IN PLAIN SIGHT

Review into System Responses to Child Sexual Abuse

Child Death Review Board

Queensland Family & Child Commission

FACT SHEET

Background

In Plain Sight is the product of a 12-month review completed by the Child Death Review Board (the Board). The review examined system responses to child sexual abuse, with a focus on 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.

The report is called ***In Plain Sight*** because the Board found:

> ***"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 danger lies not only in their cruelty, but in our inability to see them clearly and act decisively."***

The review is the broadest review of Australia's response to child sexual exploitation since the *Royal Commission into Institutional Responses to Child Sexual Abuse* and is the first to consider contemporary issues such as early childcare, online perpetration, the darknet and online child exploitation material.

The review's report is based on extensive research, stakeholder engagement, and input by experts, as well as victim-survivors, and national and international bodies.

49 formal information requests issued for records (s29P)

494 documents supplied in response to our requests

20,262 pages of information

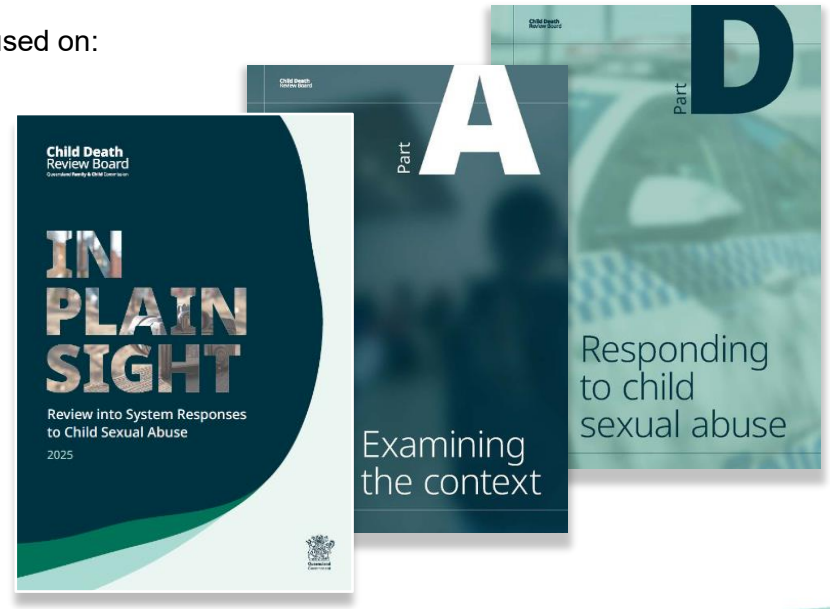
39 hours of recordings received in response to formal requests

51 written submissions received including **6** submissions from impacted parties

5 research reports commissioned

The report is structured over seven parts focused on:

- **Part A** Examining the context
- **Part B** Establishing the timeline
- **Part C** Detecting risks, threats and harm
- **Part D** Responding to child sexual abuse
- **Part E** Support and healing for victim-survivors
- **Part F** Preventing child sexual abuse
- **Part G** Safeguarding the future



Key findings

The review confirms that the offending could and should have been detected earlier. The offender was subject to three police reports, three Early Childhood Regulatory Authority (ECRA) reports and six complaints to early childhood education and care (ECEC) management. The Board has found that across the 20 years of offending, there were more than 18 points where the offending could have been detected or disrupted earlier, including:

- **5 missed opportunities** where action could have been taken to identify or stop the offender; and
- **13 outcome-defining events** representing critical junctures that enabled the offender to remain undetected *(see Chapter 11).*

The Board has identified at least three, and possibly five, instances where the offender would have been reported to the Reportable Conduct Scheme had it been in place at the time. The Board speculates this would have disrupted the offending and the Board is critical of the time taken by Queensland to implement the Reportable Conduct Scheme, "eight years and eight months after it was recommended" *(see Chapter 13).*

The report contains data on the prevalence of child sexual abuse in Australia and Queensland. It confirms that child sexual abuse is far more common, and closer to home, than most Australians expect.

Key findings from the review:

1. The offending could, and should, have been detected and disrupted earlier. Concerns were recorded to have enabled earlier intervention had they been consolidated and treated as part of broader safeguarding intelligence.
2. Parents, children and staff repeatedly raised legitimate concerns, but no obvious resolution followed. The offender was caught uploading images online—not because anyone acted on the warnings that were repeatedly raised.
3. Criminal justice responses are prioritised over detecting safety threats to children. This meant opportunities to intervene were lost, and victims and their families were left with no pathway to resolve their concerns once police determined there was insufficient evidence to proceed.
4. Criminal thresholds for action, combined with police resourcing limitations, inhibited earlier detection and contributed to missed opportunities.
5. The Working with Children Check (WWCC) Blue Card system functioned as intended but offered no meaningful protection to children. At all times of his offending the offender was entitled to, and eligible for, a Blue Card.
6. Actions by organisations were taken in isolation, often resulting in the offender being 'moved on' rather than risks being systematically addressed.
7. The legislative and policy framework covering child sexual abuse is fragmented.
8. Public submissions underscored the absence of a clear pathway to raise concerns and receive services for suspected child sexual abuse. This vacuum leaves families and organisations without a protective mechanism, and children at continued risk.

