Part B

Establishing the timeline

Chapter 7

Drawing together patterns over time

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

49 s29P requests issued for records

20,262 pages of material reviewed

6 submissions from impacted parties

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.

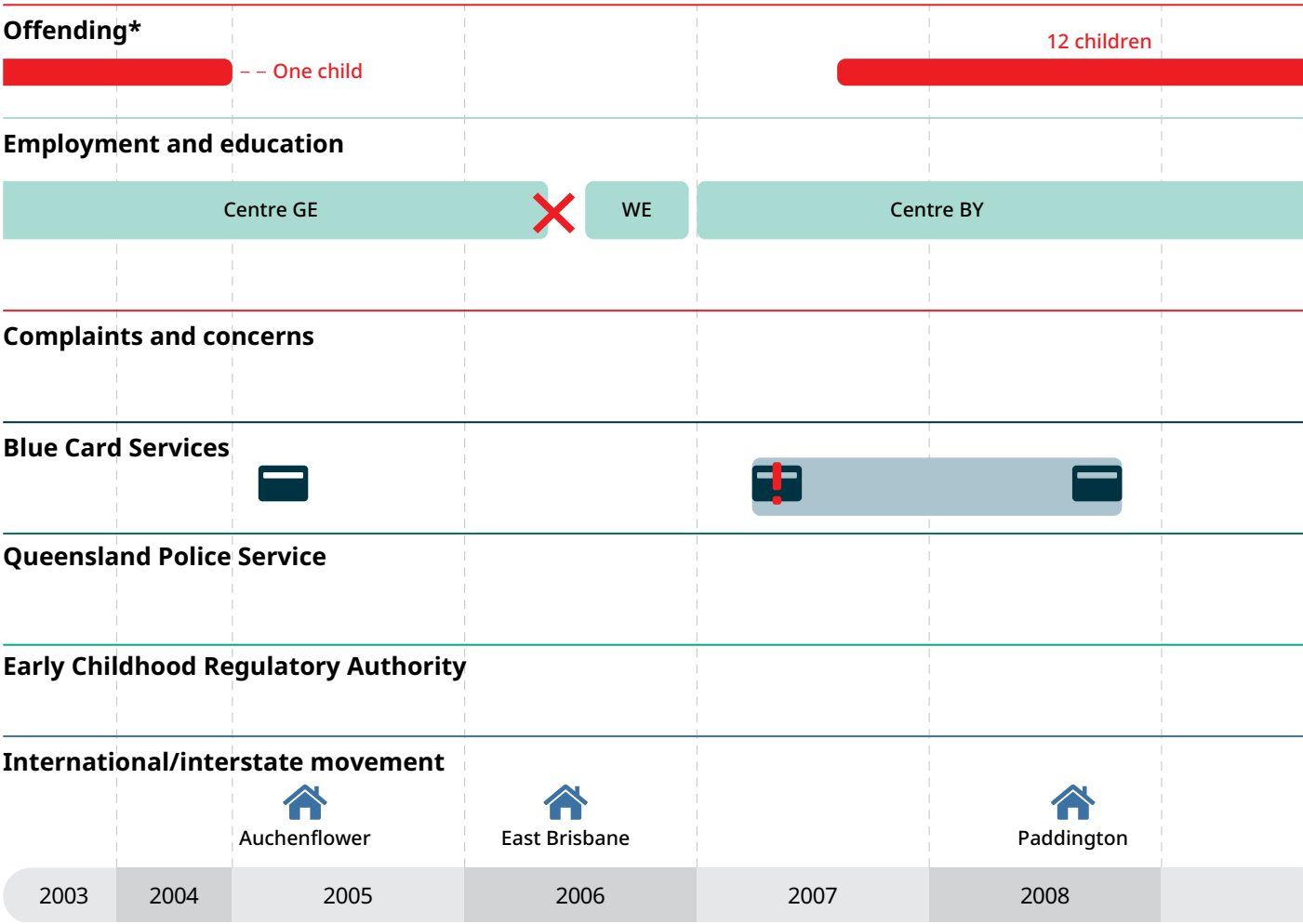
During his career, particularly in the later years, several complaints were made about the offender to his employers, the Early Childhood Regulatory Authority (ECRA), and the Queensland Police Service (QPS), however, these complaints were either deemed unsubstantiated by the regulator or did not meet 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

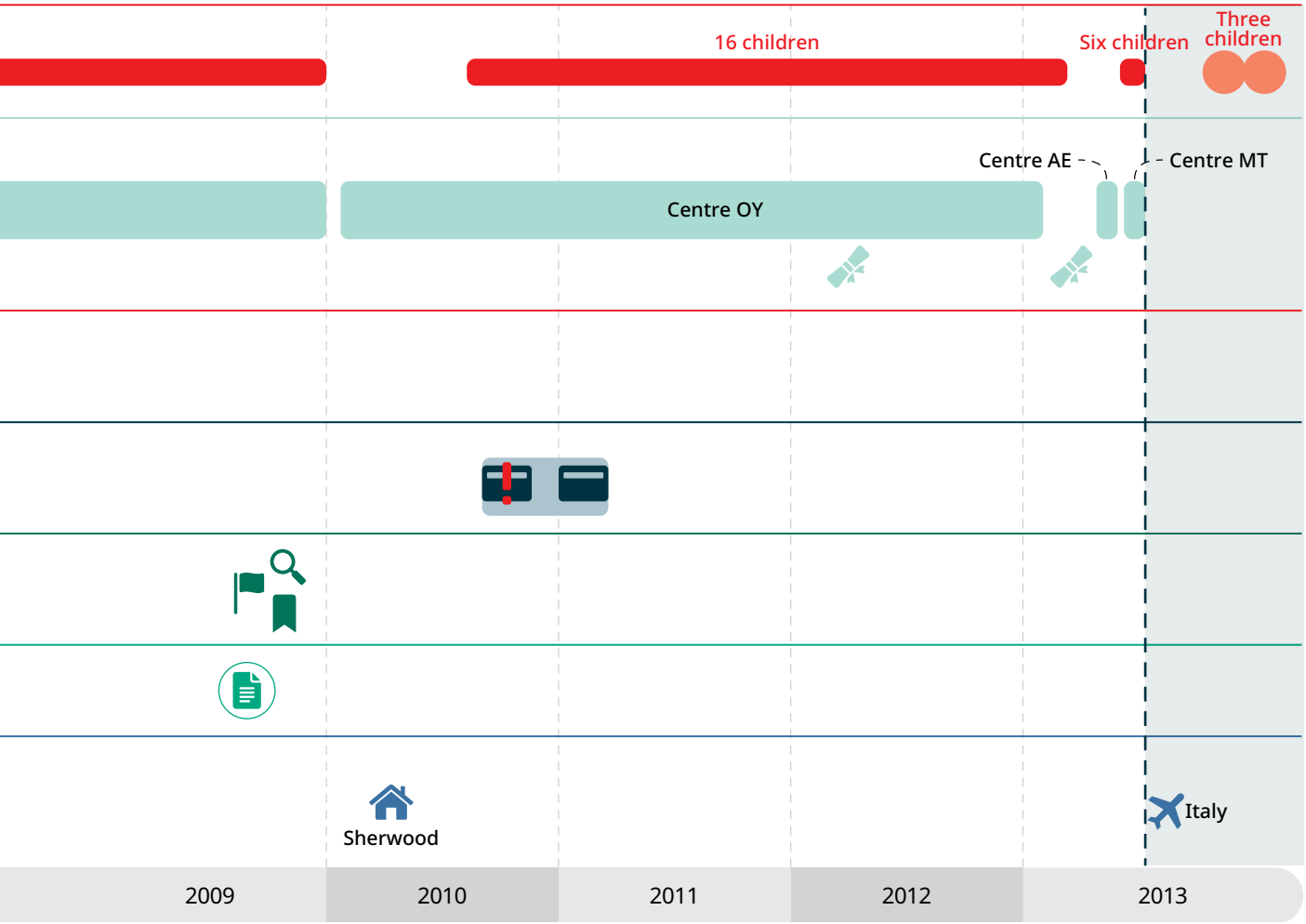
- Moved overseas/interstate
- Returned to Queensland
- Moved suburb

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)

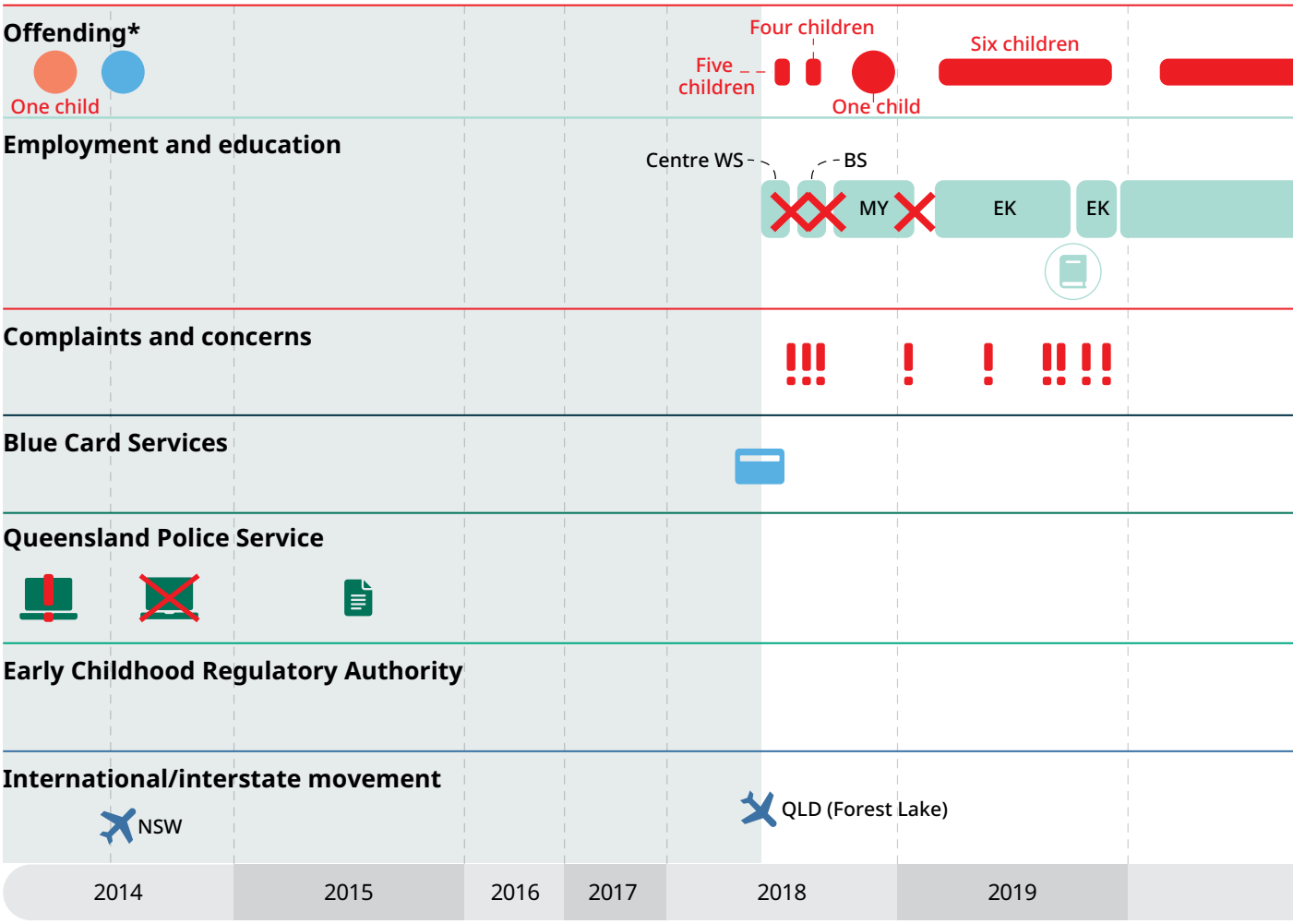
- Blue Card issued
- Blue Card expired
- Exemption Card issued
- Exemption Card suspended
- Exemption Card cancelled
- BCS notify other agencies and the offender of suspension
- Time without an approved blue card

