Part C

Detecting risks, threats and harm

Chapter 14

Detecting abuse, grooming and risk

Detecting abuse, grooming and risk

> *Look at the prevalence rates [of child sexual abuse]. We're missing the ordinariness of this. It's not 'out there' - it's in here, and it's part of all of us.*[1]

The modern challenge of safeguarding children rests not only on responding to crimes already committed but on anticipating and disrupting threats before they happen. Systems that only respond once abuse has occurred inevitably fail to prevent the profound trauma, lifelong consequences, and intergenerational impacts that child sexual abuse leaves behind.

Communities expect more than reaction; they expect vigilance, foresight, and a commitment to preventing children from being hurt in the first place. This requires shifting the focus from catching perpetrators to anticipating and disrupting threats before they materialise.

Children deserve safe environments where risks are actively identified and mitigated, where organisations are alert to patterns of behaviour, and where warning signs are taken seriously. The emotional and social cost of waiting until a crime has been committed is too high. Safeguarding must be proactive, not reactive—driven by the imperative to detect threats to a child's safety rather than repair damage once it has been done.

Rather than relying solely on reactive enforcement, effective systems must invest in the intelligence required to uncover intent, capability, and opportunity long before criminal acts occur, or at the very least, before they escalate. Threat detection sits at the core of this challenge. It is the process by which signals of emerging risks are collected, analysed, and interpreted to prevent potential harm.

Such efforts require layered strategies. Tactical intelligence enables authorities to act swiftly on imminent threats, while strategic intelligence builds an understanding of long-term trends, organised deceptive behaviours, and systemic vulnerabilities. Both levels demand sustained coordination across agencies, integration of technology and human expertise, and the cultivation of public trust to ensure intelligence flows from communities to institutions to enforcement agencies.

Routine activity and situational theories remind us that opportunities for crime are rarely spontaneous; they can be mapped, predicted, and disrupted if detection mechanisms are strong enough. In this way, threat detection shifts focus from the individual crime event to the broader conditions that make crime possible. Theoretically, threat detection draws on principles from intelligence studies and criminology. Intelligence-led crime prevention requires authorities to build a picture of likely threats through the systematic collection of information from diverse sources - surveillance, data analysis, informants, and community reporting networks.

Ultimately, threat detection is not a peripheral function of protecting children—it is its frontline defence.

By collecting, connecting, and analysing fragments of information, systems can disrupt perpetrators before they cause harm. In doing so, detection not only protects potential victims but also strengthens the resilience of communities against evolving forms of offending.

Perpetrators take calculated steps to create opportunities for abuse to occur and to reduce the likelihood of detection. This involves deliberate strategies such as isolating children from protective adults, grooming colleagues and families to build trust, and normalising inappropriate behaviours so that warning signs appear less obvious.

Perpetrators deliberately seek to hide in plain sight, embedding themselves in trusted environments where their behaviour is less likely to be questioned. They cloak themselves as positive and engaged friends of children, parents and others, and they deliberately weaken barriers to detection.

When families, staff, workplaces, and communities are not equipped to identify abuse, grooming, or other indicators of risk, these behaviours may go unnoticed or unchallenged. A lack of awareness or confidence in recognising and responding to early warning signs allows offending behaviour to continue undetected and children to remain at risk.

This chapter examines how child sexual abuse can be identified and recognised. It explores the systems, practices, and cultural factors that support or hinder detection and considers:

- system awareness and understanding of grooming and other indicators of child sexual abuse

- challenges with recruitment and selection practices and the use of labour hire firms which may impact the early identification of people that pose a potential risk to children
- risk identification and assessment tools, frameworks, and practices designed to identify both potential perpetrators of child sexual abuse and children who may be at heightened risk
- institutional recordkeeping and information sharing practices which may impact how indicators of harm are understood over time, and across systems.

Policy and legislative mechanisms that seek to strengthen threat detection and disruption are also discussed. These include:

- intelligence gathering and improved information exchange across institutions
- multi-agency collaboration to enhance both risk recognition and threat assessment
- organisational and regulatory systems to aid detection
- community awareness raising on the signs and indicators of a threat.

Together, these measures aim to move systems towards earlier, more reliable detection of threats to children, so that action can be taken before harm occurs. Significantly, in having regard to all these issues, the Child Death Review Board also calls for a fundamental change in our approach.

We must bring our systems of protection together into a centralised intelligence hub. This helps to weave together different pieces of information about threats and other indicators of harm over time that are otherwise lost in agency databases and centre records.

Identifying child sexual abuse in ECEC Settings

A confronting reality of this Review is understanding that perpetrators, including the offender, specifically target very young children who have no or limited vocabulary to articulate their experiences of abuse. This is a known reality and one that we, as a community, must contend with across systems, settings and sectors.

Recognising the signs of child sexual abuse in very young children requires careful observation due to their developmental stage.[2] This is because they often lack the language to be able to describe their experiences of abuse or the developmental ability to recognise the behaviour as sexual abuse.[3]

Potential indicators that a child may be experiencing child sexual abuse include:

- sudden changes in behaviour such as increased fear or withdrawal
- regression to earlier developmental stages (e.g. bedwetting)
- unexplained injuries
- a sudden intense attachment to a particular adult
- the display of sexualised behaviours or language inappropriate for their age.[4]

Research conducted by University of New South Wales to inform this Review identified seven international case studies from Australia, the United Kingdom, the United States, the Netherlands and Sweden that highlight how child sexual abuse occurs, and continues, without detection.[5] There were compelling similarities across all cases, irrespective of the country where the abuse happened. The abuse involved children under the age of five and highlighted significant failings in organisational oversight, communication and safeguarding practices.[6] These cases also shine attention on the complex interplay between perpetrator behaviour, institutional weaknesses and child vulnerabilities.

Compelling lessons from these cases highlight that:

- identified risks were not managed or responded to, and protective action was not taken in response to formal risk assessment, parents' complaints or staff observations; instead, perpetrators were only identified because of police investigations into uploaded child exploitation material (CEM)
- perpetrators exploited gaps created by the use of casual, agency or trainee positions which created institutional blind spots
- cultures of loyalty, weak whistleblower protections and a presumption of competence resulted in failures in organisational cultures and governance
- existing institutional detection mechanisms were ultimately insufficient, and some cases involved perpetrators working in broader networks, which highlights the importance of multi-agency coordination and intelligence sharing.[7]

When considering these cases collectively we must ask ourselves a critical question – who is most likely to offend in these types of settings and what are the patterns that make them identifiable?

> *Child sexual abuse by adults does not happen because of a lack of respect or consent. It happens because adults weaponise their power over children. Adults who harm children—especially prolifically—often take great care to conceal their offending and intentions.* [8]

Recognising threats: contextualising grooming behaviours

While acts of child sexual abuse may occur behind closed doors or where there are lapses of guardianship, other behaviours, when considered in context, can act as key signals of a potential threat to a child or children.

Most significantly, this includes grooming, which is a central feature of child sexual abuse.[9] It is a tactic used by perpetrators to create opportunities for abuse to occur. There is no universally consistent definition of grooming.[10]

The Royal Commission into Institutional Responses to Child Sexual Abuse (Royal Commission) defined grooming as:

> *behaviours that manipulate and control a child, their family and other support networks, or institutions with the intent of gaining access to the child, obtaining the child's compliance, maintaining the child's silence, and avoiding discovery of sexual abuse.*[11]

While grooming is generally tailored to context and situation, it often includes a number of key elements.

Perpetrators groom children and adults with the intent of sexually abusing a child.

- Grooming may include the normalisation of behaviour, such as kissing a child on the face in front of their parents or other staff to justify physical contact.
- If a perpetrator suspects their grooming strategies are being recognised, they may change tactics to avoid detection.
- Grooming can occur in any context. It can be challenging to identify as it often looks like the behaviour of a caring adult.[12]

Grooming of a child may include acts that are designed to develop trust, isolate a child, make them feel special, lower a child's inhibitions and prevent them from disclosing the abuse (such as through threats or gifts).

Grooming is not just targeted at children. Perpetrators groom other adults in a child's life. This may include:

- a perpetrator ingratiating themselves with families by positioning themselves as a trusted caregiver to the child, including offering to babysit, attending birthday parties and socialising with them
- a perpetrator creating opportunities to offend by manipulating situations and environments so they can be alone with a child.

> ***Grooming is interpersonal but also institutional and structural, as adult offenders manipulate the peripheral networks around the child to cut them off from help and make other adults unwittingly complicit. And when abuse does come to light, adults within those networks fear reflected guilt for their inaction and support of the offender.***
>
> ***Without a sharp focus on their specialised methodology, adults who deliberately harm children can continue to hide behind a shield of confusion that sanitises and erroneously conflates their harm with a lack of respect and/or a lack of consent.***[13]

There is often a general assumption that individuals working in child-related services are well intentioned.[14] However, the Royal Commission illustrated how perpetrators can groom entire organisations by using their positions of employment or authority to manipulate trust and gain access to children. Perpetrators may exploit their roles in staff or volunteer positions to appear trustworthy and caring.[15] This is sometimes referred to as 'institutional grooming.'

Perpetrators also groom children online. The internet enables perpetrators to entrench themselves into a child's life through consistent contact across multiple channels so that they can commit sexual abuse and sexual exploitation via technology.[16]

Placing behaviour in context is key to supporting the identification of grooming. While no single act can clearly be defined as 'grooming', being alert to potential signs and patterns of behaviour can support improved detection. As articulated by Bravehearts in their submissions to the Review:

> *Offending behaviour often occurs in private and is enabled by secrecy, grooming, and institutional failures to recognise or respond to warning signs. As such, identifying risk factors and behavioural patterns associated with child sexual offending, such as inappropriate boundary-crossing, attempts to isolate children, or the use of digital technologies for grooming, can support early intervention and prevention.*

Importantly, while grooming is often conceptualised as occurring over a prolonged period this is not always the case. In this case, the offender is known to have perpetrated abuse against some children in a very short timeframe including within two shifts that he worked in one centre. One staff member described the offender's ability to build relationships with children by stating:

> *[the offender] developed a quick relationship with [child] to the point that [child] wanted to sit next to [the offender] by lunch time. [Staff member] recalled this was highly unusual. There was one educator that [child] was attached to, but she didn't really develop attachments with other educators. Especially not that quickly.*

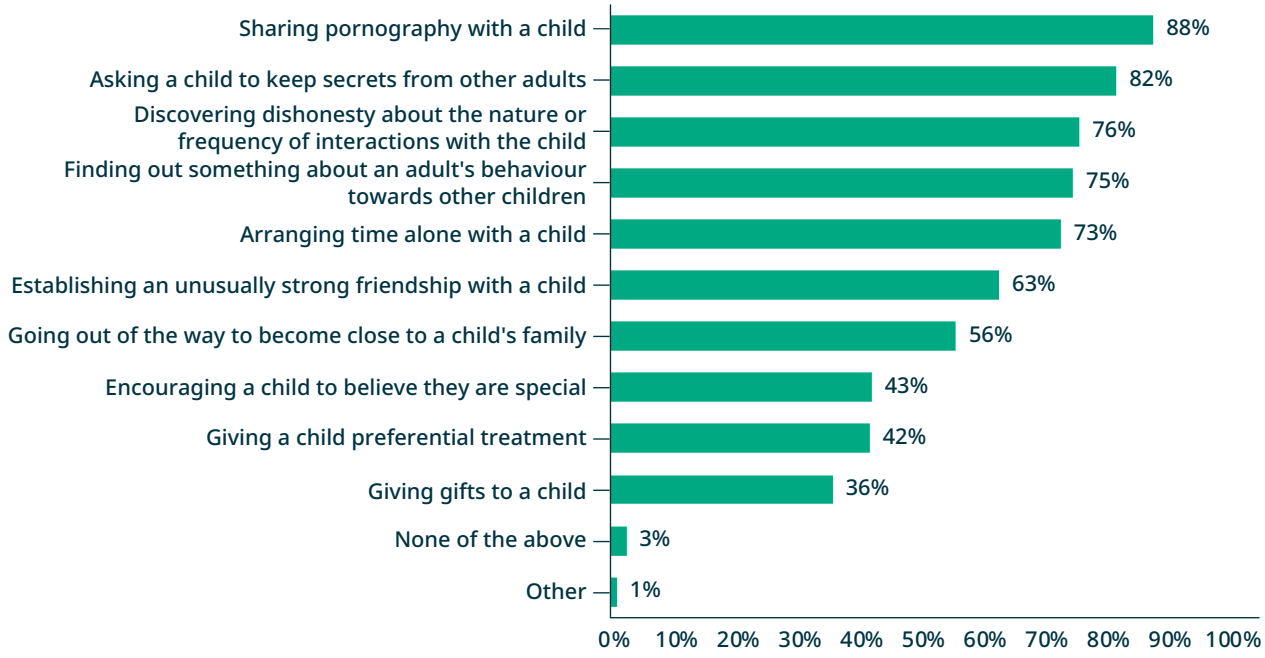
The offender's capacity to rapidly ingratiate himself with others was also facilitated by his reputational standing as a comparatively well-educated and experienced educator, which situated him in a position of trust before he had even commenced working in a centre. He demonstrated an intense focus on children in his social and work relationships alongside repeated attempts to isolate children and reduce the level of supervisory oversight.

