IN PLAIN SIGHT

Review into System Responses to Child Sexual Abuse

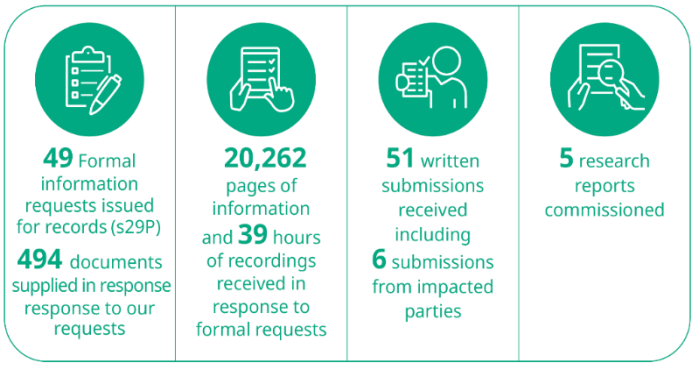
Child Death Review Board

Queensland Family & Child Commission

MEDIA BRIEF

About the review

- *In Plain Sight* reports on the outcomes of a 12-month review of Queensland's system responses to child sexual abuse, completed by the Child Death Review Board. It examined systemic issues across the early childhood education and care sector, police services, and the blue card system, using the matter of Ashley Paul Griffith as a case study.
- It was the broadest review of Australia's response to child sexual exploitation since the Royal Commission into Institutional Responses to Child Sexual Abuse, and it was the first of its type in Queensland.
- The report is titled *In Plain Sight* because those who seek to harm children are too often operating openly in our community, visible to systems, neighbours and institutions, yet unseen for who they truly are and for the risk they pose to children.
- The review was built on extensive research; sector engagement; national legislative mapping; and advice from experts including Bob Atkinson AO APM, Hetty Johnston AM, Jon Rouse APM, Conrad Townson, Alison Geale, the Daniel Morcombe Foundation, victim-survivors, and national and international child safeguarding bodies.
- The review team gathered extensive evidence and information throughout the review period.



Child sexual abuse in numbers

Child sexual abuse is viewed as rare, exceptional or confined to particular settings, rather than recognised as a significant and systemic issue.

Child sexual abuse is more prevalent than the community realises, occurring at higher rates and in more common places than we expect (p.33).

- The Australian Centre to Counter Child Exploitation received **82,764** reports of online child sexual abuse in 2024–25 (p.35).
- **43,812** child sexual abuse offences were reported to or identified by Queensland Police Service between 2015–16 and 2024–25 (p.35):
  - 82% of victim-survivors were girls
  - 49% were younger than 12
  - 15% were younger than 5.
- One case of Queensland-based child sexual abuse is reported in the media every two days (p.36).

Key findings

1. **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. **Parents, children and staff repeatedly raised legitimate concerns, but no obvious resolution followed.**
   The offender was apprehended only 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 opportunities.**
   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.**
   At all times of his offending, the offender was entitled to, and eligible for, a blue card. 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.

Focus areas

THE OFFENDER

- Perpetrators of child sexual abuse deliberately manipulate systems, groom colleagues and exploit system weaknesses to avoid detection (p.267)
- The offender was highly strategic in grooming and deceiving everyone around him, including parents, workers and regulators (p.167–169).
- He 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 (p.267).
- Across the 20 years, the offending could have been detected or disrupted earlier at a number of points (p.194–204). These included:
  - **5 missed opportunities**, where action could have been taken to identify or stop the offender but was not
  - **13 outcome-defining events**, representing critical junctures that enabled the offender to remain undetected
  - **at least 3 instances** where the offender would have been reported to the Reportable Conduct Scheme had it been in place at the time.
- Missed opportunities related to lack of understanding and response to grooming and concerning behaviour; poor supervisory and recordkeeping practices; absence of a central information sharing mechanism; and inadequate investigations (p.195).
- The offender was caught uploading images online—not because anyone acted on the warnings that were repeatedly raised (p.156–7).

BLUE CARD

- More than one million Queenslanders—almost one in five people—hold a blue card (p.84).
- In the case study, the blue card system functioned as intended yet offered no meaningful protection to children.
- The gap between the legal operation of the blue card system and community expectations of its protective factors means community trust is mislaid (p.92).
- We need to view blue card as part of a safety ecosystem and not a primary safeguard, and recognise it does not proactively identify risks to children that are not already known.