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
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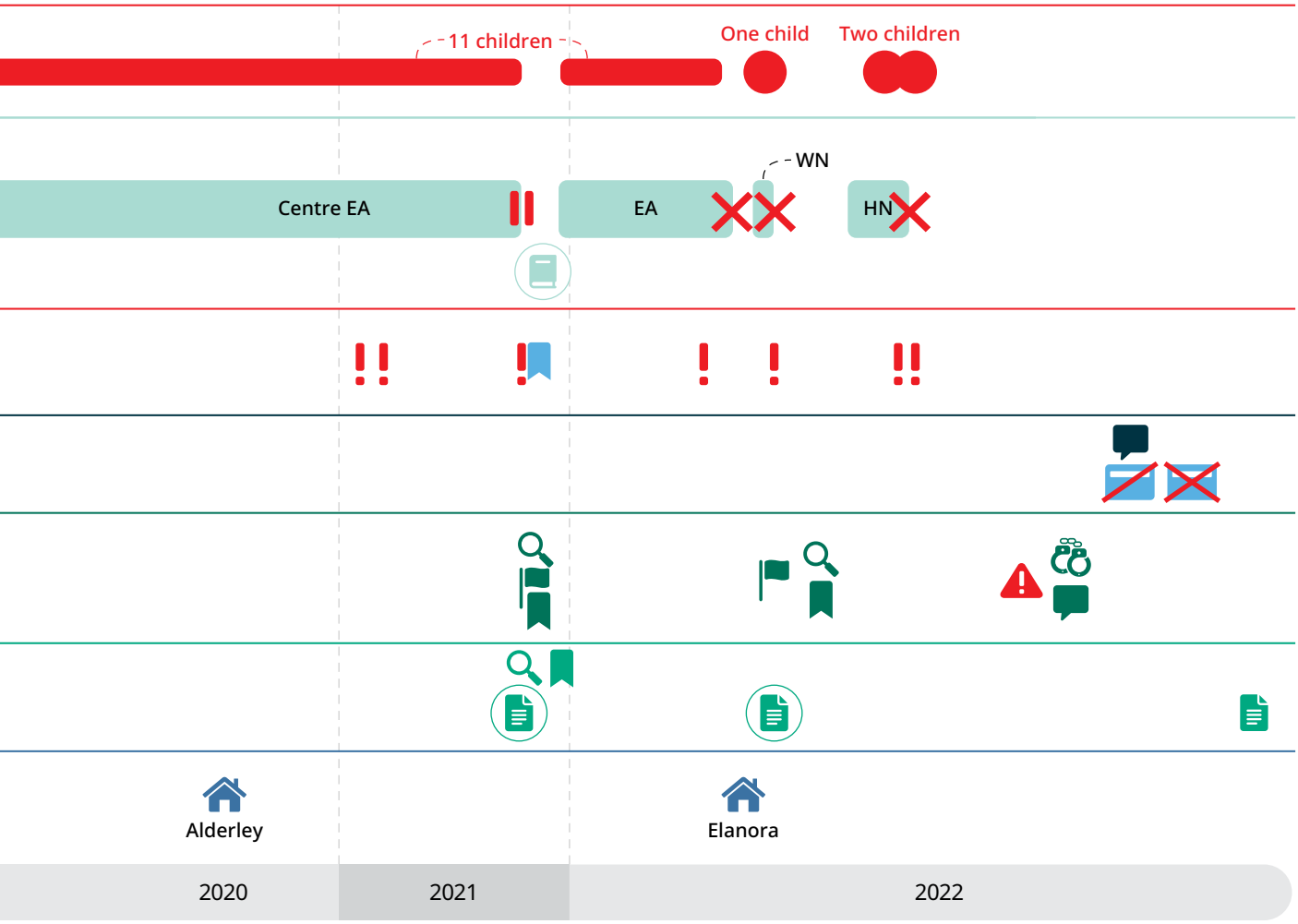

Early Childhood Regulatory Agency (ECRA)

- Incident disclosed to ECRA
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- 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
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Casual employment

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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.

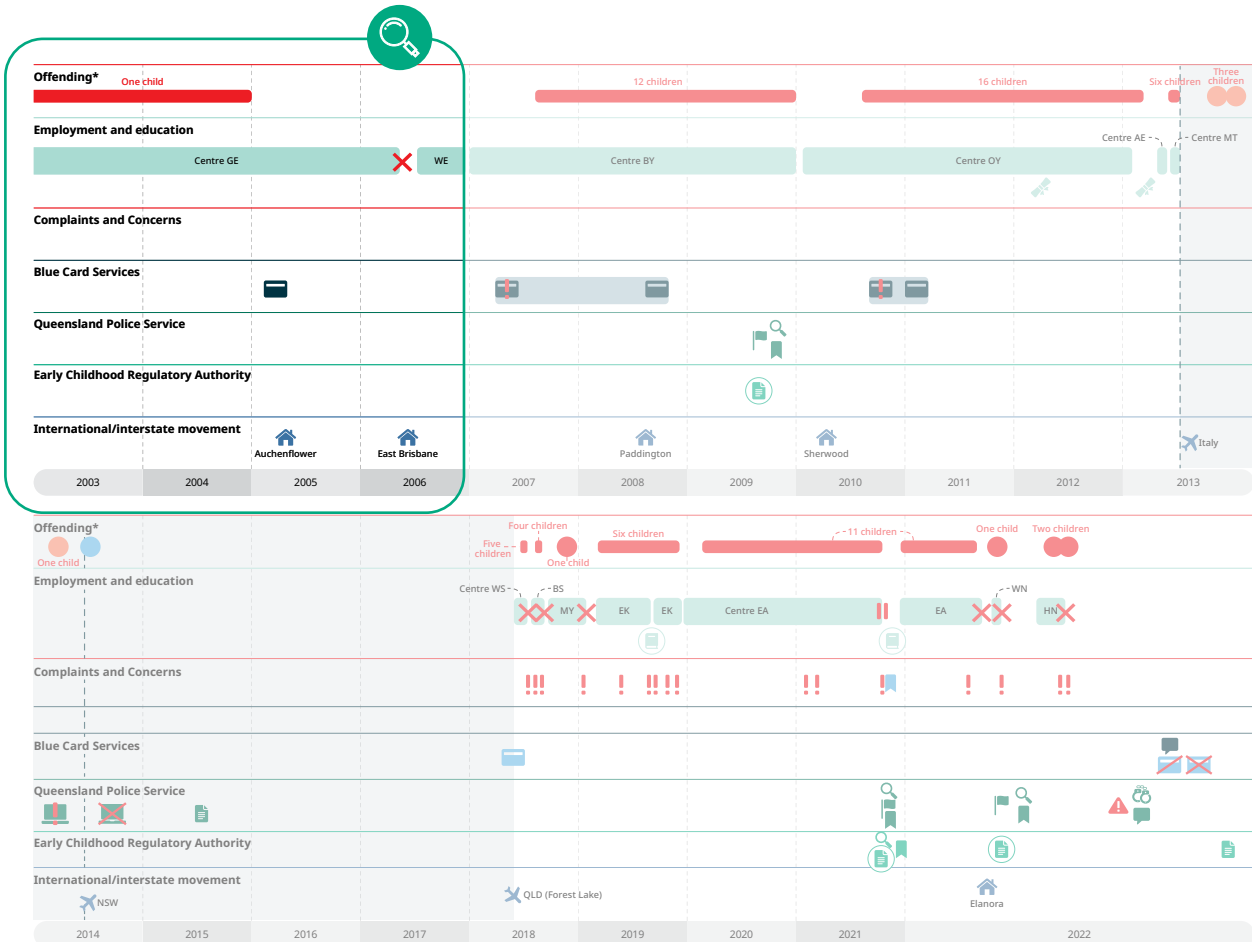
The offender worked in Centre GE for approximately three years before his employment was terminated "*due to performance issues*".

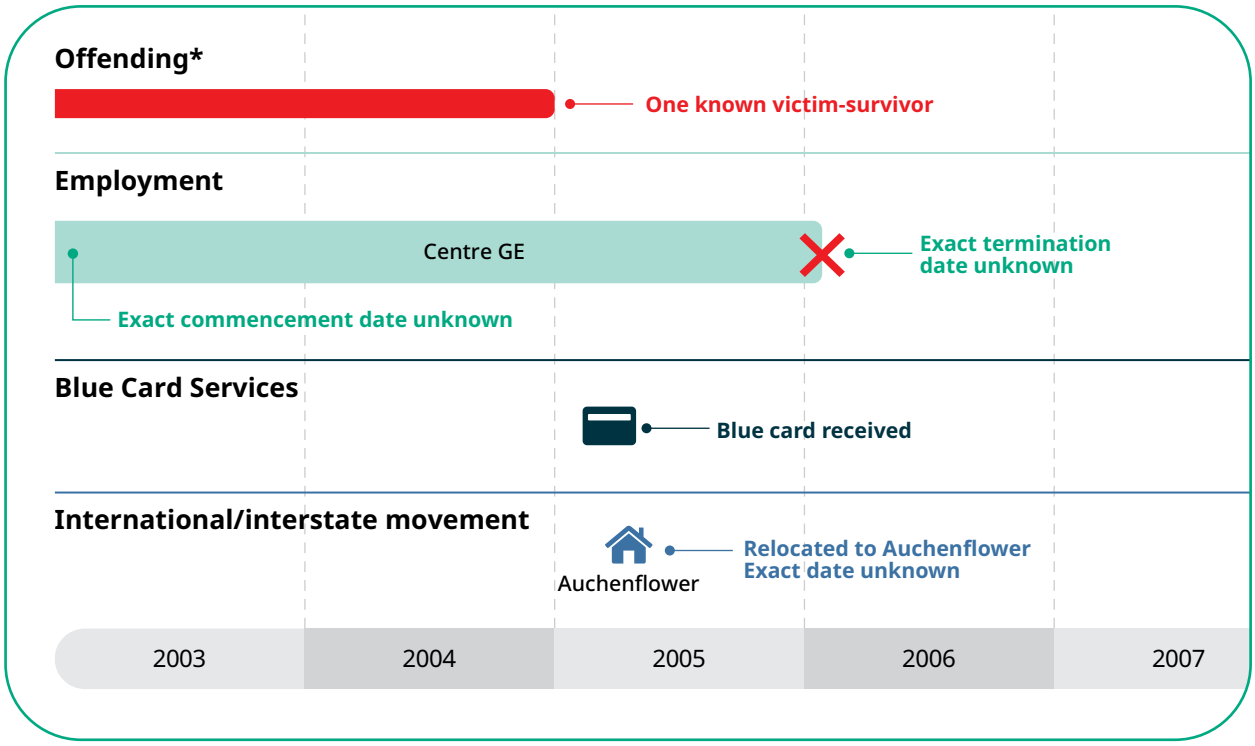
Centre GE ceased operating in 2015. Records were requested from Centre GE as part of this Review. While they were willing to provide these records, files were stored in paper form in an unindexed archive which required manual searching which could not be completed in the requisite timeframes. As such, 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.