> *That's where we get it wrong. Grooming the child is almost like the last part of the process. Think about grooming the family, grooming the organisation they're working for, [how they gradually] break down those rules and those boundaries.*[17]

A 2023 survey undertaken by the National Centre for Action on Child Sexual Abuse of 4040 participants highlighted that while 75 per cent acknowledged grooming is always a form of child sexual abuse, there was a notable proportion who thought that sometimes it was not (**16%**) or they did not know (**6%**).[18] Survey participants also reported a lack of understanding of some of the known indicators that grooming may be occurring (Figure 1).[19]

Figure 1: Participants self-reported understanding of indicators of grooming 2023 (n=2029)

Source: National Centre for Action on Child Sexual Abuse 2023



A standalone criminal offence

Grooming a child under 16 years, or a parent or carer of a child under 16 years, has been a stand-alone offence in Queensland under Section 218B of the *Criminal Code Act 1899* (Criminal Code) since 2013. In Queensland, an adult who engages in conduct with the intent to facilitate the procurement of a child for a sexual act, or to expose them to any indecent matter, with the child or with their carer, commits the offence of grooming.

- 'Procure' in this context means to 'knowingly entice or recruit for the purposes of sexual exploitation'.
- An 'indecent matter' relates to media such as film or photography with an indecent nature.

The Criminal Code is explicit that a sexual act for which a child is groomed to participate in does not need to be intercourse or even involve physical contact. A person guilty of grooming is liable to imprisonment for five years, or 10 years if the child is under 12 years of age. It is a defence to a charge of grooming if the person believed on reasonable grounds that the child was 16 or over (or 12 or over for the circumstance of aggravation noted above).

Procurement of a child for sex is an offence under s.217 of the Criminal Code. In practice, the absence of tangible evidence as to the intent of the perpetrator means grooming can be a difficult offence to prove. According to the explanatory note to the amending legislation:

> *The creation of the new offence of 'grooming' will capture wide-ranging behaviour that is designed to facilitate the later procurement of a child for sexual activity. This allows for the potential for police to intervene before a sexual act or sex-related activity takes place.*[20]

In the five years to 30 June 2025, a total of 314 instances of grooming have been prosecuted under s 218B of the Criminal Code. Of these, 37.90 percent were discharged, dismissed or withdrawn; 35.03 per cent resulted in a period of actual imprisonment.

The stages of grooming

There are a number of stages in the grooming process. Not all of them need to have happened for grooming to occur, and they may occur in any order.[21]

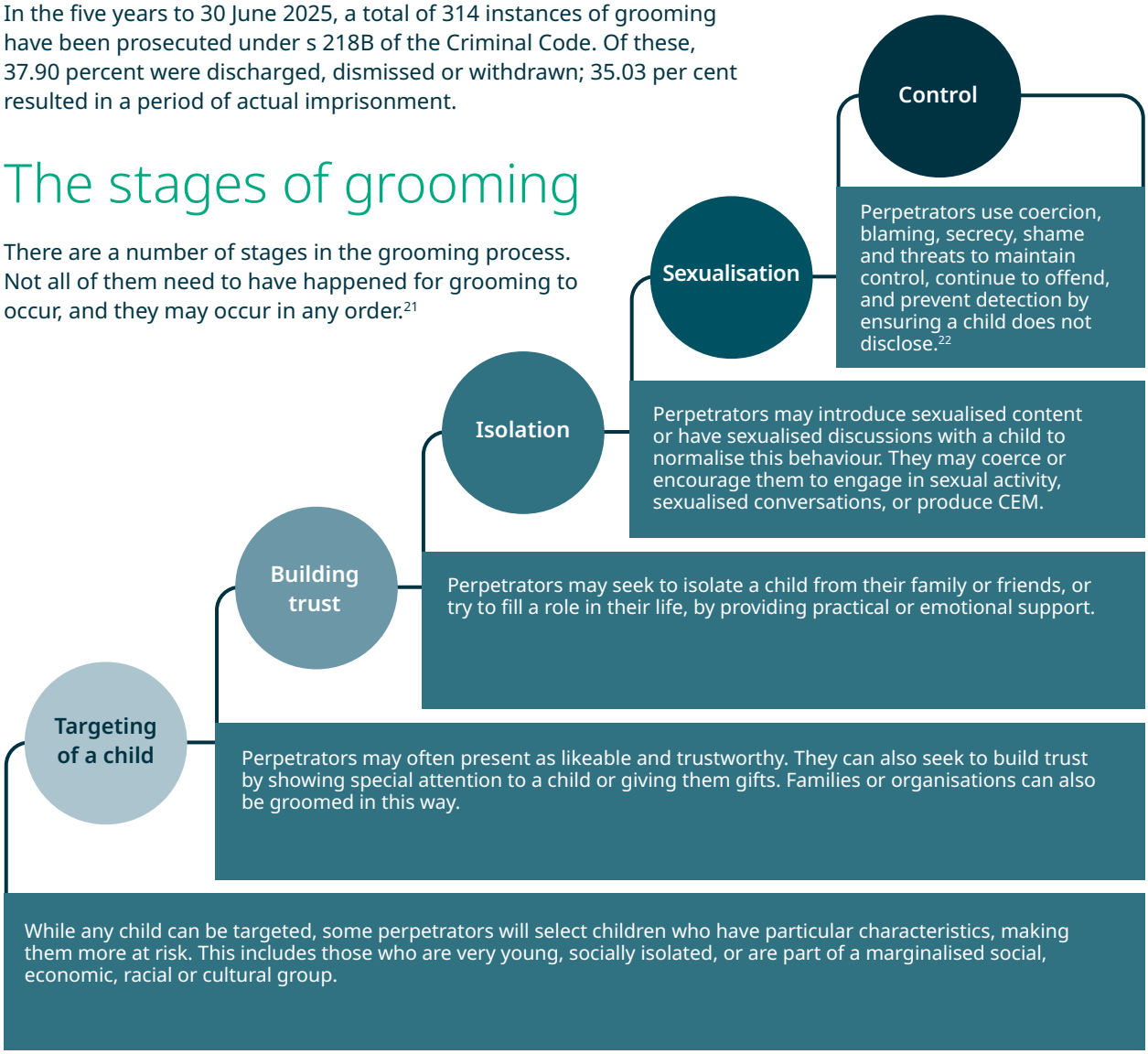


Table 1: Identified acts of grooming by offender

Targeting of a child	The offender was known to have a good relationship with children who enjoyed arts and crafts, and to put effort into knowing children's strengths and weaknesses. The offender also demonstrated favouritism towards children, particularly girls, which was raised as a performance concern in two centres. As part of an investigation into the offender's conduct in one centre, staff identified children who they knew as favourites of the offender. Some of these children were later identified as victim-survivors. In this same centre, a staff member recalled that the offender 'was kind of obsessive with ...' one child and reportedly said, 'the mum doesn't really care about her, she should just give her to me'. This child was later found to have been a victim-survivor. In a second centre, the offender's favouritism towards certain children was raised in his mid-year appraisal. Management stated that other staff and families had noticed this behaviour. The offender was observed to establish rapport with children unusually quickly. At one centre, it was noted that by lunchtime on his first shift, he had already developed a connection with a child who had previously not formed close relationships with any staff.
Building trust	The offender built strong relationships with some parents, attending birthday parties and church with the families, or babysitting the children. Although some centres do not appear to have been aware of this behaviour at the time, records show that at least two centres were. One centre received multiple letters and emails from parents praising the offender and expressing disappointment when he resigned. These letters and emails spoke to the strong bonds made between the children, parents and the offender. The offender normalised the use of personal devices to take photos of children under the guise of capturing moments for presentation to families. Early in his employment at one centre, the offender showed centre management photos and videos of children from previous workplaces on his camera. This was done as a suggestion as to how he could document the children's learning. In another centre, staff stated that the offender used a camera 'all of the time' and that he preferred to use his personal camera and a tripod. In a reference given to a third centre, the referee (a parent) spoke about how the offender would put on video nights for parents each term where he played video compilations of the children's activities and learning.
Isolation	The offender separated groups of children from other children and educators. In one centre, the offender introduced outdoor rest times for the children and would take a group of children out to a fort for rest. The blinds inside the centre were closed and sometimes the offender hung up sheets around the fort. In this centre, the offender would also take children to spend time in his office which already had obstructed views and drawn curtains. The offender appears to have used his position of authority as a director to manipulate staffing arrangements in a way that enabled unsupervised access to children. He was responsible for creating staff rosters and appears to have deliberately scheduled minimal staffing levels. Records suggest that he may have intentionally kept enrolment numbers low to avoid the requirement for additional staff, thereby increasing opportunities for isolated contact with children. An investigation by the Early Childhood Regulatory Authority (ECRA) found that on at least one occasion, the offender was left alone with up to 14 children, in clear breach of regulatory supervision requirements. In another centre, the offender controlled the indoor space while his assistant educator managed the outdoor space. Half the children (mostly girls) were inside, and half outside. The outdoor educator would float between both spaces but was mostly outdoors assisting with the children with 'higher needs', leaving the offender to manage the indoor space largely unsupervised.

Sexualisation	One centre identified the offender as 'overly physically affectionate'. Staff referred to the offender as 'like a friendly uncle' or 'like a big kid'. The offender was known to lay down with children, roll with them on the day bed he brought into the centre, tickle them, have them sit on his lap, and take selfies with them on the centre iPad. The offender normalised physical touch between educators and children. In one centre, as part of an investigation into the offender's conduct, the offender spoke about 'professional love', stating that this theory talks about 'touch practices'. He further stated that this theory was communicated through staff meetings and that physical touch and affection had been a huge part of the culture of the centre. During this investigation, the offender spoke about 'not shying away from physical interactions in front of parents' and stated that this approach is embraced by families. He was known to pick up and cuddle children in the presence of parents.
Control	The offender was the Director of one centre, giving him the opportunity to review policies, procedures and practices, modify the environment, manage staff movement and rostering, control enrolment numbers and manage complaints. At this centre, the enrolment numbers were between 24 and 47 per cent capacity. It appears that the offender was deliberately ensuring low enrolment numbers to reduce the number of staff required to meet ratio requirements. The offender was known to start earlier and finish later than all other staff as a matter of routine. In one centre he would start two hours before his shift. It is speculated that this formed part of his control of the contextual environment.

Workforce understanding of grooming

While any single act may not in itself be indicative of grooming, when viewed collectively they show a clear pattern of manipulation by the offender to avoid detection and perpetrate abuse. Improving knowledge of the signs of grooming, including in workplaces, families and the broader community, helps to put conduct in context and improve its earlier detection. This can be further enhanced by ensuring strong recordkeeping practices are established that appropriately document concerning behaviour, and that decision making is in the best interests of the child.

The Board consistently heard that current workforce training is often limited, not sufficient, or delivered in a piecemeal way. It also tends to primarily focus on ensuring workers meet their mandatory child protection reporting obligations. While child protection is a critical component of safeguarding practices, this type of training predominantly focuses on risk of harm to children from their parents or guardians. It may not specifically contemplate risk in an institutional setting that may be posed by other staff, volunteers or caregivers. This results in a critical knowledge gap, where staff are not trained to see the threats among them.

In submissions received by the Board, the Archdiocese of Brisbane highlighted the difference between child protection and child safeguarding practices, and the need to embed safeguarding in all aspects of organisational governance, culture and practice:

> *Safeguarding and child protection are related but distinct concepts, and clarity between the two is essential for effective practice. Safeguarding refers to the broad framework of policies, culture, and preventive measures designed to ensure that children and vulnerable people are safe, respected, and able to flourish. It encompasses proactive steps such as safe recruitment, ongoing training, risk assessments, and fostering environments where concerns can be raised without fear. Child protection, by contrast, is a narrower term that relates specifically to the formal actions taken when there are concerns or disclosures that a child may be experiencing harm or abuse. While child protection is a crucial component, safeguarding is the overarching commitment to prevent such situations arising in the first place. Both must operate hand-in-hand: safeguarding as the proactive culture, and child protection as the responsive mechanism when risks materialise. This distinction is important because it underscores why safeguarding requires cultural and systemic reform, not simplistic solutions. As the Royal Commission made clear, preventing harm cannot be reduced to narrow measures or one-off fixes; it must be embedded in the structures, culture, and practices of every organisation.*[23]

Of the seven centres where information was available about staff training, policies and procedures, only three referred to grooming, and none included a clear definition of what it is. In one centre grooming was defined in training delivered in October 2024 (after the offender was arrested) as:

> *Child groom[ing] is when someone deliberately: makes a child or young person feel special (eg., with treats, attention, or affection) WITH THE AIM OF making a child think that doing sexual things with them is OK or normal. Groom(ing) strategies include:*

- *Identifying vulnerable children*
- *Identifying vulnerable or receptive families*
- *Isolating the child from other children or their guardian*
- *Conferring a special status on the child*
- *Gradually desensitising the child to sexual touch*
- *Becoming indispensable to significant adults in the child's life*
- *AND SNEAKIER AND UGLIER (BUT CAN APPEAR NORMAL) BEHAVIOURS*

In other centres, training was provided about child protection related matters. Although some centres referred to annual child protection training, 'Mandatory Reporting Workshops' and external child protection training providers, there is limited reference to grooming in any of the material reviewed. In one centre mandatory training was provided by an external training provider. The mandatory training referred to 'Building a Protective Environment for children', however did not cover grooming. While identifying grooming was a standalone module available through the provider, it was not mandatory and was offered only after the first five modules in the series were completed. Both Centre EA and Centre EK used the same training provider.

