27-year-old daycare worker and babysitter in Amsterdam, was arrested for sexually abusing at least 87 infants and toddlers. He was employed across multiple childcare facilities and provided babysitting services. His partner was also arrested for facilitating and concealing offences. The abuse came to light when investigators reviewing CEM footage identified a distinctive Dutch toy. Dutch authorities broadcast censored images, leading a grandfather to recognise R.M. as his grandchild's babysitter. The case shocked the Netherlands and led to major reforms in staff vetting, oversight, and interagency information sharing.

This case demonstrates how perpetrators exploit weak oversight, fragmented employment systems, and communication barriers. It underscores the value of structural safeguards such as the 'Four Eyes Principle.'

Sources: BBC News (2010); Lindauer et al. (2014); Turrell (2023).

Risk factors

- Deliberately targeted preverbal children; stopped once children began speaking.
- Selected workplaces and homes without CCTV or nanny cams.
- Worked across multiple childcare centres, exploiting lack of coordination.

System failures

- No centralised vetting or staff tracking system.
- Absence of supervision protocols or dual-staffing arrangements.
- Prior concerns (2008) dismissed by both childcare centre and police.
- Previous CEM conviction in Germany (2003) not detected in Dutch checks.

Barriers to detection

- Identified only via international CEM investigation.
- Very young victim-survivors unable to articulate their experiences of abuse.

Post-case measures

- Introduction of the Four Eyes Principle: no childcare worker ever alone with a child.
- Longitudinal study into long-term impacts on victim-survivors and families.
- Heightened scrutiny of childcare safety, especially in institutional/home-based settings.

Case Study Two

S.M. (South Australia, 2014) At least seven victim-survivors, aged between 18 months and 13 years. The victim-survivors were mostly female.

S.M. worked across multiple ECEC services before entering state-run residential care. His crimes were discovered not in childcare settings, but via online investigations into CEM by Taskforce Argos in Queensland. He was a key figure in an international offender network.

This case highlights failures in screening, risk assessment, and staff escalation. Detection occurred only through specialist online investigation, not service-level vigilance.

Sources: Child Protection Systems Royal Commission (2016); Prosser (2016).

Risk factors

- Targeted preverbal/developmentally vulnerable children, including children with disabilities.
- Had only basic training and learned 'on the job.'
- Worked across multiple institutions and countries (including Canada and the United States of America).

System failures

- Employment proceeded despite a psychological assessment rating him 'very unsuitable'.
- Concerns about inappropriate interactions raised as early as 2010 but not escalated.
- Multiple staff complaints ignored across agencies.

Barriers to detection

- Very young victim-survivors unable to articulate their experiences of abuse.
- Workplace cultures discouraged reporting.
- Whistleblowers faced intimidation and discrimination.

Post-case measures

- Establishment of the Child Protection Systems Royal Commission.
- Reforms to recruitment, vetting, staff training, and reporting protocols.
- System-wide push for stronger oversight and escalation pathways.

Case Study Three

D.N. (Sweden, 2014) At least 19 victim-survivors, ranging in age from 12 months to three years. The victim-survivors were all female.

D.N., a 40-year-old childcare worker, was arrested after abusing a 10-year-old girl at an amusement park. Police searches uncovered CEM, including material filmed in ECEC settings. D.N. had worked in over 40 centres via a staffing agency.

Highlights the dangers of rotating agency staff in ECEC. Lack of cross-institutional accountability is a major vulnerability.

Sources: Kjellgren et al. (2022); The Local (2015); Kristianstad District Court (2015).

Risk factors

- Agency employment enabled rotation across many centres.
- Often worked alone or with minimal scrutiny.
- Victim-survivors too young to report.
- Trusted due to calm, professional manner.

System failures

- Staffing agency model lacked consistent vetting.
- No cross-institutional tracking or flagging system.
- Protocols emphasised general care, not abuse detection.
- Diffusion of responsibility between preschools.

Barriers to disclosure

- Very young victim-survivors unable to articulate their experiences of abuse.
- Abuse occurred during routine care (e.g. nappy changes).
- No suspicion raised by staff or parents.

Post-case measures

- Crisis management frameworks reviewed.
- Support mechanisms for preschool staff/managers considered.
- Broader discussions about vigilance in 'trusted' preschool settings.

Case Study Four

J.S. (Sweden, 2014) At least 13 victim-survivors aged between three and four years. The victim-survivors were primarily females.

J.S., a 21-year-old trainee, systematically abused children during a practicum placement. He targeted non-verbal children during nap times and toileting. Evidence was discovered via mobile phone recordings. This case demonstrates the risks of allowing student trainees unsupervised access and suggests value in explicit 'no-lone-worker' provisions.

Sources: Sveriges Radio (2014); Kalmar Tingsrätt (2014).

Risk factors

- Very young, non-verbal victim-survivors.
- Unsupervised access during high-risk caregiving tasks.
- Perceived as caring and competent by staff.
- Preschool included low-visibility areas.

System failures

- Inadequate background checks or screening for trainees.
- No supervision protocols restricting trainee contact.
- Parents not informed about new male trainee.
- Absence of safeguards for intimate care tasks.

Barriers to disclosure

- Very young victim-survivors unable to articulate their experiences of abuse.
- Grooming tactics used to silence victim-survivors.
- Abuse concealed within routine care.

Post-case measures

- No formal institutional reforms implemented.
- Responsibility not extended to the preschool or practicum system.

Case Study Five

V.G. (United Kingdom, 2009) At least 30 children between the ages of two and five years.

V.G., a child care worker in Plymouth, was arrested for producing and distributing CEM involving children in her care. She collaborated online with other perpetrators and shared images taken within the centre. Many images were cropped or anonymised, which prevented identification of some victims. V.G. never disclosed the names of the children she abused, compounding distress for families.

The case exposed the absence of robust internal reporting cultures and highlighted the catastrophic impact when abuse is facilitated by a trusted female worker in ECEC settings. It illustrates the risks of digital devices in childcare, the additional complexity of female offending, and the deep trauma caused when institutions cannot confirm whether a child was a victim.

Sources: BBC News (2009); Serious Case Review (2010).

Risk factors

- Worked in a trusted role with very young children.
- Had unsupervised access to children during care routines.
- Used personal mobile phone on site, enabling production and distribution of CEM.

System failures

- Nursery did not restrict staff use of personal devices.
- Colleagues noted inappropriate comments but did not escalate.
- Safeguarding training focused on external risks, not staff behaviour.
- Lack of clear escalation pathway for parental or staff concerns.

Barriers to detection

- Very young victim-survivors unable to articulate their experiences of abuse.
- Offending came to light only via online intelligence, not nursery reporting.
- Parents left in uncertainty due to V.G.'s refusal to identify victims.

Post-case measures

- National review of nursery safeguarding standards.
- Stronger restrictions on mobile phone use in childcare settings.
- Enhanced staff safeguarding training on peer behaviour.
- Guidance emphasising the role of whistleblowing policies in nurseries.

Case Study Six

B.M. and E.M. (United States, 2015) 10 victim-survivors, aged between one and 14 years.

B.M. and E.M. a married couple operating a home-based childcare service, were convicted of producing CEM using children in their care. They recorded and distributed abusive material, exploiting their position as trusted in-home providers. Discovery came through federal investigation into online CEM distribution.

Highlights risks of abuse in informal or home-based settings, where oversight and accountability mechanisms are weaker. Reinforces the importance of rigorous vetting, monitoring, and restrictions on isolated caregiving contexts.

Sources: U.S. Department of Justice (2015); Associated Press (2016).

Risk factors

- Abuse occurred in a home-based childcare environment with minimal oversight.
- Perpetrators operated as a couple, reinforcing secrecy and normalising offending.
- Very young children targeted due to inability to disclose.

System failures

- Limited regulation and inspection of family-based childcare providers.
- Absence of unannounced visits or external oversight.
- Lack of reporting culture due to isolation of home settings.

Barriers to detection

- Very young victim-survivors unable to articulate their experiences of abuse.
- No suspicions raised by parents due to high trust in couple's 'family' environment.
- Offending detected only through online CEM investigation.

Post-case measures

- Renewed debate on regulation of home-based childcare providers.
- Calls for increased inspection regimes and stricter vetting.
- Strengthened federal-state collaboration on child safety in licensed care.

Case Study Seven

T.D. (New South Wales, 2017–20) 30 child victim-survivors ranging in age from infancy to 16 years.

T.D., a childcare worker, was arrested in 2020 for extensive sexual abuse offences across multiple childcare centres in New South Wales. He produced and distributed CEM, some of it live-streamed. He deliberately sought employment in childcare settings to access victims, exploiting systemic weaknesses in recruitment and monitoring. The case was described as one of Australia's worst child abuse matters. It sparked national debate on background checking systems and the adequacy of Working With Children Checks.

This case illustrates systemic vulnerabilities even in highly regulated contexts. Reliance on background checks without ongoing monitoring created blind spots. This reinforces the importance of proactive supervision, escalation, and inter-centre coordination.

Sources: New South Wales Police (2020); ABC News (2021); Sydney Morning Herald (2022).

Risk factors

- Systematically targeted infants and toddlers in institutional care.
- Moved across multiple centres, avoiding detection.
- Exploited routine childcare tasks (e.g. nappy changing, toileting) for offending.
- Groomed colleagues with charm and apparent professionalism.

System failures

- Working With Children Check cleared T.D. to work with children despite red flags.
- No system to track movement between centres.
- Concerns raised by colleagues dismissed or minimised.
- Lack of supervision during intimate care tasks.

Barriers to detection

- Very young victim-survivors unable to articulate their experiences of abuse.
- Abuse disguised within ordinary care routines.
- Detection relied on digital evidence from online investigations, not childcare vigilance.

Post-case measures

- New South Wales inquiry into Working With Children Checks and childcare regulation.
- Heightened national scrutiny of vetting, reporting, and institutional safeguards.
- Renewed emphasis on information sharing across agencies and states.

Table 5: Summary of case study themes

Theme	Key issues
Child-level risk factors	Very young/preverbal children, children with disabilities, children in out-of-home care
Institutional risk factors	One-on-one access during intimate care; agency/trainee staff, home-based or isolated settings, weak supervision protocols, agency staff
System failures	Inadequate background checks, poor information sharing across employers, weak regulation of family-based care, failure to act on staff concerns, weak/ignored background checks, poor oversight across employers, workplace cultures suppressing reporting
Barriers to detection	Non-verbal victim-survivors, abuse disguised in caregiving routines, reliance on online CEM detection, reluctance of staff to escalate concerns
Post-case responses	Inquiries and reviews, 'Four Eyes Principle', restrictions on mobile phones, strengthened vetting/oversight frameworks

These cases reveal recurring vulnerabilities in ECEC environments: child age and vulnerability, offender manipulation, institutional weaknesses, and systemic blind spots. Together, they highlight the need for multi-layered safeguards, integrated oversight, and mandatory escalation processes.

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Part

B

Establishing the timeline

Chapter

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Drawing together patterns over time

Exposing opportunity

Sexual abuse offending is rarely a discrete or spontaneous event. It typically unfolds as a process, involving a sequence of actions, decisions, omissions, and responses across time.

Developmental and life-course criminology has long established that most serious offending, including sexual and interpersonal violence, is preceded by precursor behaviours, risk exposures, and gradual escalations. A timeline seeks to render this progression visible. It shows how opportunity structures emerge and evolve, how behavioural signals compound, and how harm is enabled—whether through active concealment or passive neglect.

“*Efforts to prevent future offending, particularly in the context of child sexual abuse, violence, and other complex or sustained harms, requires us to build systems capable of learning, anticipating, and acting before abuse is perpetrated.*”

This chapter provides an overview of the timeline of our case study. It includes the offender’s history of employment, and complaints or reports about the offender and his conduct. This temporal mapping is indispensable in understanding not only what occurred, but how it was allowed to occur, and why it persisted. Central to our aim of understanding how to prevent and detect the behaviours in our case study has been the construction and use of this comprehensive offending timeline. It is not merely a historical reconstruction but a critical analytical tool that has helped surface behavioural patterns, institutional failures, systemic blind spots, and the cumulative nature of risk and response. The timeline we have built has formed the foundation for our inquiries into systemic reform, victim-centred justice, and more comprehensive approaches to prevention.

The analytical value of timelines lies in the capacity to draw together patterns across multiple cases and contextualise this with research, policy and practice. This moves beyond anecdotal or singular accounts to paint a composite picture of how systems behave over time. This knowledge can then be operationalised through the development of early warning indicators, staff training, information sharing reforms, and decision-support tools in high-risk sectors such as child protection, education, policing, justice and health.

Timelines also serve a critical function in justice and redress processes. For victim-survivors, the act of assembling a timeline is often part of reclaiming narrative agency. Particularly in cases of delayed disclosure or prolonged abuse involving multiple victims, timelines help victim-survivors situate their experiences in relation to others, validate their memory of events, and demonstrate the systemic nature of this abuse.

It is our hope that this timeline anchors our findings and enables readers and decision makers to understand the priority and impact of the recommendations for reform that we go on to make.

“*A timeline of offending is not an academic exercise. It is a statement of what was tolerated, what was ignored, and what must never be repeated. It is also, crucially, a guide to intervention—a map of where prevention, detection and response failed and where it could have succeeded.*”

A more detailed examination of this timeline is undertaken in the following chapters which consider:

- the offender’s motives, methods and patterns, to determine how he managed to evade detection for such a significant period of time (Chapter 8)
- organisational structures, culture and blind spots, and the missed opportunities to have detected the offending earlier (Chapter 9)
- the experiences of the victims of the offender and their families to centre the voices of lived experience in the Board’s consideration of the changes required (Chapter 10)
- how agencies and systems responded after the offender’s arrest (Chapter 11).

This deeper analysis of the timeline invites the reader to engage not only with the facts of the case but with the broader challenge before us: how do we build systems that see patterns before they become tragedies, and that use the past not as a record of blame but as a foundation for safety.

What emerges from this body of work is a fundamental proposition: prevention is not a matter of prediction, but of pattern recognition. Patterns are visible only when we look across time. The future cannot be protected unless the past is understood—not as a set of discrete incidents, but as a process that unfolds through time, shaped by both action and inaction.

The timeline of offending has been generated from information gathered from the sentencing remarks and associated reporting, as well as information compelled by Child Death Review Board (the Board) under section 29P. During the course of this review information requests were issued to centres where the offender worked, to law enforcement and regulatory bodies that held investigation material, and through written submission and interviews with people directly impacted by the offending, including victim-survivors and their families.

In compiling this timeline, there were notable discrepancies and contradictions in the case material, with a differing quality of information provided across centres. While some of these issues relate to the length of time over which the offending occurred, the passage of time since that offending, and the closure of some of the centres where the offender worked, it also highlights inadequacies in duplicative agencies' recordkeeping and retention practices.

Centre quality ratings under the National Quality Framework (NQF) were also considered in the development of the timeline where available. Early childhood education and care (ECEC) these ratings are intended to provide information about the quality of the early childhood education and care service.

Caution must be exercised when considering self-reported information from the offender as it cannot be independently verified. While this information is confronting to review, it has been included to help build a more complete picture of how the offender managed to evade detection for such a significant period of time.

Information requests



Our case study

The offender sexually abused children at multiple early childhood education and care services across Queensland over nearly two decades. Despite multiple concerns being raised about the offender's conduct over this time, his offending was not formally detected until his arrest in August 2022, when he was charged with offences against 65 girls in Queensland aged between one and nine years. He pleaded guilty to these charges in November 2024.

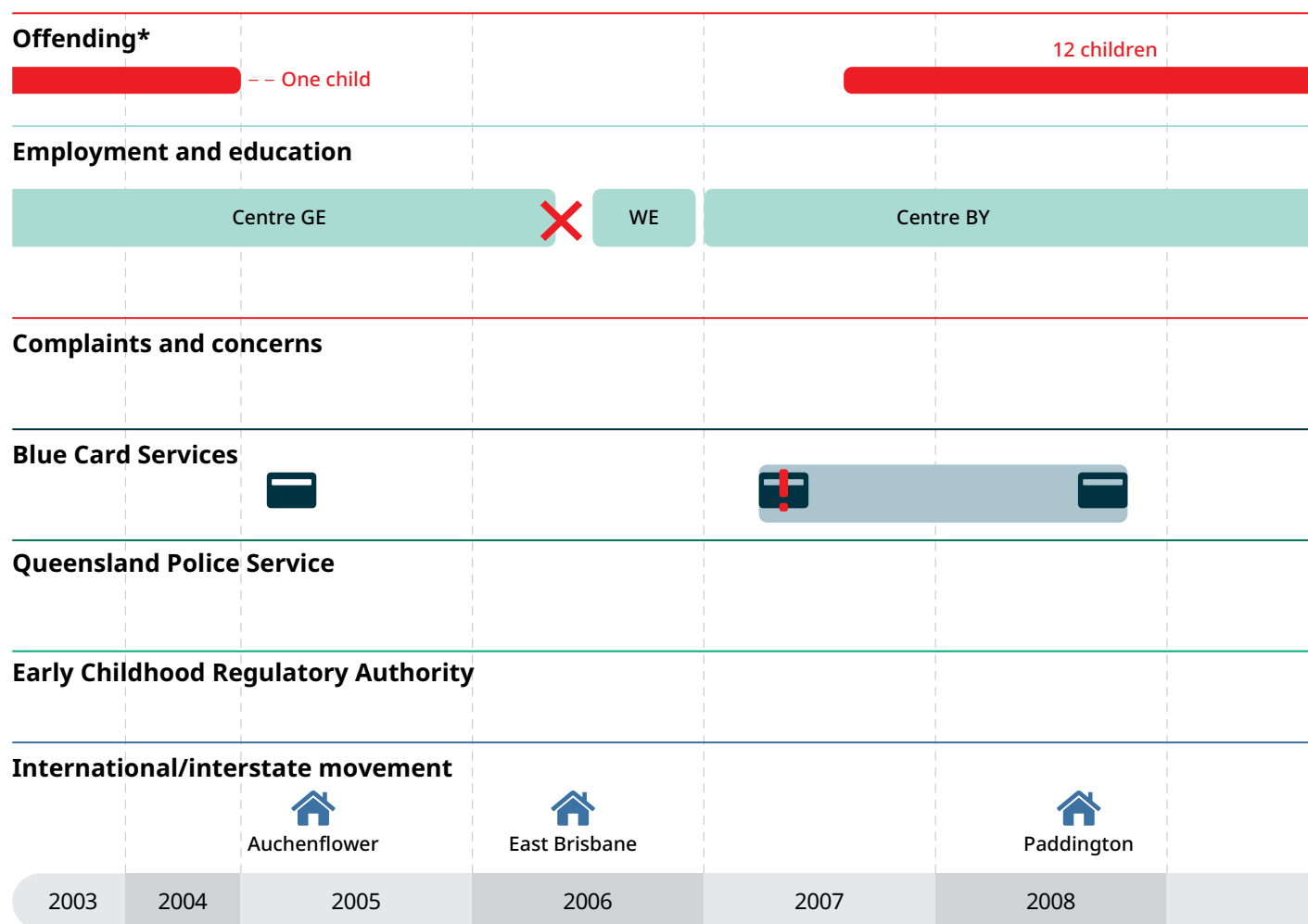
During his career, particularly in the later years, several complaints were made about the offender to his employers, the Early Childhood Regulatory Authority (ECRA), and the Queensland Police Service (QPS), however, these complaints were either deemed unsubstantiated by the regulator or did not meet the threshold for further police investigation.

At the time of his arrest, the offender had no pending investigations, no charges, no convictions, and he satisfied all requirements to obtain and retain a blue card or Working with Children Clearance (WWCC).

The offender's qualifications, including a Graduate Diploma of Learning and Teaching (Primary) and a Diploma of Children's Services (Early Childhood Education and Care), along with his professional experience and WWCC, enabled him to continue working in childcare and maintain access to children throughout his career.

The timeline of offending

Figure 1A: Timeline of offending, 2003–13



*Offending behaviour was not known until arrest. The offender was overseas or interstate between July 2013 and July 2018. These periods of time have not been examined by the Board due to pending legal proceedings.

Offending

- Offending event or period
- Use of a carriage service

Residential movement

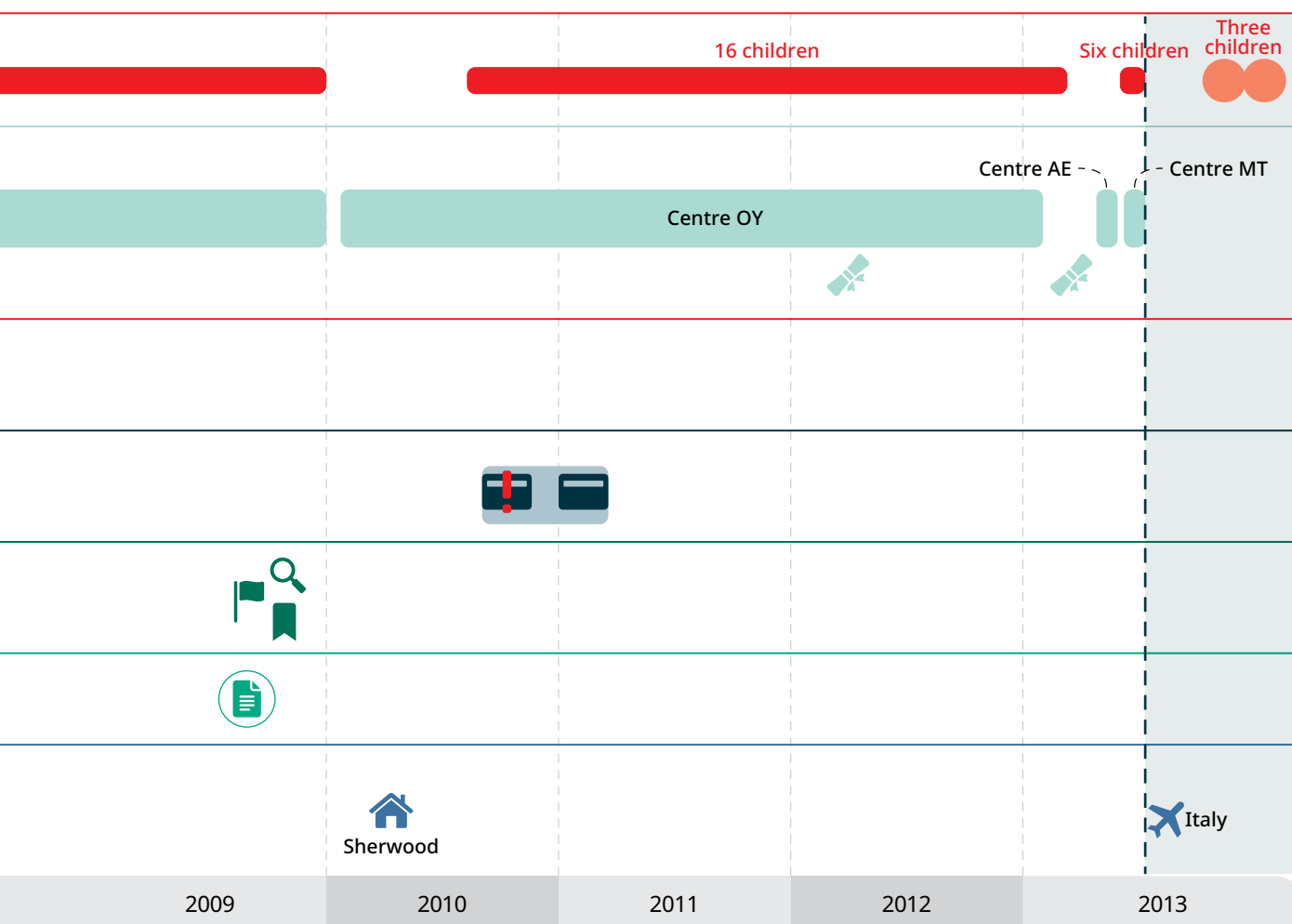
- Moved overseas/interstate
- Returned to Queensland
- Moved suburb

Centres

- Performance or behavioural concern raised by centre or parent
- Childcare centre complete internal review and find breach of policy

Police

- 'Zimble' account on the Love Zone identified by QPS
- The Love Zone website shut down
- Incident disclosed to QPS
- QPS interview child/witnesses/offender
- Incident unsubstantiated/does not meet investigative threshold
- Offender identified as 'Zimble'
- Police notified other agency/s of findings
- Offender arrested
- AFP received list of male childcare workers from Education Qld



Early Childhood Regulatory Agency (ECRA)

- Incident disclosed to ECRA
- ECRA begins internal investigation
- ECRA determine no breach of early childhood law or regulations
- ECRA receives list of impacted childcare centres

Employment and education

- Termination of employment, redundancy or request to not return
- Diploma or Graduate Diploma received
- Offender reviewed policies and/or completed training
- Offender stood down for investigation

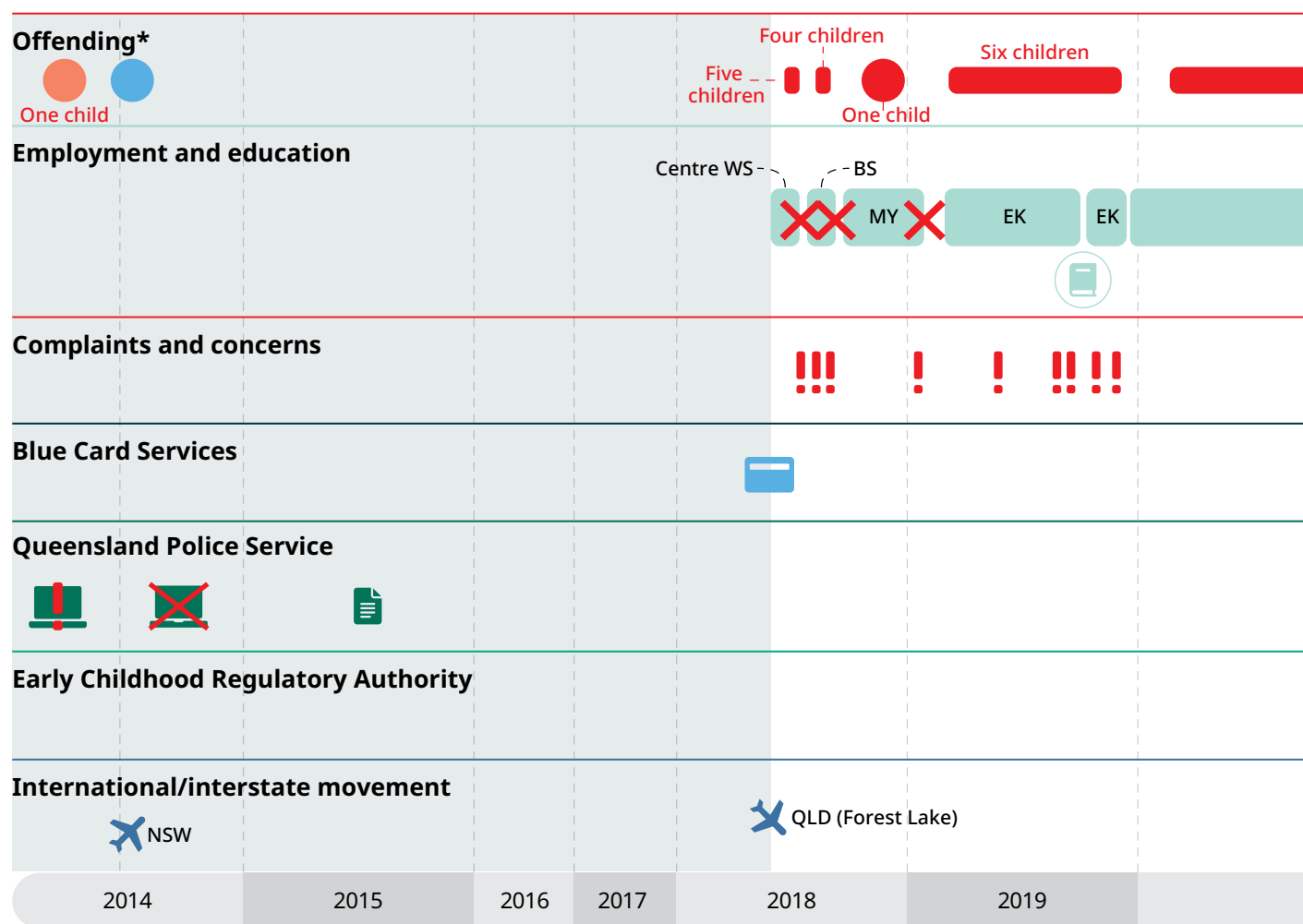
Blue Card Services (BCS)

- Blue Card issued
- Blue Card expired
- Exemption Card issued
- Exemption Card suspended
- Exemption Card cancelled
- BCS notify other agencies and the offender of suspension
- Time without an approved blue card

Casual employment

The offender worked at a further nine centres in 2022 as a relief educator.
No offending is known to have occurred in any of these centres.

Figure 1B: Timeline of offending, 2014–22



*Offending behaviour was not known until arrest. The offender was overseas or interstate between July 2013 and July 2018. These periods of time have not been examined by the Board due to pending legal proceedings.

Offending

- Offending event or period
- Use of a carriage service

Residential movement

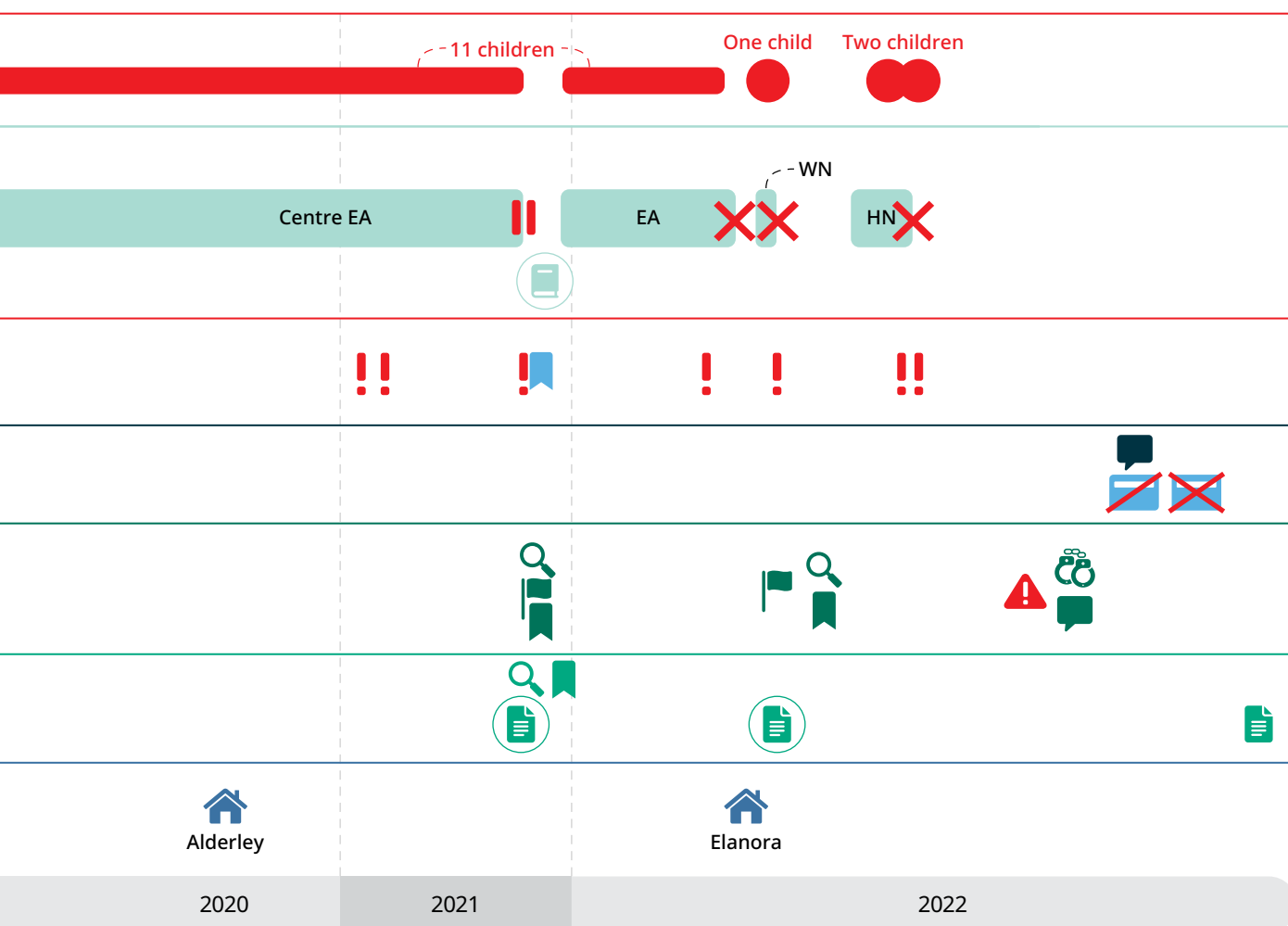
- Moved overseas/interstate
- Returned to Queensland
- Moved suburb

Centres

- Performance or behavioural concern raised by centre or parent
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- Time without an approved blue card

Casual employment

The offender worked at a further nine centres in 2022 as a relief educator.

No offending is known to have occurred in any of these centres.

1996–2003 - University

The offender began university studies in 1996 and completed a Bachelor of Science in 2000. In 2003, he briefly enrolled in a Bachelor of Arts program but withdrew after one semester.

Following his arrest in 2022, authorities discovered that the offender was in possession of child exploitation material (CEM), with files dating back to January 2000. As possession of CEM did not become a criminal offence in Queensland until 2005, retrospective prosecution was not legally permissible. Consequently, the offender was only charged in relation to possession of CEM from 2005–2022.

The finding of this material raises questions about statements the offender made during criminal proceedings, where he claimed that his sexual interest in children only began after he commenced working in a child related field.

2003–06 - Centre GE

Centre GE was an outside school hours care provider for primary school children. It is unclear as to the exact date the offender commenced employment in Centre GE; however, it is believed to have been while he was still in university.

In **2005**, Blue Card Services (BCS) issued the offender his first Working with Children Clearance (blue card) as he did not have any known history of offending at the time.

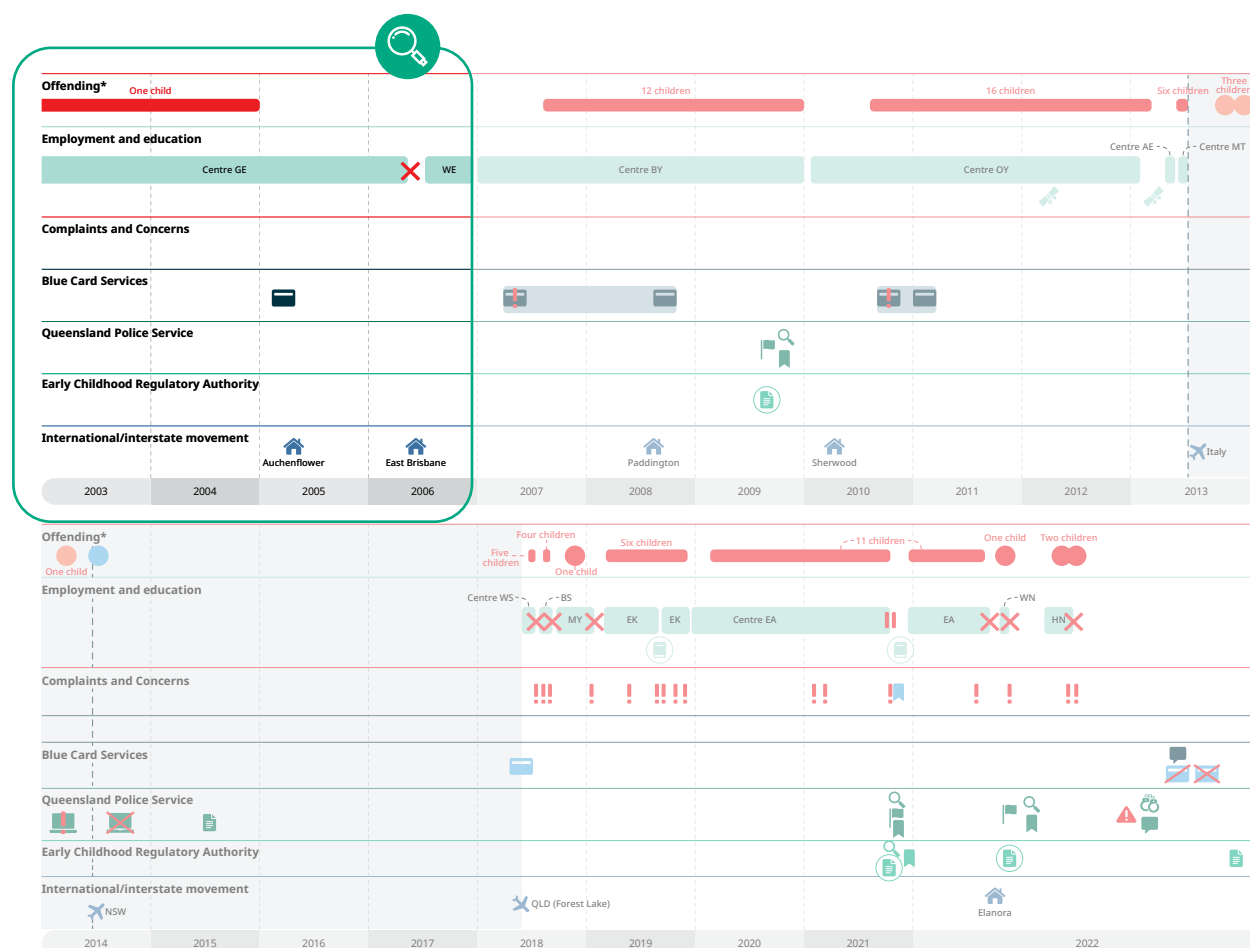
The offender worked in Centre GE for approximately three years before his employment was terminated "due to performance issues".

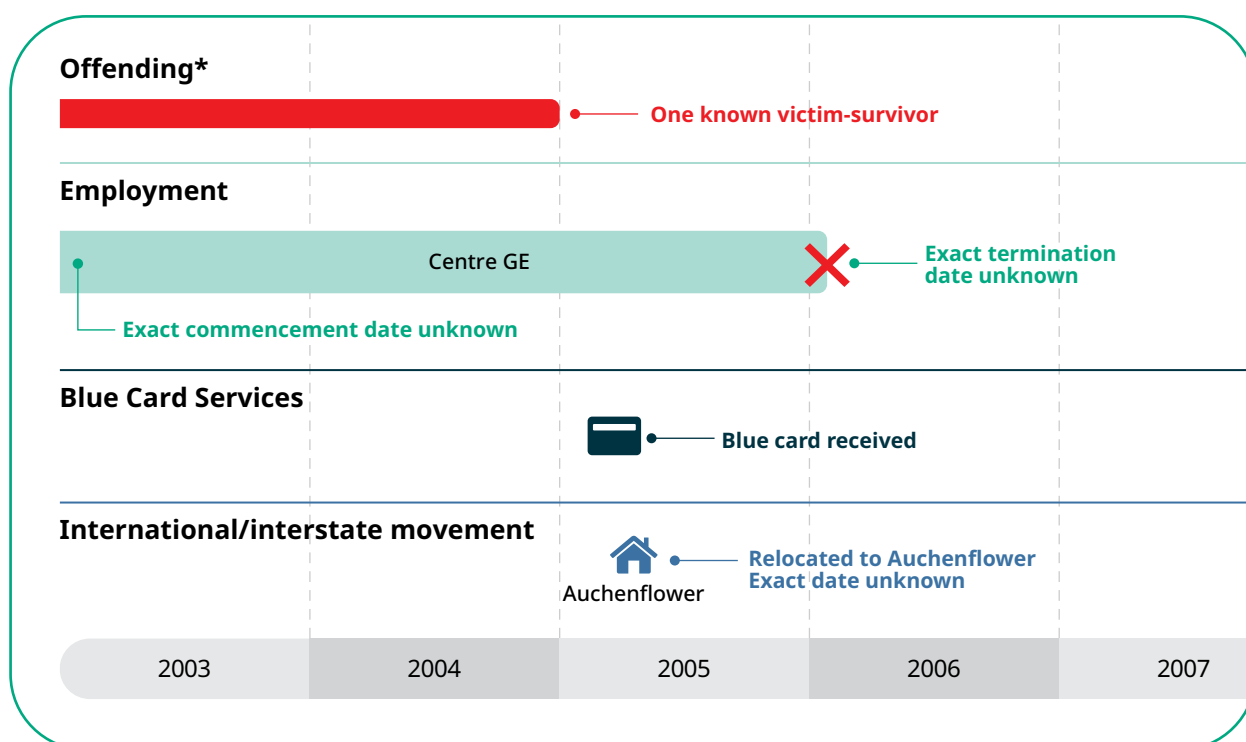
Centre GE ceased operating in 2015. Records were requested from Centre GE as part of this Review. While they were willing to provide these records, files were stored in paper form in an unindexed archive which required manual searching which could not be completed in the requisite timeframes. As such, details of the performance issues and the reason for termination remains unknown.

In 2024, the offender pleaded guilty to offending against one child who attended this service. This victim came forward following media attention associated with the offender's arrest.

There is no evidence that the offender produced CEM with respect to this child. This is the only child for whom the offending was not prosecuted based on CEM.

Figure 2: Timeline of offending in Centre GE, 2003–06





2006 - Centre WE

In or around **2006**, after being terminated from Centre GE, the offender briefly worked at Centre WE. The offender is not known to have offended at this centre. In July of the same year, the offender's blue card was linked with Queensland University of Technology (QUT) where he was a student.¹

2007–09 - Centre BY

In **2007**, the offender began working as an assistant at Centre BY. His blue card expired in May that year, and although renewal reminder notifications were sent to him, he did not apply for a new card until October 2008. Under the legislation in place at the time, it was the employer's responsibility to apply for the blue card renewal and ensure a valid card was held before allowing the individual to work with children. His blue card was subsequently renewed in November 2008. This was the first centre where the offender worked without a valid blue card.

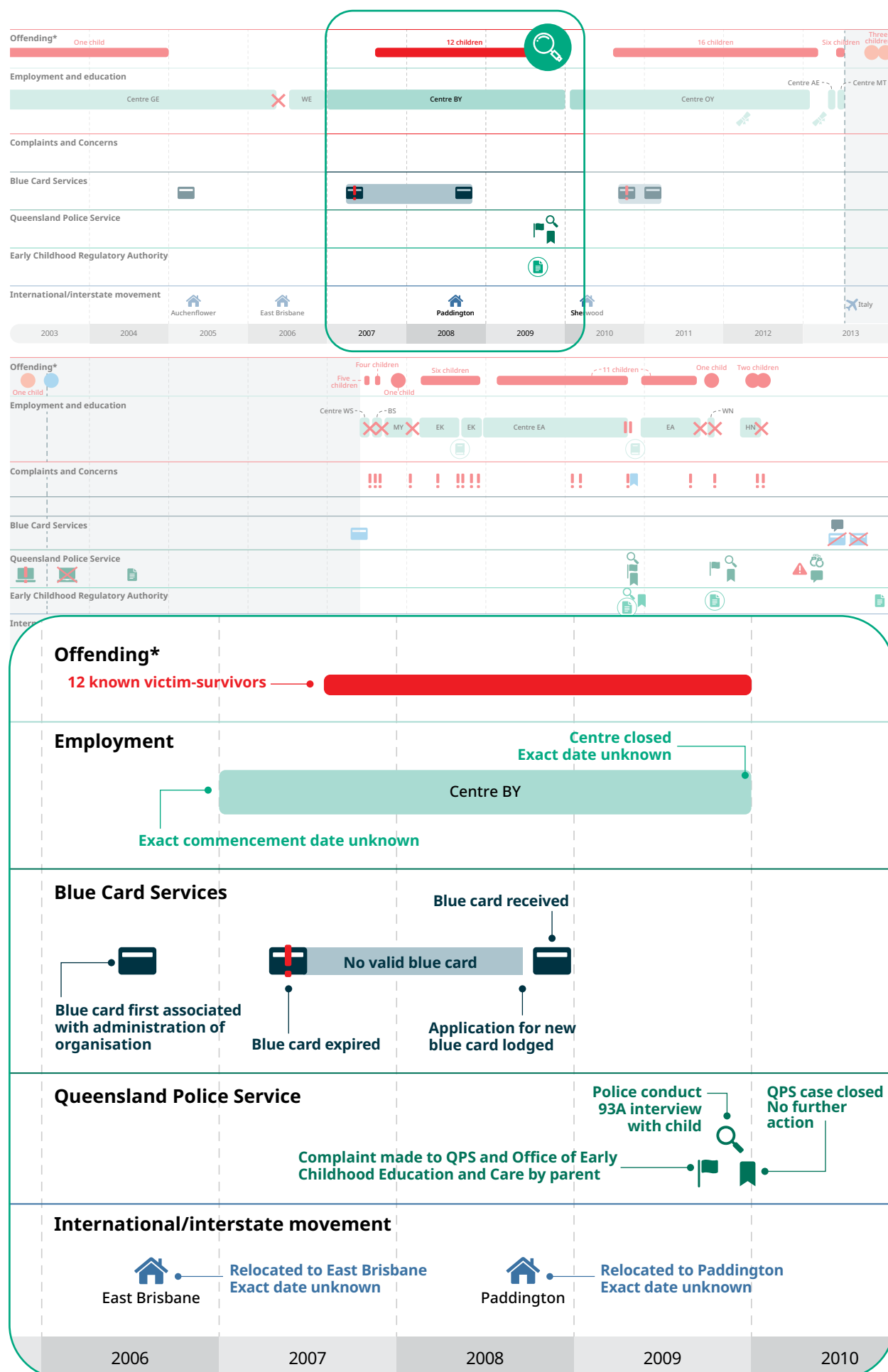
In **October 2009**, a parent made a complaint to QPS, reporting that their child had disclosed abuse by a male educator in Centre BY, named 'Ashley'. The child reportedly disclosed that 'Ashley' would hurt them when changing a nappy and described explicit details of sexual abuse. Following a QPS interview with this child, officers made the decision to file the complaint pending any new information. The officers recorded details about the allegation using the name 'Ashleigh' and no further inquiries were made into his identity. No charges have ever been laid with respect to this complaint.

Another parent reported that sometime in 2009, they raised concerns with the centre management about the offender's behaviour. In their submission for this review, they outlined that he allowed children to climb on him, and he often took the children to his office alone to play on his computer. They reported that they raised the concerns with the leadership, 'but nothing changed'. Centre BY closed in late 2009, ending the offender's employment.²

Following his arrest in 2022, the male educator in question was identified as the offender. The parent, seeing the publicity, contacted police regarding their 2009 report. It was at this point that the error in recording 'Ashleigh' instead of 'Ashley' was identified.

In 2024, the offender pleaded guilty to offending against 12 female children who attended this centre. The offender recorded the offending across approximately **four and a half hours of video and 175 photographs**. Over 45 per cent of the recorded offending occurred during rest time or in a sleep and rest area. Approximately 22 per cent of the recorded offending occurred in an office area and ten instances occurred in the staff room or the kitchen.

Figure 3: Timeline of offending in Centre BY, 2007-09



January 2010–July 2013 - Centres OY and AE

Centre OY

In **2010**, the offender commenced work as both an assistant and an early childhood teacher at Centre OY. While the offender was working there, this centre was rated as meeting the National Quality Standards (NQS).

In **November 2010**, the offender's blue card expired, despite renewal reminders having been issued to him prior to the expiry date. He did not submit a renewal application until **January 2011**, and his blue card was reinstated in the same month. The legislation in effect placed responsibility on the employer to apply for the blue card renewal and ensure that a valid card was held before allowing a person to continue to work.³ This was the second centre where the offender worked without a valid blue card.

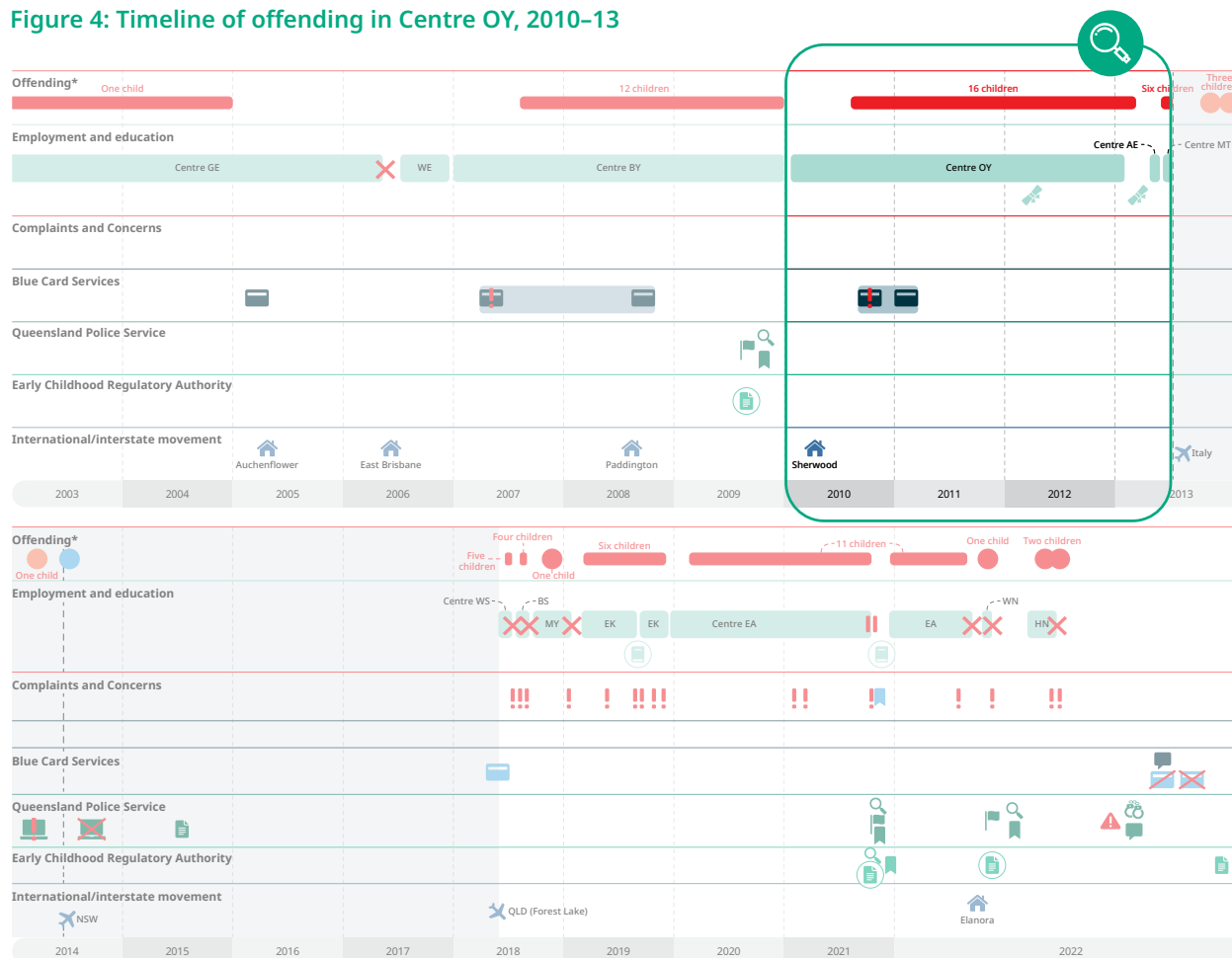
In **2012**, while working at Centre OY, the offender completed a Graduate Diploma of Learning and Teaching (Primary) at the University of Southern Queensland and in **2013**, he completed a Diploma of Children's Services (Early Childhood Education and Care) at Queensland TAFE.

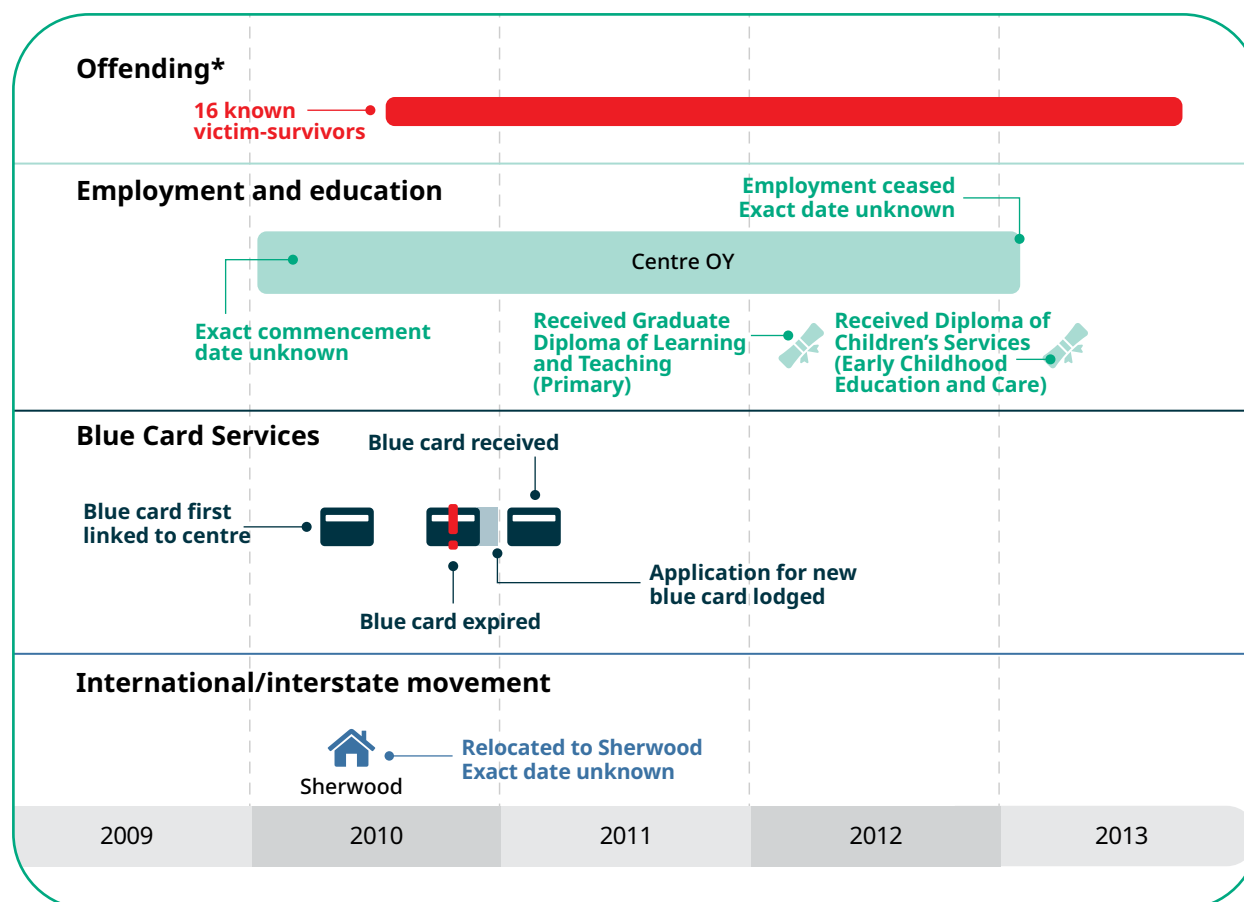
The offender ceased working at Centre OY in **January 2013**, as there was no ongoing teacher role available for him.

In 2024, the offender pleaded guilty to offending against 16 female children who attended this centre.

The offender recorded the offending across approximately **21 hours of video and 61 photographs**. Over half of the recorded offending occurred during rest time or in a sleep and rest area. Eight instances occurred in the bathroom, particularly during change time.

Figure 4: Timeline of offending in Centre OY, 2010–13





Centre AE

The offender worked a trial shift at Centre AE in **July 2013**. At the time, this centre had a provisional rating as it had not yet been assessed against the NQS, due to the standard grace period provided to all new services. Information provided by the centre to the review outlined that the offender was accompanied by another educator all day. The offender is not known to have offended at this centre.

July–August 2013 - Centre MT

Between **July and August 2013**, the offender worked for six weeks at Centre MT. At the time, this centre was rated as working towards the NQS due to the centre's physical environment.

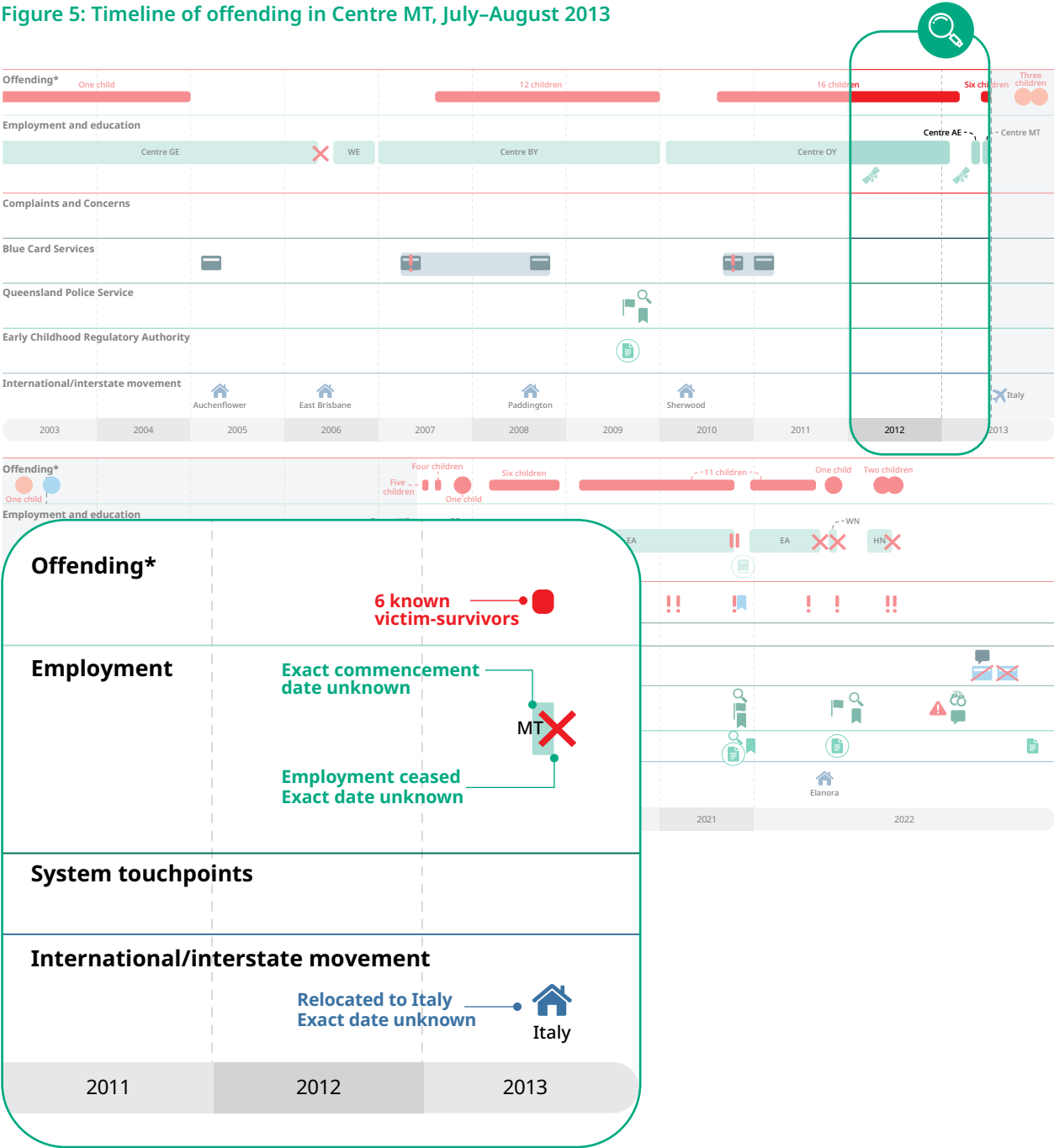
The offender pleaded guilty to offending against six female children who attended this centre.

The offender recorded the offending across approximately **two hours of video and four photographs**.

Unlike previous centres, most of the offending at this centre took place in the main area, and four incidents occurred in a storeroom.

Two videos showed other educators present in the background. While these staff members were not involved in the offending, it demonstrates the boldness of the offending behaviour.

Figure 5: Timeline of offending in Centre MT, July–August 2013



August 2013–July 2018 - Italy and New South Wales

Between **August 2013 and July 2014**, the offender lived in Italy, where he worked as a teacher at a childcare centre in Pisa.

In October 2013, the offender accessed the darknet and a website called 'The Love Zone' which contained CEM. Using the account name 'Zimble' he uploaded CEM that he had created onto this website. It is alleged that his motivation for uploading this material was to gain access to the VIP area of the site.

Upon his return to Australia in **July 2014**, the offender resided in New South Wales.

In 2024, the offender pleaded guilty to offences relating to his offending in Italy and online. These included four counts of producing, one count of distributing and one count of using a carriage service to distribute CEM outside Australia.

July 2018 - Centre WS

In **July 2018**, the offender returned to Queensland from New South Wales, completed a phone interview in June 2018 and commenced employment at Centre WS the following month. As this centre was new, it had not yet been assessed against the NQS.

In late July 2018, he was issued an exemption card by BCS, as he was a registered teacher with the Queensland College of Teachers (QCT) and had no known history of offending at the time.

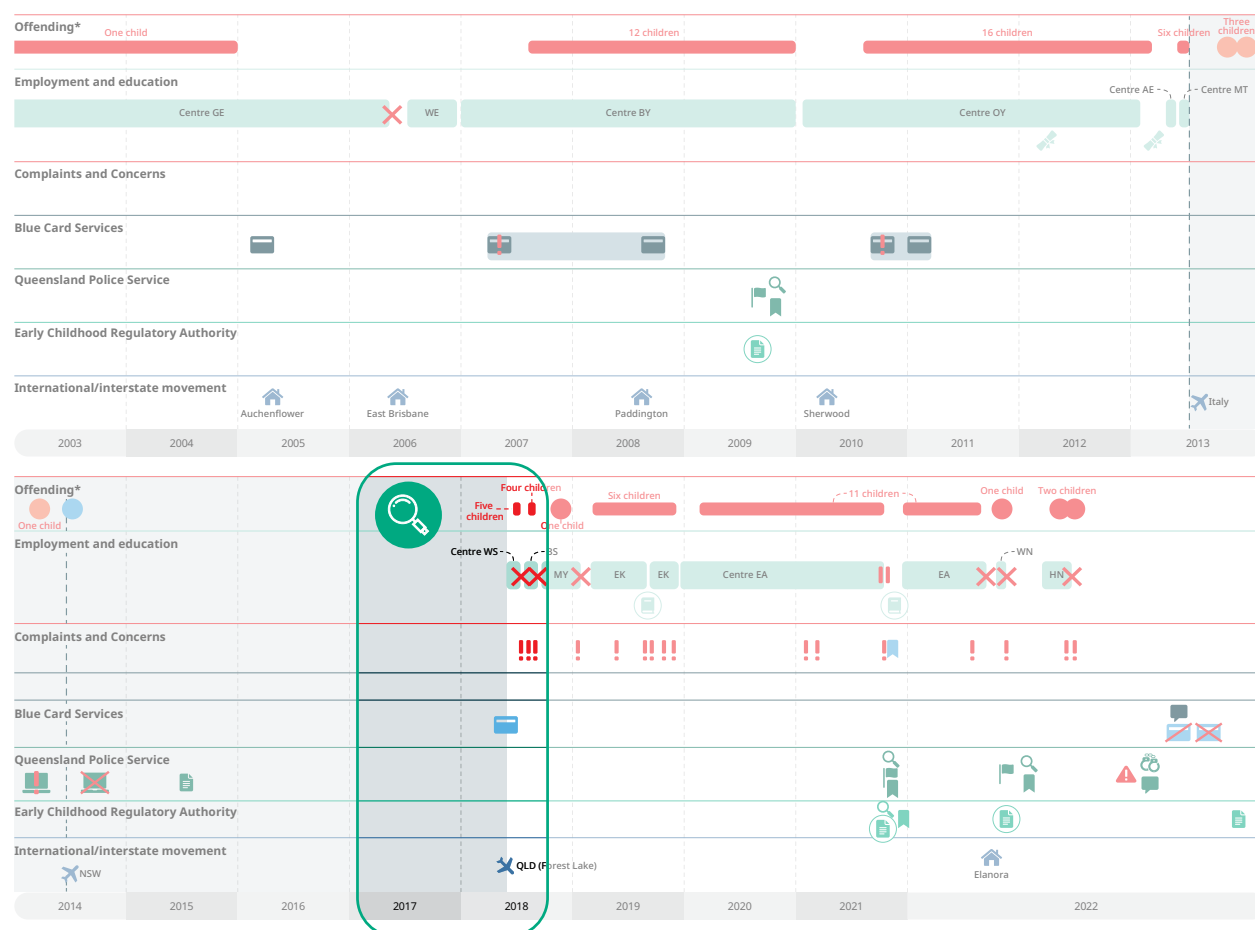
The offender remained at Centre WS for approximately four weeks before being terminated during his probation period. During an ECRA interview in 2025, the Centre Owner stated that the offender's termination was due to him not undertaking appropriate planning and programming and consistently being late.

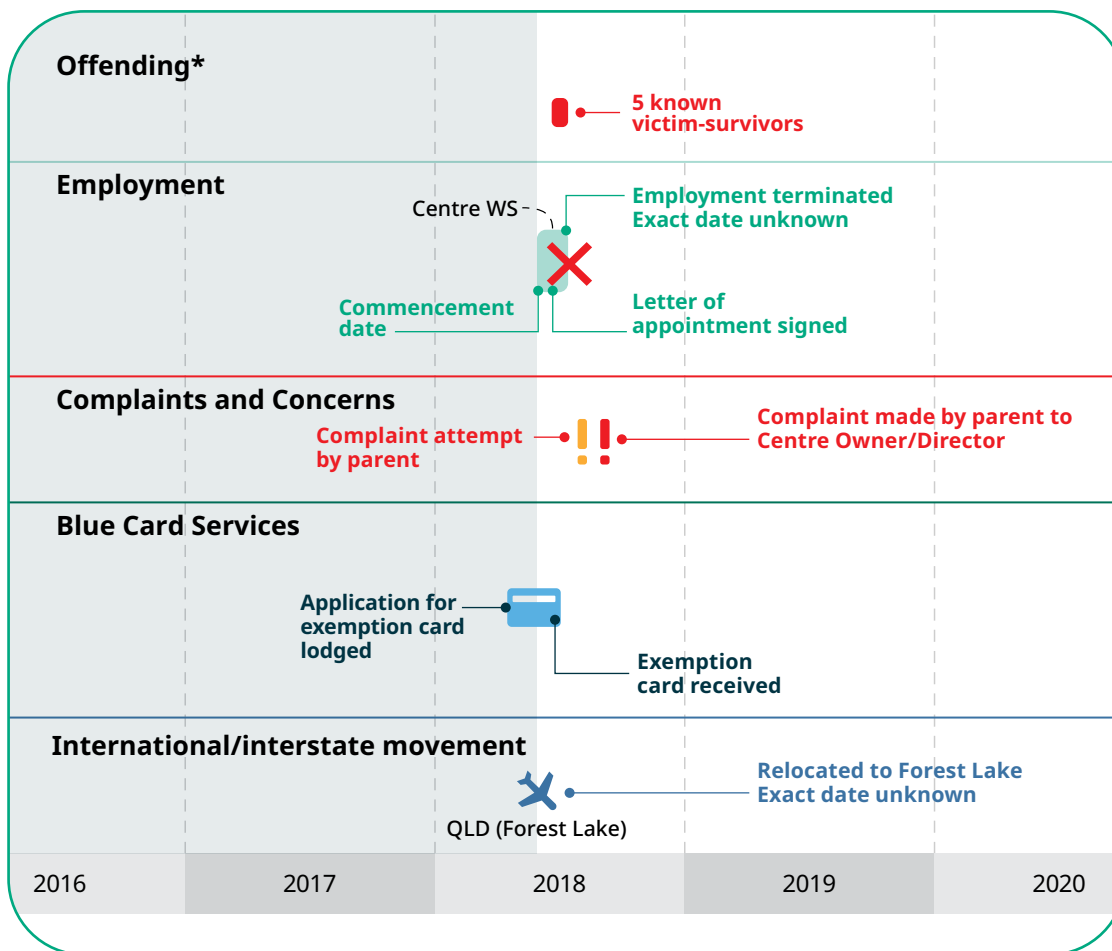
After the offender's employment ended, a parent tried to make a complaint to the centre. The parent reported they had witnessed the offender threatening to smack another child (not their own). In response, the Director/Owner informed the parent that the offender no longer worked at the centre. The parent stated in reports to ECRA that they found the response 'aggressive' and did not follow through with the complaint. Approximately a week later, the Director/Owner called the parent into their office, apologised for the previous reaction to the complaint, and asked what the parent had been wanting to say. The parent then shared the complaint.

The witness parent reported that it is their understanding that the parents of the child who had been threatened by the offender were never informed of the incident by the centre. No further action appears to have been taken in response to this complaint. There are no records of this complaint in centre files, with the centre owner stating that they had no recollection of the parents' report. There is ambiguity in the available information as to whether the parents' concerns were received by the owner or director. The outcome of the ECRA investigation in 2025 'preferred' the version of events provided by the parent and the centre were found to be non-compliant with National Law requirements. This decision is currently subject to an application for an internal review by the centre to ECRA.

In 2024, the offender pleaded guilty to offending against five female children who attended this centre. The offender recorded the offending across approximately **30 minutes of video and 63 photographs**. Over half of the offending occurred during rest time. Most occurred in or outside the bathroom area, or in the sleeping area.

Figure 6: Timeline of offending in Centre WS, August 2018





September 2018 - Centre BS

In **September 2018**, the offender commenced work at Centre BS. At the time, the service was rated as exceeding the NQS.

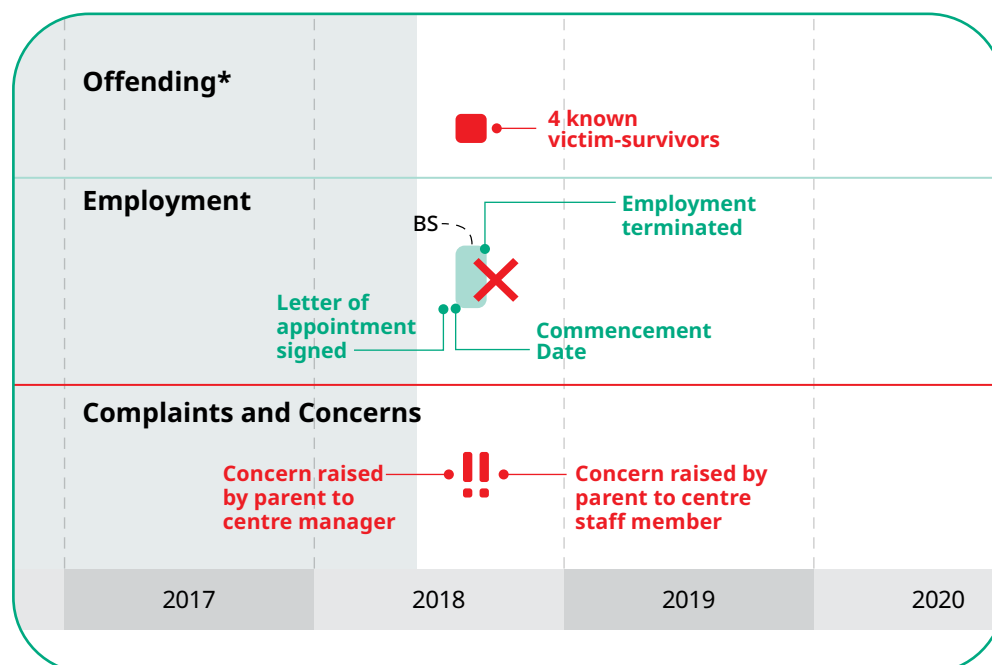
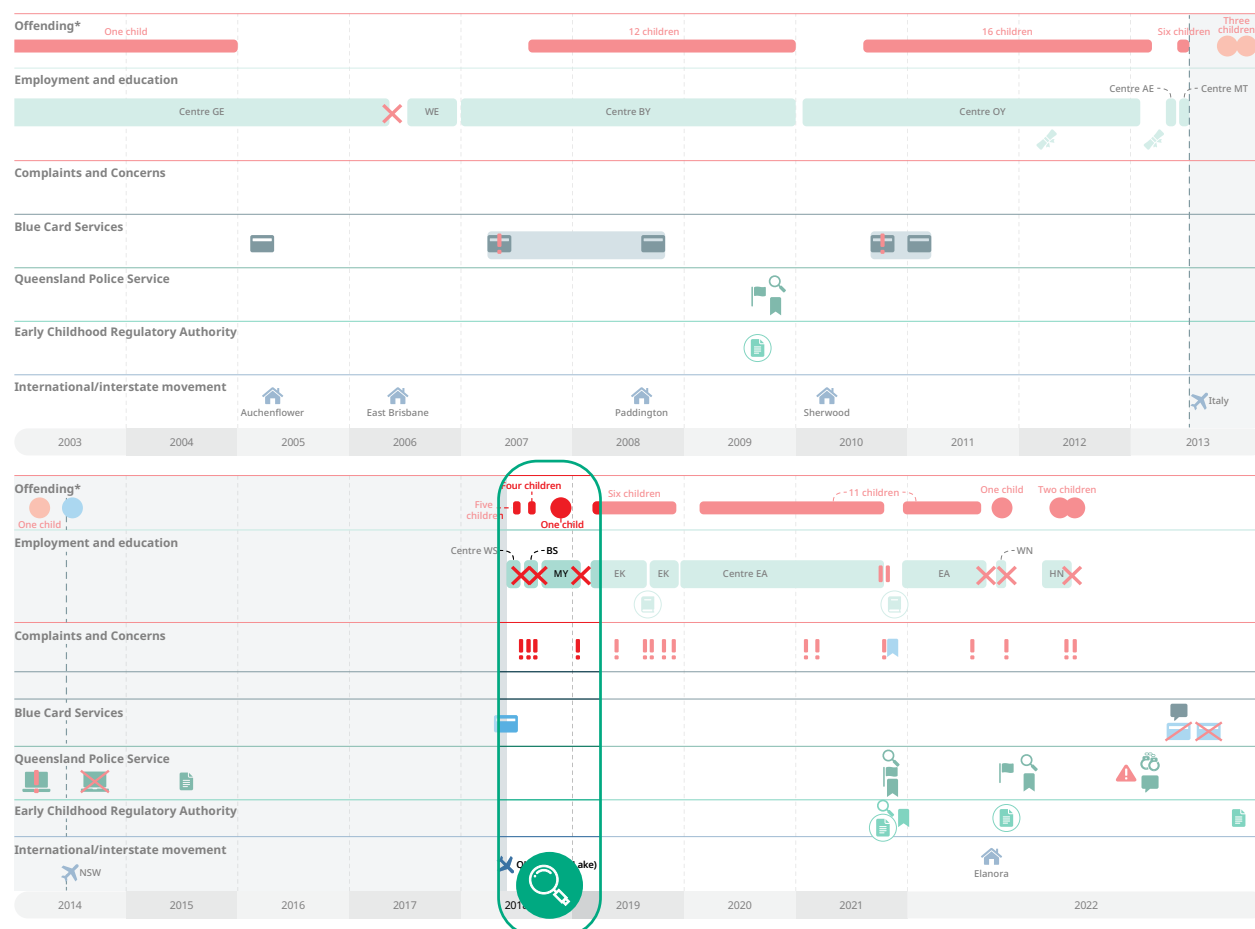
In **mid-September 2018**, a parent reportedly told the centre manager that the offender made them feel uneasy and requested this be recorded. There are no records of this in the files provided to the Board as part of this Review.

In **late September 2018**, the same parent arrived to collect their daughter who could not be located. The daughter was not in either of the two regular areas, and the parent had to wait for their daughter to be found. There are no records of this incident in the files provided to the Review.

The offender was terminated from this centre three weeks into his probation period due to performance issues. His termination was effective immediately and he was paid out the notice period. No further details relating to the offender's performance or reason for termination were recorded. In an ECRA interview in 2025, the acting manager at the time stated that the offender's employment was terminated due to being a poor fit with the centre, lack of engagement with staff and children, poor programming, and failure to follow best practices by having children sit on his lap.

In 2024, the offender pleaded guilty to offending against four female children who attended this centre. Information provided to the Review indicates that the offender recorded the offending across approximately **two hours of video and 16 photographs**. Recorded offending occurred primarily in the main areas of the centre and approximately five recordings were created during rest time.

Figure 7: Timeline of offending in Centre BS, September 2018



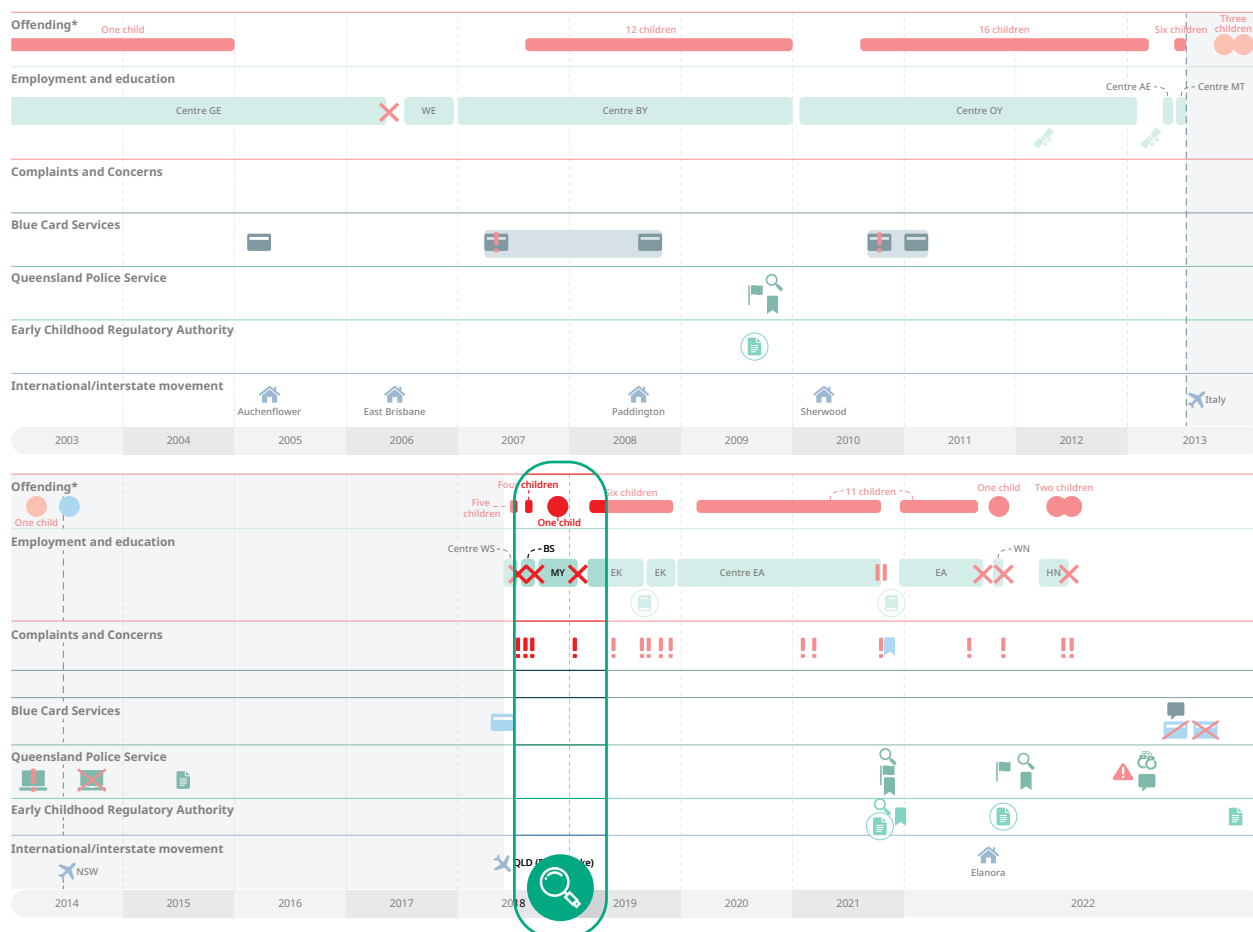
October 2018–February 2019 - Centre MY

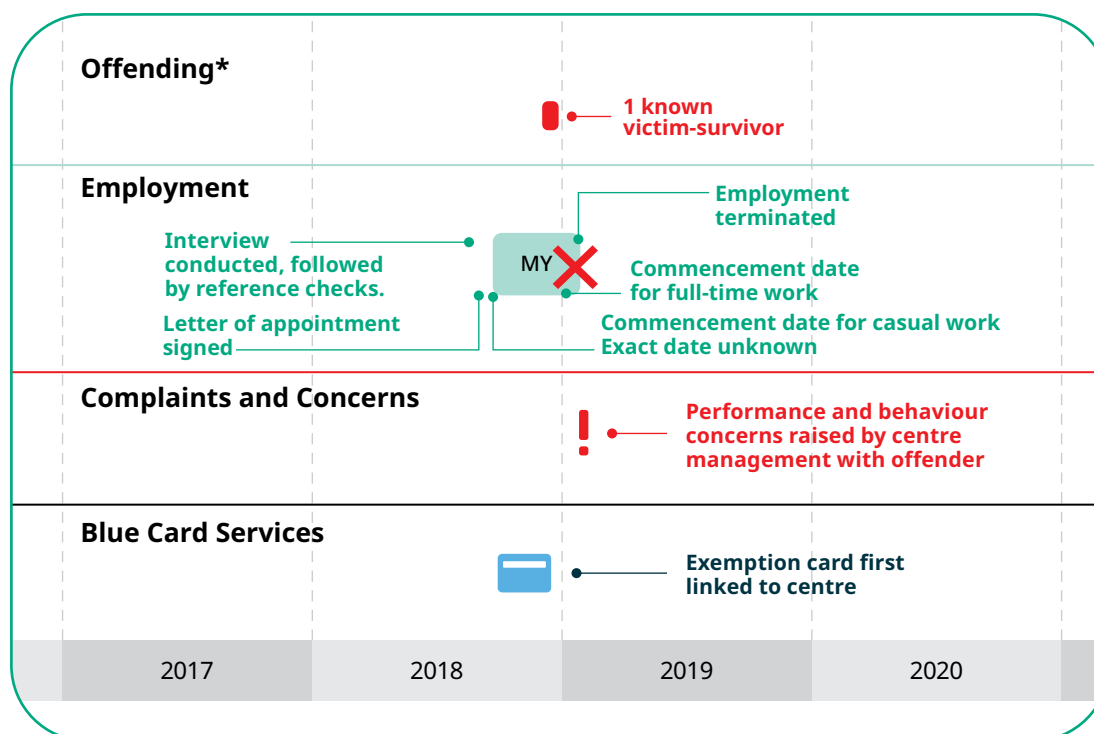
The offender was employed at Centre MY from **October 2018 to February 2019**. At the time, this centre was rated as working towards the NQS.

Initially engaged as a casual employee, the offender transitioned to a permanent full-time early childhood teacher role in **January 2019**, which also marked the beginning of his probationary period. In early **February 2019**, following a disagreement with the assistant educator, centre management raised concerns regarding the offender's lesson planning and his interactions with children and parents. Daily monitoring was implemented to assess his performance. Later that month, his employment was terminated due to an unsuccessful probation period. His termination was effective immediately and the offender received payment in lieu of the required 10-day notice period.

In 2024, the offender pleaded guilty to offending against one child who attended this centre. The offender recorded the offending across approximately **eight photographs**, all of which were taken during rest time.

Figure 8: Timeline of offending in Centre MY, October 2018–February 2019





February–December 2019 - Centre EK

In **February 2019**, Centre EK received the offender's talent profile from a national employment agency. The offender commenced work at the centre approximately one week later.

The Approved Provider, who was responsible for recruitment, believed that the national employment agency was responsible for conducting all necessary suitability checks prior to placement. At the time, this centre was rated as excellent, the highest rating against the NQS.

In early **May 2019**, management raised a serious concern with the offender after he brought toxic paint into the centre. This was recorded as a serious performance breach, and the offender was informed that any other events of this nature would result in dismissal.

In late **August 2019**, the offender had his mid-year appraisal. Management discussed issues with the offender's recordkeeping practices, namely being late or incomplete; his communication - particularly 'non-desirable tones used with some children and families'; favouritism towards some children; and his personal camera use. Management asked the offender to review the centre policies and procedures and provided him with an SD card to use in his camera and leave at the centre. In ECRA interviews in 2024, management stated they were concerned with the offender using a personal SD card as he used public transport to get to and from work and they did not know who he lived with.

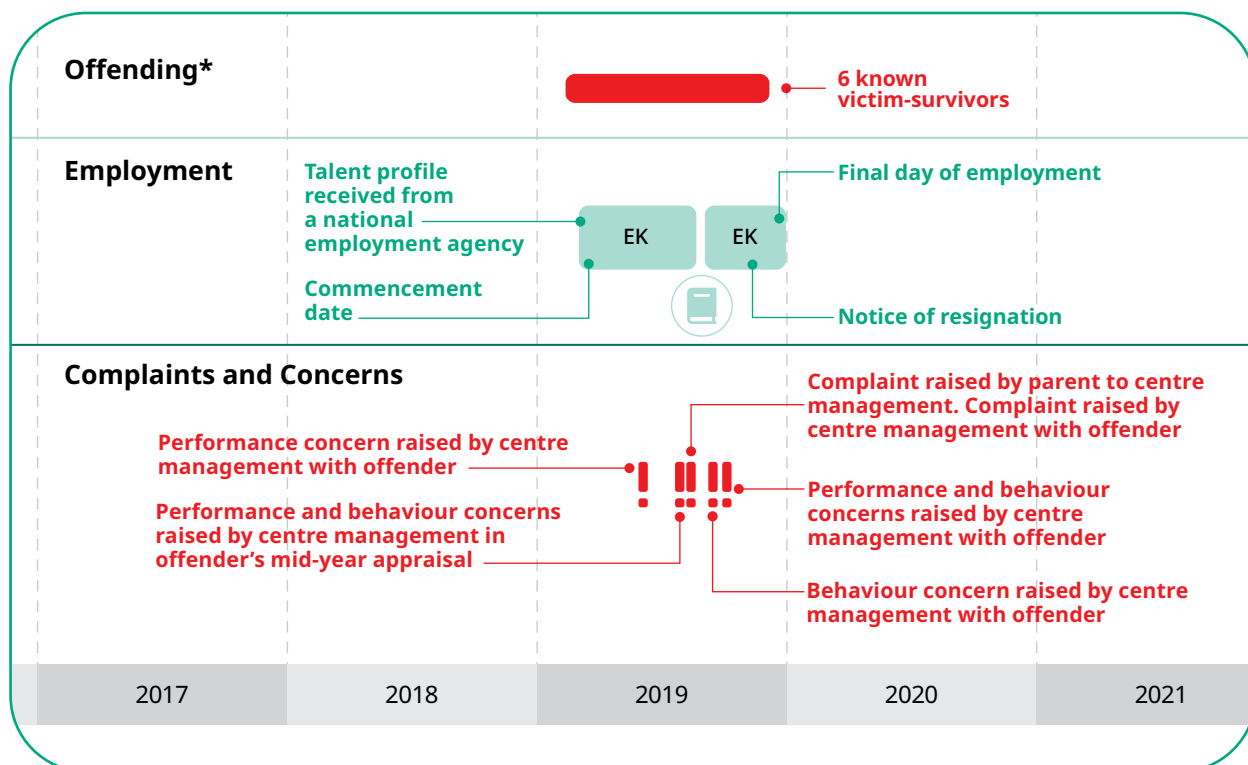
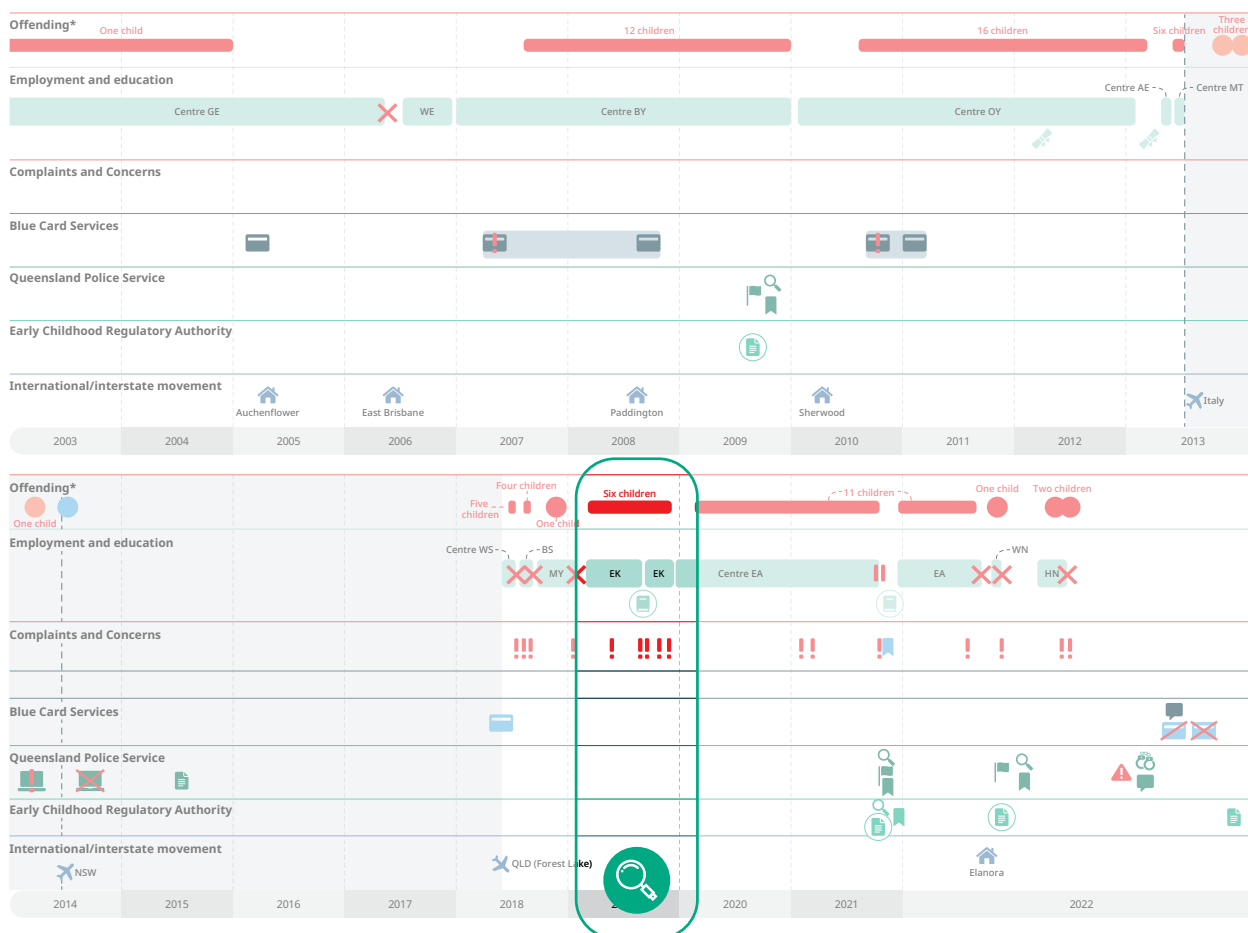
Two days after the mid-year appraisal, a parent contacted Centre EK and reported that the offender had grabbed and squeezed their son's arm. The child also told management this when asked. Management gave the offender the option to resign immediately or take leave to complete behaviour management training. The offender chose to complete training and provided details of a behaviour management course. Centre management approved this course and requested the offender provide a written summary of his learnings upon completion.

In **mid-September 2019**, management again met with the offender over the use of his camera. The offender had not been using the provided SD card in his personal camera as requested. Management prohibited the offender from using his personal camera in the centre from then on.

In **mid-October 2019**, management raised further performance concerns with the offender, including poor recordkeeping practices and 'not pulling his weight'. The offender resigned from his position the following week, with his final day of work to be at the end of the term, in **mid-December 2019**.

In 2024, the offender pleaded guilty to offending against six female children who attended this centre. The offender recorded the offending across approximately **three hours of video and 35 photographs**. Over half of the offending occurred during rest time. Some of the offending occurred outside, though most occurred in the main areas of the centre.

Figure 9: Timeline of offending in Centre EK, February–December 2019



December 2019–April 2022 - Centre EA

The offender began working at Centre EA in **December 2019**, in a joint Early Childhood Teacher and Director role. At this time, this centre was rated as exceeding the NQS.

Within his application the offender provided a “*Statement of service*” from the owner of EK and a New South Wales-based employer. While this confirmed his employment at these centres, it did not provide any details about his conduct in these centres. Available records indicate that the reference checks completed in November 2019, along with his qualification checks, were completed by a national employment agency.

The Board requested information from the employment agency, however only minimal records were provided with the employment agency citing pending legal proceedings as to the rationale for not providing full records.

Centre EA was reassessed and rated in **April 2020** while the offender was Director. The centre went from a rating of exceeding the NQS to meeting the NQS. The NQS changed between the initial and subsequent rating for the centre, which made it more difficult for the centre to achieve the higher rating. The centre scored lower in areas of educational program and practice, children’s health and safety, staffing arrangements, relationship with children and governance and leadership.

In **January 2021**, the offender had an annual performance review. As part of the dual role, management had allocated time for the offender to complete documentation and other tasks required as part of the Director role. They raised concerns that the offender was rarely using this allocated office time and was instead working directly with the children on the floor. This performance review stated:

You have been allocated 2 days of office time, and seldom would I find you in there on Mondays and Tuesdays (your office allocated days). This is supported by staff when I asked, it would appear you spend very little time in the office but love being out on the floor with the children. We discussed at 6 months your need to focus more in this area – nothing much has changed in terms of your focus.

Around **May 2021**, two senior staff members witnessed the offender stand behind a child and kiss her on the top of her head. After discussions between themselves, it was decided that the more senior staff member would have a discussion with the offender about this incident. In response to the incident being raised, the offender reportedly apologised but said ‘they were a small centre and she didn’t understand how they operated and that children hug him in front of parents and it is okay’. The staff member stated that this was not appropriate and should not happen again. This was not reported to ECRA, and the service maintains it did not meet the threshold for reporting because the behaviour “did not impact the child’s health, safety or wellbeing”.

Centre management had an ‘informal coaching conversation’ with the offender in **May 2021** regarding appropriate interactions with children and how his interactions may be perceived by others. No further details about these concerns are recorded. The centre informed the Board that this type of informal caution and conversation is in line with the organisation’s performance management frameworks and ‘appropriate for a first time observed behaviour of this kind’.

In **June 2021**, a social media post reportedly suggested that Centre EA was involved in a ‘paedophile ring’. The offender sent a letter to families of the centre advising of the post. He provided reassurance that all staff had blue cards and undertook annual child protection training. The letter he wrote and signed stated:

It has been brought to our attention that there is a scurrilous post on social media implicating [Centre EA] in illegal activity. Please be advised we are taking the issue very seriously and are currently seeking legal advice though [Management]. We want to reassure families that the well-being and safety of you and your family are of paramount importance to the centre and that we take child protection extremely seriously. All employed staff undergo rigorous screening through the blue card system which included police and criminal history check. All staff also undertake yearly training in child protection as mandated by legislation.

In **October 2021**, a staff member at Centre EA made a complaint about the offender to ECRA and QPS, reporting that they saw the offender kissing a child who was sleeping outside in the fort. The centre suspended the offender’s employment with full pay, pending investigation. The matter was immediately referred to ECRA and the QPS.

The centre began their own internal investigation led by their Policy and Compliance Officer and Human Resources Officer two days after they referred the complaint to QPS. During October 2021, interviews and statements were taken from the reporting staff member, offender and witnesses as part of the internal investigation. In an ECRA interview in 2024, the Compliance Officer stated that the offender told her during a phone call that he had gone to stay in a hotel because he “*was worried police would go to his house*”.

QPS interviewed the staff member and the offender in **November 2021**, a month after receiving the complaint. The offender denied any wrongdoing, and the staff member who lodged the complaint could not provide any further evidence. QPS determined that the complaint was unsubstantiated and did not undertake any further investigation.

Centre EA closed their investigation five days after receiving correspondence regarding the QPS findings. A breach of the *Educator and Management Policy – Code of Conduct* was substantiated by the centre's internal investigations team. This included a finding that the offender was showing favouritism and physical affection to children and lying down with children during rest periods. The offender was required to review centre policies and procedures, before returning to work a week later. Consistent with the applicable requirements in place at the time, BCS was not notified as the complaint was assessed as not reaching the threshold for a criminal charge. This was the first organisation to complete an investigation and make a finding against the offender.

ECRA was advised of the outcome of the internal investigation and of the police closure of the matter, which they relied on to close the notification without conducting any further investigation. The regulator did not exercise its power to request a copy of the investigation report or any matters related to the investigation. No breaches of the National Law or National Regulations were recorded by ECRA.

In **December 2021**, a child disclosed to her parents that a female teacher had touched her under her underwear. The child's parent contacted Centre EA to inform them of the disclosure and the offender responded to this incident. The offender notified ECRA of this complaint, which subsequently resulted in QPS interviewing the child. No charges were laid with respect to this complaint.

It was later identified that the child who made the complaint was a victim of the offender. After his arrest, the offender disclosed that this child may have been confused about the identity of the teacher they had made the complaint about, due to his offending against her. The offender was a key part of the information chain in this matter, being the one to receive the complaint for action and the one to notify ECRA of the disclosure.

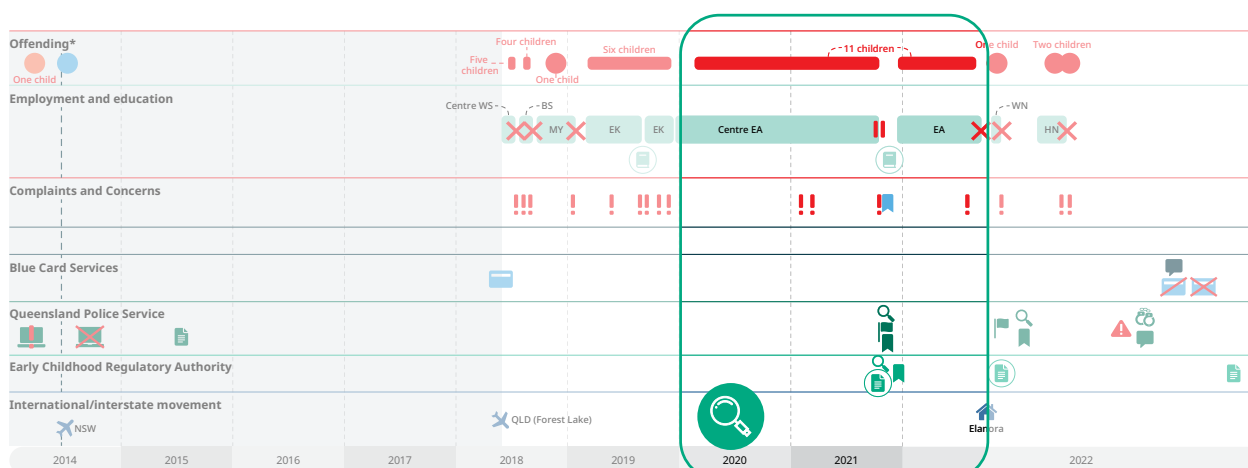
In **March 2022**, upper management raised concerns about the declining number of enrolments at Centre EA. The Board was advised that the reason for ceasing employment was that the role was no longer required, and ending the employment for other reasons would have given rise to industrial relations risks. Upper management sought a separation of the Director and early childhood teacher role that the offender was employed in. This was discussed with the offender. He was given the opportunity to reapply for one of the positions which he felt was 'unfair'. In this letter to upper management the offender wrote that he felt it was:

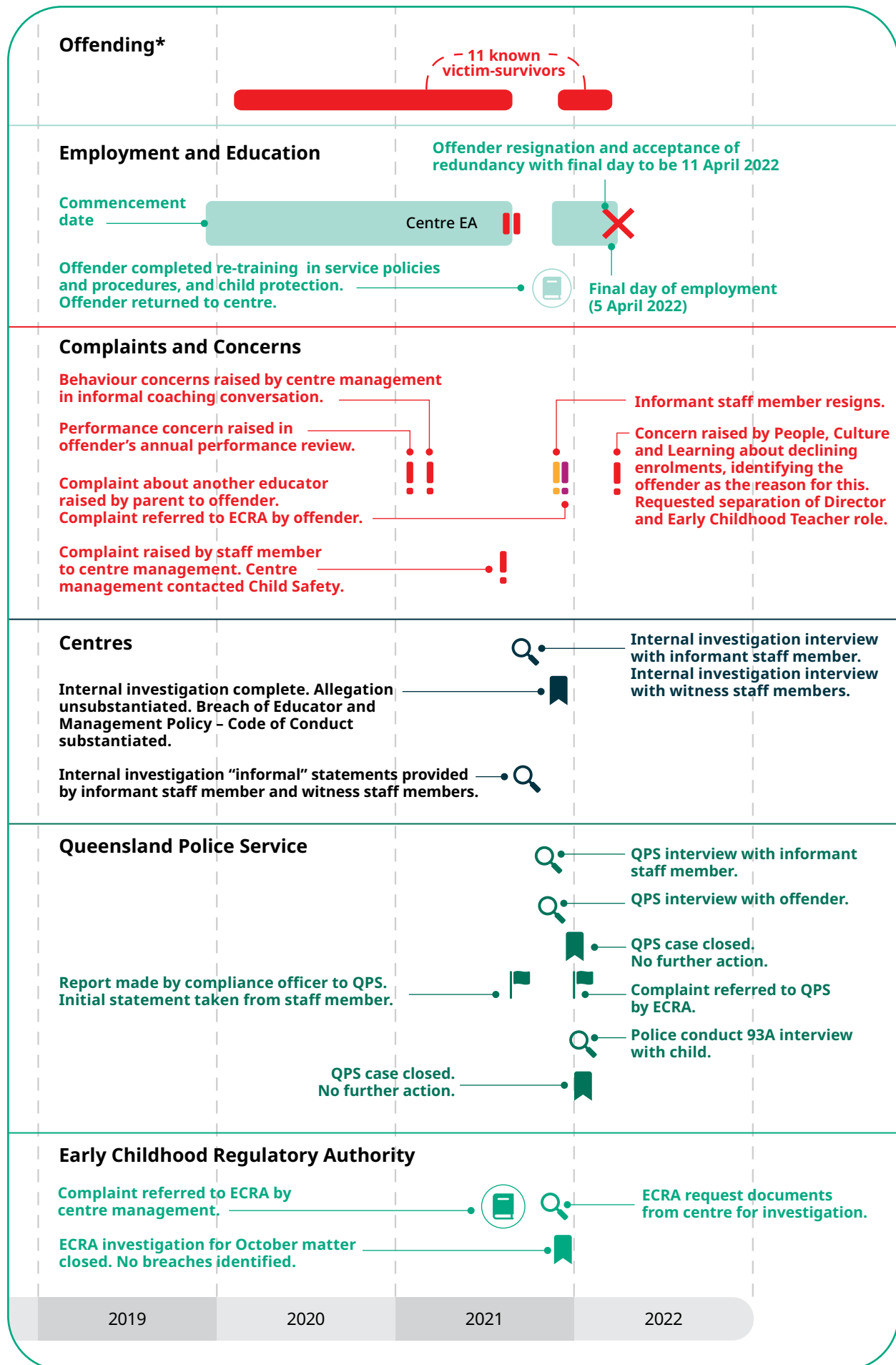
very unfair to have to choose which part of my role I should give up.... With the support of long-term educators, we have managed to re-establish the quality reputation that [Centre EA] has always enjoyed.... I find this actually quite outrageous that anyone would be asked to accept this. While I understand the rationale behind the proposal I do not feel I should have the choose between my own needs (financial or otherwise) and the needs of the centre, accepting both a demotion AND a payout (which is what it is, it is not just a 'change')

Three weeks later, the offender resigned with four weeks' notice and received a redundancy payment. The offender stopped working in Centre EA in **early April 2022**, two weeks before the date specified by the centre. There are no records as to the reasons for this early departure.

In 2024, the offender pleaded guilty to offending against 11 children who attended this centre. The offender recorded offending in this centre across approximately **51 hours of video and 21 photographs**.

Figure 10: Timeline of offending in Centre EA, December 2019–April 2022





April–June 2022 - Casual employment, Centre WN and Centre HN

Casual employment

Throughout 2022, the offender worked on a casual basis while contracted by a national employment agency. There is some evidence to suggest that during this time the offender worked at nine childcare centres. Although they did not provide full records about the offender's contractual arrangements, the employment agency did confirm that the offender was employed for a brief period of two months over this time, stating "... (the Offender) was employed for a brief period of two (2) months between 12 April 2022 and 21 June 2022. Further, the Offender had worked for a total of 189 hours during the period of casual employment." This is contrary to the information available to the Board that indicates the offender's engagement with the employment agency dates back to 2019.

Given the employment agency did not provide the Board with information about the offender's employment history while contracted by them, the Board is unable to construct a full timeline of the offender's employment movement in 2022. While the employment agency expressed their appreciation of the seriousness of the matter, they cited legal privilege as the reason for non-disclosure of the information.

Available details about the offender's employment at these centres can be found in Table 1.

Some centres have also closed down during this time, with ownership transitioned to other providers. This means that no records exist about the offender's employment at these centres.

There are no recorded victims for any of these centres.

Table 1: Centres the offender worked while engaged through the national employment agency

Casual centre	Dates worked	Complaints or concerns
Centre GK	12 April 2022 18 May 2022 2 June 2022	None recorded
Centre IA	26 April 2022 - 29 April 2022	None recorded
Centre CD	7 June 2022	None recorded
Centre GT	Approximately 28 June 2022 – 21 August 2022	None recorded
Centre EP	Unknown	Unknown
Centre WL	Unknown	Unknown
Centre KE	Unknown	None recorded
Centre UN	Unknown	Unknown
Centre PN	Unknown	Unknown

In October 2023, the Gold Coast Bulletin reported that a parent had made a complaint to a Gold Coast childcare centre where the offender was working casually after his employment ended at Centre EA in 2022. The parent complained that the offender 'wasn't wearing a uniform, didn't introduce himself to parents and was staring at the kids'. The media reported that the parent was accused of gender bias, and the complaint was dismissed. Centre GT informed the Board that that 'no complaints were raised about his [the offender's] conduct' and further clarified that 'this was a concern raised by a parent about not wearing a uniform [and the offender] not introducing himself to one particular parent. This was not actionable, as none of the staff wore a uniform [and the offender] was introduced to all families through the parent communication portal'. There have been no known victims identified at this centre.

Centre WN

In **April 2022**, the offender worked two shifts at Centre WN, after being supplied as a relief educator by a national employment agency. At the time, this centre was rated as working towards the NQS.

During the ECRA investigation in 2024, the Nominated Supervisor advised that they contacted the employment agency after his first shift and requested that he not return to the centre. As they did not have any other available educators, the employment agency reportedly sent the offender back for his second shift at the centre.

Following the offender's second shift, a parent contacted Centre WN requesting an urgent response. The parent shared that their child had disclosed that the offender touched the child's private parts during rest time. The centre notified ECRA, and the parents had already notified QPS. The centre also advised QPS directly, and provided a written report to them; with officers giving permission for the Nominated Supervisor to advise the employment agency of the report to police about their concerns in relation to the offender.

After the initial disclosure to them, the parent of the child made a recording of the child's statements. The QPS later determined that they could not use this recording due to 'leading questions' by the parent.

Witness statements from the staff who were in the room at the time were gathered by the centre Director/ Nominated Supervisor. After interviewing the child and speaking to the Nominated Supervisor who stated that neither she nor any other staff members present on the day had witnessed the offender inappropriately touch the child, QPS made the decision to file the complaint pending any new information. The offender was not interviewed by QPS. The offender has never been charged with respect to this report.

During their interview with ECRA in 2024, the Nominated Supervisor of Centre WN advised they had a conversation with an employment agency staff member on the day regarding the notification made to the police and ECRA about the concerns raised.

ECRA's investigation was closed in **June 2022**, by which point the offender had commenced employment at a different centre (Centre HN). ECRA's decision to close this investigation was based on an assessment that there was no information to support non-compliance by the provider.

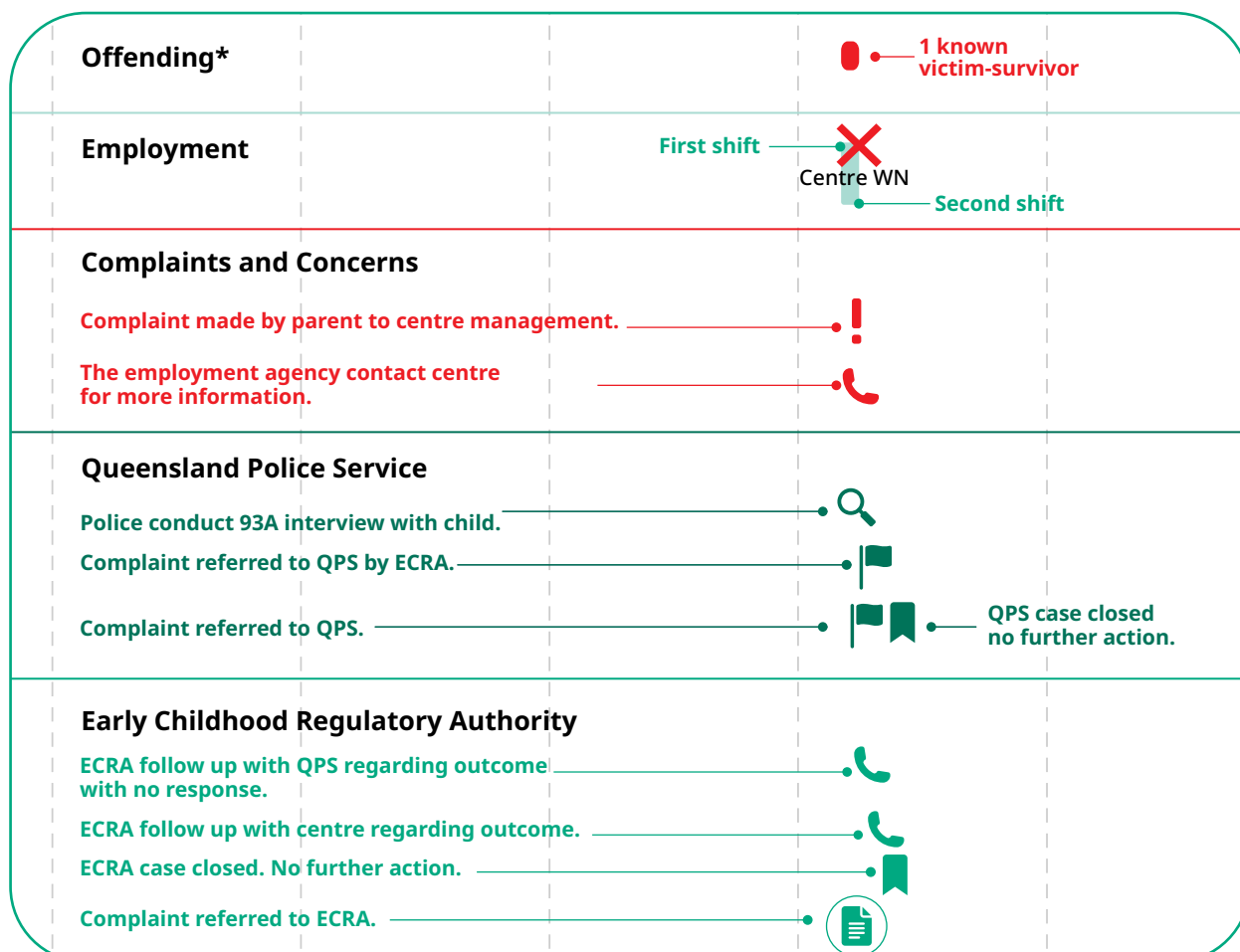
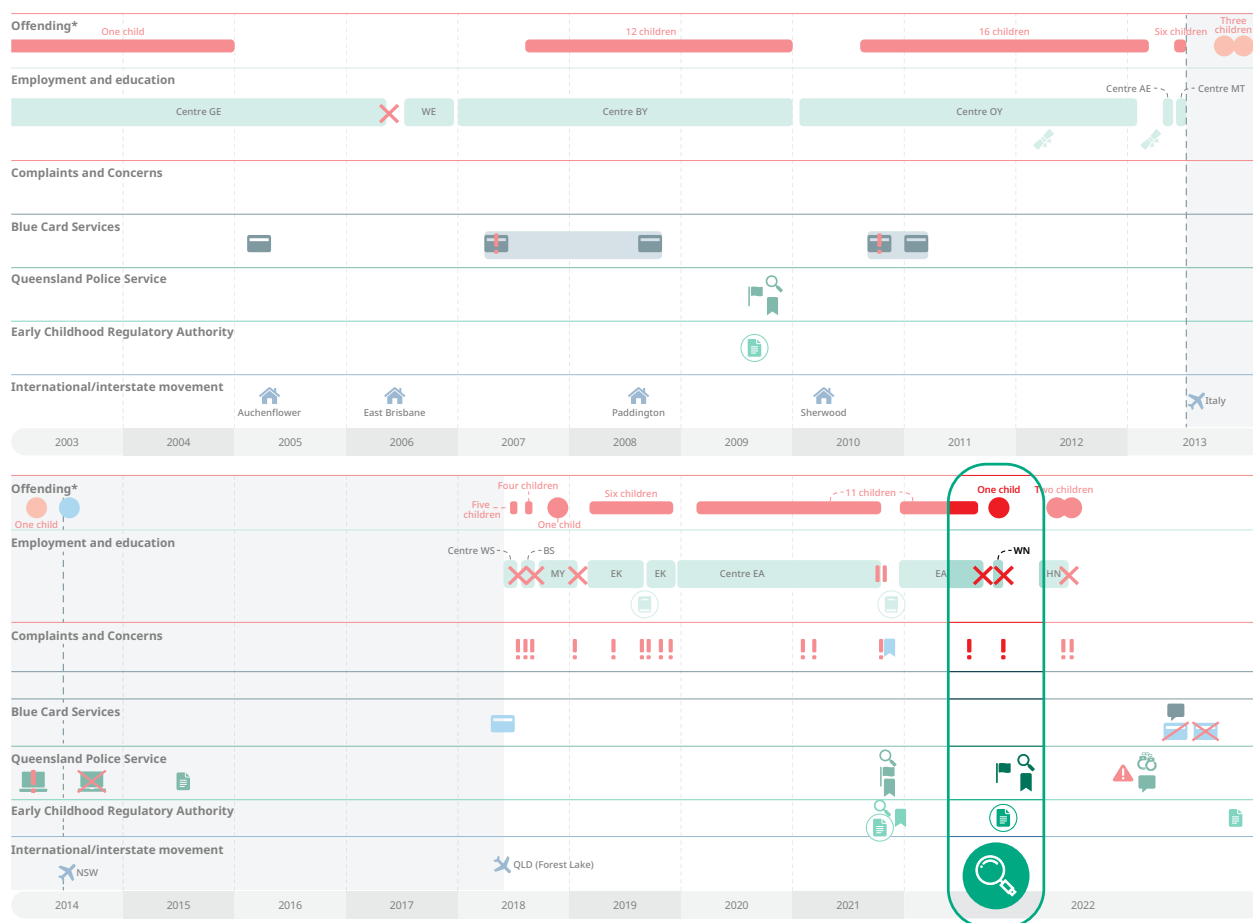
ECRA did not interview the child, parents, offender or staff as part of its investigation.

The offender was not sent back to this centre following concerns expressed by the Nominated Supervisor that he should not be placed anywhere while the investigations were ongoing, and after the Nominated Supervisor's previous request.

Consistent with the relevant requirements in place at the time, BCS was not notified as the complaint did not reach the threshold for a criminal charge or investigation.

In 2024, the offender pleaded guilty to offending against one child who attended this centre. The offender recorded the offending across approximately **eight minutes of video**. The recorded offending occurred during rest time, and another adult was heard speaking in the video suggesting the proximity within which offending occurred. There is no suggestion that the other adult was involved in the offending.

Figure 11: Timeline of offending in Centre WN, April 2022



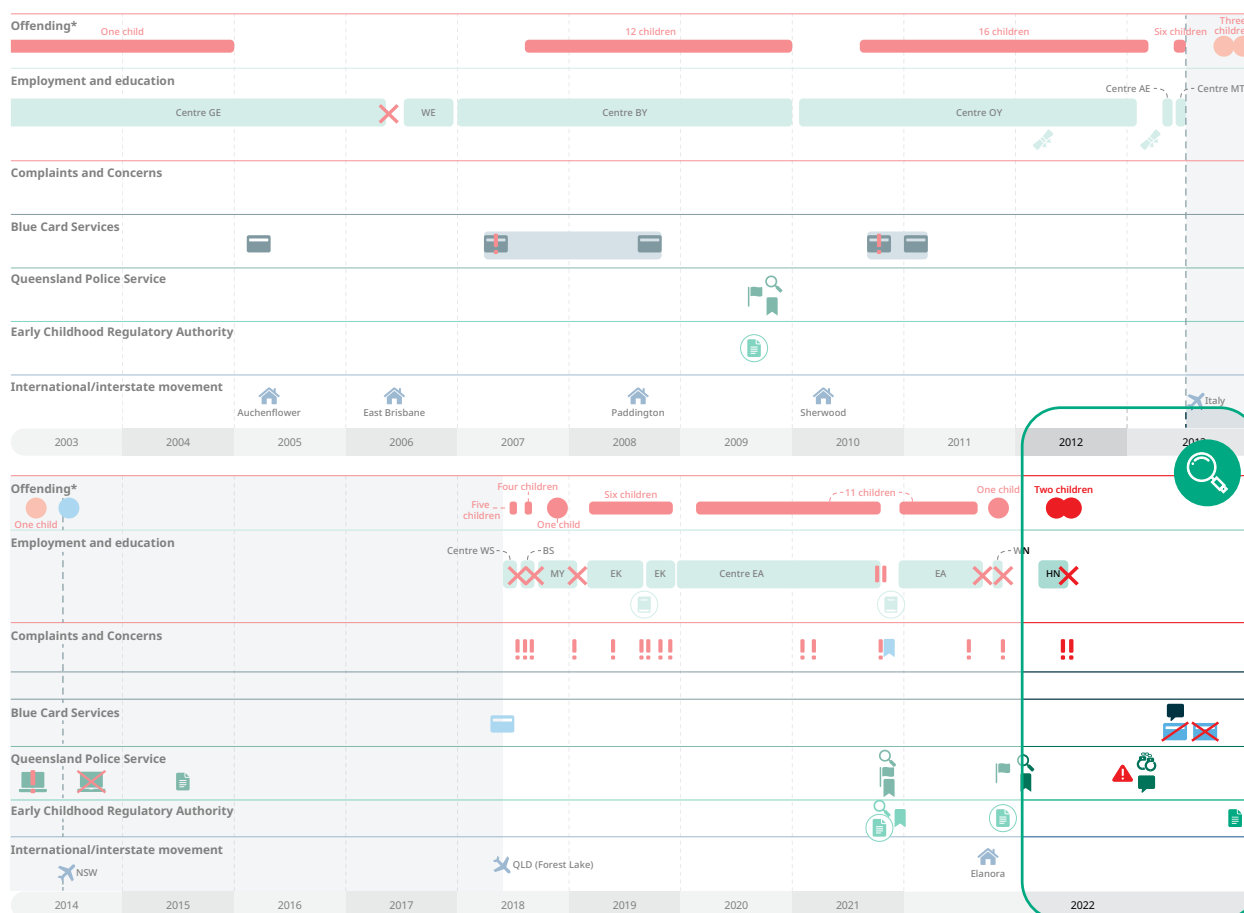
Centre HN

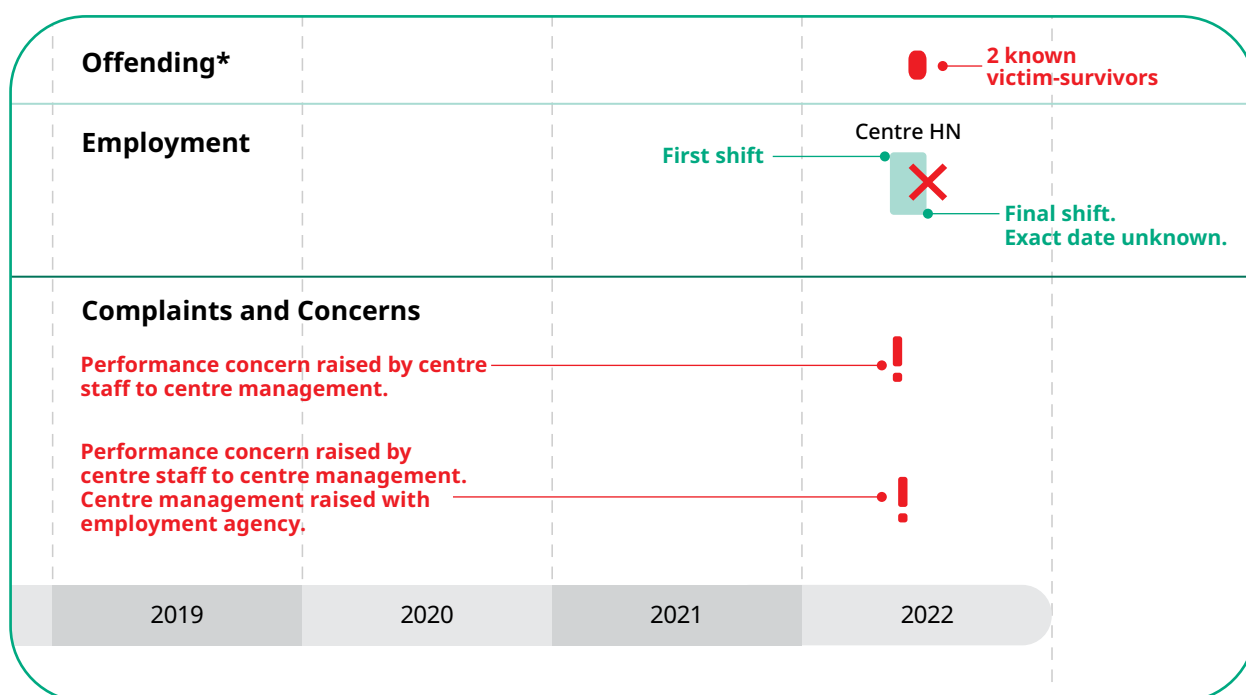
In **May 2022**, after being supplied as a relief educator by a national employment agency, the offender worked his first shift at Centre HN. At the time, the centre was rated as exceeding the NQS.