Within its narrative the Board has acknowledged the value and benefit of recent work of the Queensland Government including: bringing forward the Reportable Conduct Scheme commencement date for all sectors; amending laws to remove ECEC rest-period exemptions; standardising and making ECEC child safety training available; investing in ECRA's compliance capability; and passing Daniel's Law.

Recommendations

The Board makes 28 recommendations (19 operational and 9 transformational recommendations) grouped across parts covering the prevention, detection, response, and recovery from child sexual abuse. Operational recommendations are framed as improvements to the current system, while transformational recommendations are presented as new and significant additions to the existing system.

Recommendation 1 asks both the Queensland and Australian governments to publish a response to the recommendations. Given the broad nature of this review several recommendations are targeted at the federal government, given their role in the case study and in national policy (i.e. the Australian Federal Police, Early Childcare Quality regulation, and eSafety).

There are three important thought processes behind the majority of the Board's recommendations:

1. there are many warning signs visible in this offender's behaviour and history however:
   - only concerns that reach the threshold for a potential crime are taken forward by police; and
   - it is currently no agency or officer's role to proactively detect and look for threats to children.

   This has led the Board to make a number of recommendations about creating a Child Safeguarding Entity, connecting the WWCC and reportable conduct schemes; authorising greater information access; and resourcing roles that proactively look for threats.
2. The organisations that employed this offender were not motivated or accountable for the quality of their recruitment, supervision and response to concerns. Across his employment history there were seven concerns reported to organisations, five dismissals, one redundancy and 10 performance concerns documented. This has led the Board to make recommendations that seek to strengthen Board, Owner, and Director liability for child safeguarding akin to their existing work health safety obligations. This includes protecting employers who dismiss staff due to concerns about their treatment of children, and increased penalties for misleading employment history or failing to create a child safe culture.
3. That the offender, like most child sex offenders, was highly skilled and adept at grooming not just children, but their parents, his colleagues, his bosses, and everyone around him. The offender:
   - deliberately circumvented recruitment and screening processes by misrepresenting his employment history and referees
   - manipulated individuals and circumstances for personal gain, including to secure unsupervised access to children
   - used his position of trust to reduce supervision, minimise complaints, and deflect concerns onto others
   - 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.

   This has led the Board to make recommendations regarding training and community awareness as well as organisational capacity building.

Transformational Recommendations

1. Create a national child safeguarding training program (Cwth)
2. Preventing threats to children from entering the workforce
3. Create a Child Safeguarding Intelligence Hub
4. Co-locate the reportable conduct and worker screening (WWCC) schemes into one entity
5. Strengthen child safeguarding duties and introduce corporate and personal accountability and liability for the safety of children
6. Establish robust and centralised national and state governance for child safeguarding
7. Improved interviewing and responses when victim-survivors present
8. Increasing the rights of child sexual abuse victim-survivors in cases of child exploitation material
9. Establish a safeguarding entity

Operational Recommendations

1. Produce a public response to this report
2. Invest more in workforce capability for child safeguarding
3. Sustained investment in capacity building and community awareness
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
7. Transparent ECRA investigations that uphold a parent's right to know
8. Conduct a future evaluation of the reportable conduct and blue card schemes
9. Enable the use of police intelligence material for child safeguarding
10. Prioritising law enforcement resourcing—both personnel and technological
11. Investing in the tracking and takedown of images of Australian victim-survivors
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
15. Requiring organisations to improve active supervision of children
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
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

How the recommendations nest and integrate for an effective safeguarding system

Leadership

8 Establish robust and centralised national and state governance for child safeguarding

- National Cabinet priority
- Queensland Cabinet priority

9 Establish a safeguarding entity

3 Create a Child Safeguarding Intelligence Hub

- **4** Co-locate the reportable conduct and worker screening (WWCC) schemes into one entity
- **4** Establish a legally authorised Child Safeguarding Intelligence Network
- **5** Enable the integration of worker registers
- **9** Enable the use of police intelligence material for child safeguarding

- **3** Sustained investment in capacity building and community awareness
- **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
- **17** Investment in research on perpetrator prevention strategies and early intervention efforts
- **18** Produce a clear long-term strategy for the protection of children

Criminal justice

- **6** Improved interviewing and responses when victim-survivors present
- **10** Prioritising law enforcement resourcing—both personnel and technological
- **11** Investing in the tracking and takedown of images of Australian victim-survivors
- **7** Increasing the rights of child sexual abuse victims in cases of child exploitation material

Institutions and organisations

- **2** Preventing threats to children from entering the workforce
- **5** Strengthen child safeguarding duties and introduce corporate and personal accountability and liability for the safety of children
- **1** Create a national child safeguarding training program
- **2** Invest more in workforce capability for child safeguarding
- **7** Transparent ECRA investigations that uphold a parent's right to know
- **15** Requiring organisations to improve active supervision of children

Community

- **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
- **16** Allocate funding and services to prevent and address behaviours that might lead to offending
- **19** Engaging young people, victim-survivors and experts in strategy and resource development

1 Produce a public response to this report