Centre EA's policies outlined the working with children legislation and the need for a child and youth risk management strategy. While it contained a number of inaccuracies, it provided information about reporting requirements relating to the sexual abuse of children under the Criminal Code stating:

> *This means that you must make a report to the police in all cases where:*
>
> - *sexual abuse or grooming has occurred,*
> - *you suspect that sexual abuse or grooming has occurred*.

There was however no information to outline what grooming is or how it presents. Additionally, this centre utilised an online external training provider, with this training largely focusing on responding to children's emotional needs, supporting children's emotional regulation, managing behaviour, the impact of trauma on the developmental brain and supporting families in need. There appeared to be no training that encompassed grooming. As part of the ECRA investigation in 2024, training records were requested for all staff at this centre between December 2019 and April 2022. The centre provided a response which stated:

> *Whilst child protection training has been provided to staff during this period, there are limited documentary records of this training which has been provided in-person.*

Centre HN which is auspiced by a government agency had a more comprehensive approach, with a range of policies and procedures that reference grooming, albeit with no clear definition, including in the:

- **Staff Code of Conduct**: which commits staff to never 'subject children to physical, emotional or sexual abuse or neglect or grooming behaviour'. It has also been updated to prohibit innuendo and sexual jokes, includes injury management protocols for personal areas, and requires staff to seek permission from children before engaging in interactions.
- **Child Protection Capability Framework**: which references that all *clinical* staff should have knowledge of potential indicators of harm in all forms including physical and emotional abuse, sexual abuse, neglect, child sexual exploitation, grooming and other signs to look out for. It does not specifically contemplate staff working within the childcare service.
- Training to support the roll out of amendments to the Queensland Criminal Code in 2021 which introduced the 'failure to report' and 'failure to protect offences'.

A failure to recognise grooming and other indicators of potential harm is not distinct to this case, or ECEC settings. It has been consistently noted in previous inquiries including most recently the *Commission of Inquiry into the Tasmanian Government's Responses to Child Sexual Abuse in Institutional Settings* which found that:

> *Too often, we saw failures to recognise child sexual abuse for what it was. It was rare for us to receive evidence that the sexual abuse of a child was directly witnessed by staff in institution... More often, complaints of inappropriate conduct were made later by children or their carers—sometimes many months or years later when the victim-survivor was an adult.* ***However, we heard many examples where risks or signs of abuse were not detected when they should have been, particularly grooming behaviours or breaches of professional boundaries.*** *These behaviours can be harder to identify, particularly where the conduct occurs under the guise of health care or when teachers could be seen to be paying particular attention to one student for good reasons. We saw too many examples of signs or reports of abuse being downplayed and denied. Sometimes, this happened because of a lack of skills and knowledge, sometimes, it was deliberate, and in other instances, it was driven by a desire to protect the reputation of a colleague, other adults or the institution. Even when reports and complaints of child sexual abuse were made directly, we saw examples of them not being recognised as such by the institution. Across the board, these actions led to inexcusable delays in managing risks to children and led to uncaring responses to victim-survivors.*[24]

Raising community and workforce awareness

> *79% of sexual abuse survivors are abused by someone known to them. And this abuse doesn't happen by chance, there are varying degrees of grooming that take place as the situation develops. I have to wonder if my mum or myself knew more about grooming at the time, would my situation be different* - Lived experience advisor

Improving community and workforce knowledge is a key strategy in any approach to detecting and preventing child sexual abuse. It helps to improve the identification of grooming and other indicators of risk. It empowers children, parents and caregivers to better understand behaviour they may find concerning. Strong safeguarding practices must be reinforced through foundational training for staff on reporting, grooming awareness, trauma-informed care and information sharing.

Research also shows that education and training related to child sexual abuse is most effective when it involves children, employees, parents and the community. Programs are typically oriented at the primary prevention level to strengthen protective factors around children.[25] Most training, including in Australian settings and overseas, is targeted at teaching children about abuse, consent and safety. Very little is targeted at employees or workplace settings.[26]

Under the National Strategy to Prevent and Respond to Child Sexual Abuse, the National Office for Child Safety commissioned 'One Talk at a Time', a TV and online advertisement campaign which launched in October 2023.[27] One Talk at a Time was backed by detailed research and supported by a children's storybook, 'My superhero voice', to maximise the coverage of its messaging.[28] The Australian Government provided $22.4 million in funding for the campaign which aims to help prevent child sexual abuse by encouraging adults to learn about the issue and have ongoing, proactive, preventative conversations with children in their lives.[29]

Tailored professional development programs are intended to build the knowledge, skills and confidence of educators to prevent, recognise and respond to abuse. Evidence shows that educators are the most frequent reporters of abuse under mandatory reporting regimes In Australia and overseas, which makes training for this sector even more important.[30]

Consultations undertaken to inform the Review highlighted the lack of current structured, systematic community awareness programs that are focused on children under the age of five:

> *Australia currently lacks a mandated national framework to ensure consistent delivery of child safe and protective behaviour education in early childhood settings where children are highly dependent on adults to care for them. This gap results in fragmented practices across jurisdictions and leaves many children without access to vital personal safety education.* – Dr Katrina Lines, Chief Executive Officer of Act for Kids

During consultations, specialist sexual violence services also emphasised that while they have been approached to deliver training in ECEC services, they are not currently funded to deliver community education and are unable to commit to doing so because of resourcing pressures.

The nature of the ECEC workforce was also raised by many submitters to our review as both a limitation and an opportunity to improve detection through a workforce capability uplift:

> *This sector, along with others (e.g. residential care, detention centres, sporting and recreation organisations), has not yet undergone the professionalisation of the workforce that the education sector has experienced over the last 20 years. Moreover, regulators in this space are often compliance driven and adopt a superficial, 'tick box' approach that is deleterious to promoting a safeguarding culture. This can 'trickle down' to individual agencies if they are not well supported to apply a meaningful understanding and application of safeguarding principles relevant to their unique environment and risk profile.*

Young or otherwise inexperienced workers also extend to management in these settings, and we have noticed a distinct lack of capability to deal with complaints and expectation setting with staff around appropriate interactions with children. There is an identified need for meaningful skill development around having difficult conversations, complaint management, procedural fairness, what is considered appropriate conduct in individual settings and what will happen if those expectations are breached. People management is closely linked with a safeguarding culture as it is enacted and reinforced by leadership and governance processes. - Halloran Morrissey Group Submission

As part of the implementation of recommendations from the *Review of Child Safety Arrangements under the National Quality Framework*, the Australian Children's Education and Care Quality Authority (ACECQA) has developed information for service providers on implementing a child safe culture and online safety under the National Quality Framework (NQF). The recommendation specified that training must include details about identifying grooming of children and adults, to ensure services are able to respond to complaints in an informed, timely manner, and that the child remains at the centre of decision making.[31]

The NQF *Child Safe Culture Guide* provides an overview of grooming and guidance to approved providers and service leaders to support educators to identify conduct that may reveal a pattern of behaviour which indicates there are potential risks to children.[32] They note that these instances may include:

- being alone with a child when there is no professional reason to do so
- spending time with a child outside the organisation
- offering children privileges, rewards, gifts, benefits and favouritism
- sharing inappropriate images, noting that the sharing of any images of a violent or sexual nature should be reported immediately to the relevant jurisdictional reportable conduct scheme.[33]

Education Ministers across all states and territories have recently committed to national child safety training that all ECEC staff will be required to complete. With an investment of up to $21 million by the federal government in targeted workforce subsidies to help cover wage costs, the training is being developed by the Australian Centre for Child Protection and is intended to be rolled out in early 2026.[34]

NAPCAN's Safer Communities for Children protective behaviours approach reinforces the collective role that the early childhood sector, communities and individuals have in keeping children safe, thriving and having the ability to reach their full potential.[35] This program aims to build resilience, communication, emotional literacy and help-seeking skills in children.

Bravehearts have also released a 'Grooming hides behind harmless' campaign, which is intended to demonstrate the subtle and manipulative nature of this type of conduct, behaviours which are often seen as 'innocent' or 'harmless'.[36] In its submission to the Review, Bravehearts noted that community awareness campaigns are foundational to primary prevention, as they seek to 'shift social norms, increase recognition of grooming and boundary violations and promote shared responsibility for child safety'.

Importantly, grooming prevention is different to respectful relationships and consent education programs that are currently delivered in schools, and distinct from protective behaviour training.

> *...abusers knowingly repurpose resources intended for the development of consensual interactions and warp them in malicious, insidious ways. They weaponise the very language of respectful relationships and consent to draw a false equivalence between healthy peer-to-peer relationships and the harm they cause.*[37]

Although the *National Strategy to Prevent and Respond to Child Sexual Abuse 2021–2030* defines grooming, and focuses on awareness raising, education and building child safe cultures (Theme 1), it does not have dedicated actions for grooming awareness. The National Office for Child Safety has published online resources focused on grooming as part of the One Talk at a Time Campaign, in recognition of this topic's importance. It also focuses on helping to prevent child sexual abuse by: raising awareness among adults and providing them with tools and resources to educate children about sexual development, healthy relationships, sexual behaviours, sexual abuse, personal safety, body autonomy and online safety.[38]

While *Queensland's Framework to address Sexual Violence* also highlights commitments to equip families, children and young people with accurate information on healthy relationships, consent and sexual violence, this predominantly focuses on respectful relationships education.

In recognition of the need for more coordinated action in this area, there have been calls for a standalone Grooming Prevention Education Framework which seeks to 'close the knowledge gap between the general public, who just don't understand offender strategies, and adult perpetrators of child sexual abuse, who benefit from our ignorance and confusion'.[39]

Operational Recommendation 2: Invest more in workforce capability for child safeguarding

One of the strongest findings of this Review is that frontline workers across sectors are often the first, and sometimes the only, adults in a position to notice the early warning signs of child sexual abuse. These include grooming behaviours, subtle changes in a child's demeanour, or disclosures made in indirect or tentative ways. Yet, many workers report a lack of confidence in recognising grooming, uncertainty about their safeguarding responsibilities, and fear about how to respond appropriately if a child discloses abuse.

While Queensland has invested heavily in Working with Children Checks (WWCC), reporting pathways, and regulatory schemes, the system is only as effective as the people who operate within it. Without widespread workforce capability, signs of risk can be missed, minimised, or mishandled. This results in lost opportunities to intervene early and prevent harm.

> *Being "safe to work with children" should reflect not only the absence of convictions but the presence of relevant education and awareness. Evidence-based online modules could ensure all cardholders have a foundational understanding of trauma, disclosure, and victim-centred practice* - Survivor-advocate.

Embedding child safeguarding knowledge and skills across the workforce is therefore essential. This skills uplift must include:

- **Identifying grooming behaviours:** helping workers understand the patterns of conduct that perpetrators use to gain trust, normalise boundary violations, and isolate children.
- **Clarifying safeguarding responsibilities:** ensuring every worker knows their legal and ethical duty to act when concerns arise, and how these responsibilities fit within broader organisational obligations.
- **Receiving and responding to disclosures:** equipping workers with the confidence to listen, validate, and report appropriately when a child chooses to speak.

Evidence from other high-risk industries such as aviation safety or health care demonstrates that mandatory, embedded training in risk identification and reporting responsibilities changes culture, sharpens vigilance, and normalises best practice. For child safeguarding, this training must be universal, regularly refreshed, and built into professional accreditation and induction programs.

The Australian Childhood Foundation highlighted that currently individuals can hold a blue card and be approved to work or volunteer with children without any demonstrated understanding of how to recognise, prevent, or respond to abuse. Embedding mandatory child abuse prevention training into the blue card registration process, would ensure that every holder of a blue card, regardless of their role, sector, or employment status would have received basic, evidence-based, victim-survivor-informed education in child safety.

In the absence of such investment, the burden will continue to fall on a small number of trained professionals, leaving the majority of the workforce ill-equipped to play their part. In contrast, a strategic investment in workforce capability has the potential to transform Queensland's safeguarding system, by making every interaction with a worker a potential point of protection for a child.

Operational Recommendation 2: Invest more in workforce capability for child safeguarding

That the Queensland Government invest in embedding mandatory training across all child-related sectors on:

- the identification of grooming behaviours (including the grooming of organisations, colleagues, parents and victims)
- how to raise, challenge and discuss behaviours of concern
- the responsibilities of workers and organisations for child safeguarding
- best practice approaches to receiving and responding to disclosures from children.

This training should be standardised, evidence-informed, and incorporated into professional registration, accreditation, and induction processes, with regular refreshers. Such investment will ensure that child safeguarding becomes a core competency of the Queensland workforce, significantly increasing the likelihood that risks are detected early, concerns are acted upon, and children are protected from harm. Government-funded training should be positioned as a complement to, not a replacement for, sector responsibility. The expectation must remain that organisations embed safeguarding capability as part of their core duties, developing and maintaining training that reflects their specific contexts and risks.

The Queensland Government's investment, therefore, should be directed toward creating high-quality, evidence-informed programs that set a consistent baseline across sectors and provide specialist expertise that individual organisations may not be able to develop on their own.

This shared infrastructure lifts standards, reduces duplication, and ensures that safeguarding knowledge is both contemporary and consistent across the state, while still holding sectors accountable for embedding and sustaining training within their workforce.

Transformational Recommendation 1: Create a national child safeguarding training program

That the Australian Government auspice the development and delivery of a compulsory and consistent online training program nationally. This training should cover:

- the responsibilities of workers and organisations for child safeguarding
- the identification of grooming behaviours (including the grooming of organisations, colleagues, parents and victims)
- best practice approaches to receiving and responding to disclosures from children.

The program should be evidence-informed, designed in collaboration with child protection experts, and delivered in a format accessible to the diverse workforce engaged in child-related roles.