The offender worked a total of eight shifts at Centre HN. On his seventh shift, in **June 2022**, the offender supervised one of the kindergarten rooms on his own due to staff absences. On this same day, a staff member noted that the offender was being 'sharp and abrupt' with children during morning teatime and not engaging with them. The staff member asked if he was okay and asked him to organise a game for morning teatime the next day. The next day, the staff member reported that the game organised by the offender did not meet the instructions. Centre HN requested that the offender not return to the centre after this shift.

In 2024, the offender pleaded guilty to offending against two children who attended this centre. The offender recorded the offending across approximately **16 minutes of video**. An adult was heard speaking to the offender in videos, and another adult was seen in one video, although they were not involved in the offending. Over half of the recorded offending occurred at rest time. Most of the offending occurred in the main areas of the centre, and in the storeroom on two occasions.

Figure 12: Timeline of offending in Centre HN, May-June 2022





August 2022 - The offender's arrest

On **18 August 2022**, the Australian Federal Police (AFP) identified the location of the childcare centres in CEM that had been uploaded by the Zimble account on the darknet site, The Love Zone.

On **20 August 2022**, they identified the offender as the owner of the Zimble account and Operation Tenterfield commenced. He was arrested the next day, **21 August 2022**. The operation included searches of the offender's house and his mother's house, as well as identifying the children in the CEM discovered in those searches.

On **24 August 2022**, BCS was notified that the offender's exemption card was seized. That same day BCS suspended the offender's exemption card and notified the employment agency and employers linked to the card of the suspension.

A month later, on **23 September 2022**, BCS also notified QCT of the suspension.

On **7 October 2022**, BCS received correspondence that the offender's teacher registration had been suspended and subsequently the offender's exemption card was cancelled.

In **October 2022**, ECRA was provided with an initial list of services where the offending was alleged to have occurred. This list was supplemented by the AFP in **October 2023**, at which time ECRA was able to commence its own investigations.

The offender was sentenced to life imprisonment on **29 November 2024**, with a non-parole period of 27 years. This sentence is currently subject to an appeal.

The timeline of detection

A timeline of detection has been developed to inform the Review and provide an overview into activities undertaken by law enforcement entities to detect and disrupt the offender, and identify the victim-survivors. It does not cover all lines of investigations and enquiries undertaken by either the AFP, QPS or other victim identification teams around the world.

Table 2: Timeline of detection by the AFP and Argos

Date	Event
June 2013	<i>Operation Lima Rhodes</i> commenced to target administrators of 'The Love Zone' and identify children depicted in 'first generation' CEM posted on this site. First generation CEM refers to material that is new and has not previously been seen by law enforcement.
September 2013	'Zimble' created his account on The Love Zone website.
13 October 2013	'Zimble' became a full member of The Love Zone website.
29 October 2013	First post by 'Zimble'.
February 2014	QPS identified a member of The Love Zone named 'Zimble' who had uploaded first generation CEM videos and still images of two female children. The offender is alleged to have shared images to access a broader range of CEM described by the offender as 'rare' and some 'hardcore' material.
7 May 2014	Images posted by 'Zimble' were uploaded to the International Child Sexual Exploitation Database by Argos during their initial training in the database. This was the first time access had been granted to Argos by INTERPOL and AFP first became aware of the matter.
10 June 2014	The Love Zone Administrator was arrested in South Australia. The website was taken over by Argos and continued to be run under a Controlled Operation.
13 June 2014	Last post by 'Zimble' on The Love Zone. The offender was not identified posting any further material after this date on any online platforms.
January 2015	The AFP made inquiries with a bedding supplier as part of its efforts to identify victims in the CEM uploaded by 'Zimble'. The owner was recorded as being 'uncooperative and unwilling to assist' when contacted by phone. At the time of this enquiry, there were three companies identified who were using the pattern/material depicted in the bedding.
August 2015	List of male childcare workers obtained from the Department of Education by Argos. The date this was requested is unknown; however, the file's server spreadsheet was created on 5 August 2015. There were hundreds of names on this list. The offender was not initially identified as a person of interest, although several others were.
11 May 2018	The AFP made further inquiries with the owner of the bedding supplier and are shown a printed contact list. AFP members photographed the list. The centre where the abuse was subsequently identified was on the list, however it was recorded incorrectly.

21 October 2021	Brisbane-based members of the Victim Identification Team in the AFP met with the previous owners of the bedding supplier. The following week they were provided with customer records for people and daycare centres who purchased sheets from them. This list did not include sales made to the centre where the abuse occurred.
18 August 2022	The offence location (i.e. specific childcare centre) for 'Zimble' images was identified following a review of the centres recorded on the customer list provided in 2018. The details recorded on that list did not match the actual location of the centre, and as such it had not been reviewed previously. Further inquiries were conducted between 18-20 August 2022.
20 August 2022	The offender was identified as responsible for the 'Zimble' images. <i>Operation Tenterfield</i> then commenced. The AFP arrested the offender. He stated to officers that he stopped posting images online as he read a news article about an arrest by Argos. The offender admitted to having abused between 50 and 100 toddlers during the last fifteen years in at least five childcare centres including the abuse of the young girls identified in the CEM footage uploaded in 2014 A warrant was subsequently executed by AFP at the offender's rented address and his mother's home, and several electronic devices were seized. A quantity of CEM was located and seized. Almost all of this CEM was never uploaded to the internet.
19-27 September 2022	QPS and AFP victim identification teams established a taskforce to identify all children depicted in the CEM seized from Griffith. Over time, 65 Queensland victim-survivors were identified.

Chapter

8

The Offender: Motives, methods, and patterns

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The Offender: Motives, methods, and patterns

Offender behaviour and evasion of detection

This chapter examines what the Board has learned about the offender's motivations, methods of avoiding detection, and patterns of offending over time.

When timelines are applied to known perpetrators or closed cases, they reveal something far more important than chronology: they expose opportunity. By turning our lens on the offender, we can learn how to better detect threats by examining how he was able to navigate around existing institutional safeguards and exploit system gaps to create opportunities for abuse to occur. Together, these insights provide a clearer understanding of how the offender was able to evade detection for approximately two decades.

Although the offending occurred in early childhood education and care (ECEC) services, this type of abuse is not unique to that setting. The strategies used by the offender reflect broader patterns commonly associated with the perpetration of child sexual abuse in institutional environments.

In compiling a timeline of offending it became evident to the Board that the offender:

- **deliberately circumvented recruitment and screening processes by misrepresenting his employment history and avoiding the use of current referees**
- **manipulated individuals and circumstances for personal gain, including to secure unsupervised access to children**
- **targeted children under the age of five, because of their limited capacity to recognise and report their experiences of abuse**
- **created opportunities for offending by altering the physical environment to reduce the likelihood of detection**
- **engaged in extensive grooming behaviours directed not only at children, but also at their families and centre staff.**

This analysis builds on what is known from research and practice about individuals who perpetrate abuse against children. This information is compiled from sentencing remarks, information gathered from centre records, staff and parents.

Personal life

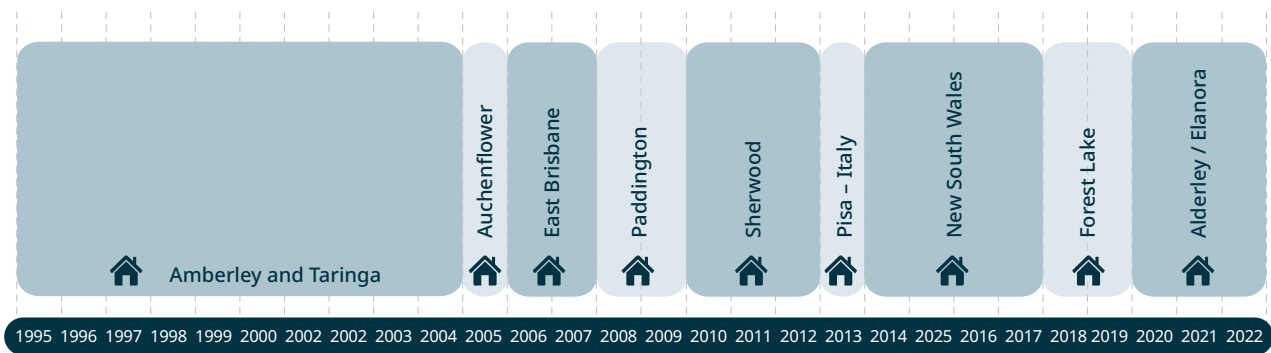
Personal background

The offender was born in Melbourne, Victoria. His family consisted of his parents and younger sister. His father worked for the Air Force and his mother was a homemaker. His family moved frequently until the offender began high school. The offender reported that the family was never affectionate towards each other and there was a 'lack of love.' His parents separated when he was 18 years old. There is no known family history of mental illness.⁴

The offender had a largely unremarkable childhood. The available information shows that he had a history of childhood epilepsy (last seizure at 10 years). The offender made no disclosures of any prior experiences of childhood physical or sexual abuse.

Since 1995, when the offender was aged 18 years, until the time of his arrest, he regularly moved residences within South East Queensland, but also lived and worked in Pisa, Italy for 12 months. Upon his return to Australia from Italy, the offender resided and worked in New South Wales for four years. He then moved back to Queensland. The below timeline of residential movements outlines his movements over this time.

Figure 13: Timeline of residential movements



Education and employment

The offender graduated from high school then went on to complete a Bachelor of Science.⁵ While he commenced a Bachelor of Arts, he ceased studying this degree following one semester, with records indicating that he failed multiple subjects, including a teaching unit.

The offender completed a Graduate Diploma of Education and a Bridging Program for Registered Primary Teachers (Diploma of Children's Services), which allowed him to work as an educator.

Educator qualifications range from Certificate III to degree level qualifications. In some circumstances, people can be employed in the sector when they are still studying for their qualification, if they can demonstrate they are actively working towards achieving one.

The only position that requires a degree level qualification is that of an Early Childhood Teacher. Given his qualifications, the offender would have been overqualified for much of the time he worked in early childhood.

Early childhood educators earn significantly less than their colleagues in primary and secondary education. Given the offender's level of education and greater earning capacity in a science related role, it is important to question his motivation to work with children in an ECEC setting.

The offender self-reported to the psychiatrist completing the pre-sentence report that he did not have a sexual interest in children when he started working with them; however, he was found to have first possessed child exploitation material (CEM) in 2000.⁶ This was before the offender started to work with children. According to the sentencing remarks:

the defendant's sexual interest in children lead [sic] to him accessing darknet websites where he would view child exploitation material and download it onto his devices. This occurred between 2000 – 2022.

and:

His statements need to be treated with circumspection. He alleged that he had an attraction to young girls and claimed the attraction commenced in 2003 which is inconsistent with the possession of child abuse material from as early as January 2000. It is submitted that his statements that the children gave him permission to engage with them show a significant lack of insight.⁷

During his last year of university, the offender commenced working at a primary school outside school hours care centre.⁸ In total the offender is known to have worked at:

- over 22 ECEC services in Queensland
- one centre in Italy
- two centres in New South Wales.

Between 2018 and his arrest the offender worked at 16 centres for lengths varying between one shift and over two years. In the latter years of his employment, the offender was contracted through an employment agency and placed at multiple ECEC services, often for very short periods of time.

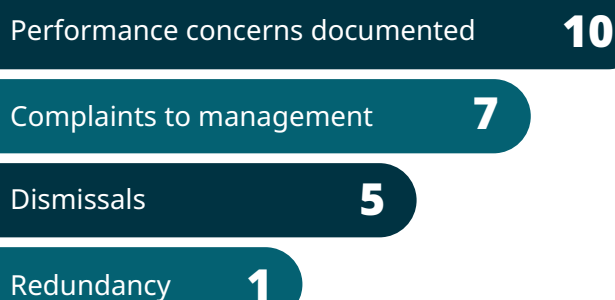
In 2022 alone, the offender worked in 12 centres.

The offender's longest length of time employed at a centre was approximately four years, at Centre OY. His average tenure across his career was approximately 11 months. While there is a high level of mobility across ECEC services generally, data shows that ECEC staff with relevant qualifications spend an average of four years at a centre.⁹ The offender spent the majority of his career working in the ECEC sector and positioned himself as a highly qualified and committed educator, which makes this type of employment instability more unusual.

Importantly, transient employment of this type can prevent the detection of offending behaviour. It can also indicate an employee who is generally problematic in the workplace and is unable to retain a role.

Evidence shows that the offender was terminated or left employment at centres on multiple occasions due to performance issues, including instances of immediate dismissal and ending employment during probation periods. In total, across the offender's employment history there were:

Recorded history of the offender's employment performance



Despite this, the offender continued to maintain employment in ECEC services, although in the latter years of his offending he was employed through a recruitment firm.

The offender was misleading in relation to the information he provided about his prior employment as part of recruitment and selection practices. He did not provide a complete picture of his employment history on his resume, omitting some centres he had worked in and was terminated from.

Between August 2018 and January 2019, the offender worked in three centres, all of which he was terminated from. On his resume he attributed this to a period of personal leave.

On multiple occasions, the offender also did not use references from his most recent place of employment. By providing referees of his preference, he was able to present himself favourably to his employers. It also meant that future employers did not have a full picture of the offender's conduct in the workplace, and any prior disciplinary concerns.

“

Always exceeded expectations – I saw [the offender] take one sick day in over 2 years. He was also always early to start and late to leave.

– Former colleague

”

“

[The offender] was an extremely dedicated and hardworking individual, often going above and beyond in the planning, reflection and documentation of his inquiries. He is incredibly child focused and cares deeply about his work.

– Former colleague

”

“

Once a term [the offender] held a parent night where he would play a video he made of the children as they developed throughout the term. (...) Would hire him in a heartbeat, considered hiring as a nanny, but couldn't pay enough.

– Parent

”

Relationships and social life

Personal

The offender self-reported having a good group of friends during high school. Throughout high school he described having had normal relationships with girlfriends, but that girls were not attracted to him. The offender self-reported that he had not had an intimate relationship with an adult since 2004.

The offender engaged with his family, including socialising with his sister and her young children. It is unknown if the offender socialised with others outside of work.

Reference checks outlined that the offender was someone who would get in early to work and be late to leave. He reportedly worked extra hours, sometimes arriving as many as two hours before start time. He was also known to have socialised with, and to babysit for, families from the centres in which he was employed.

Staff

Based on the available information, the offender did not appear to maintain close relationships with his colleagues. Reports from staff who worked with the offender indicated that he generally did not socialise with coworkers during or outside of work hours, except at formal work functions.

While some staff members described having a positive relationship with the offender, characterising him as warm, trustworthy, professional, and sociable, others found him difficult to engage with. They described him as rude, stand-offish, reserved, introverted, unfriendly, and, in one instance, a 'slob'. He was also noted for avoiding interaction with colleagues during lunch breaks, often choosing not to sit with others. Some staff raised concerns with their supervisors about his odd behaviour, though these concerns appear to have been dismissed.

The offender seemed to get along with colleagues who shared his views and working practices. When given the opportunity, he would schedule himself to work alongside these individuals. Conversely, he had difficulty working with those who challenged him or attempted to assert authority over him. He was also reported to be wary of outsiders or new staff members.

The offender manipulated people and situations to serve his own interests, specifically, to gain unsupervised access to children. This is particularly evident in Centre EA where he was a Director. In this centre, he reportedly instructed staff to supervise rest time inside the centre while he took a group of children outside on his own, allowing him alone time with the children.

This was further evidenced by his rostering practices whereby he rostered staff for one part of the day, whilst remaining the sole educator for the other part of the day. There was at least one occasion where these rostering practices meant that staff to children ratio was not met.

Additionally, even with ongoing marketing campaigns to increase the number of enrolments in this centre, the occupancy rate remained below 50 per cent, ensuring a lower number of staff were required to meet ratios. The offender was cited as the reason for the low number of enrolments.

On the occasion another staff member filed a complaint against him, the offender displayed resentment toward the educator who had attempted to have them reprimanded, claiming the complaint about him kissing a child was vexatious and the educator was after his position.



Case study

During an investigation into the offender's behaviour, the offender spoke on the phone with an employee where he voiced he wanted reprisal for the complaint.

He spoke aggressively wanting the complainant reprimanded for making a vexatious complaint.

“

In a letter the offender wrote in response to the allegations put to him, he stated he was “deeply hurt and offended by what has been alleged”.

”

The offender stated:

- He takes his role very seriously and is proud of the work accomplished at the centre and the strong reputation of the service.
- He has a strong commitment to child protection and has made it a strong focus in his practice.
- He is not sure if the allegation is merely misinterpretation, lack of consideration for the importance of physical interactions with children, or a deliberate attempt to ruin his reputation.
- He does not want to believe it is a deliberate “smear attempt” but will seek legal advice regarding his rights against false allegations.

The offender questioned why parents have not raised concerns with his behaviours because he is openly physical with the children in front of parents in order to be open and transparent.

Parents of victim-survivors and other children enrolled in services in which he worked

Parents' views of the offender were similarly mixed. According to the available records, the offender was reportedly seen to be happy and welcoming of parents on some occasions, while other times he was perceived as rude and off-putting.

On one occasion while the offender was being investigated by police, some parents reported not believing that he would do anything to the children. One parent reported providing the offender with a 'box of chocolates' once he was reinstated, attributing the complaint to a 'misunderstanding'. The parent reported having written a reference letter for the offender and wanting to show that there were no 'ill feelings' following this complaint. They were of the view that the offender would not have done anything to their child given his close relationship to their family.

Similarly, in response to the offender moving on from Centre EA, some parents expressed their dissatisfaction with the centre management by writing letters of support for the offender, and others removed their children from the centre in response to his departure.

The offender was reported to have babysat children from services, attended functions and spent time with families. The offender spent a lot of time with one family, including attending church with them, while a different family reportedly considered hiring him as a nanny.

Other parents, however thought the offender was odd and found his interactions with children uncomfortable. Some parents raised concerns with the offender's supervisors, centre directors or owners.

Positive descriptions of the offender included:

“ ‘lovely educator’;
‘passionate about early childhood’;
‘polite and respectful’ to staff.
He was observed to have a real
passion for early childhood,
artwork and engineering. ”

Negative descriptions of the offender included:

“ being ‘creepy’; unsettling,
felt uncomfortable with him, he did
not talk freely, and was ‘odd’,
‘arrogant’, and awkward. ”

Offending behaviour

Following his arrest, the offender was diagnosed with paedophilic disorder exclusive type females under 12.¹⁰ A psychiatric assessment undertaken to inform the offender's sentencing described the offender as 'unremarkable' with an average level of intelligence.¹¹ The offender presented with problems with self-awareness, limited coping strategies and severe problems with social adjustment.¹² The psychiatrist also made an assessment that there was no evidence of psychiatric conditions such as psychotic or mood disorders and while the offender was known to have used cocaine and ecstasy, he was assessed as not having a substance use disorder.¹³

The offender was aged between 25 and 44 at the time of known offending. Prior to his arrest he had no recorded criminal history and no obvious anti-social personality disorder.¹⁴ Having no previous criminal history meant that there were positive assessments of his application with Blue Card Services on each occasion that he applied for one.

All known offending occurred in ECEC services where he was employed. He created CEM against all but one of the known victim-survivors.

While he repeatedly offended against most of the victim-survivors, he was convicted of having repeatedly offended against 15 children over a prolonged period. Based on the facts gathered, he was able to offend quickly, including in the first few days of meeting a child.

The offender accessed CEM via the darknet between 2000 and 2022. While he uploaded some CEM onto the online forum 'The Love Zone' over the period October 2013 to June 2014, it appears he created CEM mainly for his own gratification, and not necessarily to share.¹⁵

The offender gained access to some material not readily available through The Love Zone by uploading and sharing a series of CEM he created. He wrote to the 'VIP requests' asking to be considered for approval as he had uploaded the required content. He was subsequently approved.

He also left comments in online forums suggestive of him abusing children and instructing others on his process. In one post he wrote 'it becomes a balance between minimising risks and seizing opportunities'.¹⁶

The offender reported that he would sometimes delete all the CEM but would then retrieve it again. An examination of the offender's electronic devices after his arrest identified 571 videos and 18,257 images of CEM. This was not CEM that he produced.

With respect to the physical contact offences that he was convicted for, it is evident from reviewing the available files that the offender exploited situations where there was lapsed guardianship. He would:

- test the child's boundaries and normalise physical contact when they were awake
- seek to distract the child, including by using an iPad
- seek to avoid detection by having children sit on his lap, which meant that he was able to be more discrete in his offending.

The offender filmed offences with either a mobile phone or camera, and sometimes with multiple devices. His use of personal devices, including to take photos of children, in the centres where he worked was well known and his promotion of himself as a photographer was likely another grooming technique. The offender transferred the CEM he made of the offending from his phone or camera onto other devices. The recordings were catalogued into daycare centres and labelled to identify the children involved and the type of sexual abuse.¹⁷

As so aptly outlined in the sentencing remarks:

*The creation and recording of content cataloguing, labelling, retention, manipulation, deletion and recovery of images shows the defendant to be a highly calculating, motivated and organised individual.*¹⁸

The offender is known to have offended when other children and staff were present. The duration of recordings varied from between about 8 seconds to 30 minutes. In one of the centres, he is known to have compiled over 50 hours of CEM.

The offender reported that he chose children under the age of five years as they were 'easier' to offend against. He also retained enrolment and attendance records or class photos of children, to create montages and films.¹⁹ His offending was persistent and prolific, and the very young age of the victim-survivors suggests a high level of sexual deviance.²⁰

After he was arrested, the offender reported that he felt 'remorse' and wanted to stop offending but he was not 'strong enough'.²¹ He claimed not to 'groom' children, although there is substantial information available to the Board which indicates that he did groom children, parents and other staff that he worked with. The offender's statement that he did not utilise grooming as an offending tactic is contested by the offender's psychiatric report. This report noted that as the offending spanned almost 20 years it likely involved extensive grooming and a degree of 'physical coercion'. The offender invested a high level of effort into being able to offend repeatedly without being caught by using psychological coercion, by abusing children while asleep, and by frequently moving jobs.²²

It was also considered very likely that the offender lacked empathy for the victim-survivors.²³ The offender minimised the severity of his offending and developed cognitive distortions that supported his continued offending. Sentencing remarks stated:

He considered that the children he offended against whilst awake were not affected at all and told police they were happily laughing or having conversations. However, during a later interview the defendant accepted that there was the potential his victims might suffer harm later in life.

There is no evidence to corroborate the offender's post-arrest statements that he felt guilty about his offending. He took no steps to stop or limit his exposure to children and continued to work in the industry until he was arrested. The offender was undeterred by possible detection on the occasions where he was investigated for inappropriate behaviour.

In 2021, he penned a letter to his employer to deny suggestions of inappropriate behaviour towards children stating:

I wholeheartedly refute the idea that I display any kind of favouritism towards certain children. I am deeply hurt and offended by what has been alleged. I take my role as Director and Nominated Supervisor very seriously I have worked with children for 21 years and never had a single complaint or allegation made against me.

Based on the available records, by this time five complaints had been raised about the offender's conduct by children and parents, five behavioural concerns had been raised by colleagues or management, and his employment had been terminated from four centres.

The offender – Four pre-conditions to child sexual abuse

For an incident of sexual abuse to occur, a motivated offender must overcome their own internal inhibitions, overcome external inhibitions and overcome the resistance of the victim.²⁴

The offender's cognitive distortions rationalised his behaviours in his own head. By manipulating environments to obtain unsupervised access to children, the offender was able to abuse children whilst they slept or distract them whilst they were awake.

Table 3: Examples of the offender's behaviour aligning with the four pre-conditions to child sexual abuse

Motivated offender	Internal inhibitions (cognitive distortions)	External constraints	Overcome victim resistance
Emotional congruence with children.	The offender abused children for his own sexual gratification.	The offender created opportunities to have unsupervised access with children.	The offender distracted his victims with an iPad or other activity.
Sexual gratification.	The offender expressed he felt 'love' towards some of the victim-survivors.	The offender groomed parents, staff and children.	Some of the offending occurred while children slept.
	The offender identified emotionally with the children.		The offender chose young victims due to their inability to disclose the offending.

The offender – Routine Activity Theory

Routine activity theory asserts there needs to be a motivated offender, presence of a potential victim and the absence of a capable guardian.²⁵ The offender was able to access children through his employment as an early childhood educator. He was able to obtain unsupervised access to young children by manipulating the environment to ensure a lack of guardianship.

Table 4: Examples of the offender's behaviour aligning with routine activity theory

The offender	Victim access	Absence of a capable guardian
Motivation to work with children.	Victim preference.	Recruitment and screening policies and practices.
Relationships (grooming) with parents and colleagues.	Worked with age groups who had limited capacity to report abuse.	Effective supervision of children.
Transient employment.	He is known to have offended in some centres and not others.	Staff awareness and understanding of child sexual abuse.
Photography and music as hobbies.		Presence of CCTV.
		Hidden and isolated physical spaces to enable abuse to occur.
		Organisational cultures that normalised the offender's conduct.

Grooming children, families and staff

Grooming is intentional behaviour by a person, designed to manipulate and control a child, their family, carers and other adults around the child, to perpetrate child sexual abuse. There is evidence of a high level of grooming perpetrated by the offender towards children, their families and centre staff which was not recognised at the time.

The offender was noted as displaying 'favouritism' towards certain children in some of the centres where he worked. One child reportedly had no relationship with other educators apart from the offender. When the Australian Federal Police sought records from one centre, the centre responded by asking if they should only supply records regarding 'blonde haired' children indicating the centre may have been aware the offender displayed preferential treatment to some children.

Grooming of children by the offender included:

- displaying positive attention, kindness, making children feel special (e.g. by attending birthday parties), arts curriculum in the classroom (e.g. drama)
- playing music for children
- pushing/testing personal boundaries by initiating intimate contact and seeking to normalise this behaviour (e.g. cuddles, kisses)
- having children sit on his knee while he engaged in activities with them
- engaging in rest time with children, including lying beside a child and 'spooning' them
- learning the strengths and weaknesses of children.

Grooming of families by the offender included:

- being seen as likeable, charming, trustworthy, and engaging with the children
- engendering trust because of his qualifications and experience
- ingratiating himself into the family's life (e.g. babysitting, attending birthday parties)
- pushing/testing parents' boundaries by engaging in intimate contact with their child in front of them and normalising the behaviour (e.g. kissing a child)
- bringing families in for support on work situations where concerns had been raised about his behaviour.

Grooming of the staff by the offender included:

- being seen as professional, exceeding expectations, child-focused and catering to their individual needs
- engendering trust because of his qualifications and experience
- pushing/testing co-workers' boundaries by engaging in intimate contact with children in front of them and normalising the behaviour
- controlling the environment and staff to facilitate unsupervised access to children
- manipulating the environment by creating hidden spaces for abuse to occur (e.g. building a fort in one centre)
- befriending a chef in one centre who could see into the room through open panels, and rostering staff who liked him to work shifts with him.

How the offender evaded detection

The offender was a motivated paedophile who created opportunities to have unsupervised access to children through his employment so he could abuse them. Through his day-to-day activities the offender was able to sexually abuse children with little effort and where the risk of detection was low.

The offender reported that he chose young children due to their inability to disclose the offending, despite his sexual preference being children up to 12 or 13 years of age. He used his interests such as photography/cinematography, music, art and literature to groom others and to offend.

The offender's cognitive distortions enabled him to continue to cause significant harm and his need for sexual gratification kept him motivated. The offender created spaces in the centres he worked in to hide his offending, and pushed the personal boundaries of children, parents, and staff to normalise behaviours such as cuddling, kissing and frequent touching. The offender was vocal about having "secure attachment" with children and expressing 'professional love' towards them.

“

Typically, people build responsive and meaningful relationships with children that respect personal boundaries and do not involve intimate contact such as kissing.

”

Despite issues and concerns in some workplaces, including instances of immediate dismissal, the offender was able to move centres frequently, and both regain employment and in some cases obtain promotion.

The offender challenged police for a variety of reasons, most significantly because he did not present as a prolific offender. The true extent of his conduct was not known until after he was arrested. Some of the known red flags of a prolific offender were missing. This included the offender having no criminal history, including for non-sexual offences, and an absence of known victim-survivors from his personal life. Although the offender created and possessed large amounts of CEM, he rarely posted CEM online, so did not come to the attention of law enforcement. He was difficult to identify in the content he posted online as there was limited personal information provided.

Despite several complaints being made against the offender, he was only detected and arrested because of his online activities, not offline behaviour or offending. The offender was able to avoid detection for such an extended period due to his ability to create opportunities to offend, regularly gaining unsupervised access to children.

In some of the CEM, both adults and children who were not involved in the offending were seen in the background, amplifying the boldness of his offending. In one of the centres where he worked, he was described as 'obsessive' towards a child and disclosed to others that he felt her mother did not value or care about her as much as he did, and that the mother 'should just give her to me'. There is no evidence to suggest the offender was ever challenged about this view.

Other than immediate family, the offender had no intimate relationships since 2004 and no known pro-social friendships since high school. Outside of work, the offender obsessed over photos, attended children's birthday parties and babysat children from the centres where he worked. As an ECEC educator, he spent more than the required hours at work, and his engagement with children was known to be prioritised over the completion of other required tasks (i.e. paperwork, and management duties). Concerns should be raised when someone invests both professional and personal time in engaging with children and has limited social engagement with adults.

In hindsight, the offender's intense focus on children through his employment and social life is obvious, but at the time was not apparent due to his superficial friendships with parents and centre staff, frequent change of employment and tertiary studies which positioned him as a highly qualified educator.

Exploiting positional power

As Director/Early Childhood Teacher at Centre EA the offender:

- was able to influence environments and create opportunities to offend, for example:
 - he built a fort and put sheets over the fort to make a cubby to minimise the likelihood of detection. He also used a sheet to screen off areas
 - he placed posters on windows and introduced a 'day bed' on which he was reportedly seen to play with the children including 'tickling'
- kept child enrolment and educator numbers low
 - he ran the centre at minimum capacity which limited the number of staff required to work while still meeting ratio requirements
- was able to make decisions about rostering, occupancy rates and programming which ensured he was alone with children
 - he implemented an indoor-outdoor program and rest time routines. This meant he would keep the younger children inside with two educators and he would take older children outside on his own during rest time
 - he also decided which children went outside. If outside resting, children would sleep on the veranda or in the fort area
- would push boundaries and normalise grooming behaviour with both educators and children
 - he would have children sit on his lap in the main room where all the children were
 - he would take some children into his office despite telling children they should not be in there
- would also push boundaries and normalise behaviour with parents by showing affection to children in front of parents
- implemented inconsistent routine resulting in other educators being unaware of what was coming next and therefore unable to maintain appropriate guardianship
- reported lack of performance by staff who disagreed with his approach to teaching and running the centre, discrediting their concerns and leading them to not being believed.

Common case themes

The unpacking of this timeline paints a picture of extreme risk, high harm and significant impact. Tragically, it is not unique. The below table summarises cross-cutting themes identified across the seven international case studies by the University of New South Wales (UNSW) that have been brought together to inform the Board's review of this case.²⁶

These patterns reflect the convergence of child vulnerability, offender strategies, environmental risk, and systemic oversight failures, and have been compared to what is known about the offender's conduct in this case.

Table 5: Comparison of case themes from *International Best Practice for Protecting Children from Child Sexual Abuse – Project 3: Identifying Perpetrators and Children at Risk*²⁷

	Themes of seven cases	Themes of the offender
Child-level risk factors	Very young or preverbal children unable to disclose abuse.	Only one child was aged 9 years at the time of the offending, with all other known victim-survivors aged five years or under, with one child being one year old. Children had minimal capacity to disclose abuse and those who did were either not believed or their disclosures were unable to be used in criminal proceedings. One parent stated that the offender ‘mainly picked on children who couldn’t speak’.
	Children with disabilities or developmental vulnerabilities.	Not applicable.
	Children in out-of-home care or with limited family advocacy.	Not applicable.
Institutional risk-factors	One-on-one access during high-risk care routines (e.g., toileting, nap time).	All abuse occurred in a care setting with the majority occurring during nap time and toileting.
	Unsupervised student placements or temp agency staff.	The offender gained employment through a labour hire company in several of the centres he worked in. Given his credentials and experience he was often left alone with the children.
	Lack of CCTV or physical design enabling concealment.	There was no CCTV in any of the centres where the recorded abuse occurred. The physical environment included hidden spaces and in the absence of these the offender created spaces that were difficult for other staff to supervise. This included designing a fort with minimal visibility, placing sheets over the fort to obstruct view, closing the blinds in the centre while alone with children outside and blocking view by placing posters and pictures over the windows.
	Absence of safeguarding protocols specific to high-risk tasks.	Safeguarding protocols were not featured in any of the centres’ policies and procedures. While policies and procedures referred to child protection, they did not specify safeguarding.

	Themes of seven cases	Themes of the offender
System failures	Ineffective background checks or ignored risk assessments.	Background checks were not always conducted due to a reliance on a labour hire company to conduct appropriate checks. The offender did not disclose his full employment history and provided outdated references which impacted the robustness of employment checks.
	Inadequate oversight across multiple settings/employers.	Inadequate oversight was evident across several centres particularly about the cessation of the offender's employment and complaints about him were not visible to others. Labour hire company continued to find employment for the offender even though they were reportedly aware of at least one complaint.
	Informal workplace cultures that suppress reporting or challenge.	Information indicates complaints made to centres about the offender were not passed onto the Early Childhood Regulatory Authority.
Barriers to detection	Young age of victims preventing verbal disclosure.	All bar one child was 5 years of age or below, with limited capacity to disclose the abuse.
	Subtle abuse during routine care mistaken for normal interaction.	Abuse occurred during routine care activities such as toileting.
	Staff reluctance to report due to fear, loyalty, or lack of clarity.	Many staff reported not believing that the abuse could have occurred. Others gave statements to the effect that they did not witness anything that would have indicated abuse. On one occasion a staff member's complaint was not substantiated, and they subsequently left the centre after the offender was reinstated. Where other staff did raise concerns about the offender's behaviour this was minimised by other colleagues.
	Detection only after external CEM investigations.	Abuse was detected as a result of the offender's use of the darknet to access and upload CEM.

Chapter

9

The organisations: Structures, culture, and blind spots

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The organisations: Structures, culture, and blind spots

Having assessed both the offender's timeline of offending, his deliberate strategies to avoid detection and the threat that he posed across institutions, the Board examined how organisational structures, systems and processes acted to facilitate his continued access to children and enabled abuse to persist. In doing so, this timeline illuminates the cumulative burden of inaction and the systemic character of harm that occurred. It demonstrates that offending persisted not solely because of the offender's intent, but because of the permissive or disorganised environments around him. It lays bare the series of interactions—between victim-survivors, perpetrators, bystanders and institutions—that convert risk into realised harm.

The findings of this deeper analysis reveal that the known offending occurred in institutions where organisational design, staffing structures, management practices, and workplace cultures combined to create blind spots that obstructed earlier detection of the abuse.

“

Despite repeated concerns being raised by children, parents and staff, opportunities to intervene were routinely missed.

”

Common patterns emerge in how concerns raised were received and responded to in centres where abuse is known to have occurred, including:

- issues raised by children, parents and staff about the offender's conduct were dismissed or minimised
- clear indicators of grooming and other problematic behaviours displayed by the offender were normalised or ignored
- recordkeeping practices were incomplete, inconsistent and, at times, inaccurate
- investigations into complaints raised about the offender's conduct were superficial, which impacted the quality of decision-making and limited the threads being brought together.

These systemic failings delayed detection and allowed the offending to continue for nearly two decades. The cumulative effect was a culture where concerns were not acted upon, and opportunities to protect children were repeatedly missed.

The sheer scale of offending and the offender's employment at more than 20 centres in Queensland provides an opportunity to systematically examine how different organisational practices, procedures and structures may have heightened, or reduced, the risk of abuse occurring. Significantly, we sought information from those centres where there was no known offending, in addition to those centres where abuse occurred. Information received from some of these centres point to high levels of supervision, robust induction processes and strong safeguarding practices.

It is also the case that the offender did not pass probation in three centres in which he worked. This points to organisational structures and induction processes that sought to screen out problematic behaviour early on and disrupted opportunities for abuse to occur *in that centre*.

Tellingly, the offender was dismissed or let go from at least five centres. This shifted the problem on to other centres, to other children and to other communities. For some of these dismissals there is limited to no records, and likewise for many recruitment decisions there was minimal checking of referees. This organisation-by-organisation weakness clearly worked in the offender's favour.

The setting where the abuse occurred

Importantly, while the abuse occurred in early childhood education and care (ECEC) services, this type of offending is not distinct to this setting. Perpetrators of child sexual abuse move across different settings and sectors to find system weaknesses and gaps, to target children, and to create opportunities for abuse to occur including in our homes, in our residential care facilities, in our schools, in our sports clubs and activity groups, and where our children play.

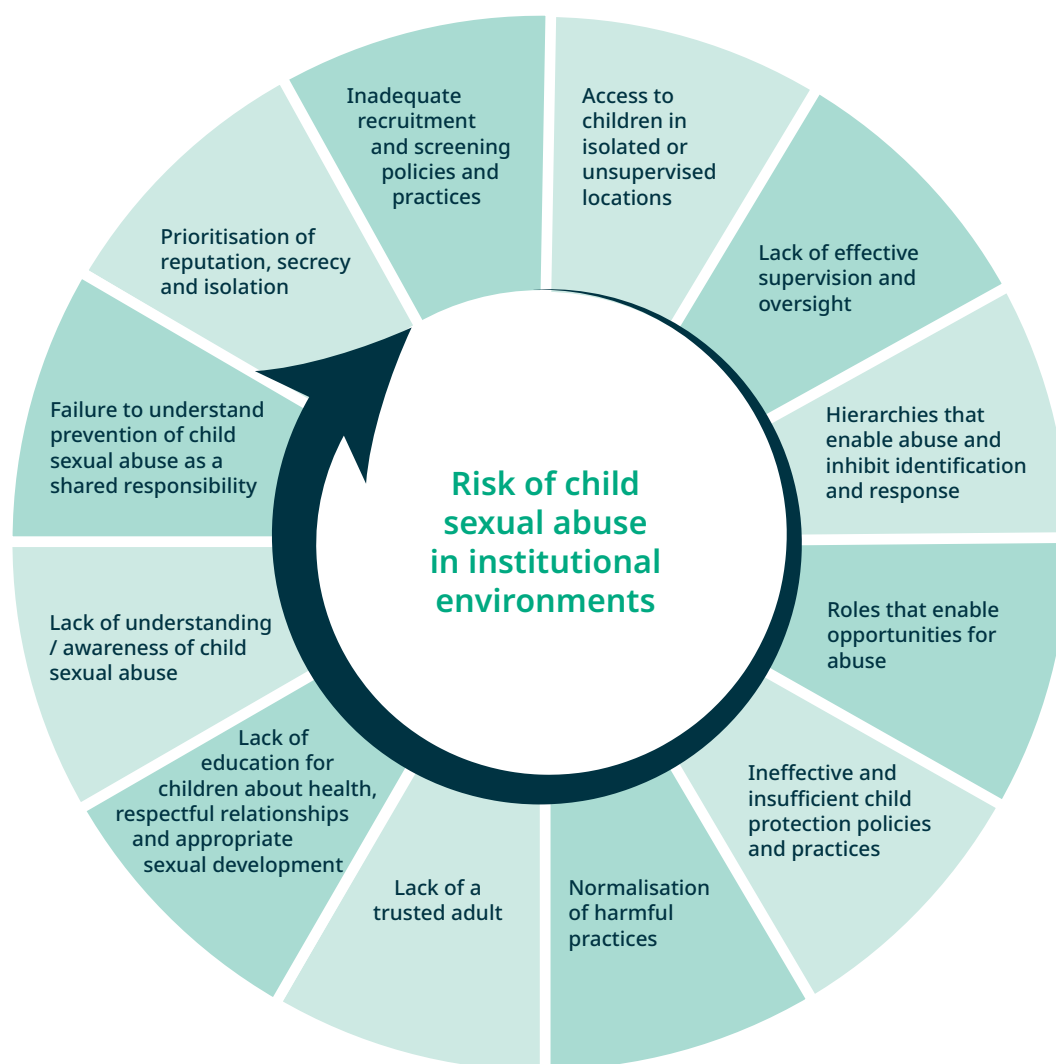
While the settings may change, the conduct remains the same. For this reason, it is paramount that we pause and reflect to consider behavioural patterns, institutional failures, systemic blind spots, and the cumulative nature of risk and response.

To support our Review, the Board has examined a range of different cultural, operational and environmental factors to identify any factors that may have elevated, or decreased, the risk of child sexual abuse occurring.

Common factors noted across centres where there was known offending included:

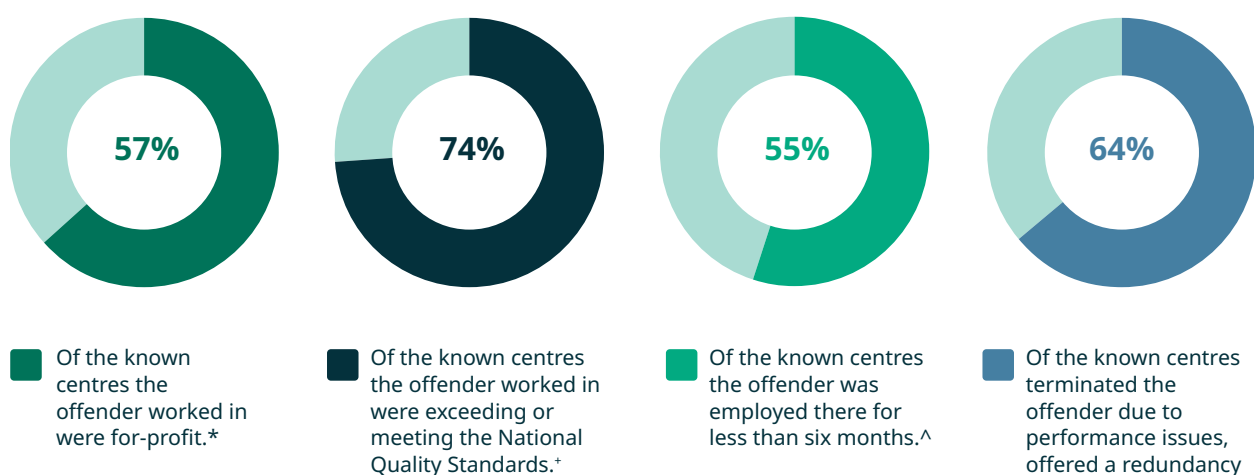
- the offender having access to children in isolated or unsupervised locations
- inadequate recruitment and screening policies and practices
- failure to provide child sexual abuse prevention education
- lack of effective supervision or oversight
- lack of understanding/awareness of child sexual abuse, and
- ineffective and inefficient child protection policies and practices.

Figure 14: Risk of child sexual abuse in institutional environments



The offender is known to have worked in 22 ECEC services in Queensland between 2003 and 2022. It is also of significance that the offender was terminated, made redundant from, or asked not to return to seven of these centres, at times due to performance issues.

Figure 15: Characteristics of the centres where the offender worked



*excludes Centre GE due to lack of information.

+excludes Centre GE, WE and BY as National Quality Framework was not yet in place.

^excludes centres where there was no know offending due to the offender's work in these centres being primarily short, casual placements or trial shifts.

Quality ratings in services in which offending was proven

Queensland services are assessed and rated by the Early Childhood Regulatory Authority (ECRA) against the National Quality Standards (NQS). They are given a rating for each of the seven quality areas and an overall rating based on these results. The process of assessing and rating a service is a combined approach of quality assurance and regulatory compliance. The quality ratings are:

- **Excellent** – can only be awarded by the Australian Children's Education and Care Quality Authority (ACECQA) and is only available to services which are rated as exceeding across all quality areas. Excellent services promote exceptional education and care, demonstrate sector leadership and are committed to continually improving.²⁸ As at 30 June 2025, only six services in Queensland were rated as Excellent. This represents 0.2 per cent of the 3,128 approved ECEC services.²⁹
- **Exceeding NQS** – service goes beyond the requirements of the NQS in at least four of the seven quality areas, with at least two of these being educational program and practice, relationships with children, collaborative partnerships with families and communities, and governance and leadership.³⁰ As at 30 June 2025, 501 Queensland services were rated as Exceeding the NQS. This represents 16 per cent of the 3,128 approved ECEC services.³¹
- **Meeting NQS** – service meets the NQS and provides quality education and care in all seven quality areas.³² As at 30 June 2025, 2,280 Queensland services were rated as Meeting the NQS. This represents 73 per cent of the 3,128 approved ECEC services.³³
- **Working Towards NQS** – service provides a safe education and care program, but there are one or more areas identified for improvement. As at 30 June 2025, 340 Queensland services were rated as Working Towards the NQS. This represents 11 per cent of the 3,128 approved ECEC services.
- **Significant improvement required** – service does not meet one of the seven quality areas or a section of the legislation and there is a significant risk to the safety, health and wellbeing of children. The regulatory authority will take immediate action.³⁴

Table 6: NQS ratings for the centres where the offender worked, during the time of offending and now

Centre	Date	Time of offender employment	Currently	Date of last assessment
OY	2010 – June 2013	Meeting NQS	Exceeding NQS	September 2018
MT	July – August 2013	Working Towards NQS	Meeting NQS	December 2018
WS	July 2018	Exceeding NQS	Exceeding NQS	September 2025
BS	September 2018	Provisional - not yet assessed	Exceeding NQS	June 2019
MY	October 2018 - February 2019	Working Towards NQS	Meeting NQS	August 2021
EK	February - December 2019	Excellent	Working Towards NQS	June 2025
EA	December 2019 - April 2022	Exceeding NQS	Meeting NQS	April 2020
WN	April 2022	Meeting NQS	Meeting NQS	November 2024
HN	May 2022	Exceeding NQS	Exceeding NQS	March 2024

Centres GE and BY are no longer in operation and were operated prior to the introduction of the National Quality Framework (NQF), therefore no rating is available. Centres OY and MT have changed owners since the offender was employed in them, in February 2024 and March 2019 respectively. This may be in part due to changes to the NQS in 2022.

Centre EA was assessed and rated during the offender's time as Director. The centre went from an Exceeding NQS rating to Meeting NQS.

Understanding and responding to the risk of child sexual abuse within institutional environments

While there is a lack of data regarding child sexual abuse within ECEC settings, according to research produced by the Australian Institute of Family Studies, ECEC services should be considered a 'high risk' setting for child sexual abuse because:

- the children have limited ability to communicate
- the children have minimal capacity to understand inappropriate behaviour
- the children are dependent on adult caregivers
- adults develop close relationships with children that are subtle and sustained over time which means that the use of grooming can be difficult to identify
- adults with a sexual interest in children may be drawn to child services to gain access to children
- perpetrators can avoid detection by using their position or influence to circumvent safeguarding measures
- individuals in childcare settings are viewed as trustworthy.³⁵

In its Final Report, the *Royal Commission into Institutional Responses to Child Sexual Abuse* (Royal Commission) highlighted a range of institutional risk factors that may impact the likelihood of children being sexually abused, and the chance of abuse being identified and appropriately responded to. This includes:

- **Cultural factors** such as leadership and organisational culture, which shape assumptions, values, beliefs and norms. These influence, among other things:
 - how individuals behave when interacting with children,
 - what is understood to be appropriate and inappropriate behaviour, and
 - how children's safety and wellbeing is prioritised.
- **Environmental factors** such as the characteristics of physical and online spaces that enable potential adult perpetrators and children with harmful sexual behaviours to access victims.
- **Operational factors** such as governance, internal structures, day to day practices, the approach to the implementation of child safe policies and the recruitment, screening and training of staff and volunteers.³⁶

For those centres where there was known offending, and sufficient records available, an assessment of the existence of the institutional risk factors identified by the Royal Commission, was undertaken as part of the Review. Due to the time since the abuse occurred, and a number of centre closures over the period of offending, assessment could only be completed against seven centres: (Centre WS, Centre BS, Centre MY, Centre EK, Centre EA, Centre WN, Centre HN). The Board is, therefore, mindful that this analysis is based on incomplete data. Despite this, the information highlights key opportunities to act to prevent and disrupt offending within institutional settings. The interplay between, and dynamic nature of, different factors may also serve to elevate or decrease risk in particular settings or services.

The most common risk factors identified across centres that were assessed, are discussed in further detail below.

Access to children in isolated or unsupervised locations and lack of effective supervision and oversight

High levels of supervision and monitoring are critical in reducing the opportunity for abuse to occur. This can be achieved by:

- designing physical spaces that increase visibility
- establishing regulations that increase transparency and opportunities for people to notice and report problematic interactions
- reducing opportunities for adults and children to interact in isolated environments or convene in spaces lacking monitoring or supervision
- minimising adults' isolated access to children in close contact, such as when helping children to dress or at sleep times
- strong monitoring practices to deter and limit the opportunity for offending to occur.

Available records show that the offender sought to modify the environment in the centres that he worked in, to reduce the line of supervision and effective oversight. This included:

- placing sheets over an outdoor fort
 - In interviews conducted by ECRA post arrest, a staff member noted that the offender *"put blankets and sheets over the top of the fort for shade"*.
- placing images and posters on windows that directly prevented line of sight to an outdoor fort
- placing images and posters on the window between the room and his office
- keeping blinds closed during rest times, despite children being split between indoors and outdoors.

There is no evidence to suggest that any concerns were raised directly with the offender in relation to his modification of the environment. This is despite a requirement in the National Regulations to ensure that education and care services are designed and maintained in a manner that facilitates supervision. One Centre advised the board that concerns regarding these issues were never raised by the regulator during the inspections, site visits and audits that were undertaken prior to the offender's arrest.

Based on existing structural design issues, some centres also did not appear to consider the physical environment in terms of adequate supervision of children and other educators. For example:

- there were poor lines of sight in teaching rooms, outdoor play equipment/structures, and bathrooms
- there were frosted glass doors between different kindergarten rooms
- in one centre there were areas that were referred to as 'secret spaces' and 'hidden spaces'.
 - The risk management strategy for one space referred to the provision of torches for children to use in those spaces.

“

Investigator: 'Are you aware of any particular hidden spaces at your service? So, things like cupboards, sheds, bathrooms, behind nooks and crannies?'

Nominated Supervisor: 'Of course there is, it's a childcare centre.'

”

Staff members were often the sole educator with children, especially during rest times. In the centre where the offender was the Director, the available information indicates that he may have kept enrolments deliberately low to circumvent staff ratio requirements.

The offender is also known to have babysat children who attended centres where he worked, providing him with further unsupervised contact with children. There is currently no legislative requirement for centres to:

- prevent educators from building relationships with families outside centres, or from babysitting, or
- prevent educators from being left alone with children if ratios are met.

In the centre where the offender held the position of a Director, the policy stated:

To ensure private babysitting arrangements do not adversely affect the reputation of the service, or affect an employee's ability to implement their responsibilities in a professional manner in line with our Code of Conduct, employees must obtain the Nominated Supervisor's approval before caring for other people's children outside the Service.

In another centre the policy stated:

Regarding babysitting; staff can babysit using discretion, though not endorsed by service. Staff cannot take children home from centre if they are babysitting.

None of the centres where there was known offending had CCTV. After his arrest, the offender reported he did not offend in centres with CCTV. In some of the centres where there was no known offending, records indicate the offender was supervised by other staff for the entire duration of the shift he worked. It was also noted by one centre, where there was no known offending, that it 'has high structural visibility which perhaps provided an inherent deterrent'. Centre GT also shared that they do not allow educators to be alone with children, even when ratios permit this. Further, they do not allow cubby houses or forts in the service, preventing line of sight issues which were identified in some of the centres where offending occurred.

Inadequate recruitment and screening policies and practices

Recruitment and screening policies and practices for child related institutions must be founded in a fundamental reality that some people who apply to work with children may be doing so to harm them. A failure to screen employees and implement robust recruitment processes that prioritise the safety of children can enable opportunities for abuse to occur.

While some centres had robust recruitment processes, these were not always followed, partly due to misleading information provided by the offender. Across multiple centres, the offender did not provide a full account of his employment history. He omitted several centres where he had previously worked and where his employment had either ended, he had been terminated, or he had been let go prior to the end of his probation period.

The offender rarely listed references from his most recent place of employment. At times he provided references from centres he worked in years earlier. There are no records outlining any attempts by centres to receive more up to date references, including from the offender's current or most recent direct supervisor.

On at least one occasion, the offender used a parent as a referee.

The offender's resume included photographs of himself with children from previous centres. This constitutes a significant breach of privacy and indicates that he retained and used centre photos for personal purposes after leaving a centre he had worked in. This did not appear to trouble any of the centres that subsequently offered him a role.

Centre screening and recruitment practices at some centres were also impacted by an overreliance on the employment agency to complete these. Between 2019 and 2022, the offender secured employment through an employment agency, which had responsibility for placing him in centres as a relief staff member. Centres appear to have assumed the employment agency had completed adequate reference checks, inductions and training with relief educators and therefore did not undertake their own. Staff in one centre noted that reference checks normally included asking if the staff have had any disciplinary incidents, but these are not undertaken for agency staff as 'the agency does that'. Considering the casual and ad-hoc nature of these work arrangements, where the offender filled shifts on one or two occasions, it is reasonable for the centre to expect the employment agency to complete all pre-employment checks and training for short-term vacancies. This forms part of the contractual agreement, however centres must ask if this appropriately safeguards children.

While records were requested from the employment agency to inform this Review, it refused to comply on the basis of pending legal proceedings. Some records are available about the recruitment and screening processes employed by this entity. For example, Centre EA contracted the employment agency to fulfill the 'Centre Manager – ECT Bachelor Qualified' position. The assignment specifications outlined the recruitment strategy which included search of the national employment agency's database of registered staff for shortlisting:

Shortlisted candidates will be fully briefed on the details provided in the assignment specification and referred for interview after thorough reference checks have been undertaken.

The placement fee for the assignment was \$8000.

Hierarchies that enable abuse and inhibit identification and response, and roles that enable opportunities for abuse

Adults have inherent power over children, because of their size, capacity, positioning, experience, knowledge and access to resources.

“

When perpetrators work in positions of trust and hold positions of authority the risk of abuse occurring, and remaining undetected, is amplified.

”

People who hold organisational roles are perceived as inherently trustworthy. We expect them to be qualified, to have passed recruitment checks, and background screening, including Working with Children Checks. It is a stark reality that these roles increase opportunities for unsupervised contact with children and provide perpetrators with control over a child's environment and daily routines. Victim-survivors may also be reluctant to disclose abuse by those in positions of power as they fear retribution or that they will not be believed.

Formal power imbalances are also created when there are hierarchical structures and junior or less qualified staff. For example, the offender's level of education, comparative to other staff working in the ECEC sector, positioned him as the 'ideal' employee. This made it difficult for staff to speak up and be heard.

There was also some contradictory advice in organisational policies about reporting responsibilities. For example one centre's Child Protection Policy contained an initial statement outlining that any person who believes a child to be in need of protection, may report concerns to child protection, followed by statements in the same policy, that all staff were responsible for "immediately document[ing] allegations" and to "ensure allegations are reported to the Nominated Supervisor/Director". The Nominated Supervisor/Director is then required "to investigate promptly, impartially and confidentially" and "to determine which concerns/issues will be managed internally, this may involve consultation with the Department of Child Safety", as well as contacting the "Department of Child Safety and/or Office of Early Childhood Education and Care", despite there being no such discretion in the applicable legislation.

In another centre the offender was the Director. This meant he was able to make changes to the environment and policies, control hiring and rostering of staff, and control enrolments of children. Staff members were often the sole educator with children, especially during rest times, often as instructed by the offender. This allowed opportunities for undetected abuse.

One centre had a policy that encouraged staff to send children to the Director's office for 'special time'.

Ineffective and insufficient child protection policies and practices

A lack of clearly defined appropriate child safety policies and procedures can increase opportunities for perpetrators to sexually abuse children in institutional contexts. It can enable abuse to go undetected and unreported, and result in complaints processes that fail to prioritise the safety and wellbeing of children and, in some cases, act to protect people who present a risk to children.

Child protection and child safeguarding policies should convey an institution's focus on the wellbeing of children. It should set expectations, establish acceptable practices, delineate professional boundaries, and make clear how inappropriate behaviour that places children at risk should be dealt with.

Services are required to have a policy and procedure regarding providing a child safe environment, which must include matters relating to the promotion of a culture of child safety and wellbeing within the service.³⁷ However, the content of this policy or procedure is not specified in the NQF, leaving it open for centres to omit critical measures to address child safeguarding.'

In the absence of legislative guidelines regarding what this policy and procedure must include, ACECQA has published policy guidelines.³⁸ While these guidelines make limited reference to child safeguarding, readers are directed to ACECQA's *NQF Child Safe Culture Guide* which expands on these issues. This was released in response to the 2023 Review of Child Safety Arrangements under the National Quality Framework.³⁹

The adequacy of prescribed policies and procedures in centres is considered by ECRA as part of the initial licensing process for a service. The ongoing adequacy and implementation of policies and procedures is not generally considered as part of proactive monitoring by ECRA, unless it considers there to be a cause to do so or as part of assessment and rating.

Across the centres the Board reviewed, policies and procedures varied considerably and were not consistently communicated to families. While some parents received documentation outlining centre policies and procedures, including clear reporting processes, this was not always the case.

The quality and clarity of the policies and procedures varied significantly. Some centres demonstrated strong policy framework examples. For instance, one centre had policies requiring concerns to be reported to the department responsible for child safety and QPS within 24 hours of a disclosure or suspicion of harm, displayed posters about child protection issues, and had a *Child Risk Management Strategy* that included teaching children protective behaviours. While issues were identified with the implementation of these policies, other centres were found to have inadequate or inaccurate policies from the outset, with one referencing non-existent legislation.

There were also instances of non-compliance with organisational policies identified. A staff member at one centre reported just 'following others' rather than the organisational policies and stated that policies were not read or used. The Nominated Supervisor of another centre reported during ERCA interviews that the policies were 'too long and convoluted' in their centre, hence they took it upon themselves to shorten these for new staff. Importantly, even minor deviations from established policies and procedures, if not promptly addressed, can normalise disregarding their purpose and significance.⁴⁰

Most centres had policies and procedures that referred to staff receiving child protection training, however there was no reference to child safeguarding. The training appears to have centred on child protection and the mandatory reporting requirements as per the *Child Protection Act 1999* (Child Protection Act). This type of training focuses on concerns regarding parents and does not include what to do when concerns are raised regarding staff members.

In some centres external child protection training was offered once a year, meaning that staff employed after this date did not undertake training until the following annual session. While all centres' policies and procedures referred to mandatory reporting as per the Child Protection Act, only three referred to the need to report grooming.

There was an apparent lack of awareness, understanding and guidance about indicators of grooming and how to respond to it, as well as appropriate and inappropriate interactions with children, including physical touch. Of those centres that mentioned grooming, none of them had a definition of what grooming is, what it entails or how to respond.

Some centres engaged external training providers to deliver content specifically focused on grooming behaviours; however, this training was not mandatory and appears to have been completed infrequently by staff.

One centre's policy normalised behaviour which is indicative of grooming (favouritism). In the *Interactions with Children Policy*, it stated that:

“*We recognise that each child will form special attachments with individual staff, and these are to be cherished and respected.*”

As part of the Review, the centre maintained that its policy should be 'referred to in full context, which includes reference to the Circle of Security and other attachments which are recognised as appropriate and well researched and used in engagement with children.'

While some staff recognised the offender's behaviour of favouring children as inappropriate and he was breached for this behaviour in one centre; there appears to have been no recognition of this conduct as grooming. This is particularly illustrated in Centre EA where he was Director. Although their policies and procedures clearly referenced grooming, the investigation conducted into a report about him kissing a child in this centre, recognised that he was favouring certain children, that he isolated children, and that he had physical contact with children. None of these behaviours appear to have been placed in context or conceptualised as grooming.

Further, this apparent lack of awareness and understanding also applied to centre policies and procedures, in relation to the 'failure to report' and 'failure to protect' offences under the *Criminal Code Act 1899* (Qld). These were introduced in Queensland from July 2021 to strengthen responses to child sexual abuse. Only two out of the seven centres where the policies were reviewed, included reference to the 'failure to report' and 'failure to protect' offences.

The offender was also involved in updating policies in Centre EA and EK which provided him with an opportunity to create gaps that enabled greater access to children and normalised some of his conduct. For example, in both centres he introduced video documentation. This meant that educators would document children's activities and learning through videos, which in turn normalised the use of technology to record children. It is important to note that the use of videos to record children's learning and daily activities was common practice in long-day care at this time. While he used his personal camera in several centres, only one centre raised concerns about him taking photos and videos of children. In response, they sought to address the behaviour by providing a centre SD card, which they later found out he was not using as it 'did not fit in his camera'.

Significantly, at the time of offending there was no legislative requirement for centres to prevent the use of personal devices or have a procedure for conducting investigations.

Normalisation of harmful practices and lack of a trusted adult

There is a higher risk of child sexual abuse occurring in institutions where children lack access to a trusted adult. This increased risk is linked to the absence of a capable guardian, and a child's heightened sense of isolation. Additionally, in such environments, inappropriate behaviour may become normalised, reducing the likelihood that concerning actions are identified or reported.⁴¹

Normalisation of harmful practices by staff and centres was particularly evident through physical touch shown to children by the offender. This occurred due to:

- accepting alignment of behaviour with pedagogical theories such as 'professional love'
- hosting video nights showing parents video montages of the children created by the offender
- not questioning behaviour by the offender that they would not personally be comfortable with, such as the offender laying down with children, 'spooning' children, taking selfies with children, children sitting on his lap, having favourite children, and tickling children
- not providing adequate consequences for breaches of policies and unprofessional/ inappropriate behaviour
- staff reporting that they did not believe the allegations about the offender as he 'wouldn't do that'.

The offender wrote a letter responding to allegations against him in Centre EA. The letter denied favouritism towards any particular children and further outlined:

In terms of my behaviour and interactions, I do not believe they are overly affectionate at all. It is perfectly normal for a child to be hugged, tickled or to sit on the lap of an educator in a care setting. This is certainly borne out in the feedback that we have received from families over and over again that this is what they love about [Centre EA], that the staff have such warm and loving relationship with children. This is also reflected in attachment theory and relationship-based pedagogy which inform all aspects of our education and care.

The offender clearly normalised close and frequent physical contact with children including, hugging, tickling and having children sit on lap, and these practices by the offender were confirmed by other staff. Although staff interviewed as part of this investigation advised that the offender engaged in behaviours they would not normally do, they still did not report this to the centre management.

Lack of education for children about health, respectful relationships and appropriate sexual development and lack of understanding/awareness of child sexual abuse

Institutions that do not provide children with age and developmentally appropriate education on sex, sexuality, self-protection and help seeking education, skills and abilities, may inadvertently increase the vulnerability of the children in their care. A lack of such education can heighten the risk of children being targeted, as they are less likely to recognise inappropriate behaviour or have the language and confidence to raise worries or disclose abuse.⁴²

In some cases, child victim-survivors had received information about protective behaviours from their parents. Although four centres referenced the inclusion of protective behaviours education in their curriculum through their policies and procedures, only one centre was able to clearly articulate the content and delivery method of this education. This centre delivered education to children through 'story books and programming'. Their child protection policy stated:

Educators will regularly include child protection issues in the curriculum. For example, they will intentionally teach children:

- *about acceptable/unacceptable behaviour, and appropriate/inappropriate contact in a manner suitable to their age and level of understanding*
- *that they have the right to feel safe at all times*
- *to say 'no' to anything that makes them feel unsafe*
- *the difference between 'fun' scared that is appropriate risk taking and dangerous scared that is not ok*
- *to use their own skills to feel safe*
- *to recognise signs that they do not feel safe and need to be alert and think clearly*
- *that there is no secret too awful, no story too terrible, that they can't share with someone they trust*
- *that educators are available for them if they have any concerns*
- *to tell educators of any suspicious activities or people*
- *to recognise and express their feelings verbally and non-verbally*
- *that they can choose to change the way they are feeling.*

The offender deliberately targeted children who lacked the language and cognitive development to articulate or report the abuse. This highlights both the critical importance of providing young children with age-appropriate education on body safety, and recognising inappropriate behaviour, to better equip them to understand and communicate when they have concerns.

“

While this type of training can help support children, it is never their responsibility to protect themselves.

”

There was an absence of capable guardianship across multiple centres in this case because staff lacked an understanding and awareness of child sexual abuse, and the risk of this occurring in the ECEC setting.

In conducting this Review, the Board has struggled with a compelling reality: perpetrators are known to target children under the age of five, because they cannot speak up and are less likely to be believed when they do. Conversely, there has been a lack of structured training that specifically targets the risk of child sexual abuse in organisations that work with children in this age group. The training that does exist is mainly focused on ensuring staff are fulfilling their mandatory reporting obligations under the Child Protection Act which predominantly focuses on children who have been, or at risk of being harmed, by a parent or caregiver in the family home. While critically important, this training does not tell staff and managers what they must know.

“

People that abuse children are in our workplaces. They are wolves in sheep's clothing, and we must be alert to the fact that they are, in some instance, our colleagues.

”

Obvious indicators of grooming were missed. The offender was able to manipulate situations, environments and others to enable abuse to occur and he was able to do this in part, because of a lack of awareness of indicators of child sexual abuse among staff.

When we do not train our workforces to prevent, detect and respond to child sexual abuse, we create institutional blind spots that perpetrators exploit.

Failure to understand prevention of child sexual abuse as a shared responsibility and prioritisation of reputation, secrecy and isolation

We all have a role to play in preventing child sexual abuse. We can do this by:

- being alert to the signs that child sexual abuse may be occurring
- questioning colleagues about their conduct
- completing relevant training
- adhering to policies, procedures and practices
- raising concerns and feelings of disquiet
- being persistent when concerns are not listened to
- responding quickly and robustly to complaints when they are made.

Prioritisation of reputation, secrecy and isolation by institutions over the safety and wellbeing of children, elevates the risk of child sexual abuse occurring. It promotes an organisational culture where concerns, complaints and breaches of conduct are managed internally, with limited transparency, oversight, or involvement from external authorities or independent bodies.

Information gathered throughout the review process indicates that complaints by parents were minimised or dismissed. One matter that was reported to a centre was dismissed with the rationale provided to the family that the offender no longer worked at the centre.

Some centres did not report complaints or concerns to ECRA, and either dismissed them or dealt with them independently, despite a requirement to report being in place at the time.

In one matter that was reported to ECRA and the Queensland Police Service (QPS), an internal investigation was conducted prior to the police interviews having been conducted with the offender and staff, and information gathered during the investigation was not provided to QPS or ECRA. ECRA was provided with the outcome of the investigation, including information that showed a persistent course of problematic behaviour in this institution. This included that the offender showed favouritism to children, was overly affectionate, and tickled, touched and laid down with children during rest periods. However, it does not appear that ECRA was provided with the full assessment which contained vital information about the offender's behaviour through interviews with his colleagues.

Five centres ended the offender's employment early, as a result of his problematic behaviours, poor performance, or for undocumented reasons. Across multiple centres the records that were kept did not reflect the:

- reasons for the offender's termination
- performance concerns pertaining to the offender
- concerns raised by parents about the offender.

This meant that there is minimal information available as to the conduct displayed by the offender which was of such significant concern that it resulted in his immediate dismissal from three centres during his probation period. A lack of clear documentation creates an environment of ambiguity about who knew what and when, and what more could or should have been done in response to the issues identified.

The Royal Commission laid bare a litany of failings in relation to poor institutional recordkeeping and information sharing practices, and ultimately found instances where absent or inaccurate records may have:

- hindered the identification and prevention of child sexual abuse
- delayed or obstructed the identification and removal of perpetrators
- misconstrued or misrepresented grooming and other abusive behaviours
- minimised or obscured the extent of institutional knowledge of child sexual abuse.⁴³

Assessment of Safeguarding arrangements in seven centres



All 7 centres had inadequate recruitment and employee screening practices

In **all 7 centres** the offender had unsupervised access to children

6 out of 7 centres had ineffective and insufficient child protection policies and practices

5 out of 7 centres failed to provide any education to children about self-protective behaviours and help seeking

Chapter 10

The human cost

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The human cost

The voices of those most affected must be at the heart of any meaningful review.

For every parent, the decision to send a child to childcare is one marked by both pride and unease. It is a moment of transition where children, often for the first time, step outside the immediate circle of their family and into a broader world shaped by teachers, carers and peers. Entrusting a child to the care of others is not a small act; it requires confidence that the environment will be safe, nurturing and protective. Alongside this trust is an undercurrent of trepidation—an awareness that children are vulnerable and that parents cannot always be present to shield them from harm.

At the heart of this experience is the dual expectation: children are asked to adapt to the rules of a new environment, while parents encourage them to follow the guidance of adults they do not yet know. From the outset, teachers and carers are framed as figures of authority. Parents instruct their children with phrases like ‘Do what you are told’ or ‘You can trust Miss C.’ They reassure them that if something feels wrong, ‘Mr C’ will listen and protect them. In doing so, parents both legitimise the authority of educators and model respect for that authority, believing it to be aligned with their child’s best interests.

It is against this backdrop of trust and authority that the most profound breach occurs when an individual in a position of responsibility deliberately seeks to exploit children. The betrayal is not confined to the act of abuse itself; it strikes at the very foundation of the parent–child–carer relationship.

The authority given in good faith is corrupted, the trust placed by parents and children alike is manipulated, and the protective space of the school is inverted into a site of harm. Such acts represent not only a crime against a child, but a fundamental violation of the implicit social contract that underpins education and care.

Throughout the Review the Board has prioritised listening to the lived experiences of children and families directly impacted by the offender’s conduct. Their experiences and perspectives have been instrumental in shaping the findings and recommendations of this report. Families and children impacted by the abuse were heard through targeted communication and open call for submissions, which continued up until the finalisation of the report. This chapter honours their perspectives and lays bare the systemic failures that meant their concerns were not heard, believed or responded to.

The offender’s interactions with children and parents

In the material available to the board, it is clear that parents’ accounts of their children’s interactions with the offender differed significantly across centres and contexts. Some parents initially described their child’s interactions with the offender as positive, however others were concerned or complained about how he made them uneasy, and how his treatment of children was not correct.

One parent reported that their child disclosed the offender had threatened them, stating they would not be allowed to return to day care if they disclosed the abuse being perpetrated against them. Another parent recalled overhearing the offender threaten a child, shouting words to the effect of, ‘bring your bag here or I will smack your bottom’. A different parent observed a noticeable shift in the atmosphere at the centre after the offender commenced employment, stating, ‘the kids would look miserable’. This parent also reflected on a significant behavioural change in their child, who began throwing tantrums and expressing fear toward the offender. The parent observed similar behaviour in at least one other child. On one occasion, they witnessed their child scream as the offender approached them. He reportedly responded, ‘I didn’t even touch them’. Additional concerns included the child returning home without underwear on one occasion and with redness of their genital area on another. This same parent described an incident during pick-up, where the offender was present at the centre with another male childcare worker and only one other child. The parent stated that they ‘did not feel safe in this situation’.

Concerns were also raised regarding the offender’s use of photography. One parent noted that prior to the offender’s employment, the centre did not display photos or videos of children. Upon his arrival, the offender began streaming photographs of children he had taken, displayed on a TV in the foyer. The parent now viewed this as an attempt to ‘normalise’ such behaviour. It was also noted that photographs of their child were taken without parental consent.

During the COVID-19 pandemic, when children of essential workers continued attending childcare, one parent reported the offender encouraged them to send their children to day care on additional days, emphasising that it was free and that educators were 'bored'. He was subsequently convicted for perpetrating abuse against this child during this time.

Parents reflected on being reassured and 'blinded' by the offender's qualifications and his promotion of dynamic programs such as 'bush kindy'. In one service where the offender worked as Director, he assured parents that children were excelling developmentally and were performing cognitively above expectations for their age and stage of development, however, upon school enrolment and subsequent assessment some of these children were found to be functioning below average, with significant developmental delays.

What parents said about the offender

“That carer seemed like a really odd choice, he didn't match anyone else it was really unusual.”

“Something about him made her feel uneasy.”

“His interactions with the father of a child was 'really weird' and he appeared 'awkward' with father. He didn't make eye contact and spoke under his breath.”

“Image of music man with an Akubra. Always had a guitar and was singing and dancing and everyone was excited.”

“Child was 'fearful' of offender by the time they left the centre [child] would physically throw themselves.”

Dealing with the service and Approved Providers

When selecting an early childhood education and care (ECEC) service, parents reported considering a combination of practical and quality factors. These included the service's location, its size, the qualifications and experience of educators, and recommendations from friends or other parents.

The availability of places also played a critical role in decision making, with some parents expressing excitement and relief at being able to secure a spot for their child. These initial considerations shaped parents' expectations and trust in the services they ultimately chose.

In most services, parents reported minimal to no day-to-day interaction with the Approved Provider prior to and during the period of offending. Communication remained absent even after the offences were identified and investigated. While in some instances this lack of engagement could be attributed to instructions from law enforcement agencies to maintain confidentiality until all families had been contacted, parents reported that Approved Providers remained silent following the offender's arrest and conviction.

Information available to the Review indicates that while some centres had policies and procedures in place regarding complaints management and child protection, including requirements to inform parents of these processes, this was not consistently implemented. As a result, parents reported being unaware of available complaint pathways. One parent reflected that it would have been helpful to have their rights clearly explained, particularly in relation to how and to whom they could make a complaint.

In a concerning incident, a parent who attempted to raise behavioural concerns about the offender was met with hostility. The provider reportedly responded in an aggressive tone, saying: 'What? Have you got something to share?'.

Complaints made by parents regarding the offender's behaviour during his employment do not always appear to have been investigated by Approved Providers, nor were they escalated to the Early Childhood Regulatory Authority (ECRA) as required under the Education and Care Services National Law (National Law).

One parent reported making multiple attempts to speak with the Approved Provider, only to be dismissed and belittled for expressing concern about the offender's conduct. Other parents expressed fears that lodging a complaint might have resulted in their child being targeted or treated unfairly by centre management.

Parents also identified ECEC management structures as a barrier to both internal complaint handling and the external notification of concerns to regulatory authorities. One parent, who had attempted to raise a complaint, reflected on the broader structural issue, stating:

Childcare centres should be managed by someone who does not have a financial stake in the business. Investigations can make their centre look bad, and therefore impact their ability to make money, so they don't even report them [complaints]. Pushing things under the rug makes them look good and reduces their paperwork but creates the perfect environment for perpetrators to move around undetected.

One parent described a lack of adequate recordkeeping, no continuity of workers, and Directors that would regularly change at the centre. They described that a group of children would be taken on walks in the gardens and when the parent asked, there would be no record of who was with their child during this time period. Under the National Law services are required to keep records if their child leaves the centre premises.

In circumstances where no charges were laid, it appeared as though centres accepted this as a lack of guilt rather than what it actually was—a lack of evidence to reach the required burden of proof (beyond a reasonable doubt). For example, a complaint related to a staff member who had observed the offender kissing a child on the mouth while under a fort during sleep time. This matter was reported to QPS, but no charges were laid. The internal investigation conducted in response to concerns about physical contact was not substantiated. The outcome of the internal investigation stated:

In consideration [sic] the evidence gathered in the above report, the allegation that [the offender] moved his mouth along the child's mouth, on a balance of probabilities, is found to be not substantiated.

Therefore, on a balance of probabilities, the allegation that [the offender]'s alleged interactions with a child... constitutes physical or sexual abuse is not substantiated.

As part of the outcome, the offender was instructed that existing sleeping arrangements should be discontinued. However, according to parents, the findings and outcome of the investigation were not communicated to them. In their submission to the Board, the centre stated that outcomes cannot be shared with parents due to requirements of the *Fair Work Act 2009*. Following the offender's return to the centre, the parent of the child involved reported that no changes were made to the sleeping practices. The offender allegedly continued to isolate select children for sleep in or under an outdoor fort, as part of the 'bush kindy' program. The parent expressed that the combination of the offender being reinstated at the centre, the lack of transparency regarding the investigation outcome, and their trust that the matter had been thoroughly addressed, along with limited awareness of formal complaint pathways, led them to refrain from raising further concerns about the sleeping arrangements. At least one service advised the Board that the *Fair Work Act* prevents parents from being advised of the investigation or its conduct or outcomes.

Parents reported being unaware of their children's sleeping arrangements and only became aware of the actual practices following the offender's arrest. One parent stated they had specifically chosen the service due to its open plan layout, which they believed would support thorough and consistent supervision. This parent's child had been placed to sleep on or under an outdoor fort that was reportedly constructed during the offender's employment as Director in the centre. The offender also added sheets to the structure, further obstructing visibility. Given the design of the fort, effective supervision was already challenging, and the modifications made by the offender significantly reduced the ability of staff to observe the children placed there. The parent indicated that if they had known about the true nature of the sleeping arrangements, they would not have sent their child to the service.

Some parents indicated the services demonstrated questionable safeguarding practices. In one service with a religious affiliation, a male pastor was known to 'hang out' at the service. In response to the Board's concerns about this, the centre shared that 'the pastor had a blue card and had been through the same vetting process as educators.' According to the material available to the Review, ECRA found that this Approved Provider failed to comply with ratio standards on at least one occasion, when the offender was left alone with at least 14 children.

At one centre, parents appear to have been provided with misleading information during a period when the offender was under investigation following a report of child sexual abuse. While the offender was suspended from duties as the QPS conducted inquiries, a parent reported that they were informed that all children had been safe in the offender's care and that his absence was unrelated to any concerns involving children. Despite these assurances, the offender was later found to have offended against 11 children at the centre, including the child who was the subject of the initial complaint.

“

Any reassurance given to parents during the conduct of an investigation of a sexual nature must be based in reality.

”

Pre-employment screening processes were also reported to be inadequate. Providers were seen to place too much emphasis on qualification levels and there was a lack of candour in the provision of reference checks. Parents were shocked to hear during the offender's sentencing that he had been terminated for 'not seeing eye to eye' with management but was then provided with glowing references.

A parent noted that the lack of publicity regarding the offences and the services in which they occurred means parents are not making informed decisions regarding where to send their children, stating that:

parents are unwittingly sending their kids in there to sleep on the same cots seven little girls were abused and raped on, where the same owner is not reporting serious incidents and treating concerned parents like annoyances.

Further, parents indicated frustration with the motivations behind limiting disclosure of information regarding the services in which the offences occurred. One parent felt that:

the suppression of this information is often touted as for the privacy of the victims, but I think it comes down to protecting business and money over all else. No one knows that abuse happened at (Centre), and I can't go around telling anyone without outing my own child as a victim, so it goes silent.

NQF and the role of the regulator

Questions were raised about the NQF quality rating system, which is administered by ECRA, and whether it was a representation of the true compliance, quality and security of the service. One parent made the point that the service where their daughter was a victim-survivor:

still boasts an 'Exceeding' rating in all categories and impossibly long waiting list, yet they let at least seven⁴⁴ girls be molested in their care over 15 days. That is not exceeding anything, it's not even achieving a basic human right of protection. Disclosure of this information would definitely be classed as important information by all families intending to enrol at the centre.

With respect to the powers of ECRA, one parent raised objections regarding the two-year limitation period for the commencement of prosecutions in the National Law stating that:

the statute of limitations for prosecuting childcare staff for breaches/negligence should be extended or abolished. We were not informed of the abuse of our daughter until five years after the incident, with the statute of limitations of two years having already lapsed.

Child-to-educator ratios were also raised as an area of concern, particularly during rest periods as it provides unique opportunities to target children requiring nappy changes (even for older children) for sleep wetting, limits adult witnesses and involves groggy or unconscious victims.

Dealing with the police

Prior to the offender's arrest as part of Operation Tenterfield, there were at least three reports made to the QPS involving the offender perpetrating sexual abuse against children. The complaints were made directly by parents, centre staff and ECRA. These parents reported their experiences with the police were negative. One parent reported that their complaints to the QPS were dismissed or minimised with comments like it 'just sounds like a rough nappy change'. In another case where parents indicated to QPS they had read their daughter a developmentally appropriate protective behaviours book, the parents reported that the QPS officers reportedly responded with words to the effect of [you have] 'probably given her these ideas by reading the book too much' (referring to the child's disclosures), before closing the matter. These parents' claims were unable to be confirmed or refuted from police records.

Information available to the Board highlighted significant delays between the initial reporting of child sexual abuse to QPS and subsequent interviews. In one instance, it took QPS over five weeks to conduct interviews following a report made by centre staff. Despite the seriousness of the allegation (the offender kissing a child), officers did not speak with the child involved or her parents. The family reported receiving little to no information about the progress or outcome of the investigation, aside from being informed that the matter had been closed.

Another parent reported later being told by an officer that had reviewed the initial report, that the police investigating the matter at the time had not built sufficient rapport with their child and had not followed processes. While this parent has had recent contact with police about their earlier complaint, they reported that they just kept getting told there is 'nothing to see here, our processes are better now'.

While some parents were grateful for the communication they received through a special AFP portal during the course of the offender's prosecution, some reported they had received inaccurate information from individual officers. One parent reported that they were advised by the AFP that their child was asleep for 99% of the time when the offending occurred, however, it is apparent from the sentencing remarks that their daughter was awake for at least three videos, one almost 30 minutes in duration.

One parent indicated that when they were contacted by the AFP as part of Operation Tenterfield in August 2022, they thought it was a follow-up to their daughter's earlier complaint from December 2021. The parent reported that it became apparent to them that AFP were not aware of the earlier complaint made to QPS when AFP sought further information from the parents and advised that they were unaware of any previous complaints. The parent reported that they had formed a view that AFP had difficulties obtaining information from QPS. This parent was of the view that the experience highlighted numerous systemic issues to them including:

- issues with how information is recorded in agency systems as their complaint 'wasn't recorded traditionally' and was recorded as 'intelligence' not a 'formal complaint'
- information sharing between systems and the QPS and the AFP, given AFP were unaware of the complaint from December 2021
- the management of allegations that do not reach the threshold for prosecution and how this is recorded
- the view of the QPS that if there was not enough information to arrest an alleged offender, nothing else would be done with the information, and that
- this represents 'cultural, process and system issues [officer's think] if I can't arrest someone, I won't bother doing anything with the information'.

Parents who made submissions to the Review reported poor communication and a lack of information sharing between police with victim-survivors and their families. They described still having very little information regarding the offences committed against their children and the scope of the investigation. They reported only knowing what they heard through the court proceedings.

One parent expressed in strong terms their frustration with the prosecution of child sexual abuse and the 'heavy reliance on the impacted individual to provide the burden of proof'. This parent had made a direct complaint to QPS when their daughter reported someone touching her at sleep time. Officers conducted a short interview with their daughter separately and indicated that they identified 'nothing untoward'. Through Operation Tenterfield it was revealed that some of the offences against their daughter occurred during sleep time. This parent questioned how prosecutions would ever succeed with victim-survivors of this age and verbal ability.

Another parent who had made an early complaint to QPS expressed feeling an 'overwhelming sense of guilt', as if they had not tried hard enough to make the police listen, and that police had made the parent feel like they were 'crazy'. This parent feels 'very fearful' that images of their child will be identified. Since making the initial complaint, they had lived in constant fear that they would be contacted about the offender's conduct, and they used to check court listings regularly to see if his name was listed. This parent expressed that part of them hoped he would be caught, and that they would see his name while also hoping and wishing they could believe that it wasn't true at all. They also said they feel overwhelmed by the volume of abuse and the number of children affected and have nightmares about it.

This parent described that they cannot 'explain the lack of trust in police, the system and society as a result' of the offending, and that 'we are not protected... we are just left picking up the pieces'.

A different parent spoke to the unfairness of the offender being able to plead guilty to a lesser number of offences. The current appeal also means that the criminal justice system process in Queensland is ongoing, and families continue to wait for closure.

Other systems

Some parents indicated that prior to the offending coming to light, they had placed a lot of 'faith and trust in the blue card system' but now have a lack of confidence in its role.

One parent was of the view that all systems and organisations that work with children should have mandatory reporting requirements which link to police mandatory data collection points, for the purpose of monitoring and suspending blue cards where appropriate.

They commented that there should be:

mandatory reporting – all systems and organisations that look after children should link to police [leading to] mandatory data collection. Multi-department collection and police should get all information about who was present at the time of the offence. Names of people [present at the time, to] cross reference the data.

This parent further outlined that 'suspension of blue card' should occur in any investigation and that all complaints should not just be recorded against the person but the centre. They were of the view that this would allow 'collection of data points' enabling detection of 'serial and repeat offenders'.

Another parent commented that reporting requirements are protective of perpetrators, and that if there are multiple complaints about a person, Blue Card Services should have something in place to be able to pick this up. They were in disbelief that the offender's 'name didn't ping' following complaints in 2021 and 2022. They were of the view that all such information should be recorded on the blue card system, which should be Australia-wide and that all 'systems need to talk'. This parent further expressed their belief that 'two reports [about a person] should allow police to execute a warrant on their property and their devices if they are working with children'.

Lack of overall therapeutic support to victim-survivors and their families was raised as an area of concern by parents. While AFP sought to facilitate opportunities for all children and their families to access counselling, some families reported it as unhelpful and felt that the response by counsellors to their experiences and trauma was invalidating.

Furthermore, parents raised concerns about a lack of support services to families and children including where a matter had not gone through court. One parent described having to do their own study about child trauma so they could help their child after the suspected offending had occurred. While the child no longer talks about the abuse, they still experience ongoing impacts as a young adult.

Chapter

Missed opportunities to detect and disrupt

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Missed opportunities to detect and disrupt

In establishing a timeline of conduct, the Board was required to consider what laws, policies and practices could or should have enabled earlier identification, investigation and prosecution of the offender. In our analysis of the case study, we searched for all instances of **missed opportunities**—defined as points where action could have been taken to identify or stop the offender but was not. Within each missed opportunity, we then identified what we termed the **outcome-defining event**. This refers to the specific missing step, link, or action that represented the critical juncture that enabled the offender to remain undetected. In our view, if that outcome-defining event had been addressed, the trajectory of the case could have been altered, whether by enabling earlier intervention, ensuring a child's safety or preventing further offending.

This approach is intended to provide points for analysis, not blame. They have been identified retrospectively, with the benefit of time. By mapping all missed opportunities, we are able to illustrate the systemic nature of the failings and the multiple points at which protective action may have made a difference. By then drilling down to the outcome-defining event within each missed opportunity, we are able to pinpoint the most consequential events—the juncture where a different decision, process, or response would likely have changed the outcome. Taken together, this framework allows us to move beyond generalised observations about failure and instead highlight the practical and concrete steps that could have disrupted the offender's actions.

To achieve this, the Board sought to identify what complaints or concerns were made about the offender. It has also considered what was known, and when, by the different systems required to respond. In doing so, the Board is mindful of the impact of hindsight bias, and the lens through which certain events may be viewed when the outcome is known. The Board is also conscious that this is neither a legal or scientific calculation, rather it is our view, based on the research we have conducted, on where an alternative course may have made a difference.

Over the 20 years of offending there has also been significant legislative and policy change to the early childhood education and care (ECEC), blue card and police systems. Consistent with the Board's terms of reference, consideration has been given to the applicable legislative framework, policies and practices which operated during the time of the offending.

While each complaint or concern that has been identified as part of this Review is set out below, there are a number of consistent themes across the centres that the offender worked in, and in the responses by the Queensland Police Service (QPS) and Early Childhood Regulatory Authority (ECRA) to the complaints.

This includes **child, parent and staff concerns being dismissed or minimised**. On a number of occasions centres did not take any further action in response to parent concerns, including in meeting the requirements to make a notification to ECRA. While some centres have submitted that they have no independent records or recollection of this report being made, the Board has determined on the balance of the information before it, that it is likely that the concerns were raised as described by those parents who have made submissions.

Missed opportunities

Complaints were received about the offender's conduct by centre management on at least **six** occasions.

6

Concerns about the offender's conduct were raised with him by management in **six** centres.

6

The offender failed to pass probation or was terminated from **five** centres.

5

Reports to police were made about the offender's conduct on **three** occasions.

3

Reports to ECRA were made about the offender's conduct on **three** occasions.

3

Centres conducted an internal investigation about the offender's conduct on **one** occasion.

1

A lack of understanding of, and response to, grooming and other problematic behaviour displayed by the offender such as persistent performance concerns being noted. This extends to evidence of immediate dismissals at some centres including during probation periods, and a lack of associated records as to the reasons why the offender was let go.

Poor or inadequate supervisory practices, which meant that the offender was alone with children with no or minimal supervision. This was not brief intervals of lapsed supervision – in total he created 383 images and over 85 hours of video, with individual videos ranging from 8 seconds to 30 minutes. On some occasions he created child exploitation material (CEM) while other staff or children were in the background or could be heard talking.

Incomplete or inconsistent recordkeeping practices, which impacted the system's capacity to identify, and respond to, patterns over time and across centres. Critical information about the offender's conduct in centres was also not shared with relevant entities, and there was **no centralised mechanism requiring or facilitating the sharing of information** or accessible to inform future system responses. This includes in individual agency databases, with prior complaints involving the offender not being properly linked on QPS systems. The National Quality Agenda IT system shared by ECRA and other ECEC regulatory authorities also did not have the capacity at the time to link complaints by the named person of concern.

Investigations on some occasions were inadequate and relied on actions taken by other entities, which meant the available information used to inform decision-making processes was limited, incomplete and susceptible to bias. This resulted in complaints being unsubstantiated or assessed as not meeting the threshold for further investigation. This was compounded by the high evidentiary threshold—beyond reasonable doubt—that must be met when pursuing criminal charges. Agencies also faced challenges in investigating reports that had been made to them, particularly as the offender targeted children aged under five years, who were non-verbal or developmentally unable to articulate their experiences of abuse.

The Board considers that there were five missed opportunities and 13 outcome-defining events across the 20 years of offending.

2009: The 'mean man'

The first known formal complaint involving the offender occurred while he was working at Centre BY. A parent reported to QPS and the Office for Early Childhood Education and Care (the predecessor of ECRA) in October 2009 that their young child, aged between two and three at the time of the incident, had disclosed that the 'mean man' named 'Ashley' that worked at Centre BY would hurt them during nappy changes.

The parent reported that their child had disclosed that 'Ashley' changed their nappy when he didn't need to. Of these nappy changes the child recalled that 'it only happened sometimes, when there was one other teacher, and they were outside', 'Ashley' would hold the child with his hips close to them and hurt their back. The child described the pain by methodically hitting their fist onto their leg and said the pain 'felt like a nail being hammered into my back'.

The parent reported to police that they had previously informed the Director of the centre that their child did not like 'Ashley' changing their nappy or pants.

The complaint to QPS included reference to the child's change in behaviour including:

- separation anxiety at day care if not left with female educators
- regressing with bed wetting
- refusing to go to the toilet
- fighting with other children
- showing aggression towards other children and parents.

The complaint also outlined that 'Ashley' took photos of the children and developed them in his home, then sold them to parents. The parent noticed that a picture had been taken of their child without permission. Following an interview with the child conducted by QPS, this complaint was filed pending any new information.

When considering the police response to this complaint the available information shows:

- There was a one-month delay in interviewing the child after the complaint was made. This is significant for such a young child and may have impacted their capacity to recount the incident to officers.
- The offender was not identified as the suspect and was never interviewed about the complaint. It is unclear what steps, if any, were taken by officers to identify the offender.

- The offender was not linked to this incident in QPRIME (the QPS information management system) until after his arrest in 2022, when the parent contacted QPS to express their frustration that they had reported their child's disclosure in 2009 but that it was not attributed to the offender or pursued further. The suspect was recorded on QPRIME as 'Ashleigh' despite the written complaint spelling it as 'Ashley'. This prevented other officers from being able to consider patterns of behaviour and draw connections between different incidents where future complaints about the offender were made.
- While it is unclear whether the centre had closed at the time of the investigation, no visit was ever made by police to the centre, and no (current or former) staff were ever interviewed with respect to the complaint.
- There is no information available about the response of the Office for Early Childhood Education and Care.
- An external review commissioned by the QPS after the offender's arrest noted that there were 'obvious deficiencies' in the response to this incident, that affected outcomes at the time and potentially had negative flow on effects for future QPS responses, and for the identification of the offender.

The decision not to interview the offender, or any workers or management of the centre, is considered an **outcome-defining event**.

2009: 'My instincts were alert'

The offender worked in Centre BY in 2009 when the centre closed down. According to a parent whose children attended the centre around 2009 they raised concerns about the offender's behaviour to the centre, but 'nothing changed'.

My instincts were alert. He let the kids climb all over him, and he often took our girls to his office alone to play on his computer. We addressed this with the daycare leadership and told them it wasn't appropriate, but nothing changed.

The Board has not been able to obtain any records of the existence of this complaint or how it was resolved.

The actions of the centre's management and leadership to this complaint was a **missed opportunity**.

2015: Access denied

After recognising the retailer of the bedsheets that appeared in the CEM uploaded by the offender (through his Zimble account), the Australian Federal Police (AFP) attempted to identify the childcare centres that had purchased the bedsheets. This occurred as part of its victim identification investigation. The first AFP inquiry made to the bedding supplier was in January 2015, in which the bedding supplier was 'not forthcoming'.

Also in 2015, *'the Department of Education provided a list of male childcare workers [to the QPS]. It cannot be confirmed if the offender's name is on the list (password protected – not known to Argos and not obtainable). There were hundreds of names on the list. Folders were created on the Argos server for some persons of interest, but [the offender] was not one of them'.*

As outlined in the *Timeline of Detection* in Chapter 7, it took some seven years after this initial request to identify the offender. Advice from the AFP indicates that the QPS and AFP investigations were running concurrently but separately, with the QPS being the lead agency for finding Zimble and the AFP undertaking enquiries as part of its victim identification investigation to identify the children in the images that Zimble had uploaded.

'While the AFP was aware that QPS were doing an investigation into Zimble and that Zimble was the person who posted the [CEM] – at that stage, there was no regular exchange of information between the two investigating agencies.'

The unwillingness of the bedding supplier to provide information to the AFP in January 2015 is considered an **outcome-defining event**.

The list of male childcare workers may have contained the offender's name, however in the absence of other information and given the scale of the list it is hard to determine if this alone is a missed opportunity.

2018: 'I'm going to smack your bottom'

The offender worked at Centre WS between July and August 2018, for a total of four weeks, after which his employment was terminated immediately during his probation period. During an interview with ECRA in 2024, the owner advised this was because the offender did not undertake appropriate planning and programming, and was consistently late.

A parent shared with the Review that in August 2018, they attempted to make a complaint to the centre after witnessing the offender threaten to smack a child. Specifically, the offender is reported to have said words to a child that 'you better bring your bag back here or I'm going to smack your bottom'. When the offender noticed the parent standing there listening, the parent reported that 'he looked wide-eyed, guilty and muttered something along the lines "I wouldn't actually have done it"'.

According to the information received, the parent's first attempt to make a complaint was met 'aggressively' by the Director/Owner.

The parent then made the complaint to the Director/Owner a week later. No further action was taken by the Centre in response to this complaint, and the informant parent later became aware that the parents of the child involved were never notified of the incident. There were no records relating to this parent's complaint provided to the review by the centre, and in submissions received by the Board the owner denied any recollection of this complaint being made to them. Under the relevant legislation in place at the time, the Approved Provider of the service was required to notify ECRA of the complaint.

Complaints alleging a breach of the legislation (an offence to use inappropriate discipline) and allegations of physical abuse occurring while a child is being educated and cared for by the service were both notifiable. The centre did not report the incident to ECRA, which had the authority to undertake its own investigation in response.

In its response to the Board's request for information, the centre owner acknowledged this requirement to report under the Education and Care Services National Law (National Law) and subordinate regulation. They also advised that a child protection policy was in place at the time of the offending which staff were required to review and adhere to.

This centre was subsequently breached by ECRA in 2025 for not reporting this complaint to them, or to the parents of the child involved. This decision is currently subject to an application for an internal review by the centre.

The failure to report the complaint to the regulator is considered an **outcome-defining event** that weakened future detection opportunities.

2018: A change of clothes

The offender was employed at Centre BS for a period of three weeks in September 2018. His employment was terminated immediately during his probation period. Reasons for his termination were not recorded. A staff termination form dated 28 September 2018, stated:

As discussed during our meeting, there have been concerns about your performance during your probation period and as a result, we have decided to terminate your employment, effective immediately. As stated in your contract, we will be exercising the option to terminate your employment today, however we will be paying out your notice period as stipulated in your contract. You are not expected to work during the notice period.

In interviews with ECRA in 2025, the acting Manager of the centre at the time stated that the offender's employment was terminated due to him being a poor fit with the centre, lack of engagement with staff and children, poor programming, and failure to follow best practices by having children sit on his lap. None of these concerns were documented in records available to the Board.

The Board requested further information from the centre regarding the reason for the offender's termination; however, they were unable to provide this information:

Please note that we have made reasonable enquiries and have not located any records relating to disciplinary, performance or conduct history for [the offender], including no records of any complaints, reports or concerns raised about his interactions with children, other than his letter of termination which references 'concerns about your performance during your probation period'.

It is important to note that the absence of records does not equate to the absence of concerns or harm to children being raised with this centre at the time of the offender's employment.

In mid-September 2018, a parent reportedly told the Centre Manager that '*something about [the offender] made her feel uneasy*'. She recounts that she 'requested centre manager make a note and was informed they would do so and investigate it'. This parent also shared two incidents that occurred during that month, which they discussed with centre staff at the time, including an occasion where their daughter could not be located one afternoon during pick up.

Despite this being an apparent breach of the National Law as the child was reportedly not being adequately supervised for that period, there were no documents available to indicate that any such incident was notified to ECRA. On another occasion the parent questioned why their daughter had been changed into spare clothes that had been in her bag that morning, while the clothes she had been wearing were clean in her bag that afternoon.

This child was later identified as a victim-survivor of the offender. There were no records relating to any of the parent's concerns in the centre file material available. The centre submitted to the Board that the comments made by the parent do not, in isolation and without further context, meet the threshold for a reportable complaint under the National Law. It further advised that the actions taken by the centre manager to end the offender's probation were made promptly, demonstrating that employees were closely monitored during their probationary period.

The failure by the centre to keep records of the complaint and to report the complaint to the regulator is considered an **outcome-defining event**.

The failure by the centre to keep records of the reasons for the offender's dismissal is considered a **missed opportunity** that weakened future detection opportunities.

2019: 'Yesterday was a tough day'

The offender was employed at Centre EK between February 2019 and December 2019. Available records show that numerous issues were raised with the offender while he was employed at Centre EK, including:

- the offender bringing toxic paint into the centre, which represented a risk to the safety of the children
- late or incomplete documentation
- poor communication with families and children
- showing favouritism towards certain children
- using his personal camera to take photos and videos of children. This included continuing to use his personal camera and SD card despite being required to use the centre-supplied memory card
- 'not pulling his weight'.

On 28 August 2019, a parent contacted the centre to report that the previous day the offender had grabbed and squeezed their son's arm. The child stated that the offender 'got angry at me and grabbed my arm and squeezed it hard...yesterday was a tough day'. In response, management gave the offender the option to resign immediately or take leave to complete behaviour management training. The offender chose to complete training.

The centre did not report the incident of physical harm to ECRA despite the legislative requirement to do so.⁴⁵ In ECRA interviews in 2024, the reason provided for not making a report to ECRA by the centre was that the parents were happy with its response to the complaint. The parents' feelings regarding the outcome are irrelevant to the obligation to notify ECRA under the National Law. Given the nature of the concerns raised, this incident should have been notified to ECRA.

The failure by the centre to report the complaint to the regulator is considered an **outcome-defining event**.⁴⁶

May 2021: ‘...Rub their shoulders and kiss them on the head’

As part of an ECRA investigation in 2024, a staff member of one centre recalled having witnessed the offender ‘standing behind a female child, rub their shoulders and kiss them on the head’. The staff member reportedly spoke with the Operations Manager of this centre who was also present during the incident and who advised they would speak to the offender about it.

During their interview with ECRA, the Operations Manager recalled an induction visit to the centre as the offender ‘wasn’t happy that people were now going to be overseeing him and the service’. During this visit the Operations Manager confirmed what they had witnessed: ‘[The offender] was standing up with a child in front of him with his hands on the female child’s shoulders and bent down and kissed her on top of her head for no reason’.

While she didn’t address the interaction at the time, she reportedly consulted with the HR colleague who had also been in attendance, before consulting with the Management of the service. She was reportedly advised that there had been no concerns raised about the offender previously but her offer of speaking with the offender was welcomed.

[Management] welcomed this action and thanked her for speaking to him about it first. She spoke to [the offender] who apologised explaining they were a small centre and she didn’t understand how they operated and that children hug him in front of parents and it is ok. She told [the offender] it was not acceptable in childcare and that he couldn’t do that anymore.

What she witnessed was an interaction not an incident and it was not managed any further by her.

There was no information provided to the Board to indicate that this incident was recorded or reported to the regulator or the parents. While the centre did reference performance issues identified in relation to the offender’s behaviour at this centre, it did not reference this incident. It was only identified during the ECRA investigation in 2024, after the offender’s arrest.

The failure by the centre to recognise grooming behaviour, record and report the incident to the regulator is considered a **missed opportunity**.

October 2021: ‘I saw something’

The offender was employed at Centre EA between December 2019 and April 2022. He left the centre after the joint Early Childhood Teacher and Director role he held was made redundant and split into separate positions. Despite marketing campaigns to boost enrolments, the centre continued to operate at between 24 and 47 per cent capacity. Feedback from potential families indicated that their interactions with the offender were the reason they did not continue with enrolment past the initial stage.

Based on the profile of the offending discussed in Chapter 8, the Board considers it likely that the offender kept enrolment numbers low to reduce the level of supervision and guardianship at this centre and to create opportunities for abuse to occur.

In October 2021, the offender was subject to a complaint by a colleague that reported witnessing him kissing a five-year-old child in the outdoor fort during rest time. The incident was reported to ECRA and QPS. The centre commenced an investigation, and staff were interviewed by centre management prior to QPS conducting interviews with the offender and staff.

One month later, following interviews with the witness and informant staff member, as well as an interview with the offender, QPS decided not to progress any further investigation relating to this complaint. This was on the basis that no criminal offences had been identified. The child was not interviewed by the police to reach this decision, as they were reported to have been asleep during the incident. This was a missed opportunity to identify other possible inappropriate behaviour by the offender towards the child. The offender later pleaded guilty to offences against this child.

The outcome of the internal investigation undertaken by centre management regarding this particular allegation was recorded as unsubstantiated. Despite the unsubstantiated outcome, the internal investigation did identify the offender had breached the *Educator and Management Policy – Code of Conduct* due to his behaviour of favouritism towards some children, physical affection towards children, and lying down with children during rest periods. The investigation report by the centre included clear indicators of grooming behaviour displayed by the offender such as:

- favouritism towards a group of girls
- introducing outside rest time, and being the sole educator outside with children
- being described as “overly physically affectionate” and “extremely affectionate”
- laying down with children at rest times most days
- tickling and touching children
- taking selfies with children on iPads
- building close relationships with parents, and
- receiving letters from parents praising him, with one stating that their child had ‘absolutely fallen in love with him’.

Information gathered as part of the internal investigation undertaken by the centre was not requested by or shared in full with either QPS or ECRA.

The ECRA investigation appears to have heavily relied on the outcome of the Approved Provider’s investigation. The communication from ECRA to the Approved Provider acknowledged the breaches identified by the internal investigation and that:

The Approved Provider is satisfied that [the offender], with appropriate support from the Area Manager and [the Centre EA] team, should continue in his role a Director/Early Childhood Teacher at [Centre EA].

The offender returned to work following this complaint after reviewing centre policies and procedures. The offender was noted to be hostile towards the informant staff member who resigned from the centre due to the offender’s return as they felt uncomfortable working with him.

Despite recognising that the offender showed inappropriate behaviour indicative of grooming such as laying down with children, tickling them, and ‘blurring the professional boundaries’, this conduct was not appropriately contextualised and there were no apparent consequences for the offender.

The decision by police that there was insufficient evidence to progress further investigation was an **outcome-defining event**.

The failure to detect grooming following the centre’s investigation was a **missed opportunity**.

The decision by the centre to not share their information with QPS or ECRA was a **missed opportunity**.

The centre’s decision to enable the offender to return back to work was an **outcome-defining event**.

December 2021: ‘...over or under your undies?’

In December 2021, a complaint was made to Centre EA by a parent whose child disclosed that a female teacher had touched her under her underwear during rest time. The offender, as Director of the centre, handled this complaint and made a report to ECRA.

This parent reported that their daughter told them ‘She had had a sleep at [the Centre] and that a teacher had touched her private parts’. When the parent asked whether ‘it was front bum or back bum, over or under your undies?’, the child reportedly stated that it was ‘front, under my undies’ and identified a female teacher but could not remember the exact name. The offender suggested a staff member with a similar name to one identified by the child and highlighted to the parent that he hadn’t seen anything inappropriate but that the female teacher had been stroking the child’s hair as she lay on her bed.

According to the offender’s report, the parents wanted to follow an informal process to try and ascertain what happened. The offender reportedly explained the centre policy to the parents before allowing them 30 minutes to think about the process. He then contacted the parents and reiterated that a report was required to be made ECRA. This information was subsequently reported by ECRA to QPS.

Following a QPS interview with the child it was determined that the teacher patted the child on her 'front bottom' area as an accident. ECRA documents indicate that:

CPIU Officer confirmed the following:

- *CPIU had received a referral and the child has been interviewed by CPIU.*
- *child has stated that she doesn't like being patted to sleep on her back and/or bottom, but didn't say anything to the educator who was patting her.*
- *child has then stated that she rolled over and the educator was still patting her, which would have resulted in the educator patting her "front bottom"*
- *child has stated that she was "inside" the room to have a sleep. Not that the educator had her hand "inside" her undies.*
- *the parents are satisfied with the outcome of the CPIU investigation and don't wish to pursue it any further.*
- *CPIU will be closing their case and will forward the referral form to the [ECRA].*

The complaint was found to be unsubstantiated. Neither the suspected teacher nor the offender, as the informant, were interviewed. ECRA followed up with the centre management regarding the matter, to which the offender responded with the following:

Please be advised that in relation to the request for information outlined below we have taken (or intend to take) the following action:

Point one (educator/s)

- *At the staff meeting at [The Centre] tomorrow evening the Centre Director, [the offender], will be reminding all educators of the importance of being vigilant and focusing their awareness on children, particularly in instances such as this, when they are touching a child in order to soothe them during the sleep and rest period.*
- *It is intended that the practice of ensuring educators are never on their own when supervising and engaging with children in education and care remains in place.*
- *In relation to [Female Educator], who is a casual employee, an outcome letter was issued to her yesterday afternoon and the Area Manager also attempted to contact her to talk through the outcome and what she may do in terms of reflecting on practice e.g., awareness etc as above.*
- *When [Female Educator] is next rostered on (in the new year) this refresher in practices will also be revisited with her.*

Point two (family)

- *I spoke with [Child's mother] (mother) this afternoon to advise her that we would not be pursuing a full formal investigation following the outcome of CPIU's preliminary investigation and provided and [sic] outline of the steps we are taking at the service (as outlined above) to mitigate recurrence.*
- *It is my intention to send her a brief follow up email reiterating the key points of our discussion and inviting her to contact me if she has any further questions or would like to discuss the matter further.*

After the offender's arrest, he disclosed that this child may have been confused about the identity of the teacher they had made a complaint about. The offender was later convicted for offences against this child.

Centre management and ECRA's overreliance on the outcome of the police investigation was evident. There was no recognition by centre management, QPS or ECRA of similarities between the two complaints at the same centre in a relatively short space of time (within three months), despite the same police officer having handled both matters. This includes that they both occurred during rest time, and that the offender was present at the centre for both incidents.

The parent of this child expressed their view that the complaints made to police should not only be connected to the person alleged to have done the wrong thing but also the centre.

The QPS decision to not interview the suspect teacher or the offender, was a **missed opportunity**.

The failure, by the centre, the QPS and ECRA, to connect the two complaints as an indicator of threat or risk to children in the centre was an **outcome-defining event**.

October 2021: It's a match

In October 2021, the AFP was provided with detailed customer records from the previous owners of a bedding supplier relating to customers who purchased bedding matching the sheets in the CEM uploaded by Zimble. This 2021 list included individuals and childcare centres who purchased the sheets, but it did not include sales made to the centre where the abuse occurred.

The centre was identified during a review in 2022 of the 54 centres recorded on the customer list previously provided to the AFP in 2018. The details recorded on that list did not match the actual location of the centre, and as such had not been reviewed previously.

In August 2022, 10 months after receiving the customer records, and following a review of the earlier list obtained in 2018, the AFP visited one of the childcare centres listed in the 2018 records and observed 'various features consistent with the abuse material'. The AFP then received a list of males who had worked at the centre from the owner, and the offender's name was on the list. The AFP was subsequently able to identify the offender as the creator of the CEM.

It should not be lost that during this timeframe the offender was subject to police inquiries and a police interview in October/November 2021 in relation to the complaint that he was seen kissing a child.

The timeframe between receiving the second list of centres from the bedsheet supplier and attending the centre where the offender worked in August 2022 was an **outcome-defining event** (for the children abused within this period).

April 2022: 'He touched my privates'

The offender worked at Centre WN for two shifts in April 2022, after being supplied as a relief educator by an employment agency. Centre WN requested the offender not be sent back after his first shift because the Nominated Supervisor felt uncomfortable with him and 'didn't like him'. She was reportedly accused of 'being sexist' in response.

Despite these concerns, the employment agency sent the offender to the centre again. While the Nominated Supervisor contacted the employment agency on the day and questioned why they had sent the offender back to the centre, she allowed him to work. The employment agency had informed her there were no other staff available and she was required to meet supervision requirements for an excursion.

While there was no conflict between the offender and other staff, the Nominated Supervisor reported feeling 'uncomfortable' around him. The Nominated Supervisor reportedly described him as not having spoken freely, 'didn't really interact with staff, he did his job but all staff felt uncomfortable with him' and stated, 'he preferred to be with children'. The offender reportedly ate lunch alone and didn't engage with other staff however he:

developed a quick relationship with [a child] to the point that [this child] wanted to sit next to [the offender] by lunch time. [Nominated Supervisor] recalled this was highly unusual. There was one educator that [this child] was attached to, but she didn't really develop attachments with other educators. Especially not that quickly.

After the offender's second shift, a parent contacted the centre and reported that their daughter had disclosed the offender had rubbed her privates during rest time. This was the same child that the offender reportedly developed a 'quick relationship' with. The child also stated that 'he doesn't get to do that as he was a boy and was different to her'. The parents reported the matter to QPS, and the Nominated Supervisor reported the matter to ECRA.

QPS officers conducted an interview with the child in which she made disclosures that the offender had touched her 'privates', which she elaborated was her bottom. QPS also received a video recording of the child disclosing to her mother that the offender touched her privates. The child stated that the offender had said that "he is a boy and doesn't know [sic] how to do it". No interview was conducted with the offender.

Police found there was not enough evidence to meet the threshold for an offence to be proven, and that disclosures made by the child in the video and the interview were 'only gained through leading and direct questioning' by parents or officers.

QPS did not speak to staff and gather information about the offender's behaviour and any concerns they had. Officers instead relied on a discussion with the Nominated Supervisor, who stated that the offender did not have access to children alone and that there was another staff member present during the time of the incident. The Nominated Supervisor also shared that she had asked the present staff members whether they had seen anything, to which they responded that they had not. The closure of the investigation occurred despite QPS closing a previous investigation into a complaint involving the offender some six months prior. The same police officer was involved in the investigation of the complaint at Centre EA, and this complaint.

Although they were informed of the incident, ECRA did not conduct their own investigation into the report. The matter was closed by ECRA based on the outcome of the QPS investigation. Information indicated that '[ECRA] determined there to be no information to support non-compliance with the National Law or National Regulations in the circumstances of the allegations and the matter was closed on 9 June 2022'. The closure of the investigation occurred despite ECRA closing a previous investigation into a complaint involving the offender some six months prior. While the same Regional ECRA office investigated the December 2021 complaint and this complaint, two different officers handled the matters.

The employment agency continued to place the offender in centres despite having knowledge of the complaint and the related investigation. During the ECRA investigations in 2024, the centre staff were approached for an interview, however five of seven people declined the opportunity to participate. Of these, four were former centre staff and no longer worked with the organisation. The Nominated Supervisor was one of two people who participated in the interview and advised the following:

[Nominated Supervisor] asked if [employment agency] had a child protection strategy but they did not have one. She is not sure if they have now implemented one. They did provide [Nominated Supervisor] with a one-line statement that they use blue card checks to ensure child protection.

Once the blue card was received [Nominated Supervisor] checked the card herself.

She had created a document which was an agreement for agency staff to come into the service and follow the service policies and procedures. [The offender] completed one of these agreements.

In addition, ECRA documents indicate that the Nominated Supervisor provided the following information:

[Nominated Supervisor] was told to contact [employment agency] to inform them there was going to be a police investigation into [the offender], but they were not to discuss this with [the offender] until police had contacted them.

A few days later, on Friday, [Staff member] from [employment agency] contacted the service and asked if there was any further information. [Staff member] advised that the QPS had spoken with her. It was [Nominated supervisor's] understanding that QPS advised [Staff member] not to send [the offender] out to services. During the conversation [Staff member] advised that [they were] still going to send him to services. [Nominated Supervisor] advised against this, but [Staff member] was adamant that he needed to work and [they] would send him out. [Nominated Supervisor] is not aware if [Staff member] did continue to send him to services.

The decision by ECRA to not conduct its own investigation was an **outcome-defining event**.

The police decision to not interview the offender was an **outcome-defining event**.

The treatment of this disclosure as a single event, in the absence of past ECRA and police investigations was an **outcome-defining event**.

The decision of the employment agency to keep placing the offender despite concerns, was an **outcome defining event**.

Overall there were five missed opportunities and 13 outcome-defining events where the offender should have been detected earlier.

August 2022: The ‘remarkable’ detection

Ultimately the offender was caught, not because of the contact offending, complaints and disclosures, but through an alternative chain of opportunities. These were:

1. Police detected an international darknet site where offenders were exchanging images.
2. The offender uploaded images to this site while he was in Italy.
3. The images the offender uploaded included bedsheets. AFP advice was that they had initially not narrowed it exclusively to sheets sold in Queensland, and police in victim identification teams later realised this.
4. The bedsheet was traced to a manufacturer/supplier, and the supplier provided a list of purchasers.
5. Police tracked the purchasers to a single ECEC service matching the uploaded image.
6. The employee records of this centre led the police to the offender.

This story, taken alone, highlights the extraordinary value, dedication, and persistence of the AFP and QPS—particularly the victim identification teams whose expertise in recognising the smallest of details was decisive. The ability to notice something as seemingly insignificant as a patterned bedsheet, trace its supply chain across borders, and then connect it to a specific ECEC service speaks to a level of diligence and determination that is nothing short of remarkable. It shows how success in this area is not the result of luck, but of painstaking analysis, international cooperation, and an unwavering focus on protecting children.

It illustrates how even in the darkest corners of the internet—where offenders seek anonymity, and where crimes are hidden by layers of technology—methodical investigative work can bring offenders to light. Victim identification teams operate at the frontier of policing, often pouring over distressing material and working with the slimmest of leads, yet their persistence demonstrates that no detail is too small to matter when a child’s safety is at stake.

“

While much of the wider case study demonstrates missed opportunities, lapses, and systemic failings, it is critical to recognise that without this international collaboration and the highly skilled investigative work undertaken in this case, the offender may never have been detected, and children may have continued to be harmed.

This outcome is a testament not only to police ingenuity but to their resilience in confronting and dismantling some of the most complex and disturbing forms of offending.

Above all, this success serves as a powerful reminder that while prevention systems must be strengthened and systemic safeguards improved, the commitment, skill, and creativity of law enforcement remain one of the most vital lines of defence in protecting children from abuse. It reinforces the value of resourcing, supporting, and expanding these specialist capabilities—because every missed detail is a potential opportunity for harm, and every identified clue can mean the difference between ongoing abuse and a child’s freedom and safety.

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Chapter 12

The aftermath – post-incident system responses

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The aftermath – post-incident system responses

Following community outcry after the offender's arrest and subsequent sentencing, systems of government across Queensland and Australia responded. In Queensland, the *Child Safe Organisations Act 2024* (Child Safe Organisations Act) was passed, alongside amendments to the *Working with Children (Risk Management and Screening) Act 2000* (WWCC Act). The Queensland Police Service (QPS) undertook internal reviews of its investigative processes into prior complaints that had been raised with them, while the Early Childhood Regulatory Authority (ECRA) commenced inquiries into the centres where abuse had occurred. At the federal level, Attorneys-General and Education Ministers advanced reforms that had been long outstanding from the Royal Commission into Institutional Responses to Child Sexual Abuse (Royal Commission), including measures designed to strengthen safeguarding across the early childhood sector and to develop a nationally harmonised system of Working with Children Checks (WWCC). This occurred in an effort to enact change and to close loopholes and meant that during the course of our Review several key systems continued to change in their design and operation. This change increased in scale following further cases of abuse in early childhood education and care (ECEC) settings in New South Wales and Victoria.

This Review has monitored these advancements closely, and in some instances contributed our own learnings and analysis of the emerging reform agenda.

When something goes wrong, it is standard practice for each department or agency to conduct its own internal review. Staff are interviewed, files are scrutinised, and governance bodies such as audit or professional standards units may oversee the process. These reviews are often robust within their boundaries: they examine compliance with relevant laws, policies, and procedures, and they can generate important insights. This kind of reflection is essential for accountability and for driving improvement within the organisation. However, the strength of these reviews can also be their limitation. As they are designed to focus on the policies and staff within a single department, the lessons learned are often siloed. The root causes of critical failures are frequently spread across multiple agencies, yet each review may only capture a fraction of the picture. Without mechanisms to share findings or to undertake cross-agency analysis, valuable insights can remain locked within one organisation. This means opportunities for broader systemic learning and for preventing future harm can be lost.

This chapter explores whether systems adequately learn from critical incidents and whether the reforms announced to date are sufficient. It outlines the steps taken by the Queensland and Australian governments during the review period. Specifically, it covers:

1. the internal review of QPS resulting from this case
2. the reviews led by ECRA of the centres where abuse occurred, and changes some centres have made since the offending was detected
3. the passage of the Child Safe Organisations Act in Queensland
4. the passage of amendments to the Working with Children Check Act in Queensland
5. the Child Safety Review under the National Quality Framework (NQF)
6. amendments to the Education and Care Services National Law (National Law) and Education and Care Services National Regulations (National Regulations)
7. Australian, state and territory government commitments regarding unfinished Royal Commission recommendations including to working with children checks
8. steps taken by the eSafety Commissioner to introduce rules and industry standards to protect children online.

The response of the QPS

Two reviews of the QPS actions in this case were undertaken. The first internal review was undertaken by a Detective Senior Sergeant in the Child Abuse and Sexual Crime Group within the QPS. Its purpose was to scrutinise the investigative steps taken and determine whether the offender could have been identified and apprehended earlier. This review concentrated on case-specific decisions and processes.

The second review was external, conducted by another jurisdictional policing agency, to provide a more independent perspective and a broader assessment of the QPS response. This review offered a level of objectivity and comparative insight, allowing practices in Queensland to be measured against approaches in another jurisdiction.

While both reviews were valuable in identifying lessons and confirming aspects of good practice, they were inherently constrained by their terms of reference. The internal review was necessarily limited to the operational decisions of QPS officers, while the external review, though broader, still focused primarily on policing responses. Neither was designed to examine how the police response interacted with other key systems - such as the early childhood education and care (ECEC) sector, blue card system, or child protection system, including where missed opportunities might also have arisen.

QPS Internal review

In November 2022, QPS undertook an internal review of the response to the previous reports it had received regarding the offender. It examined the first response by QPS, and the subsequent investigation conducted by CPIU. It focused on the reporting and process applied to these investigations and considered information sharing with external agencies.

This first review considered the two reports made to QPS in 2021 (one where the offender was the subject and one where he was the informant) as well as the complaint made in 2022 about the offender.

This internal QPS review did not consider the earlier 2009 report made to police about the offender, as it had not yet been linked to the offender.

2021 Report of suspected harm to a child

- A co-worker made a formal complaint that the offender was kneeling over a sleeping child swaying his face back and forth 2cm from the child's face for several minutes.
- When the coworker was interviewed by police, she stated that at no point did she see the offender touch the child. The co-worker reported what she saw felt wrong and she needed to report it.
- The offender was interviewed by QPS, and he denied his lips touched the child's lips stating he was trying to gently wake the child up.
- This complaint was filed by officers, with ECRA notified of the outcome.

The findings of the internal review indicate this investigation was completed adequately. It was noted that while the conduct of the offender may have been 'professionally and morally unacceptable' no offence had been identified.

2021 Street Check

- The informant, who was the offender, reported a female child disclosed she had been touched on the 'front bottom' by a female childcare educator.
- A section 93A interview was conducted with the child, and it was determined the incident was accidental.
- The offender was not initially linked to the occurrence but has since been linked by the Australian Federal Police (AFP).

The internal review confirmed that this matter was entered as a street check as per standard procedures. QPS advised that the offender was the informant, reporting third hand on behalf of the Centre there was no suggestion or indication that he was the offender, and that this incident related to a female educator. The internal review determined that the investigation was appropriately filed, with required external agencies advised of the QPS outcome.

2022 Indecent treatment of a child

- A parent made a formal complaint that their three-year-old daughter said the offender touched her private parts.
- A section 93A interview was conducted with the child but there were limited disclosures.
- Police contacted the Director of the centre in relation to the complaint who identified the offender as the male childcare worker. He had been hired as a temporary educator with the employment agency.
- The Director made enquiries with staff, and it was reported the offender did not have unsupervised access to children when the incident was said to have occurred.
- No staff saw the offender touch any child inappropriately. The offender was not interviewed, and the complaint was filed.

The internal QPS review determined that each investigation was adequately dealt with, and no adverse findings were identified. A missed opportunity by not interviewing the offender in relation to the 2022 report was identified.

External review

In October 2024, another jurisdictional policing organisation undertook a peer review of the QPS internal review. The review considered the same three reports as the internal review. The 2009 report was mentioned but not expanded on to 'avoid prejudicing any misconduct investigation that may arise from it'.

This second external review included interviews with staff involved in the case. According to the external review, 'all police officers interviewed by the review team expressed observations that today's system of investigating child sex offending has vastly improved since the first incident of 2009', and this very system continues to offer further opportunity for strength-based enhancements in the areas of:

- information sharing, including:
 - authorisation levels for sharing information
 - 'overprotection' of information between agencies
 - legislative constraints
 - barriers to what information can be loaded into different databases
 - technological constraints.
- victim and offender identification practices
- systems development to connect disparate information sources to better identify risk.