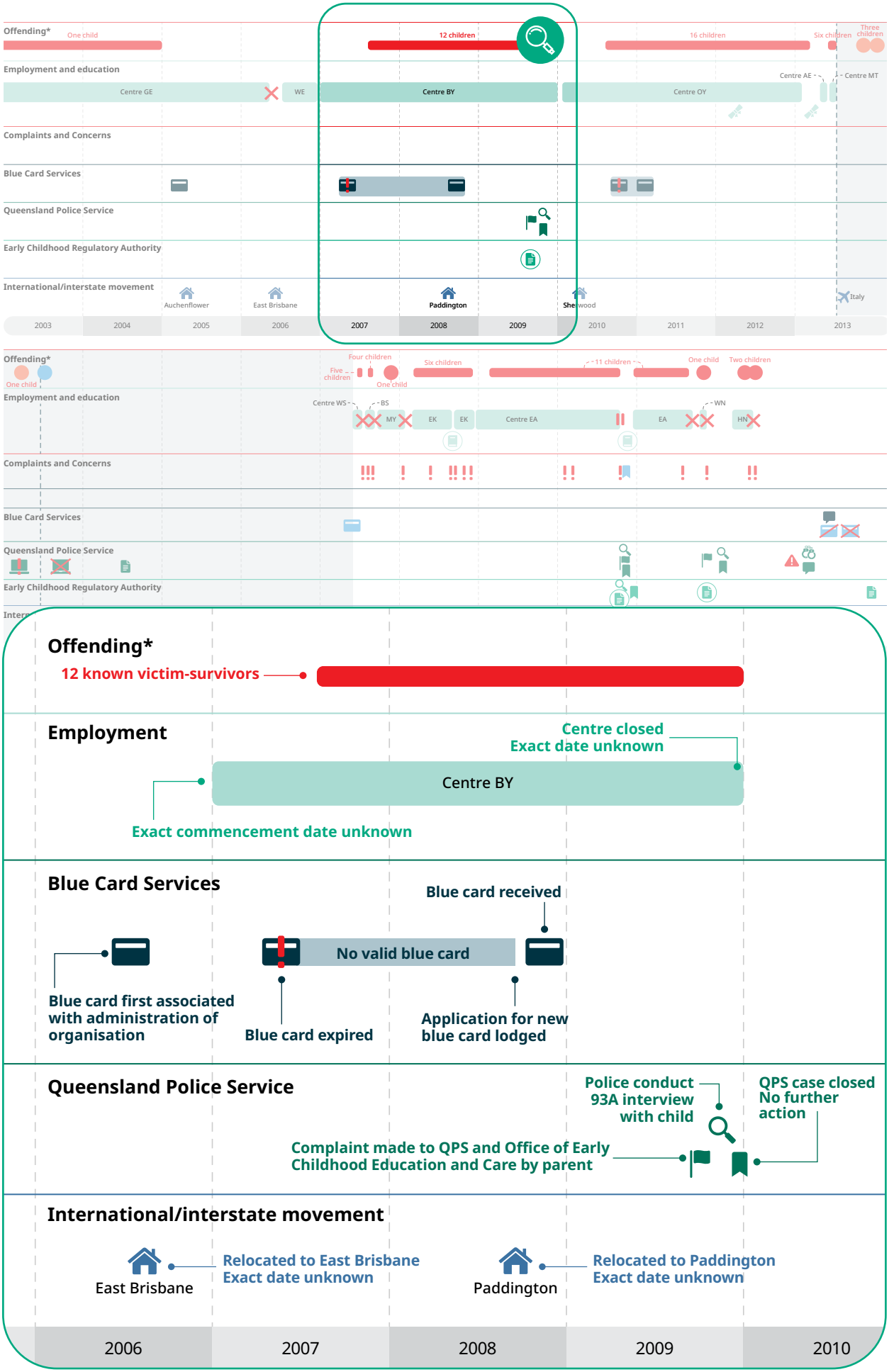
In **October 2009**, a parent made a complaint to QPS, reporting that their child had disclosed abuse by a male educator in Centre BY, named 'Ashley'. The child reportedly disclosed that 'Ashley' would hurt them when changing a nappy and described explicit details of sexual abuse. Following a QPS interview 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.

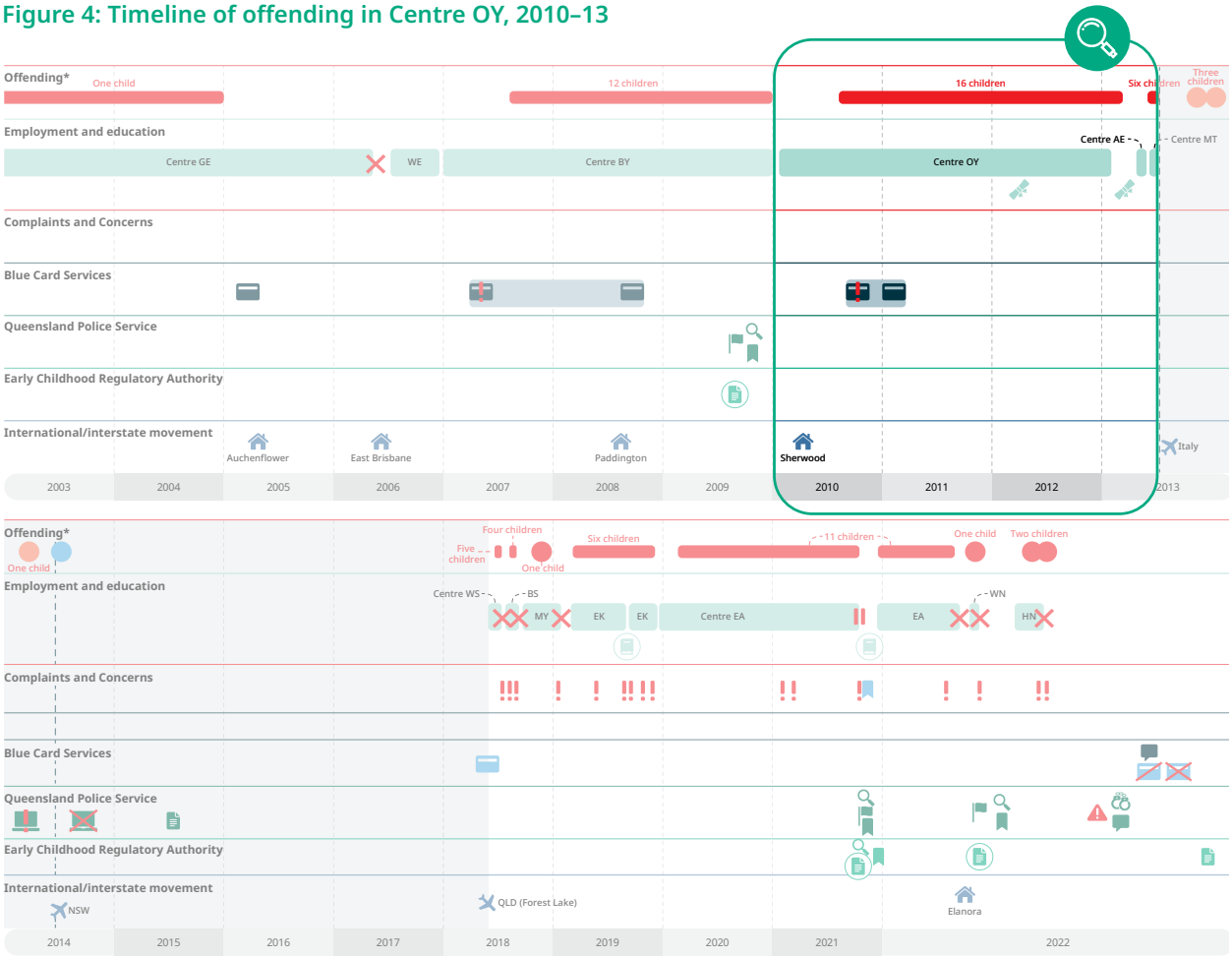
In **2012**, while working at Centre OY, the offender completed a Graduate Diploma of Learning and Teaching (Primary) at the University of Southern Queensland and in **2013**, he completed a Diploma of Children's Services (Early Childhood Education and Care) at Queensland TAFE.

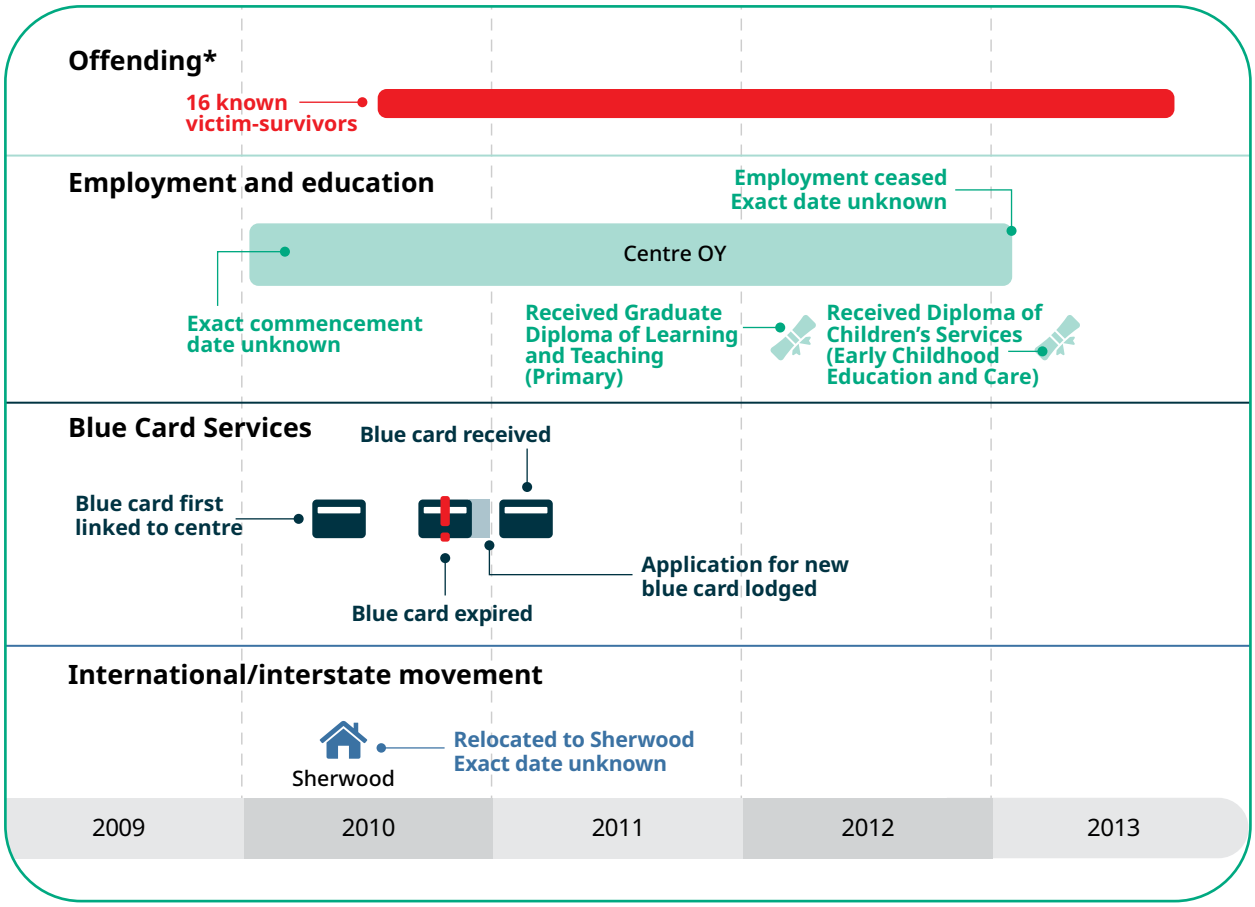
The offender ceased working at Centre OY in **January 2013**, as there was no ongoing teacher role available for him.