Each state should make completion of the training a precondition for WWCC approval, with mandatory refreshers tied to WWCC renewal cycles. This should also extend to professions exempted from the WWCC scheme (including health and teachers). By embedding safeguarding education directly into the WWCC framework, the program would establish a consistent national baseline of knowledge and capability, regardless of jurisdiction or sector. This approach would address current fragmentation across states and territories, ensuring that every adult permitted to work or volunteer with children has received contemporary safeguarding training. This should occur ahead of, and not be dependent on, national harmonisation.

The Commonwealth's role should be to develop and fund the shared infrastructure for this training, while maintaining the expectation that organisations continue to provide context-specific safeguarding education relevant to their workforces. In this way, the national program functions as a foundation: lifting standards, reducing duplication, and guaranteeing consistency, while leaving space for sector-led initiatives that respond to particular risks and settings.

Operational Recommendation 3: Sustained investment in capacity building and community awareness

One of the clearest findings of this Review is that safeguarding children requires both strong organisational capability and informed, engaged communities.

> *Before entering the sector as a survivor-advocate, I had no understanding of the United Nations Conventions on the Rights of the Child or domestic child protection policy. My abuser exploited that ignorance, convincing me that I, rather than he, was breaking the law. At school, I repeatedly heard that producing "child pornography" was illegal and could lead to imprisonment. There was inadequate and misleading education about coercive control, grooming, or how young people can be manipulated into producing sexual material. Had schools fulfilled their duty to educate students about their rights and the dynamics of abuse, I might not have remained silent for four years, believing I would be prosecuted if I spoke up* - Survivor-advocate.

The introduction of Queensland's Child Safe Standards from October 2025 marked an important step forward. However, **without sustained investment in sector capacity building and public awareness, there is a risk that these standards will remain a compliance exercise rather than drive the cultural transformation they are intended to achieve.**

Sector specific capability and capacity building grant packages have already demonstrated their value in supporting organisations to understand and begin embedding child safe practices.[40] Yet we heard from many services, particularly smaller organisations, regional services, and volunteer-run groups, that one-off or time-limited funding is not sufficient to build the systems, training, and cultural change required. Embedding safeguarding into daily practice takes years, not months, and requires ongoing access to training, resources, and specialist advice. Extending the 2024–25 grants program for a further three years would provide continuity and stability, enabling organisations to consolidate the changes required.

Community awareness is the other essential pillar. It is not enough for organisations to have safeguarding systems if parents, carers, and children are unaware of what safe practice looks like or how to recognise grooming and early warning signs. The current $1 million campaign, 'Raising the standard', has shown that public messaging can break down stigma, encourage reporting, and reinforce accountability across sectors.[41] But the reach and impact of this campaign has been limited. Doubling the investment for the next three years will allow for broader coverage, targeted campaigns for high-risk sectors, and messaging tailored for parents, carers, and children themselves.

This dual investment—in organisational capacity and community awareness—will accelerate the development of a safeguarding culture across Queensland. It will empower parents and carers to make informed choices, strengthen public confidence in organisations that care for children, and provide services with the tools they need to meet their responsibilities. Most importantly, it will help prevent harm by ensuring that safeguarding is not an abstract policy, but a lived practice embedded in both organisations and communities.

This sustained investment will provide continuity for organisations, strengthen community engagement, and accelerate the shift towards a culture where safeguarding children is understood as a shared and non-negotiable responsibility across Queensland.

Operational Recommendation 3: Sustained investment in capacity building and community awareness

That the Queensland Government extend and expand its investment in child safeguarding capability through:

- Sector and Organisation Capacity Building Grants – extending the $2 million per annum Child Safe Organisations Capacity Building grants program for a further three years, to ensure that organisations have the resources, training, and tools needed to embed the Child Safe Standards into their operations.
- Community Awareness Campaign – re-funding the 2024–25 investment in the child safe community awareness campaign of $1 million for the next three years, to build broad public understanding of child safeguarding and the identification of grooming to empower parents and carers, and create a culture where communities actively support safe organisations for children.

Chapter 15

Identifying the perpetrators who work among us

Identifying the perpetrators who work among us

In addition to the grooming behaviour displayed by the offender, he also demonstrated other problematic behaviours in the centres where he worked. These include:

- a pattern of high mobility across centres, often moving quickly and with limited notice
- conflictual or resistive behaviours when he was challenged about his conduct
- general performance concerns, including prioritising contact with children over his other job requirements
- emotional congruence with children whereby his emotional attachment and dependency needs appear to have been met by interacting with children rather than adults. He rarely associated with his work colleagues, even at work.
- a lack of concern for other adults in the work environment with a clear focus on the children. For example, the offender would prefer to skip lunch and lay with children at rest time instead of having lunch with his colleagues.

The offender was also reported for other problematic behaviours in the workplace. This includes being witnessed threatening to smack a child in one centre, and in another centre grabbing a child by the arm and squeezing it. The offender sought to minimise his conduct on the second occasion by attributing it to 'maybe losing his temper'. In a different centre, parents reported that they went to pick up their child and found her alone with the offender in the 'kindy room', which she was not allowed in. The offender was not this child's teacher. Of this interaction, the father stated that the offender was 'really weird' and 'awkward'. Although this was not reported to the centre at the time, it reflects the concerns held by parents about the offender's conduct in the workplace towards their children.

When considered in isolation, the individual indicators or concerning behaviours were not enough to prompt further action, or they were dealt with by centres as general performance concerns where the potential risk that the offender posed to children was not recognised.

While no one entity held all the information about the offender's conduct, when viewed collectively it shows a pattern of problematic behaviours across centres and over time.

In reflecting on the offending timeline, the Board noted that frequent job changes, abrupt departures and a failure to pass probation in child-related roles should be treated as red flags. For people that pose a risk to children, this type of transiency was noted as a way for some centres to 'move the problem on'. Organisations appear to have held concerns and acted individually without any strategic or holistic consideration of the ongoing risk the offender may have posed to other children.

For example, in Centre EA concerns were raised about the offender's conduct approximately five months prior to a report being made to police by a staff member. These incidents appear to have been viewed in isolation of each other, and information about the first instance was not shared with the Queensland Police Service (QPS) or Early Childhood Regulatory Authority (ECRA) when they were investigating the latter complaint. Available records indicate that during the ECRA investigation in 2024, staff recalled an interaction with the offender that occurred in early 2021:

> *She recalled an interaction between [the Offender] and a child during a visit to the service with HR officer (...). She and [HR Officer] were at the service to do an induction with [the Offender] as he wasn't happy that people were now going to be overseeing him and the service. [the Offender] was standing up with a child in front of him with his hands on the female child's shoulders and bent down and kissed her on top of her head for no reason. She thought what's going on here and began to question if she was questioning the interaction because [the Offender] was a male and if it were done by a female would she be concerned. She didn't address the interaction at the time and when she left the service, she called [HR Officer] on the phone and [HR Officer] had said the interaction didn't sit well with her either. She had enough experience to know that she needed to address this with [the Offender] and he needed to be reminded of his interactions. The service was still under the control of the [organisation] and [the Offender] was their employee so the next day she went and spoke with [Management] about the interaction she witnessed. She told [Management] what she'd witnessed and asked if there had been any concerns raised about [the Offender], she was told no. She then sought permission to speak to [the Offender] about the interaction due to him being their staff member. [Management] welcomed this action and thanked her for speaking to him about it first. She spoke to [the Offender] who apologised explaining they were a small centre and she didn't understand how they operated and that children hug him in front of parents and it is ok. She told [the Offender] it was not acceptable in childcare and that he couldn't do that anymore. What she witnessed was an interaction not an incident and it was not managed any further by her.*

A casualised workforce

In its submissions to the Review, the Daniel Morcombe Foundation confirmed employment transiency and rapid, frequent role changes as red flags which should trigger enhanced scrutiny but noted privacy rules currently limit the ability for this information to be investigated and shared.

The highly casualised nature of the early childhood education and care (ECEC) workforce, and employment through labour hire firms, was noted as being generally typical of the sector. Questions were therefore raised about whether this conduct in isolation was a significant cause for concern.

> ***Between 2003 and 2022 the offender is known to have worked in at least 22 ECEC services and left more than half (55%) within six months of commencement. In comparison, in 2024 ECEC staff with relevant qualifications had spent on average four years at their current centre.[10]***

Saliently, in 64 per cent of the known centres where the offender worked, he was terminated, dismissed, offered a redundancy, or asked not to return to work there. This was not a worker who moved roles because of personal choice or career progression. He moved because he was asked to leave and not return. As noted by Act for Kids in its submissions to the Review:

> *The [Offender's] case is an example of a childcare worker who had the ability to move from centre to centre, state to state while continuing to commit depraved acts on children due to a lack of consistent and appropriate WWCCs, legislative frameworks and reportable conduct requirements across multiple jurisdictions. This deeply disturbing case highlighted not only the detrimental impact of inconsistencies between, and lack of communication or cross-referencing, across jurisdictions; it also demonstrated how easy it was for someone to move across workplaces and jurisdictions in order to escape detection in their criminal offending against children over a long period of time.*

There is an increasing casualisation of the ECEC workforce, and a reliance on engaging staff through labour hire companies. In 2023 it was estimated that around 21 per cent of the ECEC workforce was employed on a casual basis, which included around 30 per cent of child carers (i.e. not educators, education aides, or managers).[42]

> *There are extraordinary everyday challenges for the ECEC workforce, which is largely female, often underpaid, and significantly undervalued, yet charged with the huge responsibility of the education, care and safety of our youngest citizens.[43]*

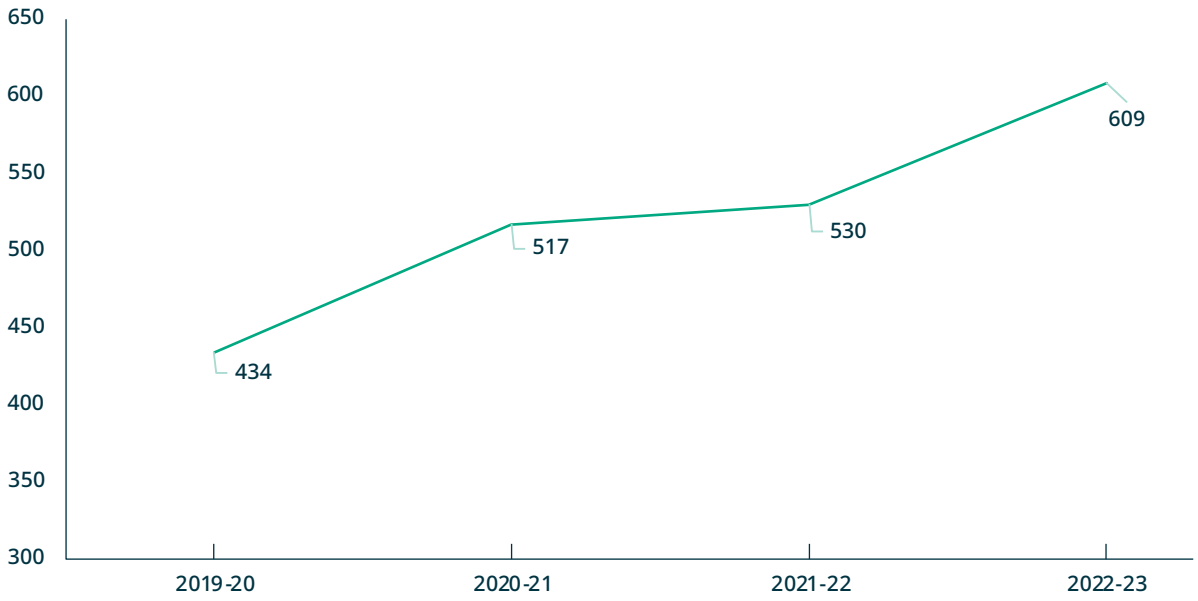
While casualisation of the workforce may indicate the use of labour hire, not all workers employed by labour hire firms are casual employees, and not all casual employees employed in the ECEC sector are sourced via labour hire. According to the Commonwealth Department of Education:

> *The use of educators under labour hire arrangements (agency educators) from recruitment agencies to meet prescribed staffing requirements is very common, especially given the workforce shortages across Australia. Agency educators often work across multiple services, for multiple approved providers (host providers) at minimal notice, and for very short periods of time.[44]*

Under the *Labour Hire Licensing Act 2017,* users of labour hire must only use providers licensed by Labour Hire Licensing Queensland (LHLQ). According to LHLQ data, the number of labour hire licences held by Health Care and Social Assistance providers has been slowly increasing since 2019, and by 2024 has exceeded 600 active licensed providers (Figure 2). Under the Australian and New Zealand Standard Industrial Classification (ANZSIC) 2006 scheme, 'childcare services' are included within this category alongside hospitals, allied health, pathology, and residential care.