In relation to key weaknesses in the system, the external review made the following observations:

- demand management is overwhelming the sharing of information in a timely manner for 'non-urgent' cases
- skills in interviewing offenders and children are perishable and can only be retained to standard if interviews are conducted regularly
- there is a reliance on individual efforts to see and respond to escalating risk.

It was also noted that there are system enhancements that could be implemented to support the identification of offenders and deter their employment in child settings, including automated workforce data background auditing and reporting.

When considered in isolation, Incidents One to Three were found to 'not afford cause for great introspection'. The offender was the reporting person for Incident Two and the evidence was weak for Incidents One and Three with the corresponding basis for considering a prosecution of either of these incidents also being weak. However, when Incidents One to Three are considered 'in light of the whole being greater than the sum of its parts', there are some opportunities for improvement.

Child sex offending presents an increasingly challenging crime environment where the traditional activities of police to identify offenders, victims and locations through investigative analysis is evolving faster than the capability and capacity of the policing jurisdictions themselves.

In summary this external jurisdictional peer review found that:

- The response to the first 2021 incident is assessed as appropriate.
- For the second 2021 incident, the failure to link the offender as the informant meant the incident was not considered by investigators in the 2022 incident.
- The response to the 2022 incident was determined to have some missed opportunities, including:
 - investigators relying on the Director of the centre to identify witnesses
 - investigators not interviewing the offender
 - investigators not considering the first 2021 incident, despite the same police officer being involved in both investigations.

The review also determined that Incident Zero (2009) 'changes this paradigm'. There were some 'obvious deficiencies' in the response to this incident by officers that not only affected outcomes at the time, but on balance had the potential for a negative flow on effect to the nature of the response to the subsequent incidents, including the identification of 'Zimble'.

The external review made three recommendations:

1. *Strong leadership is needed inside and above the CPIUs to support investigators to take the time to do each job properly and consider series of incidents holistically rather than individually.*
2. *QPS should continue to develop partnerships to leverage technological advancements to improve data access, storage and search capabilities.*
3. *QPS should consider analysis of its systems of assessment and response that operate over disparate information sources, to evolve information more quickly into intelligence so that evidentiary thresholds are reached sooner. CPIU managers and Crime Intelligence Command should identify existing barriers to all aspects of information collection, enhancements and sharing to advance the existing culture so that it constantly asks, 'what more can be done?'.*

The review sought to determine if police should have known sooner about the offender committing sexual abuse against children. It was considered that:

[The offender] challenged police services over many years for a variety of reasons and that the true extent of his behaviour was not known until after his arrest. This challenging behaviour included that the offender rarely posted online and then never appeared again which meant that the case of 'Zimble' became cold.

The review also noted that child protection notification reports are causing a demand-management pressure 'that can only be met if local police streamline responses'. It stated that:

“

The online child sexual offending environment is exploding with new creators and new viewers. Resources are thin.

”

Australian Federal Police

There has been no review by the AFP into the adequacy of its involvement in this case. In communication to the Board, the AFP acknowledged that there were challenges along the way which have provided opportunities for learning and improvement in future investigations.

The AFP advised the Board that while they sought to provide detailed information to families about offences identified as part of the investigation, and continue to be available to do so, they recognise that 'the complexity and evolving nature of the investigation meant the circumstances of offending against a child may have changed as the investigation progressed.' As they were reliant on the accuracy of previous reporting recorded on state police systems to inform their investigation, where this was inaccurate or not recorded, this impacted their visibility of previous incidents.

To help manage communication with families, AFP established an online communication portal in addition to maintaining individual lines of communication with victims and their families. The AFP also sought to ensure appropriate and simplified referral pathways were in place to relevant support services, including Victims Assist Queensland, with a focus on minimising the extent that victim-survivors and their families would have to recount their experiences. The AFP's Victim Management Plan devised by the team in this case, has since been recognised as 'best practice' and is a model now used by other jurisdictions (both domestically and internationally) where there are a large number of impacted victims or families.

Since the capture of the offender the AFP and Australian Centre to Counter Child Exploitation (ACCCE) have implemented a range of measures under the National Strategy. Key recent achievements of ACCCE include:

- Appointing additional resources to the Child Protection Triage Unit who assess and triage incoming reports of online child sexual exploitation.
- Delivering the AFP's first technology detection dog capability nationally to assist child protection search warrants in finding devices, such as USBs, increasing frontline investigative capability and capacity.
- Improved leadership, coordination and collaboration by hosting several joint taskforces, investigations, operations and training.
- Developing the *ACCCE Technological Enhancement Roadmap* to meet advances in technology and improve disruption capabilities.

The AFP have also delivered the National Victim Identification Framework which seeks to enhance capability, increase collaboration and coordinate victim identification efforts including through training delivery and taskforce facilitation.

The ACCCE maintains ACCCENet which allows state and territory law enforcement agencies access to the Australian Victim Identification Database. In May 2024, the AFP established a national Microsoft teams space for collaboration for all victim identification investigators in Australia. This platform facilitates communication on proactive investigations, cold case reviews, and general victim identification deconfliction.

Early childhood education and care

ACECQA's National Child Safety Review

In May 2023, the Australian Children's Education and Care Quality Authority (ACECQA) commenced the *Review of Child Safety Arrangements under the National Quality Framework* (the Child Safety Review) at the request of the Australian Government. The final report of the review was delivered in December 2023.⁴⁷ While the Child Safety Review did not specifically address the facts of Operation Tenterfield, it acknowledged that the need and urgency were highlighted by these incidents coming to light.

The purpose of the Child Safety Review was to 'identify new or refined systemic safeguards needed to support Approved Providers of ECEC services to protect children, with a focus on reducing harm, abuse and neglect'.⁴⁸ The review's terms of reference extended to the consideration of inter-related child protection mechanisms such as WWCC, teacher registration and reportable conduct schemes.

Through targeted consultation with relevant stakeholders it became apparent that although the National Quality Framework (NQF) was aligned with child protection mechanisms and principles, there were opportunities to address emerging issues, close loopholes, strengthen policies and practices, support staff capabilities and improve the protection of children in the face of new online technologies.⁴⁹

The final report found that while the NQF is a robust regulatory scheme, it exists in the context of a broad, interconnected child protection landscape, often at the jurisdictional level, which can be confusing to navigate and results in overlap.

The report outlined 16 recommendations which fell across two categories:⁵⁰

1. Building additional safeguards into the NQF:
 - a. strengthening child safe governance, leadership and culture
 - b. embedding prevention and early intervention
 - c. building and sustaining child safe capabilities.

2. Inter-related child protection mechanisms outside the NQF.

In February 2024, Education Ministers agreed to the implementation of recommendations from the Child Safety Review, subject to expert advice, broad consultation, and regulatory impact analysis. Some recommendations of the Child Safety Review were expedited. These regulatory changes took effect on 1 September 2025, including:

- a requirement for services to have new policies and procedures relating to the safe use of digital devices including the use of closed-circuit television (CCTV)
- a reduction in notification timeframes for reporting allegations or incidents of physical or sexual abuse from seven days to 24 hours.⁵¹

Other changes from the Child Safety Review that have also been progressed include:

- The development of the National Model Code⁵² and Guidelines which address child safe practices for the use of electronic devices while providing education and care.
- The publication on 15 June 2025 of the NQF Child Safe Culture Guide⁵³ which helps embed child safe cultures, and the NQF Online Safety Guide⁵⁴ which provides support to keep children safe when using online and digital technologies.

Other more complex recommendations proceeded through the regulation impact assessment process to allow careful consideration and broader consultation. The Decision Regulatory Impact Statement and recommended policy options were considered by Education Ministers on 22 August 2025.⁵⁵

Following this meeting, Commonwealth Education Minister the Hon Jason Clare MP led a press conference in which he announced multiple measures stemming from the ACECQA Child Safety Review including:⁵⁶

- the ability to apply for service waivers related to building design to improve adequate supervision of children at all times will be removed (Recommendation 2.1).
- restrictions and bans on the use of personal mobile phones when working directly with children to be progressed as a matter of priority (Recommendation 2.3-2.4).
- a national CCTV assessment will occur in up to 300 services, guided and overseen by experts including the Australian Centre for Child Protection (Recommendation 2.6).
- enabling Regulatory Authorities to proactively share the identity of prohibited individuals and individuals subject to enforceable undertakings with Approved Providers (Recommendation 11).
- new national child safety training developed by the Australian Centre for Child Protection to be completed by all ECEC staff (Recommendation 12).

Management and oversight of compliance activities within the Child Care Subsidy Program

In June 2025, the Australian National Audit Office (ANAO) published its performance audit of management and oversight of compliance activities within the Childcare Subsidy Program.⁵⁷ The report criticised the Australian Department of Education's lack of a 'policy to guide decisions on whether, and in what circumstances, to take enforcement action' meaning the department 'is unable to assess whether decisions to take enforcement action are fair, impartial, consistent, or proportional'.⁵⁸

In 2022–23 and 2023–24, the Australian Department of Education issued 113 infringement notices totalling \$1.1 million in fines but withdrew 41 of these notices (\$473,010 in fines).⁵⁹ Over these 2 years:⁶⁰

- seven conditions on approval were imposed as a consequence of non-compliance,
- 53 approval suspensions were processed (15 under family assistance law and 29 resulting from National Law suspensions) of which 47 went ahead, and
- 319 approval cancellations were processed (61 due to the department's regulation under family assistance law and 207 due to a National Law cancellation) of which 299 went ahead.

The ANAO report found the Australian Department of Education's process to cancel or suspend Child Care Subsidy approval following a state or territory regulatory authority's cancellation or suspension was inefficient.⁶¹

Quality in education and care: the financial imperative

In July 2025, media and public attention turned to allegations of child sexual abuse by educators in other jurisdictions, namely Victoria and New South Wales. While proceedings are ongoing for both cases, publicly available information shows compelling similarities with the offender's conduct. Both alleged perpetrators abused the trust of parents, children, colleagues, managers and the community by using their positions in ECEC services to gain access to their victims and perpetrate abuse against them in connection with the activities of these institutions.⁶²

As part of its response to strengthen regulation of the ECEC sector, the Australian Government activated its primary lever for incentivising behaviour under the ECEC system—money—by progressing amendments to the childcare subsidy.

On 23 July 2025, the Australian Minister for Education introduced the *Early Childhood Education and Care (Strengthening Regulation of Early Education) Bill 2025* into federal parliament. The Bill was rapidly passed and the *Early Childhood Education and Care (Strengthening Regulation of Early Education) Act 2025* received assent on 2 August 2025.

To receive the childcare subsidy, a provider must receive approval from the Commonwealth. The new legislation empowers ECRA, and equivalent entities in other jurisdictions, to refuse to grant approval or withdraw approval from a provider if they fail to 'provide high quality and safe care'. Additional compliance powers were also introduced as part of this legislation, including:

- powers to publish conditions placed on a provider, the reasons why a provider was refused approval, and details of any infringement notice issued to a provider
- powers to enter a provider's premises without notice to ensure compliance with the approval granted to the provider, mirroring the powers of entry used by state and territory regulators under the National Law.

As of 15 August 2025, the Department of Education had used its new compliance powers to issue notices under the amended legislation in relation to 37 services which were failing to meet the National Quality Standards in areas such as play area safety, hygiene, staff training and supervision. These notices mean that an ongoing failure to meet the National Quality Standards may result in the cancellation of the service's child care subsidy. As services are so dependent on this funding, it is unlikely that they could operate without it.⁶³

The relevant services were given 48 hours to notify parents and up to six months to improve their performance.⁶⁴

August education and care reforms

Following the Education Minister's Meeting on 22 August 2025, The Hon Jason Clare MP led a press conference in which he announced that the Australian Government, in coordinated action with state and territories, would invest up to \$189 million to strengthen safety and quality in ECEC settings. The measures outlined as part of this announcement, that did not stem from ACECQA's Child Safety Review include:⁶⁵

- **A National Educator Register** to be developed by ACECQA. Development of this was to commence immediately, with a pilot in December 2025 and national roll out from February 2026.

- **More unannounced spot checks** – an additional 1,600 unannounced visits per year will be carried out by Commonwealth officers and the first of these additional spot checks are expected to commence in November. The Australian Government will invest additional funding in compliance actions to lift integrity and safety in ECEC, including to implement new powers that cut off funding to providers that don't meet quality and safety standards.
- **Funding for joint regulatory action** – the Commonwealth will provide funding for joint compliance work and monitoring with states and territories and to improve data exchange.
- **Improved transparency for parents** – the Starting Blocks website will be upgraded to display information about conditions and compliance breaches and enforcement. The Commonwealth will invest \$2 million for this work and provide a further \$5 million to ACECQA to support families to better understand safety and quality in ECEC.
- **Tougher penalties** – fines under the National Law and National Regulations will be tripled.
- **Improving supervision rules** – ACECQA will conduct a rapid assessment of child supervision practices, reporting back to Education Ministers by the end of the year.
- **Regular assessment and rating visits** – states and territories will ensure that all services are assessed on average every three years, with more frequent visits for those rated 'Working Towards' the National Quality Standard.

A number of legislative reforms were also agreed upon as part of this meeting, including:

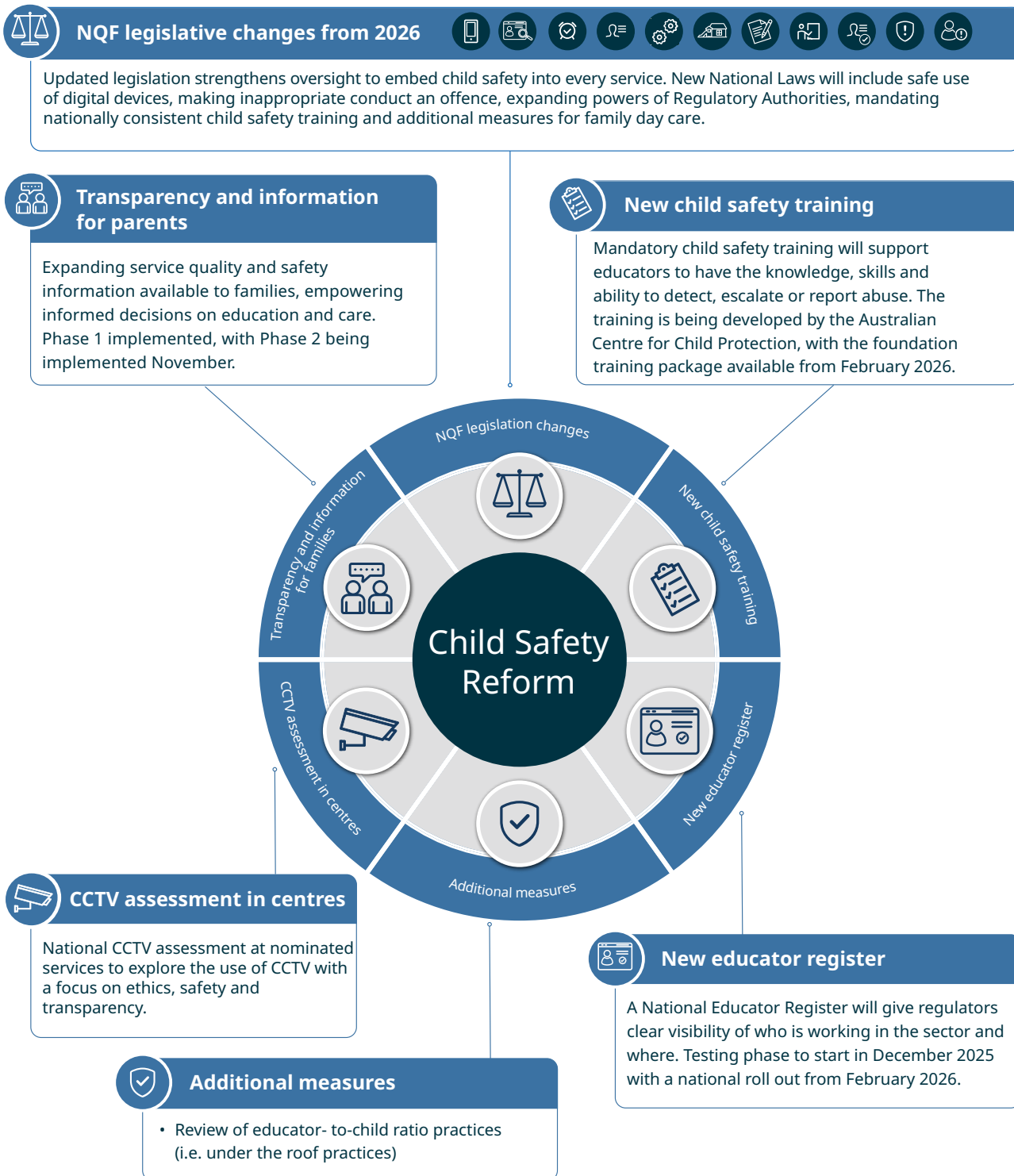
- extending the limitation period for offences to enable prosecution to be undertaken. As it stands, proceedings for an offence must be commenced within two years of the date of the alleged offence.⁶⁶
- making the safety, rights and best interests of children the paramount consideration under the Education and Care Services National Law (National Law), strengthening existing provisions regarding the paramountcy principle in the National Law.⁶⁷

In addition to reforms agreed as part of this meeting, Education Ministers have endorsed amendments to the National Law that will mean the two-year limitation period commences from the time that the regulator becomes aware of the alleged offence, rather than the time of the offence, and will introduce a 'stop the clock' provision in the event of a concurrent investigation on the part of police or other agencies. These amendments are expected to be introduced in the Victorian parliament during November 2025.

Table 7: Proposed implementation timetable

August 2025	Announcement of measures to strengthen child safety and quality in ECEC
September 2025	Australian Centre for Child Protection will commence work to develop mandatory national child safety training. National CCTV assessment will commence in up to 300 services, guided and overseen by experts including the Australian Centre for Child Protection. The use of personal mobile phones or digital devices capable of taking images or videos while working directly with children will be banned or restricted. Upgrades to Starting Blocks website to display information about conditions imposed on centres and regulator visits will commence. Work will commence to determine what information, as well as what legislative changes will be required to physically display meaningful compliance information.
November 2025	Additional unannounced spot checks will commence. Upgrades to Starting Blocks website to commence to show compliance breaches and enforcement actions.
October 2025	Education Ministers will receive an update regarding the physical display of meaningful compliance information.
December 2025	National Educator Register testing phase will begin.
End of 2025	ACECQA will report back to Education Ministers regarding its rapid assessment of child supervision practices.
Early 2026	Mandatory national child safety training will roll out to the sector.
February 2026	National Educator Register will be rolled out nationally and its use will become mandatory.

National Reforms for ECEC announced in 2025



The National Quality Framework (NQF) operates through an applied law system, comprising the Education and Care Services National Law and the Education and Care Services National Regulations.

Australia's system for regulating and improving the quality of early childhood education and care services.

Key objective is to ensure children experience safe, high-quality early education and care.

All Australian Governments have agreed to the NQF.

Approved learning frameworks place the highest expectations on learning, development and wellbeing for children.

Queensland approach

In addition to leading the response of states and territories to the national Review of Child Safety Arrangements, ECRA has progressed significant operational and policy reform in response to Operation Tenterfield. Fundamental to this reform process has been a high level of engagement with the sector, experts in child safeguarding, QPS, Blue Card Services (BCS), the Department of Families, Seniors, Disability Services, and Child Safety and all early childhood regulatory authorities across Australia.

In February 2024, in response to the outcomes of Operation Tenterfield, ECRA established Project Safeguard. Coordinated by the Child Safeguarding Team, a dedicated taskforce of specialist investigators, Project Safeguard sought to:

- ensure that any potential breaches of the Education and Care Services National Law (National Law) by the involved centres were identified, investigated and actioned
- determine any organisational, contextual or situational deficiencies that may have contributed to opportunities for offending
- investigate any acts or omissions on the part of Approved Providers and Nominated Supervisors of the involved centres that may have led to the commission of offences
- make recommendations to reduce opportunities for offending in the future.

ECRA made the decision to prioritise for investigation the services where the offender had more recently worked. In addition, several services had changed operators and some no longer exist, which limited the scope of the investigations able to be undertaken.

It is also worth noting that the National Law at the time of the investigations required that proceedings for an offence must be commenced within two years of the date of the alleged offence⁶⁸ and that the approved provider of a service is only required to retain staff records for three years.⁶⁹

Table 8: Overview of Project Safeguard initiatives undertaken by ECRA

Initiative	Aim	Details
Investigation of non-compliance	Identify any non-compliance with the National Law on the part of approved providers where there was known offending and take compliance and enforcement action as appropriate.	• Creation of dedicated Regulatory Response team of specialised investigators. • Close liaison with the AFP re. initiation of investigations and access to evidence. • Conduct Project Safeguard investigations into 10 approved ECEC services.
Review of investigatory practice	Ensure ECRA investigatory processes specific to matters relating to educator conduct reflect contemporary best practice.	• Centralisation of all child sexual abuse complaint and notification assessments and investigations in ECRA. • Creation of new investigation protocols, processes and templates.
Review of information sharing	Ensure ECRA ability to share information with co-regulators about child sexual abuse allegations relating to individuals is maximised in existing legislative parameters.	• Negotiation of new information sharing processes with BCS, enabling information to be shared regarding allegations in the absence of disciplinary action in certain circumstances. • Negotiation of consistent recordkeeping practices, and arrangements for information sharing, with all state and territory regulatory authorities. • Review of all historical notifications of child sexual abuse allegations and creation of intelligence records in the National Quality Agenda IT system for each individual.

Initiative	Aim	Details
Expert advice	Provide opportunities for expert advice in relation to the behaviour of offenders in child and youth-facing organisations to inform policy and practice responses to Operational Tenterfield.	• Work closely with Griffith University Youth Forensic Service to disseminate current research findings regarding offender behaviour and implications for prevention and detection of child sexual abuse in early childhood settings. • Provide opportunities to present to regulatory staff, state and national policy makers and the early childhood sector. • Develop a behaviour-led detection system for use by ECRA to allegations relating to educator grooming-type behaviours.
National policy development	Ensure that emerging findings from the Project Safeguard investigations inform the national Review of Child Safety Arrangement under the National Quality Framework (2023).	• Queensland leadership of the national implementation approach to the Review recommendations, as co-chair of the Child Safety Review Group. • Provide policy input into key recommendations including new offence of inappropriate conduct and new powers of Regulatory Authorities to share information with approved providers and require information from labour hire companies. • Co-lead with NSW to undertake further review of reform opportunities within two years, informed by findings arising from Operation Tenterfield.
Queensland policy development	Ensure that emerging findings from the Project Safeguard investigations inform policy relating to Queensland-specific legislative requirements.	• Undertake comprehensive review of Queensland-specific rest period conditions, including options for legislative reform. • Work with the early childhood sector to raise awareness of child safety risks associated with sleep and rest time and encourage voluntary amendment of service approval to remove rest period conditions. • Implement new Queensland Government child protection training protocol to close identified loophole in National Law and ensure s.162A requirements in National Law apply in Queensland.
Sector engagement	Promote effective preventative practice in ECEC services through dissemination of research, best practice and emerging themes from Project Safeguard investigations.	• Regular presentations to the Queensland Regulatory Advisory Committee, representing large early childhood providers and sector peaks. • Co-design and launch with the Queensland early childhood sector of the Shared Statement of Commitment, which sets out the responsibilities of educators, approved providers and regulators in keeping children safe: 'every interaction counts'. • Promotion of Positive Relationships with Children as one of four regulatory priorities for ECRA.

In addition to activities undertaken as part of Project Safeguard, the Queensland Department of Education reports that it has invested in a number of initiatives to strengthen protections for children's safety. This includes:

- \$1.8m to partner with the Australian Centre for Child Protection to develop the nation's first formal child safety training package, to be rolled out nationally from January 2026, for all early childhood staff
- \$9.15m from 2024–25 to 2026–27 to partner with NAPCAN and Autism Queensland for the delivery of the Positive Behaviour Guidance Coaching Program to promote protective behaviours and positive behaviour guidance in Queensland
- \$7.4m from 2024–25 to 2025–26 for a Leadership and Management Program to build leadership and management capability in early childhood services in Queensland, and
- \$1m to deliver an education and training program to support the early childhood sector implement the new child safety legislative reforms and guidance materials during 2025–26 in Queensland.

Queensland has also progressed jurisdictionally specific amendments as part of ACECQA's review of child safety arrangements.

Rest period conditions, which allow for reduced educator-to-child ratios during sleep and rest periods were carried over from the *Child Care Act 2002* and were initially intended to apply as jurisdictionally specific transitional provisions. However, in 2017, they were adopted permanently.⁷⁰

ECRA has indicated that while their investigations showed that rest period conditions were likely not a causal or a direct contributing factor to the offending, given the correlation of some patterns of offending with rest periods, it is a time when heightened vigilance is required, and therefore, were inconsistent with the reduced staffing levels position facilitated by rest period conditions.

Accordingly, removing this provision was seen as a priority however, at the national level, it was considered as necessary for the regulatory impact of its removal to be considered. While the regulatory review and impact assessment process was being progressed, ECRA sought voluntary surrender of remaining rest period conditions (including waiving the associated fee). As a result of this approach 330 services with a rest period condition voluntarily surrendered their condition.

On 16 October 2025, the Education (General Provisions) Amendment Bill 2025 was passed which included provisions that removed the ability for approved providers to hold rest period conditions on their service approvals under both the National Law and the state-based *Education and Care Services Act*. This means that existing rest period conditions will no longer be in effect from 1 January 2026, and services will have to comply with national educator-to-child ratios at all times.

ECRA also led work nationally with other regulatory authorities to strengthen risk identification and management in the National Quality Agenda IT System. As a result of this work, details regarding any educator subject to allegations of assault on a child are stored and now searchable in the National Quality Agenda IT System, regardless of whether those allegations were able to be substantiated. A body of work is also being progressed to ensure that this is retrospectively applied, which is resource intensive given how information has previously been stored in this system.

In September 2025, ECRA released its regulatory priorities for 2025–27 which include child safety and staffing. Regulatory priorities inform ECRA's communications strategy, engagement with the sector and are targeted as a part of monitoring visits for the period of their operation. The inclusion of child safety as a regulatory priority highlights how updates to the NQF resulting from the Child Safety Review, and the commencement of Queensland's Child Safe Standards and the Reportable Conduct Scheme will strengthen the safety of children in ECEC services. A focus on staffing will also advance this priority by ensuring child safety starts right from the point that staff are recruited.

The services where abuse occurred

In response to requests for information some services provided advice about the changes that they have enacted since the offending was detected. These are discussed in further detail in later chapters of this report.

Centre EA

The Approved Provider of Centre EA is a medium size, not-for-profit provider, operating only in Queensland. Centre EA has less than 30 approved places for children aged 24 months and above. Centre EA submitted that they have 'proactively introduced' centre-wide improvements, some of which 'significantly exceed regulatory requirements'. Changes have been implemented to:

- staffing practices
- safety, reporting and investigation practices
- training and professional development practices
- induction and onboarding
- auditing and policy oversight
- device monitoring and technology.

Centre EA has also installed mirrors to assist with supervision, particularly for the outdoor fort and has stopped allowing educators to hang sheets from the fort or use sheets to make 'cubbies'.

Centre WS

The Approved Provider of Centre WS is a small for-profit provider, operating two services in Southeast Queensland, providing services for children from birth. The service currently has a condition relating to the use of mirrors to aid supervision. These conditions are used when ECRA is of the view that an aspect of the ECEC service premises has not been designed to facilitate adequate supervision.

Centre WS reports that it has implemented significant updates to its child protection framework to strengthen existing policies and ensure all staff are equipped with the knowledge and tools necessary to identify and respond to serious incidents involving children. This includes new policies and procedures, as well as updates to training and ongoing education.

While this centre advised that the 'CPP [Child Protection Policy] is reviewed and if necessary, updated annually'. The most current Child Protection Policy is reported to have been updated in July 2025, but appears to be substantively the same as that previously provided by ECRA, dated July 2018. Notably, the policy includes several inaccuracies including references to legislation that is non-existent or from other jurisdictions, as well as incorrect definitions.

Centre BS

The Approved Provider of Centre BS is a large for-profit provider, operating across Australia. It is a large service with 141 approved places and is approved to provide education and care from birth. The service is in a multi-storey building, and has a series of conditions to address evacuation risks associated with multi-storey buildings. This centre has advised that it has implemented a renewed commitment to child safety, recruitment and training measures, and increased reporting and oversight.

Centre HN

Centre HN is a medium size service with 78 approved places for children from birth. Centre HN is operated directly by the Approved Provider. As part of ongoing improvement programs relevant to the operations of Centre HN, a range of changes have been implemented over time. This centre reports that it has made changes to its infrastructure and visibility enhancements, updated its policies and increased education to children on personal safety.

Working with Children Checks

Across his offending timeline, the offender did not hold a valid blue card from 9 May 2007 to 24 October 2008, and from 20 November 2010 to 10 January 2011. This meant at times he worked in centres without a valid WWC clearance, however as there were no charges or convictions against him there is no suggestion that he would not have obtained one if he (or his employer) had submitted renewal applications on time. In the latter years of his offending, he held an exemption for a blue card as he maintained his registration with the Queensland College of Teachers (QCT).

The offender met all requirements to obtain, hold and maintain a blue card over the nearly two decades that he is known to have offended.

An examination of the actions of BCS after the offender's arrest shows how the system should have operated, how the system did operate, and limitations that were identified as a result of this case.

While the period after the offender's arrest saw progress being made at the national level with respect to Working with Children Checks, this progress was not a reaction to the arrest but the ongoing implementation of recommendations from the Royal Commission.

Table 9: Blue Card Services' immediate actions following the offender's arrest

19 August 2022	BCS received a request from QPS for a blue card check for the offender and a list of linked services.
21 August 2022	The offender was arrested.
22 August 2022	AFP provided information to the QPS Blue Card liaison officer regarding the offender's arrest and seizure of his exemption card.
24 August 2022	BCS received notification that the offender's exemption card was seized by QPS. BCS requested a national police check. BCS sent an email to QPS requesting information about charges it had seen on the courts database. BCS received confirmation from QPS that offender was charged with one Commonwealth offence and two Queensland offences. BCS made the decision to suspend the offender's Exemption Card. Actions taken by BCS included: • Notifying the offender of the offender's Exemption Card suspension and required actions. • Notifying linked services of his Exemption Card suspension and of their obligations. • Notifying the Department of Education in its capacity as a Notifiable Person under the WWCC Act of the suspension of the offender's Exemption Card.
1 September 2022	QPS sent an email to BCS about the offender's blue card history, requesting any historical allegations made to BCS. BCS responded, informing QPS that there were no historical allegations made to QPS and acknowledging receipt of the offender's exemption card from QPS.
6 September 2022	BCS sent an email to QPS about the offender still showing as a registered teacher and requested information about whether QPS or AFP would notify QCT. QPS responded that QPS is required to notify, but that the charges against the offender were instigated by AFP. QPS were unaware of whether the AFP was required to notify QCT.

9 September 2022	A National Police Check for the offender was undertaken by QPS for BCS.
20 September 2022	BCS notified the offender that his exemption card was returned to BCS by QPS.
21 September 2022	BCS notified QCT of the suspension of the offender's Exemption Card.
30 September 2022	BCS requested information from linked services on whether the offender was still employed.
7 October 2022	BCS received advice from QCT that the offender's teacher registration was suspended.
	BCS cancelled the offender's exemption card, and notified linked services and the offender that 'the working with children exemption [BCS] issued to [the offender] has expired because [the offender] is no longer a registered teacher.'

Patching the gaps

While QPS has provided BCS with daily notifications of changes in criminal history of state offences for blue card applicants or holders since 2003, at the time of the offender's arrest the same did not apply for Commonwealth charges.

BCS were first notified of the change in the offender's police information when on 24 August 2022, it received notification from the QPS that the offender's exemption card had been seized upon the offender's arrest, three days earlier. This delay highlights the importance of reforms previously recommended by the Royal Commission and currently being progressed by the Australian Government in relation to the National Continuous Checking Capability of WWCC cardholders' police records.⁷¹

As the National Continuous Checking Capability remains in its development stage (some ten years after it was recommended by the Royal Commission), BCS entered into a Memorandum of Understanding (MoU) with the Joint Anti Child Exploitation Taskforce (JACET) in the AFP from 8 November 2024 to establish direct reporting from AFP to BCS. Under this MoU, JACET agreed to notify BCS of charges laid against blue card holders for serious Commonwealth child sex offences.

As of June 2025, JACET had advised BCS of 10 instances of charges being laid, leading to the suspension and cancellation of several current blue card holders. This unilateral MoU highlights flaws in the operationalisation of a national scheme, and it is unknown if other states and territories have matching arrangements with the AFP and indeed how the AFP determines which state or territory WWCC schemes to notify for online offences committed by highly-mobile offenders.

Strengthening the Blue Card risk-based decision-making framework

On 11 September 2024, the Queensland Parliament passed the *Working with Children (Risk Management and Screening) and Other Legislation Amendment Act 2024* which ‘implements a new fit-for-purpose decision-making framework that is more consistent with other jurisdictions’. In a press release, the Attorney-General stated that:

The new framework adopts nationally agreed criteria, which must be considered when a person returns information of concern... As part of its decision making, Blue Card Services, within the Department of Justice and Attorney-General, will be able to seek specialist knowledge and advice to assist in deciding a blue card application...New powers have also been included to enable the suspension of a person’s card where there would be a risk to the safety of children if the person was allowed to continue to work during reassessment.⁷²

The creation of a risk-based assessment within the blue card scheme operates on the presumption that a blue card will be issued unless there is an exceptional case where it is not in the ‘best interests of children’ to do so. The new test is based on whether there is a ‘real and appreciable risk to the safety of children’ such that a reasonable person would not allow an applicant to have contact with children. This shift to a risk-based threshold brings the WWC Act into broad alignment with other Australian jurisdictions, the National Standards for WWCC, and Royal Commission recommendations.

“

The safety of our children is an absolute priority for the...Government. We continue to work closely with other jurisdictions to ensure we do everything we can to strengthen laws and procedures when it comes to protecting children.⁷³

”

From 1 July and 20 September 2025, further changes came into effect:⁷⁴

- New types of child-related work now require a blue card.
- Standardised exemptions, self-disclosure obligations, a simplified decision-making framework, and stronger compliance and enforcement powers were introduced for BCS.

In addition to these amendments, in May 2025 BCS finalised a project with an external consultant from Griffith University who was engaged to develop an analysis tool to be used where ‘behaviours of concern’ are identified during the risk assessment process. The tool aims to address concerns raised that have not reached the criminal threshold. BCS advised the Board that this process will be an important part of a suite of tools the organisation uses to assess risk among individuals who exhibit child-related behaviours of concern which have not necessarily led to a charge or a conviction.

While a copy of the tool and supporting research was requested by the Board to inform its assessment of the blue card systems responses to child sexual abuse, the Department of Justice declined to provide this information. The department cited that access to the tool had been restricted as it provides an insight into the behaviours of perpetrators of child sexual abuse and if inadvertently released, could lead to misuse by perpetrators, diminishing its effectiveness.

Chapter 13

Child Safe Organisations and the Reportable Conduct Scheme – a missing piece

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Child Safe Organisations and the Reportable Conduct Scheme – a missing piece

“

*We cannot consider our working with children check scheme to be comprehensive in Queensland when we don't have a reportable conduct scheme feeding into that.*⁷⁵

”

Over its five-year inquiry, from 2012 to 2017, the *Royal Commission into Institutional Responses to Child Sexual Abuse* (Royal Commission) explored the devastating impacts of child abuse in organisations. In its final report delivered in December 2017, it recommended a wide range of measures designed to keep children and young people safe including that all states implement the Child Safe Standards (the Standards) and establish nationally consistent reportable conduct schemes:

Recommendation 7.9: State and territory governments should establish nationally consistent legislative schemes (reportable conduct schemes), based on the approach adopted in New South Wales, which oblige heads of institutions to notify an oversight body of any reportable allegation, conduct or conviction involving any of the institution's employees.⁷⁶ Recommendation 7.10: Reportable conduct schemes should provide for:⁷⁷

- a. an independent oversight body.*
- b. obligatory reporting by heads of institutions.*
- c. a definition of reportable conduct that covers any sexual offence, or sexual misconduct, committed against, with, or in the presence of, a child.*
- d. a definition of reportable conduct that includes the historical conduct of a current employee.*
- e. a definition of employee that covers paid employees, volunteers and contractors.*
- f. protection for persons who make reports in good faith.*
- g. oversight body powers and functions that include:*
 - i. scrutinising institutional systems for preventing reportable conduct and for handling and responding to reportable allegations, or reportable convictions*
 - ii. monitoring the progress of investigations and the handling of complaints by institutions.*

In total, the Royal Commission made eight recommendations to support the establishment of reportable conduct schemes across jurisdictions, and 31 recommendations to embed the Standards into practice.

The Queensland Government accepted these recommendations and committed to systemic reform. In its response to the Royal Commission's recommendations published in June 2018, the government indicated that 'the establishment of a reportable conduct scheme is a priority for Queensland'.⁷⁸ From 2018–22 it produced annual reports on its implementation of the recommendations.

Up until late 2020, the Department of the Premier and Cabinet were responsible for implementation of both the Standards and the Reportable Conduct Scheme. Responsibility for the Reportable Conduct Scheme was subsequently transitioned to the former Department of Justice and Attorney-General (currently the Department of Justice). The former Department of Child Safety, Youth and Women became responsible for the identification of options for statewide implementation of the Standards in Queensland.

Departmental advice provided to the Board outlined that:

while these were two separate projects, both departments worked closely together to ensure coordinated thinking about the possibilities for regulation and oversight.

This included by commissioning financial modelling for different regulatory options and conducting targeted consultation in 2021 on the *Growing Child Safe Organisations in Queensland: Consultation Paper* with peak bodies and other sector representatives on potential options.

The government's consultation included a discussion paper seeking responses on key questions such as:

- Do the categories recommended by the Royal Commission appropriately represent those that should be subject to a potential child safe standards system? Is this scope too broad or too narrow, and why?
- If a regulatory response to child safe standards is implemented, should some sectors be subject to regulation and oversight before others? Why, or why not?
- Should there be a staged approach to implementing child safe standards focusing on awareness and capacity building before imposing regulation and oversight functions?
- How could an oversight body target monitoring and compliance activities to where they are most needed?
- In your sector, which bodies have a role to play in the regulation and oversight of the handling of employee-related child protection matters (such as allegations of child sexual abuse)? How could these functions align with a separate body overseeing a reportable conduct scheme?⁷⁹

In its Fourth Annual Progress Report (December 2021), the government reaffirmed its focus on implementing the scheme, stating:⁸⁰

Queensland Government agencies are incorporating the Child Safe Standards into our work with children, and we have made good progress with our project to identify options for regulation and oversight.

The views of stakeholders are informing the development of options for potential regulation and oversight of Child Safe Standards across Queensland, as well as options for a Queensland Reportable Conduct Scheme.

During 2021, we consulted government and non-government stakeholders to assess sector readiness and understand the potential cost and resource implications of a reportable conduct scheme.

On 21 August 2022, the offender was arrested.

In its Fifth (and final) Annual Progress Report (December 2022), the government confirmed its commitment to implementing the scheme, stating:⁸¹

In 2018, the Queensland Government accepted the child safe standards as informing best practice for departments that provide services to children. Since then, Queensland Government departments have continued to incorporate child safe standards (as provided in recommendation 6.5) into policy, procedure and practice. The Queensland Government is undertaking work to determine suitable options to support statewide implementation of child safe standards following targeted consultation in 2021.... DCSSDS and DJAG continued work to identify options for: potential regulation and oversight of child safe standards across Queensland; and the establishment of a Queensland reportable conduct scheme. Informed by the results of targeted consultation and an independent actuarial analysis, options for the development of a reportable conduct scheme model were developed. The Queensland Government will consider these options to determine the best way forward for Queensland.

The government ceased reporting on its implementation actions in 2022. The Department of Families, Seniors, Disability Services and Child Safety (DFS DSCS) advised the Board that during this period they:

committed to continuing to work through key policy issues such as scope of organisations, information sharing, reducing duplication with other regulatory frameworks, and the appropriate oversight body through development of the legislation.

In June 2023, as part of the 2023–24 Budget the Queensland Government committed:⁸²

\$746,000 over three years to support continued project implementation and \$10 million per annum (ongoing from 2023–24) held centrally to support implementation of Child Safe Standards and the establishment of the Reportable Conduct Scheme in non-government organisations.

On 1 August 2023, the AFP and QPS held their first press conference to advise the public of the case.

Nine days after the announcement that the offender had been arrested, on 10 August 2023, the Queensland Government released the *Growing Child Safe Organisations Consultation Regulatory Impact Statement* (CRIS).⁸³ The CRIS explored implementation options for the Standards and a Reportable Conduct Scheme in Queensland. It sought public input into the recommendations.

This was five years after the Royal Commission recommendations were made.

The Board sought to understand the timing of the public release of the CRIS and requested information about this from both the Department of Justice and the Department of Families, Seniors, Disability Services and Child Safety. This was in part to address potential cynicism that the CRIS was released as a direct response to the offender's case, rather than a matter of good policy development. The Board was keen to understand the relationship between advancements in child safeguarding legislation and critical incidents. Unfortunately, the documentation requested was not provided, on the basis that it was Cabinet-In-Confidence.

The Department of Justice did provide an internal briefing note titled *'Adverse media associated with recent arrest of a child care worker'* which contained little further evidence of the decision making. This brief provided a history of the blue cards issued to the offender, as well as details of the suspension of his blue card. It also sought to answer two questions:

- Are there enough checks and balances in the blue card system?
- How would the Child Safe Standards and Reportable Conduct Scheme make a difference in this case?

This brief noted that:

In this case, the Blue Card system has served its intended purpose and immediate action was taken in response to the relevant criminal charges as soon as BCS was made aware of the charges...Blue card screening is recognized as one of the strongest checks in Australia but is only one aspect of protecting children, particularly in the regulation of the childcare sector..

There have been previous recommendations made by the Queensland Family and Child Commission in their reports...in relation to allowing the QPS to share information about a suspect with BCS while an investigation is finalised. However, these recommendations have not been implemented. This is based on a review of police investigations involving blue card holders undertaken by the QPS which determined that the sharing of suspect information was unlikely to mitigate risks to children.

The brief also provided an overview of the Royal Commission's recommendations in relation to the Standards and the Reportable Conduct Scheme, and noted that:

Implementation of the CSS [Child Safe Standards] and RCS [Reportable Conduct Scheme] would build knowledge and capacity amongst employees (and potentially others) to better equip people to recognize and counter problematic attitudes and behaviour that put children at risk, and to know how to respond to warning signs and indicators.

The Department of Justice advised that this draft brief was not approved beyond the relevant Executive Director. A section of the internal brief which included cabinet-in-confidence information was not provided by the department in response to the Board's request.

The Board therefore cannot confirm whether, or how, the offender's case contributed to the decision to progress planning for reportable conduct scheme through the release of the CRIS.

To support public input, the Government produced six supplementary resources:

1. Overview Guide to the CRIS.
2. Embedding Cultural Safety.
3. Scope for Child Safe Standards and Reportable Conduct Scheme.
4. Options for Child Safe Standards.
5. Overview of Reportable Conduct Scheme.
6. CRIS Frequently Asked Questions.⁸⁴

The Department of Families, Seniors, Disability Services and Child Safety advised that extensive consultation was undertaken in 2023 on the CRIS, which sought feedback on regulatory options for the Standards and Reportable Conduct Scheme in Queensland, including an integrated child safe organisations system. The consultation process involved:

- two online information sessions, attended by over 170 participants
- 63 written submissions
- targeted consultation with young people through the CREATE Foundation, Queensland Youth Parliament, Queensland Family and Child Commission, Indigenous youth leadership programs, and Youth Empowered Towards Independence in Cairns
- a cross-sectoral forum in Cairns with over 20 key stakeholders
- direct engagement with over 10 organisations and regulators across sectors including education, arts, transport, disability, health, housing, child protection and ECEC services.

Submissions closed on 22 September 2023, and stakeholders strongly supported legislative action to improve child safety. Young people, in particular, advocated for laws that make child safety a non-negotiable standard across organisations.

On 3 October 2023 the offender was identified in the press.

On 22 March 2024, the Queensland Government published the *Growing Child Safe Organisations Decision Impact Analysis Statement* (DIAS) and a summary of findings. The DIAS recommended the establishment of an integrated Child Safe Organisations system, comprising:⁸⁵

1. A collaborative regulatory model mandating the Standards and ensuring compliance by in-scope organisations.
2. Oversight of institutional child abuse complaints and allegations via a nationally consistent Reportable Conduct Scheme.

On 12 June 2024, the *Child Safe Organisations Bill 2024* (the Bill) was introduced to Parliament. It established:⁸⁶

- Mandatory implementation of the 10 National Principles for Child Safe Organisations and the Universal Principle of cultural safety for Aboriginal and Torres Strait Islander children.
- A Queensland-based Reportable Conduct Scheme aligned with national models.

The Bill proposed to provide the Queensland Family and Child Commission with legal responsibility for leading the establishment and administration of the Child Safe Organisation system. The Bill was referred to Parliamentary Committee who accepted submissions, held public hearings and reported to the Assembly.

With respect to the budgetary commitments to support the scheme, at the 9 July 2024 Community Support and Services Committee Public Briefing on Child Safe Organisations Bill 2024 the Department of Families, Seniors, Disability Services and Child Safety advised the Committee that:⁸⁷

the Queensland Government has committed \$43.525 million over four years and ongoing funding for the QFCC to operate as the oversight body, and to support some agencies' ongoing role as collaborative regulators for the child safe organisations system established by the Child Safe Organisations Bill 2024 (the Bill).

\$36.059 million over four years from 2024–25 and \$9.444 million ongoing has been committed to the QFCC for its child safe organisations oversight body functions, subject to passage of the Bill.

On 2 September 2024, the offender pleaded guilty.

On 19 September 2024, the *Child Safe Organisations Act 2024* received assent. The Act proposed a phased implementation timeline, such that:

- April 2025: Sector and industry education and capacity building begins.
- October 2025: Phased rollout of Child Safe Standards and the Universal Principle.
- July 2026: Phased rollout of the Reportable Conduct Scheme.
- July 2027: Full implementation of the Child Safe Organisations system.
- July 2030: Three-year post-implementation review.

In October 2025, amending legislation was passed to bring forward and synchronise commencement of the Reportable Conduct Scheme on 1 July 2026.⁸⁸

Consequently, the Queensland Reportable Conduct Scheme will commence eight years and eight months after it was formally recommended by the Royal Commission.

Why did it take so long?

Queensland is one of the last jurisdictions in Australia to implement a reportable conduct scheme. The *Child Safe Organisations Act 2024* (the Act) passed 25 years after New South Wales established its Reportable Conduct Scheme, which has been followed by Victoria (2017), Western Australia (2023) and Tasmania (2024). Only South Australia and the Northern Territory do not have Reportable Conduct Schemes currently operating in their jurisdiction.

The Board asked the agencies to provide copies of briefings, implementation updates and progress reports relating to the reportable conduct scheme. Limited information was provided with agencies citing that the information could not be disclosed due to cabinet privilege. Each agency provided a timeline that aimed to provide a comprehensive outline of key milestones in the development and design of the scheme.

While these timelines demonstrate that progress was being made towards the development of the scheme in the years leading up to the offender's arrest, they do not provide insight as to what, if any impact, the offender's arrest had on the timing of its implementation. A brief provided by the Department of Justice shows that the issue of whether the Standards and Reportable Conduct Scheme would have made a difference in the offender's case was considered in some sections of the Department. This brief is dated 3 August 2023, two days after the first press conference about the offender's arrest, and seven days prior to the release of the CRIS for consultation.

Table 10: Implementation timeline

Timeframe		Agency response	Milestone
2015	August	DFSDSCS Department of Justice	The Royal Commission released its Working with Children Checks report.
2016	April	DFSDSCS Department of Justice	The Council of Australian Governments agreed in-principle to harmonise reportable conduct schemes across jurisdictions, consistent with the New South Wales model.
2017	March	DFSDSCS Department of Justice	Public consultation on a reportable conduct scheme commenced with the release of Queensland: A Reportable Conduct Scheme Issues Paper by the Department of the Premier and Cabinet. Consultation closed on 2 May 2017.
	July	DFSDSCS Department of Justice	The Queensland Family and Child Commission released its report Keeping Queensland's Children More than Safe: Review of the Blue Card System. This report included recommendations related to the Standards and a reportable conduct scheme.
	December	DFSDSCS Department of Justice	The Royal Commission released its Final Report.
2018	June	DFSDSCS Department of Justice	The Queensland Government tabled its response to the Royal Commission, accepting or accepting in principle all recommendations related to the Standards and a reportable conduct scheme in Queensland.
	December	DFSDSCS Department of Justice	The Queensland Government accepted the Royal Commission's the Standards as informing best practice that provide services to children in its first annual progress report.
2019	February	DFSDSCS Department of Justice	The former Council of Australian Governments endorsed the National Principles for Child Safe Organisations.
Responsibility for implementation of the Standards and RCS transitioned from the Department of the Premier and Cabinet to the Department of Justice and Attorney-General (DJAG) and Department of Child Safety, Youth and Women (DCSYW)			

Timeframe		Agency response	Milestone
2020	September	DFSDSCS	Responsibility for implementation of the Standards and Reportable Conduct Scheme recommendations transitioned to the then: DCSYW – responsible for the statewide implementation of the Standards in Queensland DJAG – responsible for the implementation of a Queensland Reportable Conduct Scheme.
	Late 2020 to early 2021	DFSDSCS	Development of a consultation paper for targeted consultation on options for the oversight and regulation of the Standards in Queensland.
2021	January	Department of Justice	The then Queensland Government commenced two projects to identify options to (a) support implementation of the Standards in Queensland and (b) establish a Reportable Conduct Scheme.
	March	DFSDSCS	Targeted consultation on the Standards and a Reportable Conduct Scheme in Queensland commenced with the release of Growing Child Safe Organisations in Queensland: Consultation Paper and a series of information sessions. Consultation closed on 23 April 2021.
	May	Department of Justice	Targeted consultation on the Standards and a reportable conduct scheme in Queensland concluded.
	Mid-end 2021	Department of Justice	As referenced in the CRIS (see below), the then Department of Children, Youth Justice and Multicultural Affairs (DCYJMA) and DJAG worked with Finity Consulting to develop indicative cost modelling estimates for options to implement the Standards and a reportable conduct scheme.
	November	DFSDSCS	Modelling of Regulatory Costs: Child Safe Standards and Reportable Conduct Scheme internal paper developed.
	2021 to early 2022	DFSDSCS	Model options developed for the oversight and regulation of the Standards in Queensland.
2022	Early-mid 2022	Department of Justice	DCYJMA and DJAG refined cost estimates and model options, which required targeted consultation with Government departments and agencies (including potential oversight bodies). DCYJMA and DJAG conducted preliminary impact assessment (PIA) as required under the previous Queensland Government's Guide to Better Regulation. Under the previous Guide, the Office of Best Practice Regulation (OBPR) were responsible for assessing the PIA to advise if a CRIS should be undertaken.
	21 August	The offender was arrested	
	6 May	DFSDSCS	The Office of Best Practice Regulation (OBPR) advised the development of a Regulatory Impact Statement would be required.
	May 2022 to May 2023	DFSDSCS Department of Justice	The CRIS was developed, the first social policy CRIS in Queensland, and cost estimates for organisations to implement different regulatory options for the Standards, a reportable conduct scheme and an integrated child safe organisations model. This process included extensive consultation with OBPR.

Timeframe	Agency response	Milestone
2023	24 May	Department of Justice Letter from the then Department of Child Safety, Seniors and Disability Services (DCSSDS) to OBPR - to assess adequacy of Growing Child Safe Organisations CRIS before it is able to be published.
	8 June	DFSDSCS Department of Justice OBPR advised the CRIS was adequate for consultation.
	1 August	The AFP and QPS held their first press conference to advise the public of the case.
	3 August	Department of Justice An internal brief 'Recent arrest of a childcare worker' was developed which provided an overview of the offender's arrest, and history of blue cards issued to the offender. This brief sought to answer two questions: Are there enough checks and balances in the Blue Card system? How would the CSS and RCS make a difference in this case?
	10 August	DFSDSCS Department of Justice Release of the Growing Child Safe Organisations in Queensland CRIS for consultation.
	August to early September	Department of Justice Consultation period for CRIS (approximately 6 weeks) including written submissions, information sessions, and in person sessions in Cairns.
	September 2023 to March 2024	Department of Justice Preparation of Growing Child Safe Organisations DIAS considering results of consultation and seeking Ministerial approval for release.
2024	January to March	Department of Justice Drafting of Bill with the Office of the Queensland Parliamentary Counsel. This includes a Cabinet submission process seeking approval of drafting.
	22 March	DFSDSCS Department of Justice Release of the Growing Child Safe Organisations in Queensland Summary Impact Analysis Statement (Summary IAS) and DIAS.
	April	Department of Justice Targeted consultation on exposure draft Bill with Government and non-Government stakeholders including potential sector regulators and the Queensland Family and Child Commission.
	May	Department of Justice Finalising drafting of Bill post-consultation.
	3 June	Department of Justice Cabinet approval sought to introduce the Child Safe Organisations Bill 2024 into the Legislative Assembly.
	12 June	DFSDSCS Department of Justice Introduction of the Child Safe Organisations Bill 2024.

Timeframe		Agency response	Milestone
2024	June to August	DFSDSCS Department of Justice	The Child Safe Organisations Bill 2024 is considered by a parliamentary committee.
	15 July	DFSDSCS	Proactive release: Child Safe Organisations Bill 2024.
	2 August	Department of Justice	Committee report tabled.
	11 September	DFSDSCS Department of Justice	Child Safe Organisations Bill 2024 debate and passage.
	19 September	DFSDSCS	<i>Child Safe Organisations Act 2024</i> receives Royal Assent.

Would an earlier introduction of a reportable conduct scheme have made a difference?

In acknowledging the prolonged implementation of the Reportable Conduct Scheme in Queensland, the Board has asked itself:

- Would the offender have been identified earlier if the Reportable Conduct Scheme had been established?
- If so, was the delay in its implementation in Queensland justified?
- Would the Reportable Conduct Scheme have efficiently and effectively identified the offender today or does it need to be strengthened?

In examining past case studies, it is important to approach analysis with care. With the benefit of hindsight, there is a natural tendency to hypothesise about how different actions or decisions might have altered outcomes. While such reflections can be valuable in highlighting potential points of intervention, they can also create a false sense of certainty. Decisions that now appear obvious may not have been apparent to practitioners at the time, given the information, resources, and prevailing frameworks available to them. Over-reliance on hypothetical alternative outcomes risks distorting understanding of both the complexity of real-time decision-making and the limitations faced by agencies and individuals.

It is both legitimate and useful to consider how the facts of past cases might be understood under new or revised legal definitions, policy standards, or professional practices. This approach avoids speculation about what ‘might have been’ and instead grounds the analysis in what ‘is now known’. For example, where a case involved conduct that was not clearly proscribed under earlier legislation, it may be instructive to map the same facts against current definitions of harm, abuse, or misconduct. This form of analysis highlights the evolution of legal and policy frameworks and helps to clarify how contemporary safeguards are intended to close previous gaps.

By carefully distinguishing between evidence-based application of case facts to new frameworks and speculative hindsight, case study analysis can serve two purposes:

- learning from the past without unfairly judging historical actors through a modern lens
- testing the strength of contemporary systems by assessing whether known facts from prior cases would now be captured, recognised, and acted upon.

The Queensland Reportable Conduct Scheme applies to certain organisations with a high degree of responsibility for children or who engage in activities where there is a heightened risk to children due to the type of institution, the type of activities undertaken or the vulnerability of the children the organisation engages with. These are called 'reporting entities'. Organisations required to implement a Reportable Conduct Scheme include:

- government entities
- child protection, justice and detention services
- education and health services, and services for children with disability
- ECEC services
- accommodation and residential services
- religious bodies.

The Scheme will commence from 1 July 2026. Reporting entities must have systems in place to:

- prevent reportable conduct by workers
- enable anyone to notify the head of the organisation about a concern or allegation of reportable conduct
- report concerns about the head of the organisation directly to the Queensland Family and Child Commission
- investigate and respond to concerns or allegations of reportable conduct
- inform the Queensland Family and Child Commission of the investigation outcomes.

ECEC and child-minding services were initially required to be compliant with the Reportable Conduct Scheme by 1 July 2027. On 10 July 2025, the Government announced that ECEC compliance with the Reportable Conduct Scheme would be brought forward by one year to 1 July 2026. This was enacted for all sectors (not just ECEC) in October 2025.

The *Child Safe Organisations Act 2024* sets out a definition of reportable conduct that includes 'reportable convictions' and 'reportable allegations'. These must be related to:⁸⁹

- a child sexual offence ('an offence of a sexual nature in relation to a child')
- sexual misconduct committed in relation to, or in the presence of a child
- ill-treatment of a child
- significant neglect of a child
- physical violence committed in relation to, or in the presence of a child, or
- behaviour that causes significant emotional or psychological harm to a child.

An assessment of known complaints made about the offender's conduct has been undertaken by those responsible for implementing the Reportable Conduct Scheme in Queensland to inform the Board's consideration of whether any notifications involving the offender would have been referred to the Scheme, under the current legislative framework (Table 11).

Table 11: Reportable Conduct Scheme assessment of known reports

Date	Report	Reportable Conduct Scheme Assessment	Conclusion
22 October 2009* - Centre BY	The Office for Early Childhood Education and Care receive a report from a parent that their child had disclosed abuse from the offender. This was forwarded to QPS.	As this was reported to QPS it is likely to have been reported to the reportable conduct scheme. This report involves an allegation of sexual misconduct that amounts to reportable conduct under the Act. The Centre would have to inform the scheme, conduct an investigation and the Queensland Family and Child Commission would have to assess the quality of the investigation. The decision of the police to not proceed with a criminal case would have been less likely to be a reason to stop the organisation's internal investigation.	Reportable conduct case 0*. *It is important to note that in 2009 the Royal Commission had not yet commenced and had not recommended Queensland implement a reportable conduct scheme.
16 August 2018 - Centre WS	The centre received a report from a parent that they witnessed the offender threaten to smack a child if she did not bring her bag back to him.	This report may amount to apprehended physical violence, or behaviour that causes significant emotional or psychological harm to a child and amount to reportable conduct under the Act.	Reportable Conduct case 1.
28 August 2019 - Centre EK	The Centre received a report from a parent that their 4-year-old son had disclosed that the offender had grabbed and squeezed his upper arm in response to him playing with Duplo instead of resting.	This report may amount to actual physical violence and amount to reportable conduct under the Act. It is noted this occurred at the same time that the centre had concerns about the offender's use of a camera, and his performance. A reportable conduct investigation led by the centre may have had a broader scope than the specific allegations in the complaint.	Reportable Conduct case 2.
Early 2021 - Centre EA (Report 1)	The offender is witnessed standing behind a child rubbing her shoulders before leaning down to give her a kiss on the head.	Allegation of kissing a child on the head may be a professional breach/ code of conduct issue. This complaint was managed internally and informally by the organisation.	Reportable Conduct case 3. The centre maintains that this incident does not meet the definition of reportable conduct. The Board considers the concerns of the co-worker should have been documented and investigated, and as such reported to the scheme.

Date	Report	Reportable Conduct Scheme Assessment	Conclusion
8 October 2021 - Centre EA (Report 2)	The centre received a report from another employee that the offender was seen kissing a 5-year-old girl at rest time, after he had taken several children outside to rest at the wooden fort. The employee stated they first saw his lips on the child's lips, before seeing him moving his head from side to side with the movement of his lips "a subtle pecking movement". This was reported to QPS and ECRA.	As this was reported to QPS and ECRA it is likely to have been reported to the reportable conduct scheme. Kissing a child on the lips, particularly when combined with the early professional boundary breach above, would amount to an allegation of sexual misconduct and to reportable conduct under the Act.	Reportable Conduct case 4. The centre completed an internal investigation that found the offender's interactions with a small group of female children unprofessional.
20 April 2022 - Centre WN	The centre received a report from parents that their three-year-old daughter had disclosed that the offender had rubbed her private parts during rest time on 19 April 2022.	As this was reported to QPS and ECRA it is likely to have been reported to the reportable conduct scheme. This report involves an allegation of sexual misconduct in relation to a child and would have amounted to reportable conduct under the Act.	Reportable Conduct case 5.

There are at least 3, and up to 5 events, on the offender timeline where a reportable conduct case should and would have been opened, reported to the Queensland Family Child Commission, investigated and quality assured.

The outcomes of these cases are difficult to speculate on; however, the actions and behaviours of the offender are likely to have changed had this occurred, as well as the system responses to this conduct.

This disruption of his behaviour, from 2019 and more specifically from August 2021, could be a significant missed opportunity, however the value of the reportable conduct scheme is not only its requirement for higher quality investigations of complaints, transparency and oversight. The critical component of the scheme is its ability to inform other employers of past complaints.

Under the current legislation, the Queensland Family and Child Commission would have case information on the offender's behaviour that it could have made available to law enforcement agencies, regulators, and ECEC services. One of the key underlying principles of the scheme is the importance of cooperation and timely sharing of information between entities in order to minimise the risk of harm to children. Among the principles guiding the scheme are that 'information should be shared between the commission, sector regulators and reporting entities in a timely way in relation to reportable allegations and reportable convictions in order to minimise the risk of harm to children.'

The head of a prescribed Reportable Conduct Scheme entity may disclose relevant information to the head of another prescribed Reportable Conduct Scheme entity (the receiving entity) for the following purposes:

(a) to lessen or prevent a serious risk or threat to the life, health or safety of a child or class of children.⁹⁰

The Child Safe Organisations Act defines ‘relevant information’ for the purposes of sharing under Section 49 as including:⁹¹

- information about the progress of an investigation
- the findings and reasons for the findings
- any action to be taken in response to those findings
- any other information about a reportable allegation or reportable conviction that would assist a prescribed Reportable Conduct Scheme entity to comply with chapter 3, which is the legislative framework underpinning the scheme.

The information-sharing powers established under the Child Safe Organisations Act represent a critical advance in Queensland’s safeguarding system. For the first time, reporting entities, sector regulators, police and the Queensland Family and Child Commission are authorised to exchange relevant information in a clear legal framework. When used effectively, these provisions can transform isolated cases into connected threads of evidence, enabling a more accurate assessment of risk and a more decisive protective response.

Properly resourced and applied, this mechanism has the potential to fill a long-standing gap: the absence of a routine, systemic means to track persons of concern, collate key indicators of abuse and harm, and construct a clear picture across agencies. No other mechanism in Queensland’s safeguarding architecture currently holds this capacity.

The requirement for timely sharing helps to prevent siloed responses and reduces the likelihood that risks to children will remain hidden. The breadth of ‘relevant information’ that may be shared—findings, reasons and actions—ensures transparency and strengthens oversight. At the same time, the Child Safe Organisations Act builds in appropriate limits to protect confidentiality, investigative integrity and procedural fairness.

In sum, the Child Safe Organisations Act equips Queensland with the foundations of the intelligence and risk assessment system it has long lacked. Its impact will depend on commitment and discipline in implementation, but its promise is profound: a system that can connect the fragments of information which, left isolated, too often fail to protect children from harm.

Knowing what we now know, is the Reportable Conduct Scheme what Queensland needs?

The question of whether Queensland’s Reportable Conduct Scheme would have led to or assisted in the earlier detection of the offender is not simply one of definitions and legislation. While the above shows that the legal application of the new Child Safe Organisations Act to the facts in the case would have resulted in at least three reportable conduct cases, outcomes of these would be dependent on the quality of operation of the scheme.

Queensland can be rightly encouraged by the introduction of the Reportable Conduct Scheme, which represents a significant new safeguard for children and an important advance in the State’s safeguarding architecture. However, it must be recognised that Queensland is comparatively late in adopting such a scheme. Other state and territory schemes have been operating since 2017 in the case of most states (immediately following the Royal Commission), or in New South Wales’ case since 1999. The Royal Commission used the NSW scheme as a model from which other jurisdictions should draw to develop their schemes and harmonise them nationally. As a result, those jurisdictions have experienced the practical challenges of implementation, refined their investigative processes, clarified legislative thresholds, and built-up sector capability through years of operational practice.

While Queensland is a late adopter, it is well-placed to design and implement a scheme that avoids the pitfalls encountered elsewhere and uses the offender’s case, and the recent cases in Victoria and other jurisdictions to build a nation leading scheme. Recent reviews of reportable conduct schemes and recent media reports about child sexual abuse in the ECEC sector in other jurisdictions have shown that a reportable conduct scheme itself is not a cure-all. By embedding these lessons from other jurisdictions at the outset, Queensland can accelerate the maturation of its Scheme and deliver on its promise: a child safeguarding mechanism that is both robust and responsive, and which quickly becomes an integral part of the state’s protective system.

NSW Review

The NSW scheme was reviewed as part of a statutory review of the *Children's Guardian Act 2019* (NSW) in 2024. The report of this review made thirteen recommendations in relation to the Scheme, in addition to recommendations about other systems administered by the Office of the Children's Guardian. Recommendations were made in response to 'to stakeholder feedback to clarify the scope of the Scheme and simplify the processes and obligations for entities' conducting investigations. Recommendations included:⁹²

- Providers of overnight camps, accommodation and respite services, and family group homes, which were included in the scheme in provisions yet to commence at the time of the review, should be included with some amendment to scope, order of commencement, and consultation.
- The *Children's Guardian Act 2019* (NSW) should be amended to clarify that only the 'part of the entity' listed in schedule 1 (being a list of categories of entities within the scope of the scheme) is required to comply with the Reportable Conduct Scheme, in recognition that the *Children's Guardian Act 2019* (NSW) currently imposed an unnecessary regulatory burden on some large organisations which deliver services to children along with other types of services.
- Private health facilities providing services for children should be included in the scope of the scheme.
- Individuals receiving vocational training should be included as 'volunteers' under the scheme.
- The application of the scheme to authorised carers should be limited to those who are employed by or in an entity covered by the scheme.
- A requirement where the head of an entity conducting an investigation should consider whether the conduct is 'in breach of established standards' should be repealed.
- The Office of the Children's Guardian (OCG) should publish guidance on how it makes a decision to commence an investigation of reportable conduct or an entity's investigation.
- To better protect the OCG and its officers, the OCG should be exempted from any legal compulsion to provide information gathered or received as part of the Scheme in any legal proceeding.
- Employees subject to reportable conduct allegations should be able to make a written submission to the head of the entity in response.

Victorian Reviews

The Victorian Reportable Conduct Scheme came into effect in July 2017 in response to the *Betrayal of Trust: Inquiry into the Handling of Child Abuse by Religious and Other Non-Government Organisations* (2013) report. The Victorian Reportable Conduct scheme has been subject to two recent reviews.

In 2022–23, the Victorian Government commissioned a review of the state's Reportable Conduct Scheme, recognising the ongoing need to strengthen child protection and safeguard the well-being of children across all sectors. The review aimed to examine how the scheme, operational since 2017, was functioning in practice, and to identify opportunities for reform that could make the system more effective, consistent, and child centred.

The final report, *Review of Victoria's Reportable Conduct Scheme* (2024) indicated that 'red flags' from unsubstantiated reports to its reportable conduct scheme were not being taken into consideration, with action stifled by poor information sharing between authorities.⁹³ It noted that 'Other jurisdictions have reported that due to resourcing not keeping pace with the volume of notifications, 85% of child abuse and harm investigations receive low or minimal oversight'.⁹⁴

The review found that the scheme has made an important impact. There has been a significant increase in the number of notifications of alleged child abuse, reflecting improved awareness of obligations among organisations and a growing willingness to raise concerns. Many organisations have strengthened internal processes for handling allegations, resulting in more timely and appropriate responses. These outcomes demonstrate the value of having a formal framework that guides organisational responsibilities and promotes accountability.

Despite these achievements, the review identified persistent challenges. One of the most pressing issues was inconsistency in how investigations were conducted across different organisations. While some organisations adhered to rigorous investigative standards, others demonstrated significant variation in quality and thoroughness, raising concerns about fairness and the reliability of outcomes. Additionally, the review highlighted gaps in the support available to children and their families during investigations. Although some organisations provided effective counselling and assistance, many lacked the resources or protocols to offer meaningful support, leaving affected children and parents without adequate guidance or reassurance.

Training and awareness were also found to be uneven. While some staff and leaders were highly knowledgeable about their obligations under the scheme, others were less confident or aware, suggesting a need for more consistent and ongoing professional development. Without this, organisations risk failing to recognise or respond appropriately to allegations, which can leave children vulnerable and undermine trust in the system.

To address these challenges, the review made several recommendations. It emphasised the need for enhanced training and accessible resources, equipping organisations to manage allegations effectively and consistently. Standardising investigative procedures was seen as critical, ensuring that every allegation is treated with the same level of scrutiny, care, and professionalism. The review also stressed the importance of providing dedicated support services for children and families, including counselling and legal guidance, so that affected individuals have a clear pathway to assistance throughout the investigative process.

Oversight and accountability were also highlighted as areas for improvement. The review recommended expanding the role of the Commission for Children and Young People in monitoring compliance, resourcing it to carry out audits, and ensuring that organisations meet their obligations. Finally, the review underscored the need to foster a child-centred culture within organisations, where the safety and well-being of children is prioritised above organisational convenience, and where transparency and accountability are embedded in everyday practices.

The Victorian Government has committed to acting on these recommendations. Legislative amendments to the *Child Wellbeing and Safety Act 2005* (Vic) are being considered to strengthen the scheme's framework, and additional funding is being allocated to support training programs, resources, and support services. Mechanisms are also being put in place to monitor implementation and evaluate the effectiveness of these reforms over time.

Overall, the review of Victoria's Scheme presents a roadmap for building a more consistent, accountable, and child-focused system. By addressing gaps in investigations, training, support, and oversight, these reforms aim to ensure that children's safety is prioritised and that organisations are fully equipped to respond to concerns. The review reflects a proactive approach to child protection, recognising that safeguarding is a shared responsibility that requires clarity, coordination, and a steadfast commitment to the well-being of every child.

Victoria's Scheme was also considered as part of the Rapid Child Safety Review announced by the Victorian Government on 2 July 2025. This review into child safety in ECEC settings was announced following allegations of sexual abuse against children in long day care services in Melbourne.

The *Rapid Child Safety Review Report* was provided to the Victorian Government on 15 August 2025.⁹⁵ It recommended urgent changes to the Reportable Conduct Scheme including that the Working with Children Check and Reportable Conduct scheme be brought together in a single entity. The Victorian Government accepted all 22 recommendations of the Review and is acting urgently to implement them.⁹⁶

Western Australia Review

The Western Australia (WA) Reportable Conduct Scheme commenced in January 2023 and is administered by the WA Ombudsman. The performance of the Reportable Conduct Scheme in its first 18 months was reviewed by the Ombudsman. This review was initiated in recognition of the need to promote greater awareness and understanding of the requirements to have systems in place under the scheme. The final report, *Western Australia's Reportable Conduct Scheme: A review of systems to protect children*, published in April 2025, is intended to build capacity in organisations as well as to inform Parliament of the operation of this recently implemented Scheme.⁹⁷

In this report, the Ombudsman identified that since the Reportable Conduct Scheme commenced on 1 January 2023, it had received 889 notifications to 30 June 2024, containing 1,441 allegations. The rate at which notifications were received rose steadily over the first 18 months. Over 40 per cent of notifications came from the education sector (i.e. schooling), with about 21 per cent coming from ECEC. The majority (around 61 per cent) of allegations related to physical assault.⁹⁸ Around 29 per cent relating to sexual misconduct or a sexual offence. Over 40 per cent of notifications came from the education sector (i.e. schooling), with about 21 per cent coming from ECEC.⁹⁹ The majority (around 61 per cent) of allegations related to physical assault.¹⁰⁰ Around 29 per cent relating to sexual misconduct or a sexual offence.¹⁰¹

With respect to ECEC services, the review further noted that:

- Most notifications came from educators or other staff in ECEC.
- Nearly a third of reports were from parents based on conduct they had witnessed, injuries they had observed, or from disclosures from their children.
- Very few allegations were reported directly to the organisation by a child.
- The most common type of reportable conduct in the early education setting was physical assault, followed by significant neglect.
- ECEC have been 'highly successful' in providing investigation reports to the Ombudsman, or obtaining an exemption from continuing an investigation.
- This speaks to the engagement of the sector with the system, but not necessarily the quality of the investigations themselves.

Australian Capital Territory Review

The ACT Reportable Conduct Scheme commenced in July 2017. It is administered by the Commonwealth Ombudsman through a service delivery agreement with the ACT Government.

The scheme was reviewed in 2019. Key findings from the final report, *Review of the Reportable Conduct Function: Final Report*, include:

- While the achievements of the scheme were considerable, the maturity of organisational compliance was yet to develop after three years in operations.
- There were issues with the capacity of organisations to comply with their requirements, and the Ombudsman was pursuing more education and awareness activities to address this.
- The breadth of skills in the staff of the Reportable Conduct Team was a strong asset to the scheme.
- That the capability of organisations impacted by the Scheme to meet the requirements of the scheme was an issue and reducing resourcing would be a high-risk strategy.

Conclusion

The introduction of a reportable conduct scheme in Queensland is a significant step that will enhance protections for children. If it had been implemented earlier, it is possible that the actions of the offender would have been disrupted. However, the experience from other jurisdictions demonstrates both the achievements and challenges of embedding a reportable conduct scheme.

Past reviews of reportable conduct schemes demonstrate that while these mechanisms are transformative for child safeguarding, their full potential depends on careful resourcing, sector maturity, and robust engagement. High volumes of notifications can challenge the scheme's capacity to proactively detect risk and limit the value of information sharing, highlighting the need for sustained investment in education, training, and capacity building across organisations.

Organisational compliance takes time to develop. Even three years into operations, many entities were still building the systems and skills required to meet their obligations, underscoring that ongoing support and guidance are essential for a Reportable Conduct Scheme to function effectively.

The scheme also reveals a clear societal expectation: parents seek a reliable pathway to report concerns arising from observed conduct, injuries, or disclosures, while very few children make allegations directly to organisations. This reinforces the importance of accessible, trusted reporting mechanisms that capture risk comprehensively.

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The reportable conduct scheme, when taken together with the Blue Card system, can become the central point of a coordinated, whole-of-society approach to safeguarding children. When effectively implemented and resourced, these mechanisms will collectively strengthen Queensland's capacity to detect, respond to, and prevent harm, creating a safer environment for all children.

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Endnotes

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Part

C

Detecting risks, threats and harm

Detecting abuse, grooming and risk

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Detecting abuse, grooming and risk

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Look at the prevalence rates [of child sexual abuse]. We're missing the ordinariness of this. It's not 'out there' - it's in here, and it's part of all of us.¹

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The modern challenge of safeguarding children rests not only on responding to crimes already committed but on anticipating and disrupting threats before they happen. Systems that only respond once abuse has occurred inevitably fail to prevent the profound trauma, lifelong consequences, and intergenerational impacts that child sexual abuse leaves behind.

Communities expect more than reaction; they expect vigilance, foresight, and a commitment to preventing children from being hurt in the first place. This requires shifting the focus from catching perpetrators to anticipating and disrupting threats before they materialise.

Children deserve safe environments where risks are actively identified and mitigated, where organisations are alert to patterns of behaviour, and where warning signs are taken seriously. The emotional and social cost of waiting until a crime has been committed is too high. Safeguarding must be proactive, not reactive—driven by the imperative to detect threats to a child's safety rather than repair damage once it has been done.

Rather than relying solely on reactive enforcement, effective systems must invest in the intelligence required to uncover intent, capability, and opportunity long before criminal acts occur, or at the very least, before they escalate. Threat detection sits at the core of this challenge. It is the process by which signals of emerging risks are collected, analysed, and interpreted to prevent potential harm.

Such efforts require layered strategies. Tactical intelligence enables authorities to act swiftly on imminent threats, while strategic intelligence builds an understanding of long-term trends, organised deceptive behaviours, and systemic vulnerabilities. Both levels demand sustained coordination across agencies, integration of technology and human expertise, and the cultivation of public trust to ensure intelligence flows from communities to institutions to enforcement agencies.

Routine activity and situational theories remind us that opportunities for crime are rarely spontaneous; they can be mapped, predicted, and disrupted if detection mechanisms are strong enough. In this way, threat detection shifts focus from the individual crime event to the broader conditions that make crime possible. Theoretically, threat detection draws on principles from intelligence studies and criminology. Intelligence-led crime prevention requires authorities to build a picture of likely threats through the systematic collection of information from diverse sources - surveillance, data analysis, informants, and community reporting networks.

Ultimately, threat detection is not a peripheral function of protecting children—it is its frontline defence.

By collecting, connecting, and analysing fragments of information, systems can disrupt perpetrators before they cause harm. In doing so, detection not only protects potential victims but also strengthens the resilience of communities against evolving forms of offending.

Perpetrators take calculated steps to create opportunities for abuse to occur and to reduce the likelihood of detection. This involves deliberate strategies such as isolating children from protective adults, grooming colleagues and families to build trust, and normalising inappropriate behaviours so that warning signs appear less obvious.

Perpetrators deliberately seek to hide in plain sight, embedding themselves in trusted environments where their behaviour is less likely to be questioned. They cloak themselves as positive and engaged friends of children, parents and others, and they deliberately weaken barriers to detection.

When families, staff, workplaces, and communities are not equipped to identify abuse, grooming, or other indicators of risk, these behaviours may go unnoticed or unchallenged. A lack of awareness or confidence in recognising and responding to early warning signs allows offending behaviour to continue undetected and children to remain at risk.

This chapter examines how child sexual abuse can be identified and recognised. It explores the systems, practices, and cultural factors that support or hinder detection and considers:

- system awareness and understanding of grooming and other indicators of child sexual abuse

- challenges with recruitment and selection practices and the use of labour hire firms which may impact the early identification of people that pose a potential risk to children
- risk identification and assessment tools, frameworks, and practices designed to identify both potential perpetrators of child sexual abuse and children who may be at heightened risk
- institutional recordkeeping and information sharing practices which may impact how indicators of harm are understood over time, and across systems.

Policy and legislative mechanisms that seek to strengthen threat detection and disruption are also discussed. These include:

- intelligence gathering and improved information exchange across institutions
- multi-agency collaboration to enhance both risk recognition and threat assessment
- organisational and regulatory systems to aid detection
- community awareness raising on the signs and indicators of a threat.

Together, these measures aim to move systems towards earlier, more reliable detection of threats to children, so that action can be taken before harm occurs. Significantly, in having regard to all these issues, the Child Death Review Board also calls for a fundamental change in our approach.

We must bring our systems of protection together into a centralised intelligence hub. This helps to weave together different pieces of information about threats and other indicators of harm over time that are otherwise lost in agency databases and centre records.

Identifying child sexual abuse in ECEC Settings

A confronting reality of this Review is understanding that perpetrators, including the offender, specifically target very young children who have no or limited vocabulary to articulate their experiences of abuse. This is a known reality and one that we, as a community, must contend with across systems, settings and sectors.

Recognising the signs of child sexual abuse in very young children requires careful observation due to their developmental stage.² This is because they often lack the language to be able to describe their experiences of abuse or the developmental ability to recognise the behaviour as sexual abuse.³

Potential indicators that a child may be experiencing child sexual abuse include:

- sudden changes in behaviour such as increased fear or withdrawal
- regression to earlier developmental stages (e.g. bedwetting)
- unexplained injuries
- a sudden intense attachment to a particular adult
- the display of sexualised behaviours or language inappropriate for their age.⁴

Research conducted by University of New South Wales to inform this Review identified seven international case studies from Australia, the United Kingdom, the United States, the Netherlands and Sweden that highlight how child sexual abuse occurs, and continues, without detection.⁵ There were compelling similarities across all cases, irrespective of the country where the abuse happened. The abuse involved children under the age of five and highlighted significant failings in organisational oversight, communication and safeguarding practices.⁶ These cases also shine attention on the complex interplay between perpetrator behaviour, institutional weaknesses and child vulnerabilities.

Compelling lessons from these cases highlight that:

- identified risks were not managed or responded to, and protective action was not taken in response to formal risk assessment, parents' complaints or staff observations; instead, perpetrators were only identified because of police investigations into uploaded child exploitation material (CEM)
- perpetrators exploited gaps created by the use of casual, agency or trainee positions which created institutional blind spots
- cultures of loyalty, weak whistleblower protections and a presumption of competence resulted in failures in organisational cultures and governance
- existing institutional detection mechanisms were ultimately insufficient, and some cases involved perpetrators working in broader networks, which highlights the importance of multi-agency coordination and intelligence sharing.⁷

When considering these cases collectively we must ask ourselves a critical question – who is most likely to offend in these types of settings and what are the patterns that make them identifiable?

“

*Child sexual abuse by adults does not happen because of a lack of respect or consent. It happens because adults weaponise their power over children. Adults who harm children—especially prolifically—often take great care to conceal their offending and intentions.*⁸

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Recognising threats: contextualising grooming behaviours

While acts of child sexual abuse may occur behind closed doors or where there are lapses of guardianship, other behaviours, when considered in context, can act as key signals of a potential threat to a child or children.

Most significantly, this includes grooming, which is a central feature of child sexual abuse.⁹ It is a tactic used by perpetrators to create opportunities for abuse to occur. There is no universally consistent definition of grooming.¹⁰

The Royal Commission into Institutional Responses to Child Sexual Abuse (Royal Commission) defined grooming as:

*behaviours that manipulate and control a child, their family and other support networks, or institutions with the intent of gaining access to the child, obtaining the child's compliance, maintaining the child's silence, and avoiding discovery of sexual abuse.*¹¹

While grooming is generally tailored to context and situation, it often includes a number of key elements.

Perpetrators groom children and adults with the intent of sexually abusing a child.

- Grooming may include the normalisation of behaviour, such as kissing a child on the face in front of their parents or other staff to justify physical contact.
- If a perpetrator suspects their grooming strategies are being recognised, they may change tactics to avoid detection.
- Grooming can occur in any context. It can be challenging to identify as it often looks like the behaviour of a caring adult.¹²

Grooming of a child may include acts that are designed to develop trust, isolate a child, make them feel special, lower a child's inhibitions and prevent them from disclosing the abuse (such as through threats or gifts).

Grooming is not just targeted at children. Perpetrators groom other adults in a child's life. This may include:

- a perpetrator ingratiating themselves with families by positioning themselves as a trusted caregiver to the child, including offering to babysit, attending birthday parties and socialising with them
- a perpetrator creating opportunities to offend by manipulating situations and environments so they can be alone with a child.

Grooming is interpersonal but also institutional and structural, as adult offenders manipulate the peripheral networks around the child to cut them off from help and make other adults unwittingly complicit. And when abuse does come to light, adults within those networks fear reflected guilt for their inaction and support of the offender.

Without a sharp focus on their specialised methodology, adults who deliberately harm children can continue to hide behind a shield of confusion that sanitises and erroneously conflates their harm with a lack of respect and/or a lack of consent.¹³

There is often a general assumption that individuals working in child-related services are well intentioned.¹⁴ However, the Royal Commission illustrated how perpetrators can groom entire organisations by using their positions of employment or authority to manipulate trust and gain access to children. Perpetrators may exploit their roles in staff or volunteer positions to appear trustworthy and caring.¹⁵ This is sometimes referred to as 'institutional grooming.'

Perpetrators also groom children online. The internet enables perpetrators to entrench themselves into a child's life through consistent contact across multiple channels so that they can commit sexual abuse and sexual exploitation via technology.¹⁶

Placing behaviour in context is key to supporting the identification of grooming. While no single act can clearly be defined as 'grooming', being alert to potential signs and patterns of behaviour can support improved detection. As articulated by Bravehearts in their submissions to the Review:

Offending behaviour often occurs in private and is enabled by secrecy, grooming, and institutional failures to recognise or respond to warning signs. As such, identifying risk factors and behavioural patterns associated with child sexual offending, such as inappropriate boundary-crossing, attempts to isolate children, or the use of digital technologies for grooming, can support early intervention and prevention.

Importantly, while grooming is often conceptualised as occurring over a prolonged period this is not always the case. In this case, the offender is known to have perpetrated abuse against some children in a very short timeframe including within two shifts that he worked in one centre. One staff member described the offender's ability to build relationships with children by stating:

[the offender] developed a quick relationship with [child] to the point that [child] wanted to sit next to [the offender] by lunch time. [Staff member] recalled this was highly unusual. There was one educator that [child] was attached to, but she didn't really develop attachments with other educators. Especially not that quickly.

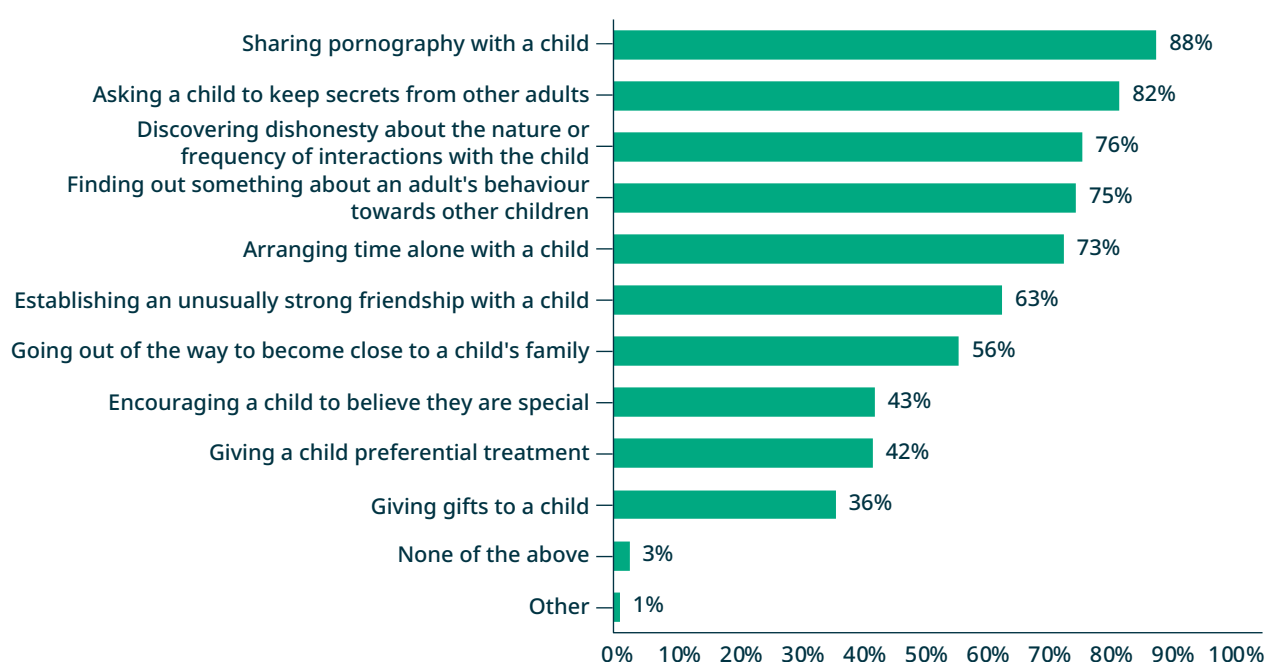
The offender's capacity to rapidly ingratiate himself with others was also facilitated by his reputational standing as a comparatively well-educated and experienced educator, which situated him in a position of trust before he had even commenced working in a centre. He demonstrated an intense focus on children in his social and work relationships alongside repeated attempts to isolate children and reduce the level of supervisory oversight.

That's where we get it wrong. Grooming the child is almost like the last part of the process. Think about grooming the family, grooming the organisation they're working for, [how they gradually] break down those rules and those boundaries.¹⁷

A 2023 survey undertaken by the National Centre for Action on Child Sexual Abuse of 4040 participants highlighted that while 75 per cent acknowledged grooming is always a form of child sexual abuse, there was a notable proportion who thought that sometimes it was not (16%) or they did not know (6%).¹⁸ Survey participants also reported a lack of understanding of some of the known indicators that grooming may be occurring (Figure 1).¹⁹

Figure 1: Participants self-reported understanding of indicators of grooming 2023 (n=2029)

Source: National Centre for Action on Child Sexual Abuse 2023



A standalone criminal offence

Grooming a child under 16 years, or a parent or carer of a child under 16 years, has been a stand-alone offence in Queensland under Section 218B of the *Criminal Code Act 1899* (Criminal Code) since 2013. In Queensland, an adult who engages in conduct with the intent to facilitate the procurement of a child for a sexual act, or to expose them to any indecent matter, with the child or with their carer, commits the offence of grooming.

- 'Procure' in this context means to 'knowingly entice or recruit for the purposes of sexual exploitation'.
- An 'indecent matter' relates to media such as film or photography with an indecent nature.

The Criminal Code is explicit that a sexual act for which a child is groomed to participate in does not need to be intercourse or even involve physical contact. A person guilty of grooming is liable to imprisonment for five years, or 10 years if the child is under 12 years of age. It is a defence to a charge of grooming if the person believed on reasonable grounds that the child was 16 or over (or 12 or over for the circumstance of aggravation noted above).

Procurement of a child for sex is an offence under s.217 of the Criminal Code. In practice, the absence of tangible evidence as to the intent of the perpetrator means grooming can be a difficult offence to prove. According to the explanatory note to the amending legislation:

The creation of the new offence of 'grooming' will capture wide-ranging behaviour that is designed to facilitate the later procurement of a child for sexual activity. This allows for the potential for police to intervene before a sexual act or sex-related activity takes place.²⁰

In the five years to 30 June 2025, a total of 314 instances of grooming have been prosecuted under s 218B of the Criminal Code. Of these, 37.90 percent were discharged, dismissed or withdrawn; 35.03 per cent resulted in a period of actual imprisonment.

The stages of grooming

There are a number of stages in the grooming process. Not all of them need to have happened for grooming to occur, and they may occur in any order.²¹

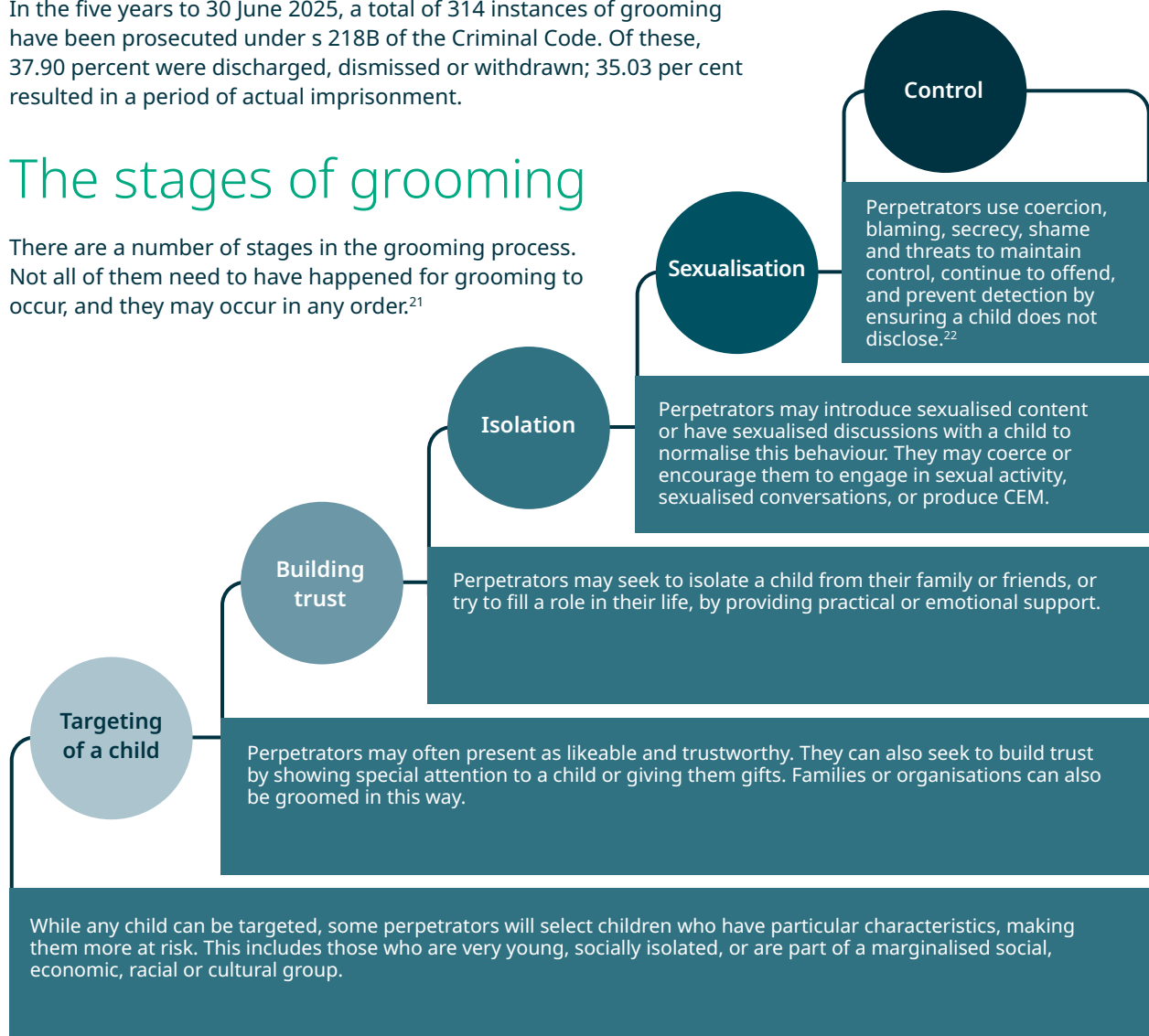
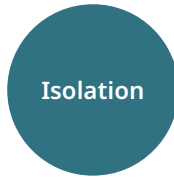


Table 1: Identified acts of grooming by offender

 Targeting of a child	The offender was known to have a good relationship with children who enjoyed arts and crafts, and to put effort into knowing children's strengths and weaknesses. The offender also demonstrated favouritism towards children, particularly girls, which was raised as a performance concern in two centres. As part of an investigation into the offender's conduct in one centre, staff identified children who they knew as favourites of the offender. Some of these children were later identified as victim-survivors. In this same centre, a staff member recalled that the offender 'was kind of obsessive with ...' one child and reportedly said, 'the mum doesn't really care about her, she should just give her to me'. This child was later found to have been a victim-survivor. In a second centre, the offender's favouritism towards certain children was raised in his mid-year appraisal. Management stated that other staff and families had noticed this behaviour. The offender was observed to establish rapport with children unusually quickly. At one centre, it was noted that by lunchtime on his first shift, he had already developed a connection with a child who had previously not formed close relationships with any staff.
 Building trust	The offender built strong relationships with some parents, attending birthday parties and church with the families, or babysitting the children. Although some centres do not appear to have been aware of this behaviour at the time, records show that at least two centres were. One centre received multiple letters and emails from parents praising the offender and expressing disappointment when he resigned. These letters and emails spoke to the strong bonds made between the children, parents and the offender. The offender normalised the use of personal devices to take photos of children under the guise of capturing moments for presentation to families. Early in his employment at one centre, the offender showed centre management photos and videos of children from previous workplaces on his camera. This was done as a suggestion as to how he could document the children's learning. In another centre, staff stated that the offender used a camera 'all of the time' and that he preferred to use his personal camera and a tripod. In a reference given to a third centre, the referee (a parent) spoke about how the offender would put on video nights for parents each term where he played video compilations of the children's activities and learning.
 Isolation	The offender separated groups of children from other children and educators. In one centre, the offender introduced outdoor rest times for the children and would take a group of children out to a fort for rest. The blinds inside the centre were closed and sometimes the offender hung up sheets around the fort. In this centre, the offender would also take children to spend time in his office which already had obstructed views and drawn curtains. The offender appears to have used his position of authority as a director to manipulate staffing arrangements in a way that enabled unsupervised access to children. He was responsible for creating staff rosters and appears to have deliberately scheduled minimal staffing levels. Records suggest that he may have intentionally kept enrolment numbers low to avoid the requirement for additional staff, thereby increasing opportunities for isolated contact with children. An investigation by the Early Childhood Regulatory Authority (ECRA) found that on at least one occasion, the offender was left alone with up to 14 children, in clear breach of regulatory supervision requirements. In another centre, the offender controlled the indoor space while his assistant educator managed the outdoor space. Half the children (mostly girls) were inside, and half outside. The outdoor educator would float between both spaces but was mostly outdoors assisting with the children with 'higher needs', leaving the offender to manage the indoor space largely unsupervised.

Sexualisation

One centre identified the offender as 'overly physically affectionate'. Staff referred to the offender as 'like a friendly uncle' or 'like a big kid'. The offender was known to lay down with children, roll with them on the day bed he brought into the centre, tickle them, have them sit on his lap, and take selfies with them on the centre iPad.

The offender normalised physical touch between educators and children. In one centre, as part of an investigation into the offender's conduct, the offender spoke about 'professional love', stating that this theory talks about 'touch practices'. He further stated that this theory was communicated through staff meetings and that physical touch and affection had been a huge part of the culture of the centre. During this investigation, the offender spoke about 'not shying away from physical interactions in front of parents' and stated that this approach is embraced by families. He was known to pick up and cuddle children in the presence of parents.

Control

The offender was the Director of one centre, giving him the opportunity to review policies, procedures and practices, modify the environment, manage staff movement and rostering, control enrolment numbers and manage complaints.

At this centre, the enrolment numbers were between 24 and 47 per cent capacity. It appears that the offender was deliberately ensuring low enrolment numbers to reduce the number of staff required to meet ratio requirements.

The offender was known to start earlier and finish later than all other staff as a matter of routine. In one centre he would start two hours before his shift. It is speculated that this formed part of his control of the contextual environment.

Workforce understanding of grooming

While any single act may not in itself be indicative of grooming, when viewed collectively they show a clear pattern of manipulation by the offender to avoid detection and perpetrate abuse. Improving knowledge of the signs of grooming, including in workplaces, families and the broader community, helps to put conduct in context and improve its earlier detection. This can be further enhanced by ensuring strong recordkeeping practices are established that appropriately document concerning behaviour, and that decision making is in the best interests of the child.

The Board consistently heard that current workforce training is often limited, not sufficient, or delivered in a piecemeal way. It also tends to primarily focus on ensuring workers meet their mandatory child protection reporting obligations. While child protection is a critical component of safeguarding practices, this type of training predominantly focuses on risk of harm to children from their parents or guardians. It may not specifically contemplate risk in an institutional setting that may be posed by other staff, volunteers or caregivers. This results in a critical knowledge gap, where staff are not trained to see the threats among them.

In submissions received by the Board, the Archdiocese of Brisbane highlighted the difference between child protection and child safeguarding practices, and the need to embed safeguarding in all aspects of organisational governance, culture and practice:

Safeguarding and child protection are related but distinct concepts, and clarity between the two is essential for effective practice. Safeguarding refers to the broad framework of policies, culture, and preventive measures designed to ensure that children and vulnerable people are safe, respected, and able to flourish. It encompasses proactive steps such as safe recruitment, ongoing training, risk assessments, and fostering environments where concerns can be raised without fear. Child protection, by contrast, is a narrower term that relates specifically to the formal actions taken when there are concerns or disclosures that a child may be experiencing harm or abuse. While child protection is a crucial component, safeguarding is the overarching commitment to prevent such situations arising in the first place. Both must operate hand-in-hand: safeguarding as the proactive culture, and child protection as the responsive mechanism when risks materialise. This distinction is important because it underscores why safeguarding requires cultural and systemic reform, not simplistic solutions. As the Royal Commission made clear, preventing harm cannot be reduced to narrow measures or one-off fixes; it must be embedded in the structures, culture, and practices of every organisation.²³

Of the seven centres where information was available about staff training, policies and procedures, only three referred to grooming, and none included a clear definition of what it is. In one centre grooming was defined in training delivered in October 2024 (after the offender was arrested) as:

Child groom[ing] is when someone deliberately: makes a child or young person feel special (eg., with treats, attention, or affection) WITH THE AIM OF making a child think that doing sexual things with them is OK or normal. Groom(ing) strategies include:

- *Identifying vulnerable children*
- *Identifying vulnerable or receptive families*
- *Isolating the child from other children or their guardian*
- *Conferring a special status on the child*
- *Gradually desensitising the child to sexual touch*
- *Becoming indispensable to significant adults in the child's life*
- *AND SNEAKIER AND UGLIER (BUT CAN APPEAR NORMAL) BEHAVIOURS*

In other centres, training was provided about child protection related matters. Although some centres referred to annual child protection training, 'Mandatory Reporting Workshops' and external child protection training providers, there is limited reference to grooming in any of the material reviewed. In one centre mandatory training was provided by an external training provider. The mandatory training referred to 'Building a Protective Environment for children', however did not cover grooming. While identifying grooming was a standalone module available through the provider, it was not mandatory and was offered only after the first five modules in the series were completed. Both Centre EA and Centre EK used the same training provider.

Centre EA's policies outlined the working with children legislation and the need for a child and youth risk management strategy. While it contained a number of inaccuracies, it provided information about reporting requirements relating to the sexual abuse of children under the Criminal Code stating:

This means that you must make a report to the police in all cases where:

- *sexual abuse or grooming has occurred,*
- *you suspect that sexual abuse or grooming has occurred.*

There was however no information to outline what grooming is or how it presents. Additionally, this centre utilised an online external training provider, with this training largely focusing on responding to children's emotional needs, supporting children's emotional regulation, managing behaviour, the impact of trauma on the developmental brain and supporting families in need. There appeared to be no training that encompassed grooming. As part of the ECRA investigation in 2024, training records were requested for all staff at this centre between December 2019 and April 2022. The centre provided a response which stated:

Whilst child protection training has been provided to staff during this period, there are limited documentary records of this training which has been provided in-person.

Centre HN which is auspiced by a government agency had a more comprehensive approach, with a range of policies and procedures that reference grooming, albeit with no clear definition, including in the:

- **Staff Code of Conduct:** which commits staff to never 'subject children to physical, emotional or sexual abuse or neglect or grooming behaviour'. It has also been updated to prohibit innuendo and sexual jokes, includes injury management protocols for personal areas, and requires staff to seek permission from children before engaging in interactions.
- **Child Protection Capability Framework:** which references that all *clinical* staff should have knowledge of potential indicators of harm in all forms including physical and emotional abuse, sexual abuse, neglect, child sexual exploitation, grooming and other signs to look out for. It does not specifically contemplate staff working within the childcare service.
- Training to support the roll out of amendments to the Queensland Criminal Code in 2021 which introduced the 'failure to report' and 'failure to protect offences'.

A failure to recognise grooming and other indicators of potential harm is not distinct to this case, or ECEC settings. It has been consistently noted in previous inquiries including most recently the *Commission of Inquiry into the Tasmanian Government's Responses to Child Sexual Abuse in Institutional Settings* which found that:

*Too often, we saw failures to recognise child sexual abuse for what it was. It was rare for us to receive evidence that the sexual abuse of a child was directly witnessed by staff in institution... More often, complaints of inappropriate conduct were made later by children or their carers—sometimes many months or years later when the victim-survivor was an adult. **However, we heard many examples where risks or signs of abuse were not detected when they should have been, particularly grooming behaviours or breaches of professional boundaries.** These behaviours can be harder to identify, particularly where the conduct occurs under the guise of health care or when teachers could be seen to be paying particular attention to one student for good reasons. We saw too many examples of signs or reports of abuse being downplayed and denied. Sometimes, this happened because of a lack of skills and knowledge, sometimes, it was deliberate, and in other instances, it was driven by a desire to protect the reputation of a colleague, other adults or the institution. Even when reports and complaints of child sexual abuse were made directly, we saw examples of them not being recognised as such by the institution. Across the board, these actions led to inexcusable delays in managing risks to children and led to uncaring responses to victim-survivors.²⁴*

Raising community and workforce awareness

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79% of sexual abuse survivors are abused by someone known to them. And this abuse doesn't happen by chance, there are varying degrees of grooming that take place as the situation develops. I have to wonder if my mum or myself knew more about grooming at the time, would my situation be different - Lived experience advisor

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Improving community and workforce knowledge is a key strategy in any approach to detecting and preventing child sexual abuse. It helps to improve the identification of grooming and other indicators of risk. It empowers children, parents and caregivers to better understand behaviour they may find concerning. Strong safeguarding practices must be reinforced through foundational training for staff on reporting, grooming awareness, trauma-informed care and information sharing.

Research also shows that education and training related to child sexual abuse is most effective when it involves children, employees, parents and the community. Programs are typically oriented at the primary prevention level to strengthen protective factors around children.²⁵ Most training, including in Australian settings and overseas, is targeted at teaching children about abuse, consent and safety. Very little is targeted at employees or workplace settings.²⁶

Under the National Strategy to Prevent and Respond to Child Sexual Abuse, the National Office for Child Safety commissioned 'One Talk at a Time', a TV and online advertisement campaign which launched in October 2023.²⁷ One Talk at a Time was backed by detailed research and supported by a children's storybook, 'My superhero voice', to maximise the coverage of its messaging.²⁸ The Australian Government provided \$22.4 million in funding for the campaign which aims to help prevent child sexual abuse by encouraging adults to learn about the issue and have ongoing, proactive, preventative conversations with children in their lives.²⁹

Tailored professional development programs are intended to build the knowledge, skills and confidence of educators to prevent, recognise and respond to abuse. Evidence shows that educators are the most frequent reporters of abuse under mandatory reporting regimes in Australia and overseas, which makes training for this sector even more important.³⁰

Consultations undertaken to inform the Review highlighted the lack of current structured, systematic community awareness programs that are focused on children under the age of five:

Australia currently lacks a mandated national framework to ensure consistent delivery of child safe and protective behaviour education in early childhood settings where children are highly dependent on adults to care for them. This gap results in fragmented practices across jurisdictions and leaves many children without access to vital personal safety education. – Dr Katrina Lines, Chief Executive Officer of Act for Kids

During consultations, specialist sexual violence services also emphasised that while they have been approached to deliver training in ECEC services, they are not currently funded to deliver community education and are unable to commit to doing so because of resourcing pressures.

The nature of the ECEC workforce was also raised by many submitters to our review as both a limitation and an opportunity to improve detection through a workforce capability uplift:

This sector, along with others (e.g. residential care, detention centres, sporting and recreation organisations), has not yet undergone the professionalisation of the workforce that the education sector has experienced over the last 20 years. Moreover, regulators in this space are often compliance driven and adopt a superficial, 'tick box' approach that is deleterious to promoting a safeguarding culture. This can 'trickle down' to individual agencies if they are not well supported to apply a meaningful understanding and application of safeguarding principles relevant to their unique environment and risk profile.

Young or otherwise inexperienced workers also extend to management in these settings, and we have noticed a distinct lack of capability to deal with complaints and expectation setting with staff around appropriate interactions with children. There is an identified need for meaningful skill development around having difficult conversations, complaint management, procedural fairness, what is considered appropriate conduct in individual settings and what will happen if those expectations are breached. People management is closely linked with a safeguarding culture as it is enacted and reinforced by leadership and governance processes. - Halloran Morrissey Group Submission

As part of the implementation of recommendations from the *Review of Child Safety Arrangements under the National Quality Framework*, the Australian Children's Education and Care Quality Authority (ACECQA) has developed information for service providers on implementing a child safe culture and online safety under the National Quality Framework (NQF). The recommendation specified that training must include details about identifying grooming of children and adults, to ensure services are able to respond to complaints in an informed, timely manner, and that the child remains at the centre of decision making.³¹

The NQF *Child Safe Culture Guide* provides an overview of grooming and guidance to approved providers and service leaders to support educators to identify conduct that may reveal a pattern of behaviour which indicates there are potential risks to children.³² They note that these instances may include:

- being alone with a child when there is no professional reason to do so
- spending time with a child outside the organisation
- offering children privileges, rewards, gifts, benefits and favouritism
- sharing inappropriate images, noting that the sharing of any images of a violent or sexual nature should be reported immediately to the relevant jurisdictional reportable conduct scheme.³³

Education Ministers across all states and territories have recently committed to national child safety training that all ECEC staff will be required to complete. With an investment of up to \$21 million by the federal government in targeted workforce subsidies to help cover wage costs, the training is being developed by the Australian Centre for Child Protection and is intended to be rolled out in early 2026.³⁴

NAPCAN's Safer Communities for Children protective behaviours approach reinforces the collective role that the early childhood sector, communities and individuals have in keeping children safe, thriving and having the ability to reach their full potential.³⁵ This program aims to build resilience, communication, emotional literacy and help-seeking skills in children.

Bravehearts have also released a 'Grooming hides behind harmless' campaign, which is intended to demonstrate the subtle and manipulative nature of this type of conduct, behaviours which are often seen as 'innocent' or 'harmless'.³⁶ In its submission to the Review, Bravehearts noted that community awareness campaigns are foundational to primary prevention, as they seek to 'shift social norms, increase recognition of grooming and boundary violations and promote shared responsibility for child safety'.

Importantly, grooming prevention is different to respectful relationships and consent education programs that are currently delivered in schools, and distinct from protective behaviour training.

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*...abusers knowingly repurpose resources intended for the development of consensual interactions and warp them in malicious, insidious ways. They weaponise the very language of respectful relationships and consent to draw a false equivalence between healthy peer-to-peer relationships and the harm they cause.*³⁷

”

Although the *National Strategy to Prevent and Respond to Child Sexual Abuse 2021–2030* defines grooming, and focuses on awareness raising, education and building child safe cultures (Theme 1), it does not have dedicated actions for grooming awareness. The National Office for Child Safety has published online resources focused on grooming as part of the One Talk at a Time Campaign, in recognition of this topic's importance. It also focuses on helping to prevent child sexual abuse by: raising awareness among adults and providing them with tools and resources to educate children about sexual development, healthy relationships, sexual behaviours, sexual abuse, personal safety, body autonomy and online safety.³⁸

While *Queensland's Framework to address Sexual Violence* also highlights commitments to equip families, children and young people with accurate information on healthy relationships, consent and sexual violence, this predominantly focuses on respectful relationships education.

In recognition of the need for more coordinated action in this area, there have been calls for a standalone Grooming Prevention Education Framework which seeks to 'close the knowledge gap between the general public, who just don't understand offender strategies, and adult perpetrators of child sexual abuse, who benefit from our ignorance and confusion'.³⁹

Operational Recommendation 2: Invest more in workforce capability for child safeguarding

One of the strongest findings of this Review is that frontline workers across sectors are often the first, and sometimes the only, adults in a position to notice the early warning signs of child sexual abuse. These include grooming behaviours, subtle changes in a child's demeanour, or disclosures made in indirect or tentative ways. Yet, many workers report a lack of confidence in recognising grooming, uncertainty about their safeguarding responsibilities, and fear about how to respond appropriately if a child discloses abuse.

While Queensland has invested heavily in Working with Children Checks (WWCC), reporting pathways, and regulatory schemes, the system is only as effective as the people who operate within it. Without widespread workforce capability, signs of risk can be missed, minimised, or mishandled. This results in lost opportunities to intervene early and prevent harm.

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Being "safe to work with children" should reflect not only the absence of convictions but the presence of relevant education and awareness. Evidence-based online modules could ensure all cardholders have a foundational understanding of trauma, disclosure, and victim-centred practice - Survivor-advocate.

”

Embedding child safeguarding knowledge and skills across the workforce is therefore essential. This skills uplift must include:

- **Identifying grooming behaviours:** helping workers understand the patterns of conduct that perpetrators use to gain trust, normalise boundary violations, and isolate children.
- **Clarifying safeguarding responsibilities:** ensuring every worker knows their legal and ethical duty to act when concerns arise, and how these responsibilities fit within broader organisational obligations.
- **Receiving and responding to disclosures:** equipping workers with the confidence to listen, validate, and report appropriately when a child chooses to speak.

Evidence from other high-risk industries such as aviation safety or health care demonstrates that mandatory, embedded training in risk identification and reporting responsibilities changes culture, sharpens vigilance, and normalises best practice. For child safeguarding, this training must be universal, regularly refreshed, and built into professional accreditation and induction programs.

The Australian Childhood Foundation highlighted that currently individuals can hold a blue card and be approved to work or volunteer with children without any demonstrated understanding of how to recognise, prevent, or respond to abuse. Embedding mandatory child abuse prevention training into the blue card registration process, would ensure that every holder of a blue card, regardless of their role, sector, or employment status would have received basic, evidence-based, victim-survivor-informed education in child safety.

In the absence of such investment, the burden will continue to fall on a small number of trained professionals, leaving the majority of the workforce ill-equipped to play their part. In contrast, a strategic investment in workforce capability has the potential to transform Queensland's safeguarding system, by making every interaction with a worker a potential point of protection for a child.

Operational Recommendation 2: Invest more in workforce capability for child safeguarding

That the Queensland Government invest in embedding mandatory training across all child-related sectors on:

- the identification of grooming behaviours (including the grooming of organisations, colleagues, parents and victims)
- how to raise, challenge and discuss behaviours of concern
- the responsibilities of workers and organisations for child safeguarding
- best practice approaches to receiving and responding to disclosures from children.

This training should be standardised, evidence-informed, and incorporated into professional registration, accreditation, and induction processes, with regular refreshers. Such investment will ensure that child safeguarding becomes a core competency of the Queensland workforce, significantly increasing the likelihood that risks are detected early, concerns are acted upon, and children are protected from harm. Government-funded training should be positioned as a complement to, not a replacement for, sector responsibility. The expectation must remain that organisations embed safeguarding capability as part of their core duties, developing and maintaining training that reflects their specific contexts and risks.

The Queensland Government's investment, therefore, should be directed toward creating high-quality, evidence-informed programs that set a consistent baseline across sectors and provide specialist expertise that individual organisations may not be able to develop on their own.

This shared infrastructure lifts standards, reduces duplication, and ensures that safeguarding knowledge is both contemporary and consistent across the state, while still holding sectors accountable for embedding and sustaining training within their workforce.

Transformational Recommendation 1: Create a national child safeguarding training program

That the Australian Government auspice the development and delivery of a compulsory and consistent online training program nationally. This training should cover:

- the responsibilities of workers and organisations for child safeguarding
- the identification of grooming behaviours (including the grooming of organisations, colleagues, parents and victims)
- best practice approaches to receiving and responding to disclosures from children.

The program should be evidence-informed, designed in collaboration with child protection experts, and delivered in a format accessible to the diverse workforce engaged in child-related roles.

Each state should make completion of the training a precondition for WWCC approval, with mandatory refreshers tied to WWCC renewal cycles. This should also extend to professions exempted from the WWCC scheme (including health and teachers). By embedding safeguarding education directly into the WWCC framework, the program would establish a consistent national baseline of knowledge and capability, regardless of jurisdiction or sector. This approach would address current fragmentation across states and territories, ensuring that every adult permitted to work or volunteer with children has received contemporary safeguarding training. This should occur ahead of, and not be dependent on, national harmonisation.

The Commonwealth's role should be to develop and fund the shared infrastructure for this training, while maintaining the expectation that organisations continue to provide context-specific safeguarding education relevant to their workforces. In this way, the national program functions as a foundation: lifting standards, reducing duplication, and guaranteeing consistency, while leaving space for sector-led initiatives that respond to particular risks and settings.

Operational Recommendation 3: Sustained investment in capacity building and community awareness

One of the clearest findings of this Review is that safeguarding children requires both strong organisational capability and informed, engaged communities.

“

Before entering the sector as a survivor-advocate, I had no understanding of the United Nations Conventions on the Rights of the Child or domestic child protection policy. My abuser exploited that ignorance, convincing me that I, rather than he, was breaking the law. At school, I repeatedly heard that producing “child pornography” was illegal and could lead to imprisonment. There was inadequate and misleading education about coercive control, grooming, or how young people can be manipulated into producing sexual material. Had schools fulfilled their duty to educate students about their rights and the dynamics of abuse, I might not have remained silent for four years, believing I would be prosecuted if I spoke up - Survivor-advocate.

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The introduction of Queensland's Child Safe Standards from October 2025 marked an important step forward. However, **without sustained investment in sector capacity building and public awareness, there is a risk that these standards will remain a compliance exercise rather than drive the cultural transformation they are intended to achieve.**

Sector specific capability and capacity building grant packages have already demonstrated their value in supporting organisations to understand and begin embedding child safe practices.⁴⁰ Yet we heard from many services, particularly smaller organisations, regional services, and volunteer-run groups, that one-off or time-limited funding is not sufficient to build the systems, training, and cultural change required. Embedding safeguarding into daily practice takes years, not months, and requires ongoing access to training, resources, and specialist advice. Extending the 2024–25 grants program for a further three years would provide continuity and stability, enabling organisations to consolidate the changes required.

Community awareness is the other essential pillar. It is not enough for organisations to have safeguarding systems if parents, carers, and children are unaware of what safe practice looks like or how to recognise grooming and early warning signs. The current \$1 million campaign, 'Raising the standard', has shown that public messaging can break down stigma, encourage reporting, and reinforce accountability across sectors.⁴¹ But the reach and impact of this campaign has been limited. Doubling the investment for the next three years will allow for broader coverage, targeted campaigns for high-risk sectors, and messaging tailored for parents, carers, and children themselves.

This dual investment—in organisational capacity and community awareness—will accelerate the development of a safeguarding culture across Queensland. It will empower parents and carers to make informed choices, strengthen public confidence in organisations that care for children, and provide services with the tools they need to meet their responsibilities. Most importantly, it will help prevent harm by ensuring that safeguarding is not an abstract policy, but a lived practice embedded in both organisations and communities.

This sustained investment will provide continuity for organisations, strengthen community engagement, and accelerate the shift towards a culture where safeguarding children is understood as a shared and non-negotiable responsibility across Queensland.

Operational Recommendation 3: Sustained investment in capacity building and community awareness

That the Queensland Government extend and expand its investment in child safeguarding capability through:

- Sector and Organisation Capacity Building Grants – extending the \$2 million per annum Child Safe Organisations Capacity Building grants program for a further three years, to ensure that organisations have the resources, training, and tools needed to embed the Child Safe Standards into their operations.
- Community Awareness Campaign – re-funding the 2024–25 investment in the child safe community awareness campaign of \$1 million for the next three years, to build broad public understanding of child safeguarding and the identification of grooming to empower parents and carers, and create a culture where communities actively support safe organisations for children.

Chapter 15

Identifying the perpetrators who work among us

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Identifying the perpetrators who work among us

In addition to the grooming behaviour displayed by the offender, he also demonstrated other problematic behaviours in the centres where he worked. These include:

- a pattern of high mobility across centres, often moving quickly and with limited notice
- conflictual or resistive behaviours when he was challenged about his conduct
- general performance concerns, including prioritising contact with children over his other job requirements
- emotional congruence with children whereby his emotional attachment and dependency needs appear to have been met by interacting with children rather than adults. He rarely associated with his work colleagues, even at work.
- a lack of concern for other adults in the work environment with a clear focus on the children. For example, the offender would prefer to skip lunch and lay with children at rest time instead of having lunch with his colleagues.

The offender was also reported for other problematic behaviours in the workplace. This includes being witnessed threatening to smack a child in one centre, and in another centre grabbing a child by the arm and squeezing it. The offender sought to minimise his conduct on the second occasion by attributing it to 'maybe losing his temper'. In a different centre, parents reported that they went to pick up their child and found her alone with the offender in the 'kindy room', which she was not allowed in. The offender was not this child's teacher. Of this interaction, the father stated that the offender was 'really weird' and 'awkward'. Although this was not reported to the centre at the time, it reflects the concerns held by parents about the offender's conduct in the workplace towards their children.

When considered in isolation, the individual indicators or concerning behaviours were not enough to prompt further action, or they were dealt with by centres as general performance concerns where the potential risk that the offender posed to children was not recognised.

While no one entity held all the information about the offender's conduct, when viewed collectively it shows a pattern of problematic behaviours across centres and over time.

In reflecting on the offending timeline, the Board noted that frequent job changes, abrupt departures and a failure to pass probation in child-related roles should be treated as red flags. For people that pose a risk to children, this type of transiency was noted as a way for some centres to 'move the problem on'. Organisations appear to have held concerns and acted individually without any strategic or holistic consideration of the ongoing risk the offender may have posed to other children.

For example, in Centre EA concerns were raised about the offender's conduct approximately five months prior to a report being made to police by a staff member. These incidents appear to have been viewed in isolation of each other, and information about the first instance was not shared with the Queensland Police Service (QPS) or Early Childhood Regulatory Authority (ECRA) when they were investigating the latter complaint. Available records indicate that during the ECRA investigation in 2024, staff recalled an interaction with the offender that occurred in early 2021:

She recalled an interaction between [the Offender] and a child during a visit to the service with HR officer (...). She and [HR Officer] were at the service to do an induction with [the Offender] as he wasn't happy that people were now going to be overseeing him and the service. [the Offender] was standing up with a child in front of him with his hands on the female child's shoulders and bent down and kissed her on top of her head for no reason. She thought what's going on here and began to question if she was questioning the interaction because [the Offender] was a male and if it were done by a female would she be concerned. She didn't address the interaction at the time and when she left the service, she called [HR Officer] on the phone and [HR Officer] had said the interaction didn't sit well with her either. She had enough experience to know that she needed to address this with [the Offender] and he needed to be reminded of his interactions. The service was still under the control of the [organisation] and [the Offender] was their employee so the next day she went and spoke with [Management] about the interaction she witnessed. She told [Management] what she'd witnessed and asked if there had been any concerns raised about [the Offender], she was told no. She then sought permission to speak to [the Offender] about the interaction due to him being their staff member. [Management] welcomed this action and thanked her for speaking to him about it first. She spoke to [the Offender] who apologised explaining they were a small centre and she didn't understand how they operated and that children hug him in front of parents and it is ok. She told [the Offender] it was not acceptable in childcare and that he couldn't do that anymore. What she witnessed was an interaction not an incident and it was not managed any further by her.

A casualised workforce

In its submissions to the Review, the Daniel Morcombe Foundation confirmed employment transiency and rapid, frequent role changes as red flags which should trigger enhanced scrutiny but noted privacy rules currently limit the ability for this information to be investigated and shared.

The highly casualised nature of the early childhood education and care (ECEC) workforce, and employment through labour hire firms, was noted as being generally typical of the sector. Questions were therefore raised about whether this conduct in isolation was a significant cause for concern.