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

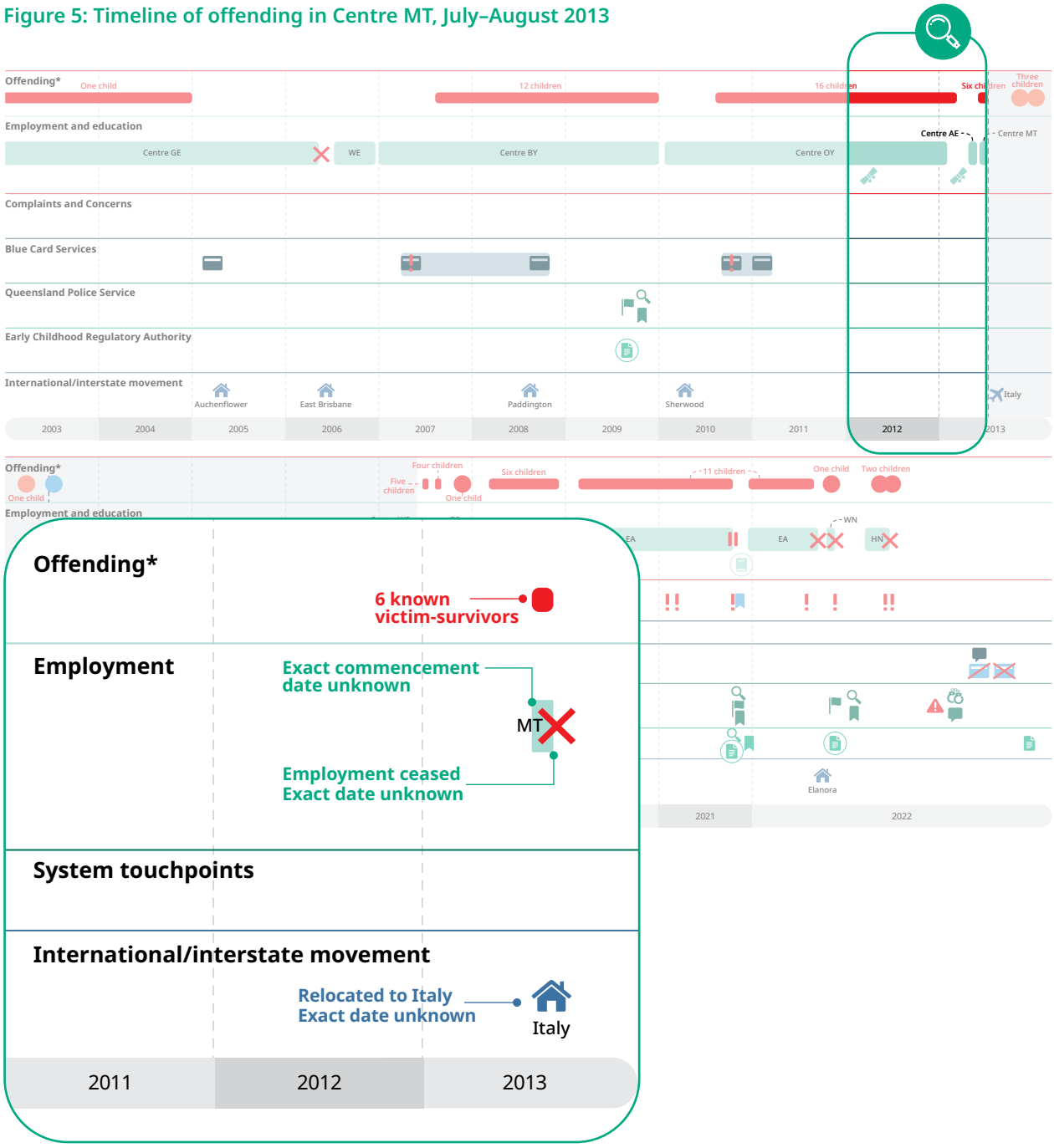
Between **July and August 2013**, the offender worked for six weeks at Centre MT. At the time, this centre was rated as working towards the NQS due to the centre's physical environment.

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.

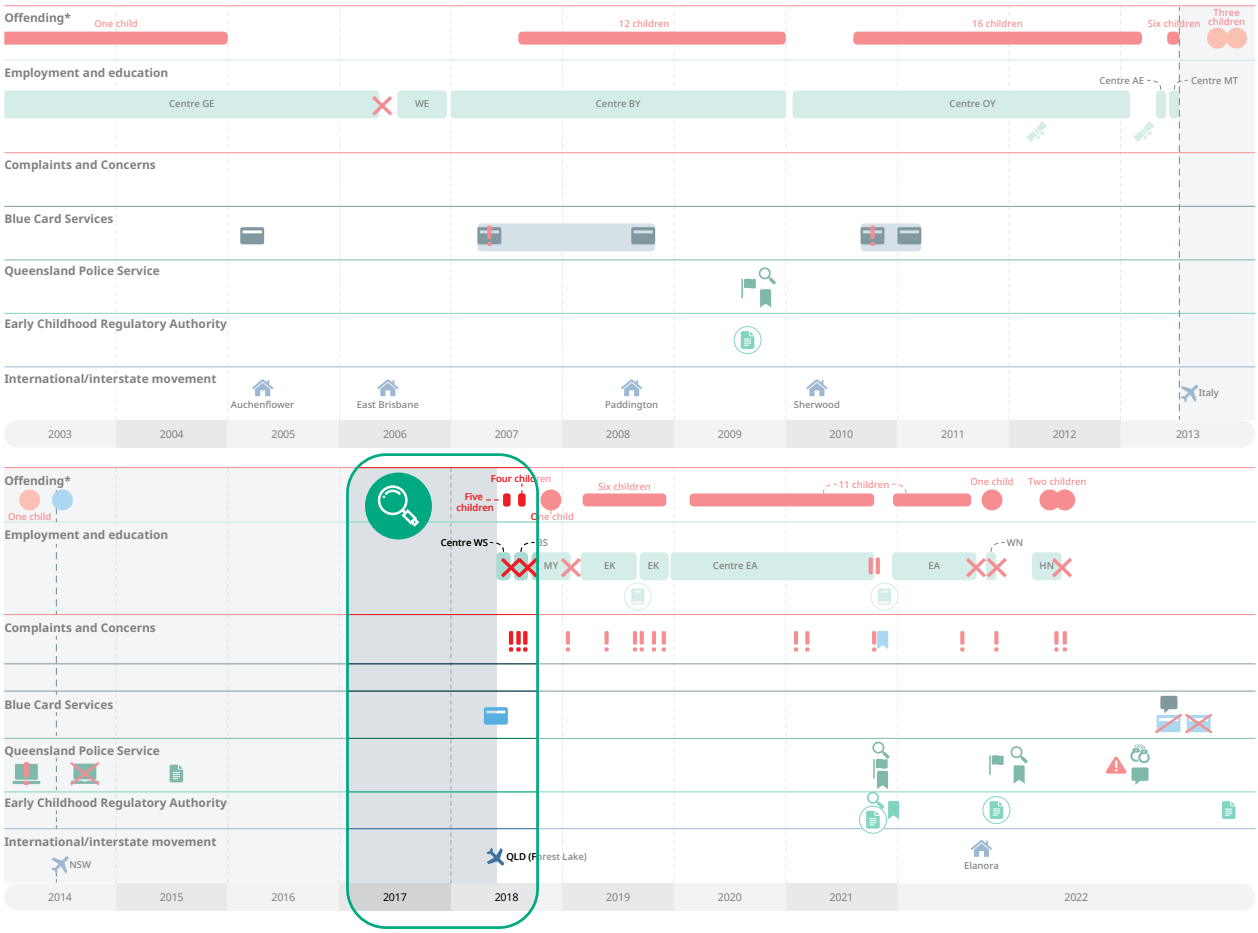
The offender remained at Centre WS for approximately four weeks before being terminated during his probation period. During an ECRA interview in 2025, the Centre Owner stated that the offender's termination was due to him not undertaking appropriate planning and programming and consistently being late.

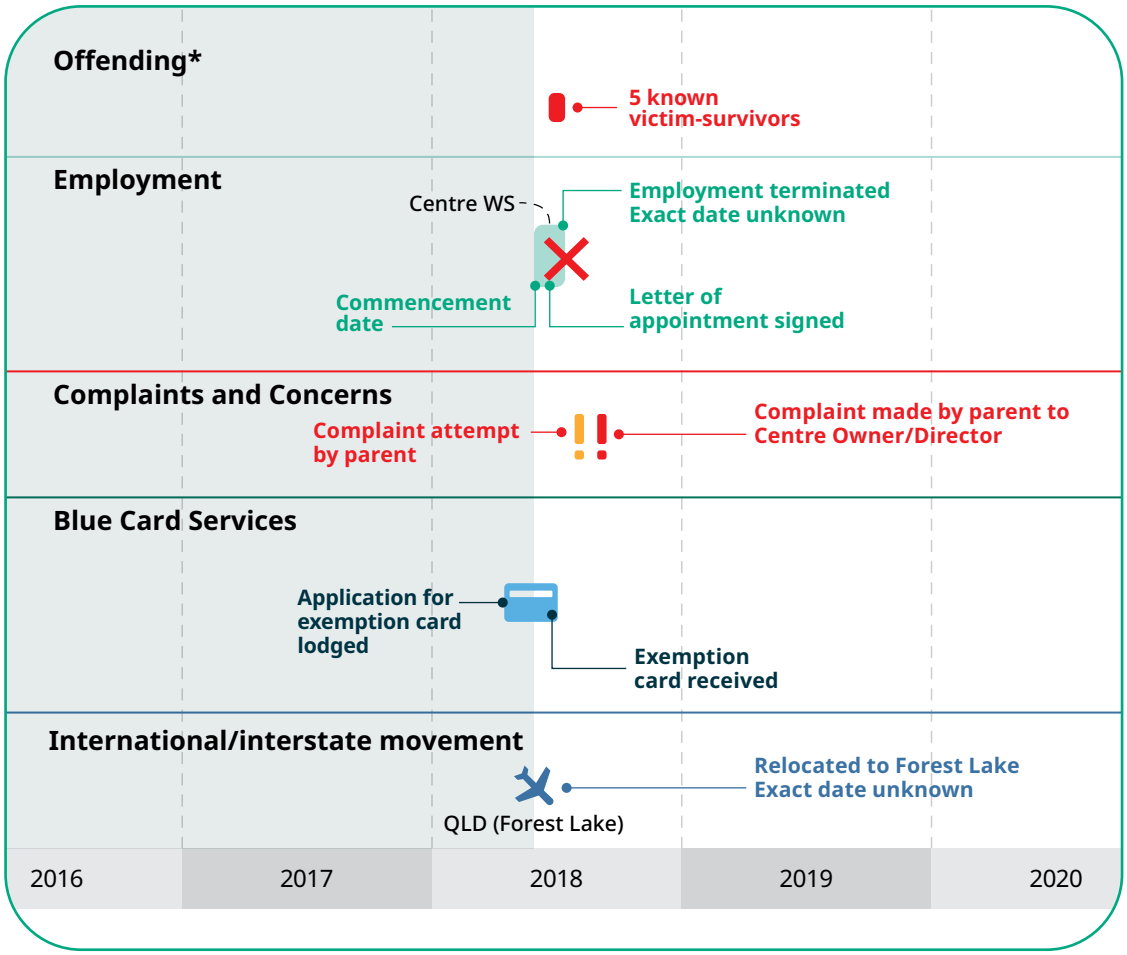
After the offender's employment ended, a parent tried to make a complaint to the centre. The parent reported they had witnessed the offender threatening to smack another child (not their own). In response, the Director/Owner informed the parent that the offender no longer worked at the centre. The parent 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.