Figure 2: Number of active labour hire licences held by Health Care and Social Assistance providers

Source: Labour Hire Licensing Queensland Anniversary Reports 2020 to 2024[45]



Casualisation has been reported as a response to understaffing. While the use of labour hire can help centres alleviate staffing shortages, it may also compromise the care provided to children. In a 2021 report published by the United Worker's Union (UWU), which represents early childhood educators, one educator told the union that:

> *Leaving children at the end of the day with casual educators who they are mostly unfamiliar with is less than ideal and highly detrimental, especially to vulnerable children who suffer from attachment and relationship disadvantages.*[46]

Casualisation can also increase workload pressures on permanent or fixed-term educators who are required to work with multiple casual staff who are not familiar with the centre, its policies and procedures, and with the children themselves.[47]

> *They want to reduce costs, so they're not going to pay people overtime or they're not going to backfill. They're going to cut corners in service provision in order to protect profits, which means that there are important checks and balances that just don't get applied.*[48]

The urgent need for structural change in the ECEC sector was identified in a study undertaken by Griffith University to inform the Board's review of this case. Consistent with the UWU report, key concerns were identified with chronic understaffing, high staff turnover, low pay, and reliance on underqualified staff.[49] Participants criticised the impact of privatisation and argued that ECEC should be integrated into the broader public education system.[50] Issues around staff-to-child ratios and declining standards due to staffing pressures also reflect deeper systemic problems.[51]

The use of labour hire arrangements in Australian employment is not unusual and has been steadily increasing. It has been found by the Fair Work Commission on multiple occasions that a labour hire arrangement between a labour hire provider and a client company does not imply the existence of an employment contract between the client and the supplier labour,[52] even when the client 'exercises a significant degree of control' over the employee.[53]

This presents its own issues when WWCCs are taken into consideration. Section 175 of the *Working with Children Act 2000* (WWC Act) provides an employer must not employ a person in regulated employment unless the person holds a blue card and the employer has given notice to Blue Card Services (BCS) (generally achieved by submitting a form or using an online portal to 'link' the employee to the organisation). Section 10 of the WWC Act provides [emphasis added]: 'For this Act, a person is employing another person **if the first person has an agreement with the other person** for the other person to carry out work'.

The result of these sections is, in labour hire situations, the client company (for example, an ECEC provider) may not be required to notify BCS that they have employed a person who is supplied by a labour hire firm, as it is the *labour hire firm* which makes an agreement with the employee to conduct work. **BCS has limited visibility over where employees of a labour hire firm are working in these arrangements, and cannot always notify the ECEC provider directly of a reassessment, suspension, or cancelling; rather, they rely upon the labour hire firm to forward that information and withdraw the employee from the provider.**

The Board has heard that providers are confused about their obligations with respect to contracted labour hire employees, which is exacerbated by insufficient and inconsistent advice and directions provided by BCS. This includes when and under what circumstances their obligations as an employer may be triggered, and how this is to be determined when the provider operates multiple centres.[18]

Notably, at the time of the offender's arrest in August 2022 four organisations were linked to the offender's exemption card and notified of its suspension, including his employment agency.

While it is apparent that the offender worked in at least nine centres while engaged with the employment agency, the Board has not been able to identify the dates of the offender's employment in these centres due to a refusal by the employment agency to fully comply with the Board's information request on the basis of pending legal proceedings. The information gathered about the offender's engagement with this agency has been drawn from other centre records and ECRA investigation material.

The employment agency advised the Board that the offender was engaged through them for a period of two months in 2022, however some centres refer to the company's engagement with centres dating back to 2019. The offender also worked at Centre WE through an employment agency in around 2006, though the exact agency is not known. This centre advised the Board that it had no records relating to the offender's employment, stating that they believe the employment agency would have retained screening and recruitment documentation.

Additionally, labour hire arrangements (particularly those made by recruitment agencies) have been a blind spot in respect to the *Education and Care Services National Law 2011* (National Law), under which ECEC providers, recruitment agencies, and regulatory authorities in each jurisdiction have faced barriers to the gathering and sharing of critical information about educators under investigation. For example, section 206 of the National Law provides that authorised officers may obtain information from approved providers, supervisors, volunteers and staff to monitor compliance, conduct rating assessments and obtain other information, however this does not include labour hire firms. In the absence of authorising legislation, recruitment agencies may be prevented from disclosing personal information, even to regulatory authorities, due to the provisions of the *Privacy Act 1988* (Cth) and their own policies.

This issue was considered in the *Review of Child Safety Arrangements under the National Quality Framework* (the Child Safety Review), and recommendations have been accepted in full by the Commonwealth, State and Territory Education Ministers to amend the National Law. Proposed amendments will:

- include recruitment agencies within section 206(4) as mentioned above
- allow a regulatory authority to disclose information about a labour hire educator with their recruitment agency as if it were an approved provider, for the purpose of sharing whether that person is subject to a prohibition notice or suspended from providing a family day care service
- make it an offence for a person subject to a prohibition notice to give a recruitment agency false or misleading information in relation to the notice or its existence.[19]

Some services where offending is known to have occurred advised the Board that they had made changes to their use of labour hire companies since the offender's arrest. For example, Centre BS reported that employment agency use is now restricted and subject to senior management approval, with a single vetted provider used in most locations. Centre EA also advised that they currently provide induction material ahead of time for agency staff, but that they are:

> *...liaising with agencies (...) to provide mandatory induction materials ahead of time for agency educators. We are working towards mandatory reading of materials by agency educators before arrival for shifts.*

In submissions made to the Board, the employment agency provided advice on the current approach taken by this entity for candidates who seek to register in ECEC services:

1. ***Sourcing/advertisement:*** *The current state includes having a statement about being a child safe organisation on advertisement, listing child safe compliance documents required to apply for a position, and listing child safe policies and procedures on website.*
2. ***Assessing suitability:*** *An assessment should be undertaken of previous experience working which children and young people. It is specifically noted to 'look for sudden career changes, especially into OSHC [Outside School Hours Care] as unqualified worker when having no child related experience'. Ensure that all documents are returned relating to:*
    - *WWCC / Blue card*
    - *Qualifications (if applicable) and this is cross referenced with ACECQA NQF approved qualifications list*
    - *Names of two work related referees*
    - *Statement that they are not a Prohibited person or subject to an enforceable undertaking*
    - *Statement regarding criminal history*
    - *Search engine check to see if the person's name is flagged for anything untoward*
    - *Interview candidate and ensure that there is a question regarding child safety / reporting or safeguarding*
    - *Human checking of this data - not reliant on AI*
    - *References need to respond to the question "Is there a reason this person should not be engaged to work with children and young people" and "why did the person leave" and "would you re-employ this person"*
    - *People making assessment need to have knowledge of child safeguarding and what to look for*
3. ***Onboarding/engagement:***
    - *Code of Conduct - Child Safeguarding signed*
    - *Induction completed which includes child safeguarding*
    - *Evidence of completion of induction records kept*
    - *Assessment against child safeguarding conducted as part of induction*
    - *Child safe policy supplied as part of the contract and readily available on the website*
    - *Linking WWCC to the agency (some states are candidate led as opposed to employer led)*
4. ***Continuous monitoring:***
    - *Regular check ins with Centre on the educator's performance and behaviours which are recorded*
    - *Processes and policies are in place for when a Child Protection allegation is raised*

The agency also provided a range of 'future state' suggestions to improve safeguarding practices:

- A national government database where all candidates must be approved / not approved to work which would flag any pending actions. This could be supported by a national code of conduct required to be included in every employment contract.
- Update WWCC / National Criminal History Check to continuously update employers of any charges or misdemeanors e.g. the WWCC notifies an employer of any criminal matter not just child related concerns.
- Mandatory online child protection and child safeguarding training for every employee that is provided by the government, has assessment attached, and is completed annually.
- If someone is stood down due to an investigation at one provider or agency then this is reported and held in a national database until a final outcome is reached and this is used to prevent the candidate moving to another agency or child related employer meaning that they are truly stood down. Any potential employer must get approval to appoint from this new body.

Strengthened recruitment and employment screening practices

The research we have compiled requires us to acknowledge that there are motivated offenders operating undetected in our community, and that they seek to work with children.[54] They are not strangers to us. They often have no relevant criminal history that would prevent them from working with children and they work in roles that may disguise their offending.

> *While, overwhelmingly, people who work with children act in their best interests, some are predatory and tactical in their grooming and abuse… Abusers need to be prevented from working in institutions, held accountable and removed from positions that give them access to children. This is generally accepted as uncontroversial but does not always translate into practice.*[55]

Robust recruitment and employment screening practices are a fundamental part of ensuring that people who present a risk to children are unable to obtain child related employment. Evidence before the Board shows that the offender sought to circumvent recruitment and employment screening practices on multiple occasions. This includes by:

- not including details about his last place of work, for those organisations where performance concerns were noted or where he did not pass probation
- not using his most current referee or from his last place of employment, and using outdated referees from other jurisdictions or from parents of centres that he worked in (not former employers)
- not providing details about previous allegations made against him.

Concerns held about the offender's conduct in some centres do not appear to have been shared with subsequent employers as part of the recruitment process.

A Statement of Service was obtained by Centre EA from Centre EK as part of the recruitment process. This statement did not refer to any of the performance or behavioural concerns Centre EA had identified during the offender's employment at this centre, or the instance of child harm by the offender.

A number of other shortcomings with recruitment processes were identified:

- limited recordkeeping about recruitment processes
- reliance by centres on an employment agency to conduct referee checking and screening
- limited formal training in recruitment processes and requirements.

Signs of grooming or concerning behaviour in the offender's resume and references were also not identified. For example, the offender talked about 'professional attachment' and 'professional love' for children. The offender also included pictures of children from other centres where he worked in his resume. This was a clear indication to future employers of the offender's willingness to keep photos of children after he had left a centre and represented a breach of privacy for those children.

In reflecting on these issues, the Board noted that strengthened recruitment and screening practices would support the earlier identification of transient or highly mobile employees in child facing roles. Improved recruitment practices, supervision and oversight—particularly for temporary or agency roles—can help to screen out, or improve the early detection of, persons of concern. This was evident in a number of services where problematic behaviour by the offender was detected early and acted upon.

In one centre, the offender was terminated during his probation period, with his inappropriate behaviour towards children contributing to this decision. In this centre, the acting manager witnessed the offender having children sit on his lap on multiple occasions and raised that this was not in line with best practice. The offender was defensive when this was raised, and became aggressive when told of his firing, questioning why he was being let go 'based on a feeling'.

Recruitment and employment selection processes can be improved by ensuring that:

1. All applicants (staff and volunteers) who are short-listed for interview are asked if they have ever been a subject of an employer investigation or been charged as an adult with a criminal offence involving children, violence, drug dealing or dishonesty.[56]
2. The current employer or most recent prior employer of all applicants short-listed for interview are contacted for suitability and screening purposes. This is to be made clear to the applicant on short listing so that they are aware that it is a prerequisite of employment.[57]
3. A minimum of three reference checks should be conducted for all applicants (staff and volunteers) short-listed for interview. These should not be written refences. They should be directly contacted via phone. The results of these are to be documented, diligently evaluated and placed on file prior to any offer of employment (paid or voluntary) being made.[58]
4. Specific questions should be asked of the referee as to whether there was any conduct, disciplinary or performance issues identified with the person applying for the role.

The Royal Commission into Institutional Responses to Child Sexual Abuse further recommended that experienced persons familiar with relevant policies and interpreting the information provided by applicants should be the only ones engaging in recruitment process.[59] Recruitment staff should also be alert to signs of unusual attitudes about children, such as if applicants:

- talk about having 'special relationships' with children
- disagree with the need for rules about child protection
- think certain rules should not apply to them
- have a desire to work with children that seems focused on meeting their own psychological or emotional needs.[60]

In its submissions to the Review, the Office of the Advocate for Children and Young People highlighted the need to make employment screening more robust, suggesting that this should include behavioural interviews, reference checks and safeguarding declarations. This was also supported by the Halloran Morrissey Group who advised that:

> *Safer recruitment practices remain a weakness in the ECEC sector in our experience. HMG recently supported a centre in dealing with numerous complaints against an employee that were not clearly indicative of misconduct but were outside of the centre's expectations for how their staff engaged with children. When explored with the centre, leadership revealed that the recruitment process for this employee revealed him to be transient between centres, which they did not explore further with him. Previous employers also raised concerns about his general attitude and inability to follow the rules during referee checks, but this information was not considered through a safeguarding lens before appointing him.*

Standard five of Queensland Child Safe Standards requires that people working with children are suitable and supported to reflect child safety and wellbeing in practice. It requires organisations to have robust recruitment, training and ongoing support systems in place to ensure the suitability and preparedness of all personnel working with children to mitigate risks, reduce the potential for harm to occur and promote trust.[61]

Key steps for organisations to take to embed these standards include:

- implementing rigorous recruitment and screening processes, including reference checks and WWCCs
- developing and maintaining role-specific position descriptions that include children's safety and wellbeing responsibilities
- including cultural knowledge and lived experience as important values in role descriptions
- providing inductions and ongoing training on children's safety and wellbeing
- establishing clear supervision and performance management processes to monitor staff suitability and conduct, with specific reference to the Child Safe Standards
- fostering a workplace culture that prioritises children's safety and wellbeing through regular discussions and professional development opportunities
- implementing a safe and responsive mechanism for staff to report any concerns about the safety of children.[62]

Development of an educator register

In support of the need for increased visibility, and in response to community concerns about the safety of children in ECEC services, all state, territory and federal education ministers committed to implementing a National Educator Register. This includes a commitment by the federal government to invest up to $45 million to establish a new national register, which will provide regulators with clear oversight of who is working in the sector and where.[63] This will deliver on recommendations from the Child Safety Review.[64]

There was general consensus for this type of register in submissions received by the Board. For example, PeakCare supported the exploration of options for a national register of ECEC workers which has the capacity to share employment history, qualifications, and identify patterns of concerning behaviour. They propose that this would act as a key measure to counter the risks presented by the current high turnover of staff in the sector.