Between 2003 and 2022 the offender is known to have worked in at least 22 ECEC services and left more than half (55%) within six months of commencement. In comparison, in 2024 ECEC staff with relevant qualifications had spent on average four years at their current centre.¹⁰

Saliently, in 64 per cent of the known centres where the offender worked, he was terminated, dismissed, offered a redundancy, or asked not to return to work there. This was not a worker who moved roles because of personal choice or career progression. He moved because he was asked to leave and not return. As noted by Act for Kids in its submissions to the Review:

The [Offender's] case is an example of a childcare worker who had the ability to move from centre to centre, state to state while continuing to commit depraved acts on children due to a lack of consistent and appropriate WWCCs, legislative frameworks and reportable conduct requirements across multiple jurisdictions. This deeply disturbing case highlighted not only the detrimental impact of inconsistencies between, and lack of communication or cross-referencing, across jurisdictions; it also demonstrated how easy it was for someone to move across workplaces and jurisdictions in order to escape detection in their criminal offending against children over a long period of time.

There is an increasing casualisation of the ECEC workforce, and a reliance on engaging staff through labour hire companies. In 2023 it was estimated that around 21 per cent of the ECEC workforce was employed on a casual basis, which included around 30 per cent of child carers (i.e. not educators, education aides, or managers).⁴²

There are extraordinary everyday challenges for the ECEC workforce, which is largely female, often underpaid, and significantly undervalued, yet charged with the huge responsibility of the education, care and safety of our youngest citizens.⁴³

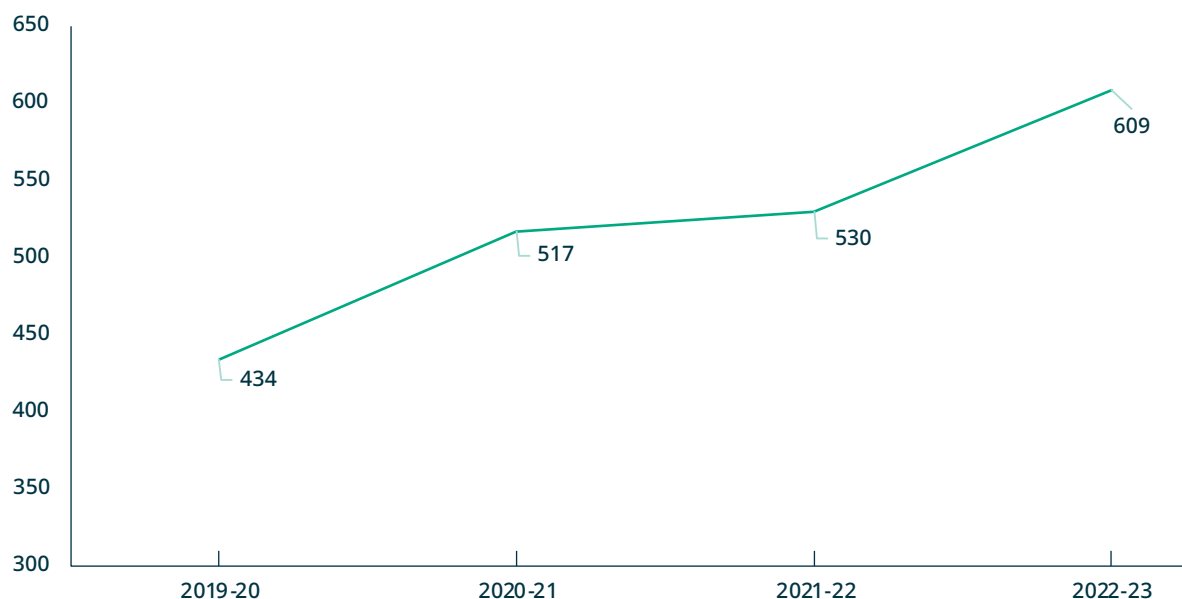
While casualisation of the workforce may indicate the use of labour hire, not all workers employed by labour hire firms are casual employees, and not all casual employees employed in the ECEC sector are sourced via labour hire. According to the Commonwealth Department of Education:

The use of educators under labour hire arrangements (agency educators) from recruitment agencies to meet prescribed staffing requirements is very common, especially given the workforce shortages across Australia. Agency educators often work across multiple services, for multiple approved providers (host providers) at minimal notice, and for very short periods of time.⁴⁴

Under the *Labour Hire Licensing Act 2017*, users of labour hire must only use providers licensed by Labour Hire Licensing Queensland (LHLQ). According to LHLQ data, the number of labour hire licences held by Health Care and Social Assistance providers has been slowly increasing since 2019, and by 2024 has exceeded 600 active licensed providers (Figure 2). Under the Australian and New Zealand Standard Industrial Classification (ANZSIC) 2006 scheme, 'childcare services' are included within this category alongside hospitals, allied health, pathology, and residential care.

Figure 2: Number of active labour hire licences held by Health Care and Social Assistance providers

Source: Labour Hire Licensing Queensland Anniversary Reports 2020 to 2024⁴⁵



Casualisation has been reported as a response to understaffing. While the use of labour hire can help centres alleviate staffing shortages, it may also compromise the care provided to children. In a 2021 report published by the United Worker's Union (UWU), which represents early childhood educators, one educator told the union that:

*Leaving children at the end of the day with casual educators who they are mostly unfamiliar with is less than ideal and highly detrimental, especially to vulnerable children who suffer from attachment and relationship disadvantages.*⁴⁶

Casualisation can also increase workload pressures on permanent or fixed-term educators who are required to work with multiple casual staff who are not familiar with the centre, its policies and procedures, and with the children themselves.⁴⁷

*They want to reduce costs, so they're not going to pay people overtime or they're not going to backfill. They're going to cut corners in service provision in order to protect profits, which means that there are important checks and balances that just don't get applied.*⁴⁸

The urgent need for structural change in the ECEC sector was identified in a study undertaken by Griffith University to inform the Board's review of this case. Consistent with the UWU report, key concerns were identified with chronic understaffing, high staff turnover, low pay, and reliance on underqualified staff.⁴⁹ Participants criticised the impact of privatisation and argued that ECEC should be integrated into the broader public education system.⁵⁰ Issues around staff-to-child ratios and declining standards due to staffing pressures also reflect deeper systemic problems.⁵¹

The use of labour hire arrangements in Australian employment is not unusual and has been steadily increasing. It has been found by the Fair Work Commission on multiple occasions that a labour hire arrangement between a labour hire provider and a client company does not imply the existence of an employment contract between the client and the supplier labour,⁵² even when the client 'exercises a significant degree of control' over the employee.⁵³

This presents its own issues when WWCCs are taken into consideration. Section 175 of the *Working with Children Act 2000* (WWC Act) provides an employer must not employ a person in regulated employment unless the person holds a blue card and the employer has given notice to Blue Card Services (BCS) (generally achieved by submitting a form or using an online portal to 'link' the employee to the organisation). Section 10 of the WWC Act provides [emphasis added]: 'For this Act, a person is employing another person **if the first person has an agreement with the other person** for the other person to carry out work'.

The result of these sections is, in labour hire situations, the client company (for example, an ECEC provider) may not be required to notify BCS that they have employed a person who is supplied by a labour hire firm, as it is the *labour hire firm* which makes an agreement with the employee to conduct work. **BCS has limited visibility over where employees of a labour hire firm are working in these arrangements, and cannot always notify the ECEC provider directly of a reassessment, suspension, or cancelling; rather, they rely upon the labour hire firm to forward that information and withdraw the employee from the provider.**

The Board has heard that providers are confused about their obligations with respect to contracted labour hire employees, which is exacerbated by insufficient and inconsistent advice and directions provided by BCS. This includes when and under what circumstances their obligations as an employer may be triggered, and how this is to be determined when the provider operates multiple centres.¹⁸

Notably, at the time of the offender's arrest in August 2022 four organisations were linked to the offender's exemption card and notified of its suspension, including his employment agency.

While it is apparent that the offender worked in at least nine centres while engaged with the employment agency, the Board has not been able to identify the dates of the offender's employment in these centres due to a refusal by the employment agency to fully comply with the Board's information request on the basis of pending legal proceedings. The information gathered about the offender's engagement with this agency has been drawn from other centre records and ECRA investigation material.

The employment agency advised the Board that the offender was engaged through them for a period of two months in 2022, however some centres refer to the company's engagement with centres dating back to 2019. The offender also worked at Centre WE through an employment agency in around 2006, though the exact agency is not known. This centre advised the Board that it had no records relating to the offender's employment, stating that they believe the employment agency would have retained screening and recruitment documentation.

Additionally, labour hire arrangements (particularly those made by recruitment agencies) have been a blind spot in respect to the *Education and Care Services National Law 2011* (National Law), under which ECEC providers, recruitment agencies, and regulatory authorities in each jurisdiction have faced barriers to the gathering and sharing of critical information about educators under investigation. For example, section 206 of the National Law provides that authorised officers may obtain information from approved providers, supervisors, volunteers and staff to monitor compliance, conduct rating assessments and obtain other information, however this does not include labour hire firms. In the absence of authorising legislation, recruitment agencies may be prevented from disclosing personal information, even to regulatory authorities, due to the provisions of the *Privacy Act 1988* (Cth) and their own policies.

This issue was considered in the *Review of Child Safety Arrangements under the National Quality Framework* (the Child Safety Review), and recommendations have been accepted in full by the Commonwealth, State and Territory Education Ministers to amend the National Law. Proposed amendments will:

- include recruitment agencies within section 206(4) as mentioned above
- allow a regulatory authority to disclose information about a labour hire educator with their recruitment agency as if it were an approved provider, for the purpose of sharing whether that person is subject to a prohibition notice or suspended from providing a family day care service
- make it an offence for a person subject to a prohibition notice to give a recruitment agency false or misleading information in relation to the notice or its existence.¹⁹

Some services where offending is known to have occurred advised the Board that they had made changes to their use of labour hire companies since the offender's arrest. For example, Centre BS reported that employment agency use is now restricted and subject to senior management approval, with a single vetted provider used in most locations. Centre EA also advised that they currently provide induction material ahead of time for agency staff, but that they are:

...liaising with agencies (...) to provide mandatory induction materials ahead of time for agency educators. We are working towards mandatory reading of materials by agency educators before arrival for shifts.

In submissions made to the Board, the employment agency provided advice on the current approach taken by this entity for candidates who seek to register in ECEC services:

1. **Sourcing/advertisement:** *The current state includes having a statement about being a child safe organisation on advertisement, listing child safe compliance documents required to apply for a position, and listing child safe policies and procedures on website.*
2. **Assessing suitability:** *An assessment should be undertaken of previous experience working with children and young people. It is specifically noted to 'look for sudden career changes, especially into OSHC [Outside School Hours Care] as unqualified worker when having no child related experience'. Ensure that all documents are returned relating to:*
 - *WWCC / Blue card*
 - *Qualifications (if applicable) and this is cross referenced with ACECQA NQF approved qualifications list*
 - *Names of two work related referees*
 - *Statement that they are not a Prohibited person or subject to an enforceable undertaking*
 - *Statement regarding criminal history*
 - *Search engine check to see if the person's name is flagged for anything untoward*
 - *Interview candidate and ensure that there is a question regarding child safety / reporting or safeguarding*
 - *Human checking of this data - not reliant on AI*
 - *References need to respond to the question "Is there a reason this person should not be engaged to work with children and young people" and "why did the person leave" and "would you re-employ this person"*
 - *People making assessment need to have knowledge of child safeguarding and what to look for*
3. **Onboarding/engagement:**
 - *Code of Conduct - Child Safeguarding signed*
 - *Induction completed which includes child safeguarding*
 - *Evidence of completion of induction records kept*
 - *Assessment against child safeguarding conducted as part of induction*
 - *Child safe policy supplied as part of the contract and readily available on the website*
 - *Linking WWCC to the agency (some states are candidate led as opposed to employer led)*
4. **Continuous monitoring:**
 - *Regular check ins with Centre on the educator's performance and behaviours which are recorded*
 - *Processes and policies are in place for when a Child Protection allegation is raised*

The agency also provided a range of 'future state' suggestions to improve safeguarding practices:

- A national government database where all candidates must be approved / not approved to work which would flag any pending actions. This could be supported by a national code of conduct required to be included in every employment contract.
- Update WWCC / National Criminal History Check to continuously update employers of any charges or misdemeanors e.g. the WWCC notifies an employer of any criminal matter not just child related concerns.
- Mandatory online child protection and child safeguarding training for every employee that is provided by the government, has assessment attached, and is completed annually.
- If someone is stood down due to an investigation at one provider or agency then this is reported and held in a national database until a final outcome is reached and this is used to prevent the candidate moving to another agency or child related employer meaning that they are truly stood down. Any potential employer must get approval to appoint from this new body.

Strengthened recruitment and employment screening practices

The research we have compiled requires us to acknowledge that there are motivated offenders operating undetected in our community, and that they seek to work with children.⁵⁴ They are not strangers to us. They often have no relevant criminal history that would prevent them from working with children and they work in roles that may disguise their offending.

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While, overwhelmingly, people who work with children act in their best interests, some are predatory and tactical in their grooming and abuse... Abusers need to be prevented from working in institutions, held accountable and removed from positions that give them access to children. This is generally accepted as uncontroversial but does not always translate into practice.⁵⁵

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Robust recruitment and employment screening practices are a fundamental part of ensuring that people who present a risk to children are unable to obtain child related employment. Evidence before the Board shows that the offender sought to circumvent recruitment and employment screening practices on multiple occasions. This includes by:

- not including details about his last place of work, for those organisations where performance concerns were noted or where he did not pass probation
- not using his most current referee or from his last place of employment, and using outdated referees from other jurisdictions or from parents of centres that he worked in (not former employers)
- not providing details about previous allegations made against him.

Concerns held about the offender's conduct in some centres do not appear to have been shared with subsequent employers as part of the recruitment process.

A Statement of Service was obtained by Centre EA from Centre EK as part of the recruitment process. This statement did not refer to any of the performance or behavioural concerns Centre EA had identified during the offender's employment at this centre, or the instance of child harm by the offender.

A number of other shortcomings with recruitment processes were identified:

- limited recordkeeping about recruitment processes
- reliance by centres on an employment agency to conduct referee checking and screening
- limited formal training in recruitment processes and requirements.

Signs of grooming or concerning behaviour in the offender's resume and references were also not identified. For example, the offender talked about 'professional attachment' and 'professional love' for children. The offender also included pictures of children from other centres where he worked in his resume. This was a clear indication to future employers of the offender's willingness to keep photos of children after he had left a centre and represented a breach of privacy for those children.

In reflecting on these issues, the Board noted that strengthened recruitment and screening practices would support the earlier identification of transient or highly mobile employees in child facing roles. Improved recruitment practices, supervision and oversight—particularly for temporary or agency roles—can help to screen out, or improve the early detection of, persons of concern. This was evident in a number of services where problematic behaviour by the offender was detected early and acted upon.

In one centre, the offender was terminated during his probation period, with his inappropriate behaviour towards children contributing to this decision. In this centre, the acting manager witnessed the offender having children sit on his lap on multiple occasions and raised that this was not in line with best practice. The offender was defensive when this was raised, and became aggressive when told of his firing, questioning why he was being let go 'based on a feeling'.

Recruitment and employment selection processes can be improved by ensuring that:

1. All applicants (staff and volunteers) who are short-listed for interview are asked if they have ever been a subject of an employer investigation or been charged as an adult with a criminal offence involving children, violence, drug dealing or dishonesty.⁵⁶
2. The current employer or most recent prior employer of all applicants short-listed for interview are contacted for suitability and screening purposes. This is to be made clear to the applicant on short listing so that they are aware that it is a prerequisite of employment.⁵⁷
3. A minimum of three reference checks should be conducted for all applicants (staff and volunteers) short-listed for interview. These should not be written references. They should be directly contacted via phone. The results of these are to be documented, diligently evaluated and placed on file prior to any offer of employment (paid or voluntary) being made.⁵⁸
4. Specific questions should be asked of the referee as to whether there was any conduct, disciplinary or performance issues identified with the person applying for the role.

The Royal Commission into Institutional Responses to Child Sexual Abuse further recommended that experienced persons familiar with relevant policies and interpreting the information provided by applicants should be the only ones engaging in recruitment process.⁵⁹ Recruitment staff should also be alert to signs of unusual attitudes about children, such as if applicants:

- talk about having 'special relationships' with children
- disagree with the need for rules about child protection
- think certain rules should not apply to them
- have a desire to work with children that seems focused on meeting their own psychological or emotional needs.⁶⁰

In its submissions to the Review, the Office of the Advocate for Children and Young People highlighted the need to make employment screening more robust, suggesting that this should include behavioural interviews, reference checks and safeguarding declarations. This was also supported by the Halloran Morrissey Group who advised that:

Safer recruitment practices remain a weakness in the ECEC sector in our experience. HMG recently supported a centre in dealing with numerous complaints against an employee that were not clearly indicative of misconduct but were outside of the centre's expectations for how their staff engaged with children. When explored with the centre, leadership revealed that the recruitment process for this employee revealed him to be transient between centres, which they did not explore further with him. Previous employers also raised concerns about his general attitude and inability to follow the rules during referee checks, but this information was not considered through a safeguarding lens before appointing him.

Standard five of Queensland Child Safe Standards requires that people working with children are suitable and supported to reflect child safety and wellbeing in practice. It requires organisations to have robust recruitment, training and ongoing support systems in place to ensure the suitability and preparedness of all personnel working with children to mitigate risks, reduce the potential for harm to occur and promote trust.⁶¹

Key steps for organisations to take to embed these standards include:

- implementing rigorous recruitment and screening processes, including reference checks and WWCCs
- developing and maintaining role-specific position descriptions that include children's safety and wellbeing responsibilities
- including cultural knowledge and lived experience as important values in role descriptions
- providing inductions and ongoing training on children's safety and wellbeing
- establishing clear supervision and performance management processes to monitor staff suitability and conduct, with specific reference to the Child Safe Standards
- fostering a workplace culture that prioritises children's safety and wellbeing through regular discussions and professional development opportunities
- implementing a safe and responsive mechanism for staff to report any concerns about the safety of children.⁶²

Development of an educator register

In support of the need for increased visibility, and in response to community concerns about the safety of children in ECEC services, all state, territory and federal education ministers committed to implementing a National Educator Register. This includes a commitment by the federal government to invest up to \$45 million to establish a new national register, which will provide regulators with clear oversight of who is working in the sector and where.⁶³ This will deliver on recommendations from the Child Safety Review.⁶⁴

There was general consensus for this type of register in submissions received by the Board. For example, PeakCare supported the exploration of options for a national register of ECEC workers which has the capacity to share employment history, qualifications, and identify patterns of concerning behaviour. They propose that this would act as a key measure to counter the risks presented by the current high turnover of staff in the sector.

The early childhood education and care sector is characterised by high levels of casualisation and staff turnover, which impacts the robustness of recruitment, supervision and compliance processes. A register would provide an additional layer of assurance, particularly where services are managing frequent staffing changes.

The agency responsible for one of the centres that the offender worked in also advised that it supported the establishment of a national employment register that outlines performance management issues and allegations or concerns which employers could access. It anticipates that this will assist with compliance checks and in identifying persons of concern. In its submission to the Review, Act for Kids called for a national standard of reportable thresholds:

If there was a national standard implemented to ensure all stakeholders working with children have a requirement to notify changes to a person's circumstances such as police convictions, suspicious behaviours, and employee issues, there would be a decreased risk of unsuitable individuals remaining in education and care settings.

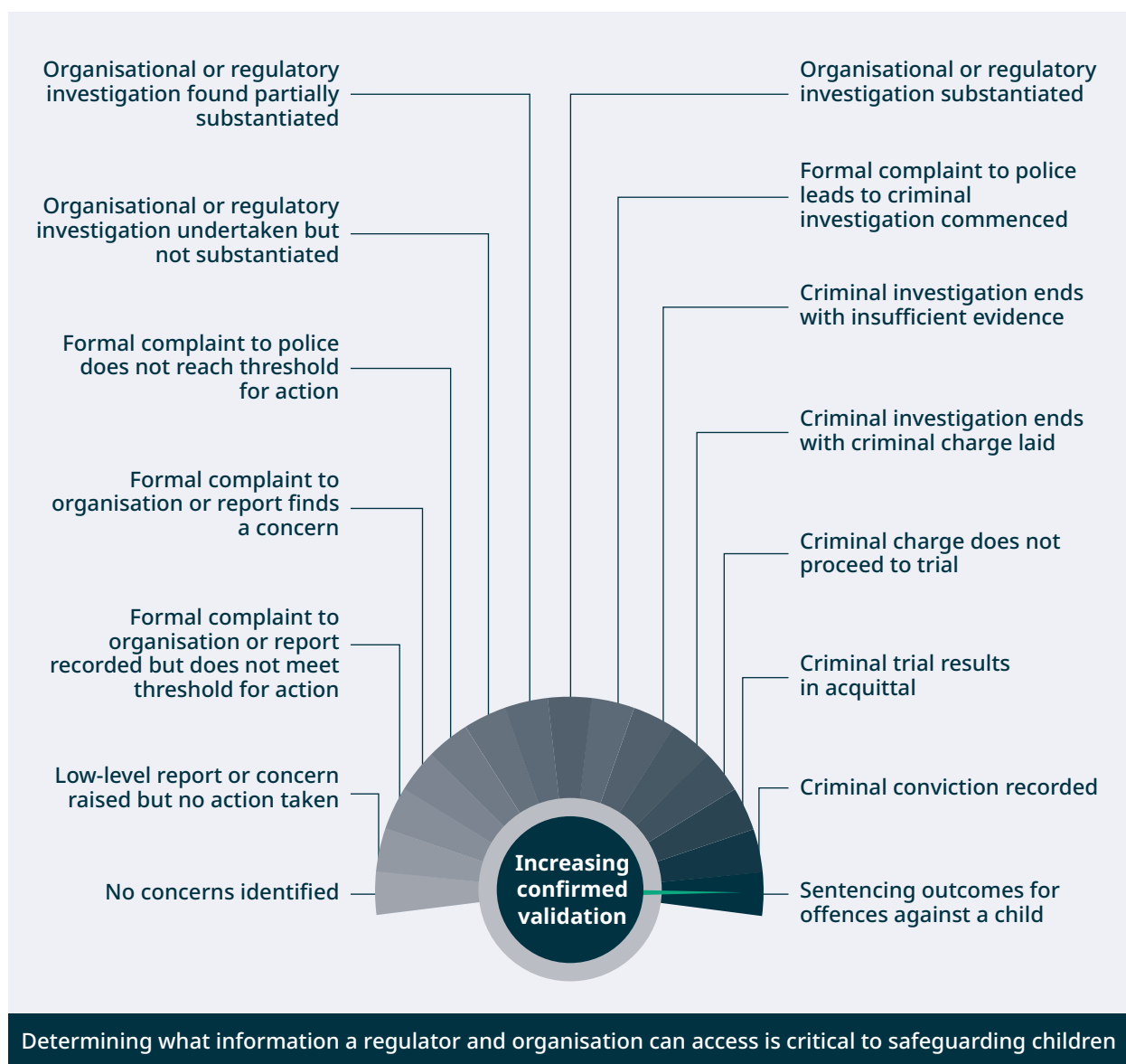
The challenge with any such register is how information included in the register should be used and operationalised. The Halloran Morrissey Group suggested that additional information about a person's disciplinary history and criminal investigations would be invaluable to employment screening assessment. They submit that:

This would allow organisations to understand all existing relevant information that they may not be aware of, and the factors taken into consideration by an employment screening agency that might mitigate risk, both of which can inform the employer's own holistic risk assessment based on its individual environment and risk profile. Such a statement in the case of [the offender] – which would include information about multiple workplace complaints and police intelligence – could have been disseminated to relevant organisations to inform their risk management strategies. The employer's threshold for risk might have been lower than Blue Card Services based on all the available information and subsequent risk assessment and this process would also facilitate transparency in employment screening processes. This could occur for first-time clearances where additional information exists but also on an ongoing basis where new information develops, triggering the questioning, suspension, or cancellation of a previous clearance. We acknowledge that privacy and procedural fairness considerations would apply to this suggestion.

Consultations undertaken by the Board to inform this Review noted concerns with the type of information collated and included in the register, and whether it should extend to unsubstantiated notifications or disciplinary concerns. Concerns were raised about prospective employers having access to a person's past disciplinary history, particularly where notifications are included which may have been vexatious.

In the Boards' view organisations tasked with safeguarding children are better able to make sound decisions about who is permitted to work with children when they are given access to information across the full continuum of concern. At present, access is often limited to the most serious end of the spectrum—charges, convictions, and sentences. Yet, waiting until an individual is convicted of offences against a child represents the very point of failure the system seeks to prevent. Earlier information—such as substantiated or partially substantiated complaints, the existence or outcomes of regulatory investigations, or the fact that a disciplinary investigation commenced but ended for lack of evidence—can provide important signals about risk, even if they do not meet the criminal standard of proof. Of course, sharing information of this kind carries privacy implications for the individuals involved. There is a risk of reputational damage, employment consequences, and unfair prejudice where complaints are not substantiated. These risks must be acknowledged and carefully managed, however, they must also be weighed against the rights of children to grow up free from abuse and exploitation, and our moral obligation as adults, organisations, and governments to take every reasonable step to keep them safe.

Figure 3: Information and intelligence about an individual



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In practical terms, providing organisations with richer intelligence enables more informed risk assessments, proportionate responses, and preventative decision-making about who is given responsibility for children. It does not require abandoning principles of fairness or privacy; rather, it requires a recalibration where the safety and wellbeing of children are given paramount consideration. In doing so, the system moves closer to its ultimate purpose: ensuring that those entrusted with the care and development of children are safe, suitable, and worthy of that trust.

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It is also critical to understand that increased monitoring or tracking of educators in one sector creates vulnerabilities in other areas that are less regulated. Motivated perpetrators move across roles, centres, sectors and in online environments to seek access to children. They may work as educators, volunteer with the local sports club, offer to babysit children and play online games as a hobby.

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In Queensland it is well known, and publicly announced, that protections in early child care are increasing and hundreds of children under five are in unlicensed residential care homes where employment screening and qualification requirements are sub-optimal. I have grave fears that people who seek to abuse children may have already moved sectors. - Luke Twyford

”

For this reason, consideration must be given to an expansion of the proposed educator register to other types of child-facing employment. The Halloran Morrissey Group submitted that:

We are of the firm view that employment screening is only one piece in the safeguarding puzzle and should not be relied upon as a sufficient proactive safeguarding strategy. Even the most sophisticated and robust employment screening process that encompasses psychometric testing, for example, is not guaranteed to prevent future harm against a vulnerable person.

Similar themes also emerged in a study undertaken by Griffith University to inform the Board's understanding of best practice responses for the prevention of child sexual abuse, which highlighted the importance of creating a safeguarding-focused organisational culture. They noted that this should involve:

- improving recruitment through thorough reference checks, values-based interviews, and clear messaging on child safety
- regular training, supervision, and strong leadership which are key to building staff confidence in recognising, reporting and mitigating risks
- a clear code of conduct, robust safeguarding policies, and an environment that encourages reporting to help prevent abuse before it starts, address concerns early and ensure staff are held accountable.⁶⁵

Transformational Recommendation 2: Preventing threats to children from entering the workforce

Perpetrators of child sexual abuse deliberately manipulate systems, groom colleagues, and exploit system weaknesses to avoid detection. In this case, the offender successfully concealed his past employment history, referee checks were not undertaken, and in several instances, he was simply let go or quietly asked not to return. This pattern strongly suggests that he was 'moved on' between employers without the risks he posed being properly addressed or recorded.

Queensland's new Child Safe Standards place a strong emphasis on ensuring that recruitment, induction, training, supervision, and management processes are designed to prevent unsuitable individuals from entering or remaining in positions of trust with children. This standard reflects the reality that the greatest risks to children often arise not from strangers, but from individuals who deliberately seek out access to children or who misuse the trust placed in them.

Organisations must move beyond compliance-based hiring and adopt robust, proactive recruitment systems that place safeguarding at the centre of all people-related decisions. Many inquiries have highlighted that individuals who pose risks to children are often able to secure positions of trust because recruitment processes are focused narrowly on technical skills, speed of hiring, or compliance with minimum requirements.⁶⁶ A child safe approach requires organisations to treat recruitment not as a transactional process, but as a critical opportunity to protect children from harm.

Effective child safe recruitment should begin at the earliest stage of workforce planning. Position design must clearly articulate child safeguarding responsibilities, the organisation's duty of care, and the behavioural expectations that apply to all staff and volunteers. This makes clear to prospective applicants that safeguarding is not peripheral to the role, but integral to its core functions.

The advertising and application process for a role must also be designed to screen for more than technical competence. Organisations should actively test a person's motivation to work with children, understanding of safeguarding principles, and respect for professional boundaries.

Structured interviews provide an essential opportunity to probe these issues further. Safeguarding-focused questions should be incorporated to assess values, attitudes, and an applicant's approach to managing boundaries. For example, applicants might be asked to describe how they would respond to a child's disclosure, or how they would ensure their interactions with children remain transparent and professional.

Reference checks must be rigorous and should never be treated as a box-ticking exercise. Organisations should conduct direct verbal conversations with referees, including probing questions about conduct, behaviour, and reasons for leaving previous roles. This practice can reveal crucial information about past safeguarding concerns that may not be evident on paper.

Verification of employment history is another critical safeguard. Too often, individuals who pose risks obscure or falsify their employment record to conceal past misconduct or disciplinary action. This practice, sometimes referred to as 'offender mobility', has been a recurrent issue in inquiry case studies. Systematic verification of previous roles, including through the use of educator registers, is essential to close this gap.

Finally, mandatory WWCC or equivalent clearances remain an important baseline requirement, but they should never be considered sufficient in isolation. While they can confirm whether a person has been formally barred from child related employment, they cannot provide any assurance about a person's suitability to work with children, attitudes, or conduct in practice.

A truly child safe recruitment system requires a mindset shift: from 'filling positions quickly' to 'safeguarding-first hiring'. Protecting children must outweigh organisational convenience or resourcing pressures.

Every hiring decision is, at its heart, a safeguarding decision.

Safeguarding training: Beyond recruitment

Recruitment is only the first step in protecting children. Organisations must recognise that ongoing education, reinforcement, and professional development are critical to embedding a robust safeguarding culture. All staff, volunteers, and contractors should receive comprehensive training that goes beyond compliance, equipping them to prevent, detect and respond to risks in real time.

Induction training must introduce the organisation's safeguarding policies, code of conduct, and clear procedures for reporting concerns. New workers should leave induction not only understanding the rules but also appreciating the organisation's commitment to creating a culture where child safety is a shared responsibility. They should feel empowered to raise concerns when they feel disquieted or uncomfortable about another colleague's behaviour or conduct towards children.

Those early warning indicators should never be viewed in isolation. They require all of us to be aware and to act.

Centres where there was known offending have themselves told the Board about the changes they have made to induction processes to strengthen their approach after the offending was detected. This includes by seeking to verify the credibility of referees where possible, increasing information about child safeguarding and reporting requirements, and strengthening probationary processes.

Scenario-based learning is also essential to translate policy into practice. By engaging with realistic examples, staff can develop the skills to recognise grooming behaviours, boundary violations, and early indicators of abuse. Such practical exercises foster critical thinking and situational awareness, helping staff respond confidently and appropriately when concerns arise.

Regular refresher training ensures that safeguarding knowledge remains current and responsive to emerging risks, particularly in areas such as online exploitation, social media, and digital peer-to-peer interactions. The digital environment evolves rapidly, and without ongoing education, staff may be unprepared to detect or intervene in these contexts.

Role-specific safeguarding training is necessary to ensure that responsibilities are clearly understood at all levels. Frontline staff require practical strategies for direct interaction with children, leaders and managers need guidance on supervising teams and modelling safe behaviours, and senior executives must understand their duty of care and accountability for organisational compliance and culture.

Embedding safeguarding into all training reinforces a culture where every individual not only understands what is prohibited but also actively contributes to safe environments for children. Effective training transforms policy into action, ensuring that safeguarding is integrated into day-to-day practices rather than treated as a static compliance obligation.

Protective leadership

Leadership plays a decisive and irreplaceable role in setting and sustaining a safeguarding culture.

The conduct of boards, CEOs, and senior managers not only determines organisational priorities but also sends powerful signals to staff, volunteers, children, and families about whether child safety is truly valued. A safeguarding culture is not achieved through policies alone; it requires consistent modelling of child safe values, transparent decision-making, and accountability at every level of governance.

To embed a culture of safety, leaders must:

- ensure that their decisions and behaviours consistently reflect the priority of child safety over reputational protection, convenience, or cost
- set a tone that strongly influences how seriously staff treat child safety obligations
- be responsible for building and maintaining systems where reportable conduct processes and complaints handling are trusted, accessible, and transparent
- ensure children, families, staff, and the community have confidence that raising a concern will lead to a fair, timely, and protective response
- be accountable for ensuring recruitment, training, and people management practices meet child safe standards
- not delegate responsibility for creating a safe workforce. It must be actively maintained and monitored by those with governance authority.
- deliberately create environments where raising concerns is encouraged, and where those who speak up are protected from reprisal
- ensure whistleblower protections are both formal and cultural, meaning staff and children are safe to report concerns without fear of negative consequences.

Without strong and accountable leadership, even the most well-designed policies and procedures risk being undermined in practice. Conversely, when leadership sets a clear and consistent tone that child safety is non-negotiable, staff are empowered to act, risks are surfaced and managed early, and children are more likely to be protected.

This was canvassed by Act for Kids in its submission to the Review:

“

Child safeguarding is often viewed as an operational responsibility within ECEC services rather than as a strategic priority. In many organisations, responsibility for safeguarding is distributed across multiple roles, resulting in gaps, duplication, and confusion.

Without designated safeguarding leads at the executive level, safeguarding systems can lack oversight, and cultural change efforts are often fragmented. Leadership teams may focus on compliance rather than proactively embedding child-centred practices.

”

Safeguarding as a core element of performance management and supervision

Safeguarding cannot be treated as a compliance exercise or an optional addition to staff responsibilities. To be effective, it must be embedded into the daily management and supervision of all personnel who work with or around children. Performance management is a critical mechanism through which organisations set behavioural expectations, monitor adherence, and intervene when early warning signs arise.

- **Supervision and Monitoring:** Organisations should require regular supervision meetings where safeguarding is a standing agenda item. This provides an opportunity not only to check compliance but also to reinforce child safe values, discuss emerging risks, and address any challenges staff encounter in applying safeguarding practices. Supervision must be both administrative and relational, creating a space where concerns can be raised safely. For example, the Royal Commission found that in many institutions, staff were left unsupervised for long periods, or supervision was perfunctory, limited to performance on administrative duties.⁶⁷ As a result, early warning signs of grooming behaviours went unchallenged, and children remained exposed to risk.
- **Behavioural Expectations:** Clear behavioural rules are essential. Organisations must establish and document expectations such as limiting one-on-one, unsupervised contact with children, maintaining visibility when working with children, and ensuring staff understand that secrecy is incompatible with safe practice. Compliance should be monitored, not assumed. The Board identified multiple instances in this case study where abuse occurred precisely because such safeguards were absent.
- **Active Verification:** Observation and spot checks are necessary to ensure safeguarding standards are applied in practice. Child safe organisations recognise that policies are not self-executing; it is only through deliberate oversight that unsafe practices are exposed. For instance, ‘pop-in’ visits by supervisors to classrooms, dormitories, or recreation spaces send a clear signal that safeguarding vigilance is ongoing.

Perhaps most importantly, organisations must also act swiftly on early indicators of risk behaviours. Warning signs include:

- breaches of safeguarding rules (e.g. engaging with children without approval and seeking to reduce supervision and guardianship)
- reluctance to be supervised or refusal to follow child protection processes
- developing unusually close or secretive relationships with particular children.

Multiple inquiries have shown that these signals are often noticed by colleagues but not acted upon by management. In one school setting, a teacher’s repeated boundary violations—staying late with children, giving gifts, ignoring reporting procedures—were tolerated for years until disclosure of abuse was made. By this stage, multiple children had been harmed.⁶⁸

Safeguarding competencies must be a criterion for performance appraisal, promotion, and contract renewal. Staff who consistently demonstrate safe practices, adhere to reporting obligations, and model protective behaviours should be recognised and rewarded. Conversely, staff who fail to comply must face clear consequences, including removal from child-related roles where appropriate. This shift ensures that safeguarding is not seen as peripheral to core business but as a central competency upon which professional progression depends.

The absence of systematic safeguarding supervision has repeatedly contributed to environments where grooming and abuse were able to flourish unchecked. Without embedding safeguarding expectations into supervision, performance management, and promotion decisions, organisations risk treating child safety as optional rather than integral.

In centres where abuse occurred, services reinforced to the Board that they had made a myriad of changes to increase oversight and accountability in centres, including by strengthening audit processes through dual-layered approaches, where audits are conducted by both centre directors and area managers. Another service reported that they have a dedicated Safety and Compliance team to audit and improve safety measures, which has quadrupled in size since 2019, an incident reporting system and a whistleblower channel. Other changes implemented by services include multi-stage recruitment processes, reinforcement of reporting obligations, revised codes of conduct, regular critical reflection on organisational policies at staff meetings, and prohibiting staff from caring for children outside centres.

One service spoke to having a zero-tolerance policy for any behaviour that may pose a risk to the safety of children, which is reinforced through regular leadership communication and prompt investigation where concerns are raised.

While it is positive to note these changes, collectively they show that we can and must do more to prevent threats to children. A recurrent and deeply troubling finding across multiple inquiries into child sexual abuse, and ours, is the capacity of individuals who pose a risk to children to resurface in new organisations after being dismissed, investigated, or subject to safeguarding concerns. This phenomenon has been described in both Australian and international contexts, often referred to as 'passing the trash' or 'moving people on'. It has been repeatedly identified as a systemic weakness that enables perpetrators to continue accessing children, sometimes for years, despite earlier warning signs being known.

The drivers of this issue are complex. Organisations may be reluctant to confront allegations due to fear of reputational damage, potential legal liability, or the difficulty of substantiating suspicions in the absence of criminal conviction. In many cases, employers have opted for negotiated 'quiet exits' - allowing the individual to resign or providing bland references that omit safeguarding concerns - rather than escalating matters through formal channels. While convenient in the short term, this practice has been shown to be catastrophically harmful to children, as it places other organisations and communities at risk.

Lying by omissions or commissions or any other forms of deceit such as not admitting responsibility and accepting accountability filters, drips, drop by drop from the top of any system, organisation, corporation, business. Just because the left hand doesn't know what the right hand is doing, does not make the left hand innocent. The body of facts remains regardless.

“

The Board noted that a fear of defamation and perceived legal risks to organisations and individuals is a deterrent to information sharing, which has flow on effects for the early detection of offending.

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To prevent this cycle, organisations must adopt clear and uncompromising policies that prioritise children's safety over institutional reputation or individual privacy. Key obligations include:

- **Documentation and Information Sharing:** All safeguarding concerns, whether substantiated or not, must be formally recorded and escalated to relevant regulatory authorities. In Queensland, this includes the Reportable Conduct Scheme (where applicable) and BCS. Proper documentation ensures that patterns of behaviour can be identified across time and settings, rather than being lost in fragmented or incomplete records.

- **Ending Quiet Exits:** Organisations must expressly prohibit ‘quiet exits’ where safeguarding concerns are ignored, minimised, or concealed. Providing neutral or misleading references is a breach of safeguarding duty. Employers must ensure that references are truthful and complete, including disclosure of any concerns about child safety that informed the individual’s departure.
- **Zero Tolerance for Moving on Risk:** It must be organisational policy that moving on a person who presents safeguarding concerns is never acceptable. Instead, such matters must be confronted directly through disciplinary action, regulatory reporting, and, where appropriate, referral to law enforcement. By taking direct action, organisations not only protect the children in their own care but also prevent the broader community from unknowingly taking on that risk.
- **Regulatory and Leadership Accountability:** These obligations cannot be left solely to frontline managers. Boards, senior executives, and directors must set the tone and accept accountability for ensuring their organisations do not contribute to the displacement of risk. Regulatory frameworks must also require timely information-sharing across sectors and jurisdictions to prevent offenders from exploiting gaps in oversight.

Employing people that will care for children demands a strong, robust and holistic approach from recruitment, to induction, to ongoing management and leadership accountability.

Submitters to the Review argued that the corporate governance, and particularly the employment laws covering organisations, do too little to protect children. The Queensland Human Rights Commission said:

Every decision, policy, and law concerning children should be able to demonstrate that the child’s best interests have been a primary consideration. Requiring that actions taken be in the ‘best interests’ of the child aims to ensure the full and effective enjoyment of all rights recognised in the Convention, and the holistic development of the child. The justification for this is the special situation of a child given their dependency, maturity, legal status and, often, voicelessness – if their interests are not highlighted, they can be overlooked.

The ability of people who present a risk to children to move between organisations, often aided by employer silence or inaction, represents one of the gravest failures of safeguarding systems. Any practice that allows ‘quiet exits’ or conceals concerns about the safety of children undermines the integrity of child protection efforts and facilitates further abuse.

Organisations must understand that unsuitable individuals are often skilled at hiding their intent and manipulating systems. This requires safeguarding processes that are rigorous, multi-layered, and embedded into organisational culture, ensuring that children’s safety is always the paramount consideration.

Transformational Recommendation 2: Preventing threats to children from entering the workforce

The Australian and Queensland governments:

- identify specific industries, such as early childcare, residential care, disability care, youth justice and boarding facilities, where they will legislate:
 - penalties for both employees and employers who do not record their employment in employee registers; and
 - penalties for employees, employers and referees for failing to disclose past employment history; concerns, complaints or investigations about the employee regarding harms or risks to children; or the reasons that employment ended
- amend the *Fair Work Act 2009* (Cth) and other industrial and workplace laws to provide explicit protection for employers who, in good faith and based on reasonable grounds, take adverse employment action (including suspension, role reassignment, or termination) due to concerns about a worker’s potential risk to children.

Chapter 16

Recognising threats by integrating intelligence

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Recognising threats by integrating intelligence

While it is important to focus our efforts on the identification of grooming and other indicators that someone poses a risk to children, there is a critical corresponding need to draw together patterns of behaviour over time and across institutions.

Robust recordkeeping practices and proactive information sharing is crucial to support the detection, disruption and prevention of child sexual abuse. While the Child Death Review Board (the Board) has been mindful of hindsight bias in the conduct of this Review, the timeline of offending discussed in Part B provides an opportunity to consider the totality of the information about the offenders' behaviour that was, or *should have been*, available to inform decision making at any point in time.

Recordkeeping practices

As so aptly highlighted by the Royal Commission into Institutional Responses to Child Sexual Abuse, poor records and record-keeping practices can:

*inhibit good governance; contribute to inconsistent practices and loss of organisational memory; hinder identification of perpetrators, victims and survivors; delay or obstruct responses to risks, allegations and instances of child sexual abuse; prevent or frustrate disciplinary action, redress efforts, civil litigation and criminal proceedings.*⁶⁹

In our review, consistent issues were identified with agency recordkeeping and retention practices across multiple centres meaning there were incomplete records with respect to the reasons why the offender was dismissed or let go.

Of the 19 centres where information was able to be requested via a section 29P request:

- One centre had closed down, with ownership transferred to a different entity, meaning records were no longer available.
- One centre held records, but they were in hard copy and had to be manually searched, which was not possible in the Review timeframe.
- Five centres provided records which were poor or inadequate and did not provide all details about the offender's employment or conduct at the centre.
- Four centres did not respond.

Only eight centres held records that were considered to be sufficiently robust to be able to develop a comprehensive picture of the offender's conduct in the workplace.

There were also concerns raised about the offender's documentation and recordkeeping practices in two centres that he worked in. A response to the Early Childhood Regulatory Authority's (ECRA) investigation by one centre alleges that the offender may have deleted or destroyed records prior to his departure from the centre, including some of the documents requested for ECRA's investigation. There are no further detail about why this was believed to be the case.

In some instances, parents and other staff reported that they had made complaints or raised concerns about the offender which were not documented in the available records. One centre advised the Board that some of the concerns raised by parents, including their unease about the offender and concerns about their daughter's clothing, did not in isolation meet the threshold for a reportable complaint under the National Law. As such, the centre was only legally required to retain records for three years under the National Regulations. There are also a lack of records about requests made by centre staff to the employment agency not to send the offender back to Centres WN and HN. Reasons provided for this by the centres of concern included:

- feeling uncomfortable around the offender, although unable to pinpoint why
- the offender being 'gruff', 'abrupt' and 'sharp' towards children
- the offender not following instructions to organise a game for children.

As the employment agency refused to provide records to inform the Board's review citing legal privilege, it cannot be confirmed what, if any, response they took in relation to the concerns raised by centre staff and indeed whether they were documented.

According to staff at Centre WN, the employment agency staff member they spoke to 'was adamant that he [the offender] needed to work and she would send him out'.

This occurred while he was subject to a report of sexual abuse made by a child.

Additional issues were also identified with how information was stored in agency databases, which impacted the capacity of any individual entity or the broader system to draw together patterns over time. This was most significantly seen with the Queensland Police Service (QPS), where the initial complaint about the offender in 2009 was not identified until after his arrest. Specifically, QPS recorded the complaint subject's name as 'Ashleigh' despite the initial complaint spelling it as 'Ashley'. Officers did not identify the offender as the subject of the complaint and subsequently did not link the complaint to him on QPRIME.

As part of Project Safeguard, further issues were identified with how ECRA recorded information in its systems, as complaints were not routinely linked to the person who was the subject of the complaint and were instead tied to the service. This reduced visibility of the offender when future complaints were made about him in different centres and impacted the capacity of ECRA staff to quickly identify what previous reports had previously been made about the offender.

During this Review, ECRA identified opportunities to strengthen information sharing arrangements with Blue Card Services (BCS) in circumstances where 'it reasonably believes the information is relevant to the functions of the Chief Executive (working with children).' ECRA submitted that this could be achieved by enacting similar provisions to those that currently exist under the *Disability Services Act 2006*. Proposed legislative amendments would ensure that there are provisions to share information with BCS, where there is insufficient evidence to prohibit a person from working in the early childhood education and care (ECEC) sector. It is understood that the agencies are working to explore the progression of these amendments.

The enduring challenge of information sharing

During our inquiry we heard examples of relevant information either not being shared, or not being shared in a timely and effective manner. This can have, and has had, serious consequences, including enabling perpetrators to continue their involvement in an institution or to move between institutions and jurisdictions and pose ongoing risks to children.

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No single institution collects all the necessary information or has all the appropriate tools to adequately protect children in [child-facing] sectors, and so the information collected must be shared to ensure an effective response.⁷⁰

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Sharing information in a timely and effective manner supports the health, wellbeing and safety of children.⁷¹ All Australian jurisdictions have laws which allow information sharing relevant to children's safety and wellbeing.⁷² There are no national standards or guidelines in Australia that outline best practice approaches to information sharing.⁷³ This means that there is no consistent or universal approach to information sharing, which impedes timely and effective information exchange.⁷⁴

There were multiple issues identified in relation to information sharing across different entities in this case, including with respect to the renewal of the offender's blue card.

When the offender's blue card was due to expire in November 2010 while he was working at Centre OY, the available records show that BCS sent notifications to the offender reminding him of the expiry date. The legislation at the time meant the centre was responsible for applying for a new blue card. Information provided by BCS stated that:

During this time, BCS sent notifications to the individual advising of the upcoming expiry of their blue card. The BCS practice of reminding individuals of the pending expiry of their card has continued to date and now includes at least four reminders to the individual prior to expiry. In addition, organisations who use the organisational portal are able to monitor renewal dates through the portal.

There is no information to indicate Centre OY was notified of the upcoming expiry and the fact that the offender could not legally continue to work at the centre without a valid blue card. Notably, as there were no pending investigations, charges or convictions against the offender at this time, he would have met all requirements to obtain and maintain a blue card on this occasion. The requirement for organisations to monitor renewal dates through a portal appears unnecessarily onerous for smaller centres, and it is unclear whether notifications are proactively sent to organisations to advise them of upcoming blue card expiry dates for staff.

Following the internal investigation undertaken by Centre EA in 2021, ECRA requested a copy of the findings from the centre. While the final outcome of the investigation was provided to ECRA, the full report was not. Centre EA also did not proactively provide a full copy of this report or details of the offender's concerning behaviour to QPS. This meant that valuable information about the offender's conduct which may have prompted a different response by agencies was not shared.

After a report was made while the offender was working at Centre WN in 2022, QPS spoke to the nominated supervisor and interviewed the child complainant before closing the case with no further action. They did not share these details with ECRA. While ECRA followed up with QPS three weeks later about the outcome of the investigation, they received no response from the QPS. ECRA then followed up with Centre WN another three weeks later and were subsequently informed by this centre that the case had been closed and QPS did not intend to investigate. The matter was subsequently closed by ECRA based on the outcome of the QPS investigation. In both of these investigations, the sharing of information following the detection of the offender's behaviour was ad hoc and fragmented.

Challenges with information sharing between AFP and QPS were also identified in the investigation into the CEM uploaded by Zimble. While there have been ongoing improvements since this time, the AFP advised the Board that the QPS were the lead agency for Operation Zimble and that it did not have any involvement in this investigation, as it was instead focused on the identification of the victims in the CEM that had been uploaded by Zimble and 'at that stage, there was no regular exchange of information between the two investigating agencies.

A system requirement to share

Legislated information sharing arrangements exist in the ECEC, police and blue card systems to guide what information *may* and *must* be shared with other agencies (Table 2). From time to time, these arrangements are supplemented by memoranda of understanding between agencies, which seek to operationalise information sharing practices and ensure that all staff are aware of their obligations.

Table 2: Existing information sharing arrangements in the ECEC, blue card and police system

Entity	Information sharing restrictions and ability
Early childhood education and care (ECEC) services	Providers of ECEC services are required under the Education and Care Services National Law and Regulations to share information with ECRA proactively through notifications and upon request. ECRA has broad powers to request and if needed, require that information relating to the operation of a service be provided to its authorised officers. The National Quality Framework (NQF) also requires a range of documents, such as illness and injury records, to be shared with parents upon request. Outside of this, approved providers must ensure that records are kept confidential and not divulged or communicated, directly or indirectly, to another person other than in prescribed circumstances such as to a parent of the child to whom the information relates. Similarly, providers have a legislative requirement to notify BCS of certain information regarding their employees. For example, providers must notify BCS when they employ a person.⁷⁵
Early Childhood Regulatory Authority (ECRA)	Information about ECEC services and educators held by the regulator can be shared with other government agencies, for a prescribed purpose, such as if it is reasonably necessary to promote the objectives of the NQF. Information regarding an individual can only be shared if it sits in one of the exceptions in the legislation such as the disclosure is authorised or required by a law of a participating jurisdiction or is otherwise required or permitted by law. ECRA must notify BCS when a prohibition notice or prescribed disciplinary action such as suspension of a provider approval is issued.
Queensland College of Teachers (QCT)	Information held by QCT regarding an applicant or an approved teacher may only be shared with other entities under provisions in chapter 11, part 1 of the <i>Education (Queensland College of Teachers) Act 2005</i>. The type of information which may be shared largely relates to criminal history screening information, details of charges or convictions reported by police, and interstate teacher registration information.

Entity	Information sharing restrictions and ability
Blue Card Services (BCS)	BCS can share confidential information with other agencies under certain circumstances. This includes for the purpose of performing a function under another law, such as monitoring compliance with the NQF. BCS must notify prescribed parties such as ECRA, the Department of Education and employers if: - a person identified as working in a school or in the ECEC sector has their blue card suspended, cancelled or is issued with a negative notice - there is a change in police information for a person who is identified as working in a school or in the ECEC sector. BCS can gather information from other entities, such as police and disciplinary information, in limited circumstances.
Queensland Police Service (QPS) and Australian Federal Police (AFP)	QPS shares information every 24 hours with BCS if changes to the police information of a blue card holder are detected. This includes new charges, convictions, or changes to child protection reporting obligations. National police information is coordinated by the AFP under the National Police Certificate system, and provided to QPS upon request (for example, for a Working with Children Check (WWCC) assessment). The AFP coordinates the sharing of information with state and territory policing agencies through cooperative bodies such as the Australian Centre to Counter Child Exploitation (ACCCE) and the Australia-New Zealand Counter-Terrorism Committee. As discussed in more detail in Chapter 12, an MOU has now been established between the AFP and BCS due to issues identified with the timely sharing of information between the two entities following the offender's arrest.

In addition to these specific regimes, overarching provisions exist allowing and, in some cases, requiring that information be shared between agencies. For example:

- Under the *Child Protection Act 1999*, prescribed bodies such as the Department of Education and the police *may* share information about suspected harm or risk of harm to a child with each other if there is a reasonable belief the information may help the recipient.⁷⁶
- Under the *Criminal Code 1899*, if agencies receive information that leads their employees on reasonable grounds to believe that a child sexual offence is being or has been committed against a child by another adult they *must* notify QPS unless they have a reasonable excuse not to.⁷⁷

While current legislation is intended to facilitate information sharing between agencies, regulatory frameworks, practices and mechanisms operating in isolation can result in failures to share in a timely and effective manner, leading to serious consequences for children.⁷⁸ As highlighted in community submissions to this Review:

Explicit and clearly defined legislation aids interpretation and application of safeguarding principles, limiting hesitation and confusion that can lead to under- or over-reporting, both of which compromise child safety. In our experience, robust, transparent, clearly (and consistently) interpretable enshrined information sharing provisions that clearly permit organisations to share information in the general interests of children's safety, welfare and wellbeing are critical to supporting the safeguarding of vulnerable people. Such legislation needs to be all encompassing to prevent misinterpretation and gaps in practice.⁷⁹

Information about risks, incidents and inappropriate conduct is currently held across numerous departments and organisations. Without an adequate reporting scheme or information sharing mechanism, this information cannot be considered and acted upon in its completeness, enabling perpetrators to continue abusing children across different institutions, sectors and jurisdictions.

“

Each scheme and program has its separate information sharing and privacy protections – but they were designed for each scheme, not for the big picture. When you step out and look at the bigger picture we still preference privacy over child protection. - Interstate Reportable Conduct Scheme Manager

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A system for information-exchange and access

Irrespective of the legislative requirement or authorising environment that exists to enable information sharing it ultimately comes down to decisions made by individuals, often under pressure and with constrained resources. In any such situation, this requires a person to be able to:

- identify that they hold information that needs to be shared
- understand that they have a responsibility or requirement to share information
- know how to share information, and who to.

Too often, this falls short of the stated ideal.

“

Every major review into child protection or child abuse in recent decades has pointed to the same failing: the system repeatedly missed opportunities to share information that could have prevented harm. Despite the enduring clarity of this finding, we have failed to resolve the problem.

”

Too often, children have suffered because agencies have operated in silos, holding fragments of information that, if brought together, would have revealed patterns of risk and prompted timely intervention.

The persistence of this issue is not the result of ignorance—it reflects the way our legal and policy frameworks have been designed. Lawyers and policymakers have historically constructed information-sharing schemes around transactional models of ‘request’ and ‘provide’. These mechanisms assume that information is neat, discrete, and readily retrievable, and that frontline workers have the time and clarity to formulate precise requests and then await responses. This approach profoundly misunderstands both the fragmented nature of information gathered by agencies and the realities of frontline practice. Information about risk is dispersed across agencies, systems, and formats. Frontline workers are often operating under intense time pressures, and the digital environment has fundamentally reshaped how information flows.

In today's context, transactional information request-response models are not only inefficient—they are unsafe. They perpetuate delay, duplication, and blind spots. What is needed instead is a fundamental shift toward systems of information exchange and access.

- **Information exchange** recognises that relevant information must flow proactively and automatically between agencies, not merely in response to requests.
- **Information access** means that authorised practitioners should be able to view, in real time and subject to safeguards, the relevant information already held across the system.

Such an approach reflects the realities of the digital world, reducing burdens on frontline staff, and creates a more complete picture of risk. Until this shift occurs, reviews will continue to identify the same ‘missed opportunities’, and children will continue to bear the consequences of a system that has been too slow to adapt.

Public submissions to the Board expressed strong support for improving information sharing, collection and analysis, including as part of the implementation of a reportable conduct scheme in Queensland:

The benefit of the Reportable Conduct Scheme is that it enables a broader range of behaviours to be reported than those that meet the threshold for mandatory reporting. It is recognised that educators in ECEC services and teachers in schools are already captured as mandatory reporters, however the reportable conduct scheme will still be of benefit because it enables behaviour that may not meet the threshold for mandatory reporting to still be identified, reported, documented and provides an overview of collective behaviour and experiences which may give cause for further examination about someone's suitability and blue card status.

The current system which enables potential perpetrators to evade detection by moving between jurisdictions has created an unhelpful loophole for potential criminals. Furthermore, there is no proactive sharing of information regarding “a person of suspect” between jurisdictions, regulators and service providers. As a transition measure towards a National Working With Children Check, consideration could be given to sharing databases across jurisdictions so that when one jurisdiction does a search on an individual, they in effect a searching a national database to see if any issues have been raised in relation to the individual's WWCC in another jurisdiction.
- Lutheran Education Queensland

Sharing and combining information in a database across departments and organisations has significant benefits including:

- providing a clearer picture of the risks posed to children
- ensuring cases and behaviours that fall below evidentiary thresholds are captured and properly considered
- enabling pattern recognition to better identify grooming and ongoing abuse indicators and monitor or prohibit individuals deemed to be a risk to children
- providing opportunities for learning and improvement in the sector
- reducing the burden on and re-traumatisation of children through repeated interviews and statements during complaint investigations.⁸⁰

Information sharing in the best interests of the child

The Board heard from consultants with experience in the delivery of child protection and safeguarding reform in the private and public sector who submitted that information sharing is a critical element of an effective safeguarding system:

In our experience, robust, transparent, clearly (and consistently) interpretable enshrined information sharing provisions that clearly permit organisations to share information in the general interests of children's safety, welfare and wellbeing are critical to supporting the safeguarding of vulnerable people. - Halloran Morrissey Group

Organisations have a responsibility to ensure that all workers are equipped to share information, and to have structures and processes in place to facilitate this information exchange. In all cases where the information relates to a person who poses a potential risk to a child, decision making should operate in the best interests of a child.

The Queensland Government *Interagency guidelines for responding to sexual assault or child sexual abuse* (the Guidelines) set out the 'roles, high-level procedures, and shared principles' for how government entities are to respond to allegations of sexual violence against adults and children.⁸¹ They apply to police, health, justice, youth justice, and child safety authorities but do not apply to schools or ECEC services. This is because they are intended to apply to only those agencies who have a specific role in the immediate response to people who have experienced sexual assault or child sexual abuse.

The Guidelines state that agencies should work collaboratively to coordinate the sharing of information to reduce the need for a child victim-survivor to share their story multiple times and require agencies to develop systems for sharing 'authorised information' with others.⁸² They otherwise provide very little guidance on information exchange and the management of concerns around privacy and confidentiality.

Multiple submissions received by the Board called for strengthened practices to facilitate information sharing and provide greater clarification of what information can be shared under different legislative instruments. Lutheran Education Queensland called for proactive information sharing which is facilitated by the sharing of databases across jurisdictions, regulators and service providers. This would mean that if issues have been raised in one jurisdiction, it is known across all states and territories. This helps to close a loophole currently exploited by perpetrators, who may move across jurisdictions to continue their offending.

The Australian Childhood Foundation also highlighted the need for statutory guidance to help sector organisations and individuals understand responsibilities, thresholds, expectations, and requirements for information sharing, intervention, and proactive risk management stating that:

“

Queensland is well placed to lead in this area by producing detailed guidance for its own context, building on the Child Safe Standards and making clear how agencies and organisations should work together to keep children safe.

”

In the United Kingdom (UK), the government issues ‘statutory guidance’ which agencies, employers, and individuals are required to comply with. This particularly applies to the social services sector. Statutory guidance, such as *Working Together to Safeguard Children 2023*, applies, in its entirety, to all education providers,⁸³ and childcare settings who have minimal authority to deviate from it.⁸⁴ This is a type of subordinate legislation unique to the UK and runs contrary to Australian and Queensland legislative practice. However, given the level of confusion and regulatory fatigue around information sharing and reporting which has identified throughout the Review, it may provide a useful model for the development of (non-binding) guidance by the Queensland Government.

What does best practice in information sharing look like?

- ✓ There is an oversight body which can enhance accountability, ensure organisations meet their obligations and provide additional safeguards.
- ✓ There is multi-agency cooperation which provides clarity around information-sharing access and practices.
- ✓ It should involve interjurisdictional cooperation and alignment in terms of best practice standards and processes.
- ✓ There should be training, support and guidance for those who will use the scheme.
- ✓ Mandatory periodic and comprehensive evaluations of its operation to ensure ongoing improvement of systems and it is effective in safeguarding children.⁸⁵

Delays in implementation of a national information sharing scheme

Issues have also been identified with interjurisdictional information sharing arrangements, which are often reliant on informal cooperation and lack national alignment. These types of gaps can allow critical information to fall through the cracks and ensures that perpetrators are able to exploit jurisdictional differences to avoid detection and continue to pose a risk to children.⁸⁶

International approaches to safeguarding children in ECEC settings provide valuable insights for strengthening regulatory safeguards in Australia. The Board heard of several leading international models, each demonstrating best practice in key areas such as worker screening, information sharing, and multi-agency collaboration. For example, the Australian Institute of Family Studies advised us that:

The United Kingdom's Disclosure and Barring Service (DBS) allows for greater discretion in information disclosure for high-risk professions. The UK system is further strengthened by the integration of Local Authority Designated Officers (LADOs), who coordinate investigations and facilitate information sharing among agencies. At the community level, Local Safeguarding Partnerships bring together ECEC organisations with other agencies, creating a coordinated and consistent approach towards safeguarding children.⁸⁷

and:

Ireland's Garda Vetting system addresses a critical gap by requiring overseas criminal record checks for applicants who have lived abroad. The Irish system, like the UK's DBS, also considers a wide range of information, including police investigations and allegations to comprehensively assess suitability for working with children.⁸⁸

In its final report, the Royal Commission found that all Australian jurisdictions actively weighted decision making towards privacy and confidentiality when considering the merits of sharing information related to children and, combined with confusion about the scope of exemptions and obligations to adhere with privacy and human rights principles, this led to barriers to the sharing of critical information.⁸⁹ For this reason, the Royal Commission recommended the introduction of a national information sharing scheme to facilitate and mandate the exchange of certain information between government and private sector entities, within and between jurisdictions, for the purposes of protecting the safety of children.

Nothing is more important than children's welfare. Every child deserves to grow up in a safe, stable, and loving home. Children who need help and protection deserve high quality and effective support. This requires individuals, agencies, and organisations to be clear about their own and each other's roles and responsibilities, and how they work together.⁹⁰

To date, the recommendations of the Royal Commission have not yet been implemented. In November 2023, a Ministerial Forum on Child Safety met to discuss a coordinated response to the recommendations of the Royal Commission which have yet to be implemented, and declared that national consistency was required to progress this work:

This included... options to enhance sharing child safety and wellbeing information across sectors and jurisdictions. These options include possible legislation and administrative arrangements for an information sharing scheme as recommended by the Royal Commission into Institutional Response to Child Sexual Abuse.⁹¹

Progress towards implementation has been sporadic and remains siloed, however there have been some developments which are discussed extensively in Part A of this report. For example, WWCC systems continue to improve in their interconnectedness, with the expansion of the National Reference Scheme and piloting of a National Continuous Checking Capability to share critical employment screening intelligence across borders. Additionally, the introduction of a Reportable Conduct Scheme in Queensland, alongside similar schemes in other jurisdictions, should ideally increase the visibility of sub-threshold indicators or persons of concern between regulators and other relevant entities to ensure this information is captured and shared where appropriate and necessary.

Throughout the reform process, we must be mindful that while information sharing schemes are carefully designed to ensure they are effective, they may still fail in practice. For example, in Victoria a comprehensive Child Information Sharing Scheme (the Scheme) operates under Part 6A and 7A of the *Child Wellbeing and Safety Act 2005*. This is intended to enable the sharing of information between organisations in the best interests of children and overrides other provisions in law that would inhibit this. However, the Scheme did not facilitate reportable conduct information being shared proactively with WWCC authorities in a recent high-profile matter.⁹² As a result the Victorian *Rapid Child Safety Review* recommended that the Reportable Conduct Scheme and WWCC systems be brought together.

Regulatory frameworks, practices and mechanisms operating in isolation can mean that information is not shared in a timely and effective manner, leading to serious consequences for children.⁹³ Information about risks, incidents and inappropriate conduct is currently held across numerous departments and organisations. Without an adequate reporting scheme or information sharing mechanism this intelligence cannot be considered and acted upon in its completeness, enabling perpetrators to continue abusing children across different institutions, sectors and jurisdictions.⁹⁴

More must be done in Queensland and throughout Australia. There remains no clear path to the sharing of reportable conduct information between jurisdictions, whether by Reportable Conduct Scheme regulators themselves or via other existing interconnected agencies. Privacy and industrial law issues continue to present barriers to private organisations sharing information between each other. There are opportunities for improved coordination and harmonisation between systems to prevent perpetrators from moving undetected within and between workplaces, industries, and jurisdictions.

Building a picture of risk, abuse and harm

Organisational and system structures that support the earlier identification of people who pose a risk of harm to children are critical. This has been a persistent issue identified in a multitude of previous reviews and inquiries, and one that has again been laid bare in this Review.

[A] multilayered approach is actually really quite crucial, and I think ensuring that you have systems speaking to one another is absolutely vital... A lot of the time, information sharing is probably the biggest inhibitor to child protection.

For example, an independent analysis of case reviews of child sexual abuse in the UK from between 2017 and 2023 identified the following system weaknesses:

- **A lack of effective coordination or handover between services:** which highlights the need for clear and concise processes, transparent communication, supportive and trusting relationships and increased follow-ups and updates across agencies.⁹⁵
- **A lack of understanding about where to refer risks:** professionals lacked an understanding of who to refer relevant information to, to ensure that risks were identified. In some cases, notifications were not made to relevant authorities.⁹⁶
- **An absence of universal information sharing standards:** professionals were restricted by a lack of a centralised or standardised information sharing platform or system. Communication issues were also encountered with incompatible agency systems which highlighted the importance of a universally compatible system to achieve best practice information sharing.⁹⁷
- **Lack of staff training or awareness:** privacy and data protection was prioritised above the sharing of safeguarding information because data protection legislation was often misinterpreted by staff.⁹⁸

A lack of independent oversight in most jurisdictions limits system wide responses and means that critical information is not centrally coordinated and shared across relevant entities. Independent oversight can also help to address conflicts of interests when organisations investigate their own staff.⁹⁹

For this reason, we need a conceptual shift. This is not just information, it is intelligence that can be used to build a picture of threats to children by persons of concern over time and across systems.

“*Potential intelligence on the alleged offender, their family, and their work history is siloed and disconnected rendering it almost useless in the identification of repeated concerning behaviours, dismissals, reports, warnings and all other WWC Balance of Probability suitability assessments.* - Hetty Johnston”

In submissions received by the Board, the Advocate for Children and Young People New South Wales proposed the development of protocols for ‘non-criminal’ risk management which empower agencies to act on patterns of concern even where criminal thresholds are not met. This could include harmful behaviour to self and others, and other ‘anti-social’ conduct.

After the offender was detected, the external review of the policing response by the QPS found that more needs to be done to develop investigative methodologies and systems that connect disparate information sources to better identify escalating risk. Recommendations from the external review highlighted the importance of thinking differently about how information is collated, stored, used and understood within and across different agencies. This includes the need for:

- police officers to be empowered to consider a series of incidents holistically rather than individually
- the continued development of partnerships between QPS, AFP and other entities, that leverage technological advancements to enhance data access, storage, collation and search capabilities
- enhanced operating environments to more quickly develop intelligence so that evidentiary thresholds are reached more efficiently
- identifying and addressing existing barriers to all aspects of information collection, enhancement and sharing.

The UK provides an example of a cross-agency database that permits the sharing of information about an individual without their consent if it is necessary to prevent abuse or harm.¹⁰⁰ This system is supported by the formation of Local Safeguarding Partnerships between agencies that require the provision of specified information to enable safeguarding of children in the area.¹⁰¹

Risk identification and assessment

The review received significant critiques of current protections:

While WWCC are a key part of keeping people who pose a risk to children out of child-focused settings, they are only able to restrict people who have previously been charged or convicted for an offence, or where relevant and concerning information has been provided to BCS which provides significant grounds to refuse a blue card.

Strengthened recruitment screening strategies, induction and probationary processes are only effective if workers receive high-quality training on how to recognise, respond and report child sexual abuse, and to identify grooming and other problematic behaviours.

Interagency collaboration is hindered by workforce turnover, as well as structural barriers that may impact information sharing where people or situations of concern are identified. This is particularly the case where there is insufficient evidence to substantiate a report of abuse to the requisite threshold due to a lack of evidence.

What this Review makes clear is that we must fundamentally change our approach to safeguarding and develop an integrated approach across our systems that weaves together different information into a cohesive whole. This includes early warning indicators, problematic behaviour, disciplinary information, transiency in employment and complaints from children, families or others.

“

*Recent alarming cases of child sexual abuse in ECEC are a critical reminder: the capacity of any one safeguarding mechanism or scheme to protect children in high-risk child related settings is, in isolation, limited.*¹⁰²

”

We must also be able to analyse and act on this information swiftly and in a way that prioritises the safety of children and keeps people who pose a risk to our children out of our systems.

In submissions to the Review, Jesuit Social Services highlighted the importance of drawing on current research by the University of New South Wales to strengthen approaches to the detection and investigation of child sexual abuse, including to inform risk assessments and build perpetrator profiles. The Office of the Advocate for Children and Young People New South Wales also called for the expansion of risk assessment criteria to include behavioural indicators, patterns of concerns and unsubstantiated but credible complaints.

The Queensland Sexual Assault Network (QSAN) raised further concerns that grooming will not meet the criteria for reportable conduct under the new Reportable Conduct Scheme, and that they consider it is essential to include boundary transgressions that fall short of the defined 'sexual misconduct' or 'sexual offence' as per the definitions in the existing Act.

In Queensland, as part of the response by agencies after the offending was detected, both BCS and the Department of Education have advised that they are seeking to strengthen their processes through the developed and use of a risk analysis tool.

ECRA has advised that a Manipulation Process Assessment model is being developed by researchers at the Griffith Criminology Institute, which is due for completion in late 2025. The intention is to develop a tiered assessment model to guide decision-makers in interpreting and responding to allegations of 'sexual misconduct' within ECEC services. It is being developed using offender-based data and is informed by learnings from investigations into perpetrators, as well as other notifications of child sexual abuse that have been made to ECRA.

Three key evidence sources are being used to support the development of this framework:

- **Behavioural data:** analysis of the frequency and patterns of over 150 manipulative behaviours used by people who have sexually abused children in child serving organisations.
- **Victim-survivor and perpetrator characteristics:** a consideration of the characteristics of children targeted, perpetrator preferences and the types of relationships and sexual contact established.
- **Recent case evidence:** integration of findings from contemporary cases of 'sexual misconduct' in ECEC settings to ensure the model reflects current risks and tactics.

ECRA anticipates that this framework will:

- refine and structure decision-making by offering clear tiers of risk, ranging from 'low-concern' behaviours through to high-risk indicators of grooming and predatory intent
- integrate international research on offender patterns with local case studies to ensure that the model is both 'globally informed and contextually relevant' to ECEC settings
- provide consistency and transparency in the interpretation of notifications and reduce subjectivity and variation in regulatory or organisational responses
- support 'proportional responses' to ensure that regulatory interventions, investigations or prohibitions are aligned with 'the severity and evidentiary strength' of the reported conduct
- seek to align with existing child safe frameworks including the *National Principles for Child Safe Organisations* and the *Child Safe Organisations Act 2024*.

The model is also intended to be shared with other jurisdictional ECEC regulators, to foster consistency, strengthen safeguarding practices and provide an innovative approach to the safety of children in the ECEC sector.

The Department of Justice have further advised that they have contracted the same researchers to deliver a synthesis of offender-based research on people in youth serving organisations and develop an analysis tool based on this research. This tool has now been deployed, with training delivered to staff in May 2025. It is being used by BCS where behaviours of concern by adults towards children in youth serving organisations are identified during the risk assessment process.

*...this tool will form an important part of the risk assessment process **where behaviours of concern by applicants engaged in child-related activities have been identified may not have resulted in charges or convictions for any offences.** It will assist BCS to make evidence-based findings **about behaviours of concern which do not reach a criminal threshold**, which in turn will ensure the risk assessment process in these cases is robust and informed.*

This tool and supporting research is intended to be used by BCS to conduct risk assessments for people seeking to work with children in regulated activities. In response to a request for a copy of the analysis tool to inform this Review, the Department of Justice advised that they would prefer not to provide the tool as they had received advice from law enforcement entities against sharing of the information. This is on the basis that access to the tool should be restricted as it provides an insight into the conduct of perpetrators of child sexual abuse, and its release may lead to misuse by perpetrators and diminishes its effectiveness.

They sought to further clarify that the tool is intended for use by assessing officers where an applicant or cardholder:

...is suspected of, or identified to have, exhibited inappropriate behaviour towards children in a setting that provides services directed at children, which is suggestive of child sexual abuse or manipulative behaviours, and which has not resulted in criminal charges. It assists officers to identify behaviours and patterns of behaviours, which on their own may not be sufficient to determine or establish that a person poses a risk to the safety of children, but when considered alongside offender-based research may support the issue of a negative notice in the absence of a substantiated finding against the person.

It is understood that information about these behaviours of concern will be gathered by BCS from existing information it is provided with, namely a person's child protection, domestic and family violence or disciplinary history. As there were no known concerns about the offender with respect to a history of domestic and family violence or child protection concerns, it is considered unlikely that this tool, in practice, would have enabled the earlier detection of the offender by BCS.

This is because information still needs to be available to BCS to make this type of assessment, and there are limited provisions through which it can request information, and no mechanism through which information can be compelled from other agencies to support an assessment.

In an internal brief provided by the Department of Justice (dated 3 August 2023) reference was made to previous recommendations by the Queensland Family and Child Commission in its *Recommendation 28 supplementary review* that had yet to be implemented. This relates to a recommendation to provide QPS with the authority to share information about a suspect with BCS while an investigation is being finalised. Specifically the internal departmental brief notes that:

- *This is based on a review of police investigations involving blue card holders undertaken by the QPS which determined that the sharing of suspect information was unlikely to mitigate risks to children. This is because QPS advised that a person is usually informed they are a suspect on the same day the person is arrested and charged. In those limited cases in which there is a delay between a person becoming a suspect and being charged, risk management strategies are employed by the QPS to limit risks to children during the finalization of the investigation.*
- *QPS has developed a formalised policy which has been included in its Operational Procedures Manual to provide officers with a consistent approach for identifying and managing risks to children during an investigation...*
- *Further, while it is possible for the QPS to provide “investigative information” (as defined in paragraph 32) to BCS under the Working with Children (Risk Management and Screening) Act 2000, this can only occur in very strictly defined circumstances where a range of specific criteria are met...Given this high threshold, investigative information is shared in very rare circumstances by the QPS.*

It has also been well established that perpetrators share information about how to target children, how to create opportunities for abuse to occur, and how to prevent detection. They discuss this in online forums and through networks. Perpetrators work in our institutions, and in child-serving roles. When we train staff and seek to strengthen safeguarding practices, including through the use of risk assessment tools, it is a fundamental reality that some of the people who have access to that training and frameworks may have a sexual interest in or sexually abuse children. They will also use this knowledge to circumvent these institutional safeguards and use them to their advantage to prevent detection.

For example, the offender is known to have completed training in child safe standards, and to have worked within these safeguards. This includes when making a report about a female educator at the centre he was a Director at in late 2021. He was later convicted for offences against the child complainant and disclosed that the child may have been confused about the identity of the teacher the complaint was about.

Additionally, when community concerns were raised on Facebook in the centre that he was a director at, the offender assured parents that all staff held a blue card and completed child protection training to allay their concerns. Importantly:

...a Blue Card simply confirms that an individual does not have a known criminal conviction at the time of application. This can provide a deceptive feeling of safety for employers and families, because it cannot account for undetected offending, concerning behaviours, or the potential for future harm.¹⁰³

Understanding what risks can and cannot be assessed

It is almost impossible to predict if someone could potentially sexually abuse a child. This is particularly the case for people who abuse children who have not been detected for their offending, as most predictive risk factors are based on known past offending. Self-reporting biases also impact the quality and accuracy of the information used to inform a risk assessment process, if the information being relied upon is predominantly provided by a potential perpetrator.

For these reasons, when considering the development or use of any risk analysis or decision-making tool, it is important to be clear on what ‘risk’ is being assessed, how it will be managed or mitigated, and the limitations of any such approach. Risk assessment processes are largely dependent on the availability and accuracy of the information used to inform the assessment. An overreliance on perpetrator self-reports or a lack of known offending can mean that someone who poses a risk to children will not be identified through existing tools.

*There is no typical profile of a perpetrator and their behaviours can change over time.*¹⁰⁴

Comprehensive sex offender risk assessment tools do exist, however they need to be completed by trained individuals who have experience in working with the relevant population, such as forensic clinicians and specialist corrective services officers. Although there are a range of actuarial risk assessment tools for sexual offenders, these have only been validated for use within the criminal justice system to manage convicted adult male sex offenders.¹⁰⁵ These include:

- **Risk Matrix 2000:** this tool was developed to assist in the management and supervision of sex offenders and is a statistically derived risk classification process used for assessing the risk of sexual recidivism among men aged over 18 years.¹⁰⁶
- **Static-99R:** this is an actuarial risk assessment tool designed to evaluate the risk of sexual re-offending in men with a history of sexual offending.¹⁰⁷
- **STABLE-2007:** this is an interview and desk-top review instrument designed to assess sexual recidivism factors which are potentially changeable in men.¹⁰⁸
- **Sex Offender Risk Appraisal Guide (SORAG):** this actuarial scale is designed to predict violent, sexual recidivism among men who have committed at least one previous contact sexual offence.¹⁰⁹

These tools all consider static and dynamic risk factors (such as criminal history, age and victim characteristics) and make predictions about re-offending.¹¹⁰ Non-actuarial risk assessment approaches also exist where a clinician considers person-specific risk factors and makes a structured professional judgment.¹¹¹ Although these have some benefits by taking into account changing risk factors, they are open to clinician error and misinterpretation.¹¹²

Importantly, for a risk assessment tool to be effective it requires:

- training to ensure that those trained are able to interpret the results, which often comes with a monetary cost
- time to gather the necessary information
- in most cases, time to interview the person.¹¹³

There are currently no known validated risk assessment tools to assist in the early identification of persons with a sexual interest in children who do not have a relevant criminal justice system history. There are also no risk assessment tools developed for use with convicted female sex offenders.¹¹⁴ As very little is known about those perpetrators who have not been caught there are some fundamental distortions in the tools and frameworks that are created to detect and disrupt any perceived threat.

Most studies are based on those perpetrators who have been caught, who are arguably less skilled at concealing their actions, who have left clearer evidence, and who have operated in a way that made detection more likely. This may result in an over-representation of certain offender types, an underestimation of institutional grooming, misleading risk profiles and system blindness which enables perpetrators to continue to hide in plain sight.

Transformational Recommendation 3: Create a Child Safeguarding Intelligence Hub: Enhancing early detection through integrated reporting and analysis

Child safeguarding remains one of the most critical challenges confronting society today. Despite significant progress in legislative reforms, regulatory oversight, and public awareness, children continue to be vulnerable to harm from perpetrators who seek to exploit or abuse them.

A major difficulty in prevention is that many concerning behaviours or risk indicators remain 'sub-threshold' - that is, they do not meet criteria for formal police investigation or action but nonetheless signal potential future risk. Moreover, reports and intelligence about such behaviours are often fragmented across agencies, organisations, and jurisdictions, limiting the capacity to connect dots and identify patterns early.

These threads leave a trail to an unseen threat, but it is currently no organisations role to systematically collect, follow or analyse these threads to identify any patterns and build a picture of harm.

The Board received contemporary submissions that continued to show the threshold issues, with one ECEC provider telling us:

There is increasing awareness among families, communities and early childhood professionals about the critical importance of identifying and reporting suspected grooming. It is generally understood that such concerns should be reported to the Queensland Police Service (QPS). However, [we] have encountered significant confusion and inconsistency during the reporting process, with referrals often redirected between QPS and the Department of Child Safety (Child Safety), Seniors and Disability Services, with each agency deferring responsibility to the other.

A recent case illustrates this issue. Our organisation reported suspected grooming to QPS, supported by evidence consistent with multiple indicators of grooming behaviour. QPS declined to act on the report, advising that it must first be submitted to Child Safety. We then referred the matter to Child Safety. After three weeks, Child Safety responded that, because the matter involved an employee, it fell outside their remit and should be directed to QPS. When this was communicated back to QPS, they advised the report did not meet the threshold for investigation and referred the matter back to us to investigate.

This lack of clarity around reporting thresholds, inter-agency communication, and agency responsibilities creates serious gaps in the system.

To ensure suspected grooming behaviour is consistently addressed, urgent improvements are required:

- *Improved training for frontline QPS and Child Safety officers on grooming indicators, thresholds for action, and inter-agency responsibilities.*
- *Clear, consistent and enforceable inter-agency protocols that outline which authority leads in various scenarios and ensure no report is dismissed or redirected without accountability.*

“*Without clear pathways and strong inter-agency coordination, organisations like [us] are placed in an untenable position, responsible for protecting children but unable to access the necessary system levers to act on serious concerns. Closing these gaps must be a priority if we are to effectively detect and respond to grooming behaviours and prevent child sexual abuse in Queensland.* - Anonymous ECEC provider, submission.

”

When the Board reviewed the evidence from the case study alongside broader research, it became clear that Queensland children face a tangible and serious threat. People within our communities are operating with motivations and intentions that are both profoundly harmful and deliberately hidden from view. In considering key challenges faced by the different systems under review, we noted:

1. **a limited ability to detect offending until significant harm has already occurred**
2. **perpetrators who are skilled at blending into everyday life, and who work together to remain hidden and cause harm**
3. **siloed law enforcement and reactive regulatory and justice responses**
4. **a community often uncertain about what to look for, and consequently how to protect itself.**

These observations naturally led us to draw parallels with, and examine, Australia's counter-terrorism framework following 9/11. This policy response demonstrated how proactive information sharing, investment in public awareness, and integrated operational approaches can improve early detection and intervention before harm occurs.

People who develop urges to harm children and those who develop urges to commit violent or extremist attacks may appear to inhabit vastly different domains of criminality. Yet, closer examination reveals striking similarities in how these behaviours form, are reinforced, and ultimately manifest as threats to society.

Both often begin in isolation, with people experiencing urges or beliefs that they may initially recognise as deviant or dangerous.

Over time, they seek validation and reinforcement, frequently finding it in online spaces where anonymity provides both safety and community. In these environments, harmful interests can be normalised, nurtured, and amplified. Within these digital communities, grooming and mutual encouragement play central roles. Just as extremist recruiters cultivate belonging and escalate commitment, people with sexual interests in children may groom newcomers by framing their urges as acceptable, inevitable, or misunderstood.

Both contexts provide training: for extremist groups, this may involve operational planning, tactical knowledge, and ideological reinforcement; for perpetrators against children, it may include sharing techniques to avoid detection, methods of grooming victims, or trading illegal child exploitation material.

In both cases, peer-to-peer reinforcement erodes inhibitions, emboldens participants, and increases the likelihood that deviant fantasies escalate to action.

The parallels extend further in terms of societal risk. Unlike many other crimes, where the primary harm may be limited, both child sexual abuse and extremist violence represent harms that reverberate across entire communities. They generate profound fear, trauma, and destabilisation. This scale of harm means that traditional reactive models of justice, i.e. waiting for an offence to be committed before intervening, is inadequate. The stakes are too high, the consequences too devastating, and the costs of failure too great.

For these reasons, society carries a heightened responsibility to detect threats before criminal acts occur. Just as intelligence and counter-terrorism agencies work proactively to identify signs of radicalisation or plots before they are realised, state governments can invest in child safeguarding systems that build mechanisms to detect grooming, identify emerging risk behaviours, and pinpoint concerning online activity.

This analogy underscores a critical principle: protection, in these contexts, is not a discretionary policy choice but a moral and practical necessity. It recognises that the significance of the harm - not just its likelihood - demands intervention at the earliest possible stage.

How Australia responded to the threat of terrorism

Following the attacks of 11 September 2001, Australia developed one of the most extensive counter-terrorism legal frameworks in the democratic world. Before 2001, Australia had no dedicated national counter-terrorism statutes. In the years following 2001, the Commonwealth Parliament enacted more than 90 federal counter-terrorism laws creating new offences, broadened investigative and intelligence powers, and established governance structures for information sharing across jurisdictions.

This transformation shifted Australia from a reactive, prosecution-driven model to a preventative, intelligence-led framework - one that allows authorities to act on suspicion and disrupt threats before they materialise.

Australia's approach to counter-terrorism included:

- 1. New laws that marked departure from traditional criminal justice principles and practices and that prioritised the mitigation of potential harm over the establishment of legal culpability:** In the ordinary criminal law framework, investigative powers are tightly constrained: authorities typically require reasonable suspicion and judicial authorisation before conducting searches, surveillance, or other intrusive actions. By contrast, counter-terrorism legislation allows agencies to intervene earlier, enabling pre-emptive action based on intelligence rather than confirmed criminal activity.¹¹⁵
- 2. The adoption of a whole-of-community approach, that framing terrorism prevention as a civil responsibility:** The National Security Hotline was launched in December 2002 and became a key conduit for public reporting of suspicious activity. Calls to the hotline reportedly generated actionable intelligence and increased public confidence in counter-terrorism measures.¹¹⁶ At the same time, campaigns encouraged vigilance with messages akin to 'If you see something, say something' and 'Be Alert but not Alarmed'. Awareness raising messages were deployed through television, radio, print, and online media, as well as on posters in public transport hubs and airports.
- 3. The focus of criminal law became inherently preventative with new offences targeted on actions taken before 'traditional' offending occurred:** These laws criminalised preparatory acts, associations, and certain forms of travel. Intelligence-led operations sought to identify threats before they manifested as actual crimes, reflecting a fundamental shift in the balance between individual rights and collective safety.
- 4. Enhanced powers of information sharing, information access and retention included lead roles for a multi-agency intelligence system:** The 2015 regime obliges telecommunications providers to store metadata—information about communications, not their content—for two years and enabled law enforcement agencies to access this data without a warrant in many cases.¹¹⁷ This was a major departure from the warrant-based access model used in most ordinary criminal investigations. The Australian Criminal Intelligence Commission was established to facilitate the real-time exchange of intelligence between federal, state, and territory agencies, including biometrics, criminal histories, and operational intelligence.¹¹⁸ This capacity surpasses the case-by-case information sharing common in non-terrorism criminal law. Joint Counter-Terrorism Teams were resourced to bring together the AFP, Australian Security Intelligence Organisation (ASIO), and state/territory police to integrate intelligence and coordinate operations, allowing for rapid detection and disruption of threats.¹¹⁹
- 5. Central leadership:** The Department of Home Affairs (Centre for Counter-Terrorism Coordination) was established to set whole-of-government policy and coordinate the National Counter-Terrorism Plan. This architecture emphasised centralised threat assessment, interagency tasking, and a high degree of operational collaboration where necessary.¹²⁰

The above elements highlight a distinct difference to our current approach to protecting children from suspected abuse and child safeguarding. Australia's legal, strategic and policy framework for preventing and detecting child sexual abuse can largely be characterised by:

- Diffuse funding across portfolios:** Funding for child sexual abuse prevention and response is distributed across multiple Commonwealth and state portfolios, including social services, education, health, justice, and policing. This model supports cross-sectoral collaboration by embedding safeguarding responsibilities into the everyday work of frontline systems that interact with children. However, it also creates challenges: transparency is reduced, it is difficult to aggregate the total level of investment, and coordination across diverse funding streams can be complex. This stands in contrast to counter-terrorism, which benefits from clear, centralised budget allocations to national security agencies, enabling sharper accountability and visibility.

- **Largely reactive system:** Child sexual abuse responses tend to occur after harm has already been alleged or identified. Law enforcement and regulators require sufficient evidence before proceeding, meaning intervention often comes late in the abuse trajectory. While this reactive orientation reflects the criminal justice and child protection frameworks within which these agencies operate, it also highlights a gap in proactive detection and disruption. Transparency and therapeutic needs for victim-survivors dominate, ensuring open processes, mandatory reporting, and trauma-informed practice. Counter-terrorism, by contrast, is explicitly proactive, with intelligence agencies tasked with identifying and neutralising threats before they manifest.
- **Fragmented and multi-jurisdictional structures:** The governance of child sexual abuse responses is inherently fragmented across states, territories, and the Commonwealth. Responsibilities are divided among child welfare agencies, schools, health systems, police, courts, and social services. This dispersal is necessary because safeguarding children requires multiple layers of intervention, but it also complicates coordination, slows responses, and risks duplication or gaps. Counter-terrorism, by contrast, is highly centralised, with Commonwealth agencies holding clear primacy and state police playing defined operational roles.
- **No analogue in the child protection domain:** By design, child protection frameworks lack covert intelligence powers. Instead, transparency, due process, and therapeutic support for victim-survivors is prioritised. Investigations are conducted within the bounds of criminal procedure. The emphasis is on responding to children, supporting survivors, and holding institutions accountable, rather than intelligence collection, threat disruption and harm minimisation. This creates a markedly different operational and ethical environment from national security work, and one which is largely failing to keep perpetrators visible and held them to account.

Noting this difference, there is, in the view of the Board, mutual learning potential between the two fields:

1. **Rapid, child-centred radicalisation/exploitation vectors.** Both violent-extremism prevention and sexual abuse prevention are grappling with younger cohorts being accelerated toward harm via the internet, social media and gaming platforms where children are targeted. These platforms also provide access to pornography, sexting, sextortion, and violent videos or imagery. This demands age-appropriate prevention, education and industry design changes.
2. **Data and capability pressures.** Rising volumes of online material and the technical sophistication of both extremists and perpetrators of child sexual abuse place pressure on digital-forensic, analytic and victim-survivor support capacity. Both sectors need scalable digital triage and cross-sector case management.
3. **Online platforms and industry cooperation.** Both prevention agendas hinge on rapid, substantive cooperation from global platforms. The *Online Safety Act 2021* gives Australia leverage in the child-safety domain; counter-terrorism also requires content takedowns and platform action. Recent public criticism of platform responsiveness by the eSafety Commissioner highlights common frustrations with the operation of these powers in practice.¹²¹

Table 3: Comparison table of Australia's counter-terrorism prevention efforts and its child sexual abuse prevention efforts

Dimension	Counter-terrorism prevention	Child sexual abuse prevention	Gaps / weaknesses in child sexual abuse response in comparison
National strategy	Comprehensive national Counter-Terrorism and Violent Extremism Strategy 2025, endorsed by all states and territories, with clear prevention, detection, and response pillars.	No single, unified national child sexual abuse prevention strategy covering all forms of abuse (online, contact, institutional, familial) with consistent state/territory buy-in. While there is a National Strategy to Prevent and Reduce Child Sexual Abuse responses are fragmented with notable delays in the implementation of key actions recommended by the Royal Commission.	Lack of a whole-of-government, whole-of-society national strategy endorsed and implemented across all jurisdictions.

Dimension	Counter-terrorism prevention	Child sexual abuse prevention	Gaps / weaknesses in child sexual abuse response in comparison
Dedicated legislation	Multiple federal laws (e.g. <i>Criminal Code Act 1995</i> Part 5.3), clear offence definitions, and prevention powers (e.g. control orders, preventative detention, passport cancellation).	Criminal laws exist at state/territory and federal level but focus mainly on post-offence prosecution. Preventative powers are narrow, siloed and unclear.	No equivalent pre-offence legal framework enabling early intervention before harm occurs.
Funding commitment	Record \$106.2 million over four years for prevention initiatives under the Counter-Terrorism and Violence Extremism Strategy, plus ongoing security agency budgets in the billions. ¹²²	While there was a Commonwealth investment of \$307.5 million for the first phase of implementing the National Strategy to Prevent and Respond to Child Sexual Abuse, funding for child sexual abuse prevention is relatively small and inconsistent; significant resourcing goes to crisis response and prosecution rather than upstream prevention. ¹²³	No sustained, ring-fenced prevention budget at comparable scale; heavy reliance on short-term grants provided to community organisations or other institutions, which are tied to specific funding requirements.
Prevention programs	National Support and Intervention Program, Step Together referral line, industry partnerships to detect and disrupt radicalisation, education sector involvement.	Ad-hoc programs run by non-government organisations (NGOs), limited early intervention services, no universal school education programs, online safety largely led by eSafety Commissioner without a unified prevention pathway.	No coordinated early-intervention referral system (like Step Together) for suspected child sexual abuse risk. Weaker integration of health, education, police, and community services.
Inter-agency coordination	High-level coordination through the Australia-New Zealand Counter-Terrorism Committee. Clear federal-state operational frameworks.	Multiple disconnected forums (police taskforces, eSafety Office, Standing Council of Attorneys-General, Education Ministers), but no standing inter-jurisdictional governance body solely focused on child sexual abuse or child safeguarding.	Absence of a permanent, formal national coordination mechanism with equivalent authority and accountability.
Intelligence and threat detection	ASIO, AFP, and state police have dedicated intelligence commands with legislative powers to collect and share information pre-offence.	Child sexual abuse detection relies on police cybercrime units, ACCCE, and individual reports from victim-survivors, NGOs, regulatory authorities or other entities. Intelligence sharing and threat detection powers are more limited and fragmented.	Fewer dedicated intelligence resources; limited capacity for proactive identification before offences occur.

Dimension	Counter-terrorism prevention	Child sexual abuse prevention	Gaps / weaknesses in child sexual abuse response in comparison
Community reporting pathways	National Security Hotline for public reports (24/7, anonymous, triaged to relevant agencies).	Reports made via police, Crime Stoppers, ACCCE online reporting tool or other entities. There is no single nationwide 24/7 public hotline for child sexual abuse prevention and early concern reporting.	Lack of a widely recognised, centralised, and promoted child sexual abuse prevention and reporting hotline.
Industry engagement	Strong engagement with technology platforms, finance sector, transport, and critical infrastructure to detect extremist activity. Legislative obligations to report suspicious material.	Engagement with tech sector through eSafety Commissioner and AFP but limited in other industries. Legislative duties for most industries are minimal, although they do exist for technology platforms. Child facing organisations have particular obligations that they must comply with under the CSO Act.	Weaker cross-industry mobilisation. While there are some obligations imposed these are not equivalent to counter-terrorism industry partnerships in breadth or enforcement.
Public education	National campaigns on radicalisation signs, 'Escape. Hide. Tell' armed attacker advice, online safety for gaming communities.	Public awareness campaigns are smaller, sporadic, and often issue-specific (e.g. ThinkUKnow, Stop It Now!). They are not continuous or nationally branded.	No long-term, consistent, high-visibility national public education campaign on child sexual abuse comparable to terrorism messaging.
Youth involvement	Youth and Mental Health Advisory Group informing policy, with direct investment to ensure youth perspectives in prevention.	Some youth consultation through NGOs and online safety programs but not embedded in government prevention planning.	No formal youth advisory mechanism consistently feeding into state, territory and national child sexual abuse prevention policy.
International partnerships	Active in Five Eyes intelligence sharing, United Nations counter-terrorism forums, and bilateral partnerships.	Australia participates in global child sexual abuse policing initiatives (e.g. INTERPOL, WeProtect Global Alliance), but partnerships are narrower in scope and lower profile.	Less political prominence and strategic weight given to child sexual abuse in international forums.
Evaluation and accountability	National strategies have defined measures of success, annual reporting, and parliamentary oversight.	Evaluation of child sexual abuse initiatives is inconsistent, fragmented, and often internal to agencies and levels of government.	System fragmentation and lack of transparent, national performance reporting against prevention goals.

To address these challenges, it is proposed that the Queensland Government establish a Child Safeguarding Intelligence Hub - a centralised, multidisciplinary intelligence unit that collects, analyses, and acts on sub-threshold indicators of concern about individuals working with or near children. By providing an accessible reporting pathway for parents, co-workers, and others, integrating intelligence techniques with law enforcement and regulatory information from entities like BCS and ECRA, and fostering collaboration across sector regulators, the Child Safeguarding Intelligence Hub could become a transformative tool for protecting children.

“

Someone needs to take leadership and ownership for the holistic assessment of risk. We see time and time again the thresholds of police and regulators being different, the purposes being divergent. There is a huge gap – and who actually steps in and puts it all together. - Interstate Reportable Conduct Scheme manager

”

This is not a unique proposal. The *Review of Child Safety Arrangements* in 2023 by Australian Children's Education and Care Quality Authority (ACECQA) recommended the establishment of a national centralised mechanism which appropriately records and shares national intelligence between authorised entities to more effectively monitor and respond to suspected or alleged misconduct, including unsubstantiated notifications.¹²⁴ It also recommended the adoption of a risk-based approach that does not wait for an offence to occur, and gives precedence to a child's right to safety, while maintaining procedural fairness principles by including the right of reply to the person of concern.¹²⁵ Over the longer term this mechanism could link to WWCC, and applicable teacher or educator registers.

The Victorian *Rapid Child Safety Review* in 2025 also recommended that its Reportable Conduct Scheme and WWCC systems be brought together with a new information and intelligence capability:¹²⁶

*To support these changes to the Working with Children Check and Reportable Conduct schemes, a new Shared Intelligence and Risk Assessment Capability must be established. That is, information and intelligence currently held in multiple places must come together. Staff must be resourced with the necessary expertise and evidence-based tools to make sound judgements around the level of risk an individual poses to a child, and provide that information to relevant decision makers so that they can act swiftly.*¹²⁷

Submissions received by the Board also highlight the need for a centralisation of function. For example, the Halloran Morrissey Group submitted that:

Given the possible risks and harms associated with child-related employment, workplace investigations with a lower standard of proof are essential in safeguarding vulnerable people in organisations tasked with their care when conducted well. An RCS [Reportable Conduct Scheme] oversight body is also well placed to 'connect the dots' between notifications to identify patterns in alleged conduct that can be shared with relevant agencies to inform risk assessments and evidentiary considerations in workplace investigations such as tendency and propensity. Our view is that one agency governing the various safeguarding schemes (employment screening, RCS, child safe standards) is the ideal and most streamlined arrangement from the perspective of organisations needing to comply with the schemes.

The implementation of a reportable conduct scheme in Queensland provides a critical opportunity to reflect on what type of cross-agency intelligence gathering and analysis capacity is needed to develop our systems of detection and disruption. Interviews with managers from interstate reportable conduct and WWCC schemes highlighted that:

“

We could do a whole lot more with data – with so many players we see risk shifting. The time bomb of information passes for the wrong reasons - Interstate Reportable Conduct Scheme manager

”

The need for an intelligence hub in child safeguarding

Traditional child protection and policing frameworks rely heavily on threshold-based interventions—where clear evidence or allegations of harm trigger investigation and action. However, many indicators of potential risk appear as subtle or ambiguous behaviours, such as inappropriate comments, boundary testing, unexplained changes in behaviour, transient employment or repeated minor complaints. These sub-threshold indicators are often dismissed or unresolved because they do not meet criteria for formal action or there is insufficient evidence to substantiate that something had occurred. Research and expert consensus increasingly recognises that the early detection of these indicators is essential to prevent abuse and to remove threats. For instance, patterns of minor misconduct, when aggregated, can reveal grooming behaviour or unsafe individuals.

It can also show attempts by an offender to reduce guardianship and create opportunities for abuse to occur, by testing the strength of an organisations approach to safeguarding. The Australian Institute of Family Studies (AIFS) research conducted for the Board found that:

The evidence suggests that regulatory frameworks, mechanisms and bodies are most effective at safeguarding against CSA [child sexual abuse] when operating as a network, rather than as isolated entities. It is important for such a network to share common goals, language, practices and learnings to ensure consistency when sharing information or when implementing reporting schemes, policies and protocols. One potential feature of this may be a uniform information sharing database, which could provide critical insights that help safeguard against CSA [child sexual abuse].¹²⁸

Yet, there is currently no formal mechanism to collect, analyse, and act on these signals across agencies, sectors and regulatory bodies. Concerns about people working with children are reported through various channels: to human resource teams in individual agencies, regulators (such as blue card or WWCC systems), complaints mechanisms, and informal communications among co-workers or parents. These sources often operate in isolation, creating information silos. As a result, critical pieces of intelligence fail to be connected or escalated. For example, a person may receive informal complaints in one workplace, have concerning behaviour reported to a regulator in another, and show troubling social media or online activity elsewhere—but none of this information is linked to reveal an emerging risk. Without integrated intelligence sharing and analysis, these fragmented concerns remain invisible at a systemic level. As articulated in one interjurisdictional consultation session:

“

As a former police officer I never knew these schemes existed. I never turned my mind to the reporting of suspicious people working with children to a body outside of the police system. The relationships between police intelligence systems is critical to child safeguarding. - Interstate police officer

”

The concept of intelligence-led safeguarding builds on established policing and security models where multiple information sources are integrated, analysed, and used proactively to detect threats before harm occurs. An intelligence hub dedicated to child safeguarding would adopt such a model—collecting a broad spectrum of concerns, applying analytical techniques to identify risk patterns, and enabling coordinated responses.

Core Functions of the Child Safeguarding Intelligence Hub

The Child Safeguarding Intelligence Hub would serve multiple critical functions designed to overcome current gaps and enhance the safeguarding system's effectiveness:

- **Integration of existing regulatory and organisational data:** The hub would link with existing regulatory systems databases, capturing data on approvals, suspensions, investigations, and complaints. This would include:
 - BCS
 - ECRA
 - Disability Services
 - Reportable Conduct Scheme
 - Child Safe Standards
 - Vulnerable persons employee registers and regulatory information
- **Cross-organisational intelligence sharing:** Legislation will enable information sharing with schools, childcare providers, sports clubs, and other child-related organisations with relevant behavioural and disciplinary information securely and confidentially. Strict data governance frameworks would ensure the hub complies with ethical standards and procedural fairness requirements, maintains the confidentiality of reports and safeguards individuals' rights to information privacy to the extent that it does not jeopardise the safety of children.
- **Centralised collection of sub-threshold reports through an accessible reporting portal:** The hub would provide an easy-to-use, confidential online platform where parents, co-workers, volunteers, educators, and others can report concerns or behaviours that may not meet formal thresholds but warrant attention. This would include observations, feelings of discomfort, minor incidents, and contextual information. To maximise accessibility, the hub would support reports via telephone, email, and potentially in-person support for those needing assistance.
- **Feedback mechanisms:** Reporters would be provided with appropriate feedback and support, reinforcing trust and encouraging ongoing reporting. Public education and training programs would accompany the hub's launch to encourage a culture of vigilance and transparency among communities and organisations.
- **Analytical risk assessment and intelligence techniques:** Using advanced data analytics and machine learning, the hub would identify patterns of behaviour or connections between reports that suggest escalating risk or grooming behaviour. Risk scoring models would prioritise individuals and cases for further assessment or intervention, ensuring resources focus on the highest risk profiles. Analysts would consider contextual factors such as organisational culture, previous employment history, and environmental stressors to interpret data accurately.
- **Coordination, referral and multi-agency collaboration:** The hub would operate as a coordination centre, sharing relevant intelligence with child protection services, law enforcement, regulatory bodies, and organisational safeguarding leads. Clear protocols would guide referrals for further investigation, support services, or regulatory action based on risk assessments.
- **Continuous learning and reporting:** The hub would produce regular intelligence reports on emerging safeguarding trends, risk hotspots, and systemic issues to inform policy and practice. Insights from the hub would underpin workforce training and resource development to improve frontline detection and response and strengthen workforce and sector capability.

By capturing and analysing sub-threshold concerns, the hub will enable earlier identification of people who pose a risk to children, potentially before harm occurs or escalates. This proactive approach enhances prevention and the safety of children. Key benefits would include:

- **Enhanced accountability and transparency:** Providing a formal, centralised reporting mechanism for concerns creates a culture of accountability. Staff, parents, and community members gain confidence that their concerns are heard and addressed appropriately.
- **Breaking down silos and improving information sharing:** The hub facilitates integrated intelligence sharing across agencies and organisations, overcoming traditional barriers that limit systemic risk detection.
- **Better regulatory oversight and decision-making:** Access to rich, integrated intelligence supports regulators in making more informed decisions about worker suitability, license suspension, or investigation prioritisation.
- **Increased community trust and engagement:** Transparent communication and visible action reinforce community trust in child safeguarding systems and encourage greater reporting and vigilance.

- **Systemic insights for policy and practice:** Aggregated data and analysis provide valuable insights into emerging risks, systemic weaknesses, and effective interventions, informing continuous improvement in child safeguarding policies.

“*Our schemes have an inherent reliance on other schemes to do their bit. And when one doesn't do it correctly the butterfly effect touches all the other schemes.* - Interstate police officer”

Operationalising the Intelligence Hub

The design and implementation of a Child Safeguarding Intelligence Hub would represent a critical evolution in protecting children from harm. By providing a centralised, integrated, and proactive platform to collect and analyse sub-threshold indicators and other concerns, the hub would overcome the current system fragmentation that hinders early detection of risk and improve the visibility of potential threats. Accessible reporting avenues for parents, co-workers, and communities empower those closest to children to contribute to safeguarding efforts.

Integrating intelligence methodologies with regulatory systems such as the blue card and reportable conduct schemes will enhance oversight and decision making, while coordinated referrals ensure that concerns translate into timely, effective action. The hub would foster a culture of vigilance, accountability, and transparency that is essential for preventing child abuse and exploitation.

The establishment of a Child Safeguarding Intelligence Hub will require a clear and deliberate investment in infrastructure, capital expenditure on information and communication technology capability, and the recruitment of dedicated specialist staff. A secure digital platform will be needed to integrate data from multiple schemes, support real-time data exchange and access, and ensure compliance with strict privacy and security requirements. Specialist analysts, data scientists, and safeguarding professionals will also be essential to interpret and operationalise the intelligence, ensuring it translates into practical prevention and protection measures.

While these costs are not insignificant, they must be understood in the context of the current system's inefficiencies. At present, multiple parallel schemes—such as working with children checks, reportable conduct, professional registration, and various regulatory databases—operate in isolation, each with its own infrastructure, staffing, and administrative burden. This duplication generates cost without delivering a coherent or complete safeguarding picture. By bringing these schemes together in a single intelligence hub, government can reduce overlap, streamline processes, and create a platform that not only enhances the safety of children but also delivers long-term efficiency gains.

In this sense, the investment in a Child Safeguarding Intelligence Hub should not be seen as an additional cost layered on top of existing systems. Rather, it represents a rational consolidation; an opportunity to reallocate resources currently dispersed across fragmented schemes, while at the same time building the capacity required to meet contemporary and future safeguarding challenges. The efficiencies created will, over time, offset the initial capital expenditure, while the improvements in system performance and the reduction in harm to children provide benefits that cannot be measured in financial terms alone.

Ultimately, investing in such an intelligence hub aligns with best practice in public safety and child safeguarding, and offers significant benefits to children, families, and communities by identifying and responding to risks before harm occurs.

In progressing such an integrated intelligence function, the Queensland Government should consider the following design principles.

Table 4: Design Principles for the Child Safeguarding Intelligence Hub

Domain	Key elements
Governance and leadership	Established under statutory or government authority with clear legislative mandate and independence to ensure credibility. Guided by a multidisciplinary advisory board including child safeguarding experts, law enforcement, regulators, community representatives, and legal experts.

Domain	Key elements
Technology infrastructure	Secure, user-friendly digital platform to facilitate reporting, data integration, and analytics. Interoperability with regulatory databases and organisational systems via application programming interfaces and data-sharing agreements. Robust cybersecurity to protect sensitive information.
Workforce and expertise	Skilled analysts trained in behavioural risk assessment, data analytics, and child safeguarding. Dedicated liaison officers to coordinate with organisations, regulators, and law enforcement. Training and support staff to assist reporters and stakeholders in using the system.
Legal and ethical frameworks	Privacy, data protection, and human rights safeguards embedded in operations. Clear policies on data retention, access, and reporting thresholds. Ethical oversight committees to ensure procedural fairness and due process.
Community and organisational engagement	Partnerships with schools, childcare services, sports clubs, and community groups. Education campaigns to promote the hub and clarify reporting responsibilities and protections. Feedback loops to engage communities in continuous improvement.
Integration with child protection and law enforcement	Formal protocols for referral and information sharing with child protection authorities and police. Joint training and exercises to strengthen inter-agency understanding and cooperation.

Transformational Recommendation 3: Create a Child Safeguarding Intelligence Hub

The Queensland Government establish a Child Safeguarding Intelligence Hub: a centralised, integrated platform to collect, analyse, and act on sub-threshold indicators of concern about individuals working with children. By linking organisational, regulatory, and community reports, applying analytical risk assessment techniques, and coordinating referrals with child protection and law enforcement, the hub will enable earlier identification of potential risks, enhance transparency and accountability, and break down information silos that currently impede proactive safeguarding. The government should ensure the Child Safeguarding Intelligence Hub is resourced with sufficient staff and technological capability to link, match and analyse data across the information silos relevant to child safety.

The operation of the Child Safeguarding Intelligence Hub should transform child safeguarding from a reactive investigation to proactive risk detection approach by integrating data from regulatory systems (blue card, Reportable Conduct Scheme, sector regulators, and other vulnerable persons registers), provide accessible reporting pathways for parents, staff, and volunteers, and apply advanced analytics to identify patterns of concern and threats to children. By doing so, it will enable earlier interventions, strengthen oversight, improve community trust, and prevent harm before it escalates.

The Child Safeguarding Intelligence Hub, should be designed to sit within a statutory or government-authorised entity with robust governance, secure technology infrastructure, skilled analysts, and clear ethical and legal frameworks. The hub would:

- collect and centralise sub-threshold reports from organisations, regulators, and communities
- analyse patterns of behaviour to detect emerging risks
- coordinate referrals to child protection and law enforcement
- provide feedback and training to reporters and stakeholders.

This integrated approach will seek to overcome fragmented information flows, strengthen systemic safeguarding, and enable proactive, intelligence-led protection of children.

Transformational Recommendation 4: Co-locate the reportable conduct and WWCC schemes into one entity

The establishment of a Reportable Conduct Scheme in Queensland from 1 July 2026, and the amendments made to shift the blue card system into a risk-based decision making framework, mean that Queensland will soon have two universal (i.e. cross-sector) schemes that collect intelligence and assess risk. In New South Wales, the Reportable Conduct Scheme sits alongside the WWCC system within the Office of the Children's Guardian. The Victorian Rapid Review of its reportable conduct scheme has also recommended that both schemes be brought together in this state:

Currently the Working with Children Check and Reportable Conduct schemes sit in 2 separate entities. The Review recommends that they be brought together (along with the Child Safe Standards) into a single entity with a new Shared Intelligence and Risk Assessment Capability. Together, these changes will significantly strengthen the safety net around children.¹²⁹

The Board considers that, from an organisational design perspective, co-locating the Queensland Reportable Conduct Scheme and the WWCC within a single regulatory body provides a significant advantage in terms of efficiency, collaboration, and impact.

Organisations are designed to facilitate coordination. When teams with closely aligned functions sit under the same structure, they benefit from shared governance, unified strategy, and streamlined decision-making. Organisational design theory shows that co-located teams reduce 'transaction costs'—the delays, duplication, and information loss that occur when separate entities must negotiate formal agreements and boundaries. This is especially important in safeguarding, where timely information-sharing and coordinated responses can prevent harm to children.

Our review heard:

Our view is that one agency governing the various safeguarding schemes (employment screening, RCS, child safe standards) is the ideal and most streamlined arrangement from the perspective of organisations needing to comply with the schemes.¹³⁰

Like this Review, the Victorian review 'heard multiple times that "breadcrumbs" of information about a person—including information which does not meet the relatively high thresholds for substantiated conduct, but which is nevertheless still concerning—is rarely able to be seen and acted upon because no one can see the whole picture.'¹³¹

Co-locating the blue card system and Reportable Conduct Scheme is not a new idea. The Queensland Family and Child Commission submission to parliament on the Child Safe Organisation Bill 2024 stated:

...in the QFCC's response to the CRIS, the QFCC recommended that the Working With Children Check (WWCC) functions be consolidated and align under the independent oversight regulatory body (similar to the NSW model).¹³²

Currently the blue card system and Reportable Conduct Scheme sit in two separate entities, the Department of Justice and the Queensland Family and Child Commission respectively. However the WWCC and Reportable Conduct Scheme share a common purpose: to identify and manage risks posed by individuals working with children. Both rely on collecting, assessing, and acting on information about behaviour, allegations, and findings. When they are housed in different organisations, valuable intelligence can remain siloed, with each team working to its own mandate, timelines, and information systems. Integration in one regulator allows for the seamless flow of intelligence, joint analysis, and coordinated risk assessments. Advice from New South Wales staff where the Reportable Conduct Scheme and WWCC sit within the one regulator included:

When we are co-located there is better understanding and less reservation. Everything became easier to work collaboratively.

and:

You get a lot more strategic tools and choices when safeguarding functions are placed together - a much more strategic approach to risk and intelligence.

The Victorian Rapid Review came to the same position in saying:

...there is benefit in consolidating the Reportable Conduct Scheme functions of the Commission for Children and Young People (which currently holds the most extensive information about individuals through reportable conduct notifications) and the Working with Children Check screening authority (which has powers to assess, suspend or cancel a Working with Children Check and prevent a person from engaging in child-related work) into one place. The Review considers the administration of the Child Safe Standards should also be included in this consolidation.¹³³

Similarly, the AIFS advised the Board that best practice approaches to WWCC should:

...have a strong and proactive review system, where once a certain number of allegations are made against an individual or the severity of the reports reaches a certain level – even when the individual allegations or reports were deemed as having too little evidence to formally investigate – their WWCC is immediately placed under review.

ACECQA's 2023 review of Australia's child safety arrangements recommended the creation of a secure mechanism for regulatory authorities to record and share information about 'persons of interest' who may be subject to unsubstantiated allegations, or potential concerns for the safety, health or wellbeing of children, with other regulators.

A similar recommendation was made following the review of the Tasmanian Education department's response to CSA [child sexual abuse], i.e. to ensure data collection of all allegations of CSA [child sexual abuse], whether substantiated or not (Smallbone & McCormack, 2021). Such an information register would need to be linked to the WWCC system to facilitate the level of proactivity required for best practice. This would enable screening processes to flag and scrutinise individuals who have not yet offended but present a reasonable and significant risk of offending, or individuals who have already offended but with little or insufficient compelling evidence.

Creating an information register to record unsubstantiated and/or weak allegations (i.e. with limited evidence) can raise concerns around privacy. Therefore, significant protections would need to be in place for employees to avoid data being released in case of malicious or other reports.¹³⁴

Collaboration within a single organisation also leverages what organisational design scholars call 'structural coupling': the ability of related functions to reinforce each other through proximity, shared culture, and common leadership. This ensures that thresholds for risk are interpreted consistently, that decisions on worker suitability are aligned, and that learning from one scheme informs practice in the other. For example, an unsubstantiated complaint captured by the Reportable Conduct Scheme may not meet disciplinary thresholds on its own, but when considered alongside WWCC data, it can provide a more complete picture of risk.

Finally, co-locating the schemes enhances accountability and public trust. Families, organisations, and professionals benefit from a single point of contact and consistent guidance, rather than navigating multiple regulators with overlapping but separate responsibilities. In system design terms, this reduces complexity and strengthens transparency.

By embedding both the Reportable Conduct Scheme and WWCC within one organisation, Queensland can create a safeguarding system where intelligence is shared by design, collaboration is the norm, and the detection of risk is proactive rather than fragmented.

Transformational Recommendation 4: Co-locate the reportable conduct and worker screening (WWCC) schemes into one entity

That the Queensland Government co-locate the Reportable Conduct Scheme, Child Safe Standards and the worker screening scheme (WWCC) within a single regulatory body and enable operational integration. Placing these schemes together in one organisational structure is intended to:

- eliminate silos by ensuring intelligence about individuals is shared seamlessly, reducing the risk of fragmented information
- enable consistent decision making on risk thresholds and worker suitability, as both schemes are interpreting and acting on the same evidence base
- strengthen collaboration by leveraging shared governance, culture, and leadership, which organisational design theory shows is far more effective than coordinating across separate entities
- improve efficiency and trust by giving families, organisations, and professionals a single point of contact, creating clarity and transparency in safeguarding oversight.

By embedding these functions within one organisation, Queensland will create a more integrated, accountable, and proactive safeguarding system that maximises the value of both schemes.

Operational Recommendation 4: Establish a legally authorised Child Safeguarding Intelligence Network

The ability for relevant organisations to share information of concern is crucial to informing decision making and actions that keep Queensland children safe. The Board has collected sufficient evidence throughout this review to highlight a growing recognition within government departments that no single agency has adequate information to address issues alone. Consequently, interventions and responses to issues must involve collaboration between different organisations and disciplines.¹³⁵

The sharing of information and intelligence across agencies is crucial to the successful safeguarding of children. In this context, information can be understood as the raw data and material that is used to create intelligence.¹³⁶ Information can come in many forms, is often from multiple sources and is collated and analysed to inform and provide intelligence. As such, data and information are characterised and understood as being building blocks for intelligence.

There are many benefits to the sharing of information or intelligence among agencies, and within an established network. A network refers to a group of individuals or organisations that work collaboratively to achieve a common goal or set of goals, they can be established formally or informally. Research suggests that for information sharing networks:

- many practitioners are reluctant to share information even when they have the legal authority to do so
- the protocols for sharing information can be considered complex
- there are too many organisations, regulators, enforcement agencies and oversight bodies to successfully understand 'who needs what when', and more importantly whose job is it to give it to them
- many agencies have a risk-averse attitude to information sharing even when this may be in the interests of clients.¹³⁷

It is also apparent that information sharing can often be passive rather than active; where agencies respond to information requests rather than proactively deciding that another agency should be provided with particular information.

An intelligence sharing network (being broader than just information sharing) may present opportunities to share information in such a way that is purposeful, driven by clear objectives, and can inform decisions to address issues of concern. This will support cross departmental collaboration, with the ultimate purpose of keeping children safe and preventing harm.

The AIFS went some way to highlight the need for this network when it advised the Board:¹³⁸

*...regulatory safeguards should unite as a network to share common goals, language, collaborative practices, and learnings from successes and mistakes. This may include mechanisms like reporting schemes and information sharing schemes, as well as cultural frameworks like policies and protocols which ensure a consistently child safe culture across the social ecology.*¹³⁹

It also said:

Although Australian information-sharing schemes explicitly articulate the prioritisation of children's wellbeing over privacy concerns, a database such as this one would require stringent privacy and data-sharing protocols—whether this is a specific ECEC sector regulator or a government agency. Further, it would have to be very carefully and sensitively managed in order to balance competing rights and protect individuals from malicious or incorrect reports of concern.

*The UK provides several examples to consider for this type of sensitive data collection and sharing, such as Local Safeguarding Partnerships and the NHS information sharing model. Queensland does not currently have such a model of a broad information database, and the information it holds/shares is limited to what is prescribed by the Child Protection Act 1999 (Qld) (i.e. only information (facts or opinions) that a person reasonably believes may help support a child who is currently in need of protection or may become in need of protection if support is not provided).*¹⁴⁰

The *Child Safe Organisations Act 2024* (the Act) provides a broad framework to allow the sharing of relevant information under the Child Safe Standards and Reportable Conduct Scheme among prescribed entities (s48-49). Relevant information may be disclosed for the purposes of lessening or preventing a serious risk or threat to the life, health or safety of a child or class of children. The Act provides confidentiality requirements for information gained and disclosed under the Act, and it is important the Queensland Family and Child Commission, child safe entities, reporting entities, sector regulators and any other persons involved in administering the Act, can access and disclose relevant information. However, the Act also requires that information entities receive, including confidential information, is protected from disclosure unless prescribed circumstances apply.

The Act also enables the Queensland Family and Child Commission to disclose confidential information obtained under the Act to an entity performing functions under a law of another state or the Commonwealth with substantially the same functions, for a matter relevant to the performance of a function by that other entity (for example, to disclose information to the Office of the Children's Guardian in New South Wales). The Board was advised by operators in New South Wales and Victoria that:

“

An intelligence function would best sit under a reportable conduct scheme, because it is an information gathering scheme. You need to carefully distinguish between an investigation and an information gathering role

- Interstate Reportable Conduct Scheme manager

”

Drawing from lessons learned across other jurisdictions and other information sharing schemes, there are a number of interrelated factors that affect information sharing between organisations. These factors can be grouped into three overarching categories of barriers: technological, organisational/cultural, and political/legislative.

Political and legislative barriers:

- individual and agency interpretations of policy documents and legislation
- governance structures.

Technological barriers:

- technical factors such as compatibility of computer system and data types
- training and support
- oversharing of data which inhibits meaningful analysis and use of information shared.

Organisational and cultural barriers:

- organisational structure and culture (relating to need-to-know mentalities, competition, culture of secrecy and ego)
- trust, rewards, incentives and other social factors
- individuals' beliefs about information sharing.¹⁴¹

A significant task

It is recognised that maintaining and transmitting information securely is a significant task, which requires trusting that recipient agencies handle and share information securely - this means that those operating within an information sharing network are expected to abide by a common set of security standards governing the storage and dissemination of information.¹⁴²

In recognising the barriers that are often experienced in sharing information across agencies, research shows that effective and appropriate information sharing can only take place in a context where the following exist:

- **Legislative framework:** there is a clear legislative and policy framework that guides the sharing of information, which may be further developed through a cross-agency or cross-organisational agreement.
- **Processes:** policies and procedures specify the appropriate processes but are flexible enough to allow for these processes to be tailored to individual situations.
- **Culture of sharing:** organisational cultures facilitate appropriate information sharing and collaborative practice while taking into account individual rights to privacy and confidentiality.

- **Training:** the workforce understands the legislative and policy framework and is trained and supported in delivering good practice.
- **Relationships of trust:** workers and agencies trust each other to use the information appropriately.¹⁴³

Research shows that the key to effective information exchange, and collaborative practice more generally, is that individuals and agencies trust each other to use information appropriately.¹⁴⁴ This relates to the importance of creating a culture of information sharing, which is a critical factor in determining the success of an information sharing network. In this context, culture can be defined as the rituals, values and behaviours of the network that give rise to the overall framework and arrangement, which shapes the willingness of individual entities or agencies to share information.¹⁴⁵

Learnings can be drawn from the creation of networks, or communities of practice which provide a platform to share and enhance knowledge and are built for collaborative advantage - they are founded on the understanding that more can be accomplished by working together, than by working alone. This recognition of collaborative advantage underpins the intent of the Act, and the intended approach to implementation. Networks have both informal and formal underpinnings. Networks are often characterised by objectives and have formal underpinnings that facilitate the networking process.¹⁴⁶ However, networks are also highly complex where members of networks learn and adapt it shared but not entirely controlled ways.