QUEENSLAND POLICE SERVICE

- Our police force is rightly focused on apprehending and prosecuting people after they offend—and they do this well.
- Police's focus on criminal justice means it prioritises detection of crimes rather than detection of safety threats to our children (p.97).
- In the case study, the criminal justice focus meant opportunities to intervene were lost, and victim-survivors and their families were left with no pathway to resolve their concerns once police determined there was insufficient evidence to proceed to court (p.200).

EARLY CHILDHOOD EDUCATION AND CARE

- There is no single early childhood education and care system; instead, discrete and disconnected organisations operate under the early childhood education and care umbrella, each with their own unique approaches to safeguarding.
- In the case study (p.194–198):
  - The operating model left gaps for the offender to exploit.
  - Actions by organisations in response to the offending were taken in isolation, often resulting in the offender being 'moved on' rather than risks being systematically addressed.
  - Staff did not have sufficient capability or awareness to identify the signs of grooming and deception that the offender displayed.
  - For staff who did identify a safety risk or observe harm, they did not always have the knowledge or courage to report this, and their management did not always know what to do or did not always have the willingness to report.

PARENTS AND CARERS

- Submissions received from the public indicated an absence of clear pathways to raise concerns for suspected child sexual abuse (p.315). This vacuum leaves families and organisations without a protective mechanism and children at continued risk.
- Parents know when something is wrong, and their concerns must always be accepted and acted upon. This didn't always happen in the case study, and no obvious resolutions followed despite the legitimate concerns parents and carers expressed.
- Widespread education and awareness raising is needed to build parents' and carers' confidence to identify signs of abuse and grooming, report to authorities, and support children to disclose.

VICTIM-SURVIVORS

- Victim-survivors bear the lifelong psychological, emotional, social, spiritual and physical consequences of sexual abuse. These harms are compounded when responses from communities, institutions or the justice system are delayed, dismissive or inadequate (p.370).
- When victim-survivors speak up, not all adults know how to manage the disclosure, and some responses cause further harm (p.380). The review recommends improved interviewing and responses when victim-survivors present (p.384).
- The review consistently heard 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 (p.379).

PUBLIC AWARENESS AND EDUCATION

- The review identified a significant lack of awareness and understanding across all levels of the community about grooming and how perpetrators manipulate children, parents, carers and co-workers (p.248).
- Significant education, particularly in professional settings and among workers responsible for caring for children, is needed to build our capability to detect threats to our children.
- The review heard that pre-verbal children were able to communicate about their abuse, but their expressions were not always recognised or understood. The review found a need for widespread education for parents, carers and professionals to build understanding of how pre-verbal children communicate.

EMPLOYMENT AND INDUSTRIAL RELATIONS LAWS

- Employment laws do little to protect children. People who present a risk to children can move between organisations, aided by employer silence or inaction (p.271). This 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 safeguarding efforts and facilitates further abuse (p.270).
- Organisations must understand that unsuitable individuals are often highly 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 (p.271).
- The review has called for greater corporate liability for people that own, run or sit in positions of power within child related organisations (p.271).

Recommendations

The Board makes 28 recommendations to strengthen child safeguarding in Queensland (p.482–491).

The recommendations focus on improving leadership, institutional and organisational practice, responses to victim-survivors; strengthening intelligence gathering and actioning; building community awareness around child sexual abuse; and reforming the criminal justice system. The complete set of recommendations are detailed from page 482 in the report.

The following six actions highlight the major recommendations needed to address the critical findings of the review and make the most significant impact to the safety of Queensland children (p.474):

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
   - 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
   - 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.**
   - Transformational Recommendation 1: Create a national child safeguarding training program
   - Operational Recommendation 2: Invest more in workforce capability for child safeguarding
   - Operational Recommendation 3: Sustained investment in capacity building and community awareness
   - Operational Recommendation 14: Empowering parents through resources, awareness and education

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

The offender

Ashley Paul Griffith was sentenced to life imprisonment in Queensland on 29 November 2024 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 focused on whether systemic issues 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 to avoid mention of his name causing further trauma, the review refers to him as 'the offender'.

Media guidelines

Responsible media reporting is essential to sensitively and appropriately raise community awareness of child sexual abuse, reduce stigma, empower victim-survivors, and prevent further harm.

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

For media information

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If you need help or support, 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