> *The early childhood education and care sector is characterised by high levels of casualisation and staff turnover, which impacts the robustness of recruitment, supervision and compliance processes. A register would provide an additional layer of assurance, particularly where services are managing frequent staffing changes.*

The agency responsible for one of the centres that the offender worked in also advised that it supported the establishment of a national employment register that outlines performance management issues and allegations or concerns which employers could access. It anticipates that this will assist with compliance checks and in identifying persons of concern. In its submission to the Review, Act for Kids called for a national standard of reportable thresholds:

> *If there was a national standard implemented to ensure all stakeholders working with children have a requirement to notify changes to a person's circumstances such as police convictions, suspicious behaviours, and employee issues, there would be a decreased risk of unsuitable individuals remaining in education and care settings.*

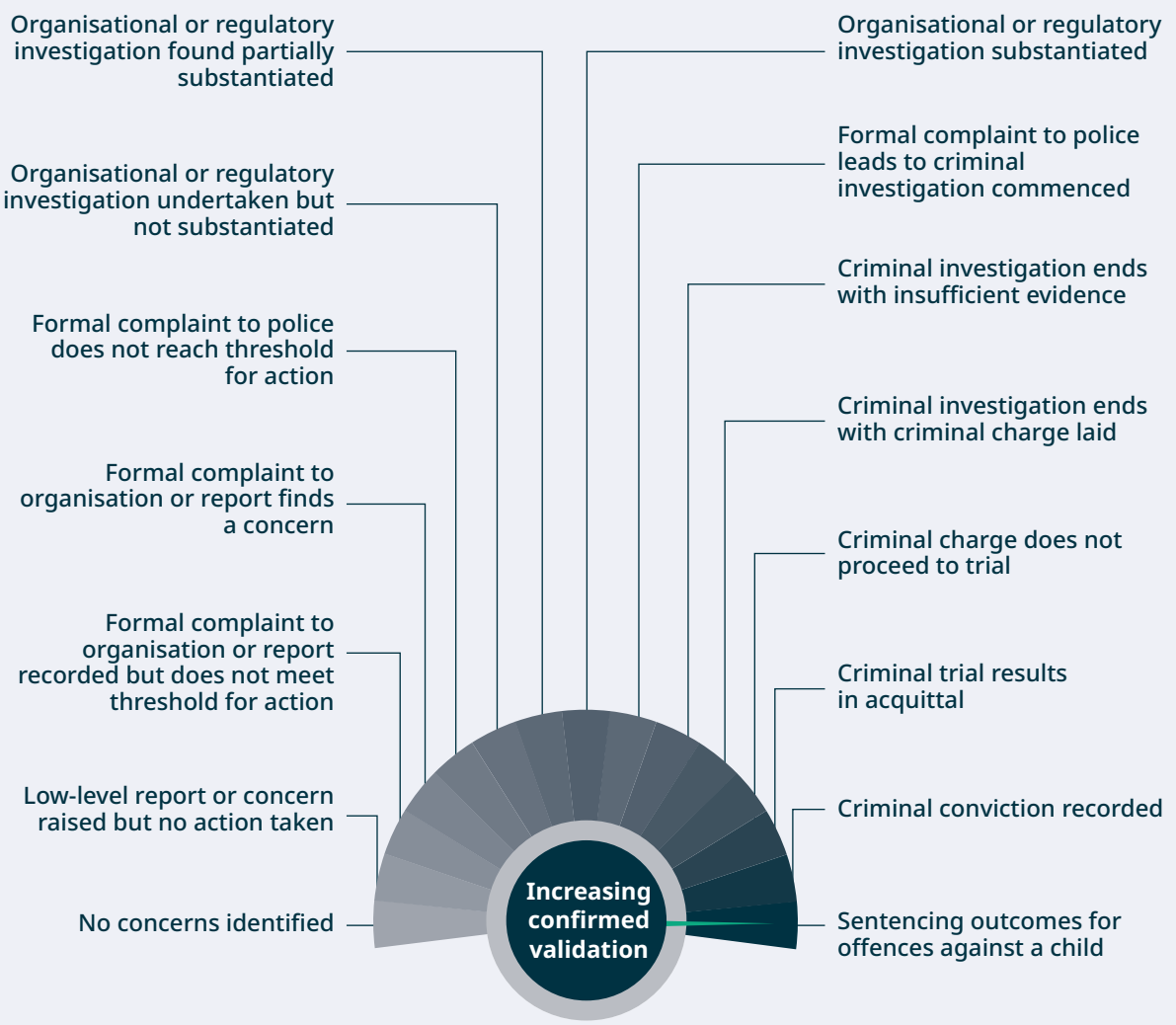
The challenge with any such register is how information included in the register should be used and operationalised. The Halloran Morrissey Group suggested that additional information about a person's disciplinary history and criminal investigations would be invaluable to employment screening assessment. They submit that:

> *This would allow organisations to understand all existing relevant information that they may not be aware of, and the factors taken into consideration by an employment screening agency that might mitigate risk, both of which can inform the employer's own holistic risk assessment based on its individual environment and risk profile. Such a statement in the case of [the offender] – which would include information about multiple workplace complaints and police intelligence – could have been disseminated to relevant organisations to inform their risk management strategies. The employer's threshold for risk might have been lower than Blue Card Services based on all the available information and subsequent risk assessment and this process would also facilitate transparency in employment screening processes. This could occur for first-time clearances where additional information exists but also on an ongoing basis where new information develops, triggering the questioning, suspension, or cancellation of a previous clearance. We acknowledge that privacy and procedural fairness considerations would apply to this suggestion.*

Consultations undertaken by the Board to inform this Review noted concerns with the type of information collated and included in the register, and whether it should extend to unsubstantiated notifications or disciplinary concerns. Concerns were raised about prospective employers having access to a person's past disciplinary history, particularly where notifications are included which may have been vexatious.

In the Boards' view organisations tasked with safeguarding children are better able to make sound decisions about who is permitted to work with children when they are given access to information across the full continuum of concern. At present, access is often limited to the most serious end of the spectrum—charges, convictions, and sentences. Yet, waiting until an individual is convicted of offences against a child represents the very point of failure the system seeks to prevent. Earlier information—such as substantiated or partially substantiated complaints, the existence or outcomes of regulatory investigations, or the fact that a disciplinary investigation commenced but ended for lack of evidence—can provide important signals about risk, even if they do not meet the criminal standard of proof. Of course, sharing information of this kind carries privacy implications for the individuals involved. There is a risk of reputational damage, employment consequences, and unfair prejudice where complaints are not substantiated. These risks must be acknowledged and carefully managed, however, they must also be weighed against the rights of children to grow up free from abuse and exploitation, and our moral obligation as adults, organisations, and governments to take every reasonable step to keep them safe.

Figure 3: Information and intelligence about an individual



Determining what information a regulator and organisation can access is critical to safeguarding children

> *In practical terms, providing organisations with richer intelligence enables more informed risk assessments, proportionate responses, and preventative decision-making about who is given responsibility for children. It does not require abandoning principles of fairness or privacy; rather, it requires a recalibration where the safety and wellbeing of children are given paramount consideration. In doing so, the system moves closer to its ultimate purpose: ensuring that those entrusted with the care and development of children are safe, suitable, and worthy of that trust.*

It is also critical to understand that increased monitoring or tracking of educators in one sector creates vulnerabilities in other areas that are less regulated. Motivated perpetrators move across roles, centres, sectors and in online environments to seek access to children. They may work as educators, volunteer with the local sports club, offer to babysit children and play online games as a hobby.

> *In Queensland it is well known, and publicly announced, that protections in early child care are increasing and hundreds of children under five are in unlicensed residential care homes where employment screening and qualification requirements are sub-optimal. I have grave fears that people who seek to abuse children may have already moved sectors.* - Luke Twyford

For this reason, consideration must be given to an expansion of the proposed educator register to other types of child-facing employment. The Halloran Morrissey Group submitted that:

> *We are of the firm view that employment screening is only one piece in the safeguarding puzzle and should not be relied upon as a sufficient proactive safeguarding strategy. Even the most sophisticated and robust employment screening process that encompasses psychometric testing, for example, is not guaranteed to prevent future harm against a vulnerable person.*

Similar themes also emerged in a study undertaken by Griffith University to inform the Board's understanding of best practice responses for the prevention of child sexual abuse, which highlighted the importance of creating a safeguarding-focused organisational culture. They noted that this should involve:

- improving recruitment through thorough reference checks, values-based interviews, and clear messaging on child safety
- regular training, supervision, and strong leadership which are key to building staff confidence in recognising, reporting and mitigating risks
- a clear code of conduct, robust safeguarding policies, and an environment that encourages reporting to help prevent abuse before it starts, address concerns early and ensure staff are held accountable.[65]

Transformational Recommendation 2: Preventing threats to children from entering the workforce

Perpetrators of child sexual abuse deliberately manipulate systems, groom colleagues, and exploit system weaknesses to avoid detection. In this case, the offender successfully concealed his past employment history, referee checks were not undertaken, and in several instances, he was simply let go or quietly asked not to return. This pattern strongly suggests that he was 'moved on' between employers without the risks he posed being properly addressed or recorded.

Queensland's new Child Safe Standards place a strong emphasis on ensuring that recruitment, induction, training, supervision, and management processes are designed to prevent unsuitable individuals from entering or remaining in positions of trust with children. This standard reflects the reality that the greatest risks to children often arise not from strangers, but from individuals who deliberately seek out access to children or who misuse the trust placed in them.

Organisations must move beyond compliance-based hiring and adopt robust, proactive recruitment systems that place safeguarding at the centre of all people-related decisions. Many inquiries have highlighted that individuals who pose risks to children are often able to secure positions of trust because recruitment processes are focused narrowly on technical skills, speed of hiring, or compliance with minimum requirements.[66] A child safe approach requires organisations to treat recruitment not as a transactional process, but as a critical opportunity to protect children from harm.

Effective child safe recruitment should begin at the earliest stage of workforce planning. Position design must clearly articulate child safeguarding responsibilities, the organisation's duty of care, and the behavioural expectations that apply to all staff and volunteers. This makes clear to prospective applicants that safeguarding is not peripheral to the role, but integral to its core functions.

The advertising and application process for a role must also be designed to screen for more than technical competence. Organisations should actively test a person's motivation to work with children, understanding of safeguarding principles, and respect for professional boundaries.

Structured interviews provide an essential opportunity to probe these issues further. Safeguarding-focused questions should be incorporated to assess values, attitudes, and an applicant's approach to managing boundaries. For example, applicants might be asked to describe how they would respond to a child's disclosure, or how they would ensure their interactions with children remain transparent and professional.

Reference checks must be rigorous and should never be treated as a box-ticking exercise. Organisations should conduct direct verbal conversations with referees, including probing questions about conduct, behaviour, and reasons for leaving previous roles. This practice can reveal crucial information about past safeguarding concerns that may not be evident on paper.

Verification of employment history is another critical safeguard. Too often, individuals who pose risks obscure or falsify their employment record to conceal past misconduct or disciplinary action. This practice, sometimes referred to as 'offender mobility', has been a recurrent issue in inquiry case studies. Systematic verification of previous roles, including through the use of educator registers, is essential to close this gap.

Finally, mandatory WWCC or equivalent clearances remain an important baseline requirement, but they should never be considered sufficient in isolation. While they can confirm whether a person has been formally barred from child related employment, they cannot provide any assurance about a person's suitability to work with children, attitudes, or conduct in practice.

A truly child safe recruitment system requires a mindset shift: from 'filling positions quickly' to 'safeguarding-first hiring'. Protecting children must outweigh organisational convenience or resourcing pressures.

Every hiring decision is, at its heart, a safeguarding decision.

Safeguarding training: Beyond recruitment

Recruitment is only the first step in protecting children. Organisations must recognise that ongoing education, reinforcement, and professional development are critical to embedding a robust safeguarding culture. All staff, volunteers, and contractors should receive comprehensive training that goes beyond compliance, equipping them to prevent, detect and respond to risks in real time.

Induction training must introduce the organisation's safeguarding policies, code of conduct, and clear procedures for reporting concerns. New workers should leave induction not only understanding the rules but also appreciating the organisation's commitment to creating a culture where child safety is a shared responsibility. They should feel empowered to raise concerns when they feel disquieted or uncomfortable about another colleague's behaviour or conduct towards children.

Those early warning indicators should never be viewed in isolation. They require all of us to be aware and to act.

Centres where there was known offending have themselves told the Board about the changes they have made to induction processes to strengthen their approach after the offending was detected. This includes by seeking to verify the credibility of referees where possible, increasing information about child safeguarding and reporting requirements, and strengthening probationary processes.

Scenario-based learning is also essential to translate policy into practice. By engaging with realistic examples, staff can develop the skills to recognise grooming behaviours, boundary violations, and early indicators of abuse. Such practical exercises foster critical thinking and situational awareness, helping staff respond confidently and appropriately when concerns arise.

Regular refresher training ensures that safeguarding knowledge remains current and responsive to emerging risks, particularly in areas such as online exploitation, social media, and digital peer-to-peer interactions. The digital environment evolves rapidly, and without ongoing education, staff may be unprepared to detect or intervene in these contexts.

Role-specific safeguarding training is necessary to ensure that responsibilities are clearly understood at all levels. Frontline staff require practical strategies for direct interaction with children, leaders and managers need guidance on supervising teams and modelling safe behaviours, and senior executives must understand their duty of care and accountability for organisational compliance and culture.