Key questions that can be considered when designing or shaping a network include:

- **Functions:** What roles and functions does the network carry out, i.e., filtering, amplifying, investing and providing, convening, community-building, and/or learning and facilitating?
- **Governance:** What are the behaviours and processes in place within the network that govern its short and long-term functioning?
- **Localisation and scope:** Where are the network and its members located both physically and thematically?
- **Membership:** Who are the network's members and how are they related to each other?
- **Capacity and skill.** Does the network, including its members, have the capacity and skills necessary to carry out its functions?
- **Resources:** Does the network have access to the inputs necessary to its functioning?
- **Communications:** Does the network have appropriate communication strategies to carry out its functions, thus amplifying messages outwardly or sharing messages and information within the institution?
- **External environment:** What are the external influences affecting the network?
- **Strategic and adaptive capacity:** Is the network capable of managing changes and shocks in its internal and external environment? Can it manage those changes on its own or does it depend on others, e.g., partners, networks, donors?¹⁴⁷

While considering these characteristics in the process of designing a network, there are also key factors that will dictate the effectiveness of establishing a network:

- **Time:** Investing time in building a relationship that involves regular and open communication is likely to lead to a sustainable, long-term relationship.
- **Common goals or objectives:** It is important to ensure that members of a partnership or network have a shared understanding of the goals and objectives they are working together to achieve.
- **Defined roles:** Clearly defining the role of other members of the partnership or network will ensure that each member is accountable and clear on their responsibilities. For a network, this includes agreeing on which organisations or individuals will help to keep the network running, for example by arranging and chairing meetings and taking minutes, if this is applicable. For a partnership, the specific roles and responsibilities of each partner organisation are clearly defined.
- **Formal agreements:** While partnerships and networks can be informal arrangements, it can be useful to have a formal cross-agency agreement in place (such as a Memorandum of Understanding) to ensure mutual understanding of roles and responsibilities, particularly if there are changes in personnel.
- **Strengths and gaps:** Each stakeholder will have particular strengths and challenges. Acknowledging and building on the strengths of members of a partnership or network and exploring how to address any gaps together can lead to a positive, collaborative relationship.
- **Transparency:** Ensure all members of the partnership and network agree on key actions and decisions. This will ensure that partnerships or networks lead to concrete actions and investing time in working together feels worthwhile.¹⁴⁸

An information sharing matrix was developed by the Australian Institute of Criminology to show information sharing for criminal intelligence purposes based on two dimensions—the level of interaction and the level of connectivity.¹⁴⁹

In this matrix, **interaction** refers to how the provider and recipient of information relate to each other, which can range from no interaction beyond the transmission of the information through to regular, direct interaction.¹⁵⁰ At some point, there needs to be a degree of processing applied to information before it can inform decision making, the term interaction situates the processing of information at the time the information is shared or at some later point. **Connectivity** refers largely to the method of sharing, ranging from at its simplest, an exchange between two entities through to a ‘free market’ of information exchange, where agencies can access the information held by another agency. An explanation of the categorisations can be found below.¹⁵¹

Types of interaction:

- **Connected interaction:** delivery of information from one agency to another. This may be associated with a ‘push’ or ‘pull’ approach. A key feature of connected interactions is limited communication between entities beyond the sharing of information, which may generally result in a one-way transfer of information. Communication between entities may include limited context about how or why the information was collected, and there may be limited joint activity between the two entities.
- **Collaborative interaction:** intelligence sharing that is characterised by greater reciprocity among two or more agencies. Information may lead collaborating agencies to ask new questions that require additional intelligence gathering, creating an iterative process of collection and analysis.

Types of connectivity:

- **Bilateral connectivity:** the provision of information is often between two entities. This may be based on a request for specific information, or it may be unsolicited information that is sent out to a receiving agency.
- **Centralised connectivity:** an information sharing structure in which multiple agencies send information to a central storage facility where it can be combined and analysed. By joining together data from multiple sources, it may help to address the linkage blindness that can result from siloing. The supplier of the data will typically deposit the data in advance for use by the end user. The information supplied may be a set of data agreed with the central agency (warehouse sharing), or information may be provided in the expectation that it will be of use to others, known as volunteer sharing.
- **Networked connectivity:** networked arrangements in which each agency in the network stores its own information but allows other agencies in the network to access its holdings, essentially creating a ‘free market’ in information exchange between agencies. This could involve any agency in the network accessing data holdings of other agencies to view information that is relevant to its own operational requirements.

Using this information sharing matrix, it would be appropriate for the Queensland Government to aim for establishing and maintaining an information or intelligence sharing model that ranges between collaborative-networked and collaborative-centralised. It is anticipated that information may be shared more than bilaterally (shared one-on-one between two entities), but it may not be appropriate to establish an information sharing structure that works as a central storage facility of information (centralised connectivity). The intention of sharing information in a way that addresses blindness associated with siloing should be a goal of the network to be established. For example, it may be that intelligence is shared in a way that resembles bilateral connectivity but is shared between numerous relevant or appropriate entities rather than just one-on-one, and that this is shared in a collaborative manner that enables an iterative process of collection and analysis (collaborative interaction).

This highlights the considerations required for establishing an intelligence sharing network, as opposed to an information sharing network, the burden associated with sharing and analysing potentially large volumes of raw data (referred to in this context as information) may prove detrimental to the intent of the network. By contrast, an intelligence network shares insights that align with established objectives of the network as a result of processed information that is collected by a member while performing member functions. Collaborative intelligence sharing underpins the regulatory approach to safeguarding children.

Operational Recommendation 4: Establish a legally authorised Child Safeguarding Intelligence Network

That the Queensland Government progress amendments to the *Child Safe Organisations Act 2024* to establish an effective Child Safeguarding Intelligence Network. This network should provide a formal legal framework and compulsion for cross-agency intelligence sharing that:

- transforms information into intelligence by empowering agencies to collate, analyse, and share insights that reveal patterns of risk and harm to children, overcoming the current fragmentation of raw data
- provides a legal foundation for proactive, not just reactive, sharing of relevant intelligence,
- overcomes existing barriers—technological, organisational/cultural, and political/legislative—by setting common security standards, developing consistent protocols, and mandating interoperability of systems
- embed collaborative practice through clear governance arrangements, defined roles and responsibilities, and formal agreements between members
- foster a culture of trust and transparency where agencies are supported and incentivised to share intelligence in the interests of the safety of children, underpinned by workforce training and professional development
- enable networked or collaborative-centralised sharing models so that intelligence is accessible across multiple relevant entities, reducing 'linkage blindness' and silo effects
- give safe access to police intelligence, especially for cases that police have determined do not reach a criminal threshold, to decision makers in the WWCC and reportable conduct schemes.

A legislated Child Safeguarding Intelligence Network will provide Queensland with the capability to identify emerging threats, connect otherwise isolated threads of information, and ensure agencies can act on a shared, accurate picture of risk. It will transform the current information-sharing environment into a proactive intelligence system that strengthens the capacity of government and non-government organisations to protect children.

Operational Recommendation 5: Enable the integration of worker registers

Across Australia, worker registers are increasingly recognised as critical infrastructure for both professional regulation and child safeguarding. Registers provide a mechanism to verify whether individuals are eligible to work with children or in other sensitive roles, and to ensure that risks identified in one setting do not simply migrate into another. At present, the architecture of registers is fragmented, with each sector maintaining its own system, and only limited capacity for cross-checking.

- **The NDIS Worker Screening Database:** The National Disability Insurance Scheme (NDIS) has established the NDIS Worker Screening Database (NWSD), administered by the NDIS Quality and Safeguards Commission. This database records whether a worker has been granted a clearance or has been barred following a worker screening check. It is a centralised, national record, ensuring that a person who is barred in one jurisdiction cannot simply move to another and obtain clearance. Access to the NWSD is limited to NDIS providers, plan managers, and self-managed participants. The database is not publicly searchable, reflecting its function as a safeguarding tool rather than a professional register.
- **Professional Registers – Teaching and Nursing:** Other sectors operate long-established, publicly accessible professional registers. For example, the Australian Health Practitioner Regulation Agency (AHPRA) maintains the register of health practitioners, including nurses, and state-based teacher registration boards maintain registers of teachers. These systems allow members of the public to search by name to confirm whether a person is registered, suspended, or subject to practice conditions. They serve not only a safeguarding purpose but also promote professional accountability and public confidence.
- **Early Childhood Education and Care – Emerging registers:** The early ECEC sector is now moving towards its own worker register. This reflects a recognition that those working with very young children require an additional level of oversight, and that professionalisation of the sector depends on transparent registration. As this register matures, it will join the broader landscape of occupational registers that overlap with child safeguarding responsibilities.
- **Working with Children Checks – A Cross-Sector Register:** In addition to sector-based registers, Australia operates the WWCC scheme. Administered separately by each state and territory, WWCCs function as a universal screening system for employees and volunteers across all sectors who engage in child-related work. While systems vary in detail, each maintains a database of cleared and barred persons. Some jurisdictions operate searchable public registers of WWCC card holders, while others restrict information to employers. The WWCC scheme is not a professional register as such, but rather a clearance register that cuts across industries, creating a baseline child-safeguarding mechanism.
- **Reportable conduct register:** An emerging register of individuals and organisations who have been reported for engaging in 'reportable conduct' will be established in Queensland from 1 July 2026. This will be similar to existing registers in NSW and Victoria.
- **Residential care worker register:** There have been previous recommendations to the Queensland Government to establish a residential care worker register by the sector, similar to the registers in place in New South Wales.¹⁵² Youth workers in residential care settings have significant access to children including infants, and there is currently no worker screening beyond WWCC. A Commission of Inquiry into Queensland's child safety is currently underway, which will examine the protection and abuse of children in residential care. It is possible a worker register may emerge as a solution from this process.
- **Aged care worker register:** The Australian government is developing a Personal Care Worker registration scheme for people working in aged care. This was an outcome of the Royal Commission into Aged care Quality and Safety. This is separate to the provider register.

While these systems all contribute to safeguarding of vulnerable persons, they are not currently designed to 'speak to each other', either across sectors or jurisdictions. A person may be barred in one register but still be able to hold clearance in another if information has not been shared or matched between registers. For example, a disability support worker barred under the NDIS screening process could, in theory, still apply for work in early childhood education or outside the NDIS unless their status was proactively checked in other systems. Similarly, a teacher who loses registration due to misconduct may still hold a valid WWCC card unless the relevant agency updates the WWCC authority. These gaps create inefficiencies for employers and, more critically, provides opportunities for unsafe individuals to re-enter child-related work under a different guise.

There is an emerging picture of fragmented but converging registers. The NDIS, health, teaching, ECEC, and WWCC systems are all developing greater sophistication in their approach to worker registers. However, the next logical step is to design interoperability of these registers, either through shared data standards, centralised coordination, or a dedicated safeguarding agency with responsibility to scan across registers. This type of reform would not only increase efficiency but significantly strengthen Australia's ability to prevent individuals who pose risks to children and other vulnerable persons from moving between sectors undetected.

Substantial efficiency and safeguarding improvements could be achieved if existing and planned registers were designed to interact. Ensuring information flows between systems presents both legal, technological and operational issues, however the benefits to safety through improved threat detection and the minimisation of gaps are immense.

Ultimately fragmented and siloed employee registers create loopholes that allow unsafe individuals to move between sectors or jurisdictions undetected. By leading with structural reform in Queensland while also embedding interoperability and national coordination, the Queensland Government can deliver the strongest protections for children, greater efficiency for employers, and a system capable of learning from patterns of risk across workforces and sectors.

The Board holds significant fears that commitments and actions taken by agencies after the offender was detected may serve to strengthen the early childcare sector's protections but will perversely displace the risk elsewhere resulting in perpetrators moving to other sectors with less safeguards.

An integrated or interoperable system would allow a single clearance decision, suspension, or adverse finding in one register to be automatically considered in others. Employers across different sectors could be confident that their checks were drawing on the full risk picture, not just the slice relevant to their industry. From an efficiency perspective, integration would reduce duplication of screening processes, minimise administrative burden, and streamline verification for employers. It would also help governments avoid the cost of maintaining parallel, siloed systems.

From a safeguarding perspective, integration would close loopholes that currently allow persons of concern to move across sectors undetected. If a single agency was tasked with monitoring risks across all registers, it could identify patterns—such as an individual facing multiple low-level concerns in different contexts—that would not be visible within a single system. This would mirror the lessons of past child protection and abuse inquiries, which consistently find that siloed information held across different databases and agencies contributes to missed opportunities to intervene earlier. These types of issues have again been laid starkly bare in the Board's review of this case.

Operational Recommendation 5: Enable the integration of worker registers

That the Queensland Government lead structural reform by consolidating employee registers and enabling linkage or matching with the Working with Children Check (WWCC) register and the reportable conduct register. Existing state and federal employee registers should be incorporated into the scheme where possible, including the early child care worker register, disability worker register, teacher worker register and the proposed residential care worker register. This will provide a central point of accountability for worker screening and safeguarding intelligence. This reform should be supported by two critical sub-elements:

- **Interoperability standards:** Develop and adopt shared data standards and interoperability protocols across all worker registers relevant to child and vulnerable person safeguarding. This will enable timely information flow across systems and jurisdictions, ensuring that risks identified in one setting are visible to all others.
- **National coordination mechanism:** Advocate for, and actively participate in, the creation of a national safeguarding register clearinghouse with authority to reconcile clearance and misconduct information across states, territories, and sectors. This clearinghouse would ensure that adverse findings or suspensions in one jurisdiction or sector are automatically recognised and acted upon in others, eliminating loopholes and enabling intelligence-led prevention.

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Part

D

Responding to child sexual abuse

Complaint and reporting mechanisms

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Complaint and reporting mechanisms

Responding to child sexual abuse

While prevention remains the ultimate goal, it is a sobering reality that some children will still experience sexual abuse. When this occurs, the quality and timeliness of the response is critical, both in terms of ensuring immediate safety and in shaping long-term outcomes for victim-survivors and their families.

Perpetrators move across sectors. They identify and exploit system gaps, and they take deliberate and intentional action to prevent detection. When we solely focus on addressing the gaps in one system, we too often only serve to displace the problem elsewhere.

The theory and practice of responding to child sexual abuse incidents is anchored in several interconnected systems. These include:

- complaint and reporting mechanisms, which act as the first gateway for children, families, and professionals to disclose concerns
- police investigations, which determine the scope and nature of the offence and safeguard others from ongoing risk
- court processes, which provide a forum for accountability and justice
- statutory reporting obligations, which ensure that all professionals who encounter risks to children act consistently to protect them.

Each element requires clarity, accessibility, and alignment with child-centred principles to be effective. Reporting obligations are a cornerstone of child safeguarding systems. Mandatory reporting frameworks, when clearly defined and consistently applied, create a culture of vigilance across health, education, justice, and community sectors.

Best practice includes not only legislative clarity but also sustained training, professional support, and clear organisational procedures to ensure that reporting is not a compliance exercise but a proactive act of safeguarding. Effective complaints and reporting systems emphasise accessibility, safety, and trust.

Research shows that children are more likely to disclose when they believe they will be listened to, taken seriously, and protected from retaliation. Too often adults refrain from raising concerns, or pressing issues, due to inherent politeness, because they are 'minding their own business' or treat behaviours as a 'one off' and because they do not want to be seen to criticise others.

Organisations must therefore design child-friendly reporting avenues, displace stigma, encourage people to speak up, provide multiple pathways for disclosure, and ensure complaints are met with immediate protective action.

The devastation child sexual abuse causes for children and young people, their supporters, and those who help carry the burden of their experiences demands we keep our hearts and minds open and take action.

“

It takes immense courage for victims and survivors to report child sexual abuse. Too often, they face significant challenges coming forward, including institutional and social barriers. It is our collective responsibility to make sure they are believed, protected and supported, and that perpetrators are held accountable.¹

”

Known barriers to reporting

Victim-survivors face numerous barriers that prevent them from disclosing their abuse including a sense of shame, fear of not being believed, fear of the perpetrator, mistrust of government organisations, and other structural barriers. They may have also been threatened by perpetrators who tell them that they will not be believed or that they will be blamed for the abuse that has been inflicted upon them.

“

Child sexual abuse is a complex and difficult thing for us to talk, think or read about. It forces us to confront physical and mental abuse, and horrific sexual crimes. But our collective silence perpetuates suffering. Often, victims and survivors don't talk about their experiences for many years – if ever.²

”

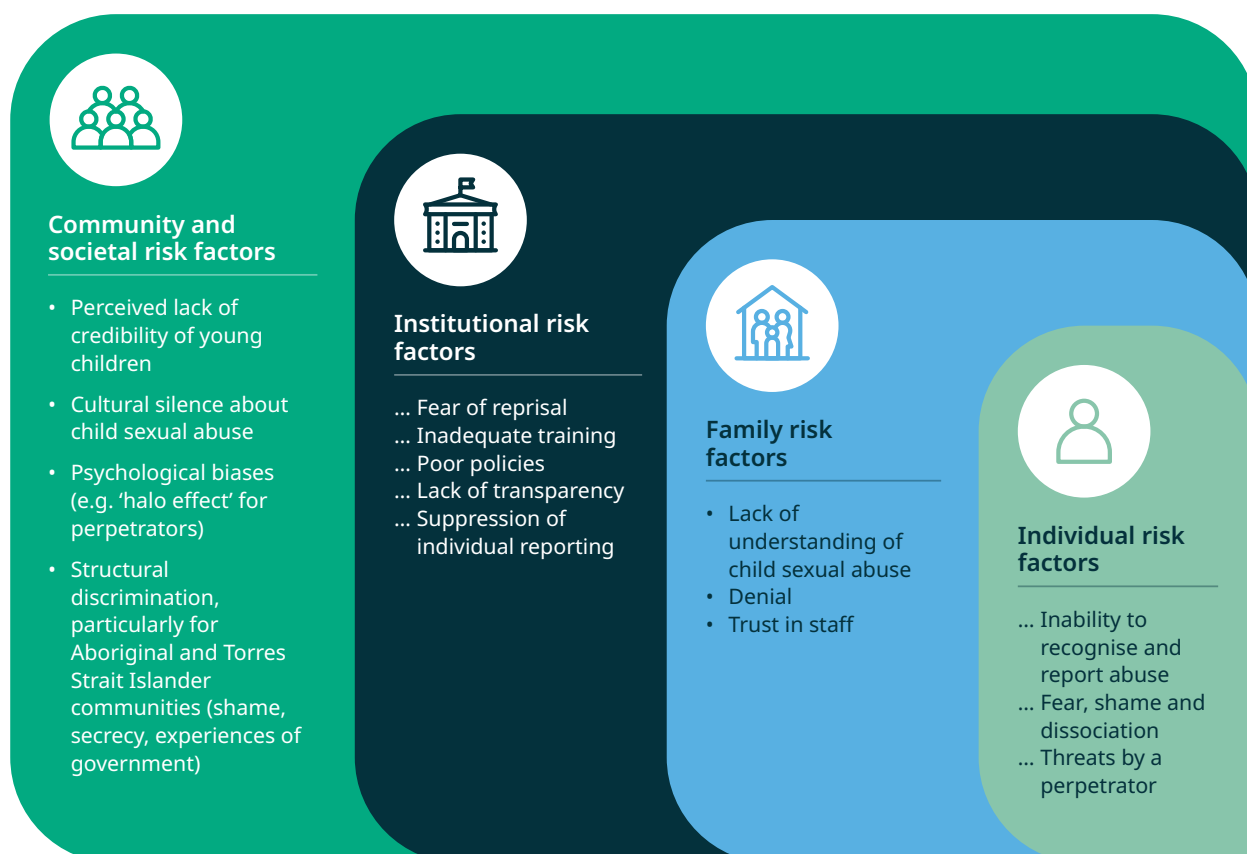
The Royal Commission into Institutional Responses to Child Sexual Abuse (Royal Commission) further highlighted that attitudes to gender, sexuality and masculinity, distrust of self, and difficulty communicating can prevent disclosure.³ Organisational culture can be an additional barrier to reporting, where it involves:⁴

- cultural attitudes which promote loyalty and punishment
- reputational prioritisation
- personal relationships within the organisation.

Dependent on their developmental stage, children and young people may also not recognise, or be able to articulate, an experience as abusive until they are older.

Table 1: Known barriers to reporting faced by victim-survivors of child sexual abuse

Source: University of New South Wales 2025⁵



Multiple studies show that a large proportion of abuse remains invisible to statutory and professional systems, and that formal reports to child protection and police services represent only a small fraction of the true incidence.

Data from the Australian Bureau of Statistics Personal Safety Survey (ABS PSS) shows that 84 per cent of women and 99 per cent of men who reported experiencing child sexual abuse never made a report to police.⁶

Data from the Australian Child Maltreatment Study (ACMS) shows that only 54.8 per cent of Australians who experienced child sexual abuse had ever told anyone about the abuse.⁷

In a 2023 survey undertaken by the National Centre for Action on Child Sexual Abuse, participants reported that they lacked confidence in recognising the signs of child sexual abuse, having conversations about child sexual abuse, or being able to respond to the disclosure or discovery of child sexual abuse.⁸

About 1 in 5 Australians report having discovered adult-perpetrated child sexual abuse or had a child disclose to them. 11 per cent have discovered a child or young person who had been harmed or was harming another child; or has had this disclosed to them.⁹

Survey participants who reported that they had discovered child sexual abuse, or had this disclosed to them, stated that they most commonly responded by:

- having a supportive conversation with the child
- making a report to police or child protection authorities
- arranging professional support for the child
- discussing it with family, friends or another professional to get advice
- workplace reporting
- phoning a helpline or looking for advice online
- a combination of the above.¹⁰

Reported child sexual abuse

Australia

While there is known underreporting of child sexual abuse, police data shows ongoing increases in the number of reports received. The number of reports to police has steadily increased since 2014 in Australia, when the number of victim-survivors who reported child sexual abuse was 13,353.¹¹

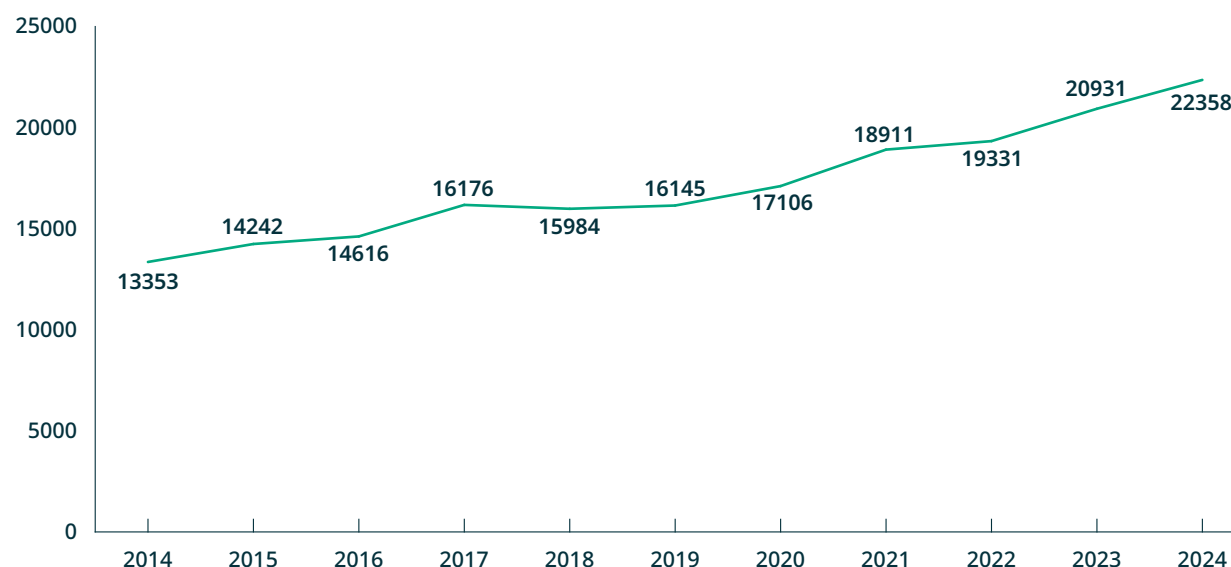
This increase is associated with a range of different factors including a growing population, community awareness, and strengthened reporting processes.

In 2023, 20,931 people were recorded by police as victim-survivors of sexual assault and were aged under 18 at the time of the incident.¹²

- 79.51 per cent (n=16,641) were female.
- 29.75 per cent (n=6227) were under the age of 10 at the time of the offence.
- 22.63 per cent (n=4739) reported the abuse as an adult.¹³

Figure 1: Number of victim-survivors of sexual assault aged under 18 years at time of incident, as recorded by police in Australia, 2014–24

Source: Australian Bureau of Statistics¹⁴



Queensland

In 2023, 4566 people were recorded by police as victim-survivors of sexual assault and were aged under 18 at the time of the incident.

- 81.47 per cent (n=3720) were female.
- 34.32 per cent (n=1567) were under the age of 10.
- 14.50 per cent (n=662) were Aboriginal and/or Torres Strait Islander.¹⁵

There is no public information regarding the number of people subject to a report of child sexual abuse as an offender. Information from the Cyber Security Cooperative Research Centre does suggest that Australia is the third largest market for live-streamed abuse and that Australians are some of the most prolific consumers of CEM.¹⁶

In 2022–23, the Australian Centre to Counter Child Exploitation (ACCCE) Child Protection Triage Unit made 545 referrals to Australian law enforcement agencies. Referrals to local law enforcement agencies or support services may occur where an alleged perpetrator and/or suspected victim-survivor is identified by ACCCE.

Navigating a complex complaints system

A confronting reality of this Review has been the discovery that children, parents and other staff spoke up about the offender but were not heard.

While multiple concerns and complaints were raised about the offender's conduct, responses to complaints varied greatly. Common issues included:

- concerns about the offender's conduct being minimised, dismissed or not responded to
- no or minimal action taken in response to the concerns raised, with no supporting documentation located to indicate that complaints had been recorded or responded to
- a lack of referral of complaints by centres to the Early Childhood Regulatory Authority (ECRA) (and its predecessor) despite there being a legislative requirement to do so
- limited investigations being carried out by the Queensland Police Service (QPS) or ECRA, including not interviewing all relevant parties
- internal investigations being conducted by centres into the complaint, with the outcomes subsequently being relied on by other agencies to finalise their investigations.

In undertaking this Review, the Board reflected that current complaints and reporting pathways are overly complex and unclear, including within individual centres, and to regulatory authorities or the police. There are also limited options for parents when making a report if the perpetrator is not a family member or caregiver, and if the police have assessed the report and determined they are unable to pursue charges. Difficulties also arise when the person subject to a complaint holds a senior role in a centre or may otherwise be involved in the investigation of a complaint.

This is only compounded for children, whose voices are often silenced, and their young age means that they are unable to articulate their experiences of abuse. For example, in one complaint the mother asked her child why they had not told her about the abuse before, and they said 'because I didn't have the words Mummy, I was only a baby... Mummy, I wanted to run away, run up the street, and find your work building'.

In another complaint, after the parents raised concerns about the offender getting angry at their child and squeezing his harm, one of the workers recorded the child's complaint as:

I said to [child] that he had told me something earlier about yesterday and asked if he would like to tell me more about it, [child] said "at rest time [Offender] got angry at me and grabbed my arm and squeezed it hard" I then asked [child] "where on your arm" [child] indicated his upper left arm. I asked [child] if we could look at his arm, we looked at his upper left arm but there was no visible mark. I asked [child] if [the offender] had said anything to him when he grabbed his arm. [Child] said "he just got mad at me and squeezed my arm really hard, my dad is going to come and pick me up today and tell [the offender] that he is not aloud [sic] to grab anyone". I said "no he is not aloud [sic] to squeeze your arm" and that we would sort it out, [child] said "thank you, yesterday was a tough day". I thanked [child] for telling his parents and me about what had happened and asked if he would like to go off and play which he did.

Another parent reported that when they tried to make a complaint about the offender threatening to smack a child, their first attempt was met 'aggressively'. This was after the parent approached her and requested a conversation about something 'sensitive in nature'. Although the parent expected to be taken to a private space, they recall that the Director/Owner stayed sitting at the desk.

In response to a question about whether the offender was still working at the centre as the parent had not seen him in a few days, they were told 'No'. After another question about whether this meant that the offender was no longer working in the Kindy room, or the whole centre, the parent reports that the Director/Owner 'abruptly stood up and put her hands on the desk and said "You got something to share?". 'Her demeanour and voice were quite aggressive, and I was taken aback so I just muttered "I guess there's no point if he's already gone" and I went to leave'. About a week later the parent reported that:

In the morning after dropping my daughters off, [the Director/Owner] yelled out for me to come into her office. She apologised for the other day saying that it must have taken courage for me to approach her about what I thought was a current employee. She asked what I wanted to tell her. I explained what I had seen and heard [the offender] say to [other child]. I told her that we weren't a smacking household and would be very upset if my children were being threatened with physical punishments at the daycare. I said I would want to know if this happened to my children and [other child]'s parents should be told. She said "Leave it with me" which I took to mean she would be informing the [family] and following through with my report to the relevant departments. The incident is never mentioned again.

There is no record of this complaint in the centre's records. However, following the ECRA investigation in 2025, the centre was breached for failing to report this matter at the time and for failing to advise the parents of the child. This outcome is currently subject to an application for an internal review by the centre to ECRA. The centre owner also advised the Board they have no recollection of this report being made, and consider that it may have been responded to by the Centre Director/Nominated Supervisor. They further noted that a contemporaneous social media post at the time initially described the offender's comment as 'not said in an angry way at all, almost sing-songy...' Irrespective, of the way a complaint is made, all concerns by parents about the safety and wellbeing of children should be validated, taken seriously and fully investigated.

As part of the Board's call for public submissions, a parent of a child unrelated to this matter outlined their concerns with the current complaints system after they tried to raise a concern about persistent issues in an ECEC service their child attended. Notably this complaint was made while this Review was ongoing. This parent outlines that they were ignored despite their numerous attempts to make complaints to the Centre Owner. They reported that they found the system to be convoluted and hard to navigate, with no guidance on how to make a complaint.

Our entire time in the daycare we were at has been an issue – even when putting it in writing wasn't responded to and it got progressively worse. Don't believe that any parent who had the capacity to remove their child would have left them there.... There was no support from the management down.

The parent explained that after attempting to contact the centre via email and not being able to find anything on their website, they attended the centre in person to obtain a copy of its complaints policy. The owner reportedly responded to the parent by saying 'you're no longer a parent or a family here I don't have to engage with you' before threatening to call the police. The parent reflected that 'the irony of this is that you would have more success getting the police to the centre than I would for what's happened to my daughter in the centre'.

This was based on the parent's previous interactions with QPS when making a complaint involving their child who stated that 'I tried to do everything by the book'.

I tried to follow up yesterday to see where it was up to, I got put through two different teams in the police and was met with the you don't have access to that information and would have to go through the Police Commissioner – when I asked how do I do that they told me to "look it up"... Police said you have nothing to say criminal offence happened so nothing for us to do.

The parent further explained that they then called ECRA who advised of the phone number for the local office they needed to contact, which they did. Of this contact, the parent stated that:

I all but had to fabricate things for her [complaints person] to take it as a complaint, she said that if I didn't have exact dates and times the complaint wouldn't be able to occur. Having to reflect back her own logic to her – "You're asking me to provide evidence from a child who doesn't speak".

The parent also stated:

The only reason I sent the documents and the supporting evidence was because the woman on the other line said wouldn't be productive or considered. The complaints officer reportedly stated that the parent needed to have records of "dates and times".

This parent also reported having been contacted by other parents from the centre to seek confirmation of dates and times given they could not lodge a complaint without these. While this parent received an automated response stating that their complaint was received by ECRA, they were not provided with any timeframes or expectations to follow.

Clear and supportive complaint pathways for parents and children

Children and their parents need to be supported when raising concerns or making a complaint, to police, services, regulatory authorities or other professionals. They also need to be kept informed of any investigation that is undertaken and the outcome of their complaint, irrespective of what entity it has been made to.

A poor or delayed response to sexual abuse compounds harm, while a compassionate, coordinated, and competent one can provide a pathway to justice, healing, and restoration of trust.

In conducting this Review, the Board reflected on the lack of clarity on how parents can make a complaint, particularly for abuse in institutional settings. Currently children and parents can make a complaint to individual institutions, police, and the relevant regulatory authority. Each entity has:

- different procedures and processes for making a complaint
- different roles and responsibilities that set how they may or must respond to a complaint
- different systems to record complaints
- different legislative and regulatory frameworks which determine how they should respond
- different obligations or evidentiary thresholds that may need to be met to respond or address a complaint.

Responses to individual complaints will also differ dependent on the person who receives the complaint, and their knowledge, experience and understanding of the complaints process. This has resulted in a patchwork system of confusion, where parents are unclear of who to call, what to expect, and how to get help.

As part of its submissions to the Review, the Office of the Advocate for Children and Young People in New South Wales highlighted the need to strengthen complaint processes to ensure they are child friendly, accessible and responsive. This includes through the establishment of an independent complaints pathway. They also recommended the expansion of powers of independent oversight bodies to monitor compliance, investigate complaints and support continuous improvement.

The Aboriginal and Torres Strait Islander Legal Service called for improved awareness about how parents and responsible adults or other caregivers can escalate complaints about concerning conduct.

In a review of the Victorian Reportable Conduct Scheme, children and young people reported having varying levels of confidence to report incidents to the organisation and identified multiple barriers to reporting. This includes identified power imbalances, concerns about their reports being shared with staff and parents, and the belief that no action would be taken.¹⁷

Common themes were identified by Griffith University in research undertaken to inform the Board's understanding of best practices for the prevention of child sexual abuse. This study highlighted the necessity for an immediate response to safeguarding concerns, including reports from mandatory reporters, workers, and other stakeholders. Emphasis was also placed on reducing the burden of reporting pathways with options for anonymous reporting, allowing all individuals—whether parents, staff, carers, or mandatory reporters—to report concerns without fear of retaliation. A multi-agency and trauma-informed response is essential, involving collaboration between law enforcement and specialist services.¹⁸ Mandatory reporters should be well-trained and supported in handling disclosures.¹⁹

Emphasis was also placed on system-wide accountability, to ensure concerns are acted upon quickly and thoroughly, with age appropriate, trauma-informed practices across all sectors, especially investigations, to protect the needs of the child and family.²⁰

Operational Recommendation 6: Dedicated support for parents and workers to navigate complaint and reporting processes

The case under review illustrates multiple instances where parents reported their concerns to the organisation and were dismissed or their matter was not adequately recorded, reported or investigated. Parents and carers continue to face challenges in reporting concerns, highlighting the confusion and lack of information on reporting pathways. While parents are directed to raise a complaint with their organisation and police regarding criminal matters, there are few alternative pathways.²¹ **The establishment of a Reportable Conduct Scheme in Queensland provides an opportunity to strengthen and centralise complaint pathways for children, parents and staff whose concerns may otherwise fall through the gap of existing mechanisms.**

A strong Reportable Conduct Scheme is essential to ensuring that concerns about adults who harm or pose risks to children are properly examined and addressed. The Queensland scheme is still in its early stages and, as experience from other jurisdictions has shown, the demand for oversight and investigation is significant and continues to grow as awareness increases. If the Reportable Conduct Scheme is not sufficiently funded relative to its demand, the result will be delays, inconsistency, and lost confidence among families, workers, and organisations. Inadequate resourcing risks undermining the scheme's ability to achieve its central purpose: ensuring children are protected and unsafe adults are held to account.

This is not a new issue. *Strengthening the oversight of workplace child abuse allegations*, the special report following the New South Wales Government's 2016 review of its Reportable Conduct Scheme reported that:

*The most significant challenge we currently face is the need to maintain, within existing resources, a high level of scrutiny over the handling of the most high-risk allegations of reportable conduct.*²²

However, the issue continues to plague agencies administering the schemes. This was demonstrated in the *Rapid Child Safety Review* provided to the Victorian Government on 15 August 2025. The final report stated that:

*Mandatory notifications to the Commission under the Reportable Conduct Scheme increased by 30 per cent between 2022–23 and 2023–24 but its base funding has not increased since 2018. The Commission for Children and Young People reports that 85 per cent of child abuse and harm investigations receive low or minimal oversight by the Commission.*²³

In addition to resourcing the core investigative and oversight functions, the Reportable Conduct Scheme requires dedicated capacity to support parents, carers, workers, and volunteers to navigate complex complaint and reporting pathways. Families frequently encounter uncertainty about whether a concern should be directed to the relevant organisation, to police, or to regulators. Likewise, staff and volunteers can be unsure of their reporting obligations or where to seek advice when they are concerned about a colleague but are unable to clearly articulate the nature of their concerns. Without practical guidance and support, there is a real risk that concerns remain unreported or are handled inappropriately.

In research commissioned by the Board to inform the Review, the University of New South Wales advised that:

Even when staff or educators can identify indicators of CSA, they may not report their suspicions due to a lack of confidence in or knowledge of CSA reporting procedures. This can be exacerbated by inaccurate understandings of reporting obligations, processes, and consequences, including beliefs that:

- *they need evidence/proof to substantiate their reports*
- *reports are to be made to their superiors rather than directly to authorities*
- *before reporting their suspicions, they need to first ascertain the cause of the abuse by contacting the child's parents*
- *instead of reporting, they should manage the abuse internally, as reporting may create further issues for the victim*
- *they can be sued and become liable for damages if their reports are not substantiated*

“

*More broadly, staff and educators' concerns about the potential consequences of reporting, including its implications for the perpetrator, the workplace environment, and their relationship with the victim and their parents, can hinder reporting. Additionally, fears related to the impacts on the institution's reputation may further disincentivise appropriate institutional responses.*²⁴

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Investment in a public-facing advice and navigation service within the Reportable Conduct Scheme would help bridge these gaps, providing clear, accessible guidance on complaint processes, ensuring referrals are properly directed, and reinforcing confidence that the system is working for children and families. This service should be available through multiple channels, including telephone, online platforms, and community outreach, to ensure accessibility across Queensland.

Ultimately, sustained and sufficient funding of the Reportable Conduct Scheme—both for demand-driven regulatory functions and for frontline guidance and support—is necessary to uphold community confidence, strengthen organisational accountability, and ensure the protection of children.

Operational Recommendation 6: Dedicated support for parents and workers to navigate complaint and reporting processes

That the Queensland Government ensure the Reportable Conduct Scheme is funded to meet demand, and that additional resources and authority is provided to enable the Reportable Conduct Scheme to establish dedicated support for parents, carers, workers, and volunteers to make and navigate complaints and reporting processes across organisations, regulators, and the police.

Operational Recommendation 7: Transparent ECRA investigations that uphold a parent's right to know

Parents and caregivers have a right to know the outcomes of complaints they have made, and to be kept informed where an investigation is being undertaken into an institution that their child is involved with, or attends.

Parents who contributed to the Review expressed frustration at the lack of response from individual centres after the offending was detected, and the lack of publicity about the centres where the abuse occurred. In their view this means that parents are unable to make informed decisions about which centres to send their children to. A parent also reported being provided with misleading information by one centre after the offender had been stood down and were assured that the offender did not present a risk to their children.

Recent similar cases in New South Wales and Victoria have highlighted the importance of parents and caregivers being kept informed about what is happening in their centres. The recent *Rapid Child Safety Review* conducted by the Victorian Government identified that:

Open and timely conversations between parents and services are more likely to happen when processes for responding to complaints and concerns are clear and transparent. When an investigation occurs, parents need to be confident the matter will be handled in an appropriate manner, and that everything is being done to keep their children safe.²⁵

ECEC services play a vital role in children's lives, often being the first institution outside the family who is entrusted with a child's daily care and safety.

Parents and carers must be able to place trust in these services not only to provide nurturing environments, but also to act with transparency and accountability when concerns arise. For this reason, there is a strong case to increase the regulatory expectation—and in time, the legal obligation—that ECEC services inform parents when a reportable conduct investigation is being undertaken that relates to their child's service.

At present, parents may not always be notified, leaving them unaware of issues that may directly affect their child's environment. A modern safeguarding framework requires that parents have a right to know when serious allegations are being investigated, subject to appropriate safeguards around privacy and due process. This transparency empowers parents to make informed decisions about their child's care, reinforces accountability for services, and builds public trust in the integrity of the child safeguarding system.

More broadly, there is a need to shift societal attitudes around complaints and reportable conduct in the ECEC sector. Reportable conduct concerns are not rare events; they are an expected feature of any system where adults work closely with children. The existence of allegations or investigations should not automatically be viewed as an indicator of unsafe services, but rather as evidence of a mature organisation that takes safeguarding seriously by identifying, investigating, and reporting concerns appropriately. By contrast, services that claim to have no complaints or no reportable conduct concerns may in fact be failing to recognise risks or may not have a culture that encourages children, staff, or parents to raise issues.

“ *I would be very worried about any organisation that claims to never have safety concerns.*²⁶ ”

Embedding a requirement for ECEC services to inform parents of reportable conduct investigations will help normalise transparency, support early resolution of issues, and send a strong message that the safety of children must always be paramount.

More importantly, transparency with children and parents transforms investigations from procedural, transactional exercises into holistic, child-focused inquiries. When families are informed and aware of the processes in place, centres are incentivised to examine the full context of concerns—patterns of behaviour, systemic issues, and environmental factors—rather than limiting their focus to isolated incidents. This approach ensures that investigations are genuinely about preventing harm and protecting children, rather than simply meeting compliance obligations.

Furthermore, increasing awareness among children and parents creates opportunities for earlier disclosures. Children, parents, and co-workers are more likely to speak up when they know their voices are not alone, and that they will be heard. By embedding transparency as a core expectation, organisations signal that raising concerns is important, safe and valued, fostering a culture where the identification of risk is proactive rather than reactive. This approach ultimately strengthens both the effectiveness of the Reportable Conduct Scheme and the broader safeguarding ecosystem.

This transparency is at odds with current practices where investigations are conducted behind closed doors, with minimal communication to parents or the broader community. Such an approach is often justified as a means 'to avoid panic' or because of procedural fairness for the person that is being investigated. While well-intentioned, this approach does very little to enhance the safety of children. It allows incidents to be treated as isolated events, limits the accountability of the organisation, and misses the opportunity to engage children and parents who may hold additional information. Worse, this secrecy can inadvertently protect perpetrators, giving them space to continue harmful behaviour undetected and perpetuating systemic risk.

By avoiding transparency, organisations reinforce a culture where concerns are hidden rather than addressed, undermining community trust and the principle that safeguarding children must be central to all decision making and actions. Evidence suggests that open, accountable processes—even when difficult or uncomfortable—are far more effective in preventing further harm, deterring potential perpetrators, and ensuring that organisations learn and improve from each incident.

Operational Recommendation 7: Transparent ECRA investigations that uphold a parent's right to know

The Queensland Government should strengthen regulatory expectations and, where appropriate, legislated obligations, for ECEC services to inform parents and carers when a reportable conduct investigation is being undertaken that relates to a service provider or centre their child attends. This requirement should:

- ensure transparency while balancing privacy and procedural fairness
- encourage holistic, child-focused investigations that examine patterns, systemic issues, and environmental factors rather than treating incidents in isolation
- promote earlier disclosures from children, parents, and staff by fostering a culture where raising concerns is safe, valued, and acted upon
- replace practices that prioritise secrecy 'to avoid panic', which can limit accountability and inadvertently allow offenders to continue harmful behaviour.

Embedding this expectation will normalise transparency, reinforce organisational accountability, and strengthen the effectiveness of the Reportable Conduct Scheme, signalling that the safety of children is always paramount.

Mandatory reporting requirements

In Queensland it is mandatory to make a report to police or child protection agencies where child sexual abuse is suspected or disclosed. This seeks to ensure that any concerns about a child's safety and wellbeing are quickly and appropriately addressed. While reporting obligations were initially in place for certain professions, such as health workers, they have continued to expand to different practitioners and sectors.

While mandatory reporting obligations may be established in legislation, workplace policies and procedures are needed to embed requirements into practice. Staff need to be aware of their obligations, know how to make a report, and be supported to do so. Reporting schemes can be strengthened by:

- focusing on cultural change where organisations encourage staff to report child sexual abuse or behaviour that makes them feel uneasy
- improving reporting pathways, with training and guides that assist staff understanding of when, how and what to report
- encouraging staff to report concerning behaviour which causes discomfort, even it does not meet a definition of child sexual abuse in and of itself.

Mandatory reporting requirements

Since **1 October 2017**, approved providers of ECEC services have been required to make a report to ECRA of any physical harm or sexual abuse to a child or any allegation of physical or sexual abuse occurring while the child is being educated and cared for by the service.

Since **5 July 2021**, any adult in Queensland who reasonably believes that a child sexual offence is being or has been committed must report the information to a police officer as soon as possible, unless they have a reasonable excuse not to. This is known as the 'failure to report offence.'

A reasonable excuse includes, but is not limited to:

- if the adult believes on reasonable grounds that the information has already been disclosed to a police officer
- if the adult gains the information as a relevant professional, such as a medical practitioner or a counsellor, in the course of a confidential professional relationship with the child in which there is an expressed or implied obligation of confidentiality between the adult and the child
- if the adult reasonably believes disclosing the information to a police officer would endanger the safety of the adult or another person, other than the alleged offender, regardless of whether the belief arises because of the fact of the disclosure or the information disclosed.

As of **1 July 2026**, all centres will be required to undertake an investigation as part of the implementation of a Reportable Conduct Scheme in Queensland (as discussed in more detail in Chapter 9) in addition to the obligations listed above.

Centres will also be required to notify the Queensland Family and Child Commission (the Commission) about the initial report and the outcomes of their investigation. The Commission will have a role in supervising these investigations, and conducting its own investigation if it believes that the centre has not adequately dealt with the report.

A failure to report and to protect

Every adult in Queensland has a responsibility to act if child sexual abuse is suspected or disclosed to them. Additional obligations are also imposed on organisations to swiftly respond where there is a known risk of sexual offending associated with the institution. In Queensland these offences are commonly referred to as the:

- **Failure to report offence:** If an adult reasonably believes (or should reasonably believe) that a child is being or has been the victim of sexual abuse by another adult, they must report it to the police—unless they have a reasonable excuse not to (section 229BC of the Criminal Code).
- **Failure to protect offence:** This offence requires a person in a position of power or responsibility within an institution to reduce or remove a known risk of sexual offending against a child by an adult associated with an institution (Section 229BB of the Criminal Code).

These offences were implemented in response to the Royal Commission, which made a suite of recommendations to ensure that any person associated with an institution who knows or suspects that a child is being or has been sexually abused in an institutional context should report the abuse to police.²⁷ The Royal Commission also recommended that state and territory governments introduce legislation to create a criminal offence of failure to protect a child in a relevant institution from a substantial risk of sexual abuse by an adult associated with the institution.²⁸ In making these recommendations the Royal Commission found that:

The impact of child sexual abuse on individual victims may be lifelong, and the impact on their families and the broader community may continue into subsequent generations... unlike other categories of crime, child sexual abuse is often not reported and stopped at the time of the abuse because the child victims face such difficulties in disclosing or reporting the abuse. When a perpetrator is not discovered and stopped from abusing a child, they may continue to abuse that child and other children.³¹

In contrast to the proportionately narrow scope of the failure to report offence recommended by the Royal Commission, which was initially intended to apply to child sexual abuse in institutional settings, the Queensland Government decided to extend the failure to report offence to all adults. This offence was expanded due to the complexity of having to establish the parameters of the offence if it was to apply only to institutional settings.²⁹ It also sought to ensure jurisdictional consistency and to send a message to the Queensland community 'that child sexual abuse is not something that can be ignored by any adult'.

The failure to report offence has not been without controversy. In the five years to 30 June 2025, only 10 charges have been laid, and five of these did not lead to conviction. Early on, stakeholders raised concerns about the broad operation and applicability of the offence, which was inconsistent with the intent of the Royal Commission's recommendations and the legitimate reasons victim-survivors have for not wanting to make a report of abuse. For older children, mandatory reporting obligations may act as a barrier to making a disclosure of abuse. This includes a fear of their parents finding out and because of the requirement for police to be told without them actively choosing to report an offence.³⁰

At the time, the Queensland Government sought to respond to these concerns, by committing the former Department of Justice and Attorney-General to develop an appropriate communications strategy as part of implementation to 'help to mitigate the possible impact by ensuring the community clearly understands the operation of the new offence'.

Despite this commitment, submissions received by the Women's Safety and Justice Taskforce (the Taskforce) in 2022 highlighted that there was confusion around, and limited understanding of, the operation of this offence. Stakeholders also raised concerns that it acted as a barrier to victim-survivors engaging with support services, in circumstances where they did not wish to make a report of abuse to police.

At the time, the Taskforce was advised by the Department of Justice and Attorney-General that awareness had been raised about the offence by writing to stakeholders, convening a forum for specialist sexual assault providers and publication of fact sheets on the Queensland Government website. The Department of Education also advised that a factsheet had been developed for students who are over the age of 18 years about the failure to report offence and noted that school employees were subject to mandatory reporting obligations and therefore higher reporting obligations than adult students.

The Taskforce ultimately found that:

...the activities undertaken to explain the new offence have not addressed the concerns voiced at the time the offence was introduced and this was negatively impacting on victim-survivors...both the service sector and the community expected something more comprehensive than what was ultimately delivered.³⁰

As such, the Taskforce recommended that the Department of Justice and Attorney-General develop and implement a broad community awareness campaign with targeted messages for children's sexual assault and health services around the scope and intent of the failure to report offence to support its ongoing implementation. It further recommended that the 'reasonable excuse' provisions be reviewed to explicitly cover the provision of sexual assault counselling and medical care.

Legislative amendments to the operation of this provision have since been enacted, which provide greater clarity for community support services when working with victims-survivors about what can or must be disclosed.³¹

In the Second Annual Report 2023–24 of the Taskforce, the Department of Justice and Attorney-General advised that work had 'commenced' to deliver a community awareness campaign to clearly explain the scope and intent of this offence and would be informed by an overarching communication strategy, stakeholder consultation and market research.³²

More recently, the National Review of Child Safety Arrangements called for national consistency in relation to the failure to report and failure to protect offences, along with a greater promotion of these laws to increase awareness about them. In making this recommendation it was noted that:

...variations in obligatory reporting models mean that institutions have different obligations to externally report institutional child sexual abuse, depending on what sector and jurisdiction they operate in. These differences can result in varying levels of protection for children and the extent of potential underreporting.³³

In conducting its Review, the Board requested information from ECRA about its understanding of the operation of the failure to report and failure to protect offences who advised that:

No specific awareness raising activities have been undertaken by the Department in relation to the requirements introduced in the Criminal Code (Child Sexual Offences Reform) and Other Legislation Amendment Act 2020. However, the Regulatory Authority's investigative protocols ensure that all allegations of child sexual abuse notified to the Department are reported to QPS.

The Department has conducted extensive awareness raising activities in relation to the mandatory reporting requirements of education and care staff under the Child Protection Act 1999, as well as in relation to approved providers' responsibilities to ensure specific roles receive child protection training (in accordance with Queensland's government protocol under s.162A of the National Law), to ensure all staff and volunteers working with children are aware of their obligations under current child protection laws (r.84 of the National Regulations), and to notify all incidents and allegations of child sexual abuse (r175(2)(d) and r(175(2)(e) of the National Regulations).

A similar question about awareness of failure to report and failure to protect offences was also asked of those centres where the offender was known to have been employed. Responses indicated varied levels of understanding of the legal requirements and inclusion in their policies and procedures.

In their response, Centre WS acknowledged that at the time of the offender's employment they were subject to mandatory obligations under Section 13E of the *Child Protection Act 1999*, and the 'analogous obligation under the National Law and its subordinate regulation'. No reference was made to any knowledge of the failure to report and failure to protect offences. These were however included in recent training conducted by the service, which provides guidance to staff about what actions should be taken where abuse is reported or suspected:

- *Monitor child wellbeing.*
- *Refer directly to support services.*
- *Refer to family and child connect.*
- *Refer intensive family support.*
- *Refer to regional intake service and child safety.*

Changes in legislation were also noted by Centre MY. While the offender was employed in Centre MY prior to the legislation having been introduced, they have provided their updated child protection policies and procedures which include the failure to report and failure to protect offences.

Centre HN demonstrated advanced recognition of these offences in their policies and procedures. They provided material in relation to the offences which had been developed in 2021, when the initial amendments were introduced. This policy is clear in outlining the responsibilities of staff with respect to the new offences including through the use of case scenarios, additional considerations and further reading.

While some centres also confirmed that they had policies and training about mandatory reporting requirements, information provided in these documents was incorrect and referred to non-existent legislation.

For example, the entity that oversees Centre WN in its *Child and Youth Risk Management Strategy Considerations for Early Childhood Services* document dated 10 July 2018, incorrectly referenced the "Child Protection Act 2000" and referred to:

Imminent legal responsibilities:

Criminal Code (Child Sexual Offences Reform) and Other Legislation Amendment Bill. These amendments include the creation of failure to report and failure to protect offences, regarding child sexual offences.

The Board noted inaccuracies in the dates of the Child Protection legislation given the incorrect year referred to in the material as well as reference to the criminal code amendment bill in a document dated 2018, despite it not being introduced until 2019. This centre's updated *Protecting Children and Young People in (...) Education Guidelines and Procedures* dated December 2021, clearly outline the failure to report and protect offences, as well as the requirement to record and retain documentation.

Although the policies and procedures of Centre BS, outline comprehensive reporting guidelines, including visual prompts in the form of posters for their staff, there is no mention of the failure to protect and failure to report offences in them. Clarification around this point was sought in addition to the initial information, the response provided did not speak to these offences in their own right.

Information about the failure to protect and failure to report offences was sought from Centres EK and MT, however, was not received.

Some services where there was known offending have provided information about the changes they have made in response to the Board's request for information, including to ensure there is an increased awareness of, and compliance with, mandatory reporting obligations. This includes regular mandatory training and improvements to induction processes to ensure that staff are aware of their obligations. Services have advised that they have implemented:

- Reporting Serious Incident Procedures, to complement the existing Child Protection Policy
- visual reminders for staff
- regular reminders for staff around mandatory reporting obligations through multiple channels, including through a people and culture hotline, a compliance hotline, incident reporting system and whistleblower channel.

With the commencement of the Reportable Conduct Scheme in Queensland in July 2026, organisations will be required to report and investigate allegations of child abuse or misconduct by their staff and volunteers. Failure to report can result in the head of an organisation receiving a financial penalty of over \$16,000.³³ While this goes toward addressing some gaps in reporting and provides strengthened oversight, the Board notes the low penalties associated with the failure to report to the scheme and recognises the need for additional safeguards.

Research conducted for the Board by the Australian Institute of Family Studies highlights that systems for reporting allegations of abuse can be strengthened in practice by:

- encouraging organisations to emphasise reporting through culture, guidelines and practices
- supporting staff to understand how and what to report, through rigorous and regular training and informational resources
- providing staff with a clear pathway to reporting, with systems that guide them to and through the reporting process
- enabling staff to feel comfortable to report concerning behaviour.³⁴

Operational Recommendation 8: Conduct a future evaluation of the reportable conduct and blue card schemes

From October 2025, Queensland's child safeguarding landscape has undergone significant reform with the commencement of the new Working with Children Check (WWCC) risk-based decision-making framework and the *Child Safe Organisations Act 2024*, followed by the launch of the Reportable Conduct Scheme in July 2026. Collectively, these three initiatives represent some of the most substantial advances in child safeguarding infrastructure in recent years. They signal a deliberate move toward more proactive, accountable, and systemic approaches to keeping children safe.

While their introduction is a major step forward, it is essential that these reforms do not end at implementation. The true measure of their success will lie in how effectively they operate in practice—whether they raise standards, strengthen accountability, reduce risk, and deliver on the expectations set by government, stakeholders, and the community. For this reason, a structured review of their operation after the first two years of operation is critical. Such a review would test whether the frameworks are functioning as intended, identify gaps or unintended consequences, and provide an evidence base for refinements and continuous improvement.

Only through ongoing scrutiny and review can we ensure that these reforms achieve their promise and that Queensland continues to build a safeguarding system capable of responding to contemporary challenges and preventing harm to children.

Specifically, the Reportable Conduct Scheme in Queensland represents a major step forward in safeguarding children within organisational settings. The Queensland legislation was based on the established frameworks in New South Wales and Victoria, however both of these have since been reviewed with proposals for amendment.

As a new initiative, the Reportable Conduct Scheme's operational effectiveness remains untested. Queensland's legislation adopts a broad definition of reportable conduct, and while this breadth is intended to capture a wide range of harmful behaviours and encourage organisational vigilance, it also creates potential challenges around practical implementation, clarity for organisations, and demand management. Swamping organisations with low-risk cases not associated with child sexual abuse may detract and limit the overall value of the scheme. Early engagement with the scheme, staff training, regulatory oversight, and the cultural acceptance of reporting mechanisms will all influence its uptake and overall impact. There is a genuine risk that, without close monitoring, the Reportable Conduct Scheme's broad legislative scope could result in diffused focus, inconsistent application, or administrative burdens that limit its intended value.

Furthermore, Queensland's implementation comes at a time when national and international standards for child safeguarding are evolving rapidly, and the experiences of New South Wales and Victoria demonstrate that even well-designed schemes require ongoing refinement. Lessons from these jurisdictions emphasise the importance of reviewing operational practices, legal thresholds, and regulatory guidance to ensure schemes are both effective and sustainable over time.

During the course of the Review, stakeholders consistently reported that the blue card system can produce outcomes that are difficult to predict and, at times, appear inconsistent. Some participants described WWCCs as overprotective, restricting individuals from child-related work despite low levels of assessed risk, while others noted that decisions can feel arbitrary, with similar circumstances resulting in very different outcomes. In their submission one parent discussed a gap in WWCC as it relates to the traineeship and apprenticeship sector for young people. The parent emphasised that providers of traineeships and apprenticeships should be required to demonstrate that they are safe workplaces for children and young people, with the WWCC serving as a minimum safeguard. This parent outlined their own child's experience of harm during the course of traineeship and their child being manipulated to provide the perpetrator access to their friends (e.g., inviting their friends to celebrations and other occasions the employer organised).

This parent further observed that, as the government funds traineeships and apprenticeships to support the skill development and workforce participation of young people, there is a shared responsibility to ensure their safety and wellbeing. This includes ensuring that funded training environments meet child safe and workplace safety standards, and that appropriate mechanisms exist to monitor, regulate, and respond to risks of harm in these settings.

This feedback highlights the challenges inherent in balancing the protection of children with procedural fairness considerations and underscores the importance of monitoring and evaluating the operation of the Reportable Conduct Scheme as part of broader safeguarding reforms.

Given these considerations, it is imperative that Queensland establishes a formal, time-bound review mechanism. Such a review would examine the Reportable Conduct Scheme's uptake, assess how effectively it identifies and responds to child sexual abuse, and determine whether its broad legislative approach enhances the safety of children without creating unnecessary administrative burden or complexity. This approach ensures that the Reportable Conduct Scheme remains fit for purpose, evidence-informed, and responsive to emerging risks in the child protection landscape.

Operational Recommendation 8: Conduct a future evaluation of the reportable conduct and blue card schemes

That the Queensland Government conduct a comprehensive review of the state's key child safeguarding frameworks—including the risk-based Working with Children Check (blue card) system, the Child Safe Organisations Act, and the Reportable Conduct Scheme—in 2028–29. This review should assess whether recent reforms are operating as intended, identify any gaps or unintended consequences to the operation of the new schemes, and provide evidence-based recommendations for improvements to strengthen accountability, reduce risk, and ensure that the child safeguarding system effectively protects children across all sectors. With specific reference the review must:

- consider the operation of the blue card system within the broader safeguarding system
- consider the operation of the Reportable Conduct Scheme and its effectiveness in preventing, detecting and responding to child sexual abuse.

The review should assess scheme uptake, operational challenges, and whether its broad legislative definition supports timely detection, intervention, and organisational accountability for preventing, detecting and responding to child sexual abuse.

Chapter 18

Interviews and investigations

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Interviews and investigations

“Maybe...the testimonies of children will get the attention they deserve, in their own right, not as an aside or a footnote. Maybe, just maybe, we can finally accept that the trauma caused by grooming, child sexual abuse and incest is unique and should be treated as such.” - Grace Tame

Effective police investigations require specialist training, multidisciplinary collaboration, and trauma-informed practice. Best practice approaches, such as the use of specialist child interviewers, joint investigative teams, and forensic interviewing protocols, minimise the need for children to repeat their story while maximising the quality of evidence. This strengthens both child safety and the integrity of the justice process.

The court process, long criticised for retraumatising children, has seen significant reform in many jurisdictions, including Queensland. Best practice now includes measures such as pre-recorded evidence, limits on cross-examination, the use of intermediaries, and closed court environments. These practices seek to protect children from further harm while maintaining the fairness and robustness of legal proceedings.

Together, these system improvements represent society's collective responsibility to respond to child sexual abuse and hold perpetrators to account through the criminal justice system. The measure of their effectiveness lies not in their existence on paper, but in the quality, consistency, and child-centredness of their application in practice. In the case of child sexual abuse, we must also ensure that the long-term consequences for victim-survivors are recognised and mitigated, and that parents and caregivers are recognised as secondary victims in the justice system.

This chapter examines investigative responses to child sexual abuse by police and the early childhood education and care (ECEC) system, highlighting both strengths and areas where further reform is required to ensure that every child who experiences abuse is met with a system that protects, supports, and delivers justice.

Interviews and investigations into the offender's conduct

Across more than two decades, repeated concerns were raised about the offender's conduct in ECEC settings. Parents, children, and staff provided accounts of the offender's inappropriate behaviour, sexual misconduct and physical harm, yet the responses from centres, police, and regulatory bodies were fragmented and insufficient. Taken together, these events show a series of missed opportunities where decisive action could have brought the offender's conduct to light much earlier, by centres, by the Early Childhood Regulatory Authority (ECRA) and the Queensland Police Service (QPS).

Despite a clear legislative requirement to do so, centres failed to notify ECRA about complaints that indicated risk of harm to children. For example, a parent reported in 2019 that the offender had grabbed and squeezed their child's arm. Staff and parents also witnessed the offender threaten to smack a child (2018) and observed inappropriate physical contact with another child, including rubbing their shoulders and kissing their head (2019–2021). Each of these incidents should have triggered a formal regulatory response. Instead, they were dealt with internally or not acted upon at all, leaving the regulatory system blind to critical warning signs.

Three separate complaints were referred to QPS between 2009 and 2022, each presenting opportunities for intervention:

- **2009:** Police interviewed the child but not the offender or centre staff. No charges were laid, and there is no record of any action taken by the centre or the then-regulator, the Office for Early Education and Care.
- **2021:** Police interviewed the complainant staff member and the offender, but not the child. Again, no charges were laid. The centre conducted an internal review, identified a code of conduct breach and required the offender to re-familiarise himself with policies and procedures. ECRA accepted the centre's investigation and concluded there was no breach of the National Law.
- **2022:** Police interviewed the child but did not interview the offender. The centre collected staff statements, which were relayed to police. ECRA determined the matter did not meet its threshold for further investigation.

“Across these complaints, investigative gaps were evident: children and potential witnesses were sometimes not interviewed, the offender was sometimes not interviewed, and regulatory oversight was limited to accepting the outcomes of narrow internal reviews.”

The shortcomings in these responses can be partly explained by the limits of police and regulatory capacity, alongside the relative immaturity of regulatory systems. Police investigations into child abuse are often constrained by the high evidentiary thresholds required to pursue criminal charges. Officers may make decisions not to interview every potential witness or suspect if they believe the initial available evidence is weak or if the complainant is very young, where reliability in court is considered difficult to establish.

While this approach reflects resource pressures and legal considerations, it risks narrowing the fact-finding process and overlooking important contextual information indicative of broader patterns of abuse and harm.

Similarly, given the timespan over which the offending occurred, regulatory authorities like ECRA were in the early stages of establishing systems for handling complex complaints and had limited specialist expertise in the investigation of reports of sexual or physical abuse. Regulators often relied on the outcomes of police investigations, in deference to law enforcement expertise and because of limited resourcing to conduct parallel inquiries. Where police found no grounds to proceed, regulators concluded there was no breach of the National Law, rather than independently assessing whether professional conduct standards or child safety obligations had been compromised.

Each system appeared to treat the complaints in isolation, rather than recognising a pattern of concerning behaviour across years and settings.

What emerges is a picture of siloed responses and lost opportunities. Centres withheld serious complaints from ECRA, QPS investigations were partial and inconclusive, and ECRA relied on the outcomes of others rather than exercising its own investigative powers. At no point were the multiple concerns consolidated, cross-referenced, or escalated to a level commensurate with the risks posed to children. The absence of a coordinated approach meant that credible reports of inappropriate and harmful conduct were repeatedly minimised or missed.

Ultimately, the offender was only identified when caught through digital evidence unrelated to these earlier complaints and investigations. The persistence of children, parents, and staff in speaking up contrasts starkly with the absence of decisive institutional action, highlighting systemic weaknesses in the mechanisms designed to protect children from harm.

Three complaints received by centres were not reported to ECRA, despite the legislative requirement to do so.

- One child told their parent that the offender had grabbed and squeezed his arm (2019).
- Two centres received reports from parents or staff that had witnessed the offender cause harm to a child or interact with them inappropriately. This includes the offender threatening to smack a child (2018), and stand behind a different child, rub their shoulders and kiss their head (between 2019 and 2021).

Three complaints received by police from parents or staff and referred to ECRA (or its predecessor).

Complaint 1 (2009):

- **Police:** Interview with child. Offender and centre staff not interviewed. No charges laid.
- **Centre:** No information available about actions taken.
- **Office for Early Education and Care:** No information available about actions taken.

Complaint 2 (2021):

- **Police:** Staff complainant and offender interviewed. Child not interviewed. No charges laid.
- **Centre:** Internal investigation by centre into complaint including staff interviews. Offender required to review policies and procedures due to code of conduct breach.
- **ECRA:** Requested centre undertake its own investigation which had been completed and requested information about the outcome. No breaches of the National Law by the approved provider were identified by ECRA.

Complaint 3 (2022):

- **Police:** Interview with child. Offender not interviewed. No charges laid.
- **Centre:** Internal statements from centre staff taken about complaint. Statements shared with police.
- **ECRA:** Matter was determined not to meet the threshold for further investigation, following outcomes of the police investigation.

Policing responses to child sexual abuse

Police are often the first point of formal contact for child victim-survivors following a disclosure of sexual abuse.³⁵ Their role is critical, not only in gathering evidence and progressing investigations, but also in shaping the child's experience of justice and recovery. The experiences victim-survivors have in their initial contact with police can determine the quality of their engagement in future processes, including in choosing to proceed with making a report. A trauma-informed, developmentally appropriate, and rights-based approach is essential to ensure that children are supported rather than re-traumatised during this process.³⁶

“A key challenge in the justice process occurs when police officers lack specialist knowledge of child development, trauma, and memory, factors which strongly influence a child's ability to disclose and be perceived as credible. Research shows that law enforcement can hold outdated or inaccurate beliefs about memory and trauma. Without appropriate training, there is a risk that police officers may misjudge a child's narrative, inadvertently undermining the child's credibility or causing re-traumatisation.”³⁷

”

As a gatekeeper to the criminal justice system, QPS faces continued scrutiny in their responses to victim-survivors of child sexual abuse, and the way that it investigates these types of offences.

In 2003, the Crime and Misconduct Commission handed down its report *Seeking Justice: An inquiry into how sexual offences are handled by the Queensland Criminal Justice System*. This inquiry was established in response to public concern about the investigation, prosecution and discontinuance of charges against a swimming coach who had been arrested for offences against children. It noted that:

*During the last decade, cultural and societal change has started to remove the veil of secrecy surrounding sexual abuse, encouraging more victims to come forward to report their experiences than in the past. It is, therefore, important that the criminal justice system responds appropriately to allegations of sexual abuse — the process must be seen both to encourage victims of abuse to come forward to report sexual abuse, and to help prevent the occurrence of such abuse... A key aspect, among many, in encouraging victims of sexual offences to officially report their victimisation clearly lies in their initial interaction and relationship with the police. The adequacy of the response by police to child sexual abuse allegations has been examined previously in Queensland and, importantly, a series of significant structural changes have been undertaken to enhance service delivery and improve effectiveness. An earlier review revealed a series of shortcomings in police investigations of child sexual abuse and identified the need to improve the coordinated service delivery model, to provide additional training support and to increase the selection and retention of specialist sexual offence staff.*³⁸

Recommendations from this report sought to improve the collection and dissemination of evidence, including through interviews to support the prosecution of sexual abuse offences, and reduce the stress associated with engaging with criminal justice systems for victim-survivors. They also sought to enhance timeliness of decision-making, strengthen court proceedings and 'enhance community confidence in the fairness and objectivity of the process'.³⁹

Twenty years on from the delivery of this report by the Crime and Misconduct Commission, the second report of the Women's Safety and Justice Taskforce (the Taskforce) in 2022 again reflected that:

*The way police interact with victims can affect the likelihood of future reporting and whether victims continue with a complaint. Police interviewing techniques have been described in the research literature as invasive, traumatising and inappropriate. This may be because police must determine whether an offence has occurred, establish victim credibility, or decide whether sufficient evidence exists to proceed to charge an alleged offender. The Taskforce observed that this can sometimes be a result of police genuinely, although misguidedly, trying to protect a victim from the realities of the criminal justice process.*⁴⁰

Over recent years, the Taskforce, the Royal Commission into Institutional Responses to Child Sexual Abuse (Royal Commission), and the Australian Law Reform Commission have made a multitude of recommendations that seek to improve policing responses to victim-survivors of sexual abuse and violence.

Implementation of these reforms by QPS is guided by the *Queensland Police Service Sexual Violence Response Strategy 2025–29*. This strategy establishes a vision of a victim-centric, trauma-informed sexual violence response that protects the community, strengthens public confidence and contributes to Queensland and National integrated action plans.⁴¹

...the QPS is often the first point of engagement for victim-survivors within the criminal justice system. The lasting impact, trauma and devastation on victim survivors of sexual violence is well-established and it is imperative the response provided by law enforcement is appropriate, effective and supportive through victim-centric and trauma-informed practices.⁴²

QPS continues to implement a range of different programs and initiatives that seek to improve its responses to victim-survivors of child sexual abuse, including in institutional settings. This includes by providing training to build workforce capacity, capability and understanding.

The **Child Sexual Abuse Fundamentals Education** is a training program for QPS staff (sworn and unsworn) to improve responses to a report of child sexual abuse. The goal of the training is to help staff understand issues raised by the Royal Commission and better support victim-survivors of child sexual abuse, and sexual assault more generally. It is about listening to, understanding, and supporting survivors so they are better able to give their accounts of what happened to them. The learning objectives relate to:

- understanding institutional child sexual abuse
- understanding trauma and applying this to practice
- understanding the unique issues for survivors from diverse backgrounds
- understanding the implications of development throughout childhood
- how to communicate effectively.

The **Interdiction for the Protection of Children** (IPC) training program is a proactive, intelligence-led initiative aimed at detecting, disrupting, and preventing child sexual exploitation, child abuse and child abductions.⁴³ The IPC Program was initially developed by the Texas Department of Public Safety (TDPS). The QPS partnered with TDPS in 2019 to develop and implement IPC for the Australian environment.

It equips frontline officers with specialist training to identify subtle indicators of harm, even without prior intelligence, enabling real-time intervention and protection for vulnerable children. Officers are trained to identify:

- people who pose a high risk to children
- children who are being trafficked, exploited, or abused by one or more adults
- children who are at risk of various forms of exploitation.

The program effectively challenges officer bias relating to the behaviour of offenders and victim-survivors. It seeks to educate officers about perpetrator and victim typologies, trauma responses, child development, legislation and child protection frameworks. The program has proven that early detection and disruption are possible even when children are not able to seek help.

The Royal Commission also highlighted that misconceptions about the function of memory, particularly in cases of childhood abuse, may negatively impact how police collect evidence and the weight courts place on it at trial.⁴⁴ These misconceptions, coupled with approaches to investigation which are not child-centric and trauma informed, may cause additional harm to child victim-survivors and witnesses while also producing lower-quality evidence.

In Queensland, police are responsible for working within the Queensland Government Interagency Guidelines for responding to children, young people and adults who have experienced sexual assault or child sexual abuse (the Interagency Guidelines).

The Queensland Government Interagency Guidelines for responding to children, young people and adults who have experienced sexual assault or child sexual abuse

The Interagency Guidelines outline key principles and a best practice framework for government agencies working with children, young people and adults who have experienced sexual assault and/or child sexual abuse, noting that people may have experienced both forms of violence.⁴⁵ The guidelines aim to ensure that individuals who have experienced sexual assault and/or child sexual abuse are provided with timely, sensitive, trauma-informed, victim-centric, high quality and coordinated service delivery responses appropriate to their needs, and appropriate to the role played by these agencies.⁴⁶

The Interagency Guidelines were first developed in 2001 and are designed to promote whole-of-government interagency cooperation and service coordination with the aim of improving government agency responses to victim-survivors of sexual assault or child sexual abuse.⁴⁷ They aim to facilitate best practice, quality service and support to people who have experienced sexual assault or child sexual abuse. The Interagency Guidelines encompass consideration of a broad range of policies and legislation.

Table 2: Legislation, policies and procedures relevant to sexual assault or child sexual abuse

Legislation relevant to and defining sexual assault or child sexual abuse includes, but is not limited to:	Policies and guidance documents that should be read in conjunction with internal agency procedures such as the:
• <i>Domestic and Family Violence Protection Act 2012</i> • <i>Police Powers and Responsibilities Act 2000</i> • <i>Criminal Law (Sexual Offences) Act 1978</i> • <i>Criminal Code Act 1899</i> (Criminal Code) • <i>Youth Justice Act 1992</i> • <i>Human Rights Act 2019</i> • <i>Mental Health Act 2016</i> • <i>Public Guardian Act 2014</i> • <i>Hospital and Health Boards Act 2011</i> • <i>Victims of Crime Assistance Act 2009</i> • <i>Public Health Act 2005</i> • <i>Guardianship and Administration Act 2000</i> • <i>Child Protection Act 1999</i> • <i>Evidence Act 1977</i> • <i>Health Act 1937</i> and associated regulations	• Health Service Directive: Caring for People Disclosing Sexual Assault • Queensland Health Guideline: Guideline for the Management of care for people 14 years and over Disclosing Sexual Assault • Ministerial Direction – Crisis Care Process • Department of Health Guideline: Conducting Child Sexual Assault Examinations • Office of the Director of Public Prosecutions Director's Guidelines • Queensland Police Service Operational Procedures Manual • Child Safety Practice Manual • Queensland Child Protection Guide 2.1 • Victim Assistance Queensland Guidelines • Youth detention operational policies • QPS Sexual Violence Response Strategy 2025–2029

The Interagency Guidelines note that the initial information obtained from a child is critical in the prosecution process, and therefore it is best practice that only investigators who have completed Interviewing Children and Recording Evidence (ICARE) training should interview children to ensure admissibility of the statement⁴⁸

Current practice and training

The offender is known to have perpetrated abuse against children in Queensland for almost two decades. He was found in possession of child exploitation material (CEM) dating back to 2000. The external jurisdictional review of the police response to complaints made to QPS about the offender prior to his arrest in 2022, identified opportunities for improvements in some of the responses and noted that there were 'obvious deficiencies' in the response by officers to the first 2009 report involving the offender. Officers interviewed as part of this review process, reflected that the current system of investigating child sexual abuse offending had 'vastly improved' since this first report.

While it is accepted that the QPS has made substantial improvements in its practices since the initial complaint was made, this should not stop the Board from considering what more could or should be done to strengthen current approaches, and ensure that victim-survivors are heard, and responded to.

In submissions made to the Board the Queensland Sexual Assault Network (QSAN) expressed:

...concerns about the conduct of some interviews with children and young people by the police, as their approach can be intimidating or their mannerisms may not create a safe space for young children to talk. Young children as young as 3 years old often do not make the statements that police require, even for older children such as primary school aged children there can be difficulties. Children [are] more likely to be open about an experience to parents, close family members etc over police, leading to cases not being proceeded with and being dropped which can result in a lack of protection for children. The burden of evidence is so high this makes it increasingly difficult in a criminal response. Children are not believed - individually or by systems, courts, police, workplaces and institutions. It can be easier for the system to not believe the child than to respond to the issue they are raising...As a result, children can be left effectively without protection as they are not believed by the criminal justice system or they do not make statements, in a way that is acceptable to the system.

Submissions from the Office of the Advocate for Children and Young People New South Wales further emphasised the need for integrated victim-centric, co-located, trauma-informed responses by police and other services. They suggest that this would improve the capacity of police to respond to reports of abuse involving young children and for 'non-criminal' risk management, that is, measures that seek to enable agencies to act on disclosures of concerning behaviour even when criminal thresholds are not met.

In discussing the investigation of allegations of child sexual abuse by police, Bravehearts also stated that:

Central to these investigations needs to be the use of trauma-informed and developmentally appropriate forensic interviewing. Interviews with children should only be conducted by trained specialists, using structured techniques that are non-leading and sensitive to the child's emotional state and age. This may require upskilling of those police working in child protection units. Particularly when the victim is a young child, the use of specialist skilled forensic interviewers, trained on working with young children, should be prioritised.

In submissions made to the Board, the Australian Centre to Counter Child Exploitation (ACCCE) advised that a skills audit undertaken in 2020 identified that members working in Australian Federal Police (AFP) child protection investigation did not receive any training specific to this crime type. A four-day Child Protection Induction Workshop was subsequently developed in response to this training gap. This training includes planning and evidence collection considerations, approaches to building rapport and interviewing offenders, and victim identification processes, however it does not specifically focus on interviewing techniques for child victim-survivors.

The NIVPP is an interactive program which is currently delivered by the ACCCE training team three to four times a year in various locations in Australia. This program seeks to develop the knowledge and skills of members who are likely to undertake investigative roles with a requirement for public engagement, witness and suspect management. It focuses on a trauma-informed approach and guides the conduct of Evidence in Chief Interviews for Commonwealth offences. The five-day interactive training program delivers training in the preparation, planning and conduct of best practice interviews and includes subject matter expert input on topics such as memory and vulnerability. The ACCCE considers that there is an ongoing need to develop AFP investigators with training in interviewing vulnerable persons, including children involved in specific proceedings, including slavery, trafficking and child sex offences.

Best practice approaches to interviewing victim-survivors

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I went back to the same intimidating police station with the confidence to recall my abuse and the specific details, only to be met with new police officers. No familiar faces. Needless to say, the police interview was not successful. Some months later, I attended a final police interview. I was interviewed by the original police officer and was able to describe in detail what happened to me, when and where. After the interview, the officer told my mum that my recollection of details would have resulted in a confident prosecution had I have done so in my first interview. This was absolutely devastating. As a 5 year old I struggled to understand why the perpetrator was not going to be prosecuted. It felt like victim blaming in some sense - like my story didn't matter - Lived experience advisor

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Research demonstrates that when interviewing child witnesses, police interviews must prioritise emotional validation and procedural transparency. Children need to feel believed, respected, and safe. When interviewers demonstrate empathy and provide clear, accessible updates about the case, victim-survivors are more likely to engage with the justice system and experience improved psychological outcomes.⁴⁹

For example the Queensland Intermediaries Scheme is a state-run initiative designed to improve communication within the criminal justice system for vulnerable complainants and witnesses in child sexual offence cases.

The scheme commenced as a pilot in Brisbane and Cairns in July 2021, as part of the implementation of recommendations from the Royal Commission.⁵⁰

Queensland Courts Services employs intermediaries who are qualified professionals in speech pathology, psychology, occupational therapy, or social work to assess witnesses' communication needs and facilitate effective communication. These intermediaries are impartial officers of the court and do not act as support persons or advocates.⁵¹

Eligibility for intermediary support is currently limited to prosecution witnesses in child sexual offence matters who have one or more of the following characteristics:

- under 16 years of age
- have an impairment of the mind
- experience difficulty communicating.⁵²

Intermediaries may be engaged during both police investigations and court proceedings. Their functions include conducting assessments, providing communication recommendations, attending interviews and hearings, and ensuring that questions and answers are understood by all parties. The Queensland Intermediaries Scheme is currently funded to operate until June 2029, with ongoing evaluation to determine its broader applicability and long-term impact.

Interviewing techniques should also be adapted to the child's developmental stage. For younger children, this includes:

- using open-ended, non-leading questions
- providing verbal affirmations and supportive comments
- limiting interview length to match attention span and cognitive capacity
- incorporating visual aids such as drawings or pictures to support communication
- supportive behaviours—such as warmth, proximity, and positive facial expressions—improve both the accuracy and completeness of children's responses, while reducing suggestibility and distress.⁵³

Benefits can also be actualised when agencies work collaboratively and prioritise the best interests of the child. The Joint Child Protection Response Program (JCPRP) in New South Wales is a collective partnership between the Department of Family and Community Services, police, and the Ministry of Health which seeks to 'foster cooperation between the three agencies and provide the best outcomes for children and their families' following an allegation of harm.

The JCPRP explicitly makes the safety, welfare and wellbeing of children the paramount principle for agency responses to allegations of harm. It is an example of a collaborative effort between government bodies made without overarching legislative initiatives. The agencies have agreed via a memorandum of understanding (MoU) to conduct a joint intake and risk assessment of any allegation which may constitute a criminal offence against a child, conducted by a Joint Referral Unit. The agreement facilitates the identification and sharing of relevant information held by each agency and sets out clear coordination to avoid duplication or confusion in the response.

There are also a number of examples of international best practice approaches to interviewing children. For example, the Interview Guidance for Investigative Police Officers (IGIpop) in Cyprus focuses on leveraging the skills of officers proven to work well with children.⁵⁴ IGIpop operates on the basis that, rather than attempting to bring all policing personnel up to the same standard of trauma-informed interviewing, a small cohort of high-quality interviewers should be assigned to conduct all relevant interviews.⁵⁵ An evaluation of this approach in 2020 found that it reduced inappropriate interview techniques and increased effective techniques, without an increase in training costs.⁵⁶

The Lundy Model of Participation in Ireland also ensures children's voices and rights are embedded in investigative processes. It conceptualises a child's freedom to express views and the right to be heard as requiring four concepts:⁵⁷

- **Space:** children are given safe, inclusive opportunities to form and express their views.
- **Voice:** children are provided appropriate information and processes are designed to facilitate the expression of their views.
- **Audience:** children's views are communicated and listened to.
- **Influence:** children's views are taken seriously and acted upon as appropriate.

Space

Have children's views been actively sought?

Was there a safe space in which children can express themselves freely?

Have steps been taken to ensure that all children can take part?

Voice

Have children been given the information they need to form a view?

Do children know that they do not have to take part?

Have children been given a range of options as to how they choose to express themselves?

Audience

Is there a process for communicating children's views?

Do children know who their views are being communicated to?

Does that person/body have the power to make decisions?

Influence

Were the children's views considered by those with the power to effect change?

Are there procedures in place that ensure that the children's views have been taken seriously?

Have the children been provided with feedback explaining the reasons for decisions taken?

Interviewing perpetrators

While it is important to strengthen policing practices when interviewing victim-survivors, it is also critical that police officers are appropriately trained in interviewing perpetrators of child sexual abuse and are aware of the strategic, manipulative and intentional tactics that perpetrators may use to avoid detection.

Police training for conducting investigative interviews usually focuses on relevant legislation, techniques and a range of evidentiary considerations to ensure that officers are able to prove an offence beyond a reasonable doubt. Given the intense focus on this, behavioural indicators representative of child sexual abuse perpetration, such as grooming and environmental manipulation, may be missed or skipped over.

As discussed in more detail in Part C, perpetrators of child sexual abuse engage in grooming not only of children but also of adults in positions of trust, including police, teachers, carers, and other professionals. Perpetrators may present as trustworthy, generous, and community-minded individuals, often described as 'pillars of the community'. They may also build relationships with professionals, including police, by:

- demonstrating helpfulness or volunteering in child-related roles
- being cooperative and respectful in interactions with authorities
- using charm, flattery, or shared interests to build rapport.

This creates a perception of credibility and reduces suspicion, making it less likely that concerns raised by children or others will be believed or acted upon. Perpetrators may also seek to influence how complaints are handled, by discrediting the credibility of victim-survivors and other complainants. These tactics are used to avoid detection, reduce suspicion, and maintain access to children.

The offender is known to have employed many of these tactics at the centres that he worked in, including by engendering trust because of his qualifications and experience, testing boundaries and ingratiating himself with others. It is considered likely that he may also have sought to employ these tactics when engaging with police. For example, when considering the 2021 complaint to police by a staff member who reported witnessing the offender kissing a child in an outdoor fort, records indicate that the staff member told QPS officers the following details:

She stated that when she walked out and looked through a window, she saw [the offender] on all fours with both of his knees and both hands on the ground on top of a female child who was asleep at the time. She further stated that she was shocked by this as she saw that [the offender's] face was super close to the girl's face. She stated that his face was about 2cm away from the girl's face and that his face was moving in a side to side motion. She stated his mouth was close to the girl's mouth. She stated that [the offender's] face was the only body part that was moving. She stated she then walked back into the classroom and paced around until she spoke to her coworker, (...). She told [other staff member] what she just saw. After about 3 minutes later, she then walked back out to the yard and still saw [the offender] in the same position on top of the girl. She called out to [the offender] three times and [the offender] looked up at her and responded angrily with a "What?" She asked [the offender] if he wanted a break and he replied to her with a "no". She stated she think [sic] he sat up when she walked back into the classroom. Five minutes later, [the offender] walked back inside and opened the door.

During the offender's interview with police he provided his version of events stating that he was only crouched for 10 seconds with the child, that he did give her face a "nuzzle", and that some children were already awake and using iPads. He also explained this was a common way to wake up the children.

Based on the interview transcript, QPS officers did not challenge the offender with the details provided by the female childcare educator despite them being inconsistent with his version. They also did not consider the offender's way of waking up children as not being 'common' and considered inappropriate by other educators (hence the complaint). From the available QPS records, it appears officers did not believe an offence had occurred, which was substantiated by the internal review of this complaint following the offender's arrest.

This internal review ultimately found that the investigation was completed adequately. It was noted that while the conduct of the offender may have been 'professionally and morally unacceptable' no offence had been identified. Notably, a staff member later disclosed during an interview with ECRA in 2024, that the offender told her during a phone call that he had gone to stay in a hotel because he 'was worried police would go to his house' presumably because of the CEM he would have had in his possession at the time.

Being aware of the stages and indicators of grooming and perpetrator tactics supports improved detection of perpetrators particularly where there is no clear history of prior known offending. To gain expertise in this field, police should be trained in:

- understanding sexual offending pathways and theories of sexual offending (e.g. routine activity theory, the four pre-conditions to sexual abuse)
- understanding sexual behaviour (e.g. inappropriate, problematic, sexual deviancy) and sexual development across the life span
- understanding sexual abuse categories (e.g. female offenders, paedophilia, the role of technology) as well as specific populations (e.g. neurodiversity).

This type of training would also support officers during interviews with alleged perpetrators, by ensuring that they are alert to situations where:

- there are inconsistencies between the suspect, victim-survivor and witness’s version of events and to challenge them about this
- the suspect expresses emotional congruence with children
- the suspect expresses unhealthy relationships, boundaries and attitudes towards children
- the suspect seeks to normalise behaviours towards children that others have raised concerns about
- there is evidence to suggest that the suspect may be exploiting policies and procedures at their place of employment or in other settings in order to gain access to children
- patterns are emerging suggestive of child sexual abuse perpetration, such as a person seeking to reduce guardianship by spending regular one-on-one time with a certain child or by circumventing institutional safeguards
- the police officer is being groomed by the perpetrator.

Having an awareness of what behaviours to look out for in perpetrators may prompt officers to consider other investigative steps that may need to be taken in response to a complaint, including by seeking access to a suspect’s phone, laptop or other devices, where there is sufficient evidence to do so. Evidence could be further strengthened by ensuring that officers routinely undertake interviews with all relevant persons in response to a complaint, including child complainants, suspects and other potential witnesses.

The standard of proof

When considering the system responses in this case, the Board discussed the complexity of undertaking investigations into a report of child sexual abuse, including for police in being able to reach the necessary threshold to prove beyond a reasonable doubt that the offence occurred. Data in relation to the outcomes of reported offences against children in the ten years to 30 June 2025 reflects these challenges.

Table 3 Outcomes of reported offences against children, 2015-16 to 2024-25

	Did not proceed	Arrest/ Warrant	Notice to Appear/ Summons	Other outcome
Rape and attempts*	6477	3833	390	643
*includes attempt to commit rape, and assault with intent to commit rape				
Indecent treatment	10,367	7175	974	2093
Other sexual offence against a child	3799	1742	266	556
Queensland CEM offences	723	312	117	1195
Commonwealth CEM offences	133	172	24	16

Source: Queensland Police Service

A substantial proportion of contact sexual offences against children do not proceed to trial (57.10% for rape and attempts, 50.30% for indecent treatment, and 59.70% for other sexual offences). While most CEM charges do lead to an arrest (only 30.81% of Queensland and 38.55% of Commonwealth CEM offences do not proceed), many Queensland offences result in a non-trial outcome. Even considering those charges which do proceed to trial, a large number do not result in a conviction or serious penalty. Queensland Courts statistics indicate that over the 5 years to 30 June 2025, less than half (43.16%) of penalties imposed for child sexual abuse offences involved actual imprisonment, and more than half (52.23%) of contact offending did not result in conviction at all.

The Board also noted the apparent overreliance of the outcomes of the centre and police investigations by ECRA which meant that they did not take any further investigation into the complaints that came to their attention.

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Prosecution is almost impossible without an immediate detailed account from an already traumatised child. In my opinion, securing testimony from child sexual abuse victims needs more time, a more consistent approach, and a much more supportive environment. Expecting children to disclose in the same way an adult does traumatises the victims further - Lived experience advisor

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In criminal courts, prosecutors must prove the elements of an offence beyond a reasonable doubt; that is, the evidence must exclude any other reasonable explanation other than that the accused committed the offence. A lower standard of proof exists in civil matters known as the balance of probabilities. This means that evidence must show that there is a greater than 50 per cent probability that the facts in contention are correct. The balance of probabilities is not static but is dependent upon the seriousness of the allegations. This is known as the Briginshaw principle—more serious allegations require more evidence.

Police investigations, and the evidence required by police and public prosecutors, are focused on securing a conviction, which means that the evidence gathered must support the beyond reasonable doubt standard of proof. Other regulators operating under their own legislation, however, are not limited at law by this high standard.

When abuse is disclosed, there can be a lack of decisive action taken because of evidentiary thresholds. The available information for this case suggests that regulators deferred to the decision by QPS to discontinue an investigation as positive evidence of a lack of harm or risk, when such investigations have a different standard of evidence and are conducted for a different purpose.

The young age and developmental stage of the children that the offender perpetrated abuse against also impacted the capacity of QPS to reach the evidentiary threshold to pursue further action.

After his arrest, the offender told officers that he targeted children under the age of five years, as they were ‘easier’ to offend against. The child victim-survivors in this case had no or limited vocabulary and limited capacity to recognise or report their experiences of abuse. They were sometimes asleep when the offending occurred. The offender also took deliberate steps to ensure children were distracted and occupied during some of the abuse or hidden from view from other witnesses.

Research by the University of New South Wales undertaken to inform the Board’s review of this case highlighted multiple similar cases that have happened in ECEC settings including internationally, where children under the age of five years have been similarly targeted. This has been further amplified by recent cases in New South Wales and Victoria that have come to light while the Review was underway.⁵⁸

The deliberate targeting of very young children by perpetrators to prevent detection has been harrowing for the Board to acknowledge, but it has also been something that has been known by law enforcement agencies for some time.

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In 2015 the Queensland Organised Crime Commission of Inquiry was told with respect to child sexual abuse offending in online environments that ‘offenders in Queensland are seeking out images and videos of younger and younger children, with many images of babies being offended against made available for viewing’.⁵⁹ Statements made to this inquiry also referenced two cases ‘where offenders planned the abuse of children even before they were born, and took requests from offenders for the production of child exploitation material’.⁶⁰

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Other research shows that men with a diagnosis of paedophilia are more likely to target very young children and use techniques to manipulate both their environments and victim-survivors to increase opportunities for abuse.⁶¹

Despite the increased vulnerability to sexual abuse of children in this age group, the Office of the Director of Public Prosecutions (ODPP) Guidelines currently place restrictions on prosecutors’ authority to call a witness under the age of five years, unless their competency has been confirmed by an expert report. For children five years and over, a prosecutor may request an assessment of their competency ‘if that is considered necessary or desirable’.

The ODPP guidelines are not law, but an expression of the Office’s practice, based on caselaw, court benchbooks, and legislation. They are designed to assist the exercise of prosecutorial decisions to achieve consistency, efficiency, effectiveness and transparency in the administration of criminal justice.⁶² One of the most fundamental decisions articulated in the guidelines, the decision to prosecute, is based on two questions:

- Is there sufficient evidence to secure a conviction?
- Is there a public interest in prosecution?⁶³

These questions necessitate a cautious approach to the witnesses who may be called to give evidence.⁶⁴

The Supreme and District Court benchbooks make very clear that children of all ages are presumed competent to give evidence, however this is only a starting point, and either party to a proceeding may request the court examine a child witness to assess: a) their competency to give evidence at all, and b) their competency to give sworn evidence. Expert evidence is admissible for this purpose.

Regardless of the difficulties of investigating reports of child sexual abuse, evidence can be strengthened by ensuring that perpetrators and other witnesses are consistently interviewed, and by assessing matters in a way that takes into account what is known about the particular offence (such as grooming).

While the capacity to meet the requisite threshold to pursue criminal charges in child sexual abuse cases is an enduring challenge, especially with very young children, the progress and outcomes of a police investigation may also provide invaluable intelligence to support robust system responses by other agencies with safeguarding responsibilities.

Even if a report is unable to be substantiated due to a lack of evidence, there are opportunities for information gathered as part of a police investigation to be shared with Blue Card Services (BCS) to support assessments of a person’s suitability to hold a working with children check, and with relevant regulatory entities so that they can consider what other action may be able to be taken to better manage or mitigate potential risks to children. QPS clarified to the Board that an offence still needs to have been substantiated but no action taken against the offender for this type of information to be shared.

ECRA have implemented a wide range of changes as part of Project Safeguard, which was established after the offender was arrested. They provided the following case study to the Board to demonstrate the role that regulatory agencies can play in responding to reports of child sexual abuse which are considered to have not met the relevant threshold for further investigation by police.

Project Safeguard case summary

In 2024, ECRA's Child Safeguarding team investigated allegations of sexual misconduct against an educator at an Outside School Hours Care (OSHC) service. While QPS initially determined not to proceed with criminal charges, ECRA undertook its own investigation and determined that both the educator and the provider presented unacceptable risks to children.

ECRA took enforcement action, including prohibition of the educator, cancellation of the provider's approval, and prosecution under the National Law. The findings were referred to QPS, who reopened an investigation and later initiated criminal proceedings against the educator.

Background

In late 2023, two children made independent disclosures of historical sexual misconduct by an educator employed at an OSHC service. In early 2024, ECRA received further information that two additional children had made similar disclosures about the educator prior to the other children coming forward.

ECRA disclosed all information to QPS, who investigated the reports but were not able to proceed with charges. ECRA commenced its own investigation into the educators' conduct, and whether the service met all obligations under the National Law.

Investigation

ECRA took a comprehensive approach to its investigation, which included:

- systematically identifying all services where the educator had been employed in the years preceding the current allegations
- reviewing conduct, appraisal, and employment records across all services where the educator worked
- undertaking structured interviews with former staff and managers to examine the educator's behaviour, with particular emphasis on interactions with young girls and the exploration of any concerns previously reported
- examining service-level policies, staff files, and incident management responses
- conducting interviews with staff, parents, the educator and leadership personnel
- inspecting the service to assess supervision arrangements and environmental risks
- obtaining expert analysis on grooming behaviours and failed intervention points.

Findings

The investigation identified:

- a sustained pattern of inappropriate interactions with pre-pubescent girls that included boundary-testing behaviours namely, inappropriate touching commonly framed as assisting or providing care, sexualised conversations and recommending age-inappropriate movies, shows and online viewing material
- persistent attempts to engage with young girls outside the regulated environment through activities such as babysitting and tutoring
- corroborated accounts from children and adults (including former colleagues and supervisors) supported by documentary records
- governance failures on behalf of the approved provider, including delayed responses to disclosures and inadequate follow-up of earlier staff concerns.

On the balance of probabilities, the educator was found to pose an unacceptable risk of harm to children. The Approved Provider was determined to have breached its statutory obligations and, as a result, was no longer considered fit and proper to hold provider approval to operate an ECEC service.

Regulatory enforcement

ECRA exercised its statutory enforcement powers to mitigate risks and uphold safeguarding standards. Actions included:

- issuing a prohibition notice to the educator
- issuing a compliance notice to the provider
- cancelling the provider approval and transferring the service to new management
- commencing prosecution against the approved provider for offences under the National Law.

This case study highlighted the outcomes that can be achieved when relevant entities exercise their regulatory responsibility to act independently of criminal justice processes, ensuring that child safeguarding remains the primary focus.

Criminal proceedings

ECRA's findings were referred to QPS, who reopened a criminal investigation and subsequently laid charges against the educator relating to his treatment of the four children. The proceedings were discontinued following the educator's death.

Safeguarding significance

In ECRA's view this case demonstrates:

- the critical importance of prompt and appropriate responses to child disclosures
- the pivotal role of governance and leadership in recognising, assessing, and addressing risk
- the value of employing an integrated investigative methodology to systematically examine behavioural trends across contexts and timeframes
- the necessity of strong collaboration between regulators, law enforcement, and partner agencies to ensure comprehensive safeguarding outcomes
- the heightened risks posed by unsupervised educator access to children.

It further underscores that safeguarding extends beyond minimum compliance and requires a proactive culture of safety, disclosure, and accountability within services.

Sector implications

ECRA also submitted that this case illustrates broader sector issues, including:

- the risks associated with educators who have a history of inappropriate child interaction
- the need for stronger cross-service information sharing and employment screening
- the importance of timely and effective service-level responses to disclosures
- the regulator's role in translating lessons from individual cases into improved sector-wide regulation.

Conclusion

This case highlights the need for timely and decisive regulatory intervention and reaffirms the role of ECRA beyond reliance on criminal justice outcomes. Where criminal proceedings do not progress, ECRA has the authority to continue to investigate allegations thoroughly and act to mitigate unacceptable risks to children.

Operational Recommendation 9: Enable the use of police intelligence material for child safeguarding

Current systems for responding to reports of harm to children often operate in silos, with police investigations and regulatory or organisational safeguarding mechanisms operating largely independently from each other. When a matter is reported to police but does not meet the threshold for a criminal investigation or prosecution, the information is often not systematically shared with child safeguarding entities. This creates significant gaps in the broader safeguarding system. Critical contextual information about patterns of behaviour, complaints, or potential risk may remain invisible to regulatory bodies, the Reportable Conduct Scheme, BCS, or other child protection agencies.

Evidence from past inquiries highlights that perpetrators can continue to work with children if prior concerns are not visible across systems. A decision not to prosecute by police does not equate to an absence of risk; rather, it may reflect evidentiary limitations, legal thresholds, or procedural discretion. Without mechanisms to share key information with relevant safeguarding authorities, opportunities to detect emerging risks, patterns of misconduct, or grooming behaviours are lost.

Police naturally maintain a protective approach to the information they collect. Investigative powers, legal obligations, and evidentiary rules constrain how information obtained during criminal investigations can be used or disclosed. These protections are essential to safeguard due process to preserve the integrity of investigations, and ensure that procedural fairness is maintained for all parties involved. The legal restrictions on using investigative material for purposes other than pursuing criminal matters are therefore both important and appropriate.

However, this necessary caution must be balanced against the overarching goal of the safety and protection of children. Police investigations are typically focused on meeting the high evidentiary threshold required for criminal prosecution, which means that much potentially relevant information about risks to children may not result in charges or convictions. While such information may not meet legal standards for criminal action, it can nonetheless be invaluable for identifying emerging threats, concerning patterns of behaviour, or sub-threshold indicators of harm to children. QPS reflected to the Board that:

'The role of QPS as investigators of criminal matters is always a blurred line and we accept we seem to be the 'go to' agency. As this review at times has highlighted our high legislative threshold is used by other entities disregarding their own lower thresholds. While highlighting QPS it should not be lost that the information was also known to the service provider and ECRA, and there were parents willing and able to protect the children.'

Past reviews have highlighted this gap. *Keeping Queensland's children more than safe* was critical of QPS failures to share relevant information with BCS in a timely manner, noting that early sharing could have supported preventative interventions and better protected children.⁶⁵ This Review has demonstrated similar shortcomings: QPS collected information that, had it been considered for its protective value rather than solely its evidentiary potential for prosecution, would have allowed more children to be safeguarded.

There is therefore a compelling case for police to adopt a dual perspective: while information must continue to be protected and used in accordance with legal obligations for criminal investigations, there is a concurrent responsibility to recognise when collected intelligence could inform child safeguarding systems.

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By enabling appropriate, lawful sharing of risk-relevant information, police can contribute to proactive protection measures, support regulatory and organisational oversight, and prevent further harm.

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The Australian Institute of Family Studies research for the Board on best practice responses to safeguard children from child sexual abuse advised that:

A best practice WWCC model should also give police the power to disclose a sufficiently wide range of information to facilitate informed decision making by regulators. The UK DBS [Disclosure and Barring Service] model allows for greater discretion among relevant local police forces in disclosing information for applicants to high-risk professions, including ECEC. Police forces and law enforcement agencies can provide any information on file, including allegations, investigations or any court orders to the DBS if it is deemed by the Chief of Police or the agency to be relevant to the applicant's desired profession and position. Although the effectiveness of this model is subject to police force attitudes towards, and understanding of, CSA [child sexual abuse] and the importance of allegations... it can lead to greater scrutiny of individuals with some suspicious behaviours, even where no formal investigation has occurred.⁶⁶

Establishing a clear obligation for police to provide key contextual information from investigations that do not result in prosecution would ensure that at least one safeguarding body has access to the full picture of potential risk. This would allow regulatory and oversight entities to take preventive or supervisory action, strengthen intelligence-led safeguarding, and improve system-wide protection for children.

A centralised approach—through BCS, the Reportable Conduct Scheme, or a dedicated child safeguarding entity—would ensure that such information is collected, assessed, and acted upon, rather than remaining in isolated records. By integrating police intelligence into child safeguarding frameworks, Queensland can move from reactive to proactive protection, reducing the likelihood that harmful individuals evade oversight simply because there is insufficient information to meet criminal thresholds.

Operational Recommendation 9: Enable the use of police intelligence material for child safeguarding

The Queensland Government should legislate a clear obligation for police to share key contextual information from investigations that do not lead to a prosecution with a relevant child safeguarding authority (WWCC, reportable conduct or the child safeguarding body). This information should include details of complaints, observed behaviours, investigative findings, and other relevant contextual data. This obligation should ensure that:

- a decision not to prosecute does not result in lost intelligence or missed opportunities to identify threats and emerging risks
- a centralised safeguarding body—either BCS, the Reportable Conduct Scheme, or a dedicated child safeguarding entity—can assess risk, detect patterns, and take protective action
- police information, especially the information gained from child interviews, witness interviews and suspect interviews, is used to protect children.

Implementing this requirement will strengthen Queensland's safeguarding system, close information gaps, and ensure that all available intelligence contributes to keeping children safe.

Chapter 19

At the policing frontier – emerging threats and spiralling demand

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At the policing frontier – emerging threats and spiralling demand

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Child sexual abuse has transcended cultural normalisation: it has become a commercial enterprise. Law enforcement and legislators are struggling to keep pace. Meanwhile, governments and regulators worldwide continue to languish in a digitally dependent economy that demands buy-in. The need for specialised, multidisciplinary child sexual abuse prevention, intervention and response methods has never been more urgent. We're in a tech arms race with offenders that we can't afford to lose. This is a global crisis of public health, but before we can even hope to address it, we must first understand it.⁶⁷

”

Child exploitation material (CEM) has become one of the fastest-growing forms of online criminal activity. Originally confined to physical media, its proliferation has been accelerated by the internet, social media platforms, encrypted communication channels, and rapidly evolving technologies which enable perpetrators to navigate online environments undetected.

These developments have enabled perpetrators to produce, distribute, and consume CEM at an unprecedented scale. Law enforcement agencies worldwide are grappling with the dual responsibility of prosecuting offenders and identifying and safeguarding victim-survivors. This task is made more difficult by the vast volume of offending, technological barriers, and the hidden nature of online abuse networks.

Conversely, once an offence has been detected and perpetrator identified, the prosecution of offences is comparatively more straightforward in cases of CEM, as the material provides law enforcement with the evidence they need to pursue criminal charges.

Over the past two decades, the global availability of CEM has surged. In 2024 alone, the National Center for Missing and Exploited Children (NCMEC) received nearly 20 million reports of suspected CEM via their CyberTipline.⁶⁸ Europol noted a dramatic increase in reports related to online child sexual abuse during the COVID-19 pandemic, attributed to perpetrators and children spending more time online during mandatory isolation and lockdowns.⁶⁹ A particularly troubling development is the rise of live-streamed child sexual abuse, often involving cross-border financial transactions, which adds further complexity to victim identification and perpetrator prosecution. This is because once the live streaming ceases, the evidence disappears.

Australians are some of the largest consumers of CEM globally. Perpetrators in our homes, our communities, and in our institutions are driving this scourge.

The rise of artificial intelligence (AI) also presents risks and opportunities. It diverts scarce and specialist resources away from the difficult task of victim identification, but it also provides an opportunity for law enforcement to continue to automate and evolve their processes.

Victim identification is a critical priority for law enforcement and often represents a race against time and over continents, where global forces work together to locate the children in the pictures, and the perpetrators that offend against them.

At times this seems like an insurmountable task. Agencies must sift through millions of files, many of which are duplicates, or AI generated, making it difficult to detect new victim-survivors. Perpetrators increasingly use the dark web, TOR networks, VPNs, and end-to-end encryption to conceal their identities and locations. The global distribution of perpetrators, victim-survivors, and service providers complicates jurisdictional cooperation. Additionally, many images lack contextual clues, making it hard to determine who the victims are or where they are located. When victim-survivors are identified, engaging them safely requires trauma-informed approaches and specialist counselling and support.

Despite these challenges, law enforcement has made significant strides through technology and international collaboration. INTERPOL's International Child Sexual Exploitation (ICSE) database enables global comparison of seized material, helping identify overlaps and generate investigative leads. As of July 2024, ICSE contained 4.9 million images and videos, and had contributed to the identification of 42,300 victim-survivors and 18,300 perpetrators.⁷⁰ AI and image analysis tools are increasingly used to detect unique objects, backgrounds, or digital fingerprints that can aid investigations. Cross-border taskforces like the Virtual Global Taskforce (VGT), which includes the Australian Federal Police (AFP), facilitate coordinated efforts and intelligence sharing among multiple countries. The VGT seeks to work with non-government organisations and industry partners to deliver a program of coordinated activity to help protect children online, no matter where they are in the world.

Progress is still hindered by systemic issues. National legal frameworks often lag behind technological developments, leaving legislative gaps related to live-streamed abuse and anonymising tools. Resource constraints mean that specialist law enforcement units are frequently understaffed relative to the scale of the problem, which is compounded by the specialist nature of the roles. The relentlessness of the task means that few people can do this work and even fewer for long periods of time.

In some jurisdictions, online platforms are not legally required to report CEM, resulting in inconsistent global detection and reporting. Australian law enforcement entities receive vast volumes of referrals from agencies like NCMEC and Europol, much of which consists of duplicative data or are informational reports. The sheer scale of incoming intelligence makes it extremely difficult to identify new Australian victim-survivors or perpetrators. Critical triaging decisions must be made on what fleeting image to follow or lead to track down.

State and territory police have limited capacity to chase down referrals while also responding to existing workloads and victim-survivor complaints. This leads to delays, backlogs, and the potential for urgent threats to children to be missed. Victim-survivors and families who report abuse often feel ignored when their complaints do not result in visible police action, discouraging future reporting and allowing perpetrators to continue to offend. This is not unique to Queensland or Australia, similar pressures are reported in the United Kingdom, Canada, and the United States of America.

To restore effectiveness and public confidence, urgent reforms are needed. This includes investing in victim identification capabilities and frontline responses, developing smarter triage tools to filter known CEM, and resourcing police and regulators to manage both online and offline intelligence. A child safeguarding system that prioritises digital files over children who make a report of abuse cannot succeed. Balancing technological tools with improved responsiveness to victim-survivors is essential to safeguarding children and disrupting offender networks.

An arbitrary distinction

Acknowledging criminal justice system complexities, the offender's case gives the perception that the rise of online child sexual exploitation has reshaped law enforcement priorities. Digital evidence, including images, videos, and chat logs, has become central to successful prosecutions, as it is less vulnerable to credibility challenges than victim-survivor testimony. Multiple recent reviews and inquiries have highlighted how community disclosures from children, parents, carers, and workers may be sidelined because of challenges in conducting investigations into these types of offences and the lack of apparent prosecutable evidence. This means that potential witnesses are not spoken to, and other evidence is not tested. The failure to listen to children and their parents, and the neglect of other organisational and community intelligence, risks missing early intervention opportunities to detect and disrupt perpetrators and undermines public trust in the justice system.

In undertaking this Review, a clear delineation has emerged that distinguishes between the complexities of policing responses to victim-survivors who make a report of abuse to police, and the extraordinary investigative techniques and resources allocated to online offending.

The QPS informed the Board that there are different challenges that are present during an investigation that involves online (digital evidence) and other child abuse investigations which are usually reliant upon witness recollection and limited corroborating evidence.

For children, there is limited distinction between the two forms of crime—online depictions and contact offending. While arbitrary distinctions can sometimes be drawn between 'contact' and online offending, each CEM image or video represents a crime scene involving a real child. Emerging research also shows that where a person is found in possession of CEM, there is a significant likelihood that they have committed a contact offence against a child.⁷¹

As set out by the Queensland Organised Crime Commission of Inquiry in 2015:

While an offender may be only involved in either online child sex offending or offences relating to child exploitation material, it is not uncommon for an offender to be involved in both types of offending. For example, an offender may make contact with a victim over the Internet and, in the course of communication, direct the child to touch himself or herself, or touch other people, in a sexual way. The offender may then record this conduct and upload the images to the Internet. In this scenario, the offender has not only committed sexual offences against a child, but has also made and distributed child exploitation material. The same offender may also have a collection of child exploitation material which has come into his or her possession quite separately from the sexual offences committed against the child. In another example, an offender may come to police attention through downloading child exploitation material from the Internet. When the offender's computer or devices are analysed by police, it may be discovered that he or she has recorded himself or herself committing sexual offences against a child.⁷²

A recent joint law enforcement *Parliamentary Committee Inquiry into Child Exploitation* explored the relationship between contact and online offending. While this inquiry noted that there were some differences between the two, it accepted evidence that highlighted the close links between contact and online offending.⁷³ The final report of this inquiry noted that online CEM networks can influence members to commit contact offences and that 'technology can blur the distinction between these two types of crime, as both live online child sexual abuse and sexual coercion can involve an offender directing abuse from afar'.⁷⁴

In submissions made to the Board, the Australian Centre to Counter Child Exploitation (ACCCE) sought to clarify that perpetrators who commit online child sexual abuse offences 'are not always or automatically contact offenders'. They also note that:

Contact offending is harder for law enforcement to detect as it occurs behind closed doors in circumstances where the victims are typically not able to come forward to seek help or support.

Notably, ACCCE's role is focused on combating online child sexual abuse and exploitation, which limits the extent to which they directly engage with victim-survivors who seek to report abuse. It is their experience that where they identify cases involving contact offending in Australia, it is often intrafamilial, happening in homes, and conducted by someone who is related or known to the victim-survivor.

Resourcing, priorities and decision-making

What has emerged from this Review is a story of resources, priorities and decision-making. Of police persistence in identifying victim-survivors in online CEM over nearly a decade, but where concerns raised about the offender by children, parents and staff were filed because of an apparent lack of evidence to substantiate that an offence has occurred.

Underpinning this challenge is a critical systemic issue. Online child sexual exploitation offences are often more easily progressed to prosecution on the basis of digital evidence, including images, videos, and files, rather than through complaints raised directly by victim-survivors or their families. This reflects the structural reality of the criminal justice system: cases underpinned by tangible digital material are often viewed as more evidentially reliable, less contested in court, and more likely to secure a conviction.

While the evidentiary strength of cases of online offending has become central to successful prosecutions, it may have consequences for the way resources are allocated, and investigations are prioritised. The QPS advised the Board that "in terms of assessing sufficiency of evidence, digital evidence such as photographs or text messages that are direct evidence of the crime are difficult for an offender to dispute. In contrast a personal recollection by a witness, without digital evidence, can be challenged by an offender. This presents challenges when prosecuting such offences". As a result, the voices of victim-survivors, families, and frontline workers—those who raise early concerns and complaints—may be minimised. Where investigations are delayed or closed early, potential witnesses are not spoken to, and leads are not chased down. This dynamic risks further silencing victim-survivors and eroding trust in already fragmented reporting pathways and complex court processes.

As so aptly articulated in the external jurisdictional review of the QPS contact prior to the offender's arrest, child protection notification reports are causing a demand management pressure 'that can only be met if local police streamline responses' and that:

The online child sexual offending environment is exploding with new creators and new viewers. Resources are thin.

This pressure is also acknowledged in the QPS's *Sexual Violence Response Strategy 2025–29* which aims to improve policing responses, prevention processes, and victim-survivor safety.⁷⁵ The strategy also identifies four 'victim-survivor principles', highlighting the need to keep victim-survivors at the forefront of responses.

While responses specifically tailored to victim-survivors of child sexual abuse are not mentioned, the strategy raises a number of identified risks to achieving this goal including:⁷⁶

- a declining confidence in police responses by victim-survivors and the community
- victim-survivors being unsupported and burdened by the criminal justice system
- lack of consideration of factors leading to attrition at key stages in the investigative process
- inability to deliver consistent responses amid increasing demand and evolving community expectations.

The offender's detection

The detection of the offender through uploaded CEM, that he posted years before his arrest, was remarkable. It is evidence of the determination of the police and specialist victim identification staff in the AFP and Argos to track down every possible lead, to leave no stone unturned and to remain focused on the task at hand.

However, while the timeline of detection is a story of persistence, it is also a cause for reflection. It took police nine years to identify the offender from the CEM he uploaded online. They experienced delays in obtaining critical information from private providers, and in analysing the information they obtained. As soon as the offence location was identified, police were able to swiftly arrest the offender. From there, police faced an almost insurmountable task of identifying the children in the CEM the offender had created, and notifying their families.

It is impossible not to question the impact of the delays encountered by police in obtaining critical information from the private bedding supplier or to ask oneself whether, if more resources had been allocated to victim identification, the offender would have been located earlier and less children harmed.

These types of investigation delays are not unique to Queensland. A recent *Parliamentary Committee Inquiry into Child Exploitation* noted concerns raised by Victoria Police in obtaining information from agencies to inform its investigations including that wait times can vary dramatically. It was further noted that:

Delays in receiving information can mean that children may be accessible to offenders whereby contact offending may be occurring. By understanding if the offenders have access to children consideration can allow resourcing to be prioritised to those investigations whereby children are being harmed.⁷⁷

Responding to the threat of online environments

Much has changed for law enforcement over the nine years that it took to locate the offender, following the uploading of CEM onto The Love Zone. Legislative frameworks have strengthened to enable police to more effectively respond to online threats, and they have continued to evolve their approach to combat the task at hand.

Queensland has also led the way in responding to threats in online environments. Initially established as a multi-disciplinary taskforce in 1997 focused on historical and institutional sexual abuse of children, Argos (formally known as Taskforce Argos) shifted to technology-facilitated offences against children, commencing in 2000. It consists of sworn officers, victim identification experts and administrative staff that support the unit's purpose of protecting children. The unit now provides a specialist statewide response to the investigation of networked paedophilia, child exploitation and technology facilitated crimes against children. Their principal focus in any investigation is the identification and rescue of children from harmful environments.

In 2018, ACCCE was established in the AFP. It seeks to provide a connected and collaborative capability to ensure cohesion by using the expertise of federal, state and territory, non-government agencies and private industry, and by allowing a cross-pollination of resources, knowledge and skillsets between stakeholders.

Collaborative operational partnerships between law enforcement, community organisations, technology companies and private providers are key to disrupting online child sexual abuse offending, both within Australia and internationally. No one entity can address this issue in isolation of others. The Board is cognisant of the insurmountable task ahead, and the need to ensure the appropriate mix and level of resourcing is available for law enforcement to continue to counter online threats, and act swiftly when new ones emerge.

Australian Centre to Counter Child Exploitation

ACCCE received a total of 82,764 reports of CEM from NCMEC in 2024–25, which represents a 44 per cent increase over the previous year. According to the AFP, these reports ‘typically involve the upload, download, or distribution’ of CEM.

The significant number of reports received by ACCCE requires a triaging process to identify children at the highest and most immediate risk. Prioritisation is generally given to the identification of ‘first generation’ CEM which is material that has not previously been detected by law enforcement. Reports that do not fall within the triaging classification criteria, have duplicate content or have an incident date or upload date older than two years, are classed as ‘informational reports’ and are used for crosschecking in future investigations.

Triage processes within ACCCE are supported by a Triage Referral Investigation Support Tool (TRIST) which supports consistent and risk-informed decision making during the triage process. A review of this tool is currently underway because of new and emergent methodologies, technological developments and the extensive nature of the data available, comparative to when this tool was initially developed. Every actionable report that comes into ACCCE is reviewed, to ensure that professional judgement is applied when triaging reports.

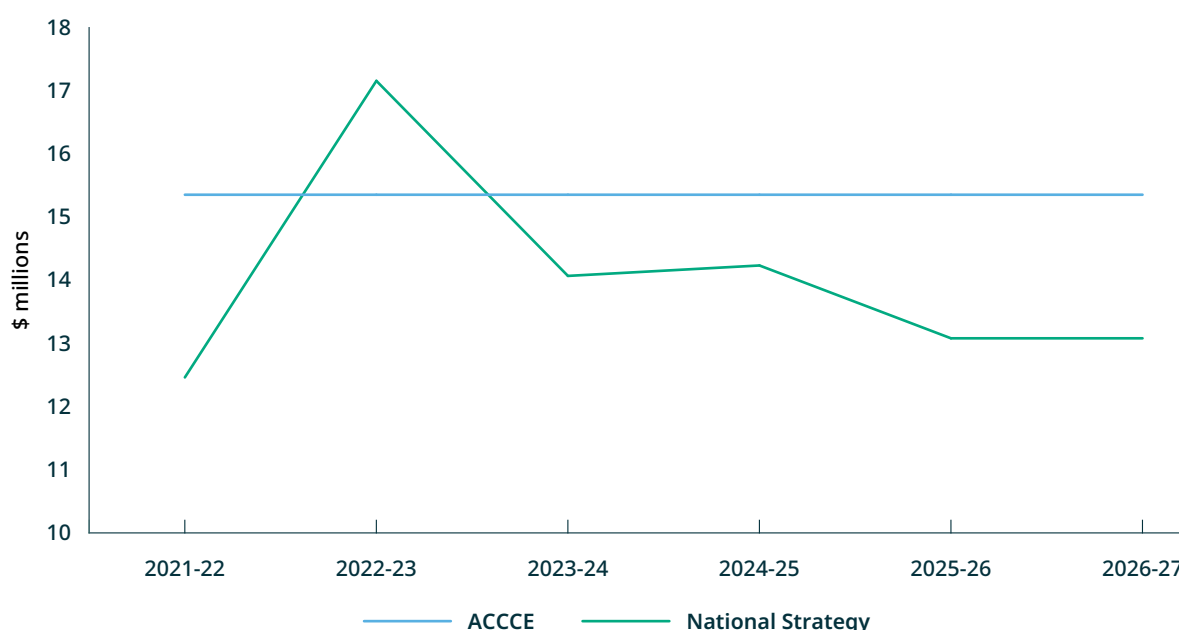
Multiple teams contribute to the goals of ACCCE:

- **Child Protection Triage Unit:** receives and assesses reports of child sexual abuse which come in from various agencies and triages them to determine what further action is required.
- **Covert Online Engagement Unit:** works in online environments to target, infiltrate and dismantle child sex offender networks.
- **Intelligence Fusion Cell:** provides intelligence support and monitors emerging threats.
- **Technical Capability Unit:** provides on-site support for frontline investigators and intelligence analysts through their technical expertise.
- **Partnerships and Outreach Team:** is responsible for leading outreach initiatives and stakeholder engagement.
- **Online Child Safety Team:** leads the national delivery of online safety education, prevention, and outreach initiatives across Australia.
- **Operations Development and Disruption Unit:** coordinates national operations between ACCCE, State and Territory Joint Anti Child Exploitation Teams (JACETs), and overseas law enforcement such as Interpol and Europol.
- **Victim Identification Unit:** leads the national coordination and de-confliction of victim identification efforts, operating as the conduit between Australian law enforcement and the International Child Sexual Exploitation database.

The AFP also provides funding for the NCMEC to employ a dedicated analyst for reported CEM which involves Australian victim-survivors or perpetrators.

The Human Exploitation Command of the AFP, incorporating ACCCE, has approximately 100 full-time equivalent staff. The AFP received \$68.6m over four years in the 2018–19 budget for the establishment of the ACCCE (ongoing at \$15.35m annually). The AFP also received funding under the National Strategy to Prevent and Respond to Child Sexual Abuse of \$109.8m over four years from 2021–22. From 2025–26, AFP will receive \$13.1m ongoing until 2030 to continue to deliver National Strategy commitments.

Figure 2: AFP funding for ACCCE and National Strategy measures 2021-22 to 2026-27



While recognising the triaging processes they have implemented that prioritise children at the highest risk of harm, the AFP advised the Board that frontline police would be able to do more with additional resources. With the increasing number of reports to the ACCCE, processes are constantly being reviewed to identify innovative new ideas and best practice. Technological solutions are also being enacted to increase efficiency and limit the psychosocial impacts for staff.

Queensland Police Service

As the number of sexual offences reported to authorities has increased, so have the demands on policing services. In response, QPS has increased its resourcing across all key operational areas related to the investigation of child sexual abuse offences and management of convicted perpetrators.

The period over which the offender committed abuse was characterised by significant demands on police in Queensland and Australia, both in terms of the novel and rapidly changing impact of the Covid-19 pandemic from 2019, several reviews and inquiries which identified inefficiencies in QPS resourcing and operations, and changes in senior leadership.