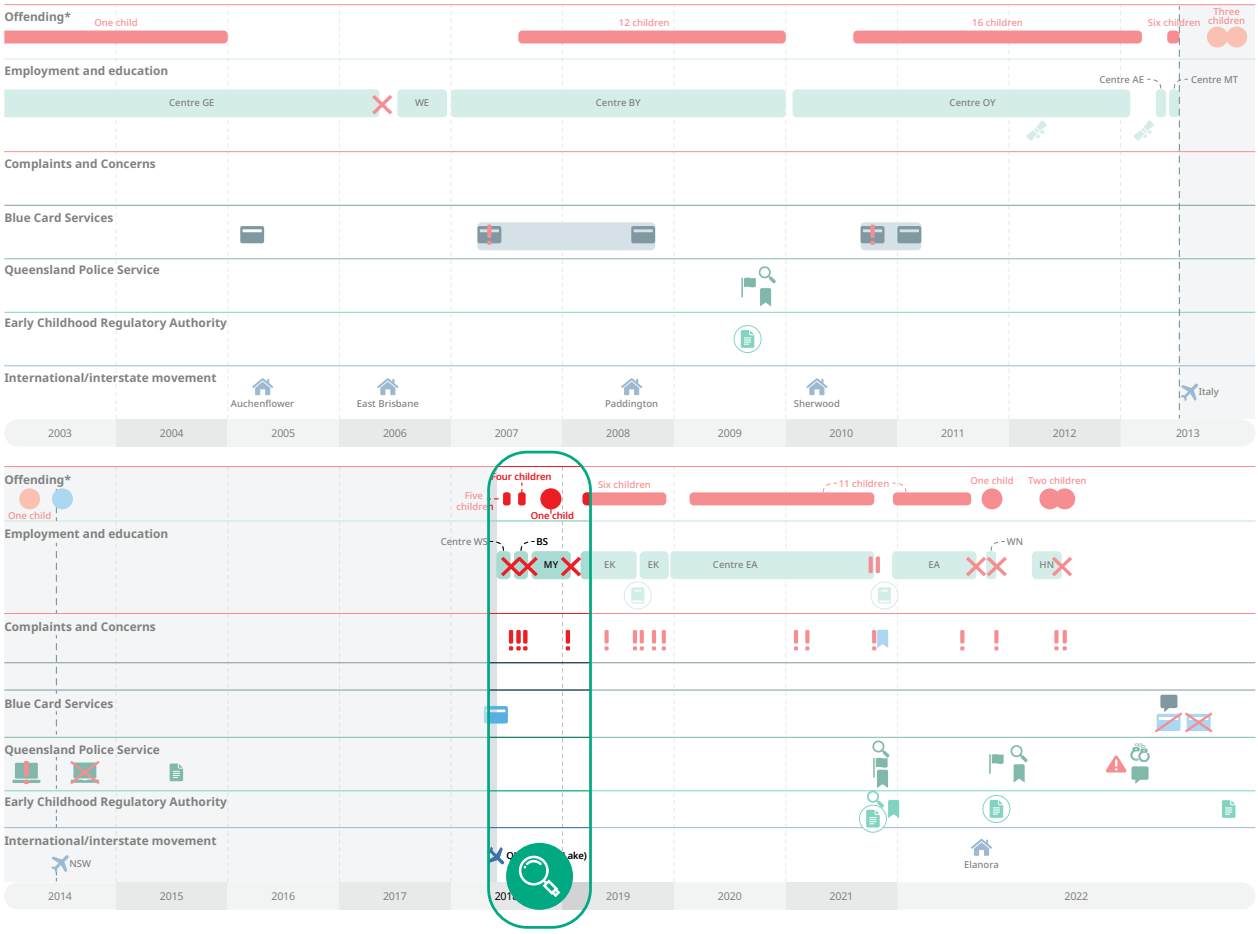
In **mid-September 2018**, a parent reportedly told the centre manager that the offender made them feel uneasy and requested this be recorded. There are no records of this in the files provided to the Board as part of this Review.

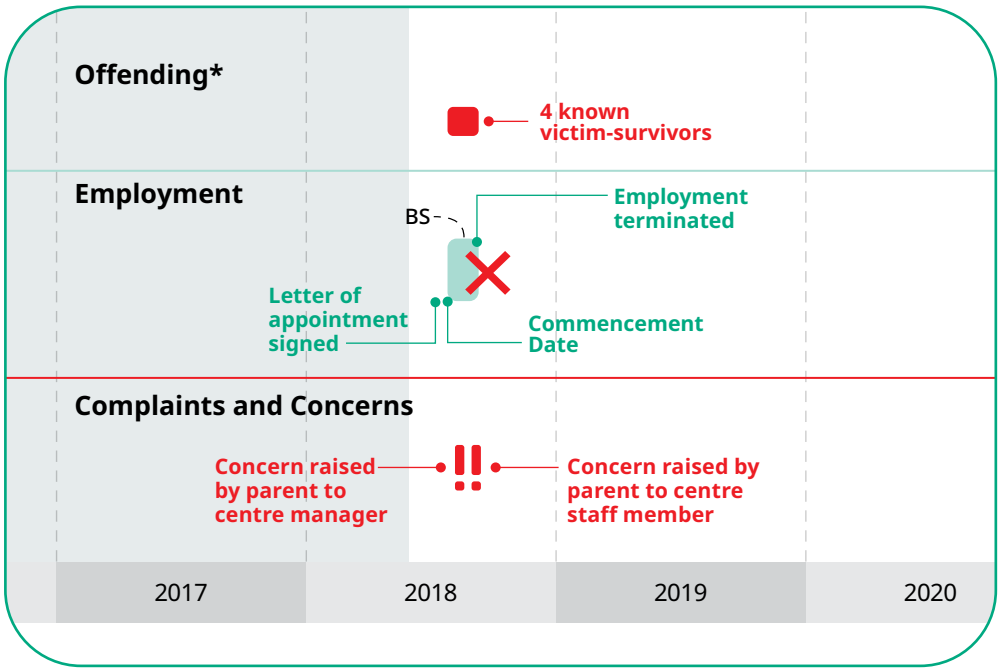
In **late September 2018**, the same parent arrived to collect their daughter who could not be located. The daughter was not in either of the two regular areas, and the parent had to wait for their daughter to be found. There are no records of this incident in the files provided to the Review.