Embedding safeguarding into all training reinforces a culture where every individual not only understands what is prohibited but also actively contributes to safe environments for children. Effective training transforms policy into action, ensuring that safeguarding is integrated into day-to-day practices rather than treated as a static compliance obligation.

Protective leadership

Leadership plays a decisive and irreplaceable role in setting and sustaining a safeguarding culture. The conduct of boards, CEOs, and senior managers not only determines organisational priorities but also sends powerful signals to staff, volunteers, children, and families about whether child safety is truly valued. A safeguarding culture is not achieved through policies alone; it requires consistent modelling of child safe values, transparent decision-making, and accountability at every level of governance.

To embed a culture of safety, leaders must:

- ensure that their decisions and behaviours consistently reflect the priority of child safety over reputational protection, convenience, or cost
- set a tone that strongly influences how seriously staff treat child safety obligations
- be responsible for building and maintaining systems where reportable conduct processes and complaints handling are trusted, accessible, and transparent
- ensure children, families, staff, and the community have confidence that raising a concern will lead to a fair, timely, and protective response
- be accountable for ensuring recruitment, training, and people management practices meet child safe standards
- not delegate responsibility for creating a safe workforce. It must be actively maintained and monitored by those with governance authority.
- deliberately create environments where raising concerns is encouraged, and where those who speak up are protected from reprisal
- ensure whistleblower protections are both formal and cultural, meaning staff and children are safe to report concerns without fear of negative consequences.

Without strong and accountable leadership, even the most well-designed policies and procedures risk being undermined in practice. Conversely, when leadership sets a clear and consistent tone that child safety is non-negotiable, staff are empowered to act, risks are surfaced and managed early, and children are more likely to be protected.

This was canvassed by Act for Kids in its submission to the Review:

> *Child safeguarding is often viewed as an operational responsibility within ECEC services rather than as a strategic priority. In many organisations, responsibility for safeguarding is distributed across multiple roles, resulting in gaps, duplication, and confusion.*
>
> *Without designated safeguarding leads at the executive level, safeguarding systems can lack oversight, and cultural change efforts are often fragmented. Leadership teams may focus on compliance rather than proactively embedding child-centred practices.*

Safeguarding as a core element of performance management and supervision

Safeguarding cannot be treated as a compliance exercise or an optional addition to staff responsibilities. To be effective, it must be embedded into the daily management and supervision of all personnel who work with or around children. Performance management is a critical mechanism through which organisations set behavioural expectations, monitor adherence, and intervene when early warning signs arise.

- **Supervision and Monitoring:** Organisations should require regular supervision meetings where safeguarding is a standing agenda item. This provides an opportunity not only to check compliance but also to reinforce child safe values, discuss emerging risks, and address any challenges staff encounter in applying safeguarding practices. Supervision must be both administrative and relational, creating a space where concerns can be raised safely. For example, the Royal Commission found that in many institutions, staff were left unsupervised for long periods, or supervision was perfunctory, limited to performance on administrative duties.[67] As a result, early warning signs of grooming behaviours went unchallenged, and children remained exposed to risk.
- **Behavioural Expectations:** Clear behavioural rules are essential. Organisations must establish and document expectations such as limiting one-on-one, unsupervised contact with children, maintaining visibility when working with children, and ensuring staff understand that secrecy is incompatible with safe practice. Compliance should be monitored, not assumed. The Board identified multiple instances in this case study where abuse occurred precisely because such safeguards were absent.
- **Active Verification:** Observation and spot checks are necessary to ensure safeguarding standards are applied in practice. Child safe organisations recognise that policies are not self-executing; it is only through deliberate oversight that unsafe practices are exposed. For instance, 'pop-in' visits by supervisors to classrooms, dormitories, or recreation spaces send a clear signal that safeguarding vigilance is ongoing.

Perhaps most importantly, organisations must also act swiftly on early indicators of risk behaviours. Warning signs include:

- breaches of safeguarding rules (e.g. engaging with children without approval and seeking to reduce supervision and guardianship)
- reluctance to be supervised or refusal to follow child protection processes
- developing unusually close or secretive relationships with particular children.

Multiple inquiries have shown that these signals are often noticed by colleagues but not acted upon by management. In one school setting, a teacher's repeated boundary violations—staying late with children, giving gifts, ignoring reporting procedures—were tolerated for years until disclosure of abuse was made. By this stage, multiple children had been harmed.[68]

Safeguarding competencies must be a criterion for performance appraisal, promotion, and contract renewal. Staff who consistently demonstrate safe practices, adhere to reporting obligations, and model protective behaviours should be recognised and rewarded. Conversely, staff who fail to comply must face clear consequences, including removal from child-related roles where appropriate. This shift ensures that safeguarding is not seen as peripheral to core business but as a central competency upon which professional progression depends.

The absence of systematic safeguarding supervision has repeatedly contributed to environments where grooming and abuse were able to flourish unchecked. Without embedding safeguarding expectations into supervision, performance management, and promotion decisions, organisations risk treating child safety as optional rather than integral.

In centres where abuse occurred, services reinforced to the Board that they had made a myriad of changes to increase oversight and accountability in centres, including by strengthening audit processes through dual-layered approaches, where audits are conducted by both centre directors and area managers. Another service reported that they have a dedicated Safety and Compliance team to audit and improve safety measures, which has quadrupled in size since 2019, an incident reporting system and a whistleblower channel. Other changes implemented by services include multi-stage recruitment processes, reinforcement of reporting obligations, revised codes of conduct, regular critical reflection on organisational policies at staff meetings, and prohibiting staff from caring for children outside centres.

One service spoke to having a zero-tolerance policy for any behaviour that may pose a risk to the safety of children, which is reinforced through regular leadership communication and prompt investigation where concerns are raised.

While it is positive to note these changes, collectively they show that we can and must do more to prevent threats to children. A recurrent and deeply troubling finding across multiple inquiries into child sexual abuse, and ours, is the capacity of individuals who pose a risk to children to resurface in new organisations after being dismissed, investigated, or subject to safeguarding concerns. This phenomenon has been described in both Australian and international contexts, often referred to as 'passing the trash' or 'moving people on'. It has been repeatedly identified as a systemic weakness that enables perpetrators to continue accessing children, sometimes for years, despite earlier warning signs being known.

The drivers of this issue are complex. Organisations may be reluctant to confront allegations due to fear of reputational damage, potential legal liability, or the difficulty of substantiating suspicions in the absence of criminal conviction. In many cases, employers have opted for negotiated 'quiet exits'- allowing the individual to resign or providing bland references that omit safeguarding concerns - rather than escalating matters through formal channels. While convenient in the short term, this practice has been shown to be catastrophically harmful to children, as it places other organisations and communities at risk.

> *Lying by omissions or commissions or any other forms of deceit such as not admitting responsibility and accepting accountability filters, drips, drop by drop from the top of any system, organisation, corporation, business. Just because the left hand doesn't know what the right hand is doing, does not make the left hand innocent. The body of facts remains regardless.*

> *The Board noted that a fear of defamation and perceived legal risks to organisations and individuals is a deterrent to information sharing, which has flow on effects for the early detection of offending.*

To prevent this cycle, organisations must adopt clear and uncompromising policies that prioritise children's safety over institutional reputation or individual privacy. Key obligations include:

- **Documentation and Information Sharing:** All safeguarding concerns, whether substantiated or not, must be formally recorded and escalated to relevant regulatory authorities. In Queensland, this includes the Reportable Conduct Scheme (where applicable) and BCS. Proper documentation ensures that patterns of behaviour can be identified across time and settings, rather than being lost in fragmented or incomplete records.

- **Ending Quiet Exits:** Organisations must expressly prohibit 'quiet exits' where safeguarding concerns are ignored, minimised, or concealed. Providing neutral or misleading references is a breach of safeguarding duty. Employers must ensure that references are truthful and complete, including disclosure of any concerns about child safety that informed the individual's departure.
- **Zero Tolerance for Moving on Risk:** It must be organisational policy that moving on a person who presents safeguarding concerns is never acceptable. Instead, such matters must be confronted directly through disciplinary action, regulatory reporting, and, where appropriate, referral to law enforcement. By taking direct action, organisations not only protect the children in their own care but also prevent the broader community from unknowingly taking on that risk.
- **Regulatory and Leadership Accountability:** These obligations cannot be left solely to frontline managers. Boards, senior executives, and directors must set the tone and accept accountability for ensuring their organisations do not contribute to the displacement of risk. Regulatory frameworks must also require timely information-sharing across sectors and jurisdictions to prevent offenders from exploiting gaps in oversight.

Employing people that will care for children demands a strong, robust and holistic approach from recruitment, to induction, to ongoing management and leadership accountability.

Submitters to the Review argued that the corporate governance, and particularly the employment laws covering organisations, do too little to protect children. The Queensland Human Rights Commission said:

> *Every decision, policy, and law concerning children should be able to demonstrate that the child's best interests have been a primary consideration. Requiring that actions taken be in the 'best interests' of the child aims to ensure the full and effective enjoyment of all rights recognised in the Convention, and the holistic development of the child. The justification for this is the special situation of a child given their dependency, maturity, legal status and, often, voicelessness – if their interests are not highlighted, they can be overlooked.*

The ability of people who present a risk to children to move between organisations, often aided by employer silence or inaction, represents one of the gravest failures of safeguarding systems. Any practice that allows 'quiet exits' or conceals concerns about the safety of children undermines the integrity of child protection efforts and facilitates further abuse.

Organisations must understand that unsuitable individuals are often skilled at hiding their intent and manipulating systems. This requires safeguarding processes that are rigorous, multi-layered, and embedded into organisational culture, ensuring that children's safety is always the paramount consideration.

Transformational Recommendation 2: Preventing threats to children from entering the workforce

The Australian and Queensland governments:

- identify specific industries, such as early childcare, residential care, disability care, youth justice and boarding facilities, where they will legislate:
  - penalties for both employees and employers who do not record their employment in employee registers; and
  - penalties for employees, employers and referees for failing to disclose past employment history; concerns, complaints or investigations about the employee regarding harms or risks to children; or the reasons that employment ended
- amend the *Fair Work Act 2009* (Cth) and other industrial and workplace laws to provide explicit protection for employers who, in good faith and based on reasonable grounds, take adverse employment action (including suspension, role reassignment, or termination) due to concerns about a worker's potential risk to children.

Chapter 16

Recognising threats by integrating intelligence

Recognising threats by integrating intelligence

While it is important to focus our efforts on the identification of grooming and other indicators that someone poses a risk to children, there is a critical corresponding need to draw together patterns of behaviour over time and across institutions.

Robust recordkeeping practices and proactive information sharing is crucial to support the detection, disruption and prevention of child sexual abuse. While the Child Death Review Board (the Board) has been mindful of hindsight bias in the conduct of this Review, the timeline of offending discussed in Part B provides an opportunity to consider the totality of the information about the offenders' behaviour that was, or *should have been*, available to inform decision making at any point in time.

Recordkeeping practices

As so aptly highlighted by the Royal Commission into Institutional Responses to Child Sexual Abuse, poor records and record-keeping practices can:

> *inhibit good governance; contribute to inconsistent practices and loss of organisational memory; hinder identification of perpetrators, victims and survivors; delay or obstruct responses to risks, allegations and instances of child sexual abuse; prevent or frustrate disciplinary action, redress efforts, civil litigation and criminal proceedings.*[69]

In our review, consistent issues were identified with agency recordkeeping and retention practices across multiple centres meaning there were incomplete records with respect to the reasons why the offender was dismissed or let go.

Of the 19 centres where information was able to be requested via a section 29P request:

- One centre had closed down, with ownership transferred to a different entity, meaning records were no longer available.
- One centre held records, but they were in hard copy and had to be manually searched, which was not possible in the Review timeframe.
- Five centres provided records which were poor or inadequate and did not provide all details about the offender's employment or conduct at the centre.
- Four centres did not respond.

Only eight centres held records that were considered to be sufficiently robust to be able to develop a comprehensive picture of the offender's conduct in the workplace.

There were also concerns raised about the offender's documentation and recordkeeping practices in two centres that he worked in. A response to the Early Childhood Regulatory Authority's (ECRA) investigation by one centre alleges that the offender may have deleted or destroyed records prior to his departure from the centre, including some of the documents requested for ECRA's investigation. There are no further detail about why this was believed to be the case.

In some instances, parents and other staff reported that they had made complaints or raised concerns about the offender which were not documented in the available records. One centre advised the Board that some of the concerns raised by parents, including their unease about the offender and concerns about their daughter's clothing, did not in isolation meet the threshold for a reportable complaint under the National Law. As such, the centre was only legally required to retain records for three years under the National Regulations. There are also a lack of records about requests made by centre staff to the employment agency not to send the offender back to Centres WN and HN. Reasons provided for this by the centres of concern included:

- feeling uncomfortable around the offender, although unable to pinpoint why
- the offender being 'gruff', 'abrupt' and 'sharp' towards children
- the offender not following instructions to organise a game for children.

As the employment agency refused to provide records to inform the Board's review citing legal privilege, it cannot be confirmed what, if any, response they took in relation to the concerns raised by centre staff and indeed whether they were documented.

> ***According to staff at Centre WN, the employment agency staff member they spoke to 'was adamant that he [the offender] needed to work and she would send him out'.***

This occurred while he was subject to a report of sexual abuse made by a child.

Additional issues were also identified with how information was stored in agency databases, which impacted the capacity of any individual entity or the broader system to draw together patterns over time. This was most significantly seen with the Queensland Police Service (QPS), where the initial complaint about the offender in 2009 was not identified until after his arrest. Specifically, QPS recorded the complaint subject's name as 'Ashleigh' despite the initial complaint spelling it as 'Ashley'. Officers did not identify the offender as the subject of the complaint and subsequently did not link the complaint to him on QPRIME.