[During Covid-19] the QPS has maintained business as usual policing operations with some adjustments to certain activities to reduce the risk of potential transmission of Covid-19. To prioritise the allocation of frontline resources to the Covid-19 response, the QPS deferred police attendance for some standard operational duties...

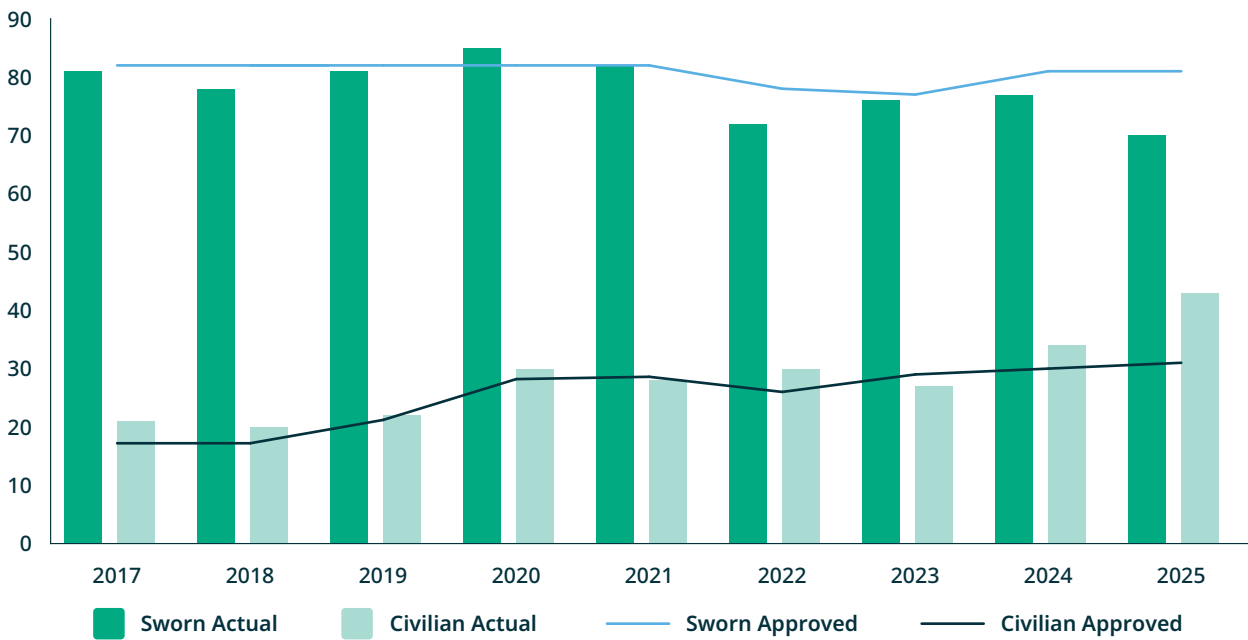
The rapid and frequent changes to public health measures in Queensland have required unprecedented levels of responsiveness and scalability from QPS...⁷⁸

The deployment of police officers to frontline roles instead of support, coupled with a general focus on recruitment to these roles, contributed to a general decrease in the number of officers available to do this work.

The data also shows that the organisation was tired and overworked and angry, because we're into the second year of COVID, and they honestly believed that the senior executive could not appreciate that the pressure was - what they were under. And on top of that... that they couldn't meet demand already from two, three previous years, and here we were putting 12, 1,300 some days to COVID, and on top of that we were going through massive reform, and particularly also in areas like [the Service Delivery Redesign Project] that had even more negative responses about leadership in that regard.⁷⁹

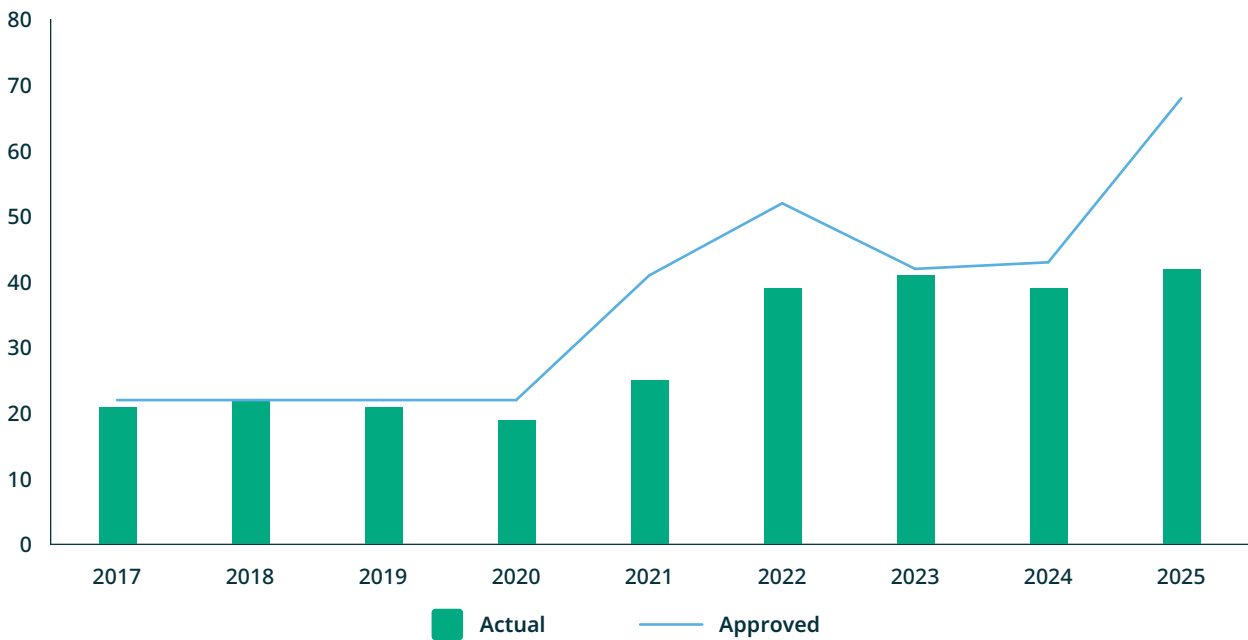
Data shows that the Child Abuse and Sexual Crime Group (CASCg) has experienced a shortfall in sworn officer allocations since 2020 despite largely consistent funding levels for over 80 full time equivalent (FTE) roles. Conversely, the proportion of civilian staff in CASCg has been steadily increasing since 2017, in excess of funded FTE positions.

Figure 3: Child Abuse and Sexual Crime Group (CASCg) Approved and Actual FTEs 2017–25



Within CASCg, CPOR has significantly increased its sworn officer FTE positions. In 2025, significant additional resources have been allocated to CPOR in response to a demand model request for growth.

Figure 4: Child Protection Offender Registry (CPOR) Sworn officers approved and actual FTEs 2017–25

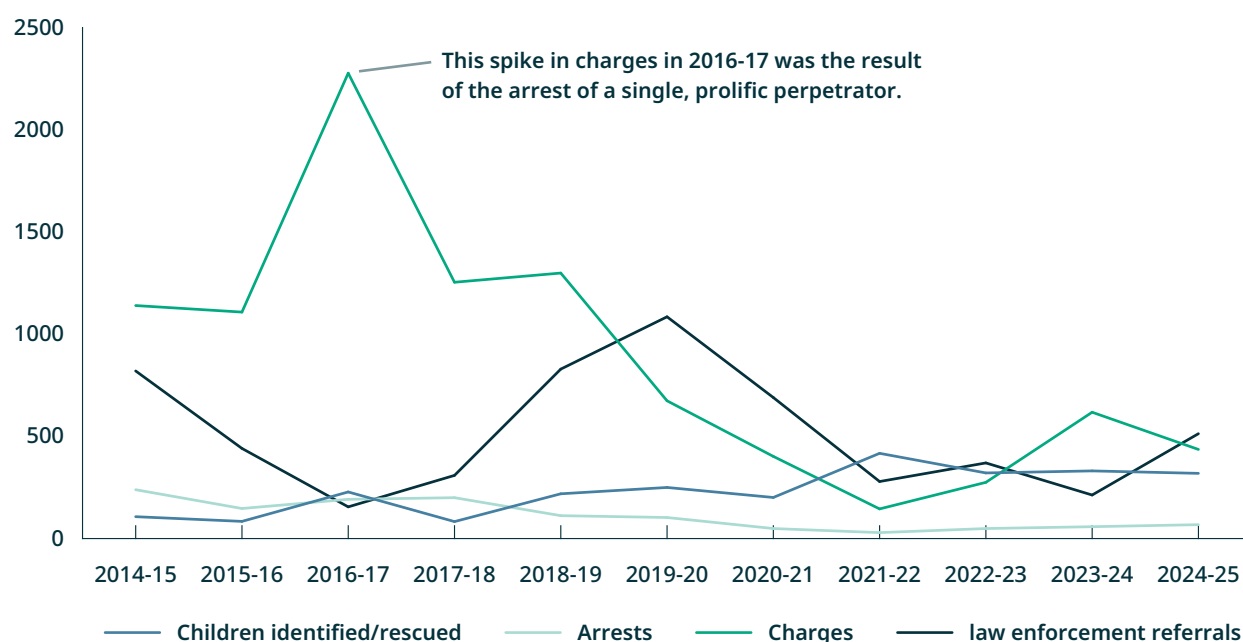


QPS also provided advice to the Board that funding for national responses to online offending has not been shared equally across jurisdictions, resulting in demand-management pressures between Commonwealth and Queensland law enforcement entities:

The First Commonwealth Action Plan [to Prevent and Respond to Child Sexual Abuse 2021–2024] focused on Federal agency responsibilities, including increased funding and resourcing for the Australian Federal Police (AFP) to enable them to better triage and on-refer NCMEC files. To date, no additional funding has been allocated to state- or territory-based policing agencies. As a result, all states and territories are now experiencing a significant increase in NCMEC files referred from the AFP. The QPS estimates it has experienced and is continuing to experience an increase of approximately 90–96% in NCMEC referrals.

While the recognition that an increase in offender management at CPOR has led to a commensurate increase in staffing allocation within that unit from 2020, the general decrease in personnel in CASCg may have adversely contributed to a reprioritisation of child sexual abuse and CEM efforts within the Argos unit.

Figure 5: Argos activity outcomes 2014-15 to 2024-25



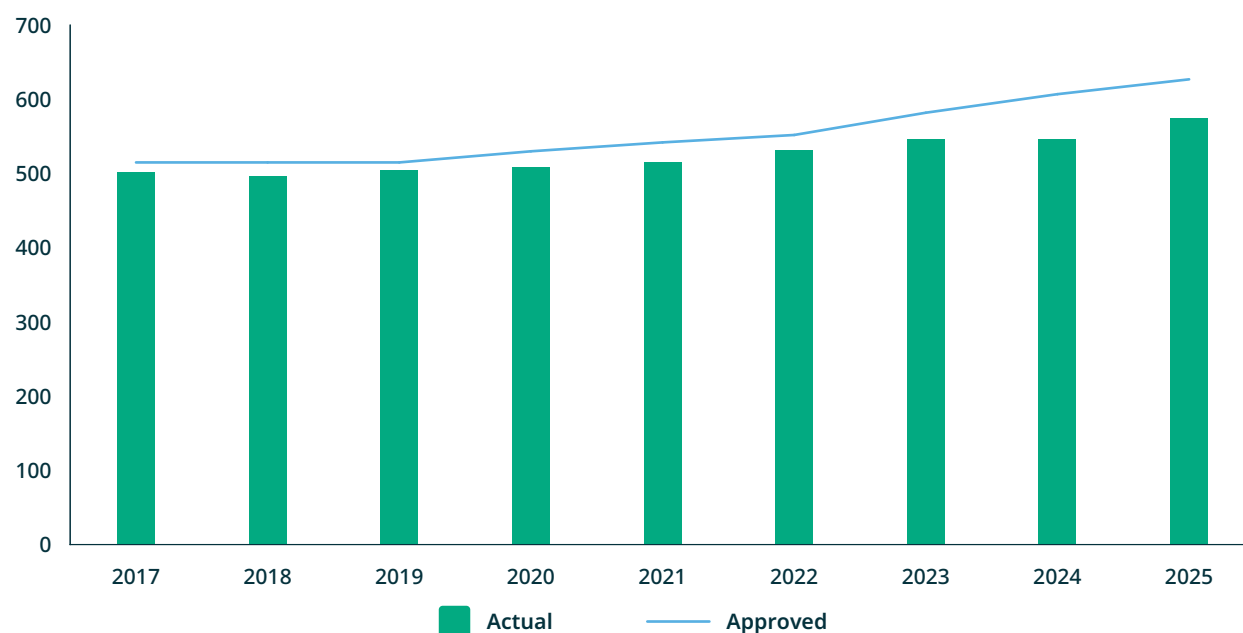
Source: QPS Annual Reports 2014-15 to 2024-25.⁸⁰

Data on Argos activities indicates that the number of arrests and charges made against perpetrators sharply fell off with the commencement of the pandemic. QPS expects the Argos workload to continue to significantly increase as CEM becomes more prevalent and new threats emerge:

The Argos Taskforce is responsible for triaging and 'packaging' (organising the necessary groundwork in identifying perpetrators and organising warrants) for referrals out to the District CPIUs. In light of the district workloads, Argos reports managing as many of these files as possible to alleviate the strain on districts already under pressure from other child protection matters. Based on the increase in NCMEC referrals being received, the QPS anticipates an increase in offences relating to online child sexual exploitation over the next several years.

In comparison to CASCg, resourcing for sworn officers in Child Protection Investigation Units (CPIU) across the state has been slowly but steadily increasing. However, the actual number of assigned CPIU officers has failed to keep pace with this increase in resourcing:

Figure 6: Statewide CPIU Sworn officers approved and actual FTEs 2017-25



QPS have advised that it anticipates it will experience further resourcing pressures associated with the implementation of Child Safe Standards and the Reportable Conduct Scheme in Queensland.⁸¹ In particular, they consider that the Reportable Conduct Scheme will impose great demands on QPS, both as an investigatory body and custodian of vast amounts of information that may relate to incidents of reportable conduct.

QPS has estimated that an additional 45 detective constables will be required by CPIU teams statewide to address the increased demands on police to investigate allegations of criminal reportable conduct, rapidly increasing to an additional \$10 million in required funding. They anticipate that significant demands will be placed on QPS civilian staff units to comply with information sharing requests, including flow on impacts to CPIUs, and the Child Abuse and Sexual Crime Group.

Key challenges faced by QPS include a rising volume of notifications placing strain on specialist investigators and contributing to case backlogs. QPS have advised the Board that staffing shortages, particularly in regional areas, have led to a junior workforce with limited access to training and development. Filling CPIU roles is challenging, with these positions being unattractive to many personnel due to the nature of the work (which, in a problematic and contradictory arrangement, involves both protecting and policing children).

Staffing shortages leading to sustained high work demand, and limited access to training or development opportunities, especially in remote and regional areas, has impacted CPIU workforce recruitment and retention. As a result, the CPIU workforce in some locations is relatively junior, with a reduction in the number of experienced senior detectives and investigators available.

Investigators are also burdened with non-core responsibilities and face infrastructure and technological limitations, such as inadequate interview facilities and digital forensic tools. Additionally, the complexity of historical abuse cases and the surge in online child sexual exploitation offences have increased demand on specialist units.

QPS advises that there has been an increasing reliance on police to carry out non-core functions on behalf of other agencies. This includes activities that fall outside conventional law enforcement but have, over time, been taken up by the QPS, particularly when responsible agencies are not available to meet community safety expectations. This extension of policing responsibilities is impacting on the QPS to meet its core functions including conducting criminal investigations.

To address these issues, QPS reports that it has:

- initiated the CPIU Workload Management Project to assess and alleviate workload pressures
- allocated new positions to CPIUs and Child Protection Offender Register teams in anticipation of legislative changes and the rollout of the Reportable Conduct Scheme
- expanded training programs to include trauma-informed and victim-centric approaches, with specialist courses for investigators handling cases involving very young children
- supported broader systemic reforms, including improved information-sharing protocols, community education on grooming behaviours, and legislative changes that facilitate the prosecution of serial offenders
- continued to partner with external support services and initiatives like the Queensland Intermediary Scheme and PACT to further enhance support for victims and improve investigative outcomes.

Operational Recommendation 10: Prioritising law enforcement resourcing—both personnel and technological

Queensland has set an international benchmark in policing child sexual abuse through its specialised units and collaborative initiatives. These units demonstrate profound levels of resilience, dedication, and strategic innovation. From meticulous digital investigations to global collaboration, the work of CPIU's, Argos, ACCCE, and JACETs showcases the state's commitment to keeping children safe and has positioned Queensland and Australia as a global leader in child protection law enforcement. Argos, based in Brisbane, is recognised globally for its innovative, proactive approach to online child exploitation. Its work has directly rescued hundreds of children, dismantled complex networks of perpetrators, and prosecuted high-profile cases with exceptional precision.

ACCCE and JACETs exemplify the power of collaborative, cross-jurisdictional operations. ACCCE has coordinated responses to hundreds of complex cases nationally, while JACETs have enabled rapid identification, arrest, and prosecution of offenders by combining federal and state expertise. ACCCE and Argos are internationally recognised for best practice methodologies in victim identification, digital forensics, and offender disruption. This includes in the case under review by the Board. Despite its other failings, the policing work done to track the origins and owners of bedding in an image shows the remarkable policing feats victim identification staff do to bring perpetrators into the light, and into justice.

This global best practice leadership is at risk. Officers involved in child protection and exploitation investigations are operating under significant and growing pressures. Interviews with frontline officers highlighted the extraordinary demand placed on their time and expertise, particularly in relation to managing and analysing electronic evidence and CEM.

The Board is concerned that many of the individuals that have made these units a success are working in small teams with growing demand pressures. The ability to build capability, transfer experience and 'pass on the baton' does not appear strong. This work is relentless and exposes officers and staff to the worst acts of depravity.

Officers we spoke to as part of this Review described spending weeks categorising and reviewing seized electronic files, noting that they typically execute two to three warrants per week, but believe that their workload could realistically support two to three warrants per day if resources were sufficient.

Similarly, victim identification staff—whose role involves painstakingly examining CEM to identify victim-survivors, locations, and perpetrators—reported frustration at months spent reviewing material that is already dated, often from previous arrests. They spoke about meticulous coding processes, which while essential for evidentiary purposes, is extremely time-consuming. Officers noted that with appropriate technology, including AI-assisted analysis, much of this work could be performed instantly, freeing their time for higher-value investigative activity.

While law enforcement has historically focused on prosecuting offenders, victim identification remains under-prioritised, despite being critical to rescuing children from active abuse. A shift towards victim-centred policing is essential. This includes greater investment in tools that can rapidly identify victims within AI-generated content, and support proactive interventions.

This issue was similarly considered by the Queensland Organised Crime Commission of Inquiry in 2015, which recognised that the classification of CEM takes an 'enormous amount' of time for police and staff in law enforcement agencies.⁸² The final report of the Inquiry noted that this 'task takes resources away from victim identification and the priority of rescuing those children from further harm' and that 'the time taken by police to classify the images and video files often means delays in prosecuting offenders'.⁸³

These issues are not new, but we do have emerging technologies that could assist in addressing them, while also minimising the extent of exposure to CEM faced by officers in categorising such material.

Recent decisions have impacted the capacity for law enforcement to explore the use of this type of technology. For example the Australian Information Commissioner made a determination on 3 November 2021 that Clearview AI Inc 'breached Australians' privacy by scraping their biometric information from the web and disclosing it through a facial recognition tool'.⁸⁴ The Board is concerned that decisions of this nature are limiting the ability of police to effectively respond to online child sexual offending.

The Board has heard from experts that the lack of a centralised database of victim-survivor images inhibits the process of identifying victim-survivors who appear in CEM found online. While privacy concerns inherent to gathering biometric data of children are legitimate and acknowledged, these must be weighed against their rights to safety and security. The Board considers that Australian privacy laws are currently not sufficient to empower law enforcement with the tools they need to locate and protect victim-survivors of child sexual abuse in an increasingly digital world.

Another recurring theme from discussions with frontline officers was the lag between police capabilities and the technological sophistication of perpetrators. Both federal and state government procurement processes were cited as key barriers: police often find themselves two to three years behind in understanding and accessing the latest technology that perpetrators exploit to commit crimes and hide evidence. This technological gap exacerbates delays, limits investigative effectiveness, and can hinder timely identification of at-risk children.

Law enforcement agencies are also constrained by limited access to the specialised tools, training, and infrastructure needed to address AI-enabled child sexual abuse. At the same time, the absence of reliable data on the prevalence and nature of AI-generated child sexual exploitation material significantly impedes policy development and prevention efforts. Without investment in these foundational areas, Australia risks falling behind in its capacity to protect children from rapidly evolving digital threats.

A submission to the review advised:

Australia's current legislative and regulatory frameworks are not yet aptly equipped to address the growing risks posed by AI in the context of child protection. There is no unified, enforceable AI legislation, leaving significant gaps in accountability and platforms can avoid responsibility for harmful outcomes. Information-sharing across agencies remains fragmented, with no standardised national or international protocols to support coordinated responses to AI-facilitated exploitation.

These insights demonstrate that ensuring the safety of children requires properly resourcing law enforcement — not only in terms of personnel, but also in ensuring that they have access to advanced technology, training, and procurement agility. Without adequate investment, police will continue to operate reactively, constrained by outdated tools and overwhelming demand, rather than being proactively equipped to counter threats and address harm. A well-resourced police service is a critical component of a comprehensive child safeguarding system, complementing regulatory, oversight, and intelligence mechanisms across government.

An obvious first step in deciding what recommendations are appropriate is to look at how the system has operated in the past... The only way that perpetrators of sexual abuse can be brought to justice is through the machinery of those who investigate, prosecute and have the charges determined by relevant Courts. Anything which detracts from the efficiency of that process must be eschewed.⁸⁵

Operational Recommendation 10: Prioritising law enforcement resourcing—both personnel and technological

The Queensland and Australian Governments take immediate action to ensure that law enforcement agencies have the resources, tools, and capabilities necessary to proactively protect children from sexual abuse and exploitation. Specifically:

- 1. Resourcing frontline investigations:** The Australian Federal Police (AFP) and Queensland Police Service (QPS) should increase the capacity for Child Protection and Investigation Unit (CPIU), Joint Anti-Child Exploitation Teams (JACET) and Victim Identification Units to ensure timely and effective investigations, including the ability to execute more warrants and analyse electronic evidence without delay.
- 2. Technology parity:** The Queensland and Australian governments should review and reform procurement, policy, and funding arrangements to ensure police have rapid access to technology and analytical tools equivalent to, or ahead of, those used by perpetrators of child sexual abuse. This must include AI-assisted analysis, digital forensics software, and secure cloud storage solutions.
- 3. Integrated safeguarding approach:** These measures should be part of a broader, coordinated strategy to embed law enforcement as a fully supported pillar within Queensland's child safeguarding system, complementing regulatory, oversight, and intelligence mechanisms.

Both governments should publish this resourcing to ensure that organisational drift does not occur and that the public can monitor changes in resourcing over time.

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Structural impediments to safeguarding our children

It goes without saying that law enforcement agencies are not the only entities with a responsibility to act when a report of child sexual abuse is made. An enduring challenge noted by the Board in undertaking this Review is the consideration of what actions could or should be taken by agencies in response to a report of abuse, where there is a lack of evidence to substantiate that it occurred.

Given the hidden nature of child sexual abuse, the barriers to reporting faced by victim-survivors and the challenges in meeting the relevant evidentiary thresholds, it is critical that proactive and protective action is taken even in circumstances where complaints have not been proven beyond reasonable doubt. Although the matter of vexatious complainants was raised with the Board as a reason for regulatory entities and agencies to take no further action where a complaint is not able to be substantiated, it is likely that such matters should be identified early on in an investigation and dealt with accordingly.

Importantly just because a report of abuse is unable to be substantiated, does not mean that the abuse did not occur.

Perhaps the most complex challenge arises when safeguarding allegations are credible but cannot be substantiated to a criminal or civil threshold. In these cases, employers face a stark dilemma: allowing the individual to continue working despite concerns, potentially exposing children or vulnerable people to risk; or terminating employment and facing significant exposure under Fair Work legislation, including the risk of uncapped general protections claims or unfair dismissal damages.

Challenges addressing employee behaviours

The prioritisation of an organisation's reputation, a fear of defamation and legal risks to organisations and individuals may act as a deterrent to raising or sharing concerns about a person of concern, particularly where complaints have not been substantiated. As discussed in more detail in Part C, there were multiple instances where the offender did not pass probation in the centres that he worked in, or where he was terminated, offered a redundancy, asked not to return and/or dismissed immediately. In most centres there was very limited information available as to why the offender's employment was ceased.

The Board identified that this was potentially indicative of centres seeking to 'move a problem on' rather than taking decisive action against the offender.

In submissions made to the Review, one centre where offending is known to occur submitted that changes to employment law are required to enable employers to terminate educators without risk to an organisation if credible allegations of abuse have been made. This should be founded on a risk-based approach which operates in the best interests of a child and enables employers to take action.

Employees in Australia are protected from unfair dismissal under Part 3-2 of the *Fair Work Act 2009* (Fair Work Act). Generally, any employee who meets the minimum employment period and is covered by a modern award or enterprise agreement is protected from unfair dismissal. The Fair Work Commission (FWC) may be asked to make a ruling on whether the dismissal of an employee was unfair. To make a determination, it must find that 'the dismissal [was] harsh, unjust or unreasonable.' A dismissal must be for a 'valid reason'. It must be objectively defensible or justifiable on the relevant facts.⁸⁶

The employer bears the burden of proving to the civil standard that the valid reason existed. For allegations of misconduct, the employer must:

- carry out an investigation
- give the employee reasonable opportunity to respond to the allegations (procedural fairness)
- form the view, based on evidence, that the employee is guilty of misconduct
- form the view that, based on all the circumstances, dismissal is justified by the misconduct.

Within the early childhood education and care (ECEC) sector, there is no provision in the *Education and Care Services National Law (Queensland) Act 2011* (National Law) or *Education and Care Services National Regulations* (National Regulations) to dismiss an educator for allegations of misconduct or which places responsibility for adherence to the National Law or Regulations above industrial law. By comparison, when providing for employers' compliance with a requirement to end a person's employment (or to not begin it), the *Working with Children (Risk Management and Screening) Act 2000* explicitly provides protection for the employer by stating that 'The employer must comply with the provision despite another Act or law or any industrial award or agreement'.⁸⁷

The Board heard from employers who face challenges in addressing allegations of inappropriate conduct by employees which do not meet the threshold for reporting.

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*We need a really good, robust, code of conduct. It needs to focus on things like crossing professional boundaries with children and what that looks like in a particular setting and it needs to be explicit.*⁸⁸

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In the absence of evidence to support an allegation which would warrant a report to a regulator or the Queensland Police Service (QPS), or which is sufficient enough to substantiate a breach of a staff code of conduct, employers are left with having to face the industrial consequences of dismissing a worker or allowing them to continue, potentially in close contact with children. The Board also became aware of cases where employers find themselves in this situation even after having reported their concerns to police, as the complaint was unable to be substantiated.

One solution that avoids legal action under the Fair Work Act by the employee is to bind them and the employer to a deed of release, which often includes a significant lump sum payment to the employee for their agreement to resign voluntarily. These deeds of release frequently have non-disclosure clauses, preventing the employer from advising others of their concerns.

The 2019 FWC case of *Horan v Tren Trading Pty Ltd* dealt with immediate dismissal on the basis of allegations of physical abuse, and the employee was found to have been unfairly dismissed. This is discussed in detail below.

Horan v Tren Trading [2019] FWC 3249

Background

An educator was employed as an Early Childhood Teacher. She resigned in May 2018 to take a job at another service but was subsequently stood down pending investigation of a complaint alleging she yelled at and forcibly isolated a child. She was dismissed a few days later for alleged serious misconduct. The email in which she was advised of her dismissal stated:

I need to ensure that we meet the requirements of the Education and Care Services National Law Act 2010 and Education and Care Services National Regulations to ensure the safety, health and wellbeing of children. Your actions have put our service approval at risk, consequently, you have been summarily terminated due to gross misconduct effective immediately.

She filed an application under s 394 of the *Fair Work Act 2009* for unfair dismissal.

Allegation and Dismissal

An anonymous complaint alleged the educator forcibly removed a child and yelled at him. The employer alleged this breached the National Law and Regulations. The employee was asked to attend a disciplinary meeting but requested 24 hours' notice and written details. Her request was refused. The employer immediately dismissed the educator by email. She considered that the meeting was to 'ambush' her about the allegations. The employee did not attend the meeting due to lack of proper notice and details, as advised by their union.

Investigation and Evidence

Several staff provided statements supporting aspects of the allegations. There were conflicting accounts on whether the educator had used force or raised their voice. The employer claimed dismissal was necessary to meet regulatory obligations and protect the service's licence under the National Law. The educator denied yelling, being aggressive, or using force. They said the child was misbehaving and that they followed standard procedure to remove him to calm down.

This employee had no prior warnings or disciplinary issues and claimed the investigation was biased and flawed.

The employer argued that, as they had an obligation to inform ECRA within 24 hours of an incident involving a child, and to advise what steps they had taken to prevent a repeat of the incident, they were under a positive obligation to take immediate action against the educator. The employee had left them no other choice when she refused to attend a meeting.

Key Findings by the Fair Work Commission

The FWC found there was no lawful reason for dismissal. The evidence did not conclusively support the allegation, and the allegations of serious misconduct had not been substantiated to the required standard. Further, the accounts of staff used to support the dismissal were inconsistent and lacked reliability.

The FWC also found that the employer's investigation lacked procedural fairness and demonstrated a disregard for natural justice. Some staff were not interviewed until after the employee's dismissal. The dismissed educator was not given a reasonable opportunity to respond, and the FWC found her refusal to attend a meeting without proper notice was not unreasonable. It was ultimately determined that the employer's regulatory obligations under the National Law did not excuse their failure to follow process under the Fair Work Act.

Conclusion

The FWC found the dismissal to be both substantively and procedurally unfair. Role reinstatement was not deemed appropriate, but compensation was awarded. Procedural fairness is critical, especially in cases of serious misconduct which must be proven, not merely alleged. A valid reason for dismissal must be 'sound, defensible or well-founded' and dismissal by email in the absence of procedural fairness is prima facie unacceptable.

Insurance and civil liability

Under the legal principle of vicarious liability, an employer will generally be liable for torts (civil harms) committed by its employees. The *Royal Commission into Institutional Responses to Child Sexual Abuse* (Royal Commission) heard from many victim-survivors and institutions about the challenges of securing redress for child sexual abuse, particularly historical cases, due to a) officials of some institutions not being considered 'employees' at law and b) the harm caused by child sexual abuse not being considered to be done 'in the course of employment'. The Royal Commission ultimately recommended that states and territories should take action to address this legal technicality.⁸⁹ In Queensland, amendments to the *Civil Liability Act 2003* in 2019 ensured that victim-survivors are able to sue institutions and receive compensation even when these barriers exist.

“*There is no deeper responsibility for institutions liable for child sexual abuse than to shoulder the burden of making reparations to the children they so terribly failed.*⁹⁰”

Civil liability payments can be a significant and potentially debilitating cost to institutions. Other financial costs incurred by organisations in the course of addressing child sexual abuse include investigation and legal costs, costs to address environmental risks, or payments made to impacted employees (such as those made under deeds of release).

The Royal Commission also recommended that all state and territory governments must require organisations which receive funding to deliver services for children to hold appropriate insurance to cover the impact of abuse. This was intended to ensure that a victim-survivor would not be prevented from accessing redress where services are delivered by non-government entities which may lack significant assets or be in an unincorporated structure that limits their ability to control or access funds.

The National Quality Framework also requires that all ECEC providers must take out and maintain public liability insurance of \$10 million or greater as a condition of service approval.⁹¹

The Royal Commission further recommended changes to the civil liability statutes in each jurisdiction to introduce a statutory duty of care for organisations to take all reasonable steps to prevent the abuse of a child by a person associated with the institution while the child is under the institution's care, supervision, control or authority of the institution, as well as a 'reverse onus' on the institution to prove it met the duty of care when a claim is brought against them by a person alleging abuse. These changes were enacted in Queensland through amendments to the *Civil Liability Act 2003* which came into effect in March 2020.

Although limitation periods on civil action for child sexual abuse claims have largely been eliminated in Queensland as part of the implementation of recommendations by the Royal Commission,⁹² uncertainty remains in these types of proceedings particularly against larger institutions. For example, a defendant may petition the court for a permanent stay on proceedings where they suggest a lawsuit is an abuse of process. In a significant recent case, the High Court overturned a decision to grant a permanent stay in favour of the State of Queensland in a historical child abuse lawsuit, on the basis that such a decision should only be a last resort in exceptional cases because of the removal of limitation periods.⁹³ As discussed elsewhere in this report, most victim-survivors may disclose their abuse many years after it occurred. This interpretation therefore provides certainty for victim-survivors who are not able to bring an action for compensation within the prompt timeframes insisted upon by the courts prior to the Royal Commission.

The insurance market has experienced challenges in this space due to the increasing number of historical child abuse claims being made, particularly against religious institutions.⁹⁴ This reached a point in 2023 when the Queensland Government began to indemnify institutions for abuse payouts, to ensure that victim-survivors could continue to receive fair payments despite the failure of the market.⁹⁵

Conversely, this has opened new opportunities for specialist insurers to enter the Australian market, providing safeguarding packages to reduce institutional risks and respond to claims efficiently. For example, Ansvar Insurance has developed a Physical and Sexual Abuse policy in consultation with Hetty Johnston AM to provide specialised insurance to organisations, which incorporates safeguarding and risk mitigation measures.⁹⁶

The above insurance and civil liability pressures, in concert with the difficulty and expense of removing employees who are subject to allegations of abuse, creates a perverse financial incentive on institutions not to report and/or to cover up instances of abuse, further endangering children.

The implementation of Queensland's Child Safe Standards represents a critical opportunity to keep children safe by embedding child safety in every aspect of an organisation's operations, including leadership, governance, staff conduct and service delivery. They must be implemented by businesses or organisations working with or providing spaces and facilities for anyone 17 years and under. This includes small volunteer and community groups, sole traders, as well as established organisations, such as hospitals, schools and churches. The Reportable Conduct Scheme places a further responsibility on organisations to report and investigate allegations of harm to children by their employees or others associated with the organisation and gives the Queensland Family and Child Commission power to conduct its own investigations when this is in the public interest to do so. Failure by an entity head to notify the Queensland Family and Child Commission of reportable allegations is an offence attracting a fine of over \$16,000.

Recent legislative amendments have been enacted in other jurisdictions to ensure that regulators and organisations place the rights and best interests of children first. For example, in September 2025 changes to the National Law legislation in New South Wales (NSW) were introduced into the NSW parliament. This followed a review into the regulation of ECEC services in NSW which 'found the regulator was significantly constrained by the National Law'.³³ The amendments have brought forward changes to the National Law recommended by the Review of Child Safety Arrangements under the National Quality Framework which are yet to be enacted nationally. Changes to the National Law in NSW include:

- creating a paramount obligation for the sector regulator and providers to place the rights and best interests of children first
- empowering the regulator to suspend or revoke quality ratings during or in response to an investigation, and to suspend individual educators
- significantly increasing financial penalties against providers for breaches of the national law, including a 900 per cent increase for large operators, and a broadening of the scope of breaches liable to penalty
- introducing a new power for the Minister or the regulator to issue a binding direction to the sector where they perceive there is an unacceptable risk to child safety.

Economic and governance concerns in for-profit early childhood education and care

The early childhood education and care (ECEC) sector has experienced sustained growth in profitability, particularly among large for-profit providers. Market consolidation and increasing private equity involvement have driven strong financial returns, with many providers reporting significant margins. However, these profits have not consistently translated into higher quality or improved child safety outcomes. Despite high and rising fees for families, there is limited evidence that additional revenue is being reinvested into frontline quality, workforce capability, or safeguarding systems.

From an economic perspective, this reflects a market failure in quality signalling. Parents are price-takers in a complex market where information asymmetry prevents them from accurately assessing the safety or safeguarding quality of a service. In this context, accreditation and regulatory compliance are treated as proxies for safety, but current frameworks, including the National Quality Framework, do not adequately measure or communicate safeguarding performance. As a result, financial incentives are misaligned: providers can capture revenue and market share without proportionate investment in the systems and workforce that ensure the safety of children.

A stronger policy and regulatory approach is needed to realign financial incentives with safety outcomes. Owners, boards, and executive management of ECEC providers must bear clear accountability for child safety breaches, supported by statutory obligations and transparent governance standards. The introduction of enforceable duties, similar to those in workplace health and safety law, would ensure that safety is treated as a board-level responsibility, not a compliance burden delegated to front-line staff.

Liability and insurance settings should also be recalibrated to reinforce these incentives. Where safety breaches result in tangible financial exposure through liability, reputational, or insurance consequences, rational economic actors will internalise these costs and reinvest more systematically in safety governance and safeguarding infrastructure. Over time, this would create a virtuous cycle of reinvestment, where maintaining high safety standards becomes not only an ethical imperative but also a financially prudent strategy.

In short, while for-profit ECEC providers play an important role in service provision and innovation, the current market configuration carries inherent risks. Without stronger governance, transparency, and accountability mechanisms, the pursuit of profit may continue to outpace the sector's investment in the very systems that protect children from harm.

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There may be leaders and members of some institutions who resent the intrusion of the Royal Commission into their affairs. However, if the problems we have identified are to be adequately addressed, changes must be made to the culture, structure and governance practices of institutions. A failure to act will inevitably lead to the continuing sexual abuse of children, some of whom will suffer lifelong harm. That harm can be devastating for the individual. It also has a cost to the entire Australian community.⁹⁶

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Reframing the approach required

Over the last half-century, Australia has fundamentally transformed the way it thinks about protecting workers. What began as fragmented, inconsistent, and largely reactive occupational health and safety regimes has evolved into a harmonised national system of Work Health and Safety (WHS) laws. These laws now span across sectors, industries, and state borders, providing a consistent framework that holds organisations accountable for creating safe environments and preventing foreseeable harm.

In contemporary Australia, worker safety is no longer a peripheral compliance issue—it is a core responsibility of CEOs, boards, and shareholders. The Australian approach has elevated employee safety from being an operational concern to a central matter of corporate governance and liability. Today, directors can be held personally accountable for breaches, insurers price risk based on safety performance, and shareholders expect transparent reporting on workplace harm. This transformation did not occur by chance. It was driven by a recognition that worker safety is a systemic duty of care that organisations owe, not an optional extra. The legislative framework reinforced this by imposing positive obligations, ensuring consistency across sectors and states, and creating enforcement powers that made negligence not only reputationally damaging but legally and financially untenable.

The parallels with child safeguarding are unmistakable. Just as workers in the past faced unacceptable risks due to piecemeal regulation and organisational priorities that did not regard safety, children today remain exposed to preventable harms because our institutional safeguarding systems are fragmented, inconsistent, and unevenly applied across settings.

Child safeguarding now stands at the same crossroads. Despite growing awareness of the risks children face in organisational settings, safeguarding is often treated as an administrative exercise rather than a core corporate responsibility.

Boards do not yet treat child safety with the same urgency as worker safety, and senior executives rarely face the personal accountability that they do under WHS law. This disparity is striking: society rightly demands that a factory floor be safe for employees, but an ECEC centre, residential care home, sports club, or school is not held to the same expectations for vulnerable children.

As so aptly articulated in the 1999 Report of the Commission of Inquiry into Abuse of Children in Queensland Institutions:

Children are our most precious resource. They are our future. Their experience as children will determine what kind of adults they become and what kind of society there will be. One act of abuse or mistreatment towards a child is one act too many. Repeated acts of abuse that have gone unrecognised and unaddressed are inexcusable. Although there have been many reasons presented to the Commission as to how and why the abuses took place, none excuse the abuse, nor do they excuse the failure of those in authority in government, churches and society in general to effectively deal with complaints of abuse. We have failed these most disadvantaged and powerless children in the past. It is vital that we do not continue to do so.

Adequate accountability systems are not in place, in institutions or on the part of the Department, to ensure that children are protected, and to ensure that where abuse occurs it is appropriately dealt with. Improving monitoring and accountability is the centrepiece of our recommendations for the future. In making our recommendations we conclude that although it was individuals who perpetrated each act of abuse, they alone cannot shoulder the whole responsibility.

Some measure of responsibility must be taken by those to whom the abuses were reported and who did not act, those in charge of the institutions who did not have sufficient safeguards in place to protect the children, those members of religious organisations who turned a blind eye, the staff and the management of the Department of Children's Services who did not adequately monitor the children in their care, successive State Governments that have not sufficiently valued children to adequately resource the Department entrusted with their care, and society, which ignored or accepted what happened to children in the care of the State. As a State, we must face up to past wrongs and make proper redress, and ensure that when children are in our care we do them no harm.⁹⁷

A 50-year journey to harmonise how organisations are responsible for worker safety

WHS laws in Australia have evolved over many years to create a safer working environment for employees and employers. Before the 1970s, there were limited and varied regulations around workplace health and safety across Australia. Each state had its own legislation, and safety standards were not uniform. Most of the laws focused on specific industries (such as mining, construction, etc.) and were often reactive rather than proactive in addressing health and safety risks.

In the 1900s industrial safety laws began to emerge but they were often focused on specific hazards such as machinery, fire safety, and hazardous substances. By the 1930s–1940s industrial safety was still treated as an issue of personal responsibility rather than something that required systemic management. Regulations were often inadequate, and workplace accidents were common.

The 1970s saw significant changes in how WHS was approached in Australia, largely driven by international movements, growing industrial advocacy, and increased awareness of workers' rights. In the 1970s there were attempts to implement more comprehensive safety standards in various industries, however, these were still largely irregular, with different standards across states and territories.

The 1980s marked a significant shift towards more consistent regulation, particularly with the introduction of national standards and codes of practice. During this time, safety standards were enforced more rigorously, with the establishment of specific health and safety authorities at the state level.

By the 1990s, the need for a unified approach to WHS laws became increasingly clear. Australia's economy was becoming more integrated, and there were growing calls for a national approach to industrial safety standards. Different state and territory laws created confusion, particularly for businesses operating in multiple jurisdictions. In 1991 the National Occupational Health and Safety Commission (NOHSC) was established to provide national leadership on occupational health and safety issues. Its role was to develop national guidelines, codes of practice, and technical standards. In 1995 the Model WHS Act was first developed by NOHSC to create a uniform framework across the country. It provided a model for states and territories to follow, though not all states and territories adopted it immediately.

The most significant reform in Australian WHS law came in the early 2010s when a process was launched to harmonise workplace health and safety laws across the country. This reform aimed to create consistent regulations, simplify compliance for businesses, and enhance protection for workers. Safe Work Australia was established and the *Workplace Health and Safety Act 2011* (WHS Act) was passed as a model law for Australian jurisdictions. The WHS Act was designed to be adopted by all states and territories, with only minor variations based on local circumstances.

Key features of the WHS Act included:

- a focus on risk management rather than prescriptive rules
- clear duties of care for employers, workers, contractors, and suppliers
- the introduction of workplace health and safety representatives and health and safety committees in larger businesses
- greater accountability and penalties for non-compliance, including the introduction of personal liability for officers (e.g. company directors) who fail to ensure compliance.

Child safeguarding in Australia sits at a point very similar to occupational safety in its early decades of reform in the 1970s and 1980s. At present, while there is strong intention, it is characterised by:

- **Fragmented systems:** Child safeguarding responsibilities are distributed across multiple regulators and oversight bodies, each with different mandates, definitions, and thresholds for action.
- **Sector-specific rules:** Requirements for safeguarding differ across sectors, education, sport, health, disability, and residential care, without a unifying framework.
- **Inconsistent accountability:** Some organisations face strong oversight (for example, through reportable conduct schemes), while others operate with minimal scrutiny.
- **Reactive models:** Too often, safeguarding efforts begin only after children are harmed, rather than addressing the early warning indicators and sub-threshold signals of risk that could help to prevent abuse.
- **Jurisdictional variation:** State-based Working with Children Checks, reportable conduct schemes, and standards create inconsistency, allowing risks to migrate between states or sectors.

The result is that much like the pre-reform WHS system, our current approach to child safeguarding is prone to failure at the points where children most need protection. The WHS journey demonstrates that meaningful change is possible, but only when governments are prepared to step back from siloed approaches and commit to a unified national framework and ongoing continuous improvement.

...15 years since the establishment of Australia's national system for regulating early childhood education and care services and the national law, and despite its many successes, we must acknowledge, confront and address the harsh realities of its failings. In large part, the national system has been reliant on goodwill. It has not required good behaviour at all times by law. Slowly, forces have crept into the sector—I would say nefarious forces—that have sought and been able to exploit the safeguards that were intended to protect wrongfully accused childcare providers or workers. Whilst only a small number across the system have sought to exploit these safeguards, they have harmed children, families and workers by focusing on profits over safety, leaving children vulnerable where the law should have better protected them.⁹⁸

The lessons are clear:

- **Shared responsibility:** Just as every employer is now accountable for workplace safety, every organisation that interacts with children must be accountable for safeguarding. However, WHS does not just place responsibility with one role or person. Every board member, CEO and employee has a duty such that everyone has a clear responsibility and role in ensuring a safe workplace.
- **Positive duty of care:** WHS laws introduced a legal obligation on organisations, their leaders, and their boards, to eliminate or minimise risks 'so far as reasonably practicable'. A similar positive duty to prevent harm should underpin child safeguarding law.
- **Harmonisation:** Workers should not be less safe depending on their industry or state, and neither should children. Safeguarding protections must be universal and consistent.
- **Prevention as the organising principle:** Both WHS and safeguarding must be grounded in risk management, hazard and threat identification, and early intervention—not crisis response.
- **Central leadership with shared enforcement:** WHS reform only succeeded because governments agreed on a harmonised model law, with regulators empowered to enforce it. Child safeguarding requires the same resolution.

“Valuing children and their rights is the foundation of all child safe institutions. Improving child safe approaches in institutions will reduce the risk of sexual abuse. The best interests of children must be the primary consideration.”

Transformational Recommendation 5: Strengthen child safeguarding duties and introduce corporate and personal accountability and liability for the safety of children

The history of WHS reform shows that fragmented, inconsistent, and reactive systems eventually give way to harmonisation when the public and governments recognise the human and social costs of failure. For child safeguarding, that moment is now. The evidence is overwhelming: without a unified, legally enforceable, and prevention-focused safeguarding framework, Queensland and Australia will continue to respond to crimes rather than prevent them.

A long-term strategy for child safeguarding must therefore chart the same course that WHS has taken: from fragmented and reactive to harmonised, preventative, and universally accountable. This is not only possible, but necessary if we are to create a society where children are as safe in their communities, schools, and organisations as workers are now expected to be in their workplaces.

Central to prioritising child safety will necessarily be new penalties for organisations and leaders who oversee processes that lead to harm. Severe consequences for non-compliance are central to shifting organisational behaviour, including leadership accountability, board oversight, insurance costs, and preventive systems. Significant cases and statistics from the WHS system stand in stark contrast to the current penalties available to organisations with weak safeguarding practices, who fail to detect, and respond to perpetrators of child sexual abuse, and prevent their employment.

Between 2020–2024, there were 1,373 WHS prosecutions nationally, accumulating \$164.22 million in financial penalties.⁹⁹ In 2023 alone, there were 293 prosecutions for WHS law breaches; total penalties approached \$40 million.¹⁰⁰ The average financial penalty per case over the four years to 2024 was \$122,920.¹⁰¹

The enforcement of WHS laws in Australia has shown that strong penalties, applied consistently, are powerful levers for changing organisational behaviour. Recent cases illustrate how fines, custodial sentences, and leadership accountability transform workplace safety from a compliance exercise into a core governance concern.

Table 4: Recent WHS case examples

Case	Jurisdiction	Outcomes
SafeWork NSW v A1 Arbor Tree Services Pty Ltd and Anor [2023] NSWDC 256	New South Wales	Despite repeated opportunities to address serious safety concerns, the company failed to act. The court imposed a penalty of over \$2 million on the business, alongside a personal fine exceeding \$100,000 for its director. ¹⁰² This case is significant not only for the size of the penalty but also for its clear message: senior leaders cannot escape personal accountability when systemic safety failures cause harm.
WorkSafe (WA) v MT Sheds (WA) Pty Ltd (Unreported, Magistrates Court of Western Australia, Esperance, 2021)	Western Australia	This case was prosecuted under the old <i>Occupational Safety and Health Act 1984</i> (WA), rather than the post-2011 WHS model law. After a worker was killed and another seriously injured due to gross negligence, the company director was sentenced to more than two years in prison. This custodial penalty underscores that WHS duties are not optional, and when lives are lost through blatant disregard for safety, directors face the same level of accountability as in other forms of criminal negligence.
Agius v Metal Manufactures Pty Ltd and Jack Platt [2024] ACTMC 16	ACT	A site manager left heavy cable racks unanchored, leading to serious injury when one toppled onto a worker. The company received a substantial fine of \$500,000 while the manager himself was personally fined. This dual approach ensures that accountability is shared: both the organisation and its leaders are responsible for creating safe systems of work.

Taken together, these cases demonstrate the escalating seriousness with which regulators and courts approach workplace safety. The penalties are not symbolic: they are large enough to impact company viability, executive careers, and industry reputation. They influence insurance settings, shape boardroom discussions, and encourage proactive investment in prevention. Most importantly, they signal to all organisations that failing to prevent foreseeable harm carries consequences of the highest order. These high-profile penalties function as powerful levers for change:

1. **Leadership and board accountability:** When fines are large or when individual directors are penalised (financially or with imprisonment), it forces boards and executives to take safety seriously. Safety becomes a matter of governance, reportable KPIs, and reputation not just compliance documents.
2. **Insurance and liability costs:** With major penalties recorded publicly, insurers adjust risk ratings and premiums. Organisations without robust safety systems face higher insurance costs, loss of coverage, and reputational risk, creating financial incentives to prevent incidents.
3. **Preventive systems over reactive responses:** When penalties include damages for foreseeable risks that weren't addressed, organisations learn that prevention (risk assessment, safe systems, maintenance, training) is cheaper than litigation and fines.
4. **Regulatory deterrence and culture:** The visibility of large penalties sends a message across industries: non-compliance has serious consequences. This spreads into sector-wide culture: better audits, safer work practices, more internal reporting, and better leadership oversight.
5. **Encouraging reporting and transparency:** Organisations that know they can be held accountable—especially senior leadership—are more likely to invest in transparent reporting, worker consultation, and hazard identification rather than hiding or minimising problems.

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Protecting children and promoting their safety is everyone's business. It is a national priority that requires a national response. Everyone—the Australian Government and state and territory governments, sectors and institutions, communities, families and individuals—has a role to play in protecting children in institutions.

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Transformational Recommendation 5: Strengthen child safeguarding duties and introduce corporate and personal accountability and liability for the safety of children

That the Australian Government commences a national reform to strengthen and harmonise child safeguarding laws across jurisdictions, embedding corporate responsibility and liability for child safety in the same way that Work Health and Safety laws now apply to worker safety so that Commonwealth laws include enforceable corporate duties of care for child safeguarding, and significant penalties for organisations, their board and their leaders where safeguarding failures result in sexual abuse or exploitation or expose children to serious risk of harm. Such a scheme is to include the appointment of child safeguarding officers in medium sized organisations and above, and the explicit inclusion of child safeguarding within risk management plans and performance reporting.

While this occurs the Queensland Government should strengthen its own state-based legislation, including *the Child Safe Organisations Act 2024*, to introduce the above corporate and personal liabilities, duties and incentives for boards, owners, and workers to implement safeguarding practices as a requirement for operating a child-related business.

Endnotes

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Support and healing for victim-survivors

Our duty to support healing

“*Surviving abuse has fundamentally changed every aspect of my life, and I am not alone in this feeling* - Survivor-advocate

”

Society has a fundamental obligation to provide healing and support to victim-survivors of child sexual abuse. Victim-survivors bear the lifelong consequences of this abuse psychologically, emotionally, socially, spiritually and physically. These harms are compounded when responses from communities, institutions or the justice system are delayed, dismissive or inadequate. The moral imperative to act is clear: children and adults who have experienced sexual abuse are owed recognition, validation, and practical support to recover.

Effective support encompasses more than immediate crisis intervention. It requires sustained access to specialist, trauma-informed counselling and therapeutic services, and social and educational support tailored to the needs of each victim-survivor. It also involves facilitating safe avenues for victim-survivors to participate in decisions about investigations, prosecutions, and institutional responses to a report of abuse, ensuring their voices are central to processes that affect them.

Beyond individual care, the obligation is collective: governments, institutions, and communities must foster environments that acknowledge the harm done, reduce stigma, and create pathways for healing. This includes addressing systemic failures that enabled offending to go undetected, implementing preventive reforms, and maintaining accountability so that victim-survivors can have confidence that perpetrators are held to account and the conditions enabling abuse are not repeated.

Meeting this obligation is not only a matter of justice—it is a societal responsibility to ensure that victim-survivors of child sexual abuse are supported in achieving safety, dignity, and recovery.

“*Child sexual abuse is not rare, and it is not isolated...This abuse occurs across a range of settings; in institutions, families, peer relationships, and increasingly, online. It also rarely occurs alone. Children who experience one form of maltreatment are far more likely to experience others, including physical abuse, emotional abuse, and exposure to domestic and family violence. For many, child sexual abuse is the first in a series of violations that can shape the trajectory of their lives. That trajectory can be changed, but only if we act.*¹

”

The impact of child sexual abuse

*Early childhood represents a crucial period of development.... Experiencing traumatic events during early childhood can therefore be especially harmful. Studies have found that experiencing CSA [child sexual abuse] in early childhood is uniquely associated with heightened risk for abnormalities in the brain, including in regions that govern attention, visuospatial recognition, memory, self-reflection, emotional regulation and threat detection. Studies have also indicated that the institutional context appears to exacerbate some of the adverse impacts associated with CSA, including across psychological, social, physical, educational and economic domains. Institutional CSA creates complex trauma manifestations that require sustained intervention and support.*²

The impacts of child sexual abuse vary according to the type, duration, and frequency of abuse, as well as victims-survivors' individual characteristics and the perpetrator's relationship to them.³ There is no one predictable or 'correct' response to abuse. Research shows that a range of adverse outcomes can be experienced by victim-survivors throughout childhood and into their adult years, including:

- mental health issues, such as Post Traumatic Stress Disorder (PTSD), anxiety, depression, eating disorders, personality disorders, self-harm and suicidal ideation and behaviour
- disrupted attachment patterns, emotional regulation and social-emotional development
- physical health concerns, including chronic pain syndromes, heart disease, bowel disorders, reproductive system disorders, and other chronic conditions
- interpersonal difficulties, such as developing and maintaining friendships and intimate relationships
- risky or inappropriate sexual behaviours
- problematic substance use and/or gambling
- disruption to education and employment, and economic security.⁴

Further, boys and men who are victim-survivors of child sexual abuse are more likely to internalise outcomes, perhaps as a result of societal norms and a fear of being stigmatised.⁵ Abuse in institutional settings can also lead to a distrust of institutions and authority, and, for those who experience abuse in religious settings, impacts on spirituality.⁶

“*The trauma of child sexual abuse is not limited to the act itself. For the most part, families and victims are ill prepared for the act itself, let alone all of the trauma and navigating through the system in the aftermath* - Lived experience advisor”

The high-profile nature of some abuse cases, and subsequent media and political attention, may also serve to exacerbate harm. While inquiries and reviews are an important part of ensuring system transparency and accountability, the Board has been cognisant throughout this review of the impact on victim-survivors and their families. The Board has chosen to deidentify the centres where the offender is known to have been employed to ensure that the focus remains on system-wide issues, and opportunities for prevention, instead of the action or inaction of any single entity or individual.

Parents who were directly impacted by the offending in this case emphasised the need for answers with the Board, as they still do not know what happened to their children. While information contained in this report is confronting and distressing, it lays bare the missed opportunities for detection and attempts to provide these answers. As highlighted in the *Report of the Board of Inquiry into past handling of complaints of sexual abuse in the Anglican Church Diocese of Brisbane*:

...the damage caused by sexual abuse never just goes away. It may be pushed down and hidden for a time but it festers away and eventually resurfaces often with the damage multiplied and the agony intensified. We've seen this in the lives of victims of abuse where the damage goes on wreaking havoc for decades, destroying the life of the individual concerned and distorting close relationships...We cannot simply say, "Leave it behind. It's all in the past. It happened a long time ago. Move on". The only way we can move on is if we face the hurtful reality of what has happened, extend care and support to those harmed and take steps to ensure as far as possible that it never happens again.⁷

It is important to note that not all victim-survivors report experiencing ongoing negative impacts, with one study finding that up to 25 per cent of victim-survivors reported experiencing no psychological problems in childhood and up to 40 per cent of victim-survivors reported experiencing no psychological problems in adulthood.⁸

While children are vulnerable to adversities and associated negative impacts, they are capable of fostering positive development when provided with appropriate support. Secure attachments and supportive caregiving environments can promote recovery and resilience. This understanding of both the potential for harm and the opportunities for positive intervention underscores the critical importance of effective strategies to safeguard against child sexual abuse. By implementing robust safeguards and providing timely, appropriate support, we can work towards minimising the occurrence of child sexual abuse.⁹

For victim-survivors, outcomes are also highly dependent upon their access to support and interventions. High levels of support from parents or caregivers, family members, friends and the community may help protect against the adverse impacts of child sexual abuse.¹⁰

In submissions received by the Board, Bravehearts emphasised that supportive, protective, and emotionally available caregivers and families can mitigate some of the negative impacts of child sexual abuse. This highlights the critical need for services to also provide targeted support to families, not just victim-survivors.

...services must also provide targeted support to families, including psychoeducation, counselling, and case management, to address parental trauma, family dynamics, and systemic barriers to recovery. Strengthening family functioning enhances a child's sense of security and improves the efficacy of therapeutic interventions.

Research also demonstrates that positive coping strategies, such as disclosing, discussing, reframing and reinterpreting the experience of abuse, as well as asserting control and focusing on the future may assist.¹¹ Critically, victim-survivors need to feel comfortable and safe to share their experiences, and it is essential that their disclosures are believed and responded to. The dynamics of child sexual abuse mean that there is an inherent power imbalance between a perpetrator and a victim-survivor, and a fundamental loss of control. This can be further compounded when systems fail to listen, fail to believe and fail to respond.

Research conducted for the Board by the University of the Sunshine Coast emphasised the importance of ensuring that investigative responses are trauma-informed, meaning they are responsive to individual victim-survivor needs, and that support services for victim-survivors have a holistic approach which addresses structural barriers and incorporates peer and family support.¹²

Effective responses to child sexual abuse disclosures must be grounded in trauma-informed, victim-survivor centred practices. Services that are empathetic, confidential, and empowering can reduce the risk of re-traumatisation and encourage safer engagement with investigative processes. The quality and responsiveness of initial support services have a lasting impact, influencing both individual recovery and broader systemic effectiveness in identifying and responding to abuse.¹³

This report further emphasises:

- the **importance of systemic and holistic approaches which are multi-layered and coordinated** across systems of both formal and informal supports, including families, friends, health, police, child protection, schools, and trusted adults. Structural barriers such as service access and fragmentation, as well as stigma, must be addressed through systemic reforms to improve service accessibility and responsiveness.
- the **critical role of parents and caregivers in providing support to a child** who has experienced sexual abuse. It can help to reduce the symptoms of PTSD, improve mental health and emotional adjustment, enhance access to services and promote a sense of safety. Supporting caregivers themselves is essential to strengthening family dynamics and minimising secondary trauma.
- that **trauma-informed, child-centred approaches, as well as relational and psychological safety** are central to healing for victim-survivors who value emotional trust and consistency over purely information or practical support. Safe reliable relationships, with parents, caregivers, support providers or other trusted adults are critical. The involvement of parents and caregivers can also significantly increase participation and completion of therapeutic interventions.¹⁴

Peer support, and the role of lived experience

For older children, research increasingly emphasises the value of peer support, which is often perceived as more impactful than parental support. Peer relationships can provide emotional validation, connection, and a sense of being understood, helping children recover from trauma.¹⁵

*One participant described the support as a form of "emotional mentoring," emphasising the importance of building trusting relationships. Young people valued the relatability of the mentor having a lived experience of sexual abuse contributed to feeling understood and forged a deep connection of knowing.*¹⁶

Peer mentoring models, where adults with lived experience support children, show promising outcomes including improved wellbeing and reduced harmful behaviours as well as emotional and practical benefits through shared activities and informal support.¹⁷ Semi-formal mentoring, situated between friendship and professional support, also fosters trust, relatability, and practical assistance, such as attending appointments or navigating services.¹⁸

In recent years there has been a significant focus on seeking, incorporating and amplifying the views and perspectives of people with a lived experience in service, program and system design, planning and reform. The recent *Commission of Inquiry into the Tasmanian Government's Responses to Child Sexual Abuse in Institutional Settings* highlighted the importance of increasing participation of children and young people, victim-survivors and service providers in policy design and delivery in its final report as this 'not only shows children and young people that they are important, but also leads to better policies and decisions.'¹⁹

Children and young people must be at the centre of the response. Young people are offering practical solutions. Their insights are critical for designing services, policies and community responses that reflect real needs...This means embedding trauma-informed training across sectors, designing inclusive services with children's participation, and ensuring every system response is shaped by what safety looks and feels like to young people themselves.²⁰

Victim-survivor experiences

Throughout the conduct of this Review, the Board has engaged with people impacted by the offending and supported them to make submissions. This has sought to ensure the voices of victim-survivors and their families were central to our understanding of the case and the issues under the Review's terms of reference.

Although the young age and developmental stage of the victim-survivors in this case review may have impacted their capacity to recognise or report the abuse, some victim-survivors did recognise the offender's behaviour as wrong or uncomfortable. The available evidence shows that victim-survivors asked the offender to stop what he was doing, physically attempted to protect themselves, and questioned what he was doing on multiple occasions.

One parent of a victim-survivor described having sought support for their child by making a report to the Queensland Police Service (QPS), however they felt officers were 'really dismissive' and they were not offered support after leaving the police station. This parent reported having also approached a doctor, however, they were unable to obtain therapeutic support for their child or family. They were also unable to access support from sexual abuse counselling and support services. One specialist service was unable to assist due to a lack of criminal proceedings at the time (a condition of their service funding agreement) and the other because of service capacity issues. After several years support was found through a not-for-profit organisation, Bravehearts.

This parent described the ongoing impact of the offender's behaviour on their child. They spoke about the initial change in behaviour including the child looking 'miserable' and throwing 'tantrums', to long term impacts to this day. The parent described having made attempts to 'try and rebuild' their child's confidence, but that the experiences have been 'incredibly traumatising'. This parent reported studying psychology and engaging in studies on child trauma to ensure that they were able to support their own child.

Following the arrest of the offender, the Australian Federal Police (AFP) partnered with Bravehearts, Act4Kids and Queensland Health to provide support for children and families impacted by the offender's abuse and to ensure that they were able to refer families for specialist sexual abuse counselling and support. The Child Protection and Forensic Medical Service, situated in Children's Health Queensland Hospital and Health Service, established a dedicated service pathway to support victim-survivors and their families. It was noted by Queensland Health that 'the first referrals, received from families who would not typically have accessed the service due to the historical nature of the abuse, highlighted a critical gap in service access.' This recognition led to the collaborative partnership with the AFP, and resulted in the formalisation of a referral pathway. The AFP also utilised the QPS support referral network to provide unique or tailored support to impacted parties depending on their individual circumstances.

In total, Queensland Health advised that they had supported 20 children and young people, along with their families, following referrals from the AFP. This included providing psychosocial support at key stages, such as during the offender's sentencing, and in preparation for the appeal process.

It is a profound thing to note when a system has to create a new service or pathway for a critical incident. It should force us to question the adequacy of the former response.

The Board heard from one parent who engaged with the Queensland Health service and reported that it provided little value to them and their family at the time. This parent described having limited access to adequate support from the start but then having no support at all upon the family's relocation interstate. This family moved due to the trauma associated with the abuse.

Another parent advised the Board that:

We were in total shock — for weeks. And all of this happened in the final week of school. On Thursday, they graduated. On Friday, they received academic awards at a ceremony. That night was their formal. And on Saturday, they left for schoolies. It was surreal — a whirlwind of celebration overshadowed by trauma. I was just trying to keep going while internally falling apart.

*The AFP provided us with several options for support, and we contacted the Children's Hospital. My daughters and my mum attended one session, but the experience wasn't helpful. The counsellor told the girls their feelings were 'normal.' That response felt completely invalidating. When someone has just been told they were sexually abused as a child, the last thing they need is to be told that their feelings are expected or ordinary. **Their situation was deeply personal and unique, and it should never have been treated like just another case.***

I didn't go to counselling. I was focused on holding everything together. But since that day, I've lived under a constant emotional weight. It has impacted every part of my life, and my daughters' lives, in ways that are hard to articulate.

My mother was also living with us at the time and helped raise the girls. She picked them up and dropped them off at daycare and knew [the offender]. This has affected her just as deeply as it has affected their father and me.

Due to the young age of the children when the abuse occurred, and that some of the offending occurred when children were asleep, families also disclosed struggling with the difficult question of whether to tell their child about the offending, particularly in circumstances where their child has no independent recollection of the abuse happening, or to wait to see whether their child remembers.

Community submissions

As part of its call for public submissions the Board heard from other victim-survivors and their families unrelated to this case. In the community submissions received by the Board, one grandparent reported their family was told by police that their grandchild was 'too young and wouldn't be believed' after the child had disclosed experiencing sexual abuse which was perpetrated against them by a young male educator at an early childhood education and care (ECEC) centre. This child initially made a disclosure to a doctor, who encouraged the family to make the report to police.

A different parent who made a complaint about their own child's experience in an ECEC centre more recently, drew attention to the impacts of experiencing abuse, and how long-term support is not available for victim-survivors.

“*I noticed her behaviour that was terrifying to me, so I went out of my way to manage it. I had to take time off work and my mum took time off work to help us. “I have a 2yr old on a mental health care plan”. I had to take stress leave. The implications on everyone around have been enormous.* - Parent of victim-survivor

The Board also heard from another parent who reflected on the long-term impacts of child sexual abuse for their child stating:

“*Now in adulthood the natural process has been for her to find herself in abusive relationships. The layers of trauma are mounting with no appropriate help or support. All of us have suffered and still do to this day. Yes, support has been implemented, it's out there, yes there is much expenditure on funding but it's not reaching the individual for long term recovery.*

- Parent of victim-survivor, Community Submissions

Significantly, the Board was contacted by a parent who had tried to make a complaint to the QPS and the Early Childhood Regulatory Authority (ECRA) about abuse their child experienced in an ECEC setting while the Review was ongoing. Their submission highlights that while reforms may have been committed to by governments, and changes may be enacted at a structural level, individual agency responses can vary significantly in practice.

It's been a hard and fast week and a half since we learned activities that have occurred in the centre of our child, it's multifaceted in terms of experience we have had. Our entire time in the daycare we were at has been an issue – even when putting it in writing wasn't responded to and it got progressively worse. Don't believe that any parent who had the capacity to remove their child would have left them there.

Situation initially it was frustration, but then it was distress. There was no support from the management down, until the issue really came down to one of the employees disclosed some information I think out of empathy for me as a mother.

*My partner and I both saw the news and both polar opposites - so he headed down in rage and got the email and contact details of the owner, more than I ever got. I contacted community supports and got the default response – **I don't have enough to be even eligible to access support.***

Statement of accounts from the centre – never signed in or out. Raised these things but didn't realise until recently how unsafe this place truly has been. Many people are not as diligent or “annoying” as I can be they would give them up. Now there is just fuel on fire. Being told no that many times most people would have given up.

I don't know what outcome I want I just want everyone to do better. I don't want compensation, but I want accountability. Centre to be closed or have an overhaul. This is not ok for parents to be threatened. For those parents who can't move their children for whatever reason, they have to accept whatever they're given.

Unsure if it's a lack of understanding of the people I got to speak to on the phone and they don't know what to do or how to navigate the system.

Another community member reflected on the awareness of child sexual abuse and how 'average people don't understand sexual assault. The first thing they say that can't be true [sic] and this retraumatizes the victims'.

Submissions from a separate community member reflected on what they knew of the system responses by centres in this case.

I can't begin to imagine the overwhelming guilt and stress that their parents felt for leaving their children in the 'care' of this monster. By enrolling their children into a [Centre], the parents/guardians were unwittingly dealing with an institution which is notorious in reverting to a 'culture of silence' when things go awry. When confronted and challenged on sensitive and uncomfortable CSA [child sexual abuse] matters, it's incomprehensible, but they choose to be silent, which is neither a reassuring, respectful, nor a helpful response to those anxious paying customers whose children had suffered abuse. No response is still a response and CSA Victims and the community deserve a whole lot better.” - Community member

One parent reported having made several complaints regarding their child's experience, including to the police and the department responsible for Child Safety. They reported not having been believed, despite their child's presentation with sore private parts. The children's young age and lack of articulation of the abuse, was regarded as a lack of evidence and no action was taken as a result.

They reported the flow on effect that because of lack of charges in relation to their children, despite the offender being charged for offences against other children, their children were unable to access support. The parent described having approached the police and their local general practitioner seeking support for their children, however nothing was available. This parent highlighted the lack of crisis intervention and support provision to bystanders. They were of the view that the non-offending parent may not be best placed or may not be able to support the children following the arrest of the offending parent, hence the need for availability of support services for all affected. They were also of the view that like in hospitals, availability of social workers should be extended to police stations. This would allow for crisis intervention and immediate support.

The Board also heard that all children need a trusted adult who makes them feel safe. One victim-survivor informed the Chair: 'When I was abused, I thought I did something wrong, and I was scared to tell anyone'. They explained that they wished their parents had spoken with them about sex earlier, so that the disclosure conversation was not the first time they had ever discussed their private parts. They described the deeply confusing process of trying to understand what had happened, why it had happened, and what they should do next. While they agreed that children need education and training, they emphasised that this alone is not enough.

Unless parents and other adults are equipped with the skills to talk openly, respond safely, and receive disclosures with care, the protective impact of education for children will be limited.

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This testimony underscores a broader truth: safeguarding is not only about teaching children how to recognise risks, but about building a culture where adults are prepared to hear and respond. Victim-survivors consistently highlight that abuse thrives in silence—when children feel ashamed, isolated, or unable to seek help. Breaking this silence requires adults to take responsibility for creating safe spaces, normalising conversations about bodies, consent, and respect, and knowing how to act when concerns are raised.

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The Board concluded that strengthening community capacity to have these types of conversations is as critical as the formal systems of screening, monitoring, prosecution and enforcement. Ultimately, protecting children depends not just on the vigilance of institutions, but on the everyday courage and preparedness of adults in their lives.

Initial support to make a report

There has been a significant focus recently on strengthening system responses to victim-survivors of child sexual abuse when making an initial report. This has been driven by multiple reviews and inquiries, including the *Royal Commission into Institutional Responses to Child Sexual Abuse* (Royal Commission) in 2017, the Women's Safety and Justice Taskforce in 2022 and the Australian Law Reform Commission (ALRC) Report into reforming justice responses to sexual violence in 2025.

Collectively, these reports have consistently emphasised calls by victim-survivors to:

- be taken seriously and be believed by authorities, especially police
- be treated with respect and dignity by the justice system
- be offered appropriate and individualised treatment options and psychological support for themselves and their families
- have access to culturally safe and informed reporting pathways and response protocols, especially for Aboriginal and Torres Strait Islander victim-survivors.

In its second report released in 2022, the Women's Safety and Justice Taskforce highlighted that the current system for responding to sexual violence, including child sexual abuse, was difficult to navigate, retraumatising for victim-survivors and lacking in adequate and appropriate support.²¹ Many factors discourage and prevent victim-survivors from making a report, including:

- myths and stigma around sexual violence
- overlapping structural inequality in the police and criminal justice system
- outdated legislation
- lack of support
- difficulty navigating the system.²²

In its final report, the Women's Safety and Justice Taskforce noted that:

Queensland women and girls live in a society where gender stereotypes and rape myths continue to negatively affect their experiences of sexual violence, including in the service and justice systems.

For the courageous women who do make a complaint of sexual violence to police and continue it through the courts, the Taskforce has heard their journey is arduous. Too many give up. Many women and girls feel they are not believed and are treated disrespectfully by police, legal practitioners, prosecutors and judicial officers.²³

In 2024, a review undertaken by Griffith University found that victim-survivors frequently feel violated by both the perpetrator and the criminal justice system.²⁴ This research showed that many victim-survivors understand the criminal justice system does not prioritise their needs and their 'vision of justice'.²⁵ Research demonstrated that victim-survivors want voice, validation and vindication, and that these things are not necessarily given through punishing perpetrators, but through a process that helps them feel heard and supported.²⁶

A recent review into justice responses to sexual violence in Australia by the ALRC further emphasised the need to improve system responses to sexual violence.²⁷ The ALRC found similar themes to the other reviews discussed, including that few victim-survivors engage with the criminal justice system due to significant barriers to engagement.²⁸ Of those victim-survivors who do engage, the ALRC also found that they are not engaged in a safe, informed and supported way and often encounter myths and stigma about sexual violence.²⁹

Anticipation of a poor experience and outcome from the criminal justice system has a deterrent effect. Research shows that common myths about sexual violence can act as a deterrent for people who have experienced sexual violence because people are aware that if their experience does not align with these myths, or they do not have evidence of a physical injury, they will likely be subject to greater scrutiny.³⁰

We start by believing

“ *The voice of the child is the greatest guide.* - Queensland Sexual Assault Network (QSAN) member ”

As highlighted by QSAN in its submissions to the Review, children are unlikely to disclose their abuse to authorities and rarely disclose to parents or trusted adults. When they do, they are frequently not believed and their disclosures not taken seriously. Saliently, while several children did try to report their experiences of abuse in this case with the support of their parents, their concerns were largely dismissed due to a lack of evidence, with no substantive protective actions taken by any of the agencies involved.

In a consultation with QSAN members, it was highlighted that there continues to be misunderstandings about children's ability to disclose abuse, including the myth that children make up their experiences.

While children may not be able to fully articulate their experiences of abuse in a way that meets adult expectations, this does not mean that the report is incorrect or falsified. A critical review of studies examining the rate of 'false allegations' of child sexual abuse published in 2018 found that:

- nearly all disclosures by children about child sexual abuse are true
- only between two and five per cent of disclosures made by children about child sexual abuse are false
- it is more likely for children to provide 'false negatives', meaning they are more likely to state that child sexual abuse did not occur despite there being evidence that it did.³¹

To meaningfully improve our responses to child sexual abuse, we must first start by believing children, and creating environments where children feel they can speak up and be heard. QSAN members highlighted the need for people to be trained in how to understand child disclosures and what to do in response.

“ *In reality, false allegations are rare and represent only a small minority. Challenging these beliefs is essential to building a system where young people are believed, and reports are not dismissed to protect reputations or on the basis of misogynistic attitudes about false disclosures* - Survivor-advocate ”

The disclosure process

“ *As a 5 year old I was taken to the police station. It was an intimidating space, with well intentioned officers that didn't necessarily create a reassuring space to disclose the most intimate and horrific personal details. And at 5 years old, with no right words to use, and fear of the perpetrator hurting me and my mum, I disclosed minimal details* - Lived experience advisor ”

As discussed previously in this report, individuals who have experienced child sexual abuse face multiple barriers to reporting abuse and it is critically important that supports are in place to assist them to make a disclosure. In support of this, the Daniel Morcombe Foundation submitted that:

Children and families must receive timely, trauma-informed support following disclosure. Services should be accessible, culturally safe and child focussed family-centred.

Family and caregiver education plays a crucial role in strengthening early detection and complaint processes. A centralised directory of services, along with coordinated case support, would significantly enhance access to the right therapeutic and advocacy resources.

Disclosure of child sexual abuse is a gradual process which can occur at any time. Some children may disclose immediately or shortly after the abuse happened. Other children may wait to make a report or share their experience of abuse, including into adulthood. Some children will never report or disclose their experiences of abuse.

Disclosure is an ongoing process. It is influenced by a range of different factors and is dynamic in nature.

Disclosure is also staged, where victim-survivors may only share some details of the abuse that they have experienced. Depending on the response of the person who they are making a disclosure to, a victim-survivor may choose to share more or less information about the abuse. The impacts of trauma, challenges with memory and the time since the abuse happened can also shape what information victim-survivors are able to share.

“

Currently, education about CSA remains inadequate and influenced by victim-blaming narratives and fear-based approaches. Many young survivors, fearing punishment, disclose abuse to peers instead of trusted adults. The ACMS found that friend disclosure is the most common form of disclosure among young people. While this may show a culture of empathy and support among youth, it also reflects systemic failure. Inadequate sexual and healthy relationships education has adultified young people, forcing them into roles as first responders, counsellors, and disclosure platforms. Protecting children from abuse is the responsibility of adults - Survivor-advocate

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To help support disclosures, victim-survivors need to feel they will be believed and listened to. They also need access to people or systems they trust, and they need to be supported to make a report to police or other services if they choose.

When victim-survivors' initial disclosures are not believed or responded to, or the allegation is minimised, it can lead to a sense of helplessness and discourage them from seeking further support or assistance.

Understanding the disclosure process and the unique needs of each child, and creating an environment of safety and trust, can help to support someone to share their experiences. There are multiple ways to improve responses to disclosures so that children feel safe and supported to disclose. These include:

- ensuring children know that if they disclose, they will be believed and taken seriously and there will be action taken
- building a culture where the safety of children overrides concerns about information sharing, reputation and personal relationships
- ensuring responses are culturally safe and considerate of a child's identity and circumstances (culture, disability, sexuality, gender, socioeconomic circumstance etc.)
- making sure responses from centres, police and support services are trauma-informed and child-centred
- ensuring support services are available, accessible and acceptable.³²

Rapport building strategies can be helpful to overcome a victim-survivor's reluctance to engage.³³

For children, disclosures can be supported by:

- clearly explaining ground rules and engaging children in conversations about their interests
- using open and friendly body language
- listening attentively and offering small verbal cues to maintain engagement
- providing general encouragement that is not dependent on the content of the answers
- paying attention and exploring any emotional reactions a child may have.³⁴

The Board heard of other structural and system changes required to support victim-survivors to safely share their experiences of abuse. During consultation processes, QSAN members suggested that a call line for parents and caregivers might be useful where they are unsure if something really happened, so that parents could be supported to believe their child and know what steps they need to take to respond. This service would need to be a 'safe space' for parents and caregivers, allowing them to receive information in a way they understand and helping them feel comfortable with supporting their child and taking the next steps.

In a study undertaken by Griffith University to inform the Board's review, participants highlighted the importance of parents believing children when they make disclosures:

If the parents are supportive and believe the child or the victim, then there's better life outcomes. So, the earlier we can support them once they've made the disclosure, the better.³⁵

QSAN members also emphasised the need for interpreter services to be trained and educated about child sexual abuse, including potential indicators of abuse, and the importance of supporting children and families during disclosure. Training for these staff is integral to ensure culturally and linguistically diverse victim-survivors are supported in making disclosures, and that interpreters do not shut down or otherwise impact a disclosure. Further, spaces need to be safe for culturally and linguistically diverse children and families to be able to disclose and take into consideration varying levels of understanding of child sexual abuse.

QSAN members also raised the need to broaden the scope of what is accepted by police as evidence of disclosures. Those taking disclosures need to be educated to understand the many ways a child may choose to disclose their experiences of abuse and know how to interpret the information that is shared. For example, children may sometimes make disclosures through drawing or storytelling.

Reducing barriers to engagement and prosecution

The Board has consistently heard throughout the Review that one of the greatest barriers to facilitating effective responses to victim-survivors of child sexual abuse, and other forms of harm, is the high threshold of criminal proof required to satisfy the criminal justice system that a crime has occurred. This has two significant and harmful impacts on victim-survivors:

1. The impact of the necessarily high standard of proof has a detrimental impact on therapeutic outcomes for victim-survivors. It can result in a lack of acknowledgement or response to abuse which has been detected and reported, but for which evidence to satisfy investigators is not at hand. In these case investigations do not commence or they stall, and services are not easily accessible.
2. To satisfy the high evidentiary threshold, police and prosecutors interact with victim-survivors in a way which is focused on the preservation of the integrity of evidence. This results in invasive investigative processes which can compound trauma and dehumanise the disclosure. This in turn can lead to protracted, adversarial court processes that facilitate further harm. It may also require the victim-survivor to have to repeatedly share their experiences of abuse to other regulators or services who have different goals and approaches, causing further harm.

“

We need to provide a 'one door' entry point for protective parents and children, where the system comes to them at one place and at one time, in a place purpose built for them, where the child's best evidence is heard at the earliest opportunity, fully recorded, all family information gathered from the various statutory departments, where experts are available to offer assistance, where a risk assessment is conducted, where the family risk report is shared with all jurisdictions and courts and where all safety concerns are responded to adequately. All of this is possible in a jointly funded Child and Family Advocacy Centre model. - Hetty Johnston

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The internationally recognised best practice approach to addressing these issues is co-located, collaborative, and trauma-informed services which incorporate forensic interviewing techniques explicitly sanctioned by law in child-friendly environments and with culturally appropriate services was consistently highlighted:

Therapeutic support services, forensic interviewing and medical examination all in one place, or at least working in multidisciplinary teams so that parents don't need to keep finding out getting referred to lots of different people making multiple appointments. (...) the risks of disclosure for children and what happens afterwards are a real disincentive because it can be [sic] the systems can be as traumatising.³⁶

International approaches, such as Child Advocacy Centres (CACs) and Barnahus ('children's house') models offer streamlined, child-focused, and multidisciplinary responses to reports of harm to children.

“*When I disclosed my abuse I was asking for help, not a criminal process.*
- Victim-survivor”

In research undertaken by Griffith University to inform the Board's understanding of best practice responses to child sexual abuse, the importance of a multi-agency response, tailored to the needs of children.

In submissions provided to the Board, Bravehearts emphasised that investigations into a report of child sexual abuse must be trauma-informed, developmentally appropriate and led by trained specialists including through forensic interviews in a multi-agency framework. This can be done through multidisciplinary hubs which should be culturally safe and community-informed.

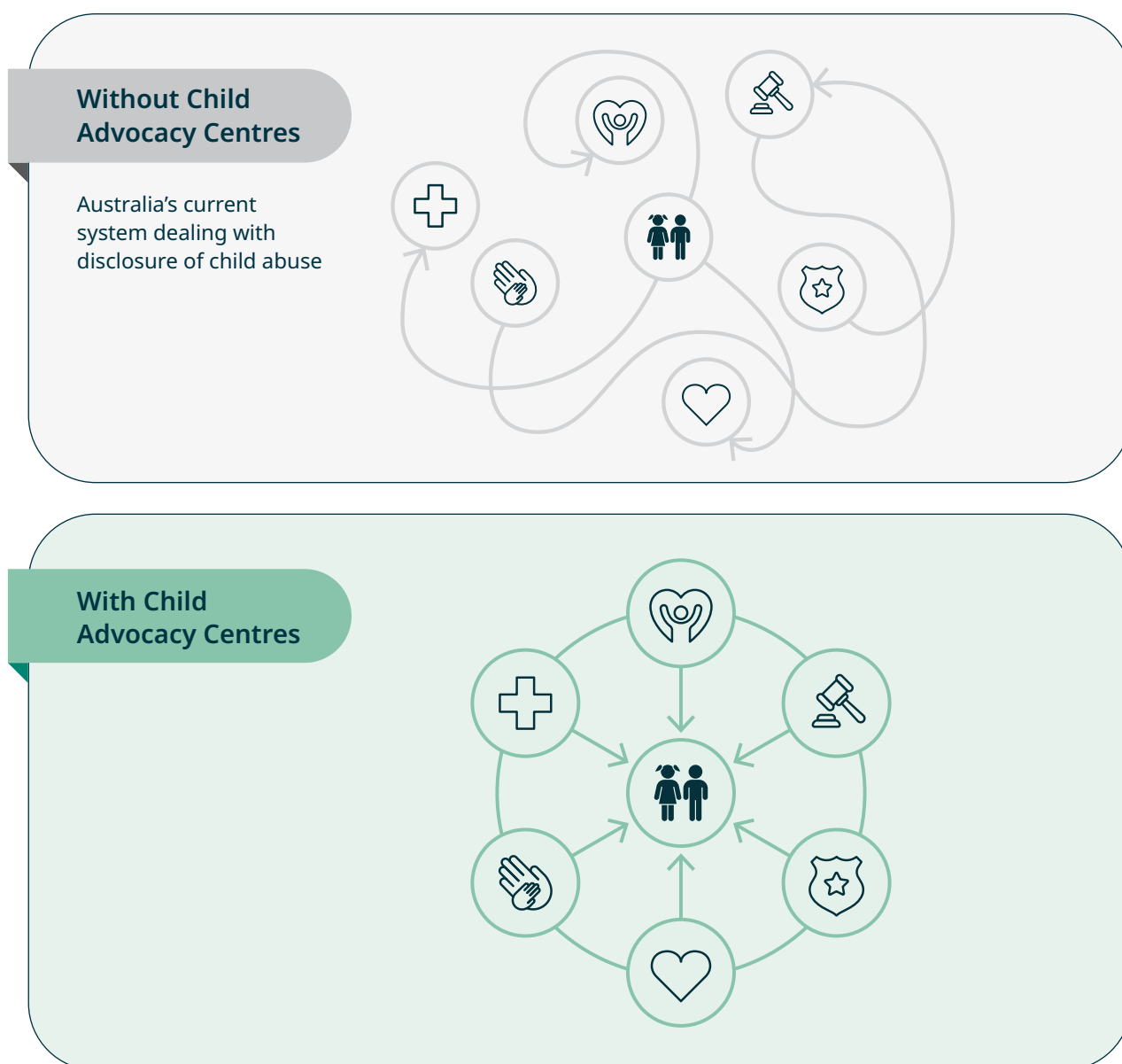
“*System-level responses are equally vital. Multidisciplinary approaches such as Child Advocacy Centres (CACs) and therapeutic assessment and treatment teams (for example, in the United States and Canada) have shown promise in reducing system-induced trauma and improving outcomes for children and families. These models offer coordinated, child-friendly services that minimise the need for children to repeat their stories across agencies and ensure streamlined access to healthcare, legal, and psychosocial supports.* - Bravehearts Submission”

A comparison of Child Advocacy Centres and Barnahus models

The Board was strongly encouraged to look into the model of CACs overseas. CACs emerged in the United States in 1985 as a way to co-locate and coordinate service delivery to children who have experienced abuse.³⁷ They provide children and families with a single point of entry to the secondary response system and a dedicated case manager while facilitating cooperation between police, health, therapeutic, child protection, domestic violence and other local services.³⁸ Critically, they usually employ a single forensic interview of a child victim-survivor from which evidence may be gathered and used by multiple services and practitioners, including the judiciary.³⁹

“*As a survivor, I feel the most effective way to conduct a successful victim interview is to ensure the environment is as comfortable as possible and not in a police station. I believe a supportive professional should be present as well as police, and all of these professionals should remain as a constant throughout the whole process* - Lived experience advisor”

Figure 1: Dealing with disclosure of child abuse with and without Child Advocacy Centres



The National Children's Alliance provides governance and oversight of the over 900 independent CACs in the United States of America (USA). Since their inception, CACs have been established in several other countries including Canada.⁴⁰ In 1997, the approach was used as the basis for the Icelandic Barnahus model, which is more fully incorporated into the criminal justice system.⁴¹ This model enables evidence gathered at Barnahus to be directly used in court proceedings, further reducing potential harm to victim-survivors. Barnahus-style centres have since been established in many European countries, and the system is endorsed by the European Union.

Given their common evolution, there are a number of similarities between CAC and Barnahus models:

- **Child-centred, trauma-informed approach:** Both models prioritise the safety, wellbeing and recovery of child victim-survivors through a trauma-informed and developmentally appropriate response. Both aim to reduce re-traumatisation by minimising the number of times a child is required to tell their story.
- **Multi-disciplinary team collaboration:** Both models co-locate or coordinate services involving law enforcement, child protection, health and mental health professionals. They seek to facilitate and enable real-time information sharing and joint decision-making on child protection and legal outcomes.
- **Forensic interviewing best practices:** Interviews are video recorded to reduce the need for repeated questioning and use trained forensic interviewers to elicit reliable testimony from children in a child-friendly setting.⁴²
- **Improved access to services:** Both approaches provide or coordinate access to therapeutic, medical and advocacy services, increasing opportunities for early and ongoing support.

Table 1: Key differences between Barnahus and CAC models

	Barnahus	CAC
Legal framework and role in justice process	Operates within the justice system in many European jurisdictions (especially Nordic countries). The forensic interview may replace court testimony, serving as admissible evidence.	In the USA and other jurisdictions, the forensic interview is not automatically admissible in court; children may still need to testify.
Governance and structural integration	Often fully state-run or embedded in the public judicial/health system, with legal mandates defining roles and responsibilities.	Usually run by non-government organisations or local partnerships; structures vary by jurisdiction, often relying on inter-agency agreements rather than statutory integration.
Victim's legal representation and procedural rights	May provide legal counsel or procedural representation for the child during the investigative process.	Generally does not incorporate legal representation for the child within the centres' services.
Scope and eligibility	Typically responds to all forms of violence, including witnessing domestic and family violence, physical abuse, and trafficking.	Historically focused more narrowly on sexual abuse, though many have expanded to include physical abuse and other traumas.
Cultural and policy context	Reflects European child rights frameworks (e.g. United Nations Convention on the Rights of the Child compliance), embedding a strong emphasis on the child's voice in legal proceedings.	Emerged from USA child protection traditions, often with more decentralised governance and service models.

Both the CAC and Barnahus models have been shown to have tangible positive impacts for victim-survivors when making a report. This includes:

- **Reduced trauma and re-victimisation:** Both models reduce the number of interviews and limit the child's exposure to intimidating justice processes. Barnahus may provide greater legal protection by reducing the need for court testimony entirely.⁴³
- **Improved therapeutic engagement:** Co-location or close coordination with therapeutic services improves early intervention and long-term mental health outcomes, facilitating earlier access to therapy by integrating health professionals more closely with investigative processes.⁴⁴
- **Increased case coordination:** Multidisciplinary teams in both models lead to better-informed investigations and case handling in the best interests of the child, and improved rates of prosecution and conviction.⁴⁵
- **Child satisfaction and engagement:** Both approaches improve children's and families' satisfaction with the process. Barnahus may outperform in jurisdictions where it reduces the need for child court appearances.⁴⁶

Transformational Recommendation 6: Improved interviewing and responses when victim-survivors present

In Australia, adoption of CACs and Barnahus models has been slow. The Parkerville Children and Youth Care in Western Australia opened the George Jones Child, Youth and Family Centre in 2011, and the Stan and Jean Perron Child, Youth and Family Centre in 2019. Both were initially referred to as CACs but have since reoriented to provide integrated services to families as well as children individually. They have also opened a similar centre at Rockingham. The Perth centres are the only 'true' CACs operating in Australia currently.

Previous inquiries and reviews have called for the trial and extension of these types of models in Australia. In 1997, the ALRC recommended that specialised interview teams comprised of police and child protection practitioners modelled on the CAC should be developed and deployed to address allegations of child maltreatment with a view to reducing trauma.

The Family Law Council previously recommended the Federal Government establish a national Child Protection Service in 2002, suggesting its function should be to investigate child protection concerns and provide information to family law courts.⁴⁷ While this specific recommendation hasn't led to a fully unified national service, the Council has continued to advocate for improvements in protecting children within the family law system, recently focusing on better information sharing between federal family courts and state child protection agencies through a National Framework endorsed in 2021.⁴⁸

The Royal Commission also considered the Barnahus model in response to submissions from a community legal centre in its discussion of alternative inquisitorial approaches to investigating allegations of abuse. While it did not make any recommendations on the adoption of this model, the Royal Commission flagged a positive evaluation by the Children's Commission for England and the benefits provided by existing Barnahus institutions to the wellbeing of children.⁴⁹

The Barnahus Model is widely recognised in Europe as a best-practice framework for the inquisitorial prosecution of child abuse cases with integrated victim-survivor support. Unlike traditional systems where victim-survivors must navigate multiple agencies, Barnahus adopts a 'one door principle', delivering legal, medical, and psychosocial services in a single, coordinated setting. Professionals come to the child, ensuring that victim-survivors are not burdened with seeking out support. Evidence is preserved efficiently, trauma is minimised, and interviews are conducted using therapeutic, age-appropriate methods.

The Barnahus Model represents best practice for inquisitorial prosecution processes with integrated support:

- Barnahus was inspired by the CAC model but integrates with the judicial system and aims to prevent victim-survivors from having to directly testify.
- It was built on the United Nations Convention on the Rights of the Child, and European legislation and conventions on the rights of children in the justice system. While it is supported by the European Union it is not yet accepted as a universal standard.
- Barnahus provides a 'one-stop' legal, medical, and psychosocial service (the 'one door principle'). Professionals go to the child rather than the victim-survivor being responsible for seeking support.
- Following supportive intervention, Barnahus preserves evidence and reduces trauma by minimising the number of interviews victim-survivors must undergo. Interviews are conducted using victim-centric, age appropriate, therapeutic methods.
- Immediate and long-term therapeutic and family support needs are assessed at the same time as police and judicial officers consider prosecution matters.
- Barnahus has been adopted widely in Europe, and the Barnahus Network has over 20 nations represented in its membership.⁵⁰

Key aspects of the Barnahus relevant to Queensland include:

- **Integrated Approach:** Simultaneous attention to legal processes and therapeutic interventions, reducing repeated interviews and stress on the child.
- **Child-Centred Practices:** Age-appropriate, trauma-informed methods that ensure children's voices are heard without undue distress.
- **Evidence Preservation:** Coordinated investigative practices that maintain evidentiary integrity while safeguarding the child.
- **Long-Term Support:** Immediate and ongoing assessment of therapeutic and family support needs alongside criminal justice considerations.

Bravehearts has long advocated for the establishment of a National Child Advocacy Centre. In a submission to an Australian Law Reform Commission review of the Family Law System in 2018, Bravehearts stated:

The establishment and trial of a National Child Advocacy Centre approach would focus on professionally establishing, on the balance of probabilities, the veracity of notifications of child harm. This centre would capture the voice of the child using a professional multi-disciplinary team. It would assign a Child Advocate to the child, compile a forensic family report, conduct a forensic interview of the child and provide a report to the Court for its consideration. We expect that adopting this model will allow for an expedient response or better yet, in many matters, will result in the matter not presenting before the court in the first place.⁵¹

Bravehearts have previously piloted a CAC model in South East Queensland in partnership with the QPS which offered opportunities to observe, evaluate, and adapt practices that align with international best practice models, particularly the Barnahus approach.⁵² It provided a demonstration site where Queensland could assess the feasibility, effectiveness, and challenges of adopting Barnahus principles to an Australian context. Insights from this pilot helped to inform policy and operational guidance, integration with police investigative processes, judicial protocols, and multi-agency collaboration. It also offered the opportunity to identify practical adaptations for local legislative, cultural, and operational contexts, ensuring that any broader rollout was evidence-informed and responsive to the unique needs of children in Queensland.

Evaluations of overseas approaches suggest that this approach has the potential to reduce trauma for victim-survivors, improve evidence quality, and support coordinated decision-making across police, regulatory agencies, and service sectors. By reinvigorating this pilot as a learning platform, Queensland can build a framework for CACs that incorporates Barnahus principles and enhances outcomes for victim-survivors of child sexual abuse.

Transformational Recommendation 6: Improved interviewing and responses when victim-survivors present

The Queensland Government improve its response to victims of child sexual abuse through the adoption of principles and approaches aligned with the Child Advocacy Centre and Barnahus models. This new approach should ensure that victim-survivors of child sexual abuse (and their parents or guardians) are protected and supported, and that any further trauma throughout the justice process is minimised. This investment should include piloting a specific Child Advocacy Centre or Barnahus service at multiple sites in Queensland.

Transformational Recommendation 7: Increasing the rights of child sexual abuse victim-survivors in cases of possessing child exploitation material

The Board heard consistent evidence that child exploitation material (CEM) has a long and persistent life once it is created and distributed. Unlike physical evidence that can be contained or destroyed, digital images and videos are easily copied, shared, and circulated across multiple platforms, including encrypted channels and the darknet. As a result, the impact of the original abuse continues long after the event itself. This affects both the victim-survivors and broader child safeguarding systems.

In 2015 the Queensland Organised Crime Commission of Inquiry noted in its final report that:

The online child exploitation material market has a significant detrimental impact on the community as it stimulates the demand for production of child exploitation material and therefore promotes child sexual assault. In addition, beyond the impact of contact offending recorded for dissemination in the child exploitation material market, it is well known that victims of exploitation for the production of material for the market often suffer ongoing harm... Purveyors and collectors of child exploitation material commonly justify their actions by citing the explanation that they are not responsible for the level of trauma caused by contact offenders who produce the material. However, victims of exploitation often report deeper psychological trauma than victims of contact offending that remains private. That is because the number of images being circulated online and the number of recipients is ultimately unknown. This phenomenon effectively prolongs the abuse, and it is commonly reported that victims claim an ongoing belief that the child exploitation material of which they are a subject is being viewed by an individual at any given point in time. That belief is far from fanciful in this digital age.⁵³

As also articulated in multiple submissions to the Australian Parliamentary Joint Committee on Law Enforcement inquiry on child exploitation in 2023:

Accessing and viewing CAM [child abuse material] is not a victimless crime, as many perpetrators believe. It has a devastating and lifelong impact on the children that are abused, with abuse images living on unfettered in the uncensored world of clandestine online CAM groups.⁵⁴

The 'uncertainty of knowing who has seen them being exploited as a child carries life-long, unresolved paranoia and emotional trauma on a victim'... Survivors tell us that the memorialisation of child sexual abuse through the production of abusive images and videos and even worse, its distribution, constitutes a most egregious insult to an already severe injury.⁵⁵

Victim-survivors are often repeatedly re-traumatised as their images are downloaded, viewed, and exchanged by perpetrators. We heard of cases in which multiple perpetrators were found in possession of a victim-survivor's images more than a decade after the original abuse, and even where the primary perpetrator had been arrested and prosecuted many years earlier. This underscores the enduring harm caused by CEM and the way it perpetuates victimisation over time.

The quantity of CEM possessed by individuals charged with such offences varies significantly, with some offenders amassing extensive collections. For instance, a Sydney ECEC worker was found with over 500,000 unique images, and a Victorian man was discovered with approximately 800,000 files.⁵⁶ These cases underscore the substantial volume of CEM that can be present in a perpetrator's possession.

For law enforcement agencies, the global nature of CEM distribution necessitates international cooperation and the development of advanced technological tools to track and remove such material effectively. Initiatives like Project Arachnid, an innovative, victim-centric set of tools which seek to combat the growing proliferation of CEM on the internet, exemplify proactive approaches to combating the proliferation of CEM and mitigating the harm caused to victim-survivors. The Board also heard that the rapid spread and persistence of CEM across the internet presents serious challenges for law enforcement. Perpetrators may acquire material from international sources or darknet networks, making tracking, investigation, and prosecution complex. However, the longevity and circulation of CEM also provide opportunities: patterns of possession, sharing, and re-distribution can be used to identify networks of offenders and prevent further abuse.

Possession, trading, and viewing of CEM itself constitutes ongoing harm to the children depicted. Evidence presented to the Board highlighted that, similar to the offender in this case, individuals charged with CEM offences often maintain large, organised stores of images and videos, which are commodified and traded across networks of perpetrators. In these vile groups, the images of abuse are given status and value.

It is incorrect and misleading to separate the creation of the material from the harm caused by its continued dissemination. Every instance of viewing, downloading, or sharing the material contributes to re-victimisation, reinforcing trauma and extending the victim-survivor's exposure to exploitation.

Even where the original abuse occurred years or decades ago, the child continues to suffer harm each time the images are accessed or traded. As articulated in the recent federal parliamentary committee on Law Enforcement Capabilities in relation to Child Exploitation:

The committee was moved by the evidence it received during this inquiry. Child exploitation is a horrific crime that causes terrible distress and trauma. Children are owed our care and protection, and yet the sad truth is that child sexual abuse continues and child abuse material (CAM) is proliferating. The severe and potentially lifelong harms of this crime demonstrate the importance of efforts to combat it.⁵⁷

It is not uncommon for law enforcement to locate victim-survivors' images in the possession of multiple perpetrators long after the initial abuse has occurred, demonstrating that the harm from CEM is cumulative, enduring, and widespread. This underscores the critical need for interventions that target both the original perpetrators and the broader networks that prolong the circulation of CEM and perpetuate the demand for this type of material.

As highlighted in the *Queensland Organised Crime Commission of Inquiry in 2015* the internet has enabled 'the development of organised, technically sophisticated rings of child sexual abusers.' This is not just isolated to the darknet however, it also occurs through peer-to-peer file-sharing, email communication, encrypted platforms and to a lesser extent in open internet forums, where perpetrators may seek to identify others with a sexual interest in children. In the final report of the Inquiry it was noted that:

One of the most concerning aspects of these types of organised criminal networks is the voracious demand for new and increasingly depraved material... On the basis of the information received by the Commission from a range of law enforcement and intelligence sources, there can be little doubt that child sex offending, particularly to feed the illicit and insatiable child exploitation material market, represents a risk with an upward trajectory. Further, there is a growing trend towards commercialisation of the child exploitation material market.⁵⁸

Evidence before the Board shows that the offender in this case joined an online forum of other perpetrators, he shared CEM material online in this forum, and he sought and was granted, access to VIP areas of this forum after he uploaded this material. He also commented in online forums about the abuse of children. After his arrest, the offender reported to police that he would sometimes delete all the CEM he had but would then retrieve it. **In total, 571 videos and 18,257 images of CEM were found in his possession that he had not produced.**

Recognising the ongoing victimisation experienced by children depicted in CEM is essential to informing legislative, policing, and child safeguarding reform. It reinforces that child sexual abuse prevention, detection and response must address both the initial abuse and the subsequent life of the material, ensuring victim-survivors are central in risk assessments, investigations, and protective measures.

It is globally recognised that the images of Australian children, who were rescued from sexual exploitation decades ago continue to be encountered in international investigations.⁵⁹

Child safeguarding measures cannot be reactive or short-term and must account for the long-term nature of digital CEM, the sophisticated means by which this material is shared and the organised networks which perpetuate demand for CEM and continue its distribution. Strategies to address child sexual abuse must include continuous monitoring, rapid identification, and coordinated interventions to minimise ongoing harm to victim-survivors and to disrupt the circulation of CEM.



Project Arachnid – A technological approach to combat child exploitation material

Developed by the Canadian Centre for Child Protection and launched in 2017, Project Arachnid is an automated web crawler designed to detect and remove CEM from the internet. Utilising advanced image and video hashing technologies, the platform identifies known CEM by matching digital fingerprints against a database of confirmed illegal content. Upon detection, it promptly issues removal notices to hosting providers, expediting the process of content removal and reducing the exposure of victim-survivors.⁶⁰

As of its eighth anniversary in 2025, the platform had issued over 47 million removal notices to more than 1,500 online service providers across nearly 100 countries. This extensive reach indicates that individual CEM can be distributed and accessed by numerous offenders worldwide but also underscores the global commitment to eradicating CEM and supporting victim-survivors.⁶¹

Project Arachnid employs both exact and perceptual hashing techniques to identify CEM. Exact hashing matches images or videos that are identical to known illegal content, while perceptual hashing detects close matches, accounting for minor modifications or alterations. This dual approach enhances the system's ability to identify a broader range of CEM, including those that have been slightly altered to evade detection.

The platform operates continuously, scanning the internet—including the darknet—for CEM. When such material is identified, Project Arachnid sends automated removal requests to the hosting service providers. This process not only facilitates the swift removal of harmful content but also assists in breaking the cycle of abuse by reducing the availability of such material online.

Project Arachnid collaborates with various international organisations and child protection entities to amplify its reach and effectiveness.

A cornerstone of Project Arachnid is its victim-centric model. The initiative not only focuses on removing CEM but also on supporting victim-survivors. By eliminating the online presence of their abuse images, the project helps mitigate the ongoing trauma experienced by victim-survivors. Furthermore, the data collected by Project Arachnid has been instrumental in legal proceedings, providing evidence that has been used in courtrooms across Canada.⁶²

With support from initiatives like Safe Online, a global investment vehicle dedicated to keeping children safe in the digital world, Project Arachnid has advanced its technological capabilities, improving automated detection and expanding its multilingual global notification system. These enhancements aim to expedite the removal of CEM and develop tools to identify images on platforms where traditional automated detection is challenging.⁶³

“

It is wrong to assume that when an offender with exploitation and abuse material is captured, that the images are then recovered. We must realise they are digital copies, and unknown and unlimited copies may still be accessed and re-copied long after the arrest.

”

The continued perpetuation of abuse

The widespread and enduring presence of CEM means that victim-survivors continue to be re-victimised as their images circulate among offenders. This persistent dissemination complicates efforts to support victim-survivors, as the material can exist in multiple locations and be accessed by numerous individuals over extended periods.

*The continued dissemination of child exploitation material can exacerbate the emotional and psychological impact on victim-survivors, often impeding their recovery and well-being.*⁶⁴

Submissions to the Australian Parliamentary Joint Committee on Law Enforcement inquiry on child exploitation in 2023 also highlighted that:

*Survivors of CEM [child exploitation material] often suffer post-traumatic stress disorder. Images can be replicated and shared again. Victims experience anxiety using the Internet because their image may reappear and they will be traumatized again. This constant re-victimization process and stress impact day-to-day functioning, degrades quality of life, increases potential physiological and mental harm, and negatively affects life course.*⁶⁵

Historically, cases involving CEM where the perpetrator and victim-survivor are unknown to each other often lacked the perspectives of the victim-survivors depicted in the images. The Canadian Centre for Child Protection has addressed this issue by facilitating the inclusion of victim impact statements in legal proceedings involving CEM related offences. This is achieved through Project Arachnid by connecting images held by perpetrators with victim impact statements written by the victim-survivors recorded in those images. This connection has enabled the voices of victim-survivors to be heard in courtrooms across Canada, providing a more comprehensive understanding of the harm caused by the distribution and possession of CEM, while also minimising the need for victim-survivors to continue to disclose the impact of their experiences of abuse, in related court proceedings.

In Queensland, under part 10B of the *Penalties and Sentences Act 1992*, victims of offences against the person, or domestic and family violence offences, including breaches of domestic violence orders, police protection notices, and release conditions under the *Domestic and Family Violence Protection Act 2012*, have the right to provide a victim impact statement at the time of sentencing of the perpetrator. A victim impact statement allows victim-survivors to describe the physical, emotional, and psychological harm they have suffered as a result of the offence. This statement is considered by the court during sentencing, providing the judiciary with a comprehensive understanding of the impact on the victim.

Victim-survivors can prepare their victim impact statement independently or with assistance. In cases where the victim-survivor is unable to provide the statement due to age or impaired capacity, another person may prepare it on their behalf. To support victim-survivors in this process, the Queensland Government offers resources such as a step-by-step guide for making a victim impact statement, which includes information on how to prepare and submit the statement.

Currently victim-survivors in images of child sexual abuse material are not treated as victims in all legal cases where a perpetrator in Queensland (or Australia) is charged with possessing the image. The construction of the relevant Queensland possession and distribution offences for CEM do not appear to contemplate these offences as being 'against the person'.⁶⁶ This makes the crime seem victimless, and less harmful than it truly is.

The Department of Justice has advised the Board that it is undertaking a holistic review of the victim impact statement regime under the *Penalties and Sentences Act 1992*, in line with recommendations 21 and 22 of the Queensland Sentencing Advisory Council report, *Sentencing of Sexual Assault and Rape: The Ripple Effect*.

The Board heard evidence of international jurisdictions that inform victim-survivors shown in CEM each time a new perpetrator is caught in possession of the material. The Board heard of the confronting and traumatic experiences of victim-survivors being notified regularly, or out of the blue, over periods of years and decades. This approach is not recommended.

Instead, it is entirely possible for a service like Project Arachnid to attach a victim impact statement to an image for perpetuity and give the victim-survivor the right to update this statement at their own discretion. This puts power back into the right place.

By attaching victim impact statements to specific images, victim-survivors would only need to provide their statements once, which would then be accessible in all subsequent legal proceedings involving those images. This approach aligns with best practices in victim-centric justice systems and would reduce the trauma associated with repeated testimonies.

Additionally, establishing a system that allows international victim-survivors to submit victim impact statements would enhance the global nature of justice in CEM cases, acknowledging the widespread impact of such crimes and ensuring that all victim-survivors have an opportunity to be heard, regardless of their location.

The International Association of Chiefs of Police has recognised the importance of creating an international database of victim impact statements to support CEM cases, highlighting the global consensus on the need for such initiatives. It resolved:

that the IACP recognizes that the creation and distribution of child sexual abuse imagery (CSAM) is a serious international problem and encourages the law enforcement community to do more to support other stakeholder efforts to reduce the public availability of CSAM; and be it FURTHER RESOLVED, that the IACP recognizes that the creation and distribution of child sexual abuse imagery often has lifelong impacts on victims around the world and more must be done to identify victims in all countries so that they can begin the recovery process; and be it FURTHER RESOLVED, that the IACP recognizes the need to reduce the ongoing victimization and harm that survivors of CSAM suffer as a result of their CSAM being accessible online.⁶⁷

Finally, while the issue of victim impact statements in child exploitation distribution or possession offences does not appear to have been considered at a national level or by other Australian jurisdictions, community impact statements in South Australia⁶⁸ have enabled greater understanding of the impacts of a certain crime type on society, including child exploitation offences.⁶⁹

The Board considered information from the Carly Ryan Foundation on the use of community impact statements in child sexual abuse cases.⁷⁰ A community impact statement's purpose is to bring to the court's attention how society as a whole is impacted by a crime type. It does not speak to the personalised experience of a victim-survivor, but to the wider, general consequences carried by a community due to an individual's criminal conduct.

It is a generally understood principle that in sentencing an offender, the sentence must adequately deter other citizens from engaging in similar offending. The judge is open to reflect on how a community is impacted by that offense, as part of that deterrence factor. While the Foundation acknowledges that the court must take into account an offender's own history, their personal circumstances and their ability for rehabilitation (amongst other factors) in reaching an appropriate sentence, the sentencing process faces challenges in representing victim voices... A Community Impact Statement is therefore able to speak, in general ways, about how victims of online child exploitation may experience the impact of the crime (such as ongoing mental health challenges, the worry of not knowing who has seen the abuse material, the knowledge that their abuse material may be used to groom other children, etc).⁷¹

Beyond providing context for sentencing judges, a community impact statement can also educate prosecutors, defence attorneys and even perpetrators in understanding the wider consequences of online child exploitation.

“*There still remains a great number of people within the community who view this as a ‘victimless’ crime as there was no ‘contact’ offending, especially amongst offenders (who need to devalue the experience of the victim in order to perpetrate the crime). Offenders may also fail to see their role in being part of the supply/demand chain in feeding this ‘industry’. In this respect, a Community Impact Statement has a greater educational and awareness-raising function, that challenges the viewpoint of it being ‘victimless’.*⁷²

”

Transformational Recommendation 7: Increasing the rights of child sexual abuse victim-survivors in cases of possessing child exploitation material

The Queensland and Australian governments both implement legislative reforms to enable the use of victim impact statements in cases involving CEM, ensuring that these statements are attached to the specific images and are admissible in all related legal proceedings regarding those images. This approach would allow victim-survivors to provide their impact statements once, while ensuring that each perpetrator hears their voice.

The Queensland and Australian governments should investigate legislative reforms that could enable the use community impact statements in CEM cases.

Furthermore, both the Queensland and Australian governments should collaborate with international partners to establish mechanisms that:

- allow victim-survivors from other countries to submit victim impact statements in cases where Australian perpetrators are charged with accessing, possessing or distributing CEM depicting foreign children. This could be facilitated through intermediaries such as Project Arachnid, ensuring that the voices of international victim-survivors are heard and considered in Australian courts.
- allow Australian victim-survivors to submit victim impact statements for use in international jurisdictions where perpetrators are charged with accessing, possessing, or distributing material depicting Australian children. These statements could be submitted through intermediaries such as Project Arachnid or other appropriate mechanisms, ensuring that the voices of Australian victim-survivors are heard and considered in foreign courts, without requiring repeated testimony.

Operational Recommendation 11: Investing in the tracking and takedown of images of Australian victim-survivors

That the Australian Government either enter a formal partnership with Project Arachnid or invest in a similar initiative within Australia (under the leadership of the eSafety Commissioner or the Australian Centre to Counter Child Exploitation) to combat the proliferation of CEM and protect the future rights of Australian children who have been abused.

Chapter

22

Enhancing access to specialist support services

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Enhancing access to specialist support services

Investment in sexual abuse counselling services

“

Child sexual abuse is a long lasting trauma. We cannot simply put a bandaid over the trauma and expect a child to lead their best life. Support and treatment needs to be ongoing, specialised, and consistent. A one stop shop where a survivor can seek assistance at different stages of life where they don't have to repeat themselves, and their experiences are heard and understood.

- Lived experience advisor

”

Child sexual abuse remains a pervasive and deeply troubling issue within Australian society, with enduring consequences that ripple across the lifespan of victim-survivors and their families. Despite concerted efforts by governments, community organisations, and health services, there remains a critical need to examine the current investment in sexual abuse counselling and recovery services, ensuring these supports are both adequate and accessible.

Experiences of child sexual abuse can have significant negative impacts. Recent research from the Australian Child Maltreatment Study shows that victim-survivors face significantly elevated risks of mental health disorders, including depression, anxiety, post-traumatic stress disorder, and substance dependence.⁷³ Beyond psychological harms, physical health complications and social difficulties often emerge, compounding the burden of trauma.⁷⁴

Child sexual abuse can also have lasting impacts on overall mental and physical health throughout a person's life.⁷⁵ As articulated in research conducted by the Australian Institute of Family Studies for the Board:

These findings make clear that child sexual abuse is not a discrete event, but a life-course issue, necessitating sustained and responsive mental health support frameworks. Counselling and recovery services must therefore be equipped to address trauma across diverse stages - from childhood through adulthood - recognising that support needs are ongoing.⁷⁶

As discussed previously, families impacted by this case reported variability in the support provided to them. While some appear to have been provided with support throughout the process, others reported receiving limited assistance that did not meet their needs. Although the Australian Federal Police (AFP) were proactive in seeking to ensure families were connected to specialist supports throughout the investigation and related criminal proceedings, the current service landscape appears inadequate, fragmented and underfunded.

Many victim-survivors remain disconnected from therapeutic services, either due to lack of awareness, accessibility, availability, or trust in support systems. In a study conducted by Griffith University to inform the Board's review, participants described a lack of services to support children and families after a disclosure and reflected that access to services is highly dependent on location and catchment areas.⁷⁷ Services were also noted to have long waiting lists, leaving children and families without high quality or specialised support options:

As I said before, it's a lottery of where you live and what services are available. I suppose, in the past, we have tried to keep a manual or pamphlets of all different services. It becomes very hard. Also, we used to try to also look at what the waitlist was for the family and the cost, because the cost is a big factor for a lot of our clientele. They can't afford private funding [healthcare].⁷⁸

There's a massive gap in service between children disclosing, having forensic examinations done, being seen by a health professional, and then seeking or receiving therapeutic care or psychosocial support. So, we know that there's massive gaps in service for wait times. Sometimes six months. And if you don't live in their catchment, you can't get access to their service. These are the families that we see who have a child that has disclosed, that has been through the police, done the 93A interview, had a medical examination and then can't go and get therapy from services because their waitlist is too long, or they don't live in that catchment area.⁷⁹

In submissions received by the Board, there was a general consensus in relation to the need for increased funding for specialist sexual abuse counselling and support services, and an expansion of the available interventions. This includes calls for:

- additional funding for the development and implementation of evidence-based, therapeutic interventions and services to support both victim-survivors of child sexual abuse, and children who display harmful sexual behaviours
- the development of a long-term sexual violence plan which includes a clear role and appropriate funding for specialist sexual violence prevention and support services
- funding for targeted, place-based support services responsive to the needs of local communities
- implementation of a 'surge' response system to deliver crisis support services to impacted communities when abuse involving multiple victim-survivors is detected.

Understanding the current service landscape

In Australia, sexual abuse counselling and support services are delivered through a complex web of government bodies, community organisations, philanthropic partnerships and health services. Federal and state governments share responsibility for funding and oversight. Nationally, the Department of Social Services (DSS) administers key grant programs targeting victim-survivor support, as well as national crisis support and advice lines like 1800Respect and the Child Wise National Child Abuse Prevention Helpline.

In Queensland, Department of Families, Seniors, Disability Services and Child Safety provides funding to a range of services that support victim-survivors of child sexual abuse and their families, and Victims Assist Queensland provides financial assistance, information and referrals. Queensland Health also manages aspects of service provision through public mental health and victim-survivor support services, including forensic examinations, follow-up counselling and initial support.⁸⁰

Non-government organisations, such as Act for Kids and Bravehearts provide critical support to children and their families, but they are not funded to deliver statewide counselling and support services. Specialist community-based organisations also provide assistance to older children and adults who have experienced child sexual abuse. For example, Zig Zag Young Women's Resource Centre, the Centre against Sexual Violence and Gold Coast Centre Against Sexual Violence Inc provide trauma-informed counselling and prevention programs, as well as information, referrals and advocacy to victim-survivors of child sexual abuse. However, many of these services have specified funding requirements, are unable to provide support to children under the age of 12 or 15 years and are only funded to provide services within their local communities.⁸¹

Recent government announcements have sought to increase funding for specialist sexual abuse counselling and support. Despite these efforts, siloed governance arrangements lead to inconsistencies in service quality, access, and coordination. This fragmentation also complicates data collection and evaluation, limiting visibility over service demand and effectiveness.

In submissions to the Board, the Advocate for Children and Young People New South Wales emphasised the importance of investing in culturally safe therapeutic support services, funding independent child advocates, strengthening complaint systems and investing in support for victim-survivors over the long term. The Aboriginal and Torres Strait Islander Legal Service also highlighted the importance of a strong focus on strengthening wraparound supports for children, particularly for children that do not have strong support systems or a stable family environment. The Queensland Human Rights Commission also highlighted the need to prioritise investment in early intervention and therapeutic models and whole of system accountability.

Awareness campaigns, high-profile inquiries, and media reporting have led to increased recognition of child sexual abuse and its consequences. As such, demand for specialist sexual abuse counselling and support services has grown substantially in recent years.

The *Royal Commission into Institutional Responses to Child Sexual Abuse* (Royal Commission) made nine recommendations specifically relating to the enhancement of advocacy, support and therapeutic treatment services (Table 2). The Australian Government accepted or accepted in principle six of the nine recommendations, and noted the second recommendation about Aboriginal and Torres Strait Islander healing as they considered that it was 'a matter for state and territory governments'. It stated that the establishment and funding of a national website and helpline and the establishment of a national centre to raise awareness needed further consideration. In 2022, the Australian Government released its fifth *Annual Progress Report*, in which progress on each of the recommendations was discussed. Progress listed can be seen in Table 2.

Table 2: Royal Commission recommendations, and response and progress by the Australian Government

Recommendation	Initial response	Progress
9.1 Funding dedicated community support services for victim-survivors that are accessible, available, trauma-informed, and collaborative	Accepted	Funding of Redress Support Services to assist victim-survivors to apply for the <i>National Redress Scheme for Institutional Child Sexual Abuse</i> (National Redress Scheme).
9.2 Funding Aboriginal and Torres Strait Islander healing approaches for victim-survivors	Noted	Investment into the National Indigenous Australians Agency to help support Healing Foundation and other wellbeing services, implement a 'healing program' in Townsville, and design and assess resources for health workers.
9.3 Funding services for victim-survivors with a disability	Accepted in principle	Funding of services to assist victim-survivors in making applications to the National Redress Scheme, of which 13 per cent of those supported between 2018–19 and 2020–21 had a disability.
9.4 Establishing and funding legal advice and referral services for victim-survivors to help access records from institutions, initiate police, civil or redress processes, and give general assistance with legal processes	Accepted in principle	Establishment and funding of Knowmore Legal Service for victim-survivors, including a call centre and offices in five of the seven states and territories (including Queensland).
9.5 Establishing and funding a national website and helpline for victim-survivors to access advice and information and to provide assisted referrals to support services	For further consideration	The development of a website for the National Redress Scheme and the response to the Royal Commission, listing support services and information.
9.6 Addressing existing service gaps by increasing funding for adult and child sexual assault services	Accepted in principle	Funding of services to assist victim-survivors in making applications to the National Redress Scheme.
9.7 Primary Health Networks supporting sexual assault services to work collaboratively with Aboriginal and Torres Strait Islander, disability-specific, culturally and linguistically diverse, youth justice, aged care and child services to better meet victim-survivor needs	Accepted in principle	Implementation of the <i>National Plan to End Violence Against Women and Children 2022–2032</i> , which includes support for victim-survivors to navigate the health system.
9.8 Ensuring policy frameworks and strategies recognise the needs of victim-survivors and the benefits of trauma-informed approaches	Accepted	Development of <i>Safe and Supported: the National Framework for Protecting Australia's Children 2021–2031</i> , of which one principle is 'trauma-informed, culturally safe and inclusive policies and actions.
9.9 Establishing and funding a national centre to raise community awareness and practitioner knowledge and competence and lead the development of better service models	For further consideration	Establishment of the National Centre for Action on Child Sexual Abuse.

The Board acknowledges the work the Australian Government has done in addressing the recommendations made by the Royal Commission around advocacy, support and therapeutic services. However, the majority of the progress reporting in the latest implementation update relates to the ongoing coordination of the National Redress Scheme.

The National Redress Scheme, which all state, territory and Australian governments have committed to, is a helpful and necessary measure to support and provide redress to victim-survivors of institutional child sexual abuse, though it is currently scheduled to end in June 2027. This is because it was envisaged by the Royal Commission that improvements made to civil litigation processes would have been enacted by governments by this time. Further, victim-survivors can only apply if:

- they were born before June 2010
- they are an Australian citizen or permanent resident
- the abuse occurred before July 2018.⁸²

This excludes a substantial proportion of the victim-survivors in the case examined by the Board, and countless other victim-survivors of institutional child sexual abuse.

