Child Death
Review Board
Queensland **Family & Child** Commission

IN PLAIN SIGHT

Review into System Responses to Child Sexual Abuse

2025

Queensland
Government

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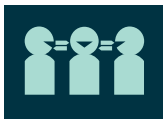

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Acknowledgements

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.

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

Child Death
Review Board
Queensland Family & Child Commission

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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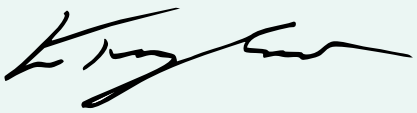
5. Considers and presents the views of impacted parties to identify the lessons arising from their experience.
6. Analyses the legislative and policy framework in place today to protect children from child sexual abuse in Queensland and identify any gaps and areas for improvement. This includes assessing 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

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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.

49 Formal information requests issued for records (under s29P)

494 documents supplied in response to our requests

20,262 pages of information and **39** hours of recordings received in response to formal requests

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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 opportunities[2]. 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.