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





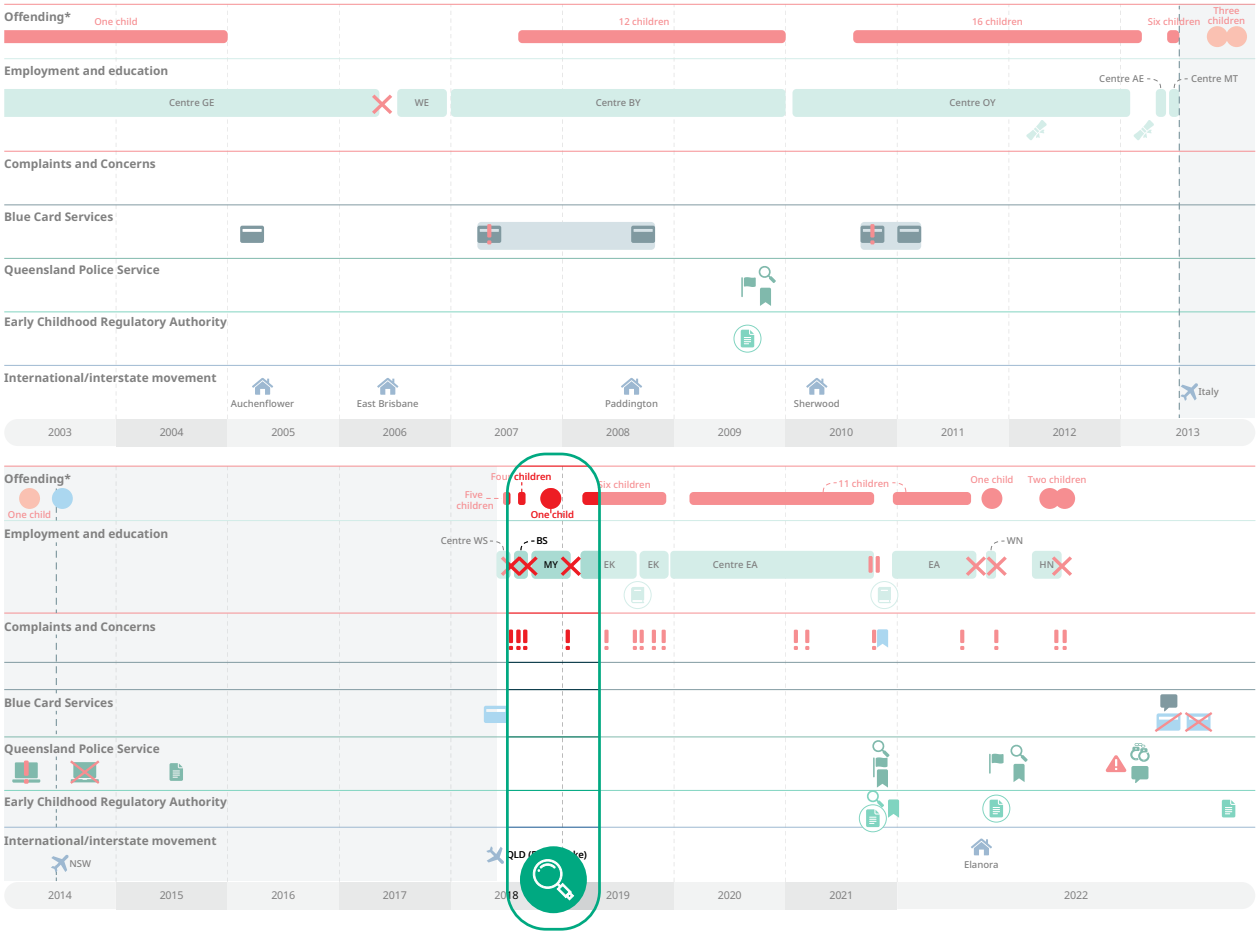
October 2018–February 2019 - Centre MY

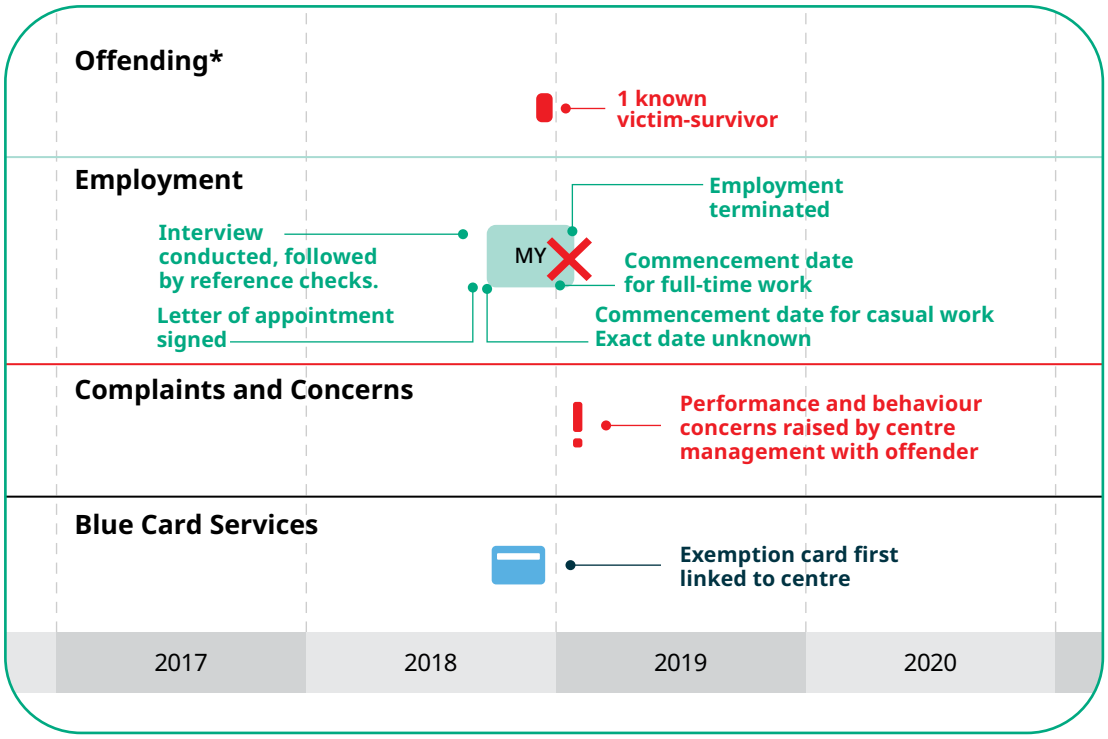
The offender was employed at Centre MY from **October 2018 to February 2019**. At the time, this centre was rated as working towards the NQS.

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.

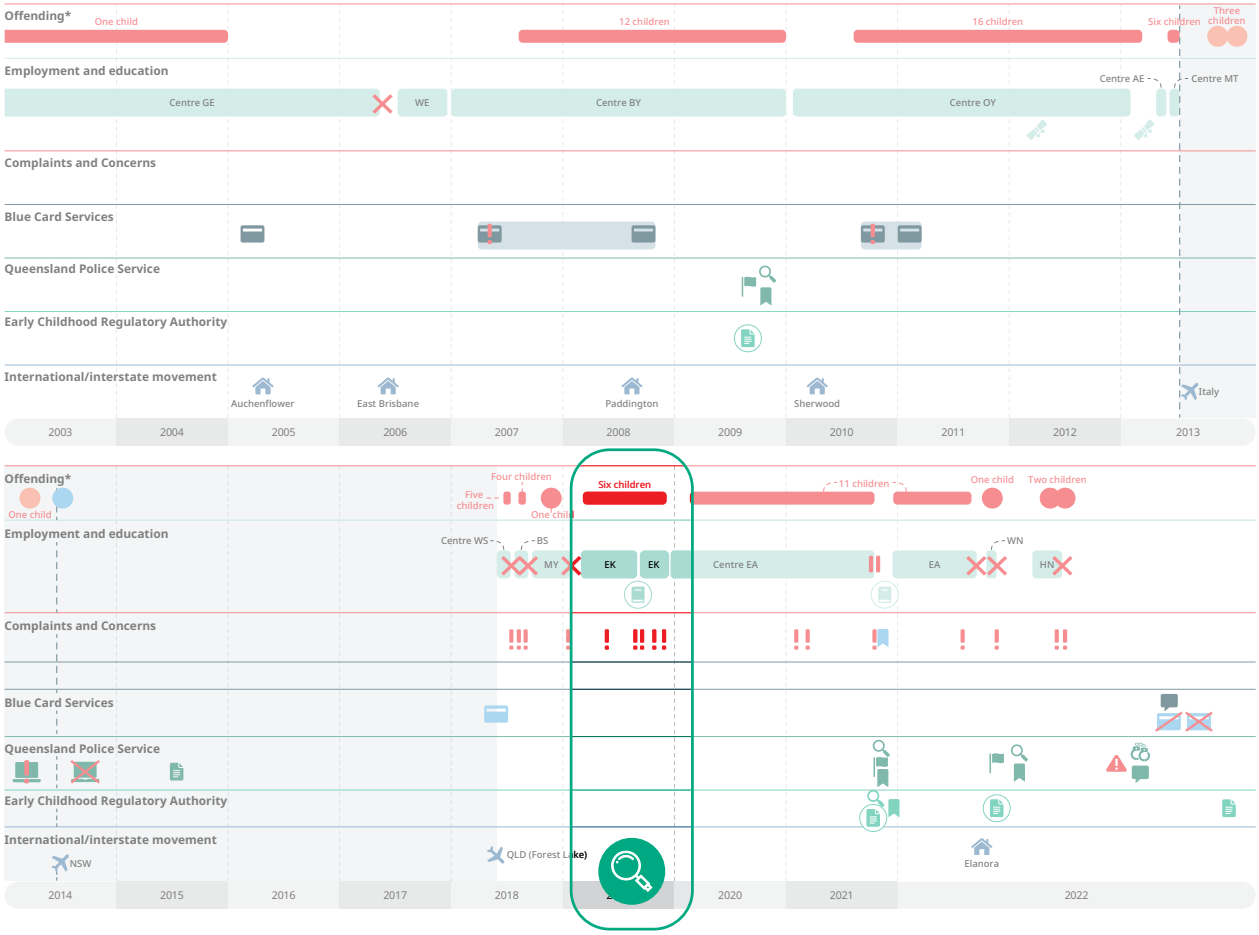
Two days after the mid-year appraisal, a parent contacted Centre EK and reported that the offender had grabbed and squeezed their son's arm. The child also told management this when asked. Management gave the offender the option to resign immediately or take leave to complete behaviour management training. 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.

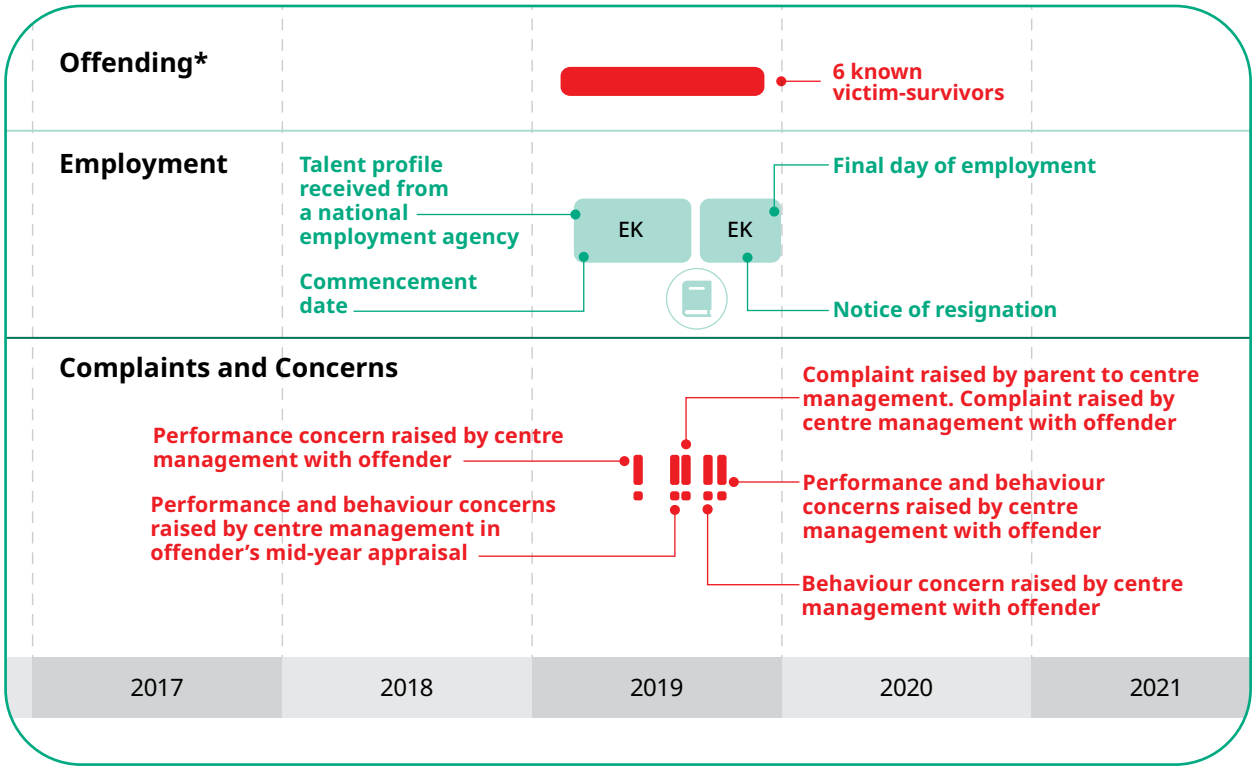
In **mid-September 2019**, management again met with the offender over the use of his camera. The offender had not been using the provided SD card in his personal camera as requested. Management prohibited the offender from using his personal camera in the centre from then on.

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.