The progress made by the Australian Government also misses the intent of many of the original recommendations made by the Royal Commission. For example, Recommendation 9.1 relates to the funding of support services for victim-survivors, though progress reports only refer to support services to help victim-survivors make applications to the National Redress Scheme. While this is one support, it does not help victim-survivors access therapeutic treatment services over the longer time, particularly assistance for those victim-survivors who have not experienced abuse within an institutional setting. Another example is the progress reported to have been made against Recommendation 9.3, which again discusses support services related to the National Redress Scheme, including additional services to support victim-survivors with a disability. There is no clear articulation of any other specialist sexual abuse counselling and support services for victim-survivors with a disability, including where the abuse did not happen in an institutional context.

The Australian Government recently made \$12.2 million available for the *Grants for Services Responding to Child Sexual Abuse and Children who have Displayed Harmful Sexual Behaviours*. This program is intended to support organisations over three years to reflect the increased need to respond to this cohort, and contributes to commitments under the National Strategy to Prevent and Respond to Child Sexual Abuse.⁸³ Yet, significant challenges remain:

- **Funding Constraints:** Despite increased investment, funding remains insufficient to meet demand comprehensively. Many services report waiting lists and limited capacity, particularly outside major metropolitan areas.
- **Workforce Shortages:** The specialist nature of trauma counselling necessitates highly trained clinicians, but there is a shortage of qualified professionals, especially in rural and remote locations.
- **Accessibility Barriers:** Geographic isolation, stigma, and cultural factors often impede access, disproportionately affecting Aboriginal and Torres Strait Islander peoples and culturally and linguistically diverse communities.
- **Variable Quality:** While some providers deliver exemplary trauma-informed care, inconsistencies exist across regions and organisations, with variable adherence to best practice standards.

Queensland Government response and progress

The Queensland Government accepted all recommendations made by the Royal Commission in principle.⁸⁴ Progress on the implementation of these recommendations is highlighted across multiple annual implementation reports from between 2019 to 2022. This includes the release of *Prevent. Support. Believe. Queensland's Framework to Address Sexual Violence*, a whole-of-government action plan to address sexual violence. As of 2022, key achievements cited against this plan include reviewing the Respectful Relationships Education Program and implementing QPS sexual violence liaison officers.⁸⁵ Other actions taken to deliver this plan include:

- investment and enhanced funding to child sexual abuse support and counselling services
- increased training for doctors and nurses about child sexual abuse and an improved service response for people who have experienced sexual assault
- partnering with Aboriginal and Torres Strait Islander individuals and organisations to embed Aboriginal and Torres Strait Islander service delivery models in the health system
- ongoing participation in the National Redress Scheme
- engagement with the *Royal Commission into Violence, Abuse and Exploitation of People with a Disability*

- participation in discussions with the National Centre for Action on Child Sexual Abuse
- investment in mental health and suicide prevention initiatives for adults and children.

The progress outlined in the Queensland Government's annual progress reports is a step in the right direction and deeply necessary to support victim-survivors. Particularly, increasing capacity of existing sexual assault support services, improving knowledge of professionals in trauma-informed approaches and embedding Aboriginal and Torres Strait Islander service delivery models in the health system are integral to improving support for victim-survivors. However, there is no clear articulation in the progress made to implement some of the recommendations. In particular, engaging with the *Royal Commission into Violence, Abuse and Exploitation of People with a Disability* does not meet the intention of Recommendation 9.3, and there is no mention of specialist support or therapeutic treatment services for victim-survivors of child sexual abuse with a disability.

Women's Safety and Justice Taskforce recommendations and response

In its final reports, the Women's Safety and Justice Taskforce made multiple recommendations relating to funding sexual assault and violence services to support victim-survivors, including of child sexual abuse.⁸⁶

In response to the recommendations, the Queensland Government developed *Queensland's Plan for the Primary Prevention of Violence Against Women 2024–2028*. Included in this plan is an action to develop a strategic investment plan to review the support services delivered and funded by the Queensland Government, including services for child victim-survivors.⁸⁷

The Queensland Government through the Department of Families, Seniors, Disability Services and Child Safety (DFSDESCS), has increased funding for support services for victim-survivors aged under 18 from 2021–22 to 2025–26 to a total of \$135.34 million (Figure 2). Services include:

- sexual violence counselling (for children 12 years and over)
- children's domestic violence counselling
- youth sexual violence and abuse services, which includes
 - sexual abuse counselling for children under 18 years who have experienced sexual abuse and who are not in out of home care
 - sexual assault services for children aged 12 and over who have experienced sexual violence
 - early intervention youth counselling (for children aged 10 to 17 exhibiting harmful sexual behaviours)
 - training for professionals
 - youth connector services to facilitate connections between children and young people and counselling.

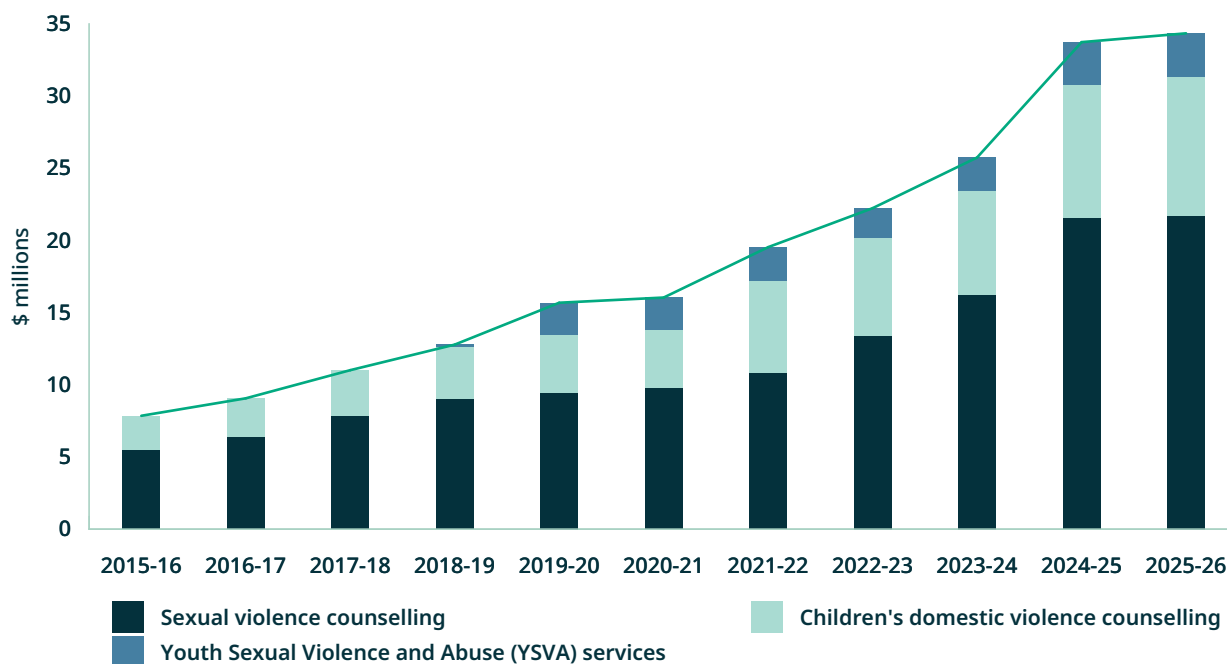
The department also funds Sexual Abuse Counselling Services for children and young people aged five years to under 18 years who are subject to child protection statutory intervention. Investment for these services in the 2025–26 financial year is \$4,815,394 per annum. These services have seen significant funding increases in the past decade, with funding now coordinated under the current Domestic, Family and Sexual Violence Investment Framework.

The DFSDESCS also funds four targeted family support services provided by non-government organisations to a total of \$2.25 million for 2025–26, providing trauma-informed sexual abuse counselling for children and personal safety education for children and parents outside of the Greater Brisbane area. These include:

- Bravehearts Gold Coast and Strathpine
- Community Support Centre Innisfail Inc
- Act for Kids Child Specialist Counselling Service (in the Cairns North and Cairns South catchment areas).

The Queensland Government recently announced funding for the Queensland Sexual Assault Network to establish a peak body to represent sexual violence support services. This entity will help to facilitate collaboration with the department, services and other entities on policy directions, innovation and sector development.

Figure 2: DFSDSCS funding for sexual violence counselling and support services, 2015–16 to 2025–26



Rising demand and service delivery challenges

While there have been some increases in funding for specialist sexual abuse counselling and support services at a state and national level, consultations undertaken as part of this Review show that this increased investment has not been sufficient to address historical funding underinvestment and increased demand for services.

A recent rapid review of prevention approaches, *Unlocking the Prevention Potential*, recommended that the Australian Government through the Australian Institute of Health and Welfare and with state and territory governments, expedite a needs analysis to determine unmet demand in domestic, family and sexual crisis response, recovery and healing (excluding police), with the view to developing a pathway to fund demand.⁸⁸ This rapid review found that services had faced chronic underfunding for decades which has created systemic problems that hinders the delivery of services and results in critical staff shortages, meaning that victim-survivors are turned away and phone calls remain unanswered.⁸⁹ It also acknowledged that 'requests for increased funding have only short-term value' and that 'before placing a dollar figure on how much is enough' a better understanding of current and future demand is required.⁹⁰

Submissions received by the Board including from Queensland Sexual Assault Network (QSAN), the representative body for sexual violence prevention and support organisations in Queensland, emphasised that further reform is necessary to improve the service system response for victim-survivors of child sexual abuse. Particularly:

- Despite the Royal Commission's recommendations, Queensland lacks a coordinated and specific strategy to respond to sexual violence against children, or adequate funding for services which exist or are proposed to help victim-survivors.
- Instances of reported and unreported child sexual abuse are expected to continue to rise, both as a result of increases in reported offending and maturing police investigatory approaches. This will have corresponding demand and resourcing pressures for an already stretched specialist sexual violence support system.
- Child sexual abuse requires a surge response model, similar to that employed in disaster relief strategies, which will enable the deployment of increased personnel and resources to provide support for victims and their families when prolific abuse cases are detected.

Opportunities to enhance support for victim-survivors of child sexual abuse within health settings have also been identified. In response to the findings of the Women's Safety and Justice Taskforce and a gap and needs analysis of forensic services to victim-survivors commissioned by Queensland Health, the *Queensland Health Sexual Assault Services Framework 2024* was developed. This framework aims to:

- improve access to timely care for victim-survivors
- increase recognition of forensic medicine and sexual assault services
- enhance capacity, capability and confidence of staff
- develop collaborative interagency communication and cooperation.

The framework highlights the need for 24/7 access to trauma-informed health support for victim-survivors across the state.

As part of the implementation of the Taskforce recommendations, and those of the Commission of Inquiry into DNA Testing in Queensland, significant issues were identified with the experience of patients who were subject to forensic medical examination in Queensland.

In response, Queensland Health has implemented a new statewide model of care for adult and child patients, which was supported by a funding allocation of \$56 million over four years from between 2024–25 to 2027–28, as part of the 2024–25 State Budget. This funding included \$12 million to support establishment of a statewide paediatric service for child sexual assault in Queensland through Children's Health Queensland Hospital and Health Service.

Initiatives implemented as part of Queensland Health's Child Sexual Abuse Service include:

- a 24-hour consultation line to provide specialist advice to healthcare staff caring for children under 14 years who have experienced sexual abuse
- the ongoing development of a statewide education pathway to build capability of healthcare professionals to respond to child sexual abuse
- the strengthening of local responses to child sexual abuse to improve knowledge sharing and service delivery between hospital and health services, in turn informing Queensland Health's Nurse Practitioner and psychosocial models of care
- the ongoing development of a Nurse Practitioner model in Brisbane to support interdisciplinary care for victim-survivors of child sexual abuse and to lead education on forensic examination procedures
- the ongoing development of a psychosocial model of care to improve support for children, ensuring it is trauma-informed and timely.

Queensland Health advised the Board that implementation of this initiative is actively progressing, and that it is committed to delivering high-quality, trauma-informed and timely care to children who have experienced sexual abuse.

Operational Recommendation 12: Improved specialist support for victim-survivors and their families

The Board has observed that Queensland's current sexual abuse counselling and support system is fragmented, constrained by inconsistent funding criteria, and inadequately resourced to meet the lifelong needs of victim-survivors and their families.

Specialist sexual abuse counselling and support services are currently provided by a patchwork of organisations, funded by multiple government departments and agencies, each with their own eligibility rules and geographic coverage. This creates significant gaps in access: for example, parents or guardians of children who experience sexual abuse have been told that they are excluded from receiving specialist support 'because they were not the victim', children in certain regions are unable to access services because they live in the 'wrong postcode', young people and adults may 'age out' of a service, and children under 12 may be 'too young' to access a service. Collectively, this results in victim-survivors of child sexual abuse and their parents struggling to find a suitable service, and unable to access support because of strict and potentially arbitrary funding specifications.

The limitations of the current system can exacerbate trauma rather than ameliorate it. Victim-survivors and families face long waiting lists, restrictive eligibility criteria, and fragmented pathways that require them to navigate multiple service providers to receive care. Importantly, the trauma from experiencing child sexual abuse does not cease when children reach adulthood; lifelong support is necessary to respond to the evolving psychological, social, and emotional needs of victim-survivors. Similarly, young people whose abuse occurred in childhood often require tailored interventions to manage the developmental challenges of adolescence in the context of past trauma.

Centralising oversight and investment in specialist sexual abuse counselling services would enable a more strategic, coordinated, and equitable system. A dedicated and sustained funding allocation would ensure that support is consistently available at key points including:

- **At point of disclosure and through court processes:** Trauma counselling for children and their parents to reduce immediate harm, promote safety, and navigate legal proceedings.
- **Support for young people:** Mental health services that respond to the specific developmental needs of teenagers who experienced abuse in childhood.
- **Support for adults who have experienced child sexual abuse:** Access to long-term therapy for adults who experienced abuse in childhood, recognising the enduring impact of trauma.

By clarifying and centralising government investment, Queensland can provide a coherent continuum of care that supports victim-survivors and families regardless of postcode, age, or relationship to the primary victim, while reducing duplication and inefficiencies inherent in the current patchwork system.

Operational Recommendation 12: Improved specialist support services for victim-survivors and their families

The Queensland Government undertake a review of its current investment in sexual abuse counselling and support services, and establish a centrally coordinated, dedicated funding allocation specifically for responding to child sexual abuse. This funding should ensure:

- Trauma counselling is available to children and parents at the point of disclosure and throughout court processes.
- Adolescent mental health support is accessible for children as they transition into adolescence.
- Adult survivors of child sexual abuse have access to ongoing therapy and support across their life-course in acknowledgement that the impact of child sexual abuse can reappear at key life events.
- Eligibility criteria and service coverage are equitable, removing postcode, age, or relational barriers that currently limit access.
- Investment is strategically coordinated across agencies to create a seamless, statewide network of trauma-informed services, replacing the current fragmented patchwork.

This approach will embed lifelong, consistent support for victim-survivors and families, and strengthen Queensland's overall child safeguarding framework.

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Part



Preventing child sexual abuse

A whole of system approach to prevention

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A whole of system approach to prevention

Preventing child sexual abuse

The more harm we prevent, the better we become as a society, not only because fewer children are hurt and abused, but also because the collective resources, trust and hope of our communities is strengthened. Prevention reduces both the personal and social costs of abuse, improves quality of life, and ensures that resources can be directed toward development and resilience rather than repair. The World Health Organization has long emphasised that *“prevention is better than cure”*, a principle equally relevant to the safety of children as it is to public health.

“*The most enduring and effective way to deter online harms is to address them before they occur.* - Julie Inman Grant, eSafety Commissioner

Perpetrators adapt and adjust to continue offending. For this reason, we must target harden any environment where children live, learn or play. Collectively we must work together to drive the structural reforms necessary to achieve sustainable, long-term change.

In the assessment of any system tasked with protecting children, prevention must stand as the central priority. While effective response mechanisms are essential when harm occurs, the overall wellbeing of our society depends on our capacity to reduce the incidence of harm in the first place.

“*A truly comprehensive prevention approach recognises the need to address not only individual risk factors, but also the broader social, environmental, and systemic conditions that create opportunities for abuse. By adopting a multi-faceted, layered approach, prevention efforts can be implemented across various levels and points in time, increasing the potential for sustained and meaningful change.*¹

By anticipating risks and putting safeguards in place, we avoid the immeasurable trauma caused when children are harmed and the heavy cost of reactive interventions. Nobel Laureate Amartya Sen put it more broadly when he argued that *“prevention is not only less costly than cure, it is also more humane”*.

Prevention is also more effective in creating the type of society to which we aspire. A society where children are loved, safe and have their rights upheld is one that unlocks human potential. The Australian Productivity Commission has observed that *“the more that is invested in preventing harm, the greater the long-term return to individuals, families and society”*.² Investment in prevention is not only an act of protection but also an act of nation-building.

Crucially, prevention strategies shift the burden from the individual child or family to the collective responsibility of communities, institutions, and governments. This reduces the likelihood of children falling through gaps in detection or intervention.

“*...the responsibility for preventing sexual abuse should never rest on children.*³

Primary prevention strategies are those that aim to stop harm before it occurs. They are universal in nature, targeting whole populations rather than specific individuals already known to be at risk. In the context of safeguarding children and building safer communities, these strategies play a foundational role in reducing vulnerability and fostering protective environments.

One of the most widely recognised primary prevention approaches is education and awareness-raising. This involves equipping children, families, and communities with knowledge about rights, risks, and protective behaviours. For example, school-based programs that teach children how to recognise unsafe situations and seek help have been shown to strengthen resilience and lower the likelihood of abuse. Parallel efforts focus on parents and caregivers, providing them with accessible information on positive parenting practices, child development, and safe online behaviours.

Another central strategy is environmental and situational design. By modifying physical, organisational, or digital environments, opportunities for harm are reduced. Examples include implementing clear child safety codes of conduct in organisations, ensuring safe physical spaces (e.g. open classrooms, supervision protocols), and building robust online safety measures. The principle is simple but effective: where risks are harder to exploit, harm becomes less likely to occur.

Policy and legislative frameworks also operate as primary prevention measures by setting community-wide expectations and minimum standards. Mandatory background checks, the National Quality Framework in early childhood education, and consistent reporting obligations across sectors are examples of universal safeguards. These mechanisms do not rely on individual vigilance alone; they systemically reduce risks by lifting baseline protections.

A further preventative measure lies in strengthening community capacity and social cohesion. Communities with strong networks, trust, and inclusion are more resilient and better able to protect children. Initiatives such as parent support groups, local community hubs, and culturally tailored services help create environments where children are visible, valued, and supported. These approaches also counteract isolation—one of the key conditions that offenders seek to exploit.

Finally, public health campaigns and universal service delivery are important tools. Campaigns that shift social norms (such as promoting child rights, gender equality, respectful relationships, and zero tolerance for violence) play a long-term role in preventing harm. Universal services, including maternal and child health, early childhood education, and accessible mental health supports, embed prevention within the everyday systems that touch all families.

Taken together, these strategies demonstrate that prevention is not a single action, but a layered and comprehensive effort. By embedding safeguards at individual, organisational, and community levels, primary prevention strategies work to make harmful conduct more difficult, less tolerated, and more easily identified when it arises.

As noted in a report on the Prevalence of child sexual abuse in Queensland (Results from the Australian Child Maltreatment Study) prepared for the Board:

A growing body of scientific literature has emerged in relation to the prevention of child sexual abuse in child-serving organisations... These scientific works reflect a solid consensus about the types of preventative measures that child and youth-serving organisations must take in order to best prevent sexual abuse of children in their care.

This accumulated body of knowledge complements a similar comprehensive suite of recommendations for making institutions safe for children, made by the Royal Commission Into Institutional Responses to Child Sexual Abuse in its 2017 Final Report...The recommendations from both the scientific community and the Royal Commission form an essential reference point for future prevention initiatives. Within a range of measures, key focus areas include: prioritising child safety in organisational policy; education and training of staff and leaders about the nature of child sexual abuse, the organisational policy, and their reporting obligations; creating codes of conduct, including prohibitions of high-risk behaviours; monitoring of staff conduct; screening and hiring of staff on intake; rigorous processes for reporting and responding to allegations of concern; reducing opportunities for offending through situational prevention; processes for implementation and auditing; and collaboration with parents and children.⁴

Approaches to prevention

Current prevention efforts in Australia are predominantly focused on education in primary schools and other community settings. While this is important, to be effective, a proactive, multi-level, whole of community approach is needed. This means that we need to target the conditions which give rise to abuse.

Put simply, effective prevention requires a whole of system approach to child safety, and a comprehensive understanding of the complex factors that contribute to risk. The socio-ecological model, a well-established public health framework, helps identify and address these factors across multiple levels—societal, community/organisational, interpersonal, and individual.⁵ This model enables policymakers and practitioners to design prevention strategies that are context-sensitive and holistic.

At the societal level, laws, policies, and cultural norms shape attitudes and behaviours that can either protect children or enable abuse. At the community and organisational level, environments such as early childhood education and care (ECEC) settings play a critical role, where poor supervision or lack of safeguards can increase risk. Individual and interpersonal factors, while less central to this report, also contribute to vulnerability and offending.

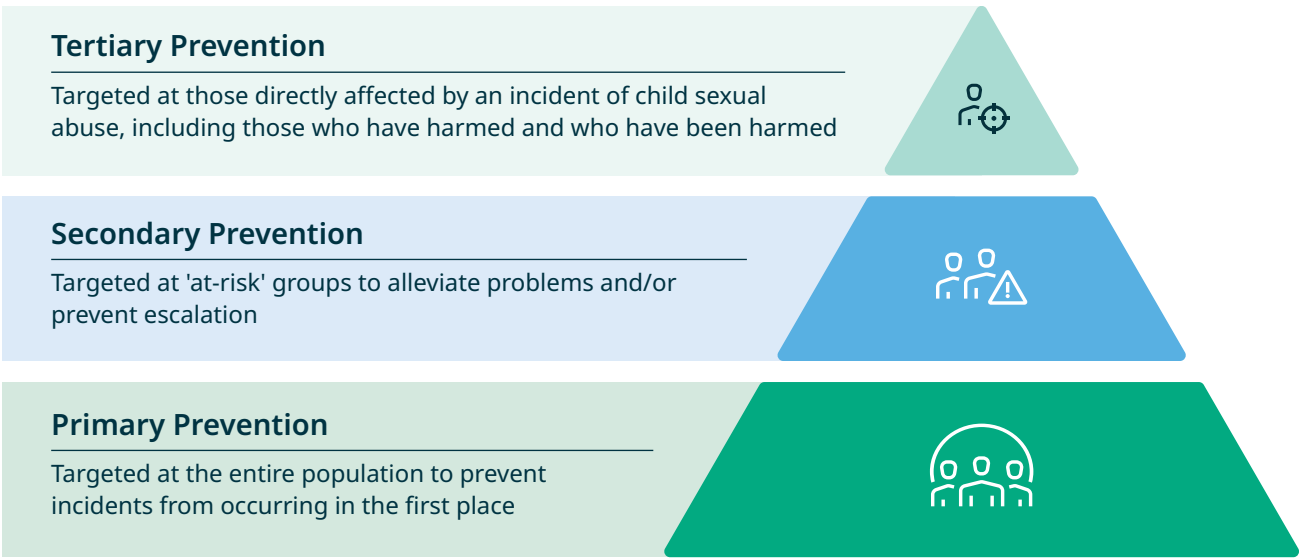
In addition to the socio-ecological model, situational crime prevention offers a complementary approach.⁶ It focuses on modifying environments to reduce opportunities for offending to occur especially in settings where children gather, such as ECEC services. This approach aims to make abuse more difficult, risky, and less rewarding for perpetrators by improving supervision, policies, and physical safeguards.

Research also suggests that best-practice approaches to prevention adopt a holistic approach focusing on whole of community (primary), interventions targeting specific people or places (secondary), and strategies after harm has occurred (tertiary).⁷ All three are required to provide a strong framework to reduce the extent and impact of child sexual abuse. Current prevention approaches tend to target the primary and secondary levels of the public health model of prevention (with the exception of some community programs which are targeted to where harm has occurred in the past and are therefore tertiary).⁸

Figure 1: Public Health Prevention Model

Source: USC report p.4, Eck 2003

Integrated Prevention Matrix



Developed by Smallbone and Rayment-McHugh (2017) the Integrated Prevention Matrix combines the public health model with Eck's crime triangle.⁹

Expanding on routine activity theory, Eck's crime triangle (2003) considers the necessary elements for any crime to occur, such as the offender, setting and victim (inner triangle). The outer triangle represents guardianship in that any of these (handler, place manager, guardian) may intervene on any element to prevent or stop the crime from occurring.

The model suggests that crime can be prevented by addressing one or more of the following components:

- Reducing opportunities for perpetrators to offend
- Reducing the vulnerabilities of potential targets or victims
- Designing and using spaces that reduce the opportunity for crime to occur.¹⁰

Motivated offenders are more likely to offend when little effort is required, the risk of detection is low, and the offending behaviour promises a highly desired reward.¹¹ If while going about their normal day-to-day activities the components in the outer triangle are strong, motivated offenders will either have to increase their effort because the risk of detection is higher or will not offend.¹² The evidence before the Board is clear that the offender in this case sought to reduce guardianship by circumventing or exploiting existing organisational and regulatory safeguards. This highlights the importance of all organisations taking steps to ensure motivated offenders have less opportunity to offend.

Figure 2: Eck's Crime Triangle

Source: USC report p.4, Eck 2003



The integrated prevention matrix is considered to be an effective means of comparing the systemic level of a prevention measure against its intended target. This framework takes into consideration people and places, as well as the three levels of prevention (e.g. primary, secondary and tertiary).

Figure 3: The Integrated Prevention Matrix

Source: USC report p.3, Smallbone & Rayment-McHugh 2017

Target	Primary	Secondary	Tertiary
 Perpetrator	Prevent risk of offending	Prevent behaviours from escalating into offending	Prevent repeat offending by addressing risks/needs
 Victim-Survivor	Prevent risk of victimisation	Reduce risk of victimisation	Address harm caused by offence and prevent revictimisation
 Setting	Prevent opportunities for offending	Reduce or limit opportunities for offending	Improve safety to prevent future offending

Prevention efforts need to encompass the full spectrum of these targets, and the Integrated Prevention Matrix provides a framework for preventing child sexual abuse across all three prevention levels.¹³ As also noted by participants in a study undertaken by Griffith University to inform this Review, motivated offenders will always exist. While we can seek to reduce their risk of offending, we can ultimately prevent more abuse by improving guardianship, increasing the skills of all staff, and changing our environments to reduce opportunities for offending and increase capacity for detection.¹⁴

*"I think you need to look very simply at Routine Activity Theory. Particularly if you're dealing with very young, pre-verbal children. The notion of capable guardianship is absolutely critical. [ECEC employees] need to internalise the notion that in order to keep these kids safe, all of us here need to be capable and responsible guardians."*¹⁵

Implications for prevention

While the prevention of child sexual abuse is something we all must strive for, the Board heard from multiple stakeholders that the current approach appears fragmented, somewhat duplicative and inconsistently funded. The *National Strategy to Prevent and Respond to Child Sexual Abuse 2021–2030* is intended to guide prevention efforts in Queensland and across Australia under the themes of:

- **Awareness raising, education and building child safe cultures:** including through the implementation and promotion of the National Principles for Child Safe Organisations, the delivery of a national awareness raising campaign on child sexual abuse, and through the provision of resources for teachers, children and young people's education on wellbeing, relationships and safety, including online.
- **Enhancing national approaches to children with harmful sexual behaviours:** including by increasing workforce capability for preventing and responding to children displaying this behaviour and supporting the community to better understand this issue.
- **Offender prevention and intervention:** including by launching an offending prevention service for adults who have sexual thoughts about children.¹⁶

Prevent. Support. Believe. Queensland's framework to address Sexual Violence sets an objective that 'everyone works together to bring about cultural, behavioural and structural change to prevent sexual violence.'¹⁷

Key actions seek to:

- Increase knowledge and understanding of sexual violence and its drivers in the broader community
- Equip families, children and young people with accurate information on healthy relationships, consent and sexual violence
- Challenge attitudes, practices and structures that lead to sexual violence and stop people speaking out
- Strengthen the capacity of workplaces and institutions to prevent sexual violence
- Implement targeted prevention and early intervention activities tailored for and designed by specific population groups.

Queensland's Framework establishes a range of key commitments, however actions are not distinct to the prevention of child sexual abuse and instead apply to all forms of sexual violence including sexual assault, sexual harassment, technology-facilitated sexual violence, child sexual abuse and youth sexual violence. In seeking to encompass all types of sexual violence, there is a clear risk that the focused and targeted action needed to combat child sexual abuse will be lost, or never fully actualised.

The need for a clearer prevention strategy was outlined in a recent report by the e-Kidna group, a collective of Act for Kids, Bravehearts and the Daniel Morcombe Foundation on primary prevention initiatives against child sexual abuse in Australia which highlighted a range of challenges with the current approach.

To date there is no implementation of a National Prevention Framework for CSA [child sexual abuse]. This would include evidence-based primary, secondary and tertiary initiatives to work towards ending CSA. An important element is a shift in funding models and theoretical approaches to the response to CSA from a reactive based system to an approach that aims to prevent CSA. The National strategy to prevent and respond to child sexual abuse, and the work of the National Centre for Action on Child Sexual Abuse is a step forward, but further shifts in funding from tertiary prevention to primary prevention will be required and additional support for potential perpetrators. The jurisdictional review revealed a significant disparity in the emphasis on primary prevention for childhood physical abuse and child maltreatment compared to CSA. The focus on childhood physical abuse and child maltreatment was found to receive more than twice as much as the attention than that given to CSA. This is disproportionate when considering the prevalence of each issue, with approximately 8.5% of adults reporting experiences of childhood physical abuse and 7.7% of adults reporting experiences of CSA.

This report ultimately found that:

- *Australia lacks a national prevention framework to eliminate child sexual abuse*
- *implementation of current primary prevention initiatives is sparse and ad-hoc*
- *there is a paucity of primary prevention initiatives solely focused on child sexual abuse*
- *current initiatives are primarily focused on upskilling children on protective behaviours rather than shifting responsibility and education to adults*
- *there is limited collaboration across sectors*
- *positively, contemporary approaches to child sexual abuse are emerging.*¹⁸

To inform its understanding of best practice responses the Board engaged the University of Sunshine Coast to develop a comprehensive report on preventing child sexual abuse.

This report highlights a range of common elements in effective collaborative prevention models include:

- **Systemic coordination:** Institutions must actively share responsibility for the prevention of and response to child sexual abuse.
- **Education empowerment:** Teaching children about boundaries and rights in age-appropriate ways.
- **Caregiver engagement:** Families are integrated into prevention and safeguarding programs.
- **Integrated service hubs:** Local services, police, schools and child protection are co-located or linked in structured systems.

Research also shows three areas of consideration which are essential for program delivery:

- **What prevention messages are these programs/strategies delivering?** - This relates to content and messaging.
- **How are these programs/strategies delivering these messages?** - This relates to selecting the appropriate forum, delivery mode and engagement technique
- **How do these programs/strategies address diversity?** - Diverse cohorts (for example Aboriginal and Torres Strait Islander people, people living with disability, people who identify as LGBTIQ+) have unique needs that must be addressed to maximise program delivery outcomes.

Table 1: Considerations for designing prevention strategies

Contextual prevention	Be informed by crime prevention through environmental design (CPTED) and situational crime prevention strategies. Be multilevel, targeted at individual, environmental, system and cultural factors. Tailored to the particular needs of at-risk cohorts and responsive to the contexts in which abuse occurs.
Co-design with young people	Be locally designed and led. Ensure relevance and trust through community partnerships, especially Aboriginal and Torres Strait Islander communities.
Focus on equity, access and inclusion	Challenge generic “evidence-based” models by asking who the program works for, and in what context.
Advocate and embed realistic evaluations	Embed evaluation from program start. Focus on what works, for whom, and under what conditions.

Education and awareness raising

“

The problem is with people not having confidence to report internally. The better option is to target that with education, awareness, capability building, and just really taking active steps to change the culture of the sector.¹⁹

”

Preventing child sexual abuse requires proactive, evidence-based strategies that reduce risk before harm occurs. Among available interventions, structured education for children and parents has emerged as the most effective, scalable, and sustainable method of prevention. By empowering children with knowledge and skills to recognise and respond to inappropriate behaviour, and by equipping parents and caregivers to create safe environments and communicate effectively with children, education addresses the root causes of vulnerability rather than reacting after abuse has occurred.

One of the most significant advantages of education is that it reduces risk by empowering children. Evidence indicates that children who receive age-appropriate education about body safety, personal boundaries, and consent are far more likely to recognise inappropriate behaviours and disclose concerns early. By equipping children with knowledge and skills, education transforms them from passive potential victims into informed participants in their own protection.

Equally important is the role of parents and caregivers. As the first line of defence, adults who are educated about grooming behaviours, the signs of abuse, and effective ways to communicate with children become better able to prevent harm. Engaged parents can reinforce protective behaviours, provide guidance, and create an environment in which children feel safe to raise concerns, further reducing opportunities for abuse to occur.

Education also has a broader cultural and systemic impact. Programs that inform both children and parents foster a culture of openness, awareness, and zero tolerance for abuse. When communities are informed, abuse is less likely to be concealed, and social norms shift toward early reporting and proactive prevention. This cultural change strengthens organisational and community responses, making child safety a shared responsibility rather than an isolated obligation.

From an economic perspective, prevention through awareness raising and education is highly cost-effective. By reducing the incidence and severity of abuse, educational initiatives help avoid long-term costs associated with police and child protection investigations, criminal justice proceedings, health interventions, and the social and economic impacts experienced by victim-survivors over their lifetime. Investment in education therefore offers substantial returns, not only by safeguarding children but also by reducing downstream societal costs.

Finally, education aligns closely with national and state safeguarding frameworks. The National Principles for Child Safe Organisations and *Queensland's Child Safe Organisations Act 2024* emphasise participation, empowerment, and the active engagement of families as central to child protection. Programs that educate children and parents directly support these principles, embedding child safety into organisational culture, reinforcing protective practices, and ensuring that safeguarding is a proactive, rather than reactive, endeavour.

Awareness campaigns and education programs have a role to play in normalising conversations and addressing stereotypes about child sexual abuse, and building the confidence of parents, carers, and other adults to identify potential signs of abuse.

In their submission, one participant advised of having worked in the ECEC sector previously, having started their career in 2003. They recalled some improvements over time, however the quality of care for the children depended on the size of the centre and the organisation. They reflected on one Church based organisation as caring and providing the best service to the children in their service. The staff were paid appropriately, and the ratios were above those of minimum standard. Other services that were owned by international investors, appeared to them to centre around profits and the service provision was “substandard”. While professional development, training, policies and procedures were somewhat better in those centres where wellbeing of the children appeared to be the priority, they reflected never having any training regarding recognising, recording and/or reporting sexual abuse of children. They reported never having received training regarding grooming and the majority of the training focused on physical wellbeing of the children. Although some practices have improved, they emphasised the need for ongoing professional development and appropriate staff remuneration.

The Board was advised that “it is difficult to identify the best content areas, pedagogy (instructional techniques) and delivery modes for teaching programs targeted at children and young people”. However, research conducted by the Australian Institute of Family Studies to inform this Review advised that:

...effective programs for children aged 2–8 years should incorporate the following features:

- *having four or more sessions*
- *active parental involvement (while acknowledging, and dealing sensitively, with the reality that not all parents are a source of safety for children)*
- *input from children, parents and professionals from a range of cultural backgrounds, to ensure culturally appropriate and sensitive content*
- *holistic implementation wherein discussions around CSA form part of sexuality education*
- *rigorous evaluations.*

Further, the Tasmanian Commission (2023) found that good educational CSA prevention programs must:

- *commence as early as possible, initially being delivered by parents*
- *include discussion of body parts, ownership of bodies and touching of bodies*
- *involve group interactions for school-age children, including with teachers*
- *use diverse and engaging resources and materials*
- *be delivered over long time frames with shorter sessions.*²⁰

Expert Professor Kerryanne Walsh indicates that children and young people should have ongoing sexual abuse prevention education throughout their entire education, including in child care and kindergarten.²¹

*Bravehearts have Ditto the lion telling kids what to do if they feel butterflies in their tummy and that's great – but it's once a year for an hour. That doesn't by any means mean that all our children are getting it or that all centres are providing that. We need to do more.*²²

As articulated in the final report of the *Commission of Inquiry into the Tasmanian Government's Responses to Child Sexual Abuse in Institutional Settings*:

*It is not the responsibility of children and young people to prevent abuse, but we consider evidence-based education can give children and young people greater confidence to identify and report safety issues, and reduces their vulnerability to grooming and exploitation. Child sexual abuse education can challenge myths and misconceptions and provide the opportunity for children to understand consent, respectful relationships and the important role bystanders can play. This is critical knowledge that will assist efforts to keep children and young people safe into adulthood and contribute to generational change in the incidence of child sexual abuse. We also expect parents and carers will indirectly benefit from these programs, which can help inform their own conversations about safety with their children. Given how common child sexual abuse is, we consider this education will also help people respond more sensitively to disclosures they may receive from family, friends and others in their lives.*²³

This aligns with Trew and colleagues' finding that knowledge and skills are retained better when reinforced over time.²⁴ Prevention through education and community-based programs has two aims:

- To equip children, educators and parents to identify and respond to harmful behaviour and abuse by delivering education which is ideally tailored to their setting and demographic
- To deliver prevention services with a place-based approach that responds to the particular risks in a location or environment.

Key elements of effective education programs also include:

- Being tailored to the developmental stage of recipients
- Delivered by professionals trained in child safeguarding
- Built on the belief that adults are responsible for preventing abuse
- Culturally informed and community-led, particularly in Aboriginal and Torres Strait Islander communities and culturally and linguistically diverse audiences
- Contain the information to equip caregivers and professionals to reinforce prevention messaging
- Target potential perpetrators and high-risk settings, not just victims.²⁵

Common themes emerged in a study undertaken by Griffith University to inform the Board's review, supporting the call for increased age-appropriate education on topics like body boundaries and safe touch, which starts early, and encourages open conversations about uncomfortable issues.²⁶ Support was also provided by participants in this study for public awareness campaigns and to encourage both families and bystanders to trust their instincts and report concerns.²⁷

In submissions to the Board, the Aboriginal and Torres Strait Islander Legal Service have strongly recommended primary prevention and early intervention strategies:

We strongly recommend primary prevention and early intervention strategies which include targeted education for parents, responsible adults/caregivers and children that: covers body safety; raises awareness of grooming behaviours; equips adults to detect early warning signs of abuse; empowers children to disclose abuse safely; and strengthens knowledge relating to how parents and responsible adults/caregivers can escalate complaints regarding concerning conduct.

Bravehearts further submitted that community awareness and outreach campaigns including Stop it Now! are effective at improving knowledge, dispelling myths, and encouraging help-seeking behaviours. They also note that primary prevention requires cultural changes around perceptions of gender, violence, and inequality. They suggest that primary prevention services should be funded and coupled with measures to drive cultural change that child sexual abuse is a preventable behavioural issue as well as a criminal one.

These programs reflect an important shift toward public health-informed approaches that view child sexual abuse not only as a criminal issue but also as a preventable behavioural and societal problem.

Education for employees, managers and executives in organisations that work with children should also focus on protective behaviours. Protective behaviour training, such as that provided by NAPCAN, is intended to “equip services with the tools and strategies to consistently embed high-quality, child-safe practices” in their centres. Protective behaviour training should fulfil Principle 7 of the National Principles for Child Safe Organisations, “Staff and volunteers are equipped with the knowledge, skills and awareness to keep children and young people safe through ongoing education and training”.

This type of training should be complementary and additional to programs available to children. For example, Bravehearts take a holistic approach to child safety by teaching children personal safety skills and strategies to help keep them safe and educating adults in child protection. Ditto’s Keep Safe Adventure Program is a live incursion for early learning centres and primary schools which meets the needs of different age groups. To complement this live performance, classroom kits and learning resources have been developed as well as a mobile game app. The aim of the program is to teach children personal safety strategies and help them build confidence and resilience to keep them safe. Child Protection Online Training Courses are also offered to those supporting and working with children. The training is specifically designed to complement the personal safety education program.

Project Paradigm provides training to professionals and agencies involved with children and young people to understand the complex nature of child sexual exploitation. Two in person workshops are available, with one focused on preventing child sexual exploitation through building understanding of the processes of control, common risk indicators, and impacts. The other workshop seeks to ensure professionals and agencies are better equipped to work with impacted children and young people.

The Daniel Morcombe Foundation also takes a holistic approach to child safety to provide education to a wide-reaching audience. There are a wide range of *Keeping Kids Safe Resources* which include books, factsheets, videos and so on for both children and adults to learn about personal safety education. *Bright Futures* includes a broad range of workshops, webinars and podcasts for adults to address the issues of problematic and harmful sexual behaviours, child exploitation material (CEM), and technology assisted harmful sexual behaviours. This is complemented by events such as the *Day for Daniel* and *Walk for Daniel* which the whole community can be involved in.

Recent research underscores the critical role of school-based education programs in preventing child sexual abuse. A recent meta-analytical study reviewed existing research into school-based educational programs for preventing any form of child abuse, offering valuable insights into the components of effective prevention programs.²⁸ This study identified several essential elements that contribute to program effectiveness:

- Programs should teach children that abuse is never their fault and equip them with strategies to escape threatening situations and seek assistance.
- Enhancing self-esteem, assertiveness, and emotional literacy is crucial for building resilience and reducing vulnerability.
- Children benefit from understanding personal rights, body boundaries, and the nature of abuse, including how to recognise risky situations.
- Programs should facilitate identification of trusted adults and encourage safe disclosure of abuse.
- Post-program support is essential to reinforce learning and address any emotional impacts.

Previous studies demonstrate that children who participate in such programs show:

- increased knowledge about abuse and protective behaviours
- improved self-protection skills
- greater likelihood of disclosing abuse.

Programs that emphasise emotional development and counteract self-blame are particularly effective. Research commissioned by the Review identified examples of best-practice education and engagement in Australia and other jurisdictions.²⁹

Table 2: Examples of child sexual abuse education and prevention programs in Australia and other jurisdictions

School-Based Programs	Parent and Caregiver Education	Professional Development Programs	Community-Based Strategies (Perpetrators)
Ditto's Keep Safe Adventure (Australia): Early childhood safety skills with songs, activities and parental involvement. Love Bites (Australia): Respectful relationships education for secondary students, preventing both victimisation and perpetration. Cyber Echo (Australia): An education resource for teachers to educate primary school aged children about online safety. Australia's Biggest Child Safety Lesson (Australia): A day connecting schools to resources run by the Daniel Morcombe Foundation.	Stewards of Children (USA): Evidence-informed training for adults on child sexual abuse signs and responses. Safe Touches (USA): In-home child safety training for caregivers of children with intellectual disabilities.	J-SAFE (Japan): Teacher training to identify and report signs of child sexual abuse. Programs for early childhood educators on grooming behaviour, trauma-informed care, and reporting obligations.	Operation RESET (WA): Police and therapist teams visit communities with known offenders to educate and prevent further harm. Prevention Project Dunkelfeld (Germany): Anonymous treatment for people at risk of offending before any crimes occur.

Figure 4: Important components of prevention based education



While education aimed at young children can be effective, it also places the onus on children to protect themselves. This has limited benefits when pursued in isolation of other initiatives and sends a harmful community message. Further, lack of an overarching strategy for the delivery of education for children in early childhood and school settings leads to inconsistency in the content and quality of this education, resulting in gaps. A systemic strategy to the delivery of education is needed.

In its submissions to the Board, PeakCare advocated for a whole of community prevention package to equip adults with the knowledge, confidence and responsibility to identify and challenge harmful attitudes and behaviours. There is also a need to ensure that programs are appropriately funded and cover the risks children face when navigating the online environment:

*'Given the ingenuity and relentlessness of online predators, and the ever-increasing appetite for new and depraved material in the child exploitation material market, those education initiatives must continue to be properly funded and delivered in a robust way by providers. The threat to children from online predators is very real, and is growing in magnitude and volume. The importance of impressing that message upon young people in an appropriate way cannot be overstated.'*³⁰

Operational Recommendation 13: Empowering children through consistent and contextual safety education

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No child should have to learn about their rights through the experience of having them violated - Survivor-advocate

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Currently, the responsibility for raising awareness of safety and risk among children falls largely on individual teachers, school initiatives, or non-profit organisations. While protective behaviours are referenced in the national curriculum, there is no mandated framework or consistent approach to ensure that all children receive this essential knowledge. As a result, the quality and consistency of safety education varies widely, and many children may miss opportunities to learn how to recognise and respond to abuse, grooming, or unsafe situations.

The early years are a critical window for laying the foundation of personal safety, self-awareness, and resilience. Research confirms that protective behaviours education in early childhood enhances children's capacity to recognise unsafe situations, assert boundaries, and seek help. Equipping children with language and confidence at this formative stage builds lifelong protective factors and helps interrupt cycles of abuse. - Act for Kids submission

The Daniel Morcombe Foundation delivers Australia's largest child safety lesson, demonstrating both the scale and effectiveness of a coordinated, expert-led approach. However, these types of initiatives remain supplementary rather than universal.

Research and experience demonstrate that knowledge is a protective factor: children who understand boundaries, grooming tactics, and how to seek help are significantly more likely to disclose concerns or avoid risky situations. By bringing these elements together into a coherent, mandatory framework, Queensland has the opportunity to ensure that every child receives age-appropriate, evidence-based instruction in personal safety.

Despite the growing evidence on the effectiveness of education in preventing child sexual abuse, there remains a significant gap in our national and state approaches to embedding prevention within schools.

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Prevention in this case is about education. Educating children with age appropriate materials at different stages throughout their development is critical. Educating professionals who work with children in either teaching units of work themselves, or supporting third party educators. Educating parents, families and the community on child sexual abuse on recognising the signs - Lived experience advisor

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...the delivery of school-based child sexual abuse prevention is not mandated in Queensland state education curriculum, the Queensland Catholic Schools curriculum or the Australian Curriculum.³¹

Opportunities to equip children with knowledge and awareness about safety, boundaries, and recognising inappropriate behaviour are currently underutilised. This gap represents more than just a missed chance to protect children; it also limits the broader capacity of our systems to detect, disrupt and deter potential offenders. By failing to provide consistent, structured education across all schooling sectors and grade levels, we inadvertently leave both children and educators without the tools necessary to respond effectively to early warning signs of abuse. The University of Sunshine Coast research conducted to inform the Board's review of this case found that:

The absence of mandated school-based child sexual abuse prevention strategies across state, Catholic, private, and the national curricula places the responsibility for delivering child sexual abuse prevention education initiatives upon individual schools and educators, creating an inconsistent approach to prevention. We emphasise the significant oversight in failing to provide school-based child sexual abuse prevention as part of the curriculum.³²

Furthermore, when we asked the University of Sunshine Coast to review the educational material provided to children 'all appeared to exclude that children are never to blame for their victimisation and online safety messaging'.³³ This is a critical missed opportunity. The Royal Commission made clear that:

*When left unaddressed, the internalised shame and stigma that arises in response to experiencing child sexual abuse can have detrimental long-term impacts across several psychological and wellbeing indicators. Hence, ensuring program content and messaging explicitly inform children that abuse is never their fault could help to limit some of the longer-term harm, if a child does experience abuse.*³⁴

Online safety also requires prioritisation and education programs can play a vital role in promoting this. Internet use is a regular and consistent feature in children's lives. Embedding child safety education within schools in a structured and consistent way would support broader community awareness. Parents, carers, and educators could rely on a clear curriculum that equips children with practical strategies for navigating both physical and online environments. This approach ensures that safeguarding is proactive, systematic, and integrated into everyday learning, rather than dependent on individual initiative.

Operational Recommendation 13: Empowering children through consistent and contextual safety education

That the Australian and Queensland governments mandate the delivery of a structured child safety and protective behaviours curriculum across all schools, drawing on best-practice programs to ensure that every child receives consistent knowledge and skills to recognise, respond, and report unsafe situations.

Operational Recommendation 14: Empowering parents through resources, awareness and education

Parent-focused education programs play a critical role in preventing child sexual abuse by equipping parents and caregivers with the knowledge, skills, and confidence needed to protect children. These programs operate in several interconnected ways: they increase parental awareness of child sexual abuse, strengthen the ability to recognise and detect abusive behaviours, support effective communication of safety messages to children, and enhance parents' skills to safely intervene in situations that may be inappropriate.

Effective training should reflect the shared responsibility of safeguarding by incorporating strategies that are complemented by education for parents and carers. Strengthening protective environments in both home and care settings requires equipping all adults in a child's life with the knowledge and confidence to respond to concerns. This includes supporting kinship carers, foster carers and residential care workers, to understand their role in safeguarding and recognising signs of abuse. PeakCare encourages the [Board] to consider how the rollout of mandatory training can contribute to a broader culture of safety, and to recommend implementation supports that ensure it is accessible to all parts of the workforce. - Peakcare Submission

Through participation in these programs, parents gain accurate information about what constitutes abuse and are able to challenge and dispel common myths surrounding child sexual abuse risks.³⁵ Importantly, parents are guided on how to communicate these safety messages to their children in a clear and age-appropriate manner, reinforcing protective behaviours and fostering environments where children feel informed and empowered to speak up if they feel unsafe.³⁶

By focusing on the central role of parents and carers, these programs provide a foundation for proactive prevention, positioning adults as key agents in reducing both the opportunity for abuse and the long-term impacts of victimisation.

While children benefit from safety and protective behaviours education, parents and carers remain a critical layer in safeguarding. Currently, guidance for parents on recognising grooming, responding to disclosures, and supporting children through safety education is inconsistent. Many parents rely on informal sources, individual educators, or non-profit programs for information, leading to gaps in awareness and confidence when addressing child safety issues.

Parent-focused child sexual abuse education programs are designed to equip parents and caregivers with the knowledge, skills, and confidence necessary to protect children from sexual abuse, both in-person and online. These programs recognise the critical role that parents and caregivers play in the early prevention, detection, and response to child sexual abuse. By building the capacity of adults responsible for children, these initiatives contribute to creating safer environments and reducing opportunities for abuse.³⁷

As articulated by the University of New South Wales in research that it conducted for the Board:

Evidence specific to [early childhood education and care] ECECs highlights the following family/parental risk factors that make children more vulnerable to CSA in an institutional context:

- lack of knowledge about the signs and symptoms of CSA [child sexual abuse],
- lack of knowledge about risk factors specific to ECECs,
- lack of involvement with the childcare institutions, and
- close relationships with ECECs staff, which makes parents more reluctant to raise concerns or believe disclosure.

Parents are often reluctant to believe cases of CSA that do not align with their expectations of the nature of the abuse or the profile of the offender, for example, in the case of a female offender. However, overall, parents tend to underestimate their children's vulnerability to sexual abuse while simultaneously overestimating their own ability to recognise the signs of abuse and children's capacity to disclose it".

The importance of these programs is particularly pronounced for children in the early childhood cohort, typically aged two to five years, who are especially vulnerable to adverse and traumatic experiences and may face long-term developmental, emotional, and social impacts as a result of abuse. In recognising diverse caregiving arrangements, these programs should encompass both parents and carers, acknowledging that some children may be cared for primarily by people other than their biological parents, and that not all parents maintain an active caregiving role.

Parent-focused child sexual abuse education programs operate within both primary and secondary prevention frameworks. They deliver content and messaging designed to prevent sexual abuse of children before it occurs while also targeting adults who may be at risk of engaging in abusive behaviours. By addressing both protective and preventative dimensions, these programs strengthen family and community systems, enhance adult vigilance, and contribute to the broader goal of reducing the prevalence and impact of child sexual abuse.

The University of Sunshine Coast advised the Board that:

*Parents and carers are an important resource in child sexual abuse prevention. Parents and carers are uniquely positioned to provide key messaging and reinforce children's learning about child sexual abuse prevention at home.*³⁸

Health services are also uniquely positioned to provide evidence-based awareness-raising materials and guidance to parents, including information on developmental considerations, signs of distress, and strategies for open communication with children. ECEC settings are also pivotal: these environments are often the first institutional spaces outside the family where children spend significant time, and staff must be trained to observe behaviours of concern and identify risk. By making targeted information available to parents in these settings, families can be equipped with knowledge to reinforce protective behaviours at home, recognise concerning behaviours, and respond appropriately to disclosures

Embedding a standard requirement for both health services, and ECEC providers to actively deliver guidance to parents would normalise conversations about safety and create a consistent community-wide approach. This proactive dissemination of knowledge ensures parents are empowered to act, reduces the likelihood that concerning behaviours go unnoticed, and strengthens the protective ecosystem around children.

Operational Recommendation 14: Empowering parents through resources, awareness and education

That the Queensland Government fund the production of key communication materials for parents and caregivers, which are available in settings frequently accessed by families. These materials are to provide accessible, evidence-based child safety education resources, and that early childhood education and care settings actively make information available to parents on:

- protective behaviours
- recognising grooming (including grooming of parents, organisations and children)
- identifying signs of distress, and
- responding to disclosures.

This initiative should be supported by a coordinated strategy across providers of health services early childhood services, and neighbourhood centres to ensure parents receive consistent, practical, and actionable guidance to safeguard children in both home and care settings.

Contextual prevention

The physical layout for organisation's activities or the organisation's setting can hide or expose child sexual abuse; with the physical structure of an organisation playing an important role in creating 'safe environments' for children and young people.

Contextual prevention refers to strategies designed to strengthen environmental, social, cultural and physical factors to better prevent, identify and respond to child sexual abuse. Rather than focusing solely on individual perpetrators or victims, this approach targets the settings and conditions in which abuse occurs.³⁹ This approach acknowledges that human behaviour is shaped by context, and by modifying environments, whether physical, social, or institutional, opportunities for abuse can be reduced.⁴⁰ It is complementary to individual focused interventions by making places safer alongside making people safer.⁴¹

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Traditional child sexual abuse prevention has focused on individual-level strategies, whereas contextual prevention models address the environmental and situational factors that enable abuse. Because youth-serving organisations are high-risk settings for CSA, contextual strategies must protect children in the environments they occupy daily. Safeguards should be tailored to specific contexts, as risks differ across schools, childcare, sports, arts, religious institutions, hospitals, and online spaces - Survivor-advocate

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Reflecting back on Routine Activity Theory discussed in more detail in Part A, unsupervised access or lack of guardianship provides opportunities for motivated offenders to commit abuse. Efforts can be made to increase guardianship through legislation, policies and procedures, as well as changes to physical environments and supervisory practices which increase guardianship. This will impact on the routine activities of potential perpetrators by reducing their opportunities to interact with potential victims in unsupervised or minimally supervised environments.

Contextual prevention of child sexual abuse comprises prevention efforts that target factors external to the individual, addressing macro-level and micro-level structures to create safer environments for children and young people.

In a study undertaken by Griffith University to inform this Review, participants highlighted the importance of creating safe environments in early childhood settings by implementing situational crime prevention strategies.⁴² These include ‘the rule of two’ or ‘four eyes’ policy, controlled access, CCTV monitoring, and appropriate staffing ratios for effective supervision. It acknowledges that motivated offenders exist but aims to reduce risks by targeting guardians, places and managers. Key measures include no phones on the floor, clear risk signage and special focus on high-risk areas like nappy changing and toileting.

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*It is critical that educators can design a learning space to meet the needs of the children in their charge and to align with their organisation’s learning philosophy. However, this cannot in anyway compromise the safety and wellbeing of children. As such, blind spots, cubbies, forts with no line-of-sight etc do not promote or maximise the safe supervision of children.*⁴³

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Submissions received from community members called for a range of contextual prevention measures, including two people needing to be in attendance when children are being changed, and phones and cameras should not be allowed:

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*What is predictable is avoidable! Due diligence means to take the appropriate, expected, or necessary attention, precautions or reasonable care required, to protect the health, safety and welfare of all staff and children.*⁴⁴

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Contextual prevention operates along a macro-to-micro continuum:

- Macro-level strategies address broader social and structural factors, such as gender inequality, cultural norms and values, and legal and policy frameworks.
- Micro-level strategies focus on proximal influences and situational risks, including lack of supervision, physical environments that allow private access to children and social dynamics that discourage disclosure or detection.⁴⁵

Micro-level interventions such as Crime Prevention Through Environmental Design (CPTED) and situational crime prevention, aim to reduce opportunities for abuse by modifying environments and contexts.⁴⁶

Environmental criminology highlights the dynamic interplay between individuals and their surroundings, showing how specific environmental features can shape opportunities for criminal behaviour. This perspective underpins both situational crime prevention and guardianship strategies, which aim to reduce offending by modifying environmental conditions. Effective environmental prevention strategies must consider:

- the importance of identifying contextual factors contributing to abuse
- the value of community collaboration
- the need to ground interventions in local realities
- the effectiveness of place-focused strategies in preventing abuse by reshaping environments and social dynamics.⁴⁷

Online contextual prevention: Keeping children safe in digital environments

The digital environment presents some of the most complex safeguarding challenges of our time. Unlike physical spaces, where adults and systems can monitor and regulate access, the online world operates across devices, platforms, and contexts that are constantly evolving. The Board heard evidence that a contextual prevention approach, tailoring interventions to the device, platform, and behavioural environment, offers the most effective strategy for protecting children online.

Device-level prevention: At the most immediate level, prevention begins with the devices that children use. Parents and carers can make use of built-in tools such as parental controls and screen time limits, helping to set boundaries around usage and access to age-appropriate content. Biometric access controls can prevent unauthorised use of devices, and geolocation technology allows parents to implement GPS-triggered restrictions that automatically reduce online risks in certain locations, such as school or late-night environments. These tools empower families to shape the digital contexts children operate in, much like setting boundaries in the physical world.

Platform-level prevention: Technology platforms hold significant responsibility for child safety. Contextual interventions such as real-time pop-ups can disrupt unsafe interactions or alert children to risks in the moment. Platforms should be required to share intelligence about offenders across services, ensuring that harmful actors cannot simply migrate from one platform to another. Further, advances in artificial intelligence allow for real-time alerts to be sent to caregivers if unusual or concerning patterns of online behaviour are detected, offering an additional layer of protection that bridges the digital and physical worlds.

Behavioural and environmental contexts: Perhaps the most critical layer of prevention lies in shaping behaviour and environment. Families can foster digital resilience in children by equipping them with the skills to recognise peer pressure, online manipulation, and grooming behaviours. Simple, practical routines such as charging devices outside bedrooms overnight, encouraging shared use in family spaces, and establishing technology-free zones or times, help create safer environments. These habits not only reduce risk, but also normalise healthy digital practices that children carry into adulthood.

Towards a holistic approach: Online contextual prevention requires the alignment of responsibility across individuals, families, technology companies, and governments. It recognises that no single tool is sufficient. Just as in offline safeguarding, a layered approach creates the strongest safety net. Device controls, platform accountability, and behavioural strategies must work together, supported by regulation and community education, to ensure that children can participate in digital life without being exposed to unacceptable risks.

Strengthening contextual prevention approaches within institutional settings

Crime prevention through environmental design focuses on altering physical spaces to deter potential offenders and increase supervision. Strategies include:

- conducting environmental audits to identify risk points
- improving visibility through lighting and architectural changes
- installing access controls in schools and youth organisations.

Examples include adding glass panels to classrooms or interview rooms, moving computers into shared spaces or installing CCTV to improve surveillance in public areas. Examples of CPTED which are relevant to the prevention of abuse in institutional settings include:

- eliminating enclosed or hidden spaces within centres where perpetrators can isolate children
- improving line of sight by landscaping and pruning in outdoor spaces, installing glass walls and doors in indoor spaces and ensuring they are kept clear of obstructions
- increasing the level of surveillance, both by creating more opportunities for employees to monitor each other in shared spaces, and by installing overt surveillance systems (i.e. CCTV).

Situational crime prevention is another approach to contextual prevention which targets individual behaviours (including perpetrators, co-workers, children and parents) to disrupt abuse. The aim is to deter offending behaviour by:

- increasing the effort required to commit an offence, through increased guardianship, adequate recruitment and staffing, and institutional safeguarding procedures
- increasing the risks of committing an offence, through increased guardianship and supervisory practices, physical layout and design, installing CCTV and clear codes of conduct
- reducing the rewards of an offence, through reduced access to personal devices
- removing excuses for breaking the law, clear safeguarding policies and procedures and codes of conduct.

Examples include training staff to identify and respond to abuse, encouraging community involvement in safeguarding and promoting protective parenting practices, such as open communication and supervision. Situational crime prevention also supports online interventions, including warning messages and chatbots, which reduce opportunities for online child sexual abuse to occur.

Place-Based Crime Prevention involves targeted approaches which seek to reduce crime in known hotspots or high-risk environments. These strategies recognise that place influences behaviour, and that prevention must be tailored to the specific risks and dynamics of each location. There are six key principles for place-based prevention:

- identify locations of concern
- understand the problem at a local level
- develop locally informed prevention plans
- establish and consult with local advisory groups
- implement and monitor prevention activities
- evaluate outcomes and share knowledge⁴⁸

Place-based strategies often incorporate CPTED and situational crime prevention techniques, and may apply to entire communities, not just individual sites.

Consultation and research undertaken to inform this review consistently highlighted the importance of strengthening contextual prevention. The University of New South Wales have suggested that child safeguarding in ECEC settings can be improved by:

- safeguarding protocols specific to high-risk tasks such as toileting
- design requirements for ECEC settings, including the use of CCTV and other measures to reduce the concealment of abuse in the physical environment
- implementation of the “four eyes” principle, to ensure that no childcare staff member is alone with a child
- routine, rigorous, and independent evaluation of these programs and measures.⁴⁹

The Board noted opportunities for strengthening contextual prevention across the different centres where abuse occurred. This was most evident in the physical design of centres, which included cubby houses, forts and enclosed spaces that children played in with limited visibility. One centre's risk assessment discussed an enclosed area that the children used as a 'cubby' and would play with torches in. Children also liked to 'box' themselves in the space. Specific measures were required by ECRA as part of the service approval for this centre, that included the installation of mirrors to enhance supervision of this space, which also had dual access.

The physical design of centres which further restricted supervision also presented a risk. For example, storerooms inside classrooms did not have locks and had no viewing panels. One classroom was divided by a whiteboard, which prevented educators on one side from seeing what was happening on the other side. In interviews conducted by ECRA after the offending was detected, this centre maintained that 'staff can see each other all the time' and that 'there's nothing to be changed.'

Although the use of the classroom has now changed, meaning there are more teachers, the whiteboard still divides the classroom, preventing clear line of sight of other children and educators, and the storerooms are solid doors with no locks. Another centre had frosted doors between different classrooms, meaning that educators cannot see between both rooms.

There is overwhelming evidence in this case that the offender created opportunities for abuse to occur by placing sheets over an outdoor fort, placing images and posters on windows, and keeping blinds closed during rest times, despite children being split between indoors and outdoors. While all centres are required to comply with minimum staffing ratios, supervisory practices across centres also meant that the offender was frequently left alone with children. Rest pause or rest period conditions resulted in the offender being left alone with children in at least three centres during sleep and rest times, for up to an hour.

In one centre, the offender was witnessed by parents multiple times to be alone with children during pick-up. In a different centre, the offender was left to manage a classroom on his own, despite being an agency contractor.

Policies and procedures further normalised children being alone with one carer. For example, one centre's policies allowed for children to be taken to the director's office for "*special*" time or for children to have one-on-one time with a teacher if they needed support with their behaviour.

Changes made after the offending was detected

There have been a raft of changes announced since the offending was detected in ECEC settings including those that aim to strengthen contextual prevention through the use of CCTV, the removal of rest period conditions in Queensland and banning of the use of personal devices in centres.

Some of the centres where the abuse occurred also provided the Board with advice on the changes that they had made since the offending was detected. Responses included a focus on contextual prevention strategies to improve guardianship through:

- increased supervision by requiring a minimum of two staff to be rostered, which exceeds regulatory requirements
- amendments to supervision plans, to ensure a clear line of sight
- a cessation of the use of rest period conditions
- the installation of glass doors in storage areas, kitchens and rooms
- restrictions on technology and device use
- regular centre visits, auditing and spot checks to ensure compliance.

Information was also sought from centres where there was no known offending about their safeguarding practices, and responses emphasised that they had a strong focus on contextual prevention when the offender worked there. For example, one centre reflected that the physical layout of the service meant that it had 'high structural visibility' which acted as a potential deterrent. The offender was also supervised during the entire shift that he worked there.

One centre where the offender worked recommended a range of regulatory and policy reforms to the Board to strengthen educator safety, accountability and child protection across the sector. This included changing regulations to always require a minimum of two staff so that no educator is alone with children and removing rest period conditions from service approvals.

Putting CCTV in focus

Notably, following his arrest the offender reported that he 'did not offend in other centres because they had cameras', referring to closed-circuit television surveillance (CCTV). While recent government commitments and community conversations have focused on the installation of CCTV in centres to improve visibility and supervision, this is just one aspect of an effective approach to situational crime prevention.

CCTV in ECEC settings has been described as 'a game changer' which protects both children and educators from incidents and allegations of abuse and inappropriate discipline.⁵⁰ CCTV has been used by centres to evidence inappropriate discipline by educators, and regulators have used this evidence in their own investigations.

However, CCTV is not a fail-safe solution. It requires that consideration be given to how CCTV footage is collated, stored and accessed. It also poses potential risks if this footage is accessed inappropriately and consideration must be given to its safe retention. CCTV requires consistent monitoring and review of footage to detect offending. Research indicates that CCTV is best used as a crime-prevention measure in circumstances where opportunistic property crime is a risk.⁵¹

As articulated by one of the centres that the offender is known to have offended:

Serious consideration needs to be given as to the usefulness of CCTV cameras. CCTV will not prevent abuse but could assist in substantiating abuse if an allegation is made. There is also the concern that unintentional content could be developed, such as a child removing their clothing and going to the locker to get new clothes. Moreover, consideration needs to be given to concerns regarding the hacking of systems and this footage then becoming available to external parties.

The recent *Review of Child Safety Arrangements under the National Quality Framework* (the Review of Child Safety Arrangements) also found that research into the presence of CCTV in ECEC settings indicated that while it provides 'the perception of preventing harm', it is not effective at preventing incidents.⁵² Indeed, the presence of CCTV in ECEC settings raises unique concerns for the privacy of children and parents and has compliance implications.

Under the *Commonwealth Privacy Act 1988* (the Privacy Act), recorded images of an individual are personal information and people must be notified before such a recording is carried out. Recordings must be destroyed or deidentified once they are no longer required. The Privacy Act applies to ECEC in each jurisdiction as if it were a law of that jurisdiction under the National Law.⁵³ It therefore applies to all Queensland ECEC providers.

Further, the *Queensland Information Privacy Act 2009* (the IP Act) applies to state schools and other government agencies, and any ECEC service attached to them. The IP Act requires agencies to only collect CCTV that is reasonably necessary for one or more of the functions of the agency, to take reasonable steps to inform individuals about the recording, and to securely store recordings.

In recognising that CCTV is likely to be installed as a risk mitigation strategy, the Australian Children's Education and Care Quality Authority (ACECQA) Review of Child Safety Arrangements found that 'providers need clear guidance about the development of policies covering communications with families, educators and all staff about the use of CCTV and how CCTV footage is collected, used and stored.'

The Board was further advised by the Australian Institute of Family Studies that:

ACECQA's findings about CCTV are consistent with extensive criminological research around CCTV, which indicates its benefits are of most value in circumstances involving property crime, specifically in carparks. In the review report, ACECQA recommended (at recommendation 2.6) that ECEC services who install cameras must also have appropriate policies in place (ACECQA, 2023).⁵⁴

Recent national commitments that seek to deliver on recommendations from the Review of Child Safety Arrangements mean that all centres are required to have established policies and procedures about the safe use of digital devices, including the use of CCTV. Where services have, or are intending to use, CCTV, they will be required to:

- inform families of its use, including the purpose of its use
- explain how data is stored, secured and accessed
- ensure timely access to CCTV footage to regulatory agencies and police where requested.

“

The use of CCTV in spaces where services are delivered to children cannot be considered a 'quick fix' – if implemented, it must be accompanied by the development and promotion of cultures which prioritise child safeguarding.⁵⁵

”

‘Under the roof’ ratios and rest period conditions

Under the NQF, child-to-educator ratios are calculated across the service, not by individual rooms, and are based on the youngest child in care. This is referred to by the sector as an ‘under the roof ratio’. The effect of this is that an educator does not need to be collocated with a child attributed to them in the ratio calculation. This approach does not however remove the need for adequate supervision to be the primary consideration.

The National Regulations require the educator-to-child ratio to be maintained no matter what activity the children or the educators at the service are undertaking. Some jurisdictions, including Queensland, have specific provisions which modify these ratio requirements when educators are taking short breaks and are not working directly with children. In Queensland a service was previously able to have a rest period condition which allowed for one or more periods during a day, totalling not more than two hours during that day, for educators to care for a greater number of children than under the standard ratios.⁵⁶

ECRA has confirmed that rest period conditions were in place in five of the 11 centres where there was known offending in this case. Following investigations into these centres, ECRA advised that:

While some incidents did occur during rest periods, investigations found that rest period conditions themselves were likely not a causal or a direct contributing factor to the offending. However, given the correlation of some patterns of offending with rest periods, we have identified this as a time when heightened vigilance is therefore required, a position inconsistent with the reduced staffing levels facilitated by rest period conditions.

For this reason, ECRA advised that they undertook a comprehensive review of Queensland-specific rest period conditions, including options for legislative reform as part of Project Safeguard. This included working with the early childhood sector to raise awareness of risks to the safety of children associated with sleep and rest time and encouraging voluntary amendment of service approval to remove rest period conditions. As a result, 330 services in Queensland with a rest period condition voluntarily surrendered their condition.

In October 2025 the Queensland Parliament passed legislation that removed the ability for approved providers to hold rest period conditions on their service approvals under both the National Law and the state-based Education and Care Services Act. This means that existing rest period conditions will no longer be in effect from 1 January 2026, and services will have to comply with national educator-to-child ratios at all times.

It is evident that the offender in this case perpetrated abuse against children when there was low or minimal supervision. The available information suggests that staff members were often the sole educator with children including during rest times, a period in which the offender is known to have committed abuse. In Centre EA, where the offender was the Director, it appears that he may have kept enrolments deliberately low to avoid staff ratio requirements. Parents whose children had been directly impacted by the offending also raised concerns to the Board about child-to-educator ratios, particularly during rest periods, because it provides opportunities to target children by limiting adult witnesses and facilitating access to groggy or unconscious victims.

There are also other persons in some of the CEM footage the offender created, with the duration of recordings varying from approximately 8 seconds to 30 minutes. In one centre he compiled over 50 hours of CEM. These are not isolated instances or momentary lapses of supervision, it demonstrates a sustained pattern across centres and over time. These issues are also not isolated to this case. A recent survey conducted by the United Workers Union of over 2000 early childhood educators highlighted significant concerns with ‘widespread understaffing’ and ‘constant breaches of child-to-educator ratios’ which were impacting children’s safety and placing children at risk.²⁸

The United Workers Union Early Childhood Education and Care Quality and Safety Census found that:

- 77 per cent of educators reported operating below minimum staffing levels at least weekly, and 42 per cent responded that it was happening daily.
- 75 per cent of educators believed that regulators should not allow centres to avoid legislated minimum staffing requirements by issuing waivers.
- 83 per cent of educators strongly agreed that the ‘under-the roof ratio’ compromises the safety and wellbeing of children.²⁹

Embedding contextual prevention into early childhood education and care settings

Early childhood is a critical window for prevention. Children under five are developing their understanding of the world and are forming attitudes towards behaviour that they carry with them into adolescence and beyond. Children at this age are also particularly at risk of harm because they are less capable of identifying abuse to themselves and their peers, are highly dependent on caregivers, and are less able and less likely to articulate experiences of abuse to trusted adults.

By employing evidence-based prevention measures, and reducing opportunities for abuse to occur, staff can be empowered to report concerning behaviour. The high demand on the ECEC sector impacts the ability of parents to identify when providers are properly implementing prevention measures. Parents lack the confidence to properly interrogate issues at the provider level.

The dominance of profit-motivated ECEC providers is a further barrier to crime prevention through environmental design measures. In older or established centres, these often require costly modifications to be made, and further regulation in the absence of additional funding to implement the changes required may result in non-compliance. Regulatory collaboration may be a mechanism to drive improvements in contextual prevention. For example, regulatory approvals for construction and renovation of commercial premises are an opportunity to introduce crime prevention through environmental design principles.

An agency who has all the policies and procedures in the world, still might not translate into the right culture on the ground with the people in the agency. Policies and procedures are only as good as your people on ground, and in particular your leaders, and not just executive leadership, but middle management as well.⁵⁷

Operational Recommendation 15: Requiring organisations to improve active supervision of children

Effective safeguarding in environments where children are cared for, educated, or supervised requires both technological and human oversight. CCTV and staffing ratios are frequently discussed as standalone mechanisms to protect children, but evidence and expert opinion indicate that their value is maximised when integrated within a broader culture of proactive safeguarding.

CCTV provides a record of interactions and can deter inappropriate behaviour because it increases the likelihood of detection, supports investigations, and helps to identify non-compliance, risks and persons of concern. However, cameras alone do not prevent abuse; they are passive tools and may provide a false sense of security. Similarly, staffing ratios are intended to ensure that children are never left in situations where abuse could occur undetected, but ratio requirements are insufficient if organisational culture and accountability are weak. For example, even with high staffing numbers, isolated supervision of children can occur if policies are not clear or staff do not follow procedures.

A strong safeguarding culture requires that it be highly unusual, and only under clearly defined circumstances, for a worker to be alone with children. Risk management processes must be embedded to ensure that deviations are reported, documented, and addressed through supervisory oversight. Organisations should analyse incidents or near misses to continuously improve staffing allocation and supervision practices, supported by CCTV as a verification and investigative tool rather than a substitute for active supervision.

Importantly, the effectiveness of surveillance—both human and technological—is amplified when directors, company owners, and boards are held accountable. Clear legal liability ensures that safeguarding measures are not treated as merely compliance obligations or reputational safeguards but as proactive, protective mechanisms. Where leadership is accountable for failures in supervision or surveillance, organisations are more likely to cultivate a culture in which staff are vigilant, reporting is robust, and risk management is genuinely preventative. Integrating CCTV and staffing ratios within this accountability framework shifts safeguarding from passive observation to active prevention. It supports early detection of risks, ensures timely responses, and embeds child safety as a central responsibility of every organisational decision, from the boardroom to frontline care.

Operational Recommendation 15: Requiring organisations to improve active supervision of children

The Queensland Government use its regulatory and oversight schemes to require all ECEC sites to develop their own unique proactive Safeguarding Plan focused on active supervision. Each plan should include:

- clear and published active supervision staff ratios that are transparent regarding under-the-roof, and rest-break calculations
- ensuring policies, training and built environments make it unusual for any worker to be alone with vulnerable children, with clearly defined exceptions and reporting requirements
- embedding risk management processes that require incidents, near misses, or deviations from supervision protocols to be reported to senior management and oversight bodies
- using CCTV not as a substitute for active supervision but as a complementary tool to verify compliance, deter misconduct, and support investigations where this is appropriate and the negative consequences are addressed.

This integrated contextual approach will ensure that surveillance—both human and technological—is part of a culture that prioritises child safety, promotes accountability at all organisational levels, and effectively prevents harm.

An organisational culture of prevention

The prevention of child abuse within organisations cannot be reduced to policies, procedures, or compliance mechanisms alone. While these structures are necessary, they are insufficient without a culture that places children's safety and wellbeing at its centre. An organisation's culture—its values, norms, and daily practices—fundamentally shapes whether safeguarding commitments are meaningful in practice or remain rhetorical.

As submitted by the Archdiocese of Brisbane:

'...cultural change, vigilance, and systemic reform – rather than blanket exclusion or technological fixes – are the cornerstone of safeguarding. Evidence demonstrates that genuine safeguarding is best achieved through robust recruitment, comprehensive training, clear accountability structures, and a culture where concerns are recognised and reported. Simplistic solutions that rely on exclusion or surveillance do not address the systemic gaps identified by this inquiry and would ultimately divert focus and resources from the reforms that are most needed. This reinforces the earlier distinction between safeguarding as a proactive cultural framework and child protection as a responsive mechanism. Proposals such as restricting male participation or mandating surveillance risk blurring these categories, diverting attention from the systemic reforms required to genuinely keep children safe.'

Research, system reviews and inquiries consistently show that abuse is most likely to occur and persist in environments where authority is unquestioned, children's voices are marginalised, and transparency is absent. Conversely, organisations with open, accountable, and child-centred cultures are best positioned to detect risks early, empower children and families, and intervene before harm escalates.

"early childhood prevention strategies must be implemented in the context of creating child-safe environments that provide safety outside of the educators too".⁵⁸

A child safe culture involves more than a passive commitment. It requires leadership, governance, and everyday decision-making to prioritise child safety even when doing so is inconvenient, resource-intensive, or disruptive to existing practices. The National Principles for Child Safe Organisations (endorsed by all Australian governments) establish cultural foundations for prevention:

1. **Child safety embedded in leadership, governance, and culture:** Prevention is not an add-on, but part of the organisation's identity. Leaders model behaviours and make safeguarding a standing agenda item in strategic and operational decisions.
2. **Children and young people are informed and participate:** Cultures that actively listen to children are more likely to pick up on early warning signs of risk and prevent abuse.

3. **Equity is upheld, and diverse needs are respected:** Abuse thrives in environments where some children are invisible. A culture that recognises and responds to vulnerability ensures risks are not overlooked.
4. **Staff are equipped with knowledge, skills, and awareness:** Training and professional development reinforce a culture where safeguarding is everyone's responsibility, not the remit of a few specialists.
5. **Complaints and concerns are taken seriously and responded to:** A transparent, just culture ensures children and adults trust the system enough to disclose concerns, reducing opportunities for abuse to be hidden.⁵⁹

The National Principles for Child Safe Organisations were developed to provide a consistent, evidence-based framework for safeguarding children across all sectors. Endorsed by all Australian governments, the national principles articulate that child safety must be embedded in leadership, governance, and organisational culture, and that children's voices must be central to decision-making processes. They provide a foundation for organisations to create environments where children are respected, empowered, and protected from harm.⁶⁰

Workforce capability is also essential in supporting a strong organisational safeguarding culture. The Australian Childhood Foundation advised the Board that:

There are no clear minimum requirements for the quality, content, or mode of delivery. Most training lacks lived experience perspectives and does not adequately address children's relational needs – how they communicate, how they build trust, and how they perceive risk. As a result, we cannot be confident that all organisations are equipping their staff and volunteers to understand, prevent, identify, and respond to child sexual abuse effectively.

This failure to standardise safeguarding training across the sector risks leaving critical gaps, particularly in ECEC settings where children are most vulnerable and depend on adults to create safe, nurturing environments. Crucially, without a strong emphasis on prevention, we risk responding only after harm has already occurred. In its current form, the system also risks entrenching inequity. Different ECEC services have varying financial and time resources, which directly impacts their capacity to offer meaningful training. Without a mandated and funded baseline of competency, children in some settings will be less protected than others, particularly those from marginalised communities.

In Queensland, the National Principles were given legislative force through the *Child Safe Organisations Act 2024*, which commenced on 1 October 2025. This legislation marked a significant step forward, requiring organisations working with children to comply with ten Child Safe Standards, thereby translating the national principles into enforceable obligations. The standards are designed to ensure a systematic and proactive approach to safeguarding, extending beyond procedural compliance to the development of organisational cultures in which child safety is prioritised in every aspect of operations.

The 10 Child Safe Standards in Queensland reflect the national principles and emphasise:

- **Child safety embedded in leadership and culture:** Leadership must actively champion child safety, modelling behaviour and allocating resources to uphold this priority.
- **Children and young people's voices are central:** Policies and practices must ensure children can participate in decisions affecting them.
- **Equity and diversity are recognised:** Organisations must identify and address risks for children from culturally and linguistically diverse backgrounds, Aboriginal and Torres Strait Islander children, and other vulnerable groups.
- **Staff and volunteers are informed and supported:** Recruitment, training, and supervision practices must promote awareness of child safety responsibilities.
- **Families and communities are engaged:** Transparency, partnerships, and information-sharing help reinforce a culture of safety.
- **Procedures for responding to concerns:** Complaints, disclosures, and incidents must be taken seriously and managed promptly.
- **Risk management strategies:** Proactive identification and mitigation of risks to children in organisational activities.
- **Safe physical and online environments:** Protective measures must extend to all spaces where children engage with the organisation.
- **Human resource management and supervision:** Ensuring ongoing suitability of personnel through supervision, monitoring, and performance appraisal.
- **Continuous improvement:** Organisations must regularly review and update practices in response to feedback, incidents, and evolving evidence.

Together, the National Principles and Queensland's Child Safe Organisations Act establish a legislative and cultural framework for safeguarding children that moves beyond compliance toward proactive prevention. By embedding child safety into organisational culture, leadership, and practice, these reforms aim to create environments where abuse is less likely to occur and more readily detected, and where children and young people are recognised as active participants in shaping their own safety.

The difference between a compliant but unsafe organisation and a truly child safe organisation lies in culture. Two organisations may have identical policies, but the one with a defensive, hierarchical, or indifferent culture will be at higher risk of abuse occurring or being concealed.

An open, respectful culture makes policies come alive: staff challenge unsafe behaviours, children trust adults with concerns, and leadership responds to allegations without hesitation. This cultural dimension is why external oversight and standards-based regulation increasingly focus on requiring boards and executives to demonstrate cultural leadership, not merely procedural compliance.

The challenge for Queensland is overseeing and measuring how safe organisations actually are. The Australian Childhood Foundation reflected to the Board that:

The current system within early childhood education and care settings remains heavily weighted towards procedural compliance, with assessors focusing on whether services have the correct policies, forms and administrative requirements in place. While having clear documentation is important, this emphasis often comes at the expense of understanding how effectively child safeguarding is being embedded into everyday practice. As a result, opportunities to support services in developing authentic child-safe cultures are being missed.

Identifying and measuring culture is not easy. The Australian Institute of Family Studies drew on emerging research to:

"...recommend a survey that measures the following expertise and capability to assess the overall capability of an organisation to embody a child safe culture.

(a) awareness of organisational policies, practices and safeguarding culture;

(b) confidence to take action when a child or young person voices a concern about their safety and wellbeing;

(c) attitudes in relation to children and young people's knowledge and access to safety education; and

(d) knowledge about the risks and prevention of child sexual abuse".

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An uncomfortable conversation – prevention of child sexual abuse perpetration

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If you think something can't happen here, you're already at risk because people have that mindset, right? People are operating in their own little worlds that 'it's just strangers', 'it's no one I know', or 'that would never happen to me'.⁶¹

”

While governments and community can seek to strengthen child safeguarding practices and build understanding through protective behaviour training and community awareness raising, focus also needs to turn to those responsible for the abuse. This ensures that perpetrators are held accountable for their actions and is intended to act as deterrent to others.

Tertiary prevention targeted at perpetrators can include a range of possible measures for people who:

- have not yet offended, but have an interest in or may be likely to sexually offend against children
- have engaged in, or are seeking to engage in, accessing or distributing child exploitation material (CEM) and may be at risk of contact offending
- have offended and need assistance or interventions to desist offending, including those who have yet to be detected for their offending.

Examples of tertiary prevention targeted at perpetrators which have been evaluated include:



The meaning of accountability

Perpetrator accountability is a multi-layered concept involving both individual responsibility and systemic action. At its core, it refers to a perpetrator acknowledging the harm they have caused and taking responsibility for their behaviour.⁶² However, accountability must also be embedded across the justice system and supported by community structures. Accountability is a 'complex, multi-layered and long-term task that requires attention at all points of the justice process.'⁶³

Effective accountability structures require a range of different interventions, which are tailored to a perpetrator's individual needs and patterns of offending.

Figure 5: Circles of support and accountability



Importantly, different forms of accountability can sometimes conflict. For example, legal accountability through prosecution may not lead to a personal acknowledgment of harm and may fail to validate the victim-survivor's experience. This tension highlights the need for a whole-of-community approach to accountability. Research also shows that rehabilitation and reintegration are most effective when delivered in tandem, with tailored interventions that promote desistance and community safety.

Measuring the 'effectiveness' of accountability strategies is complex. Studies often define effectiveness based on their own parameters, which may vary significantly. In this context, effectiveness is considered in terms of:⁶⁴

- reducing reoffending
- supporting perpetrator accountability
- improving community safety.

It is also important to note that many accountability strategies, particularly in rehabilitation and reintegration, are not specific to child sexual abuse perpetrators.⁶⁵ Much of the available research applies broadly to sexual offenders, with limited studies focused exclusively on child sexual abuse. Where specialised findings exist, they should be prioritised and further developed.

Stages of accountability

Accountability should be pursued across the entire justice continuum:



Prosecution: Legal consequences reinforce societal condemnation of abuse and uphold the rule of law.



Rehabilitation: Interventions can help perpetrators understand the harm they've caused and reduce the risk of reoffending.



Reintegration: Community-based support and monitoring are essential for long-term desistance and public safety.

As noted by the University of Sunshine Coast in research developed to inform this Review, perpetrator accountability is a significant policy issue, however, some community protection strategies may be designed more to manage public perceptions than to genuinely protect children. This raises concerns about the symbolic use of accountability in political and media discussions. Research highlights that politicians and media have a role in promoting a more progressive and inclusive agenda, challenging harmful narratives and supporting holistic responses that include rehabilitation and reintegration.⁶⁶

For example, community management strategies are a key component of post-release accountability. These include:

- surveillance and monitoring (e.g. parole conditions, electronic monitoring)
- support services to assist with reintegration into the community
- multi-disciplinary care for high-risk, high-needs offenders, including emotional regulation strategies
- technology, such as remote monitoring software, which has been found to be effective and even appreciated by some perpetrators as a way to demonstrate compliance and good behaviour.⁶⁷

Professionals also report that these types of strategies can reduce reoffending and act as a deterrent. Outside of the criminal justice system, the community plays a central role in perpetrator accountability. They can contribute to:

- preventing reoffending through social support and supervision
- fostering a culture of safety and responsibility
- challenging denial and minimisation of abuse.⁶⁸

A community-based approach ensures that accountability is not only punitive but also transformative, aiming to prevent future harm and support healing for all involved.⁶⁹

In reality, community attitudes towards perpetrator-focused prevention can be a barrier to the establishment or implementation of effective prevention programs. Societal distaste for perpetrators can lead to a desire for more punitive measures and more surveillance, however:

*'the effectiveness of monitoring and restriction mechanisms at the individual level is mixed. Sex offender registers have been found to be ineffective in that they do not reduce the commission of sexual or non-sexual crimes and because they can lead to societal disenfranchisement which can actually be more problematic.'*⁷⁰

Prevention of future offending

Most of our current prevention efforts involving perpetrators focuses on the prevention of future offending, to try and stop those who have been caught from reoffending. Rehabilitation of offenders is a core part of the current response to child sexual abuse in Queensland, Australia and internationally. For example, sentencing decisions are required to take into account a person's potential for rehabilitation. It also forms the focus of interventions while offenders are in prison and is required to be considered in parole decisions.

“

The sentencing of offenders involves an often complex task of applying the principles and purposes of sentencing to the characteristics of the offence and the subjective characteristics of the offender... The sentencing of child sex offenders is an important issue. This is in part because of the role sentencing plays in achieving some of the purposes of the criminal justice system – particularly punishment and deterrence.⁷¹

”

The available sentences for child sexual abuse offences under Queensland and Commonwealth criminal laws are broad. When considering the offences the following maximum sentences apply (as of 2025):

Table 3: Maximum sentences for child sexual abuse offences in Queensland

Offence	Maximum sentence of imprisonment
Grooming child under 16 years or parent or carer of child under 16 years (Criminal Code s218B)	5 years (10 years if the child is under the age of 12)
Making child exploitation material (Criminal Code s228B)	20 years (25 years if the offenders used a hidden network or anonymising service)
Distributing child exploitation material (Criminal Code s228C)	14 years (20 years if the offenders used a hidden network or anonymising service)
Possessing child exploitation material (s228D)	14 years (20 years if the offenders used a hidden network or anonymising service)
Indecent treatment of children under 16 (Criminal Code s210)	14 years (20 years if the child is under the age of 12 or has an impairment of the mind, is a lineal descendent of, or under the care or guardianship of the perpetrator)
Repeated sexual contact with a child (Criminal Code s229B)	Life imprisonment
Rape (Criminal Code s349)	Life imprisonment
Using a carriage service for child abuse material (Cth Criminal Code s473.22)	15 years

It is a general principle of law that the penalties available to be imposed, and the sentencing standards and considerations for the court to reach a decision on sentence, should be those which were available at the time the offence occurred. This was discussed in the Royal Commission into Institutional Responses to Child Sexual Abuse, which found that the ‘use of historical sentencing standards is particularly relevant to matters of institutional child sexual abuse, which are often prosecuted many years, even decades, after the offending occurred.’²⁰ Due to the trend towards more severe penalties for child sexual abuse offences in recent years, this practice sometimes results in the imposition of penalties which are less severe, distressing victim-survivors and running counter to community expectations.

As a result, the Royal Commission recommended that legislative amendments should be made so that courts must apply modern sentencing standards to child sexual abuse offences, but to ensure fairness to the accused, the maximum penalty available should be that which applied at the time of the offence.

The Queensland government tabled this recommendation for further consideration, noting consultation was required before any change to the sentencing regime in the *Penalties and Sentences Act 1992* (the Penalties Act) could be considered.²¹

The maximum penalty imposed on an offender is determined by the court with consideration given to previous similar cases. This encourages consistency in sentencing for similar behaviours, and proportionality in sentencing behaviours which are determined by the court to have different degrees of seriousness. The imposition of the maximum penalty is typically “reserved for the worst type of case” falling within the definition of a given offence in the legislation.²²

In 2012, Queensland introduced new sentencing to deal with repeat serious child sex offenders. Under part 9B of the Penalties Act, a perpetrator who is convicted for a ‘serious child sex offence’ as an adult, and who had previously been convicted for another serious child sex offence, is liable to imprisonment for life regardless of the maximum penalty otherwise available to a court. This ‘cannot be mitigated or varied under any law’.²³ This was intended to recognise that ‘that child sex offending is so heinous and presents such a risk to the safety of the community that the strongest legislative response is called for to ensure appropriate punishments are imposed’.²⁴

Besides imprisonment, courts have many options available to them in sentencing, depending upon the relative weight applied to the various purposes for which a sentence may be lawfully imposed. These purposes are articulated in section 9 of the Penalties Act:

- (a) punishment
- (b) rehabilitation
- (c) deterrence
- (d) denouncement
- (e) community protection
- (f) a combination of the above.

When sentencing a perpetrator for multiple offences (as in the offender’s case), most frequently a court will declare that sentences are to be served ‘concurrently’. This is particularly the case when the most serious offence (MSO) has a maximum or mandatory life sentence attached and the court determines to impose a sentence of life imprisonment as a head sentence.

Courts in Queensland and other jurisdictions apply the principle of totality when sentencing for multiple offences. This means that the sentence imposed for all the offences of which the accused is found guilty must be reasonable and proportionate; that is, sentencing is not simply a matter of applying the sentence on each conviction without regard to the others. This typically acts to reduce the total sentence imposed.

Courts can also specify a parole eligibility date at sentencing. This is most relevant for determining how long the person will effectively serve in prison. This non-parole period is frequently associated in public and media discourse as the ‘actual’ sentence imposed.

Parole

Parole is a form of supervised release from prison which may be granted before a term of imprisonment is completed. Parole may be court-ordered or parole-board-ordered. Court-ordered parole was introduced in Queensland in 2006 to increase the number of offenders who may be subject to supervised release in the community, and reduce the population of short-sentenced, low-risk prisoners in Queensland Corrective Services facilities.²⁵ Otherwise, the Parole Board of Queensland is responsible for considering and making decisions on applications by prisoners for parole. A prisoner who is released on parole may be returned to incarceration if they breach the conditions of their parole.

If released on parole a perpetrator sentenced to life imprisonment will remain under supervision for the rest of their life. Parole eligibility for life sentences is set automatically by section 181 of the *Corrective Services Act 2006*, however courts do have a discretion to impose a longer non-parole period if the circumstances demand it. A person sentenced for a serious violent or sexual offence must have parole eligibility date set by the court when it sentences them.²⁶

It is generally considered to be advantageous for parole to be granted (especially when life imprisonment has not been imposed), as this means the perpetrator is likely to spend more time in the community under supervision and management by law enforcement, which increases their chances of successful reintegration.²⁷

Typical sentencing outcomes

To accomplish the specified purpose of sentencing, a court is required to consider other options in sentencing before imprisonment, which is considered a 'last resort'.²⁸ This may include requiring a payment of a recognisance or other financial penalty, a term of probation, community service or an intensive correction order, or a term of imprisonment that is wholly or partially suspended.

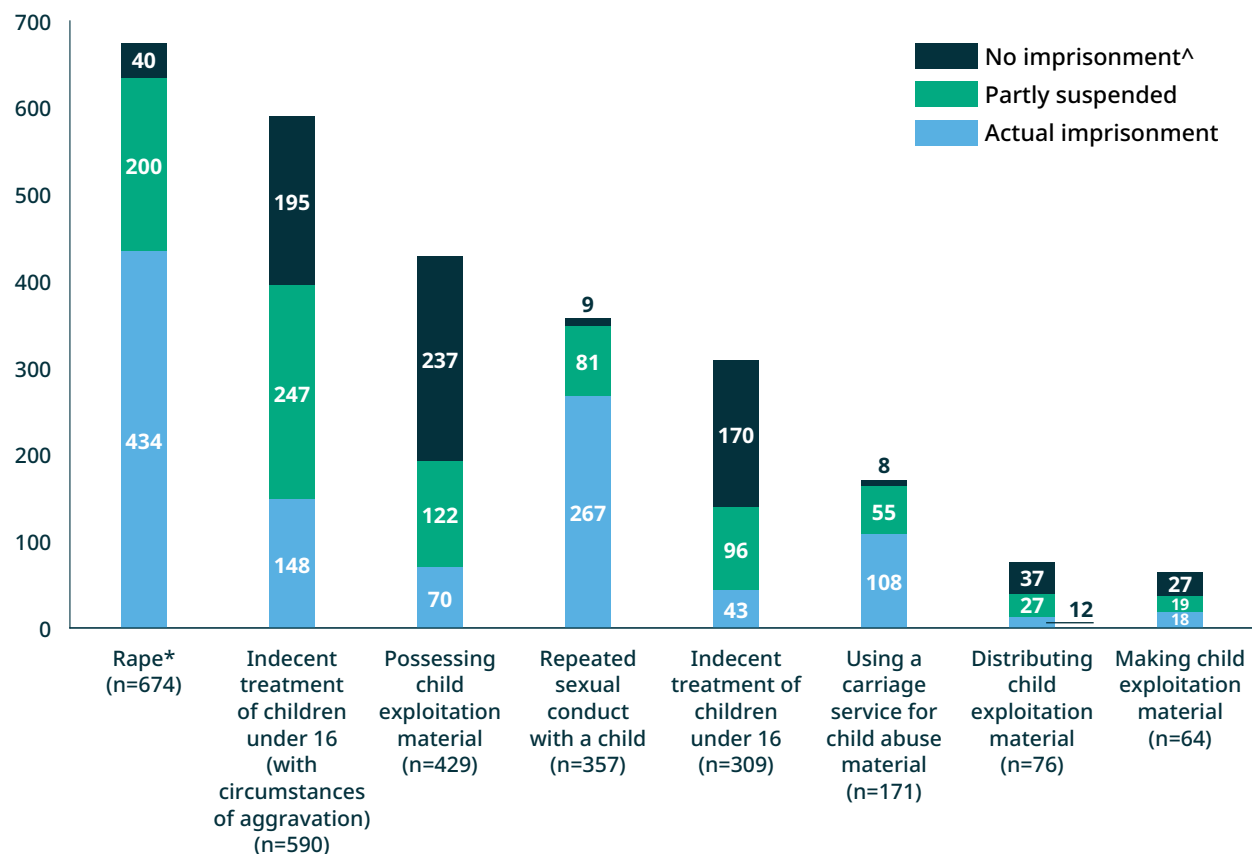
Most convicted perpetrators (72.9% of sentences) from 2019–20 to 2023–24 in Queensland received sentences that included actual imprisonment, even if some of the sentence was suspended. This included sentences for rape (94% of sentences where rape was the MSO),²⁹ repeated sexual conduct with a child (97.5%), using a carriage service for child abuse material (95.3%), indecent treatment with aggravation (66%), making (57.8%) and distributing CEM (51.3%). Indecent treatment without aggravation (45%) and possessing CEM (44.8%) were less likely to receive a sentence of actual imprisonment when these were the MSO. The number of sentences involving actual imprisonment, party suspended imprisonment, and no imprisonment, is set out in Figure 6 below.

Figure 6: Sentences for child sexual abuse offending by adults (2019–20 to 2023–24)

Source: Queensland Sentencing Advisory Council, Sentencing DataHub. Numbers represent the sentence imposed when the nominated offence was the 'most serious offence' (MSO)

* Includes adult and child victims

^Includes wholly suspended terms of imprisonment, intensive correction orders, probation, and other non-custodial penalties



The most common term of imprisonment (without suspension) handed down to perpetrators in the same period is set out in table 4:

Table 4: Most common term of imprisonment for child sexual abuse offences 2019–20 to 2023–24

Most serious offence (MSO)	Most common term of imprisonment (not suspended) imposed 2019–20 to 2023–24
Indecent treatment of children under 16 (n=43)	Less than 1 year (24)
Making child exploitation material (n=18)	Less than 1 year (9)
Possessing child exploitation material (n=70)	1 to 2 years (26)
Indecent treatment of children under 16 (with circumstances of aggravation) (n=148)	1 to 2 years (47)
Using a carriage service for child abuse material (n=108)	1 to 2 years (47)
Distributing child exploitation material (n=12)	3 to 4 years (5)
Rape (n=434)	6 to 7 years (73)
Repeated sexual conduct with a child (n=267)	9 to 10 years (43)

Over this period, four life sentences were handed down each for rape and repeated sexual conduct with a child. The offender’s sentence is not included in this data as he was sentenced in late 2024.

Reforming the Serious Violent Offences Scheme in Queensland

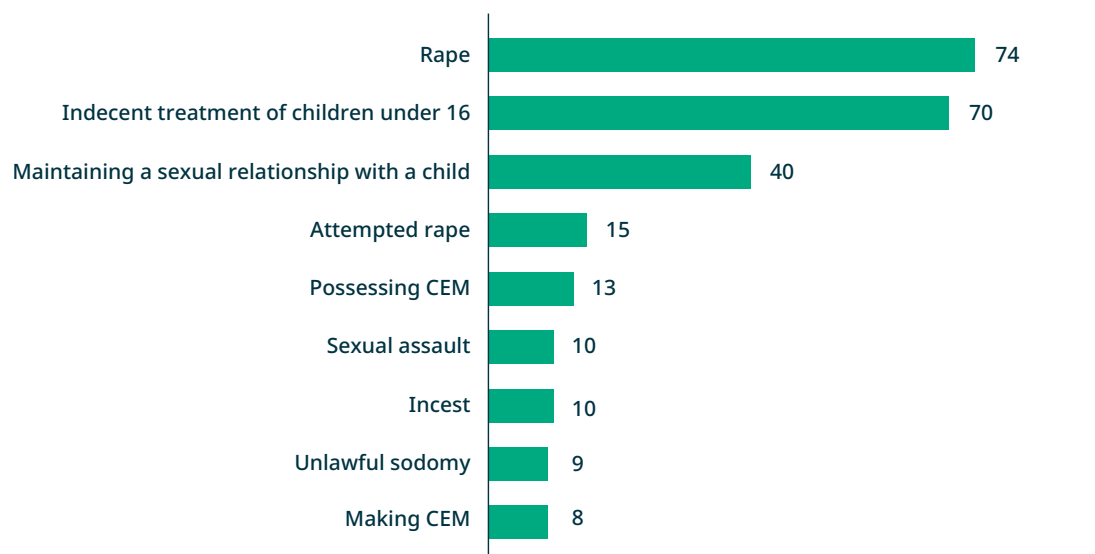
The Serious Violent Offences (SVO) scheme mandates that offenders declared under the scheme must serve at least 80 per cent of their sentence or 15 years (whichever is lesser) before becoming eligible for parole. This is mandatorily applied to listed offences with sentences of 10 years or more, and discretionarily to those between five and 10 years. The Queensland Sentencing Advisory Council’s (QSAC) 2023 report *The 80 per cent Rule: The Serious Violent Offences Scheme in the Penalties and Sentences Act 1992 (Qld)* provides a comprehensive evaluation of the SVO scheme’s effectiveness, fairness, and alignment with sentencing principles under the Penalties and Sentences Act.

In the nine years to 30 June 2020, 437 individuals were sentenced under the SVO scheme, with 72.8 per cent receiving mandatory declarations. Discretionary declarations were made in only 27.2 per cent of cases, despite the seriousness of most offences falling below the 10-year imprisonment threshold. The most common offences to attract an SVO declaration (mandatory or discretionary) were maintaining an unlawful sexual relationship with a child (n=91), and rape (n=71). Perpetrators sentenced for these offences under the SVO regime were the least likely to be granted parole (35.1% and 38.1% respectively).⁷²

The report identified that one in five cases of maintaining an unlawful sexual relationship with a child³⁰ was declared an SVO. As an MSO this offence was frequently tried alongside charges of rape, attempted rape, indecent treatment, and additional counts of maintaining an unlawful sexual relationship with a child. This indicates that such offending rarely occurs in isolation or in the absence of other types of violence.

Figure 7 over the page indicates the number and type of offences commonly associated with the maintaining offence when declared an SVO:

Figure 7: Offences most commonly associated with maintaining a sexual relationship with a child SVO (2011–12 to 2019–20)



In undertaking its review of the SVO scheme, QSAC identified several systemic issues with its operation. Judicial discretion was significantly constrained by the mandatory nature of the scheme, leading to inconsistent sentencing outcomes. In some cases, judges were observed to reduce head sentences to avoid triggering the mandatory declaration. Between 1997 and 2020, 17.9 per cent of SVO prisoners did not apply for parole, resulting in unsupervised release at the expiry of their sentence. Among those who did apply, parole was granted in 63 per cent of cases, compared to more than 80 per cent of non SVO prisoners over the same period.

Victim-survivor consultations revealed dissatisfaction with the scheme's discretionary application, particularly in cases involving serious harm where no declaration was made. Victims also expressed concern about the lack of post-release supervision, which they perceived as undermining community safety.

QSAC considered the application of the SVO scheme to child sexual abuse offences, highlighting both its symbolic and practical significance. Stakeholder submissions, particularly from advocacy organisations such as Knowmore, emphasised that victim-survivors often feel that sentencing outcomes do not adequately reflect the gravity and lifelong impact of the offending.

While the scheme's mandatory nature ensures that perpetrators serve a substantial portion of their sentence, it can paradoxically result in shorter head sentences when judges seek to avoid automatic declarations that limit parole discretion. This judicial workaround, reducing sentences to just below the 10-year threshold, can undermine the scheme's intent and diminish victim-survivor satisfaction.

Victim-survivors reported feeling let down when the seriousness of the offence was not reflected in either the sentence length or the time served. The report acknowledged these concerns and recommended a presumptive model that retains judicial discretion while ensuring that serious child sexual abuse offences are appropriately recognised through longer custodial periods and supervised release.

This approach aligns with broader community expectations, and the findings of the Royal Commission which advocated for sentencing practices that reflect contemporary standards and the enduring harm caused by such offences.

In response to the evolution of the SVO scheme and the limitations identified in the report, QSAC made 26 recommendations. These included replacing the current model with a presumptive declaration scheme for listed offences sentenced to over five years, allowing courts to set parole eligibility between 50 and 80 per cent of the sentence, and revising the list of applicable offences to expand beyond strictly "violent" offences, including (but not limited to):

- CEM offences (producing, distributing, and possessing)
- prostitution offences involving children as a circumstance of aggravation
- choking, suffocation or strangulation in a domestic setting.

QSAC also recommended renaming the scheme to the "Serious Offences Scheme" to better reflect the proposed scope change and ultimately found that the current SVO scheme is overly rigid, undermines judicial discretion, and fails to promote effective reintegration for offenders. The proposed reforms aim to create a more balanced, evidence-based, and victim-sensitive sentencing framework.

To date, the Queensland government has not formally responded to the QSAC report or its recommendations. In its recent report on sentencing for rape and sexual assault, QSAC recommended the government formally respond to and implement the recommendations previously made in the SVO scheme review.⁷³

Review of sentencing for Commonwealth child sex offences

The *Sexual Crimes Against Children and Community Protection Measures) Act 2020* (Cth) (SCAC Act) was introduced to address perceived inadequacies in the sentencing of child sex offenders under Commonwealth law, particularly with the sentencing of Commonwealth offences by State and Territory courts. The State and Territory courts are generally responsible for prosecuting and sentencing perpetrators of offences under Commonwealth criminal law, however the principle of consistency requires judges to maintain similar sentencing practices across jurisdictions.

The objectives of the SCAC Act included increasing custodial penalties to better reflect the gravity of offending, enhancing general and specific deterrence, and ensuring that community expectations are met. The Act introduced mandatory minimum sentences for the most serious offences and for recidivist offenders, established a presumption in favour of actual imprisonment and cumulative sentencing, and required courts to consider rehabilitation and the misuse of community standing as aggravating factors.

A recent *Statutory Review of Sentencing for Commonwealth Child Sex Offences* assessed the first three years of the SCAC Act's operation, from 23 June 2020 to 22 June 2023.³¹ It considered the operation and effectiveness of these provisions, their impact on sentencing outcomes, and whether further reform was warranted.

This review found that actual imprisonment remained the predominant sentencing outcome, imposed in 71.58 per cent of cases during the relevant timeframe. While the proportion of offenders receiving custodial sentences was slightly higher prior to the SCAC Act (74.36%) than after its commencement (69.96%), the average duration of imprisonment increased. The average total effective sentence rose from 2.75 years in 2020–21 to 3.5 years in 2022–23, while the average minimum custodial period increased from 1.5 to 2.1 years over the same period. These findings suggest a modest upward trend in sentencing severity following the legislative reforms.

Mandatory minimum penalties were applied in 11.4 per cent of cases during the review period. Their application increased over time, from 0 per cent in 2020–21 to 17.4 per cent in 2022–23. The review found that the introduction of mandatory minimums had a more pronounced effect on second strike offenders, whose average total effective sentence increased from 3 years (pre-SCAC Act) to 4.8 years (post-SCAC Act), and whose average minimum custodial period rose from 1.6 to 2.5 years. In contrast, first strike offenders experienced only marginal increases in sentence length, although the imposition of actual imprisonment became more consistent.

The SCAC Act sought to preserve incentives for guilty pleas by allowing sentence reductions of up to 25 per cent in mandatory minimum cases. The review found that guilty pleas remained prevalent, with 98.84 per cent of charges resulting in such pleas. Among offenders whose sentencing remarks specified a discount, 96.93 per cent received a reduction of 25 per cent or less. The average reduction was 24 per cent for a guilty plea and 9 per cent for cooperation with law enforcement. These findings indicate that the legislative reforms did not deter guilty pleas and may have contributed to procedural efficiency and reduced trauma for victim-survivors.

Rehabilitation is a key focus of the SCAC Act. Courts are required to consider an offender's prospects for rehabilitation and the availability of treatment programs. The review found a slight increase in pre-sentence rehabilitation participation since the introduction of the SCAC Act, from 38 per cent to 42.6 per cent. Post-sentence rehabilitation planning was more common, with 92 per cent of post-SCAC offenders indicating an intention to participate in treatment, compared to 85 per cent pre-SCAC. However, access to custodial rehabilitation programs remained inconsistent across jurisdictions, and eligibility is often limited to high-risk or long-term offenders.

The review noted that victim impact statements were referenced in only 7.67 per cent of sentencing remarks, and witnesses were mentioned in just 1.64 per cent of cases. This low level of victim-survivor engagement reflects the nature of Commonwealth child sex offences, which is discussed elsewhere in this report. Sentencing judges consistently acknowledged the serious harm caused by such offences and the broader societal impact of CEM.

The SCAC Act introduced a presumption in favour of actual imprisonment, unless there were “exceptional circumstances.” Courts retained discretion to release offenders immediately under recognisance release orders where exceptional circumstances were found. The review identified a range of factors considered exceptional by judges, including COVID-19-related hardships, rehabilitation prospects, and time served in pre-sentence custody. Among offenders who released on sentencing, the median duration of pre-sentence custody was six months for pre-SCAC cases and ten months for post-SCAC cases.

The review concluded that the SCAC Act had partially achieved its objectives, with early evidence of increased sentencing severity and consistency. However, it identified three areas where legislative amendment could enhance clarity and equity:

1. The sentence reduction for cooperation with law enforcement should be expanded to include assistance in relation to state and territory child sexual abuse offences.
2. The application of second strike mandatory minimum penalties should be limited to cases where the second offence was committed after the first offence was charged.
3. The presumption in favour of actual imprisonment should be extended to include state and territory sentencing options adopted under section 20AB of the Crimes Act 1914 (Cth).

This review highlighted the importance of maintaining judicial discretion in the sentencing of child sexual abuse offences, and emphasised the importance of enhancing access to rehabilitation and preserving procedural safeguards for victim-survivors and offenders as key areas to be improved.

The use of ‘good character’ evidence and an absence of victim impact statements

Historically, character evidence has been permitted in court to provide evidence that the behaviour a person has been convicted is ‘out of character’ for them, and weighs against a conviction or the imposition of a severe sentence. According to the Queensland Supreme Court benchbook:

*It is a matter for assessment in each case whether the evidence is relevant to either the Defendant's credibility or the unlikelihood of his having committed the offence in question or both.*⁷⁴

A recent review of sentencing for sexual assault and rape offences by QSAC, found that there were strongly conflicting views in the community and legal sector around the appropriateness of good character evidence for use in trials for offences involving sexual violence:

*The Council was told by victim survivor and advocacy groups' stakeholders that character references can be deeply distressing and retraumatising for victim survivors and undermine the sentencing purposes of denunciation. This stakeholder cohort was concerned that these references are accepted – seemingly without question – and appear to be given mitigating weight, despite the very serious nature of the offending involved.*⁷⁵

This is particularly relevant when considering the extent to which perpetrators of child sexual abuse may use grooming of other adults to create opportunities for abuse to occur and to avoid detection, including by presenting as credible, committed and outstanding members of the community. In this sense, the ‘good character’ displayed by a perpetrator was actually part of the offending, and should be understood in this way.

In its final report, QSAC recommended several changes to sentencing law and practice to respond to this, and other issues identified by victim-survivor advocates. This included:

- Creating a new aggravating factor for offences against children (who are nonetheless over the age of consent) to acknowledge the vulnerability of this cohort and the increased culpability of adult offenders in these circumstances.
- Exclude the consideration of good character evidence in the sentencing of an adult perpetrator for sexual offences, ‘unless such evidence is relevant to assessing the person's prospects of rehabilitation or risks of reoffending’.⁷⁶
- Review the victim impact statement (VIS) regime to ensure it is serving the best interests of victim-survivors, including prohibiting courts from drawing an inference that harm was not caused to a victim in the absence of a VIS.

In September 2025 the *Penalties and Sentences Act 1992* was amended...in particular implementing QSAC's recommendation to limit the use of good character evidence in the sentencing of sexual offences.⁷⁷

This intended to make the process of sentencing sexual offences more just and considerate of the experiences of victim-survivors, including children.

Reintegration and registration

When community integration is done with supervision, intervention and support it can increase community safety. However there are a range of individual and structural barriers that exist which can prevent successful community integration. These include:

- Self-motivation
- Social isolation
- Socio-economic disadvantage
- Cultural factors
- Labelling by the community and media.

While there has also been a focus on registration of offenders as a way to manage them in the community, and respond to community concerns, these can provide a false perception of safety. This is because they cannot protect the community from offenders who have not been caught and convicted for their offending. It is similarly important that the community does not develop a false sense of security about public sex offender registers, given the low rates of detection and conviction of perpetrators of child sexual abuse.⁷⁸

They can also act as a barrier to reintegration and undermine rehabilitation efforts, by increasing labelling.

Daniel's Law

On 27 August 2025, the *Community Protection and Public Child Sex Offender Register (Daniel's Law) Bill 2025* was tabled in Parliament by the Queensland government. The Bill is intended to create a publicly searchable child sex offender database, modelled on the registers established in Western Australia (WA) in 2012⁷⁹ and South Australia in 2024.⁸⁰

Funding of \$10 million was allocated in the 2024 State budget for the establishment of the scheme.⁸¹ The Queensland Attorney-General has described the planned register under Daniel's Law as a 'three-tiered system' which will:

- publish online particular information on reportable offenders who have failed to comply with their obligations
- implement an application-based system to identify high-risk offenders in a local area
- help parents to determine whether individuals who have unsupervised contact with their children are reportable offenders (a 'Community Protection Disclosure Scheme').⁸²

*Daniel's Law should be viewed as one component of a multi-faceted approach to preventing child sexual abuse. When integrated with offender monitoring, therapeutic support and interagency collaboration, controlled disclosure schemes can provide a pragmatic and ethical mechanism for reducing harm... A major challenge for Queensland is the need to ensure such schemes do not shift attention away from systemic issues like education, early intervention, and support services.*⁸³

Sexual Offender Treatment Programs

Sexual Offender Treatment Programs are tailored programs which can be delivered in prisons or the community. In Queensland, they are generally only accessible to people who are subject to Queensland Corrective Services orders, and they are not accessible to people on remand. Sexual Offender Treatment programs aim to equip offenders with the knowledge, skills, attitudes and self-belief they need to work towards a fulfilling life (offence free). Some of the topics covered include:

- engagement with the program (key component to reduce offending)
- self esteem
- criminogenic targets such as attitudes and cognitions; healthy relationships; and behavioural issues.⁸⁴

To increase effectiveness of the intervention, rehabilitation must be tailored to the individual needs and cultural context of the offender. Male sexual offender treatment programs are not suitable for female perpetrators of child sexual abuse, due to different motivators and behaviours.

There is also evidence to indicate that offenders who participate in treatment programs are less likely to reoffend.⁸⁵ Programs which focus on tailored treatment, which is supported by community reintegration, are likely to be the most effective.

Research conducted by the University of New South Wales has found that approximately one in six (15.1%) Australian men reported sexual feelings towards children. Around one in 10 (9.4%) Australian men has sexually offended against children, with half this group reporting sexual feelings towards children.⁸⁶

These are undetected offenders who have not come to the attention of authorities or the systems that meant to protect our children. Some of the men identified in the study expressed that they wanted help with their feelings towards children.

This type of work requires specialist training. Health professionals such as general practitioners and psychologists are unequipped to address a person's concerns about sexual thoughts and feelings towards children. Given the highly taboo nature of child sexual abuse, it is also unlikely that someone with sexual interest in children would discuss this in non-specialist therapeutic settings.

Preventative interventions and support for those who are concerned about their thoughts or feelings towards children are important.

International Case Study to Prevent Offending

Prevention Project Dunkelfeld (translation "dark field") was both a community awareness campaign and therapeutic support service for children and adults who self-identify as having a sexual attraction towards children. The public awareness component involved a public media campaign, with posters, radio and social media advertising a free and anonymous 24-hour helpline. The media campaign for this helpline adopted a non-judgmental approach, with the slogan "You are not guilty because of your sexual desire, but you are responsible for your sexual behaviour. There is help! Do not become an offender!" The helpline was run by clinically trained and experienced counselling support staff, to conduct screening to support referral into the therapeutic support component of the project.

The therapeutic support component provided, Berlin Dissexuality Therapy, delivered a tailored treatment program for people who were referred through the helpline, that aligned with the integrated theory of sexual offending. It adopted a group-based and multi-modal approach, including pharmacological and psychological intervention strategies. The program employed cognitive behavioural therapy, relapse prevention strategies, self-regulation and the Good Lives Model. The treatment program was delivered weekly for 45-50 three-hour sessions, lasting approximately 12 months. Although discussions about treatment of offenders is largely beyond the scope of this Report, this program was designed specifically for people who had not yet engaged in offending behaviour, as a secondary prevention strategy.

During the first 10-years of the project (i.e., 2005–15), an average 15–20 people contacted the helpline per month, resulting in more than 2,100 applications for the treatment program, 906 assessments for treatment and offers for treatment to 459 people.⁸⁷ However, early evaluation data indicated that people who had committed offences were also accessing the service, alongside those at risk of perpetration. Nonetheless, program data revealed that the treatment program had resulted in improved psychological functioning, with reductions in emotional deficits and pro-offending attitudes, and increased sexual self-regulation. In an offending sample of 53 participants, there was some evidence of a reduction in offending-related behaviours, though offending did persist for 29 of 32 users of CEM, highlighting the complexities of child sexual abuse and challenges of reducing further offending.⁸⁸ However, in a more recent study, Beier and colleagues (2024) reported that the content or nature and frequency of CEM offending had reduced among these participants.⁸⁹ This showcases the value of targeted community-based prevention strategies that should be implemented alongside broader primary prevention strategies for a comprehensive child sexual abuse prevention agenda.

The Royal Commission made several recommendations relating to creating child safe communities through prevention, including by focusing attention on perpetrators.⁹⁰ This included by ensuring that information and help-seeking services to support people who are concerned they may be at risk of sexually abusing children are available. The Royal Commission noted that the design of these services should be informed by Stop It Now! which is a model previously implemented in Ireland and the United Kingdom. It further recommended that there should be help seeking services for parents and other members of the community concerned that:

- an adult they know may be at risk of perpetrating child sexual abuse
- a child or young person they know may be at risk of sexual abuse or harm
- a child they know may be displaying harmful sexual behaviours.⁹¹

In seeking to deliver this recommendation, the National Strategy to Prevent and Respond to Child Sexual Abuse 2021–2030 highlights that there is currently a lack of early intervention services for people who have a sexual interest in children, but that these services are necessary to prevent harm. Under the key theme of offender prevention and intervention, the National Strategy committed to strengthening law enforcement responses to child exploitation and victim identification for online child sexual abuse, legislative reforms to strengthen digital evidence gathering powers and to the launch of an offending prevention service for adults who have sexual thoughts about children or young people.⁹²

Stop It Now! Australia is an anonymous helpline and website run by Jesuit Social Services offering support to individuals concerned about their own or someone else's sexual thoughts or behaviours towards children. The program provides a non-judgemental and confidential space for people to seek help, aiming to prevent child sexual abuse by offering support and advice. The service is designed to be accessible to anyone affected by child sexual abuse, including concerned family members and professionals.⁹³

In submissions to the Board it was noted by Jesuit Social Services that:

Efforts by individual organisations and institutions to keep children safe cannot be disconnected from a broader societal context. A systemic, government-led effort is required, focussed on the positive and tangible actions that can be taken by individuals, groups and organisations to create communities that are safe for all children.

'Stop it Now! Australia' was commenced as a pilot program in September 2022, funded entirely from grants and philanthropic donations. Stop it Now! provides an anonymous helpline which men may call to talk about their concerns about sexual feelings towards children, or those of another person such as a friend or colleague. Jesuit Social Services modelled the program on similar successful perpetrator prevention programs in other jurisdictions such as the United Kingdom and United States (where it has been operating since 1992).

Stop it Now! also provides online, self-paced education modules in a program called 'Get Help! Australia' which provide resources to assist men understand and manage their behaviour in healthy ways. The two elements of the program help manage the risks of offending before harm occurs, in alignment with the Royal Commission recommendations.

Building on their experience delivering Stop It Now! and in response to 'an absence of secondary early intervention prevention services for children and young people', Jesuit Social Services established the Worried About Sex and Pornography Project (WASAPP), in collaboration with the University of Melbourne. This work led to the launch in August 2025 of a scoping study for a new service, *What's OK? Australia*, to support young people concerned about their own or someone else's sexual thoughts or behaviours, as well as parents, carers, and professionals who are worried about a young person's harmful sexual behaviour. Key features of the proposed service include an anonymous helpline and a dedicated website offering accessible resources and psychoeducation. The *What's OK?* website will launch in 2026, but additional funding is required to establish the anonymous helpline. Prevention programs like *What's OK?* will require government funding to ensure their longevity and effectiveness.

The Australian Government has recently confirmed funding for Jesuit Social Services to establish and deliver an expanded child sexual abuse prevention service, building on the Stop It Now! Australia pilot program. This funding fulfils commitments under the National Strategy and will establish Australia's first national, federally funded child sexual abuse offending prevention service. It is anticipated the National Offending Prevention Service (NOPS) will be launched in early 2026.

Since its commencement in September 2022, Stop It Now! Australia has received over 800 calls and live chats and had more than 45,000 people access its website. In the UK, Stop it Now! received over 11,000 calls for support and over 100,000 unique website viewers over a four-year period to 2018.⁹⁴ An evaluation of the success of this program, coupled with a nationally-televised and online public awareness campaign, suggested that 66 per cent of respondents had changed their behaviour as a result.⁹⁵ Frequently reported behavioural changes were stopping viewing CEM, engaging with help services, changing behaviour to avoid risky situations, and ceasing pornography use.

The efficacy of Stop it Now! is currently being evaluated; initial results indicate that it has been effective within the limited time it has been in operation.

However, the greatest risk to the success of programs such as Stop it Now! has always been resourcing and the ability to provide the services they offer to a broad cohort. In the First National Action Plan under the National Strategy, measure 21 committed to the delivery of an offending prevention service similar to Stop it Now!. The National Office for Child Safety, situated in the Attorney-General's Department, was responsible for procuring the NOPS, which has been allocated \$6.2 million over five years. A recent report by the Australian National Audit Office in June 2025 found that the procurement process had suffered 'significant delays', required further clarification before the tender could be accepted, and lapsed before these could be finalised.⁹⁶ In general, the tender process was found to not meet the Commonwealth Procurement Rules.

Operational Recommendation 16: Allocate funding and services to prevent and address behaviours that might lead to offending

Online and digital interventions are an increasingly important component of a comprehensive child sexual abuse prevention agenda, particularly given the rapid growth of online offending and digital perpetration.⁹⁷ Within primary and secondary prevention, strategies include the use of prevention messages (such as pop-up warnings) and chatbots, which aim to interrupt potentially harmful online behaviour and prevent escalation.⁹⁸ Public awareness campaigns and parent-focused education programs can complement these strategies by encouraging parents to implement protective measures on their children's devices, including content filtering and communication controls.⁹⁹

While many online interventions operate within tertiary prevention, responding to offending after it occurs, primary and secondary strategies play a critical role in deterrence and early intervention. Tertiary interventions include content blocking on web searches, web crawlers utilising artificial intelligence, facial recognition software, peer-to-peer network monitoring, and targeted online stings. Although essential, these strategies are beyond the scope of this report.