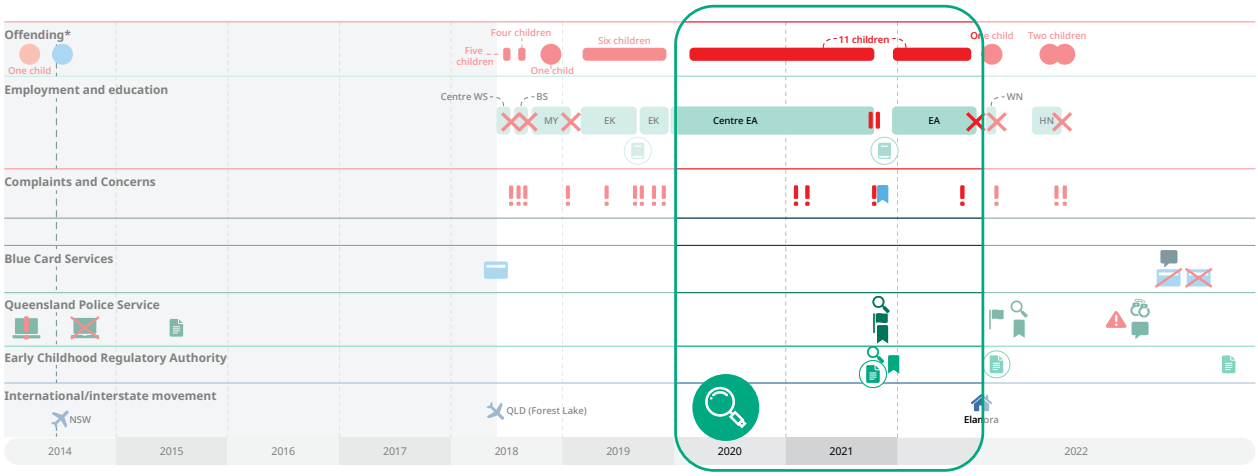
In **March 2022**, upper management raised concerns about the declining number of enrolments at Centre EA. The Board was advised that the reason for ceasing employment was that the role was no longer required, and ending the employment for other reasons would have given rise to industrial relations risks. 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:

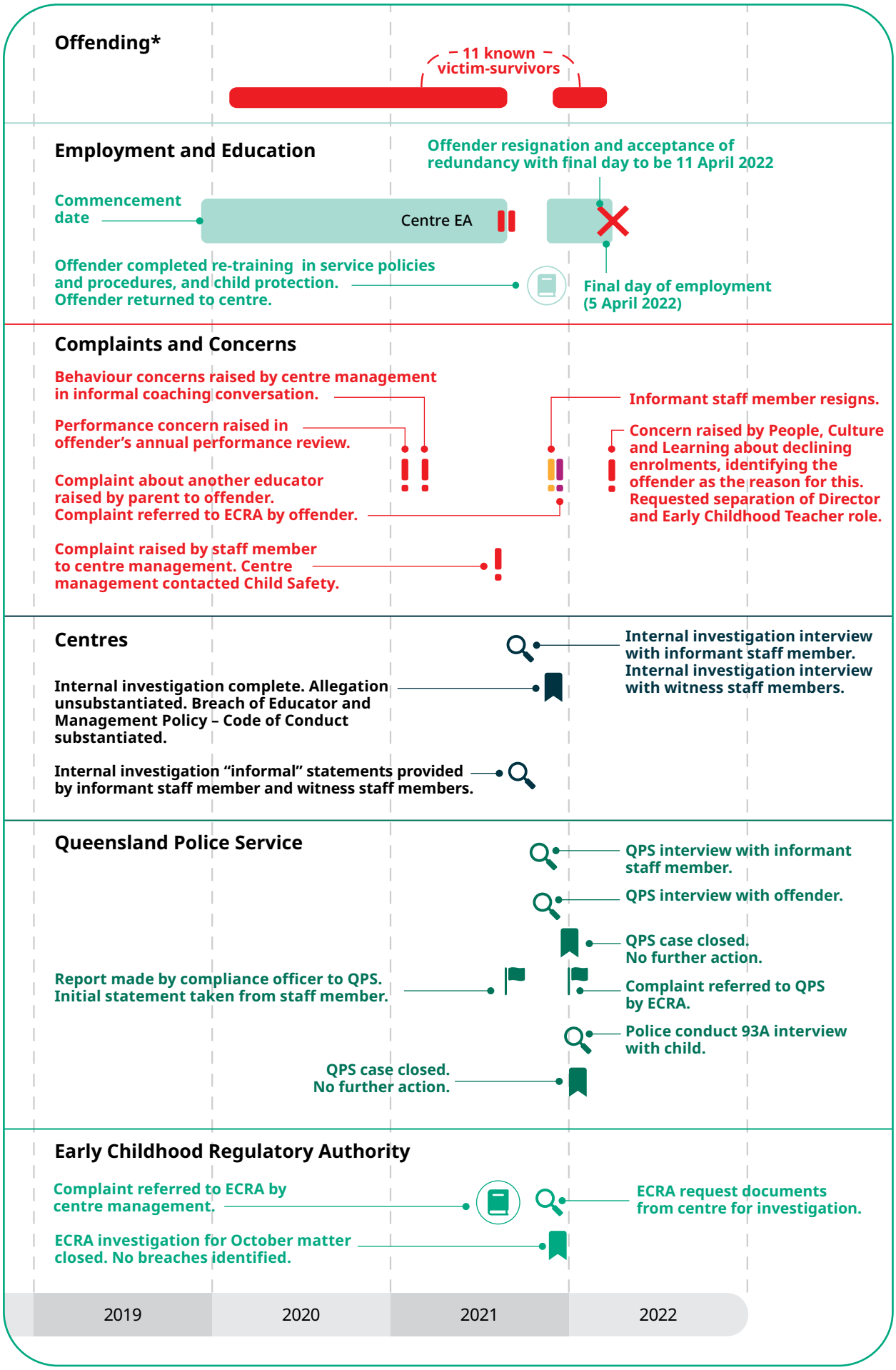
> *very unfair to have to choose which part of my role I should give up.... With the support of long-term educators, we have managed to re-establish the quality reputation that [Centre EA] has always enjoyed.... I find this actually quite outrageous that anyone would be asked to accept this. While I 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 paycut (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




Offending*
11 known victim-survivors
Employment and Education
Offender resignation and acceptance of redundancy with final day to be 11 April 2022
Commencement date
Centre EA
Offender completed re-training in service policies and procedures, and child protection. Offender returned to centre.
Final day of employment (5 April 2022)
Complaints and Concerns
Behaviour concerns raised by centre management in informal coaching conversation.
Performance concern raised in offender's annual performance review.
Complaint about another educator raised by parent to offender. Complaint referred to ECRA by offender.
Complaint raised by staff member to centre management. Centre management contacted Child Safety.
Informant staff member resigns.
Concern raised by People, Culture and Learning about declining enrolments, identifying the offender as the reason for this. Requested separation of Director and Early Childhood Teacher role.
Centres
Internal investigation interview with informant staff member. Internal investigation interview with witness staff members.
Internal investigation complete. Allegation unsubstantiated. Breach of Educator and Management Policy – Code of Conduct substantiated.
Internal investigation "informal" statements provided by informant staff member and witness staff members.
Queensland Police Service
QPS interview with informant staff member.
QPS interview with offender.
QPS case closed. No further action.
Report made by compliance officer to QPS. Initial statement taken from staff member.
Complaint referred to QPS by ECRA.
Police conduct 93A interview with child.
QPS case closed. No further action.
Early Childhood Regulatory Authority
Complaint referred to ECRA by centre management.
ECRA request documents from centre for investigation.
ECRA investigation for October matter closed. No breaches identified.
2019
2020
2021
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.

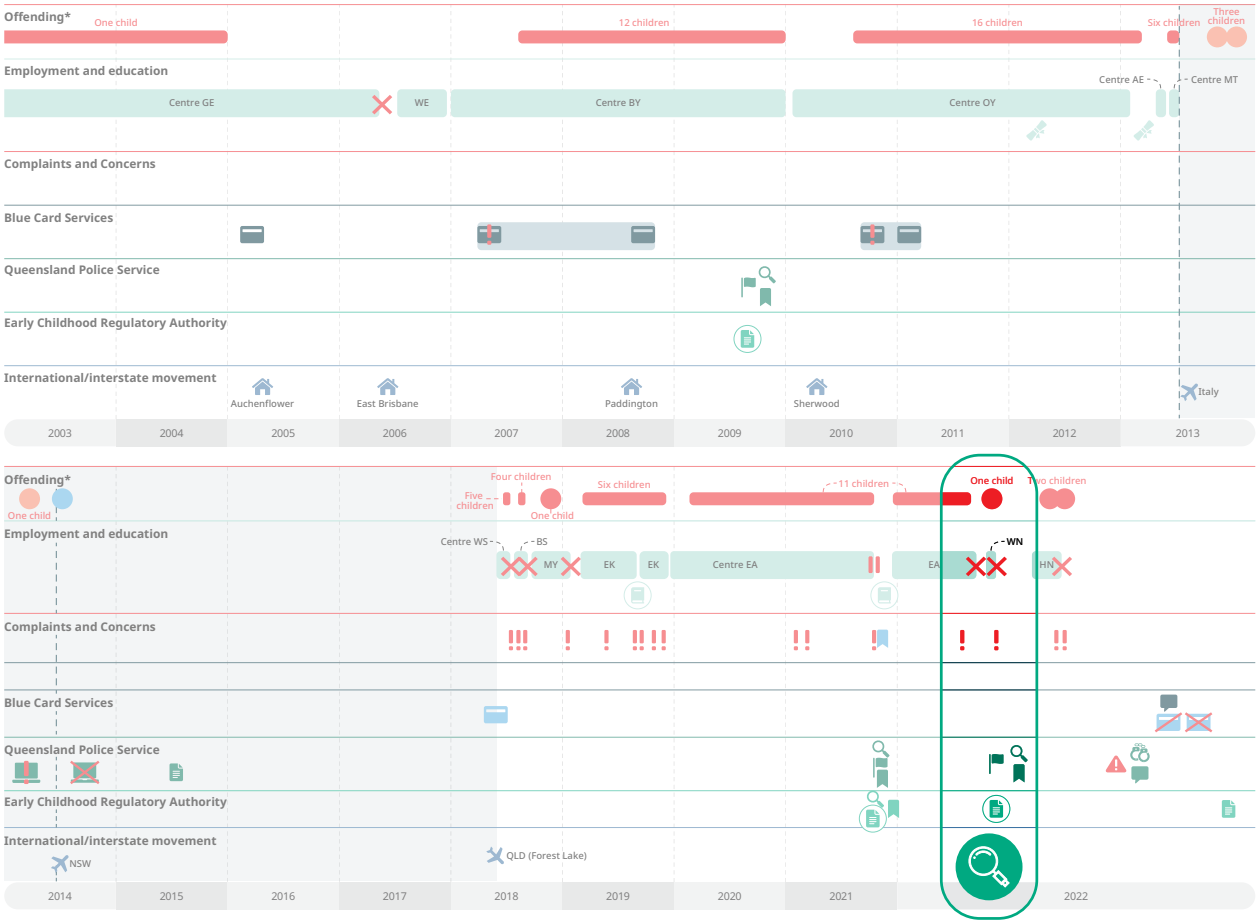
ECRA did not interview the child, parents, offender or staff as part of its investigation.

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



Offending*

1 known victim-survivor

Employment

First shift

Centre WN

Second shift

Complaints and Concerns

Complaint made by parent to centre management.

The employment agency contact centre for more information.

Queensland Police Service

Police conduct 93A interview with child.

Complaint referred to QPS by ECRA.

Complaint referred to QPS.

QPS case closed no further action.

Early Childhood Regulatory Authority

ECRA follow up with QPS regarding outcome with no response.

ECRA follow up with centre regarding outcome.

ECRA case closed. No further action.

Complaint referred to ECRA.

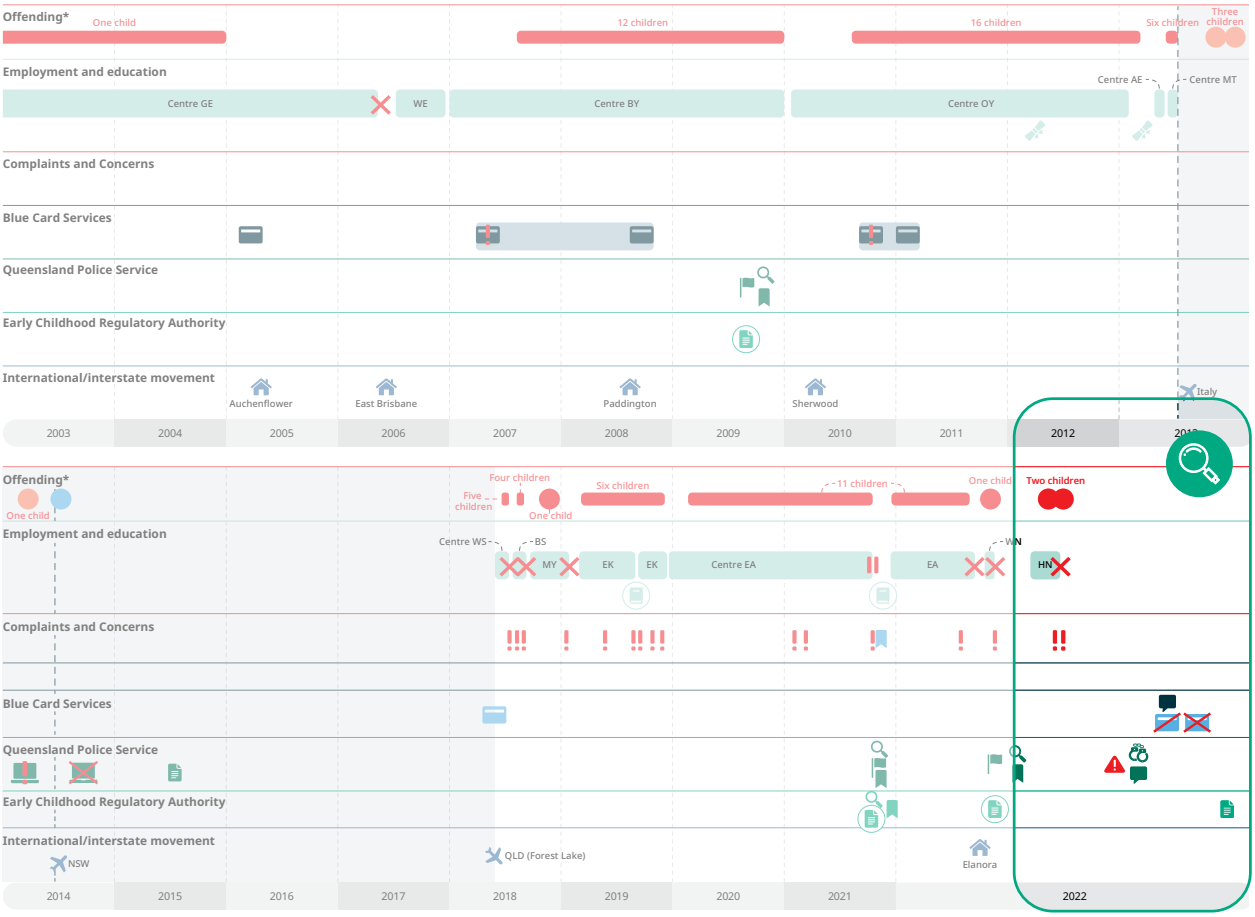
Centre HN

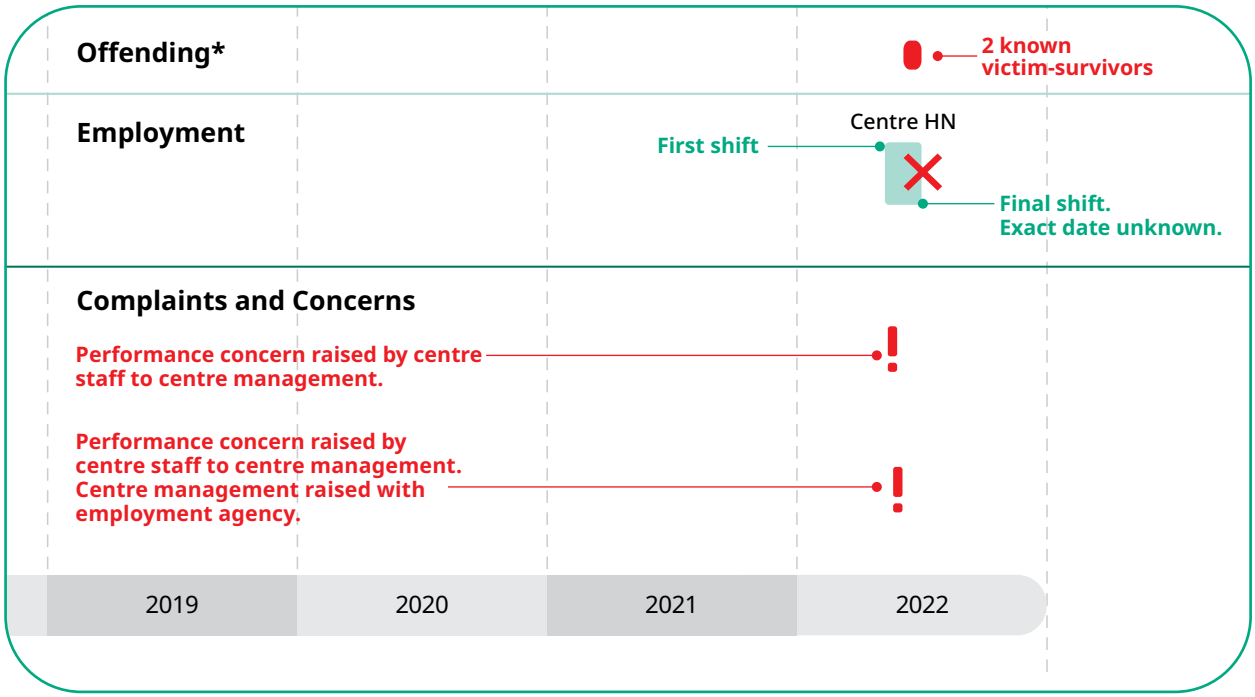
In **May 2022**, after being supplied as a relief educator by a national employment agency, the offender worked his first shift at Centre HN. At the time, the centre was rated as exceeding the NQS.

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	*Operation Lima Rhodes* 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. *Operation Tenterfield* 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

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

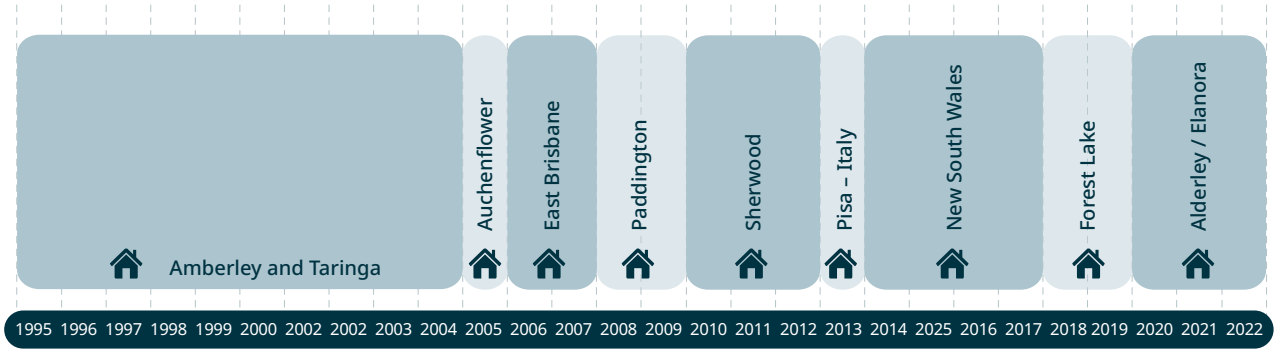
Personal background

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. Sexual gratification.	The offender abused children for his own sexual gratification. The offender expressed he felt 'love' towards some of the victim-survivors. The offender identified emotionally with the children.	The offender created opportunities to have unsupervised access with children. The offender groomed parents, staff and children.	The offender distracted his victims with an iPad or other activity. Some of the offending occurred while children slept. 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. Relationships (grooming) with parents and colleagues. Transient employment. Photography and music as hobbies.	Victim preference. Worked with age groups who had limited capacity to report abuse. He is known to have offended in some centres and not others.	Recruitment and screening policies and practices. Effective supervision of children. Staff awareness and understanding of child sexual abuse. 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 has 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

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.

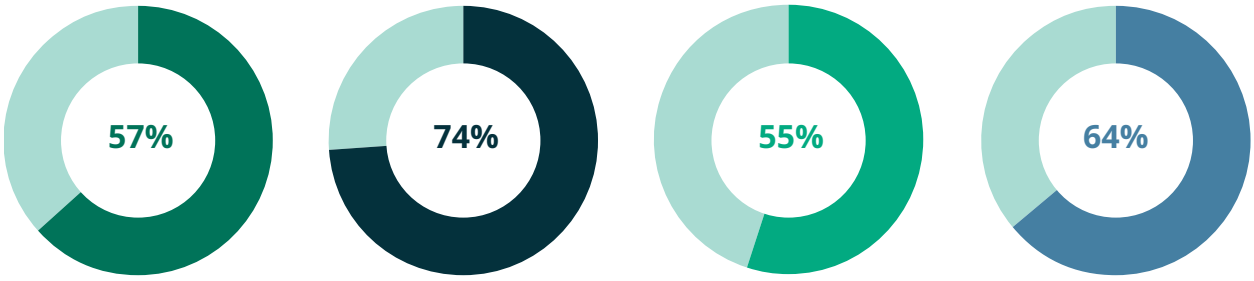
Common factors noted across centres where there was known offending included:

- 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



- Of the known centres the offender worked in were for-profit.*
- Of the known centres the offender worked in were exceeding or meeting the National Quality Standards.+
- Of the known centres the offender was employed there for less than six months.^
- Of the known centres terminated the offender due to performance issues, offered a redundancy or asked that the offender was not sent back.^

*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 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 worker 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

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 seven[44] 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 at the centre. 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 4

Missed opportunities to detect and disrupt

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 known [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.*

Chapter 12

The aftermath – post-incident system responses

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 Childcare 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 Code[52] 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 Guide[53] which helps embed child safe cultures, and the NQF Online Safety Guide[54] 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

NQF legislative changes from 2026

Updated legislation strengthens oversight to embed child safety into every service. New National Laws will include safe use of digital devices, making inappropriate conduct an offence, expanding powers of Regulatory Authorities, mandating nationally consistent child safety training and additional measures for family day care.

Transparency and information for parents

Expanding service quality and safety information available to families, empowering informed decisions on education and care. Phase 1 implemented, with Phase 2 being implemented November.

New child safety training

Mandatory child safety training will support educators to have the knowledge, skills and ability to detect, escalate or report abuse. The training is being developed by the Australian Centre for Child Protection, with the foundation training package available from February 2026.

CCTV assessment in centres

National CCTV assessment at nominated services to explore the use of CCTV with a focus on ethics, safety and transparency.

New educator register

A National Educator Register will give regulators clear visibility of who is working in the sector and where. Testing phase to start in December 2025 with a national roll out from February 2026.

Additional measures

- Review of educator- to-child ratio practices (i.e. under the roof practices)

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 offence[68] 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

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 (DFSDSCS) 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 different 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	*Child Safe Organisations Act 2024* 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 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 Victoria 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.

> *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.*

Endnotes

1 Further documentation relating to the offender's studies at QUT was not requested as part of this Review.
2 Records for this centre were not available to the Review because of the centre's closure.
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