Digital prevention messages serve as both a deterrent and an educational tool. Pop-up warnings can appear when individuals search for illicit content or attempt to upload abusive material to cloud servers, delivering brief, targeted messaging that challenges attitudes, highlights the harms of abuse, warns of detection risks, or directs users to support services. Chatbots build on this approach by engaging users in anonymous, automated conversations at critical decision points. They can provide brief psychoeducation, encourage help-seeking, and connect individuals with therapeutic or helpline resources.

These strategies are designed to disrupt potential offending trajectories, promote help-seeking, and reduce opportunities for harm by intervening at key moments of online decision-making, reflecting a secondary prevention focus that targets both behaviour and environment. Once implemented, digital prevention measures can be highly cost-effective. However, their success depends on the cooperation of online service providers, internet providers, and governments. As many platforms are privately owned, prevention efforts can be inconsistent.

To address this, Australia and several other countries—including the UK, US, Canada, and New Zealand—have published the *Voluntary Principles to Counter Online Child Sexual Exploitation and Abuse*, which outline guidance for technology companies to prevent the distribution of abusive material, block and filter illicit searches, address livestreaming and predatory behaviour, and adopt trauma-informed approaches for impacted children. These principles have been endorsed by major technology companies such as Google, Meta, and TikTok, many of which have already implemented measures such as pop-up warnings and educative messaging to reduce online offending.

The University of Sunshine Coast advised the Board that:

One notable example of an Australian online prevention strategy involved researchers deploying a web-based prevention messaging intervention where online pop-up messages were introduced to deter internet users from attempting to access "barely legal" pornography as a surrogate or gateway into accessing child sexual abuse material. ...This strategy targeted perpetration, while simultaneously targeting the moment of deciding whether to view child sexual abuse.

Despite these efforts, the online environment presents unique challenges. Digital platforms provide unprecedented anonymity and accessibility, lowering inhibitions and increasing the likelihood of harmful behaviour by individuals who may underestimate the risks of detection and consequences. Perpetrators use the internet to access illegal material, groom children, and connect with like-minded individuals who normalise and reinforce abusive behaviours and attitudes. Social media, gaming platforms, and encrypted messaging services can facilitate the sharing of illicit content, creating ongoing challenges for prevention and enforcement.

Operational Recommendation 16: Allocate funding and services to prevent and address behaviours that might lead to offending

That the Australian Government ensure ongoing funding and support for evidence based early intervention programs aimed at preventing child sexual abuse, particularly those that provide confidential support, public education, and guidance for adults concerned about their own thoughts or behaviours. Funding should be sufficient to enable expansion of outreach, maintain phone and online counselling services, and deliver consistent awareness campaigns.

This should include continued funding and support of the Stop it Now! Australia program, recognising its current role in preventing child sexual abuse through early intervention, public education, and confidential support for adults concerned about their own thoughts or behaviours.

Programs such as these help communities and individuals access preventative support before harm occurs and should be considered a core component of Queensland's child safeguarding strategy.

Children and young people who use harmful sexual behaviour

On some occasions, children may themselves commit sexual offences against another child. This behaviour is referred to as harmful sexual behaviour and includes behaviour outside the developmentally expected range. It may be exhibited due to past trauma, exposure to pornography and adult content or the child themselves experiencing sexual abuse. Children may not know that this behaviour is inappropriate, and specialised therapeutic support is often required. This is a complex issue which requires different interventions and responses. Given the nature of the offending in this case study, it has not been explored in depth by the Board as part of this Review.¹⁰⁰

Data from the Australian Child Maltreatment Study (ACMS) showed that although rates of reported child sexual abuse are declining overall, sexual offences committed by children against other children has increased. 13.2 per cent of 16 to 24-year-olds reported experiencing abuse as a child from another child whom they were not in a relationship with, while 5.7 per cent reported experiencing abuse from another child whom they were, or had previously been, in a relationship with.¹⁰¹

In 2022–23, girls aged 10 to 17 years made up the majority of female offenders proceeded against for child sexual abuse offences. This was mostly for the handling of unlawful sexual material offences (90%, n=237).¹⁰² A recent study found that the majority of CEM offences committed by females between 2012 and 2021 involved girls under 18. This 2024 study about women involved in online sexual exploitation stated that they appear to have a higher likelihood of engaging in CEM production offences than other CEM offences, though it was acknowledged that this may be driven by the number of children in the study cohort who had come to police attention for 'sexting', as they had taken or shared explicit photographs or videos of themselves.¹⁰³

The odds of 'perpetrating' a CEM offence were found to be 20 times higher for girls than for adult men or adult women, and 7.7 times greater than for boys. This was found to be likely due to the transition to online social and sexual interactions, and that a lot of the CEM concerning girls is 'self-generated' - meaning that they took the photo themselves - including under coercion by another party. The study also highlighted that a proportion of the CEM may have involved other children.¹⁰⁴

Engagement in this behaviour by children may:

- be part of contemporary, normalised sexual exploration
- be the result of peer pressure or harmful sexual behaviour exhibited by same or similar-aged partners or other children
- be the product of being groomed and coerced by an adult.¹⁰⁵

In either situation, responses outside of the criminal justice system for the child who has made the material is required. Education about healthy relationships and consent is paramount in addressing this issue, as well as targeting adults who seek to exploit and coerce children in this way. These children are themselves victims of child sexual abuse, regardless of whether they have 'self-generated' unlawful sexual material.

Victim-survivors of child sexual abuse should not be criminalised for their experience of abuse.

Bright Futures: National leadership in preventing harmful sexual behaviours

The Daniel Morcombe Foundation's Bright Futures program stands as a nationally recognised exemplar in the prevention of child sexual abuse and the mitigation of harmful sexual behaviours among children and young people. Operating across Australia, the program is designed to build the confidence, competence, and capability of professionals who work with children, equipping them to recognise, prevent, and respond to problematic sexual behaviours before they escalate.

Unlike traditional approaches that react to incidents after they occur, Bright Futures prioritises early identification and proactive intervention. By delivering evidence-based education, workshops, and forums to educators, frontline workers, and community professionals, the program fosters a culture of awareness and preparedness, ensuring that individuals who interact with children are not only alert to risks, but are empowered to act effectively. Its national reach, combined with a structured approach to professional development, positions Bright Futures as a benchmark for prevention programs both within Australia and internationally.

Central to the program's success is its comprehensive and multi-layered approach. Bright Futures provides tailored learning opportunities, including scenario-based workshops, webinars, and podcasts, all designed to translate complex safeguarding principles into actionable strategies. Professionals are trained to identify early indicators of harmful sexual behaviours, understand the nuances of online and technology-assisted exploitation, and engage with children and families in ways that prioritise safety, dignity, and empowerment. This focus on practical, applied learning ensures that the program delivers real-world impact beyond theory, equipping professionals with the tools they need to intervene effectively.

The program's alignment with current research and national frameworks enhances its credibility and effectiveness. Bright Futures integrates insights from child development science, criminology, and safeguarding practice, and reflects the principles underpinning the National Child Safe Standards. Its forums create opportunities for cross-sector collaboration, bringing together educators, child protection practitioners, law enforcement, and allied health professionals to share knowledge, discuss complex cases, and develop cohesive strategies. This cross-disciplinary approach not only amplifies the reach of prevention efforts, but also strengthens the broader child safeguarding ecosystem.

Moreover, *Bright Futures* exemplifies best practice in its use of technology and media to extend its impact. Through online webinars, podcasts, and resources, the program reaches professionals in regional and remote communities who might otherwise lack access to specialised training. This innovative use of digital platforms ensures equitable access to high-quality education and contributes to the program's status as a leading national initiative.

The program also reinforces the importance of community engagement in prevention. By fostering professional networks and encouraging ongoing dialogue, Bright Futures creates a sustainable culture of learning, reflection, and vigilance. Its success is evident not only in the high participation rates across jurisdictions, but also in the tangible improvements in professional confidence and competence reported by participants. These outcomes demonstrate that prevention programs grounded in practical training, collaboration, and evidence-based practice can effect meaningful change in safeguarding children.

Bright Futures is more than an education program; it is a national leader in the proactive prevention of child sexual abuse and harmful sexual behaviours. Its commitment to professional development, cross-sector collaboration, and evidence-based practice exemplifies what best practice in child safeguarding looks like. For Queensland and Australia more broadly, Bright Futures represents a critical investment in equipping the adults responsible for children with the knowledge, skills, and confidence to intervene early, prevent harm, and foster safe environments for all children.

Operational Recommendation 17: Investment in research on perpetrator prevention strategies and early intervention efforts

In its submission to the Board, Jesuit Social Services emphasised the importance of building a stronger evidence base about the perpetration of child sexual abuse:

High quality research into child sexual abuse perpetration, particularly by undetected, specialist offenders, is crucial to prevent, detect and deter child sexual abuse. To provide targeted prevention and intervention programs, and continue building child-safe organisations, institutions and communities, we must understand more about the extent of child sexual offending, pathways into perpetration, and characteristics of those who commit child sexual abuse.

This insight highlights a significant gap in the current knowledge base. While much of the existing research focuses on victim experiences and institutional failings, there is limited large-scale, contemporary research into perpetrator behaviours, motivations, and pathways. Without this understanding, policy responses risk remaining reactive rather than preventative.

Comprehensive research is essential to building an effective, prevention-focused response to child sexual abuse. A stronger evidence base will allow governments, service systems and communities to move beyond reactive approaches and towards strategies that anticipate and reduce risks before harm occurs.

Such research is critical to identifying behavioural patterns and risk indicators, including those associated with undetected perpetrators. By understanding how offending develops and manifests, systems will be better placed to recognise early warning signs and intervene before abuse takes place.

Research also plays a vital role in informing the design of prevention and intervention programs. Evidence-based insights enable the development of strategies that are targeted to specific contexts, populations and environments, ensuring that responses are both effective and proportionate to the risks faced.

Finally, comprehensive research strengthens child-safe practices across organisations, institutions and communities. By examining risk and protective factors in different settings, it provides the knowledge needed to reinforce safeguards, close gaps in practice, and build cultures that prioritise the safety and wellbeing of children.

Such research would enable Queensland to move beyond a reliance on retrospective case analysis, building a forward-looking approach to child protection and safeguarding that can reduce the likelihood of future harm.

Operational Recommendation 17: Investment in research on perpetrator prevention strategies and early intervention efforts

That the Queensland Government invest in a dedicated research program to inform targeted prevention strategies and early intervention efforts, along with the translation of research findings into key messages that can be shared with organisations, frontline workers and parents. This research should examine:

- the behaviours and attitudes of perpetrators of child sexual abuse
- risk and protective factors across different population groups, places and settings
- pathways into offending, including developmental, relational and situational factors
- the role of online environments and digital grooming in facilitating child sexual abuse
- the effectiveness of current community education and prevention campaigns in shaping public awareness and protective behaviour
- barriers that prevent children and families from recognising or disclosing sexual abuse
- the characteristics and impact of organisational environments that enable or deter abuse
- factors that support early identification and rehabilitation of individuals at risk of offending
- emerging trends and changes in the behaviours, conduct and prevalence of offending.

Chapter

25

Parents and guardians as partners in safeguarding

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Parents and guardians as partners in safeguarding

Parents as partners in safeguarding

Parents play a critical role in child safeguarding. Parents are constantly in services, can identify changes in a service's compliance and quality, interact with staff, and can observe changes in their children's behaviour towards the service. When services fail to inform parents about the safeguarding systems scaffolding children in ECEC, an important opportunity is lost for the systems that protect us to receive contemporaneous information regarding the operation of the service, identify early warning indicators and act swiftly to detect and respond to people who present a risk to children.

This Review has laid bare multiple instances of parents who held concerns about the offender's behaviour or incidents that occurred during his time at centres. They observed behaviours and conduct that they found to be unsettling, and they tried to raise the alarm to the centres that they entrusted the care of their children to.

Parents of victims who made submissions to the Board reflected a lack of understanding about the service operation and its legislative obligations, how to complain and who to complain to, which acted as a barrier to escalate concerns.

Parents also indicated they were concerned that complaining to a service would make their children a target for management. In some suburbs of Queensland, childcare spaces are limited and wait lists long, which restricts the choices parents have available to them.

“When I reported incidents over my years as a parent utilising different childcare centres, it was always an uncomfortable situation. I'd have to traipse around the centre looking for a senior employee, hesitant that my 'complaining' will make my children a target, speaking in emotional terms and being left with vague statement like 'I'll take care of it'.”

To allow parents to play an empowered role in the safeguarding of their children throughout their journey through the education and care system, it is important to understand what safeguarding looks like and who else is involved.

What is safeguarding?

Child safeguarding refers to the proactive implementation of mechanisms and actions taken by organisations to promote and protect the safety and wellbeing of children and prevent harm. To be effective, actions must be embedded into institutional practices which are clear about how the organisation responds to risk and harm. Responsibility for safeguarding practices sits with the organisation, its leadership and its workers.

Child safeguarding practices seek to create an environment where harm does not occur. They require us to think broadly about how to protect children from harm within our institutions.

While child protection is part of safeguarding, it is primarily reactive and focuses on protecting individual children who have experienced or are at risk of experiencing significant harm, particularly from parents or caregivers.

Partners in safeguarding children in ECEC services

	Regulator	ECRA is responsible for regulating early childhood education and care services which includes receiving and investigating complaints from parents.
	Funding body	The Australian Department of Education provides the child care subsidy and approves services to be able to claim the subsidy. The service must maintain a standard of quality to remain eligible for this funding.
	Business owner	The approved provider of the service is responsible for ensuring their childcare centre complies with the law and regulations. This includes the duty to notify the regulatory authority of matters occurring within the service including allegations of child sexual abuse occurring in the service.
	Service level management	The Nominated Supervisor or other staff member placed in day-to-day charge of the service manages the day-to-day operation of the service.
	Service staff	Educators work directly with children both in their room and across the service.
	Consumers	Just as parents and guardians are partners in safeguarding their own children, so too are they partners in safeguarding all the children in services in which they attend. By sharing information and staying alert, parents and guardians can be a powerful part of the safeguarding system.
	Blue Card Services	Blue Card Services is responsible for conducting and maintaining working with children checks.
	Police	Police are always partners in safeguarding regardless of the sector

From 1 July 2026, the Queensland Family and Child Commission will join as a partner in safeguarding, accepting notifications of concerns and allegations of reportable conduct. While the examples provided are specific to the ECEC sector, many of these categories are likely to apply across other child serving organisations.

What to look for in an early education and care service

Who is in charge?

The name of the approved provider and all the nominated supervisors for the service must be displayed in a position clearly visible from the entrance.¹⁰⁶

Approved providers and nominated supervisors are in charge of the operation of an ECEC service. The Nominated Supervisor is generally in day-to-day charge of the service and is a good place to start with any questions about the services operation and the communication of concerns or grievances. They are ultimately responsible for the service's compliance with the legislation.

Are the service and its staff compliant with the National Law and National Regulations?

For information regarding the service's history of compliance, parents and caregivers can ask to see the service's record of compliance which must be provided to any person upon request.¹⁰⁷

This record of compliance will not include information about the conduct of a nominated supervisor or staff nor does ECRA publish compliance action naming individuals.

If the service has a compliance history, the following questions are useful to ask:

- When were the breaches confirmed?
- What were the breaches?
- What was the statutory action?
- What was the service required to do to reestablish compliance?

What are the different compliance tools?

A full list of the available compliance tools is available in ACECQA's Guide to the NQF.¹⁰⁸ They range from low level administrative action to higher level statutory action such as prosecution and license cancellation. While the National Law allows for the issuing of infringement notices, ECRA has made the policy decision not to issue infringement notices.

Serious compliance action taken in relation to a service or approved provider is published by ECRA.¹⁰⁹ If the compliance concerns regarding an individual reach the level of a prohibition, then the individual will no longer be able to work in a service and Blue Card Services will be notified and their eligibility to continue to hold the card may be affected.¹¹⁰

What other factors relating to the approved provider are worth considering?

The size of the approved provider, whether they are for profit and how many services they hold may have an impact on outcomes at the service.

Approved providers can range from an individual with one service approval to large corporations with shareholders and services across Australia.

Regardless of the size of organisation parents should identify who to lodge grievances with. This person may be at the service or in the case of larger providers in a central location. The policies and procedures of the service are likely to contain this information.

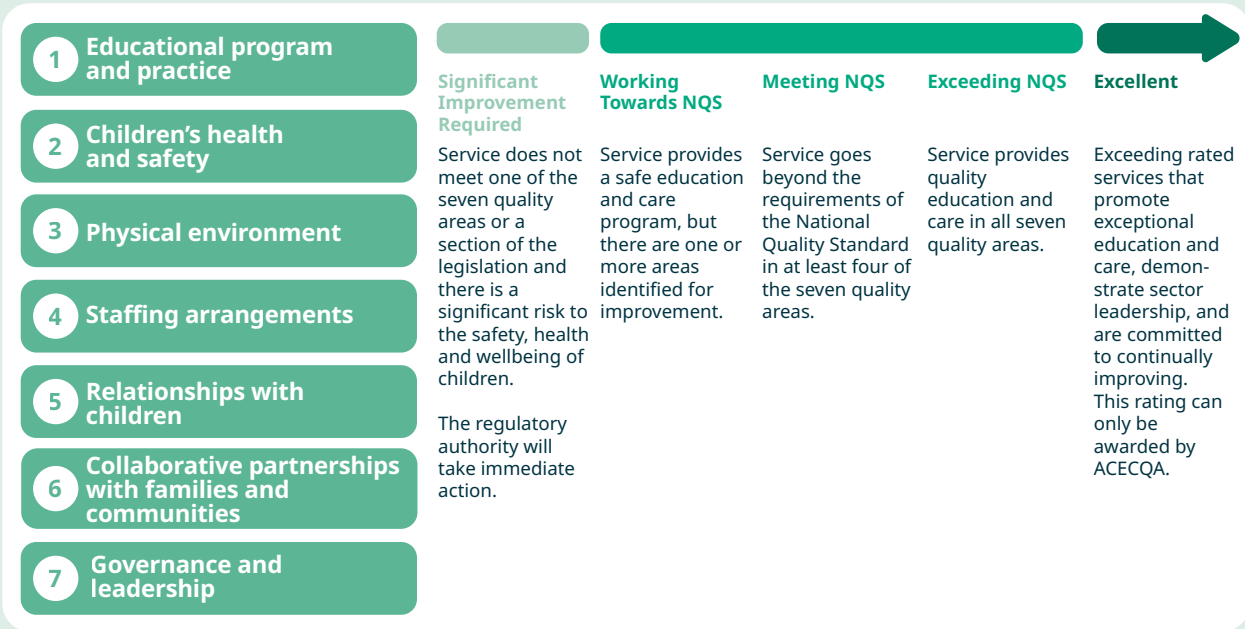
Information regarding approved providers and the number of services they hold can be obtained from the ACECQA National Registers (www.acecqa.gov.au/resources/national-registers).

Information about the compliance history of approved provider is published by ECRA. As this only relates to statutory compliance action taken against providers in Queensland, national providers may also have been subject to compliance actions in other states. Information regarding statutory compliance action in other jurisdictions can be obtained from the relevant jurisdictional regulatory authorities (www.acecqa.gov.au/help/contact-your-regulatory-authority).

What is the service’s rating against the National Quality Standards (NQS) and when was it assessed?

The quality rating must be displayed in a position clearly visible from the service entrance.¹¹¹ This is the regulatory authority’s assessment of how the service is meeting the standards. Services can be rated Excellent, Exceeding NQS, Meeting NQS, Working Towards NQS and Significant Improvement Required.

Figure 8: The Quality rating criteria



A copy of all the Elements and Standards is available on the ACECQA website.¹¹² Certain standards and elements will give greater insight to the service’s safeguarding practices than others. For example:

- 2.1 Health - Each child’s health and physical activity is supported and promoted and
- 3.1 Design - The design of the facilities is appropriate for the operation of a service.

From 1 January 2026, refinements to the NQS will commence to sharpen the focus on child safety and explicitly reference child safety within Quality Areas 2 and 7 in response to ACECQA’s Review of Child Safety Arrangements under the National Quality Framework. While the assessment and rating process allows parents to compare services against established standards and target those areas of greatest concern, the date of the assessment must be considered. A service’s rating may not be the best indicator of the service’s current operation with up to 7 years between full rating assessments.

In August 2025, following the Education Ministers Meeting, the Australian Government announced that it was investing up to \$189 million to strengthen safety and quality in ECEC settings. This investment includes funding to support state and territory regulatory authorities to ensure that all services are assessed on average every three years.

Concerns regarding the National Quality Framework and child safeguarding assurance

While the National Quality Framework (NQF) establishes an important baseline for quality in early childhood education and care (ECEC), it has not effectively informed parents about safety threats within services. Families generally assume that NQF licensing guarantees that a service is safe for children, yet the current assessment and rating process does not meaningfully examine how risks of abuse, grooming or exploitation are managed. As a result, parents are often unaware of weaknesses in a service's child protection culture, screening practices, or incident-response systems.

The National Quality Framework (NQF) must do more to embed the National Principles for Child Safe Organisations (or the ten Child Safe Standards) within its regulatory expectations and assessment tools. At present, the standards relating to children's health, safety and wellbeing (Quality Area 2) focus primarily on physical safety and supervision rather than organisational safeguarding systems. The NQF should evolve to include a structured assessment of how each provider prevents, detects, and responds to child abuse, including the robustness of staff screening, induction, reporting processes, and child participation mechanisms. Embedding the ten Child Safe Standards would ensure that ECEC providers are not only compliant with quality indicators but demonstrably safe environments. It would also strengthen public confidence by ensuring that accreditation outcomes genuinely reflect a provider's capability to protect children from harm — not just to deliver quality learning experiences.

What is the service's reflection on its quality and what plans for improvement does it have?

Services must have a quality improvement plan (QIP).¹¹³

The QIP is a document created by an approved provider to help services self-assess their performance in delivering quality education and care and to plan future improvements. Current and prospective parents can ask to see this document, and it must be provided upon request.¹¹⁴

As with the assessment and rating outcomes, when reviewing this document, one can target the areas of greatest concern.

What is the service's philosophy?

The service must prepare a statement of philosophy as part of its QIP which is designed to guide all aspects of the service's operations. Services which are proactive and informed regarding safeguarding are likely to reference their approach in their philosophy.

As the philosophy forms part of the QIP, it must be provided to prospective and current parents and guardians upon request.¹¹⁵

What are some workforce and service factors that can be considered?

Outside of the documents prepared by the service, information can be obtained by asking the service about:

- Continuity of staff and staff qualifications. While some services display images of staff identifying their qualifications and length of service this is not a requirement under the NQF. This means you may need to ask about these details.
- Usage of agency staff and induction of agency staff. While this issue may be canvassed in the services staffing policy, the NQF does not require the staffing policy to address this issue. You may wish to enquire with the service regarding its policy with respect to agency staff and if they do use agency staff, what due diligence does the service undertake to ensure the staff are suitable and aware of the service's policies and procedures?
- Induction and ongoing professional development for staff.
- What is the service's approach to induction of its staff? How does it ensure that its staff understand how the service operates before they provide education and care to children? What steps does the service take to ensure that its staff remain aware of contemporary best practice?

- How staffing is managed and who will be looking after your children on a given day? There is no prescribed way in which this information must be communicated. Ask the service how they communicate this information.
- How the staff interact with the children. Are they respectful and appropriate?
- Whether the ratios are being maintained. While this is sometimes a complicated calculation based on the ages of children, this is something that parents and guardians can easily observe.
- Room groupings – what are the ages of the children in your child's class and how does the service manage the periods at the beginning and end of the day when the number of children in attendance is lower?
- Does the service have any conditions on its service approval and what is the effect of those conditions? Any conditions on the service will be recorded on the service approval. This is clearly visible to anyone from the main entrance of the service.¹¹⁶

What is the service's physical environment like?

The service environment and the extent to which it is designed to facilitate supervision is considered as part of the licencing process before the service approval is granted.

ECRA has an ongoing role in monitoring the physical environment at the service and ensuring it continues to comply with the regulations.

Questions parents may ask themselves or the service about the environment include:

- How is the furniture arranged?
- Is there information or art hanging on the windows which affects the line of sight for supervision?
- What is the connection between the indoor and outdoor environments? Is there clear visibility between the two?
- Do the nappy change areas and toileting areas balance the dignity of the children with the need to ensure that they are safe?
- Where do the children sleep, and can they be adequately supervised while sleeping?

What are the policies and procedures that underpin the operation of the service?

The NQF requires services to have a prescribed list of policies and procedures such as providing a child safe environment, staffing and dealing with complaints.¹¹⁷ ACECQA, in consultation with state and territory regulatory authorities, has developed guidelines to help providers prepare these policies and procedures.

The adequacy of these documents is considered by ECRA as part of the service approval process.¹¹⁸

Parents and guardians of prospective and current enrolled children have a right to access these documents at any time.¹¹⁹

Some of these policies may provide more information regarding the service's approach to safeguarding than others including those relating to:

- Complaints
- Staffing, including whether staff members ever work alone with children
- Governance and management
- Health and safety, including sleep and rest.

How does the educational program support a culture of safeguarding?

The ECEC curriculum embraces ideas such as children developing a strong sense of wellbeing and the development of secure, respectful and reciprocal relationships with educators.¹²⁰ Questions can be asked of the service regarding how they interpret this element and how developmentally appropriate safeguarding is incorporated into the programming.

Some services choose to engage with safeguarding specialists such as Bravehearts to provide training to educators, parents or children.

How can parents and guardians be involved in shaping practice in a service?

Services which are meeting the NQS should be supporting families to be involved in the service and to contribute to service decisions.¹²¹

Every service has a different approach to this. Many services now rely on sector specific online platforms to engage with parents. Their platforms allow services to share photos, videos, and documents related to children's care and learning and generally allow two-way communication.

Parents and guardians should ask the approved provider or person in day-to-day charge about opportunities to contribute.

Table 5: Who should parents and guardians contact:

About your child on any given day	The lead educator in your child's room
About the day-to-day operations of the service	The service's nominated supervisor or the person nominated as the responsible person at any given time. The name and position of the responsible person in charge of the service must be displayed and clearly visible to anyone from the main entrance. ¹²²
If you have a complaint about something that has occurred at the service (excluding complaints alleging sexual or physical abuse)	Review the service policy and procedures on dealing with complaints and follow the procedure. The service must provide this to you upon request. If you are concerned about the quality or compliance of an ECEC service, you may make a complaint to ECRA. A complaint form is available on its website (www.earlychildhood.qld.gov.au).
If you are concerned that your child may have experienced physical or sexual abuse while in the service	Follow the complaints policy as outlined above. If you communicate your concerns to the approved provider, they are required to notify ECRA within 24 hours. Contact ECRA directly by lodging a complaint through its website or by contacting your local regional office, the details for which are available of the ECRA website (www.earlychildhood.qld.gov.au). ECRA will notify the QPS of these allegations. Contact QPS directly. From 1 July 2026, concerns regarding conduct at ECEC services can also be referred directly to the Queensland Family and Child Commission as the agency responsible for administering Queensland's Reportable Conduct Scheme. If the system works as intended all parties will become aware of your allegations regardless of which organisation you contact first.

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Part

G

Safeguarding the future

Defining the required multi-layered approach to preventing, detecting, and responding to child sexual abuse in Australia

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Defining the required multi-layered approach to preventing, detecting, and responding to child sexual abuse in Australia

Safeguarding the future

Child sexual abuse remains one of the most severe and complex threats to the safety and wellbeing of children in Australia. Responses require coordination across multiple systems and environments.

It is clear that there have been systemic failings in the safeguarding and response to child sexual abuse in this case, and that these raise concerns about the capability and capacity of our current systems.

The evidence gathered through this review confirms:

1. **That the offending could—and should—have been detected and disrupted earlier.** Across organisations and agencies, sufficient concerns were recorded to have enabled earlier intervention had they been consolidated and treated as part of a broader safeguarding picture. Instead, information remained siloed, and the warning signs were never fully connected.
2. **The reality is stark: parents, children and staff repeatedly raised legitimate concerns about the offender, but no obvious resolution followed.** Ultimately, the offender was only apprehended after uploading digital images, not because of any effective response to the concerns that adults and children legitimately expressed.
3. **Our prioritisation of a criminal justice response means we are focused on detecting crimes rather than detecting safety threats to our children and consequently opportunities to intervene are lost.** Victim-survivors and their families were left with no pathway to resolve their concerns once police determined there was insufficient evidence to proceed.
4. **Police thresholds for action, combined with resourcing limitations, further inhibited earlier detection and contributed to missed opportunities.** These left children unprotected and families unsupported, effectively closing the door on concerns despite the potential of ongoing risks.
5. **The Working with Children Check (blue card) functioned as intended, yet offered no meaningful protection to children in this case.** Its operation did not prevent the abuse, nor did it alert organisations to the pattern of risk. The gap between the legal operation of the blue card system and community expectations of its protective factors means that trust is mislaid.
6. **At the organisational level, actions were taken in isolation, often resulting in the offender being 'moved on' rather than the risks he posed being systematically addressed, recorded and communicated.** Such responses delivered no strategic or holistic benefit to the community, and critically, did not safeguard children.
7. **The legislative and policy framework is itself fragmented.** There is no clear single owner of child safeguarding in Australia or Queensland, and the response remains overly dependent on the criminal justice and child welfare systems with a significant gap between the two.
8. **Public submissions underscored the absence of a clear pathway to raise concerns and receive services for suspected child sexual abuse.** This evidence made it clear that there is a clear gap when neither police nor the Department of Child Safety are involved. This vacuum leaves families and organisations without a protective mechanism, and children at continued risk.

Taken together, the Board's findings demonstrate systemic weaknesses: siloed information, fragmented responsibilities, insufficient thresholds for action, and a lack of coordinated safeguarding architecture. The effect is that risks are routinely identified but remain unmitigated, while families and victim-survivors are left without redress until catastrophic harm is undeniable.

Taken together, these findings point to the need for a stronger whole-of-system approach, underpinned by proactive detection, coordinated responses, investment in prevention, and sustained recovery pathways. Only by strengthening each of these domains can we deliver on our responsibility to keep children safer and support them to thrive.

A multi-layered approach to preventing, detecting, and responding to child sexual abuse in Australia is necessary. Australia can no longer rely on criminal justice system and community-based prevention activities. Perpetrators are exploiting weaknesses in our civil-law and organisational architecture, which mean that they are able to avoid detection and continue offending.

A protective ecosystem

The need for an integrated safeguarding system is clear. Child sexual abuse is a complex issue that requires a coordinated response across all levels of society and all stages of intervention. Ecological models provide a valuable framework for understanding the multifaceted nature of child sexual abuse and the importance of interconnected systems. To protect children effectively, it is essential to build systems that not only function well individually but also work seamlessly together. By bridging the gaps between systems, we can create a comprehensive and responsive safeguarding environment that prioritises the safety and wellbeing of all children.

This Review, and its associated research and public submissions, has highlighted weaknesses within and across governments, organisations and society. Challenges include managing cross-jurisdictional differences, addressing online forms of abuse, ensuring adequate resourcing for organisations, and connecting the missing pieces. Another challenge is balancing the need for coordination without creating unnecessary duplication.

Child sexual abuse in institutional settings, including ECEC settings, should be contextualised with an ecological framework. This requires child sexual abuse to be framed and considered as the interplay of a multi-level system involving:

- **individual characteristics** (of children, educators, parents, perpetrators and officials)
- **relationships** between individuals and organisations (for example, between a perpetrator and their co-workers and children in their care)
- **social structures and societal norms and attitudes** towards, for example, abuse, sex, gender, crime and punishment.

Understanding child sexual abuse through an ecological lens underscores the importance of addressing all levels simultaneously. A failure at any level—in supporting children and their families, in equipping our workforces, in a community's indifference, or a society's inadequate laws—can lead to the perpetuation of abuse. Throughout this report, our findings and recommendations repeatedly highlight the necessity of building an integrated safeguarding system that spans all levels of society and all stages of preventing, detecting, and responding to child sexual abuse, and supporting those who have been impacted.

Central to this argument is the recognition that the quality of connections between these layers and stages is paramount. Too often, systems are developed in isolation with the hope that they will function effectively on their own; however, the real threat to the safety of our children lies in the gaps between these systems. A strong ECEC sector, a strong blue card system, and strong policing system will still create risks if there are gaps between them.

“

The primary threat to child safety is not the failure of individual systems but the gaps between them that mean early warning indicators are missed, information is not shared and threats are not detected or responded to.

”

This Review has highlighted six key layers through which we can analyse and understand the safeguarding system around our children. They are:

1. the political-leadership layer
2. the criminal justice layer
3. the oversight layer
4. the institutional-organisational layer
5. the community layer
6. the family layer.

The safeguarding layers



Leadership layer

The political-leadership layer sits above and around all other layers. It is about how political actors, systems, and decisions shape the environment in which child sexual abuse is prevented, detected and responded to, and how victim-survivors and families are supported. Unlike the criminal justice or civil-law layers, which are bounded by specific systems, the political layer is broad, systemic, and multi-directional — it sets the priorities, resources, and culture that influence all other layers. Political will is necessary to sustain momentum beyond media cycles, ensuring support is not treated as a one-off event. It recognises that safeguarding children is not just technical or operational. Without sustained political leadership, other layers (families, communities, organisations, regulators, justice) may operate in fragmented, under-resourced, or inconsistent ways. The political layer provides the legitimacy, resources, and societal mandate that underpin effective multi-layered safeguarding.



Criminal justice layer

The criminal justice system plays a central role in investigating, prosecuting, and deterring child sexual abuse. Key actors include the Australian Federal Police (AFP), state and territory police, prosecutors, courts and the judiciary. This layer is responsible for holding perpetrators accountable, protecting victim-survivors, and ensuring justice. This layer sees abuse as a societal violation requiring legal accountability and therefore prioritises evidence against and punishment for perpetrators.



Oversight layer

The regulatory oversight system is emerging as a network of organisations, legal entities, and informal structures that exist between the government and the private sector that aim to prevent harm by managing risks and imposing regulatory safeguards. This approach complements criminal justice responses by managing risks before offences occur or where offences cannot be proven. This layer focuses on societal structures and governance to prevent abuse before it happens, using preventative legal mechanisms.



Institutional and organisational layer

Organisations that work with children must implement strong child safeguarding measures. This includes compliance with Child Safe Standards, staff training, clear safeguarding policies, and effective reporting processes. This layer treats institutions as microcosms where culture, policy, and behaviour shape risk; emphasising proactive prevention and ethical responsibility.



Community layer

Communities play a crucial role in prevention and detection. Local councils, NGOs, volunteers, and grassroots organisations help build protective environments, raise awareness, and identify risks. This layer recognises that community norms, awareness, and shared responsibility are crucial for early detection and support; social cohesion strengthens prevention.



Family layer

Families form the first line of protection for children. Parents, guardians, and extended family members must be equipped to create safe environments, teach children about healthy boundaries, and support disclosures. This layer recognises that family is the immediate protective environment; interventions are personalised, relational, and preventative at the most granular level.

These layers are most effective when they reinforce one another. Information and learning should flow both upward (from families and communities through organisations and regulators to the justice system) and downward (from policy, regulation, and law enforcement to communities and families). Such coordination ensures child protection is comprehensive and avoids duplication or fragmentation.

Each layer functions differently but strengthens the whole framework across prevention, detection, response, and support. Protection is maximised when:

- communities foster vigilance and responsibility and set behaviour expectations
- families are empowered to prevent and detect early
- sectors and institutions embed safeguards and accountability
- oversight entities enforce regulatory compliance and civil-law deterrence
- the criminal justice system delivers justice and deterrence.

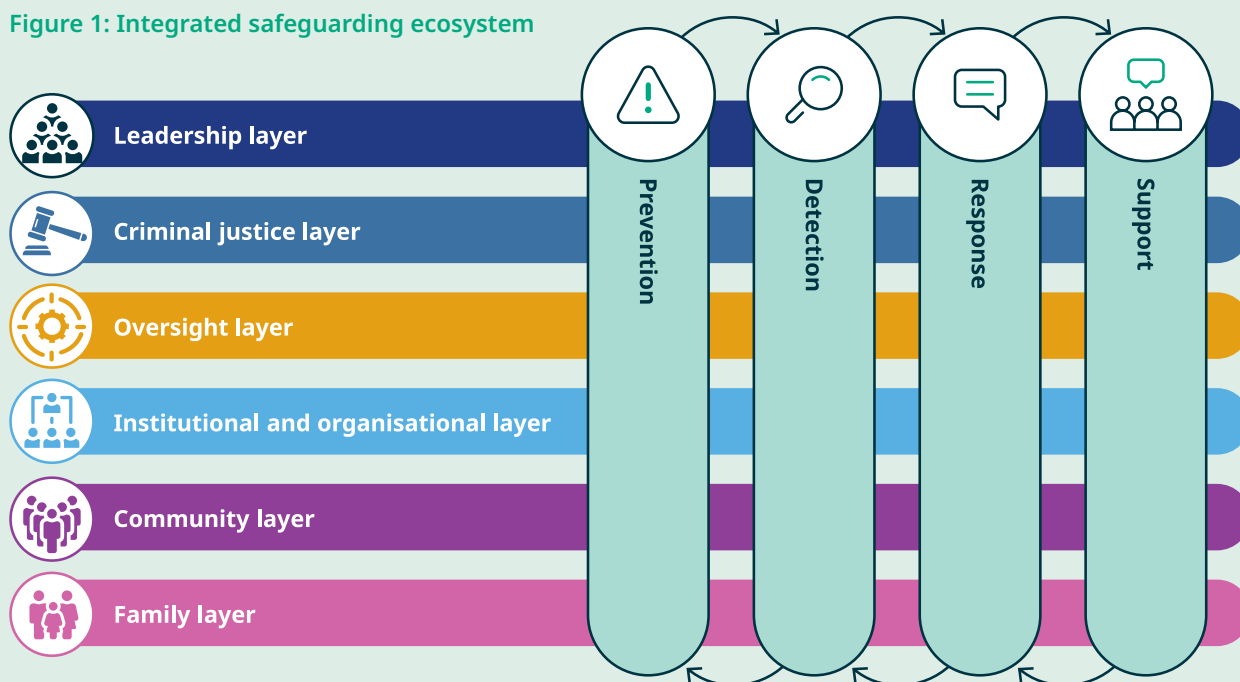
Prevention, detection, response and support are not isolated tasks they function as interconnected layers that only succeed when aligned and mutually reinforcing. Effective approaches to child safeguarding require:

- **Multi-layered situational awareness** – Each layer (family, community, institution, regulator, justice system) sees risks and harm differently. Families may notice behavioural changes, communities may observe patterns, regulators track systemic failures, and justice agencies monitor criminal activity. Only by combining these perspectives can hidden threats be surfaced early.
- **Trust networks** – Victim-survivors and their families are more likely to disclose and seek help when they have trusted relationships with safe adults, institutions, or communities. Trust also underpins information-sharing between agencies and sectors, reducing silos and preventing offenders from slipping through gaps.
- **Cross-level coordination** – No single system can carry the responsibility alone. Families need support from communities, institutions must be accountable to regulators, and civil law needs to reinforce the work of the criminal justice system. The strength of the framework lies in how these parts interlock, preventing harm where possible, detecting it quickly when it arises, and mounting an effective and compassionate response.

Each layer complements the others—legal enforcement, regulatory oversight, organisational policy, community vigilance, and family protection must communicate and reinforce one another—and information and insights can flow upward (e.g. family reports to organisations, organisations report to regulators) and downward (e.g. policy guidance reaches families and communities).

In this way, the desired safeguarding system is more than a set of discrete actions; it is a protective ecosystem where vigilance, care, and accountability are distributed across society.

Figure 1: Integrated safeguarding ecosystem



Leadership

Leadership is the key to prevention. In child safeguarding, this principle is starkly true: without committed leadership, even the most sophisticated safeguarding frameworks remain inert.

Prevention is not merely a collection of policies, procedures, or training programs; it is a mindset, and that mindset is set from the top. Leaders hold the unique position of seeing the system as a whole—the moving parts, the points of risk, and the opportunities to intervene before harm occurs. As one prominent thinker on organisational safety has observed, ‘Culture is shaped from the top. If leaders do not prioritise safety, no amount of rules or processes will create it’.

As noted in the recent report of the Commission of Inquiry into the Tasmanian Government’s Responses to Child Sexual Abuse in Institutional Settings, *Who was looking after me? Prioritising the safety of Tasmanian Children* (2023):

Across all the types of institutions we examined, we rarely saw examples of child-centred leadership. Sometimes this was because of a lack of skill and good processes to guide leaders, which led to clumsy, slow and ineffective responses. But in other instances, we saw what can only be described as a callous lack of care for victim-survivors of abuse. This was more difficult for us to understand, with some leadership failings so extreme they caused enormous pain and suffering to those affected. The driving factors behind this poor leadership included an apparent disregard for children or victim-survivors, laziness or lack of interest, outdated understandings of child sexual abuse, lack of skill and capability, overwhelm and unreasonable workloads.

We consider leadership failures are more likely to occur, and be far more damaging, where there is a lack of accountability. We saw some senior leaders use terms like ‘shared accountability’, in some cases, to sidestep their individual accountability. Sometimes, this individual accountability comes from a person holding a legal duty, a professional duty or a moral duty. Yet we saw leaders lack curiosity or initiative, delegate their responsibilities or shift blame to others. We saw defensiveness rather than self-reflection. Some of these attitudes endured throughout our Inquiry, even when confronted with the devastating scale of what went wrong. This type of leadership can have much broader implications, by discouraging people from speaking up about child safety or signalling that promoting child safety is not a priority for staff more broadly.

While we agree that child safety is a responsibility that should be shared among all adults working in an institution, leaders should have specific responsibilities that reflect their power and influence in decision making. They need professional development and support to make sure they are equipped to identify and respond well to risks of abuse. If leaders make mistakes, they should acknowledge them and commit to learning more, so they can do better in future. Leaders should model a culture of improvement and self-reflection, so it positively influences everyone in the organisation.¹

A leader who makes prevention a priority communicates its importance through decisions, resource allocation, and accountability measures. They ensure that staff understand not only what to do, but why it matters, creating a culture in which identifying and mitigating risk is part of everyday practice. Conversely, when leadership does not signal that prevention matters, risk becomes siloed, responses become reactive, and opportunities to stop abuse before it occurs are lost. Visible, committed leadership is the single strongest predictor of whether prevention and safeguarding programs will succeed or fail.

Prevention naturally benefits from seeing the ‘whole picture’—understanding how policies, processes, people, and systems interact, and where gaps may allow abuse to occur. Leaders are uniquely positioned to integrate these perspectives, bridging across silos and disciplines to create coordinated responses. In child safeguarding, this means connecting regulatory oversight, organisational policy, workforce culture, family engagement, and community awareness into a coherent whole. Without such holistic leadership, the system remains fragmented, and children remain exposed to preventable risks.

Ultimately, leadership is both the driver and the safeguard of prevention. It is leadership that ensures risk is identified before abuse occurs, that resources are allocated to proactive measures, and that accountability is embedded into the fabric of an organisation. As one child safety expert put it, ‘Prevention is not something that happens by accident; it is the product of deliberate, informed, and unwavering leadership’. In this sense, investing in leadership, and holding leaders accountable for prevention, is not an optional strategy—it is the very foundation upon which all effective safeguarding rests.

Transformational Recommendation 8: Establish robust and centralised national and state governance for child safeguarding

You will not find a political leader in Australia that has not talked about children being our most precious resource, or our number one priority, however children have long been treated as diffuse, secondary considerations in the architecture of government and in national policy.

This has created significant gaps, duplication, and inconsistencies in the way governments approach child safeguarding and threats to children. While it is universally recognised that children are a uniquely vulnerable population, the structural frameworks through which Australian governments manage priorities often fail to reflect this reality. The decentralisation of child-related responsibilities across multiple portfolios has contributed to a complex, undefined, and sometimes ineffective policy landscape that leaves children at risk.

The establishment of National Cabinet in March 2020 was intended to improve intergovernmental coordination, replacing the Council of Australian Governments (COAG). While COAG had a broader architecture in which child-related issues were addressed—most notably through the Community and Disability Services Ministers' Conference (CDSMC), which endorsed the *National Framework for Protecting Australia's Children (2009–2020)*,² National Cabinet does not include a central, dedicated focus on children. Since this transition, there has been an observable fragmentation of child-focused policy, with responsibility dispersed across multiple portfolios, from Health and Education to Women's Safety, Housing, and Disability Reform. National Cabinet's priorities are regularly refreshed in response to emergent national issues. As of 2024–25, these priorities include gender-based violence, disability reform, health reform, housing, intergovernmental cooperation, and Closing the Gap. While some of these intersect with child safety and wellbeing, none of them explicitly prioritise children as a distinct policy cohort. Instead, children are largely absorbed under broader issues e.g. as 'women and children' within gender-based violence or as beneficiaries within disability or health reforms, rather than recognised as a primary national focus in their own right.

Ministerial Councils report to National Cabinet across a wide spectrum of domains, including Agriculture, Attorneys-General, Community Services, Data and Digital, Education, Emergency Management, and more. Children's issues, however, remain scattered across these portfolios, often resulting in inconsistent approaches, overlapping responsibilities, and policy duplication. Some councils may meet to fulfil statutory obligations without any requirement to report to National Cabinet, further diluting accountability for child-focused outcomes.

The consequences of this decentralisation are tangible. Without a central locus of responsibility, there is no single entity charged with monitoring the effectiveness of child safety policies, no dedicated mechanism for resolving inconsistencies across jurisdictions, and no clear strategic direction for advancing national priorities for children. Policy complexity increases as governments attempt to coordinate responses across portfolios that may have competing objectives, timeframes, or accountability measures. The net result is that children, despite being among the most vulnerable in society, are left outside the political and administrative spotlight, making it more difficult to identify systemic risks, address failures, or ensure effective intervention.

This structural reality underscores a critical lesson: the priority that political leaders place on children must be reflected in government architecture. If children are genuinely to be considered a national priority, their interests cannot be decentralised across a patchwork of portfolios or buried under broader policy agendas.

Instead, governments must create centralised, accountable structures with dedicated oversight, clear lines of responsibility, and authority to coordinate child-related policy across jurisdictions. Only through such a model can policy be coherent, consistent, and effective, ensuring that the safety, wellbeing, and development of children are treated as the urgent national priority they deserve to be.

In short, the absence of a central, dedicated focus on children in the highest levels of national policy is not merely an administrative gap—it is a structural barrier to effective child protection. For policy to work, government structures must mirror political priorities, giving children a clear, visible, and central place in national planning and decision making. Until this occurs, children will remain at risk of falling through the cracks of fragmented governance.

National Cabinet is a forum for the Prime Minister, Premiers and Chief Ministers to meet and work collaboratively. National Cabinet was established on 13 March 2020 and is chaired by the Prime Minister.

National Cabinet's priorities are regularly reviewed and updated. National Cabinet is a dynamic forum, responding to matters requiring national coordination as they arise. Accordingly, its priorities are refreshed on an ongoing basis. National Cabinet's current priorities are:

- **Addressing gender-based violence:** Actions towards achieving the shared goal of ending violence against women and children.
- **Disability reform:** Reforms to improve the experience of National Disability Insurance Scheme (NDIS) participants and restore the original intent of the scheme, including designing a new foundational supports system.
- **Health reform:** Actions to embed long-term, system-wide structural health reforms including a new National Health Reform Agreement.
- **Housing reform:** National reforms to improve housing affordability and supply, and to strengthen renters' rights.
- **Intergovernmental cooperation:** Overseeing the development of, and commitment to, Intergovernmental Agreements to achieve national objectives across priority areas including education, housing, skills and workforce and infrastructure.
- **Closing the Gap:** Objectives outlined in the National Agreement on Closing the Gap, agreed by all Australian Governments and the Coalition of Peaks, remains a commitment across all priority areas.³

Ministerial Councils responsible for delivering these priorities are required to report regularly to National Cabinet on their progress, ensuring First Ministers continue to drive these reforms. Current Ministerial Councils reporting to National Cabinet in 2024–25 are:

- Agriculture
- Attorneys-General
- Community Services
- Council on Federal Financial Relations
- Data and Digital
- Disability Reform
- Education
- Emergency Management
- Energy and Climate Change
- Environment
- Health
- Housing and Homelessness
- Infrastructure and Transport
- Joint Council on Closing the Gap
- Planning
- Skills and Workforce
- Trade and Investment
- Veterans' Affairs
- Water
- Women and Women's Safety.⁴

This list may change in accordance with National Cabinet priorities.

The absence of children is stark.

While the COAG itself did not have a dedicated ‘COAG Council for Children’, child-related issues were addressed through COAG’s broader architecture. Specifically, the CDSMC, endorsed the *National Framework for Protecting Australia’s Children (2009–2020)*, one of the most significant child-focused national reform agendas coordinated under COAG.⁵

Since the move to National Cabinet, there has been no central role focused on children, and an observable fragmentation of child-related policy. Recent cases of abuse in early childhood education and care (ECEC) services highlight the competing but intersecting roles of Education Ministers, Attorneys-General, Police Ministers, Communications Ministers, and other roles such as Treasurers and Employment Ministers.

To date, the national response to current cases in Queensland, New South Wales and Victoria has predominantly related to policy changes within the ECEC sector. There are grave fears that this will simply move perpetrators to other sectors where there are greater system vulnerabilities.

Queensland suffers the same fragmentation as all other states and territories, including a child protection portfolio that is swamped in demand related to familial abuse and has no capacity to respond to community-based threats to children.

Since October 2024, Queensland has taken a significant step by appointing a Cabinet Minister for Families. This appointment signals a welcome elevation of the importance of child safety, however it remains that that children require a coordinated, cross-portfolio approach. Yet, the title alone is insufficient. For this commitment to translate into meaningful outcomes, the Minister must be empowered with sufficient resources, authority, and mechanisms to operate across Cabinet and across portfolios. Only a Minister with a holistic view of children’s needs can ensure that policy is coherent, integrated, and responsive.

This Queensland example underscores a broader principle: children’s lives cannot be divided into discrete categories that match bureaucratic structures. Holistic oversight is essential to identify systemic risks, prevent gaps in service, and coordinate policy and practice in ways that genuinely protect children. Without a centralised, empowered leadership role, children remain vulnerable to the fragmentation and inefficiencies that have long undermined child safeguarding at both national and state levels.

If it is acceptable and appropriate for the Board of an early childcare centre to prioritise child safety, and have dedicated mechanics to ensure this priority, then the same must be true for the mechanics of government.

A common critique of creating a dedicated approach for children is that children are already considered across multiple government portfolios - health, education, housing, disability, and justice - and that a standalone portfolio risks isolating children from broader policy work. While children are referenced in existing portfolios, the operational reality of government shows that without centralised leadership, children’s interests are dispersed, inconsistently applied, and often secondary to other objectives.

Elevating the safety of children within the machinery of government does not create a silo; it centres children and families in the decision making of government, ensuring that all policies and programs are examined through the lens of their impact on childhood wellbeing.

Analogies to other cross-cutting portfolios help illustrate this principle:

1. **Business** – A Minister for Business is responsible for driving economic policy across multiple departments—industry, innovation, taxation, employment, and trade—ensuring a coherent strategy. Business issues touch multiple areas, but a dedicated minister provides oversight, coordinates initiatives, and aligns departments towards shared economic outcomes. This central leadership does not isolate business policy; it integrates it across government functions.
2. **Tourism** – Tourism spans transport, environment, culture, hospitality, and regional development. A Minister for Tourism ensures that all relevant departments contribute to the growth, promotion, and sustainability of the sector. Without such leadership, efforts can be fragmented, with competing priorities and inconsistent outcomes. Central oversight ensures strategic direction, resource allocation, and accountability.

Similarly, centring a whole-of-government approach to children and families would not confine child-focused work to one department or create redundancy. Instead, the role places children and families at the centre of government mechanics, aligning policies to ensure every decision affecting children is considered holistically, that resources are allocated effectively, and that systemic gaps or conflicts between portfolios are identified and resolved.

The lived reality of childhood spans multiple domains. A child's safety cannot be compartmentalised into discrete policy silos; their health, education, housing, and social development are interdependent. Without a central leader, no single department can see the full picture or respond effectively to overlapping risks. The Board holds legitimate concerns, that for example, given the recent actions to strengthen ECEC, and the known number of infants in Queensland residential care, the threats to children may have already moved to a new sector or alarmingly, continues undetected in other sectors.

A dedicated approach ensures a consistent, strategic approach, reduces fragmentation, and reinforces that children and families are a political and operational priority rather than an afterthought.

Ultimately, centring children and families in the mechanics of government strengthens oversight, accountability, and outcomes. It ensures that all portfolios work in concert for children, rather than including them as secondary considerations, and it provides the structural leadership necessary to translate political commitment into practical, cross-departmental action.

Transformational Recommendation 8: Establish robust and centralised national and state governance for child safeguarding

To ensure the protection of children from abuse and neglect is treated as a matter of the highest national priority, it is recommended that the Australian and Queensland Governments immediately establish dedicated and enduring governance mechanisms for children and child safeguarding. This must include:

- formally establishing clear federal Ministerial accountability and a permanent Ministerial Council on Child Safeguarding as a standing committee of National Cabinet, providing a cross-jurisdictional mechanism for driving coordinated national policy, sharing critical intelligence, and progressing nationally consistent child safeguarding legislation and systemic reform, including the outstanding recommendations from the Royal Commission
- making the safety of children an explicit priority within the Queensland cabinet process (by establishing a dedicated Cabinet Sub-committee charged with overseeing the state's responses to child abuse and neglect, ensuring accountability across portfolios, and embedding a whole-of-government approach to preventing harm and supporting recovery).

This governance reform is essential to elevate child safeguarding to a national and state leadership level, enable urgent system improvements, and ensure that past failures to protect children are not repeated.

Operational Recommendation 18: Produce a clear long-term strategy for the protection of children

The Review has reinforced the imperative that child safeguarding must sit at the centre of government planning and action. Current arrangements, while comprehensive in parts, remain fragmented across departments, sectors, and programs. Children's wellbeing is not consistently embedded as a primary consideration in decision making, leading to systemic gaps where risks persist undetected and interventions are reactive rather than preventative.

Current national strategies tend to focus on primary prevention and welfare-oriented models, which are vital for promoting wellbeing but do not fully capture the spectrum of threats children face. They often conceptualise children as secondary participants, relying on adult behaviour change or parental capacity to reduce risk. While important, this approach insufficiently recognises children as potential targets of deliberate harm, including sexual abuse and exploitation, nor does it adequately integrate proactive threat detection and intelligence-based safeguarding.

This has been laid stark for the Board when it was confronted by the compelling reality that law enforcement entities have known for some time that perpetrators strategically and intentionally target children under the age of five to prevent detection, yet there has been a paucity of protective actions taken to respond to this threat.

A Queensland strategy must centre children in the design and delivery of safeguarding systems, not only in the sense of protecting their welfare but also by acknowledging the real and present dangers they may face in modern society. This requires reframing children not only as beneficiaries of protection but as individuals whose safety is a measurable outcome across all government functions. Child safeguarding cannot succeed in isolation from family and community contexts. Evidence demonstrates that effective protection and resilience are contingent on supporting parents, caregivers, and communities to provide safe, nurturing environments. A long-term strategy would embed mechanisms that recognise the dual role of government: to prevent harm directly to children and to strengthen protective environments around them. This dual focus ensures that child safety is treated as a societal responsibility rather than a narrow departmental obligation.

Current national approaches, including those oriented towards child sexual abuse prevention, have achieved important progress in education, awareness, and risk reduction, however, these models:

- focus on parents and adults rather than systematically assessing emerging threats to children
- fragment responses across sectors, limiting the ability to aggregate intelligence and identify patterns of risk across schools, care settings, and community environments
- emphasise reactive interventions, responding to abuse after it occurs rather than integrating predictive risk assessment and early intervention strategies.

Our Review has shown that the landscape for children is changing rapidly, with new threats emerging in digital environments, transient living arrangements, and multi-jurisdictional interactions. A strategy limited to welfare and primary prevention cannot respond to these realities. Queensland requires a clear, long-term, child-centred framework that unites intelligence, prevention, response, and oversight across government and society.

A long-term Queensland child safeguarding generational strategy should:

1. Elevate child safety as a core government priority.
2. Integrate parents, caregivers, and communities into the child safeguarding framework, recognising their role in prevention and resilience.
3. Adopt a threat-focused perspective, addressing both known risks and emerging challenges including sexual abuse, exploitation, neglect, and systemic failures.
4. Establish clear accountability and oversight mechanisms, including centralised leadership and cross-sector intelligence sharing.
5. Enable adaptive planning, incorporating evolving evidence, technological change, and socio-cultural shifts over time.

In short, Queensland needs a generational strategy for child safeguarding, not a series of disconnected policies or short-term programs. By thinking strategically long term, government can move from reacting to incidents to predicting, preventing, and mitigating threats, ensuring that children are genuinely safe, supported, and central to all protective interventions.

Operational Recommendation 18: Produce a clear long-term strategy for the protection of children

That the Queensland Government develop and implement a long-term child-centred safeguarding strategy that places the safety of children at the centre of government planning and decision making. The strategy should:

- be framed on the prevent, detect, respond and support themes emerging from this report
- integrate intelligence, oversight, prevention, and response across all relevant government departments, regulators, and programs
- recognise the critical role of parents, caregivers, and communities in protecting children and strengthening protective environments
- shift the focus from children as secondary participants to active consideration of emerging threats, including sexual abuse, exploitation, neglect, and systemic risks
- embed clear accountability and leadership mechanisms to ensure coordination, transparency, and continuous improvement across the child safeguarding system
- be adaptive and evidence-informed, incorporating emerging research, technological change, and evolving social contexts to ensure enduring effectiveness
- promote a culture of proactive prevention, early intervention, and continuous learning, ensuring children's safety remains a central and measurable outcome across all government functions.

This strategy should serve as a generational blueprint for child safeguarding in Queensland, replacing fragmented, short-term approaches with a sustained, coordinated, and accountable framework designed to protect children from harm into the future.

Operational Recommendation 19: Engaging young people, victim-survivors and experts in strategy and resource development

The Review has highlighted that children and young people, along with people with lived experience of child sexual abuse, possess unique insights that are critical for effective safeguarding strategies. Their perspectives illuminate the realities of risk, barriers to reporting, the gaps in our systems and the supports that are genuinely effective in preventing harm and promoting healing.

Involving young people and victim-survivors as expert advisors ensures that policy and program design is informed by those directly affected, rather than solely by adult professionals or bureaucratic assumptions. This engagement fosters trust, accountability, and transparency, demonstrating a genuine commitment to centring the voices of children in safeguarding efforts.

Across Australia and internationally, engaging lived-experience panels has become recognised as best practice in policy and program design. Such panels provide practical guidance on:

- identifying emerging risks in both physical and digital environments
- improving reporting mechanisms and pathways for disclosure
- designing prevention and education programs that are relevant and accessible to children and young people
- shaping policies that balance child safety with empowerment and participation rights
- evaluating the effectiveness of interventions and oversight mechanisms from the perspective of those most affected.

Importantly, engaging victim-survivors in this way should be done safely, ethically, and respectfully, with appropriate support, safeguards, and compensation for participation. Their contributions should influence decision making at the highest levels, ensuring that the strategy reflects lived realities as well as legislative and organisational priorities.

Embedding these voices at the outset positions Queensland's child safeguarding system as participatory, informed, and accountable, strengthening the legitimacy and impact of the safeguarding system.

Operational Recommendation 19: Engaging young people, victim-survivors and experts in strategy and resource development

That the Queensland Government establish an Expert Advisory Panel to inform the development, implementation, and ongoing evaluation of the long-term Child Safeguarding Strategy. The panel should include young people, victim-survivors, parents, researchers and experts. These members should:

- be actively involved in shaping strategy priorities, policies, and programs
- provide insights on emerging risks, reporting pathways, and effective prevention and intervention approaches
- operate with appropriate safeguards, support, and recognition of participants' wellbeing
- ensure lived experience informs decision making at all stages, creating a child- and victim-survivor-centred approach
- contribute to the evaluation of the strategy's effectiveness, providing feedback on its relevance, accessibility, and impact from the perspective of young people and victim-survivors.

Engaging this panel will ensure that Queensland's child safeguarding system is authentic, accountable, and responsive to the needs and realities of those it is designed to protect.

Transformational Recommendation 9: Establish a safeguarding entity

This Review has consistently found that Queensland's current approach to child safeguarding is fragmented, reactive, and insufficiently accountable. While there is widespread acknowledgement that protecting children is a shared responsibility, in practice this responsibility is dispersed across multiple agencies, regulators, and organisations each holding only part of the picture.

Without a central entity to lead, coordinate, and hold accountability for the protection of all children from sexual abuse, our initiatives to prevent, detect, and respond to threats risk being applied unevenly across sectors, and their impact will be diluted.

Our findings reveal that there is a system-wide lack of understanding about child sexual abuse and safeguarding practices. This deficit is not limited to individuals or frontline services; it extends into how government structures itself. Different agencies collect information, regulate practice, and intervene in risk, and while so many good people are doing their roles well, there is no clear mechanism to integrate intelligence or to drive a unified safeguarding agenda.

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This absence of centralised leadership creates duplication in some areas, gaps in others, and ultimately leaves children less safe. The Board considers that unless we shift the paradigm of how government works in child safeguarding, Queensland will always be chasing crime rather than preventing threats.

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Current arrangements are designed around institutional boundaries rather than the needs of children. As a result, warning signs are missed, risk is assessed in silos, and opportunities for prevention are lost. Bringing together related services and regulatory schemes would strengthen and amplify Queensland's approach. It would reduce duplication, promote consistency, and ensure that insights gained in one part of the system immediately inform decisions in another. Queensland has an opportunity to move beyond fragmented oversight and establish a safeguarding model that sets the national benchmark.

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We want to see when an allegation is raised a clear agreement on who does what and when. We need someone to lead this centralised approach, with a resulting risk assessment. What we need to move towards is clarity on who provides the primary role of assessing and making recommendations on risk.

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Multiple submissions received by the Board reflected on the need to streamline and centralise processes. For example, the Australian Childhood Foundation suggested that duplication and regulatory fatigue could be avoided by establishing or identifying a single lead agency to receive, triage, and coordinate all allegations of reportable conduct and concerning behaviour involving those working with children, similar to the Local Area Designated Officers model in the United Kingdom; which should be supported by a streamlined digital reporting platform.

To achieve this, Queensland should establish a new Child Safeguarding Entity. This entity would provide a single point of leadership, accountability, and coordination for child safety and wellbeing across the state.

It should integrate the following core functions:

- **Blue Card Services**, ensuring that suitability assessments are informed by real-time safeguarding intelligence.
- **Reportable Conduct Scheme**, enabling cross-organisational risk detection and response.
- **Child Safe Standards**, driving cultural change in organisations and embedding safeguarding practice.
- **System Intelligence and Oversight**, collating information across sectors to identify risks and trends, and ensuring accountability for responses.
- **Coordination of community awareness and capacity building** to prevent and respond to child sexual abuse.
- **Coordination of organisational capacity building** to prevent and respond to child sexual abuse.
- **A safety net for concerns and complaints from parents and coworkers** who have found responses by organisations, regulators, police, or other criminal justice agencies to be insufficient to protect children.

Government could also consider including within the new Child Safeguarding entity:

- all or part of the early childhood regulatory authority (ECRA) with specific focus on the specialised teams that investigate child abuse and neglect
- residential care licensing (noting this may be subject to the current Commission of Inquiry into Queensland's child safety system)
- functions of the current Office of the Public Guardian including child advocacy; guardianship of children in care; and community visitor program (noting this may be subject to the current Commission of Inquiry into Queensland's child safety system).

Such a body would not replace the existing responsibilities of frontline agencies but would instead **align and elevate their efforts**, ensuring that the whole system functions as more than the sum of its parts. It would provide:

- **Leadership**, by setting the agenda for safeguarding reform and monitoring progress.
- **Accountability**, by being clearly responsible for ensuring children are protected across all settings.
- **Intelligence**, by collating and analysing data from multiple sources to detect threats earlier.
- **Transparency**, by reporting to government and the community on performance and outcomes.
- **Consistency**, by ensuring that safeguarding standards are applied uniformly across sectors.

Transformational Recommendation 9: Establish a safeguarding entity

That the Queensland Government legislate to establish a new safeguarding entity to provide a central point of leadership, accountability, and coordination for child and vulnerable person safeguarding. This entity should consolidate related regulatory and safeguarding functions and act as the system's intelligence hub, ensuring Queensland moves from fragmented responses to a unified, proactive safeguarding system.

By addressing these areas, systems can bridge the gaps that currently compromise the safety of children. An integrated approach ensures that all levels of society are working together towards the common goal of preventing and responding to child sexual abuse.

Conclusion

This Review is the first of its type in Queensland. It is the first time the Board has ever been requested to undertake such a review by the Attorney-General which does not involve the death of a child. It is also the first time that the Board has engaged with families and undertaken a public call for submissions. The Board has been mindful when making recommendations in this report of the enormity of the issues the Review has identified, which have been further amplified by similar cases happening in other jurisdictions and a renewed national focus on responding to institutional child sexual abuse, almost ten years to the day since the Royal Commission into Institutional Responses to Child Sexual Abuse made its first recommendations in the Working with Children Report, many of which have yet to be implemented.

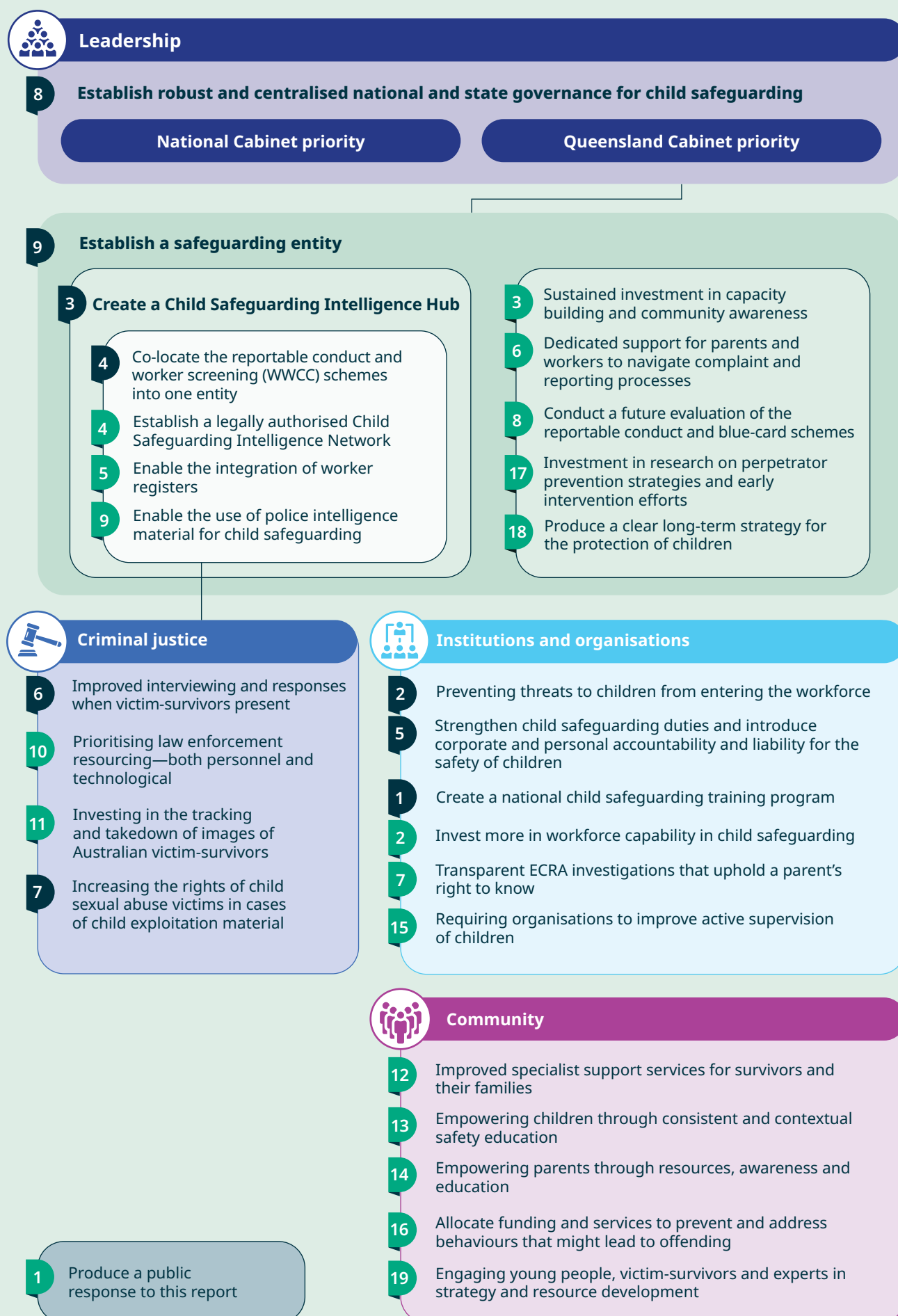
It is these ongoing cases, that have led us to recommend a future where there is an integrated approach to child safeguarding.

Our recommendations are deliberately designed to operate across multiple layers of the ecological model, recognising that child safeguarding requires coordinated interventions at the individual, relational, organisational, community, and societal levels. No single reform is sufficient on its own; each recommendation reinforces and amplifies the others, creating a comprehensive system of protection.

In having regard to the critical findings of the Review, and the need to take a multilayered and ecological approach, the following major recommendations are considered to make the biggest impact to the future safety of children:

1. Empowering better collation of integrated intelligence below the criminal justice threshold in a way that enables and authorises civil-law to develop and deliver threat assessments – **Transformational Recommendation 3: Create Child Safeguarding Intelligence Hub.**
2. Provide a central point of accountability for proactively seeking intelligence, developing the integrity of the integrated intelligence hub, and pushing information to the police, regulators and organisations that are required to act – **Transformational Recommendation 9: Establish a safeguarding entity.**
3. Lifting the safety of children as a primary issue within the mechanics of government – **Transformational Recommendation 8: Establish robust and centralised national and state governance for child safeguarding.**
4. Strengthening the obligations on organisations to detect, prevent and respond to threats of child sexual abuse before they occur – **Transformational Recommendation 2: Preventing threats to children from entering the workforce** and **Transformational Recommendation 5: Strengthen child safeguarding duties and introduce corporate and personal accountability and liability for the safety of children.**
5. Improving the response to children who have been offended against, and their families – **Transformational Recommendation 6: Improved interviewing and responses when victim-survivors present** and **Transformational Recommendation 7: Increasing the rights of child sexual abuse victim-survivors in cases of child exploitation material.**
6. Improve worker and community awareness of child sexual abuse, grooming and the likelihood of threats – **Operational Recommendation 2: Invest more in workforce capability for child safeguarding; Transformational Recommendation 1: Create a national child safeguarding training program; Operational Recommendation 3: Sustained investment in capacity building and community awareness** and **Operational Recommendation 14: Empowering parents through resources, awareness and education.**

Figure 2: How the recommendations nest and integrate for an effective safeguarding system



At the organisational level, measures such as enhanced training for staff, embedding safeguarding into recruitment and performance management, and providing accessible therapeutic and counselling support empower children, families, and professionals with knowledge, resilience, and tools to identify and respond to risks. Relational interventions, including improved reporting processes, mandatory parent notification, and clear pathways for disclosures, strengthen the immediate networks around children, ensuring that concerns are acted upon promptly and effectively.

Organisationally, our recommendations on leadership accountability, governance, and risk-informed staffing practices create cultures where safeguarding is embedded into everyday operations rather than treated as a compliance exercise. Community-focused measures, including awareness campaigns, educational programs for children and parents, and cross-sector collaboration initiatives broaden the protective environment beyond individual organisations, reinforcing norms around child safety and collective responsibility.

Finally, societal and systemic reforms—such as the establishment of a central child safeguarding entity, integrated worker registers, and improvements to national frameworks and regulatory oversight—ensure consistency, transparency, and alignment across sectors and jurisdictions. By designing recommendations to interact across these levels, we create a multi-layered, mutually reinforcing safeguarding system capable of both preventing abuse and responding effectively when it occurs.

To make the rationale for our recommendations clear, we have developed a visual map that plots each reform across the ecological model. Rather than simply showing interconnections, this map demonstrates that we have deliberately targeted specific interventions to each level of the system. Our approach has been to analyse the child safeguarding ecosystem in its entirety, identify the critical weaknesses at each level—from the individual child and their immediate relationships, to organisational cultures, community networks, and systemic, cross-jurisdictional structures—and design reforms that address those precise vulnerabilities.

By targeting each level deliberately, our intention is to treat the ailments present across the system, making the whole safeguarding ecosystem healthier, more resilient, and capable of preventing harm rather than merely reacting to it.

Critically, our review has identified that one of the most harmful gaps in the modern child safeguarding landscape is the distance between the thresholds of the criminal justice system and the remaining layers of protection. While police and prosecution agencies operate at a high evidentiary bar, the surrounding organisational, sectoral, and regulatory safeguards are often left to function in isolation. This disconnect allows harmful individuals to exploit system gaps, leaving children exposed to risk.

Our most radical recommendations are deliberately targeted at closing this gap. The creation of an **integrated intelligence hub**, the **merger of the Working with Children Check and Reportable Conduct Scheme**, and the establishment of a **centralised child safeguarding entity** are designed to bridge the divide between criminal justice responses and sector-specific regulatory frameworks. By linking intelligence, regulatory oversight, and operational practice, these reforms ensure that emerging threats to children are identified, shared, and acted upon—long before harm escalates to a criminal threshold.

In effect, these measures seek to connect the high-threshold criminal justice response with preventative and organisational layers, creating a continuous safeguarding network. This integrated approach means that no child is left unprotected simply because existing systems failed to communicate or coordinate. It transforms our child protection architecture from a set of isolated silos working across different layers into a cohesive, proactive system where risks are more easily visible, managed, and mitigated across all levels.

We hope that both the Queensland and Australian Governments respond to our proposals with similar precision and ambition, taking a holistic yet level-specific approach to child safeguarding that matches the complexity of the risks children face today.

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Protecting children from sexual abuse is not the responsibility of any single agency—it is a shared obligation that demands coordinated and sustained action. These reforms are not incremental adjustments—they constitute a transformative vision for child safeguarding in Queensland.

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Figure 4: Our key recommendations across our safeguarding framework



Operational Recommendations

- 1 Produce a public response to this report
- 16 Allocate funding and services to prevent and address behaviours that might lead to offending
- 17 Investment in research on perpetrator prevention strategies and early intervention efforts

- 10 Prioritising law enforcement resourcing—both personnel and technological
- 11 Investing in the tracking and takedown of images of Australian victim-survivors

- 4 Establish a legally authorised Child Safeguarding Intelligence Network
- 5 Enable the integration of worker registers
- 6 Dedicated support for parents and workers to navigate complaint and reporting processes
- 8 Conduct a future evaluation of the reportable conduct and blue card schemes
- 9 Enable the use of police intelligence material for child safeguarding

- 2 Invest more in workforce capability in child safeguarding
- 7 Transparent ECRA investigations that uphold a parent's right to know
- 15 Requiring organisations to improve active supervision of children

- 3 Sustained investment in capacity building and community awareness
- 12 Improved specialist support services for victim-survivors and their families
- 13 Empowering children through consistent and contextual safety education

- 14 Empowering parents through resources, awareness and education
- 18 Produce a clear long-term strategy for the protection of children
- 19 Engaging young people, victim-survivors and experts in strategy and resource development

Final say - Chairperson

This year-long review has reinforced a clear and urgent truth: protecting children from sexual abuse is not the responsibility of any single agency, sector, or level of government—it is a shared obligation that requires coordinated, comprehensive, and sustained action. This sharing of obligation, however, cannot dissolve or limit leadership accountability.

The evidence examined throughout this review demonstrates that piecemeal approaches, siloed responsibilities, and fragmented systems produce critical gaps that perpetrators exploit and that leave children vulnerable.

To create meaningful change, Queensland must move beyond incremental reforms and towards a fully integrated, forward-looking child safeguarding system.

Ultimately, what this review seeks to achieve is a future system in which accountability, intelligence, prevention, detection, response, and support are deliberately unified and robustly resourced. At its core, this requires a reformed architecture of government, providing *a single point of leadership and accountability for child safeguarding* across both state and national levels. Such a structure will empower Ministers and departments to execute their functions effectively while closing the gaps that currently exist between portfolios and agencies.

Central to this architecture is the establishment of a new *Child Safeguarding Entity*, designed as a pivotal component of a focused child protection scheme. This entity would consolidate existing mechanisms—the blue card, Reportable Conduct Scheme and Child Safe Standard—into an integrated operation that bridges the critical gap between legitimate concerns and the criminal threshold. It would operate an *Integrated Intelligence Hub*, resourced to proactively detect threats to children by consolidating and analysing information from across state and national regulatory bodies, institutions, employee registers, and policing activities. This entity would also lead the development of a *long-term Queensland strategy* for the prevention, detection, and response to child sexual abuse, while delivering accessible resources for organisational and community awareness, training, and support.

Importantly, this system would provide *a trusted avenue for parents, family members, colleagues, and staff* to report concerns that do not meet the police threshold, ensuring that even early or ambiguous warning signs are received, recorded and analysed. It would *coordinate resources for support and healing*, including specialist counselling support for victims and their families, recognising that safeguarding is not limited to preventing abuse but encompasses comprehensive support for those who have been impacted.

Organisations must be held to *higher standards of organisational accountability*. Boards, directors, and individuals should bear responsibility for recruitment decisions, referee checks, and the documentation of dismissals. Penalties should be imposed for failing to report or maintain records of complaints and concerns. These measures ensure that organisations do not merely react to abuse but actively safeguard against it.

The police response to child exploitation material must be resourced and specialised.

Dedicated staffing for the frontline work associated with victim identification must be doubled, and technological tools—including AI—should be systematically integrated into detection processes. Similarly, the criminal justice system must adapt to enable victim impact statements to accompany child exploitation material, recognising and amplifying the voices of victim-survivors within prosecutorial processes.

Taken together, these reforms are not incremental adjustments—they constitute a transformative vision for child safeguarding in Queensland.

A future system built on these principles will be proactive, intelligence-led, and holistic; it will unite government services, organisations, and communities in a shared responsibility for children's safety. Most importantly, it will close the gaps that currently allows perpetrators to remain undetected and abuse to occur unaddressed, ensuring that every child grows up in an environment that is not only safe but actively protective.

This review presents a vision: safeguarding children is not a task that can be delegated or compartmentalised. It demands integrated structures, shared accountability, and unwavering commitment at every level of our society. We all have a role to play.

By implementing our recommendations, Queensland can instead build a system that is not only responsive to abuse when it occurs, but anticipatory, preventative, and restorative—ultimately delivering on the promise of a safer future for every child.



Luke Twyford
Chairperson,
Child Death Review Board
November 2025

Recommendations

Operational Recommendation 1: Produce a public response to this report

That the Australian and Queensland Governments both separately produce a public statement outlining the strategic transformation it commits to leading. This public statement should directly respond to the future system presented in Part G of this report, and include information on the planned timing, accountability and resourcing allocated to improve the prevention, detection, response and recovery from child sexual abuse.

Operational Recommendation 2: Invest more in workforce capability for child safeguarding

That the Queensland Government invest in embedding mandatory training across all child-related sectors on:

- the identification of grooming behaviours (including the grooming of organisations, colleagues, parents and victims)
- how to raise, challenge and discuss behaviours of concern
- the responsibilities of workers and organisations for child safeguarding
- best practice approaches to receiving and responding to disclosures from children.

This training should be standardised, evidence-informed, and incorporated into professional registration, accreditation, and induction processes, with regular refreshers. Such investment will ensure that child safeguarding becomes a core competency of the Queensland workforce, significantly increasing the likelihood that risks are detected early, concerns are acted upon, and children are protected from harm. Government-funded training should be positioned as a complement to, not a replacement for, sector responsibility. The expectation must remain that organisations embed safeguarding capability as part of their core duties, developing and maintaining training that reflects their specific contexts and risks.

The Queensland Government's investment, therefore, should be directed toward creating high-quality, evidence-informed programs that set a consistent baseline across sectors and provide specialist expertise that individual organisations may not be able to develop on their own. This shared infrastructure lifts standards, reduces duplication, and ensures that safeguarding knowledge is both contemporary and consistent across the state, while still holding sectors accountable for embedding and sustaining training within their workforce.

Transformational Recommendation 1: Create a national child safeguarding training program

That the Australian Government auspice the development and delivery of a compulsory and consistent online, national training program. This training should cover:

- the responsibilities of workers and organisations for child safeguarding
- the identification of grooming behaviours (including the grooming of organisations, colleagues, parents and victims)
- best practice approaches to receiving and responding to disclosures from children.

The program should be evidence-informed, designed in collaboration with child protection experts, and delivered in a format accessible to the diverse workforce engaged in child-related roles.

Each state should make completion of the training a precondition for WWCC approval, with mandatory refreshers tied to WWCC renewal cycles. This should also extend to professions exempted from the WWCC scheme (including health and teachers). By embedding safeguarding education directly into the WWCC framework, the program would establish a consistent national baseline of knowledge and capability, regardless of jurisdiction or sector. This approach would address current fragmentation across states and territories, ensuring that every adult permitted to work or volunteer with children has received contemporary safeguarding training. This should occur ahead of, and not be dependent on, national harmonisation.

The Commonwealth's role should be to develop and fund the shared infrastructure for this training, while maintaining the expectation that organisations continue to provide context-specific safeguarding education relevant to their workforces. In this way, the national program functions as a foundation: lifting standards, reducing duplication, and guaranteeing consistency, while leaving space for sector-led initiatives that respond to particular risks and settings.

Operational Recommendation 3: Sustained investment in capacity building and community awareness

That the Queensland Government extend and expand its investment in child safeguarding capability through:

- Sector and Organisation Capacity Building Grants – extending the \$2 million per annum Child Safe Organisations Capacity Building grants program for a further three years, to ensure that organisations have the resources, training, and tools needed to embed the Child Safe Standards into their operations.
 - Community Awareness Campaign – re-funding the 2024–25 investment in the child safe community awareness campaign of \$1 million for the next three years, to build broad public understanding of child safeguarding and the identification of grooming to empower parents and carers, and create a culture where communities actively support safe organisations for children.
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Transformational Recommendation 2: Preventing threats to children from entering the workforce

The Australian and Queensland governments:

- identify specific industries, such as early childcare, residential care, disability care, youth justice and boarding facilities, where they will legislate:
 - penalties for both employees and employers who do not record their employment in employee registers; and
 - penalties for employees, employers and referees for failing to disclose past employment history; concerns, complaints or investigations about the employee regarding harm or risks to children; or the reasons that employment ended
 - amend the *Fair Work Act 2009* (Cth) and other industrial and workplace laws to provide explicit protection for employers who, in good faith and based on reasonable grounds, take adverse employment action (including suspension, role reassignment, or termination) due to concerns about a worker's potential risk to children.
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Transformational Recommendation 3: Create a Safeguarding Intelligence Hub

The Queensland Government establish a Child Safeguarding Intelligence Hub: a centralised, integrated platform to collect, analyse, and act on sub-threshold indicators of concern about individuals working with children. By linking organisational, regulatory, and community reports, applying analytical risk assessment techniques, and coordinating referrals with child protection and law enforcement, the hub will enable earlier identification of potential risks, enhance transparency and accountability, and break down information silos that currently impede proactive safeguarding. The government should ensure the Child Safeguarding Intelligence Hub is resourced with sufficient staff and technological capability to link, match and analyse data across the information silos relevant to child safety.

The operation of the Child Safeguarding Intelligence Hub should transform child safeguarding from a reactive investigation to proactive risk detection approach by integrating data from regulatory systems (blue card, Reportable Conduct Scheme, sector regulators, and other vulnerable persons registers), provide accessible reporting pathways for parents, staff, and volunteers, and apply advanced analytics to identify patterns of concern and threats to children. By doing so, it will enable earlier interventions, strengthen oversight, improve community trust, and prevent harm before it escalates.

The Child Safeguarding Intelligence Hub, should be designed to sit within a statutory or government-authorised entity with robust governance, secure technology infrastructure, skilled analysts, and clear ethical and legal frameworks. The hub would:

- collect and centralise sub-threshold reports from organisations, regulators, and communities
- analyse patterns of behaviour to detect emerging risks
- coordinate referrals to child protection and law enforcement
- provide feedback and training to reporters and stakeholders.

This integrated approach will seek to overcome fragmented information flows, strengthen systemic safeguarding, and enable proactive, intelligence-led protection of children.

Transformational Recommendation 4: Co-locate the reportable conduct and worker screening (WWCC) schemes into one entity

That the Queensland Government co-locate the Reportable Conduct Scheme, Child Safe Standards and the WWCC (worker screening scheme) within a single regulatory body and enable operational integration. Placing these schemes together in one organisational structure is intended to:

- eliminate silos by ensuring intelligence about individuals is shared seamlessly, reducing the risk of fragmented information
- enable consistent decision making on risk thresholds and worker suitability, as both schemes are interpreting and acting on the same evidence base
- strengthen collaboration by leveraging shared governance, culture, and leadership, which organisational design theory shows is far more effective than coordinating across separate entities
- improve efficiency and trust by giving families, organisations, and professionals a single point of contact, creating clarity and transparency in safeguarding oversight.

By embedding these functions within one organisation, Queensland will create a more integrated, accountable, and proactive safeguarding system that maximises the value of both schemes.

Operational Recommendation 4: Establish a legally authorised Child Safeguarding Intelligence Network

That the Queensland Government progress amendments to the *Child Safe Organisations Act 2024* to establish an effective Child Safeguarding Intelligence Network. This network should provide a formal legal framework and compulsion for cross-agency intelligence sharing that:

- transforms information into intelligence by empowering agencies to collate, analyse, and share insights that reveal patterns of risk and harm to children, overcoming the current fragmentation of raw data
- provides a legal foundation for proactive, not just reactive, sharing of relevant intelligence
- overcomes existing barriers—technological, organisational/cultural, and political/legislative—by setting common security standards, developing consistent protocols, and mandating interoperability of systems
- embed collaborative practice through clear governance arrangements, defined roles and responsibilities, and formal agreements between members
- foster a culture of trust and transparency where agencies are supported and incentivised to share intelligence in the interests of the safety of children, underpinned by workforce training and professional development
- enable networked or collaborative-centralised sharing models so that intelligence is accessible across multiple relevant entities, reducing 'linkage blindness' and silo effects
- give safe access to police intelligence, especially for cases that police have determined do not reach a criminal threshold, to decision makers in the WWCC and reportable conduct schemes.

A legislated Child Safeguarding Intelligence Network will provide Queensland with the capability to identify emerging threats, connect otherwise isolated threads of information, and ensure agencies can act on a shared, accurate picture of risk. It will transform the current information-sharing environment into a proactive intelligence system that strengthens the capacity of government and non-government organisations to protect children.

Operational Recommendation 5: Enable the integration of worker registers

That the Queensland Government lead structural reform by consolidating employee registers and enabling linkage or matching with the Working with Children Check (WWCC) register and the reportable conduct register. Existing state and federal employee registers should be incorporated into the scheme where possible, including the early child care worker register, disability worker register, teacher worker register and the proposed residential care worker register. This will provide a central point of accountability for worker screening and safeguarding intelligence. This reform should be supported by two critical sub-elements:

- Interoperability standards: Develop and adopt shared data standards and interoperability protocols across all worker registers relevant to child and vulnerable person safeguarding. This will enable timely information flow across systems and jurisdictions, ensuring that risks identified in one setting are visible to all others.
 - National coordination mechanism: Advocate for, and actively participate in, the creation of a national safeguarding register clearinghouse with authority to reconcile clearance and misconduct information across states, territories, and sectors. This clearinghouse would ensure that adverse findings or suspensions in one jurisdiction or sector are automatically recognised and acted upon in others, eliminating loopholes and enabling intelligence-led prevention.
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Operational Recommendation 6: Dedicated support for parents and workers to navigate complaint and reporting processes

That the Queensland Government ensure the Reportable Conduct Scheme is funded to meet demand, and that additional resources and authority is provided to enable the Reportable Conduct Scheme to establish dedicated support for parents, carers, workers, and volunteers to make and navigate complaints and reporting processes across organisations, regulators, and the police.

Operational Recommendation 7: Transparent ECRA investigations that uphold a parent's right to know

The Queensland Government should strengthen regulatory expectations and, where appropriate, legislated obligations, for ECEC services to inform parents and carers when a reportable conduct investigation is being undertaken that relates to a service provider or centre their child attends. This requirement should:

- ensure transparency while balancing privacy and procedural fairness
- encourage holistic, child-focused investigations that examine patterns, systemic issues, and environmental factors rather than treating incidents in isolation
- promote earlier disclosures from children, parents, and staff by fostering a culture where raising concerns is safe, valued, and acted upon
- replace practices that prioritise secrecy 'to avoid panic', which can limit accountability and inadvertently allow offenders to continue harmful behaviour.

Embedding this expectation will normalise transparency, reinforce organisational accountability, and strengthen the effectiveness of the Reportable Conduct Scheme, signalling that the safety of children is always paramount.

Operational Recommendation 8: Conduct a future evaluation of the reportable conduct and blue card schemes

That the Queensland Government conduct a comprehensive review of the state's key child safeguarding frameworks—including the risk-based Working with Children Check (blue card) system, the Child Safe Organisations Act, and the Reportable Conduct Scheme—in 2028-29. This review should assess whether recent reforms are operating as intended, identify any gaps or unintended consequences to the operation of the new schemes, and provide evidence-based recommendations for improvements to strengthen accountability, reduce risk, and ensure that the child safeguarding system effectively protects children across all sectors. With specific reference the review must:

- consider the operation of the blue card system within the broader safeguarding system
- consider the operation of the Reportable Conduct Scheme and its effectiveness in preventing, detecting and responding to child sexual abuse.

The review should assess scheme uptake, operational challenges, and whether its broad legislative definition supports timely detection, intervention, and organisational accountability for preventing, detecting and responding to child sexual abuse.

Operational Recommendation 9: Enable the use of police intelligence material for child safeguarding

The Queensland Government should legislate a clear obligation for police to share key contextual information from investigations that do not lead to a prosecution with a relevant child safeguarding authority (WWCC, reportable conduct or the child safeguarding body). This information should include details of complaints, observed behaviours, investigative findings, and other relevant contextual data. This obligation should ensure that:

- a decision not to prosecute does not result in lost intelligence or missed opportunities to identify threats and emerging risks
- a centralised safeguarding body—either BCS, the Reportable Conduct Scheme, or a dedicated child safeguarding entity—can assess risk, detect patterns, and take protective action that the police information, especially the information gained from child interviews, witness interviews and suspect interviews, is used to protect children

Implementing this requirement will strengthen Queensland's safeguarding system, close information gaps, and ensure that all available intelligence contributes to keeping children safe.

Operational Recommendation 10: Prioritising law enforcement resourcing—both personnel and technological

The Queensland and Australian governments take immediate action to ensure that law enforcement agencies have the resources, tools, and capabilities necessary to proactively protect children from sexual abuse and exploitation. Specifically:

1. **Resourcing frontline investigations:** The Australian Federal Police (AFP) and Queensland Police Service (QPS) should increase the capacity for Child Protection and Investigation Unit (CPIU) Joint Anti-Child Exploitation Teams (JACET) and Victim Identification Units to ensure timely and effective investigations, including the ability to execute more warrants and analyse electronic evidence without delay.
2. **Technological parity:** The Queensland and Australian governments should review and reform procurement, policy, and funding arrangements to ensure police departments have rapid access to technology and analytical tools equivalent to, or ahead of, those used by perpetrators of child sexual abuse. This must include AI-assisted analysis, digital forensics software, and secure cloud storage solutions.
3. **Integrated safeguarding approach:** These measures should be part of a broader, coordinated strategy to embed law enforcement as a fully supported pillar within Queensland's child safeguarding system, complementing regulatory, oversight, and intelligence mechanisms.

Both governments should publish this resourcing to ensure that organisational drift does not occur and that the public can monitor changes in resourcing over time.

Transformational Recommendation 5: Strengthen child safeguarding duties and introduce corporate and personal accountability and liability for the safety of children

That the Australian Government commence a national reform to strengthen and harmonise child safeguarding laws across jurisdictions, embedding corporate responsibility and liability for child safety in the same way that Work Health and Safety laws now apply to worker safety so that Commonwealth laws include enforceable corporate duties of care for child safeguarding, and significant penalties for organisations, their board and their leaders where safeguarding failures result in sexual abuse or exploitation or expose children to serious risk of harm. Such a scheme is to include the appointment of child safeguarding officers in medium sized organisations and above, and the explicit inclusion of child safeguarding within risk management plans and performance reporting.

While this occurs the Queensland Government should strengthen its own state-based legislation, including the *Child Safe Organisations Act 2024*, to introduce the above corporate and personal liabilities, duties and incentives for boards, owners, and workers to implement safeguarding practices as a requirement for operating a child-related business.

Transformational Recommendation 6: Improved interviewing and responses when victim-survivors present

The Queensland Government improve its response to victims of child sexual abuse through the adoption of principles and approaches aligned with the Child Advocacy Centre and Barnhaus models. This new approach should ensure that victim-survivors of child sexual abuse (and their parents or guardians) are protected and supported, and that any further trauma throughout the justice process is minimised. This investment should include piloting a specific Child Advocacy Centre or Barnhaus service at multiple sites in Queensland.

Transformational Recommendation 7: Increasing the rights of child sexual abuse victim-survivors in cases of child exploitation material

The Queensland and Australian governments both implement legislative reforms to enable the use of victim impact statements in cases involving CEM ensuring that these statements are attached to the specific images and are admissible in all related legal proceedings regarding those images. This approach would allow victim-survivors to provide their impact statements once, while ensuring that each perpetrator hears their voice.

Furthermore, both the Queensland and Australian governments should introduce legislative reforms that enable the use of community impact statements in CEM cases.

Queensland and Australian governments should collaborate with international partners to establish mechanisms that:

- allow victim-survivors from other countries to submit victim impact statements in cases where Australian perpetrators are charged with accessing, possessing or distributing CEM depicting them. This could be facilitated through intermediaries such as Project Arachnid, ensuring that the voices of international victim-survivors are heard and considered in Australian courts
 - allow Australian victim-survivors to submit Victim Impact Statements for use in international jurisdictions where perpetrators are charged with accessing, possessing, or distributing material depicting Australian children. These statements could be submitted through intermediaries such as Project Arachnid or other appropriate mechanisms, ensuring that the voices of Australian victim-survivors are heard and considered in foreign courts.
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Operational Recommendation 11: Investing in the tracking and takedown of images of Australian victim-survivors

That the Australian Government either enter a formal partnership with Project Arachnid or invest in a similar initiative within Australia (under the leadership of the eSafety Commissioner or the Australian Centre to Counter Child Exploitation) to combat the proliferation of CEM and protect the future rights of Australian children who have been abused.

Operational Recommendation 12: Improved specialist support services for victim-survivors and their families

The Queensland Government undertake a review of its current investment in sexual abuse counselling and support services, and establishes a centrally coordinated, dedicated funding allocation specifically for responding to child sexual abuse. This funding should ensure:

- trauma counselling is available to children and parents at the point of disclosure and throughout court processes
- adolescent mental health support is accessible for children as they transition into adolescence
- adult survivors of child sexual abuse have access to ongoing therapy and support across their life-course in acknowledgement that the impact of child sexual abuse can reappear at key life events
- eligibility criteria and service coverage are equitable, removing postcode, age, or relational barriers that currently limit access
- investment is strategically coordinated across agencies to create a seamless, statewide network of trauma-informed services, replacing the current fragmented patchwork.

This approach will embed lifelong, consistent support for victim-survivors and families, and strengthen Queensland's overall child safeguarding framework.

Operational Recommendation 13: Empowering children through consistent and contextual safety education

That the Australian and Queensland governments mandate the delivery of a structured child safety and protective behaviours curriculum across all schools, drawing on best-practice programs to ensure that every child receives consistent knowledge and skills to recognise, respond, and report unsafe situations.

Operational Recommendation 14: Empowering parents through resources, awareness and education

That the Queensland Government funds the production of key communication materials for parents and caregivers, which are available in settings frequently accessed by families. These materials are to provide accessible, evidence-based child safety education resources, and that early childhood education and care settings actively make information available to parents on:

- protective behaviours
- recognising grooming (including grooming of parents, organisations and children)
- identifying signs of distress, and
- responding to disclosures.

This initiative should be supported by a coordinated strategy across providers of health services, early childhood services, and neighbourhood centres to ensure parents receive consistent, practical and actionable guidance to safeguard children in both home and care settings.

Operational Recommendation 15: Requiring organisations to improve active supervision of children

The Queensland Government use its regulatory and oversight schemes to require all ECEC sites to develop their own unique proactive Safeguarding Plan with a specific focus on active supervision. Each plan should include:

- clear and published active supervision staff ratios that are transparent regarding under-the-roof, and rest-break calculations
- ensuring policies, training and built environments make it unusual for any worker to be alone with vulnerable children, with clearly defined exceptions and reporting requirements
- embedding risk management processes that require incidents, near misses, or deviations from supervision protocols to be reported to senior management and oversight bodies
- using CCTV not as a substitute for active supervision but as a complementary tool to verify compliance, deter misconduct, and support investigations where this is appropriate and the negative consequences are addressed.

This integrated contextual approach will ensure that surveillance—both human and technological—is part of a culture that prioritises child safety, promotes accountability at all organisational levels, and effectively prevents harm.

Operational Recommendation 16: Allocate funding and services to prevent and address behaviours that might lead to offending

That the Australian Government ensure ongoing funding and support for evidence based early intervention programs aimed at preventing child sexual abuse, particularly those that provide confidential support, public education, and guidance for adults concerned about their own thoughts or behaviours. Funding should be sufficient to enable expansion of outreach, maintain phone and online counselling services, and deliver consistent awareness campaigns.

This should include continued funding and support of the Stop It Now! Australia program, recognising its current role in preventing child sexual abuse through early intervention, public education, and confidential support for adults concerned about their own thoughts or behaviours.

Programs such as these help communities and individuals access preventative support before harm occurs and should be considered a core component of Queensland's child safeguarding strategy.

Transformational Recommendation 8: Establish robust and centralised national and state governance for child safeguarding

To ensure the protection of children from abuse and neglect is treated as a matter of the highest national priority, it is recommended that the Australian and Queensland Governments immediately establish dedicated and enduring governance mechanisms for children and child safeguarding. This must include:

- formally establishing clear Ministerial accountability and a permanent Ministerial Council on Child Safeguarding as a standing committee of National Cabinet, providing a cross-jurisdictional mechanism for driving coordinated national policy, sharing critical intelligence, and progressing nationally consistent child safeguarding legislation and systemic reform, including the outstanding recommendations from the Royal Commission
- making the safety of children an explicit priority within the Queensland Cabinet process (by establishing a dedicated Cabinet Sub-committee charged with overseeing the state's responses to child abuse and neglect, ensuring accountability across portfolios, and embedding a whole-of-government approach to preventing harm and supporting recovery).

This governance reform is essential to elevate child safeguarding to a national and state leadership level, enable urgent system improvements, and ensure that past failures to protect children are not repeated.

Operational Recommendation 17: Investment in research on perpetrator prevention strategies and early intervention efforts

That the Queensland Government invest in a dedicated research program to inform targeted prevention strategies and early intervention efforts, along with the translation of research findings into key messages that can be shared with organisations, frontline workers and parents. This research should examine:

- the behaviours and attitudes of perpetrators of child sexual abuse
- risk and protective factors across different population groups, places and settings
- pathways into offending, including developmental, relational and situational factors
- the role of online environments and digital grooming in facilitating child sexual abuse
- the effectiveness of current community education and prevention campaigns in shaping public awareness and protective behaviour
- barriers that prevent children and families from recognising or disclosing sexual abuse
- the characteristics and impact of organisational environments that enable or deter abuse
- factors that support early identification and rehabilitation of individuals at risk of offending
- emerging trends and changes in the behaviours, conduct and prevalence of offending.

Operational Recommendation 18: Produce a clear long-term strategy for the protection of children

That the Queensland Government develop and implement a long-term child-centred safeguarding strategy that places the safety of children at the centre of government planning and decision making. The strategy should:

- be framed on the prevent, detect, respond and support themes emerging from this report
- integrate intelligence, oversight, prevention, and response across all relevant government departments, regulators, and programs
- recognise the critical role of parents, caregivers, and communities in protecting children and strengthening protective environments
- shift the focus from children as secondary participants to active consideration of emerging threats, including sexual abuse, exploitation, neglect, and systemic risks
- embed clear accountability and leadership mechanisms to ensure coordination, transparency, and continuous improvement across the child safeguarding system
- be adaptive and evidence-informed, incorporating emerging research, technological change, and evolving social contexts to ensure enduring effectiveness
- promote a culture of proactive prevention, early intervention, and continuous learning, ensuring children's safety remains a central and measurable outcome across all government functions.

This strategy should serve as a generational blueprint for child safeguarding in Queensland, replacing fragmented, short-term approaches with a sustained, coordinated, and accountable framework designed to protect children from harm into the future.

Operational Recommendation 19: Engaging young people, victim-survivors and experts in strategy and resource development

That the Queensland Government establish an Expert Advisory Panel of young people and individuals with lived experience of child sexual abuse to inform the development, implementation, and ongoing evaluation of the Child Safeguarding Strategy. The panel should:

- be actively involved in shaping strategy priorities, policies, and programs
 - provide insights on emerging risks, reporting pathways, and effective prevention and intervention approaches
 - operate with appropriate safeguards, support, and recognition of participants' wellbeing
 - ensure lived experience informs decision making at all stages, creating a child- and victim-survivor-centred approach
 - contribute to the evaluation of the strategy's effectiveness, providing feedback on its relevance, accessibility, and impact from the perspective of young people and victim-survivors.
 - Engaging this panel will ensure that Queensland's child safeguarding system is authentic, accountable, and responsive to the needs and realities of those it is designed to protect.
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Transformational Recommendation 9: Establish a safeguarding entity

That the Queensland Government legislate to establish a new safeguarding entity to provide a central point of leadership, accountability, and coordination for child and vulnerable person safeguarding. This entity should consolidate related regulatory and safeguarding functions and act as the system's intelligence hub, ensuring Queensland moves from fragmented responses to a unified, proactive safeguarding system.

By addressing these areas, systems can bridge the gaps that currently compromise the safety of children. An integrated approach ensures that all levels of society are working together towards the common goal of preventing and responding to child sexual abuse.

Endnotes

- 1 Tasmanian Government, Who was looking after me? Prioritising the safety of Tasmanian children, Commission of Inquiry into the Tasmanian Government's Responses to Child Sexual Abuse in Institutional Settings, 2017.
- 2 Community and Disability Services Minister's Conference, Adelaide [media release], Australian Government, 4 June 2010, accessed 17 September 2025.
- 3 Department of the Prime Minister and Cabinet, National Cabinet priorities, Australian Government, 2024.
- 4 Department of Prime Minister and Cabinet, Ministerial Councils, Australian Government, n.d., accessed 17 September 2025.
- 5 B Shorten and J Macklin, Community and Disability Services Minister's Conference, Adelaide [media release], Australian Government, 4 June 2010, accessed 17 September 2025.

Appendix

Appendix A: Methodology

The conduct of the Review

On 4 December 2024, for the first time since the Child Death Review Board was established in 2020, the Attorney-General used the power in section 29I of the *Family and Child Commission Act 2014* (the FCC Act) to ask the Board to carry out a review.

This section allows the Attorney-General, in exceptional circumstances, to ask the Board to carry out a stated review to identify opportunities for continuous improvement in systems, legislation, policies and practices and to identify preventative mechanisms to help protect children.

In this case, the Attorney-General requested that the Board consider the offending of Ashley Paul Griffith (the offender) as a case study to identify any weaknesses in the laws, policies, procedures and practices that occurred across the early childhood education and care (ECEC), police and blue card systems.

Terms of Reference for the System Response to Child Sexual Abuse Review (the Review) were approved by the Board on 20 December 2024 and were released publicly in January 2025. Under the Terms of Reference, the Board was required to:

- 1. establish a timeline of conduct by the offender
- 2. examine the legislative framework, policies and procedures that operated during the time of offending
- 3. identify the context of child sexual offending in Queensland
- 4. identify best practice for protecting children from sexual abuse
- 5. seek and consider the views and experiences of people directly impacted by the offender’s behaviour
- 6. analyse the legislative and policy framework in place to protect children from child sexual abuse
- 7. examine the responses of the early childhood education and care, police and blue card systems.

A dedicated team of seven staff was established within the Queensland Family and Child Commission (the Commission) to support the Board to conduct the Review. Two members of the team were secondees from the Queensland Police Service and the Department of Education.

Information requests

Pursuant to s29P of the FCC Act, the Board Chair can request information to support the Board to carry out its reviews. To inform the Board’s response to the Terms of Reference, the Chair used s29P powers to request information from government and non-government entities. In response to these requests over 20,000 pages of material were disclosed from relevant parties.

The Chair used the s29P information request powers 49 times to request information from government and non-government agencies.

Table 1: List of s29P requests 2024–25

Request type	Recipient	Request date
S29P	Australian Federal Police (AFP)	20-Dec-24
S29P	Queensland Police Service (QPS)	20-Dec-24
S29P	Department of Education (DOE)	20-Dec-24
S29P	Department of Justice (DOJ)	20-Dec-24
S29P	National Employment Agency	5-Mar-25
S29P	Queensland College of Teachers (QCT)	5-Mar-25
S29P	QPS	5-Mar-25
S29P	DOJ	5-Mar-25
S29P	DOE	5-Mar-25
S29P	Centre BS	11-Mar-25

Request type	Recipient	Request date
S29P	Centre WS	11-Mar-25
S29P	DOE	26-Mar-25
S29P	DOJ	19-May-25
S29P	QCT	19-May-25
S29P	National Employment Agency	20-May-25
S29P	Department of Families, Seniors, Disability Services and Child Safety	2-Jul-25
S29P	Centre EA	7-Jul-25
S29P	Centre UN	7-Jul-25
S29P	Centre WE	7-Jul-25
S29P	Centre KE	7-Jul-25
S29P	Centre GK	7-Jul-25
S29P	Centre GT	7-Jul-25
S29P	Centre IA	7-Jul-25
S29P	Centre CD	7-Jul-25
S29P	Centre AE	7-Jul-25
S29P	DOE	7-Jul-25
S29P	Centre EP	7-Jul-25
S29p	DOE	7-Jul-25
S29P	QPS	7-Jul-25
S29P	Australian Centre to Counter Child Exploitation (ACCCE)	7-Jul-25
S29P	Centre EA	7-Jul-25
S29P	AFP	8-Jul-25
S29P	DOJ	21-Jul-25
S29P	Centre BS	21-Jul-25
S29P	Centre WS	21-Jul-25
S29P	Centre OY	23-Jul-25
S29P	Centre MT	23-Jul-25
S29P	Centre EK	23-Jul-25
S29P	Centre EA	23-Jul-25
S29P	Centre GE	24-Jul-25
S29P	Centre MY	24-Jul-25
S29P	Centre WN	24-Jul-25
S29P	Centre WS	28-Jul-25
S29P	Centre EA	20-Aug-25
S29P	DOE	25-Aug-25
S29P	Centre WE	15-Sep-25
S29P	Centre EP	15-Sep-25
S29P	Centre MT	15-Sep-25
S29P	Centre KE	15-Sep-25

Consultation and research

Impacted parties and victim-survivors

The views and experiences of people directly impacted by the offender's behaviour were sought to ensure that the voices of victim-survivors, their families and former colleagues of the offender were central to the Board's understanding of the case and the issues under the Review's Terms of Reference.

The Australian Federal Police (AFP) made its communication portal available throughout the Review to allow the Board to contact known victim-survivors of the offender, and their family members. A call for submissions was released on 28 March 2025 through this portal and through the Board's website on 31 March 2025. The portal was also utilised to provide regular updates regarding the progress of the Review.

This engagement assisted the Board to identify gaps in the system responses and improvements needed to strengthen safeguards. To support this process and ensure trauma informed engagement with impacted parties, additional psychological and emotional support was implemented.

Research

The Board commissioned research to identify best practice across Australia and internationally in relation to protecting children from sexual abuse, identifying perpetrators and children at risk, and responding to allegations of child sexual abuse. To ensure the robustness of this research a targeted procurement process was undertaken with Griffith University, the University of New South Wales, the University of Sunshine Coast and the Australian Institute of Family Studies being successful in their proposals.

In addition, the Queensland University of Technology provided focused findings from the Australian Child Maltreatment Study that were relevant to the scope of the Review.

Stakeholder engagement

In February, the Chair reached out to 51 non-government stakeholders and experts, to invite them to consider preparing a submission addressing the issues before the Board.

The Chair also contacted children's and families' commissioners and advocates, ombudsmen and regulators in other jurisdictions in relation to research and policy work on the topic of child sexual abuse. This included seeking advice on any evaluations, assessments or reports that demonstrate the impact or effect of a reportable conduct scheme. Responses were received from:

- Tasmania
- Western Australia
- Northern Territory
- Australian Capital Territory
- Victoria
- New South Wales.

Policy roundtables

On 30 April and 25 July 2025, the Chair convened policy roundtables for Board members and experts, which included input from representatives of Marrawah Law and the universities contracted to conduct research for the Review. The roundtables provided an opportunity to identify and understand key contemporary issues and explore potential areas for recommendations that would address the identified system weaknesses.

Community submissions

In June, the Board issued a public call for submissions, and the submission period was open until 31 July. The Board took 19 submissions both verbally and in writing from:

- members of the community
- government entities
- non-government organisations.

Site inspections

The Chair of the Board attended:

- five of the ECEC services where the offending occurred
- the Australian Centre to Counter Child Exploitation
- the Child Abuse and Sexual Crime Group, QPS including Argos and members of the Northern Command Joint Anti Child Exploitation Team.

Government consultation

During the review period, we engaged with senior officers across relevant government departments through a targeted program of consultation. This included a structured recommendation scoping workshop, as well as a series of unilateral interviews where we sought to test and refine our emerging proposals. These conversations were deliberately one-way in nature: rather than inviting negotiation or shared authorship, we directed our enquiries to understand the current government response to the case study, and to gather intelligence on the likely feasibility, uptake, and impact of our recommendations. This approach allowed us to draw on the expertise and insights of senior officials without diluting the independence of the Board's analysis. The Chair convened a discussion with the chief executive of relevant Queensland government agencies to discuss the proposed recommendations, and consider any potential implementation risks.

Adverse comments

Under section 29L of the Act, the Board must not include any adverse information about an entity unless the entity has been given a copy of the information and is allowed a reasonable opportunity to make a submission. If a submission is made in relation to any adverse comment, in accordance with section 29L(2)(b), a fair summary of the information provided must be included in the Report. Feedback received highlighted the importance of the Board's review of this case, with the majority of entities providing clarifying details about their actions and responsibilities and requesting technical amendments to ensure factual accuracy. These changes have been incorporated into the final version of this Report. Although some entities have raised concerns about recollections shared with the Review by impacted parties, the Board's terms of reference explicitly required it to seek and consider the views of impacted parties to identify the lessons arising from their experience. It is therefore considered critical that these perspectives are published. The removal of victim perspectives and recollections simply because they are not evidenced, is another way the systems minimise victims.

Governance of the Review

Reporting

The Board committed to publishing regular reports regarding the progress of the Review and did so in April, June and September.

Over the course of the Review, the Board issued three progress reports to provide transparency, maintain accountability, and share emerging findings with government and stakeholders. Each report marked a significant phase in the work, documenting both the evidence gathered and the directions the Board was pursuing.

The first progress report focused on establishing the scope of the review and inviting impacted party and expert input. It set out the key agencies and processes engaged in responding to child sexual abuse and outlined the Board's early methodology for evidence collection and case study analysis.

The second progress report built upon this foundation by presenting preliminary thematic findings from the case study and the information collected to that date. It detailed systemic barriers that prevented effective identification and response to abuse, including shortcomings in information sharing, thresholds for intervention, and coordination between justice, child protection, education, and regulatory bodies. It was released alongside an open call for community submissions.

The third progress report announced the closure of submissions and released the Marrawah Law research paper.

Taken together, the three progress reports chart the evolution of the Review from exploratory mapping, through thematic analysis, to the development of evidence-based recommendations aimed at strengthening system responses to child sexual abuse.

These were all available to the public through its webpage.

What we do not know

The Board has sought to compile as comprehensive a timeline as possible regarding the offender's movements, employment, and conduct. Substantial and significant information was obtained, and we are confident that sufficient knowledge of the facts has been gathered to enable our systemic review. Noting this, however, there remain gaps in the evidentiary record. In particular, the Board has been unable to draw together details in relation to:

- **Casual employment in 2022:** The offender worked across at least five other centres on a casual basis, yet the Board has not been able to determine whether concerns about his conduct were raised at these sites, nor the extent to which any issues were recorded, escalated, or acted upon.
- **Social media allegations:** The source or nature of the claims that gave rise to a social media post alleging the existence of a 'paedophile ring' at Centre EA have not been identified.
- **Employment agency placements:** Key information about the offender's recruitment through the Employment Agency remains incomplete, including a list of all placements where he worked; confirmation of training, induction, and recruitment checks undertaken; records of complaints or concerns raised about his conduct; and the organisation's responses to such complaints.
- **Employment at Centres GE, WE, and BY:** The Board has been unable to confirm exact dates of employment at these centres, nor the reasons for the offender's termination at Centre GE.
- **Movements across jurisdictions:** The reasons for the offender's departure from Queensland, and his subsequent return, remain unclear.
- **Offending outside Queensland:** The scope of the Board's terms of reference prevents consideration of any alleged offending that may have occurred outside Queensland's jurisdiction.

While the Sentencing Remarks indicate that other concerns were raised about the offender's conduct, including on one occasion to health, individual victim-survivor records were not requested to uphold their privacy and given the systemic nature of the Review. These incidents were not otherwise able to be identified and verified in the investigative material. Furthermore, the Board's work has been impeded by a range of structural barriers. These include:

- **Inadequate recordkeeping practices:** Many organisations had poor or incomplete records, particularly in relation to casual staffing arrangements, recruitment and induction processes, and complaints management. Some centres attributed this to current record retention requirements, which mean that they are only required to retain employment and other records for a discrete period of time.
- **Closure of multiple centres:** The permanent closure of several ECEC services limited access to records and institutional knowledge.
- **Non-cooperation by organisations:** Three organisations initially refused to provide records, citing claims of legal privilege. Two of these later produced the requested documents. One Queensland State Government Department initially refused to provide requested records, citing Cabinet confidentiality and sensitivities, however appropriate documents were later provided.

Because we have avoided contact with the offender (in recognition that there is an active appeal of his sentence) we have limited information regarding the offender's personal and social life. This represents a critical blind spot in understanding the offender's childhood and pathway to offending, and how the offender may have gained access to children outside of his formal employment. In particular, there does not appear to have been systematic consideration of:

- the offender's interactions with children and families within his neighbourhood (noting that he resided at multiple addresses during the review period)
- whether the offender gained access to children through informal social, sporting, or cultural settings on weekends, evenings, or during holiday periods.

While we have some assurance that the offender kept meticulous records of his offending and that the appropriate police response was applied to this evidence, the Board considers that further exploration of these issues may have provided valuable insights into patterns of risk and opportunity beyond formal organisational settings. The appropriate time to conduct this deeper review will be when the criminal case is settled.

Overall, the conduct of this Review and the response from institutions raises concerns about organisational accountability and the adequacy of recordkeeping. In particular:

- The poor quality of recordkeeping, coupled with incomplete or inconsistent information about complaints, raises doubts about whether organisations are able to meet their responsibilities to identify and respond to risks of harm to children.
- The variable initial willingness of organisations to participate fully in this review calls into question the sector's readiness to cooperate under a statutory reportable conduct scheme.

These findings reinforce the need for clear legislative obligations on organisations to record, retain, and disclose information relevant to allegations of misconduct involving children.

Appendix B

Glossary of terms and acronyms

Term or acronym	Meaning
Agencies or organisations	
ABS	Australian Bureau of Statistics
ACCCE	Australian Centre to Counter Child Exploitation
ACEQCA	Australian Children's Education and Care Quality Authority
ACIC	Australian Criminal Intelligence Commission
AFP	Australian Federal Police
AIFS	Australian Institute of Family Studies
ALRC	Australian Law Reform Commission
ANAO	Australian National Audit Office
ASIO	Australian Security Intelligence Organisation
BCS	Blue Card Services, part of the Department of Justice
the Board	Child Death Review Board
CASCG	Child Abuse and Sexual Crime Group, as part of Queensland Police Service
COAG	Council of Australian Governments
the Commission	Queensland Family and Child Commission
CPIU	Child Protection Investigation Unit, as part of Queensland Police Service
CPOR	Child Protection Offender Registry part of the Queensland Police Service
DCYJMA	The former Department of Children, Youth Justice and Multicultural Affairs
DFSDSCS	Department of Families, Seniors, Disability Services and Child Safety
DJAG	The former Department of Justice and Attorney-General
DoJ	Department of Justice
DSS	Department of Social Services (Commonwealth)
ECRA	Early Childhood Regulatory Authority, as part of the Department of Education
FWC	Fair Work Commission
IACP	International Association of Chiefs of Police
IWF	Internet Watch Foundation
LHLQ	Labour Hire Licensing Queensland

Term or acronym	Meaning
NCMEC	National Center for Missing and Exploited Children, based in the United States
NDIS	National Disability Insurance Scheme
NOCS	National Office of Child Safety
NOHSC	National Occupational Health and Safety Commission
OAIC	Office of the Australian Information Commissioner
OBPR	Office of Best Practice Regulation
ODPP	Office of the Director of Public Prosecutions
QCAT	Queensland Civil and Administrative Tribunal
QCT	Queensland College of Teachers
QPS	Queensland Police Service
QSAC	Queensland Sentencing Advisory Council
QSAN	Queensland Sexual Assault Network
QUT	Queensland University of Technology
TDPS	Texas Department of Public Safety
UNSW	University of New South Wales
UWU	United Worker's Union
Legislation	
Child Care Acts	Child Care Act 1991 (Qld) and Child Care Act 2002 (Qld)
FCC Act	Family and Child Commission Act 2014 (Qld)
Child Protection Act	Child Protection Act 1999
Criminal Code	Criminal Code Act 1899
Child Safe Organisations Act	Child Safe Organisations Act 2024 (Qld)
ECS Act	Education and Care Services Act 2013
Fair Work Act	Fair Work Act 2009 (Cth)
IP Act	Queensland Information Privacy Act 2009
National Law	Education and Care Services National Law
National Regulations	Education and Care Services National Regulations
Penalties Act	Penalties and Sentences Act 1992
PPRA	Police Powers and Responsibilities Act 2000
Privacy Act	Privacy Act 1988 (Cth)
PSA	Penalties and Sentences Act 1992
SCAC Act	Sexual Crimes Against Children and Community Protection Measures Act 2020
WHS Act	Workplace Health and Safety Act 2011 (Cth)
WWC Act	Working with Children (Risk Management and Screening) Act 2000
Jurisdictions	
ACT	Australian Capital Territory
NSW	New South Wales
UK	United Kingdom

Term or acronym	Meaning
USA	United States of America
WA	Western Australia
Other Terms	
ACMS	Australian Child Maltreatment Study
AHPRA	Australian Health Practitioner Regulation Authority
AI	Artificial intelligence
Blue card	Working with Children Clearance, previously known as a 'positive notice', issued under the <i>Working with Children Act 2000</i> (Qld)
C3P	The Canadian Centre for Child Protection
CAC	Child Advocacy Centre
Carmody Inquiry	Queensland Child Protection Commission of Inquiry
CCTV	Closed Circuit Television
CDSMC	Community and Disability Services Ministers' Conference
CEM	Child exploitation material as defined in the Criminal Code, including child abuse material as defined in the <i>Criminal Code Act 1995</i> (Cth) May be referred to in quotes as 'child abuse material (CAM)' or 'child sexual abuse material (CSAM)'.
Child Safety Review	Review of Child Safety Arrangements under the National Quality Framework
CISS	Child Information Sharing Scheme
CPOR	Child Protection Offender Reporting Scheme
CPTED	Crime Prevention Through Environmental Design
CRIS	Growing Child Safe Organisations Consultation Regulatory Impact Statement
DBS	Disclosure and Barring Service
DIAS	Growing Child Safe Organisations Decision Impact Analysis Statement
ECEC	Early childhood education and care
ECT	Early Childhood Teacher
Forde Inquiry	Commission of Inquiry into Abuse of Children in Queensland Institutions
ICARE	Interviewing Children and Recording Evidence
ICT	Information and communication technology
ICSE	International Child Sexual Exploitation Database
Interagency Guidelines	The Queensland Government Interagency Guidelines for Responding to Children, Young People and Adults Who Have Experienced Sexual Assault or Child Sexual Abuse
IGIpop	Interview Guidance for Investigative Police Officers
IPC	Interdiction for the Protection of Children program
I2P	Invisible Internet Project, a browser allowing access to the darknet
JACET	Joint Anti Child Exploitation Taskforce
JCPRP	Joint Child Protection Response Program, in New South Wales
LADOs	Local Authority Designated Officers
MoU	Memorandum of Understanding

Term or acronym	Meaning
MSO	Most serious offence
National Principles	National Principles for Child Safe Organisations
National Redress Scheme	National Redress Scheme for Institutional Child Sexual Abuse
NOPS	National Offending Prevention System
NCCC	National Continuous Checking Capability
NGOs	Non-government organisations
NQF	National Quality Framework
NQS	National Quality Standards
NRS	National Reference System
NWSD	NDIS Worker Screening Database
the offender	Ashley Paul Griffith
OSHC	Outside School Hours Care
PIA	Preliminary Impact Assessment
PSS	Personal safety survey (conducted by the ABS)
PTSD	Post Traumatic Stress Disorder
QIP	Quality improvement plan
the Scheme	Reportable Conduct Scheme
the Review	System Responses to Child Sexual Abuse Review
Royal Commission	Royal Commission into Institutional Responses to Child Sexual Abuse
R4Q	Regulating for Quality
SORAG	Sex Offender Risk Appraisal Guide
the Standards	Child Safe Standards
SVO	Serious Violent Offences Scheme
TOR	The Onion Router, a browser allowing access to the darknet
VIS	Victim Impact Statements
VPN	Virtual private network
WASAPP	Worried About Sex and Pornography Project
WHS	Workplace Health and Safety
the Taskforce	Women's Safety and Justice Taskforce
WWCC	Working with Children Check





Child Death Review Board

Queensland **Family & Child** Commission