As part of Project Safeguard, further issues were identified with how ECRA recorded information in its systems, as complaints were not routinely linked to the person who was the subject of the complaint and were instead tied to the service. This reduced visibility of the offender when future complaints were made about him in different centres and impacted the capacity of ECRA staff to quickly identify what previous reports had previously been made about the offender.

During this Review, ECRA identified opportunities to strengthen information sharing arrangements with Blue Card Services (BCS) in circumstances where 'it reasonably believes the information is relevant to the functions of the Chief Executive (working with children).' ECRA submitted that this could be achieved by enacting similar provisions to those that currently exist under the *Disability Services Act 2006*. Proposed legislative amendments would ensure that there are provisions to share information with BCS, where there is insufficient evidence to prohibit a person from working in the early childhood education and care (ECEC) sector. It is understood that the agencies are working to explore the progression of these amendments.

The enduring challenge of information sharing

During our inquiry we heard examples of relevant information either not being shared, or not being shared in a timely and effective manner. This can have, and has had, serious consequences, including enabling perpetrators to continue their involvement in an institution or to move between institutions and jurisdictions and pose ongoing risks to children.

> *No single institution collects all the necessary information or has all the appropriate tools to adequately protect children in [child-facing] sectors, and so the information collected must be shared to ensure an effective response.*[70]

Sharing information in a timely and effective manner supports the health, wellbeing and safety of children.[71] All Australian jurisdictions have laws which allow information sharing relevant to children's safety and wellbeing.[72] There are no national standards or guidelines in Australia that outline best practice approaches to information sharing.[73] This means that there is no consistent or universal approach to information sharing, which impedes timely and effective information exchange.[74]

There were multiple issues identified in relation to information sharing across different entities in this case, including with respect to the renewal of the offender's blue card.

When the offender's blue card was due to expire in November 2010 while he was working at Centre OY, the available records show that BCS sent notifications to the offender reminding him of the expiry date. The legislation at the time meant the centre was responsible for applying for a new blue card. Information provided by BCS stated that:

> *During this time, BCS sent notifications to the individual advising of the upcoming expiry of their blue card. The BCS practice of reminding individuals of the pending expiry of their card has continued to date and now includes at least four reminders to the individual prior to expiry. In addition, organisations who use the organisational portal are able to monitor renewal dates through the portal.*

There is no information to indicate Centre OY was notified of the upcoming expiry and the fact that the offender could not legally continue to work at the centre without a valid blue card. Notably, as there were no pending investigations, charges or convictions against the offender at this time, he would have met all requirements to obtain and maintain a blue card on this occasion. The requirement for organisations to monitor renewal dates through a portal appears unnecessarily onerous for smaller centres, and it is unclear whether notifications are proactively sent to organisations to advise them of upcoming blue card expiry dates for staff.

Following the internal investigation undertaken by Centre EA in 2021, ECRA requested a copy of the findings from the centre. While the final outcome of the investigation was provided to ECRA, the full report was not. Centre EA also did not proactively provide a full copy of this report or details of the offender's concerning behaviour to QPS. This meant that valuable information about the offender's conduct which may have prompted a different response by agencies was not shared.

After a report was made while the offender was working at Centre WN in 2022, QPS spoke to the nominated supervisor and interviewed the child complainant before closing the case with no further action. They did not share these details with ECRA. While ECRA followed up with QPS three weeks later about the outcome of the investigation, they received no response from the QPS. ECRA then followed up with Centre WN another three weeks later and were subsequently informed by this centre that the case had been closed and QPS did not intend to investigate. The matter was subsequently closed by ECRA based on the outcome of the QPS investigation. In both of these investigations, the sharing of information following the detection of the offender's behaviour was ad hoc and fragmented.

Challenges with information sharing between AFP and QPS were also identified in the investigation into the CEM uploaded by Zimble. While there have been ongoing improvements since this time, the AFP advised the Board that the QPS were the lead agency for Operation Zimble and that it did not have any involvement in this investigation, as it was instead focused on the identification of the victims in the CEM that had been uploaded by Zimble and 'at that stage, there was no regular exchange of information between the two investigating agencies.

A system requirement to share

Legislated information sharing arrangements exist in the ECEC, police and blue card systems to guide what information *may* and *must* be shared with other agencies (Table 2). From time to time, these arrangements are supplemented by memoranda of understanding between agencies, which seek to operationalise information sharing practices and ensure that all staff are aware of their obligations.

Table 2: Existing information sharing arrangements in the ECEC, blue card and police system

Entity	Information sharing restrictions and ability
Early childhood education and care (ECEC) services	Providers of ECEC services are required under the Education and Care Services National Law and Regulations to share information with ECRA proactively through notifications and upon request. ECRA has broad powers to request and if needed, require that information relating to the operation of a service be provided to its authorised officers. The National Quality Framework (NQF) also requires a range of documents, such as illness and injury records, to be shared with parents upon request. Outside of this, approved providers must ensure that records are kept confidential and not divulged or communicated, directly or indirectly, to another person other than in prescribed circumstances such as to a parent of the child to whom the information relates. Similarly, providers have a legislative requirement to notify BCS of certain information regarding their employees. For example, providers must notify BCS when they employ a person.[75]
Early Childhood Regulatory Authority (ECRA)	Information about ECEC services and educators held by the regulator can be shared with other government agencies, for a prescribed purpose, such as if it is reasonably necessary to promote the objectives of the NQF. Information regarding an individual can only be shared if it sits in one of the exceptions in the legislation such as the disclosure is authorised or required by a law of a participating jurisdiction or is otherwise required or permitted by law. ECRA must notify BCS when a prohibition notice or prescribed disciplinary action such as suspension of a provider approval is issued.
Queensland College of Teachers (QCT)	Information held by QCT regarding an applicant or an approved teacher may only be shared with other entities under provisions in chapter 11, part 1 of the *Education (Queensland College of Teachers) Act 2005*. The type of information which may be shared largely relates to criminal history screening information, details of charges or convictions reported by police, and interstate teacher registration information.

Entity	Information sharing restrictions and ability
Blue Card Services (BCS)	BCS can share confidential information with other agencies under certain circumstances. This includes for the purpose of performing a function under another law, such as monitoring compliance with the NQF. BCS must notify prescribed parties such as ECRA, the Department of Education and employers if: • a person identified as working in a school or in the ECEC sector has their blue card suspended, cancelled or is issued with a negative notice • there is a change in police information for a person who is identified as working in a school or in the ECEC sector. BCS can gather information from other entities, such as police and disciplinary information, in limited circumstances.
Queensland Police Service (QPS) and Australian Federal Police (AFP)	QPS shares information every 24 hours with BCS if changes to the police information of a blue card holder are detected. This includes new charges, convictions, or changes to child protection reporting obligations. National police information is coordinated by the AFP under the National Police Certificate system, and provided to QPS upon request (for example, for a Working with Children Check (WWCC) assessment). The AFP coordinates the sharing of information with state and territory policing agencies through cooperative bodies such as the Australian Centre to Counter Child Exploitation (ACCCE) and the Australia-New Zealand Counter-Terrorism Committee. As discussed in more detail in Chapter 12, an MOU has now been established between the AFP and BCS due to issues identified with the timely sharing of information between the two entities following the offender's arrest.

In addition to these specific regimes, overarching provisions exist allowing and, in some cases, requiring that information be shared between agencies. For example:

- Under the *Child Protection Act 1999,* prescribed bodies such as the Department of Education and the police *may* share information about suspected harm or risk of harm to a child with each other if there is a reasonable belief the information may help the recipient.[76]
- Under the *Criminal Code 1899,* if agencies receive information that leads their employees on reasonable grounds to believe that that a child sexual offence is being or has been committed against a child by another adult they *must* notify QPS unless they have a reasonable excuse not to.[77]

While current legislation is intended to facilitate information sharing between agencies, regulatory frameworks, practices and mechanisms operating in isolation can result in failures to share in a timely and effective manner, leading to serious consequences for children.[78] As highlighted in community submissions to this Review:

> *Explicit and clearly defined legislation aids interpretation and application of safeguarding principles, limiting hesitation and confusion that can lead to under- or over-reporting, both of which compromise child safety. In our experience, robust, transparent, clearly (and consistently) interpretable enshrined information sharing provisions that clearly permit organisations to share information in the general interests of children's safety, welfare and wellbeing are critical to supporting the safeguarding of vulnerable people. Such legislation needs to be all encompassing to prevent misinterpretation and gaps in practice.*[79]
>
> Information about risks, incidents and inappropriate conduct is currently held across numerous departments and organisations. Without an adequate reporting scheme or information sharing mechanism, this information cannot be considered and acted upon in its completeness, enabling perpetrators to continue abusing children across different institutions, sectors and jurisdictions.

> *Each scheme and program has its separate information sharing and privacy protections – but they were designed for each scheme, not for the big picture. When you step out and look at the bigger picture we still preference privacy over child protection.* - Interstate Reportable Conduct Scheme Manager

A system for information-exchange and access

Irrespective of the legislative requirement or authorising environment that exists to enable information sharing it ultimately comes down to decisions made by individuals, often under pressure and with constrained resources. In any such situation, this requires a person to be able to:

- identify that they hold information that needs to be shared
- understand that they have a responsibility or requirement to share information
- know how to share information, and who to.

Too often, this falls short of the stated ideal.

> *Every major review into child protection or child abuse in recent decades has pointed to the same failing: the system repeatedly missed opportunities to share information that could have prevented harm. Despite the enduring clarity of this finding, we have failed to resolve the problem.*

Too often, children have suffered because agencies have operated in silos, holding fragments of information that, if brought together, would have revealed patterns of risk and prompted timely intervention.

The persistence of this issue is not the result of ignorance—it reflects the way our legal and policy frameworks have been designed. Lawyers and policymakers have historically constructed information-sharing schemes around transactional models of 'request' and 'provide'. These mechanisms assume that information is neat, discrete, and readily retrievable, and that frontline workers have the time and clarity to formulate precise requests and then await responses. This approach profoundly misunderstands both the fragmented nature of information gathered by agencies and the realities of frontline practice. Information about risk is dispersed across agencies, systems, and formats. Frontline workers are often operating under intense time pressures, and the digital environment has fundamentally reshaped how information flows.

In today's context, transactional information request–response models are not only inefficient—they are unsafe. They perpetuate delay, duplication, and blind spots. What is needed instead is a fundamental shift toward systems of information exchange and access.

- **Information exchange** recognises that relevant information must flow proactively and automatically between agencies, not merely in response to requests.
- **Information access** means that authorised practitioners should be able to view, in real time and subject to safeguards, the relevant information already held across the system.

Such an approach reflects the realities of the digital world, reducing burdens on frontline staff, and creates a more complete picture of risk. Until this shift occurs, reviews will continue to identify the same 'missed opportunities', and children will continue to bear the consequences of a system that has been too slow to adapt.

Public submissions to the Board expressed strong support for improving information sharing, collection and analysis, including as part of the implementation of a reportable conduct scheme in Queensland:

> *The benefit of the Reportable Conduct Scheme is that it enables a broader range of behaviours to be reported than those that meet the threshold for mandatory reporting. It is recognised that educators in ECEC services and teachers in schools are already captured as mandatory reporters, however the reportable conduct scheme will still be of benefit because it enables behaviour that may not meet the threshold for mandatory reporting to still be identified, reported, documented and provides an overview of collective behaviour and experiences which may give cause for further examination about someone's suitability and blue card status.*
>
> *The current system which enables potential perpetrators to evade detection by moving between jurisdictions has created an unhelpful loophole for potential criminals. Furthermore, there is no proactive sharing of information regarding "a person of suspect" between jurisdictions, regulators and service providers. As a transition measure towards a National Working With Children Check, consideration could be given to sharing databases across jurisdictions so that when one jurisdiction does a search on an individual, they in effect a searching a national database to see if any issues have been raised in relation to the individual's WWCC in another jurisdiction.*
> - Lutheran Education Queensland

Sharing and combining information in a database across departments and organisations has significant benefits including:

- providing a clearer picture of the risks posed to children
- ensuring cases and behaviours that fall below evidentiary thresholds are captured and properly considered
- enabling pattern recognition to better identify grooming and ongoing abuse indicators and monitor or prohibit individuals deemed to be a risk to children
- providing opportunities for learning and improvement in the sector
- reducing the burden on and re-traumatisation of children through repeated interviews and statements during complaint investigations.[80]

Information sharing in the best interests of the child

The Board heard from consultants with experience in the delivery of child protection and safeguarding reform in the private and public sector who submitted that information sharing is a critical element of an effective safeguarding system:

> *In our experience, robust, transparent, clearly (and consistently) interpretable enshrined information sharing provisions that clearly permit organisations to share information in the general interests of children's safety, welfare and wellbeing are critical to supporting the safeguarding of vulnerable people.* - Halloran Morrissey Group

Organisations have a responsibility to ensure that all workers are equipped to share information, and to have structures and processes in place to facilitate this information exchange. In all cases where the information relates to a person who poses a potential risk to a child, decision making should operate in the best interests of a child.

The Queensland Government *Interagency guidelines for responding to sexual assault or child sexual abuse* (the Guidelines) set out the 'roles, high-level procedures, and shared principles' for how government entities are to respond to allegations of sexual violence against adults and children.[81] They apply to police, health, justice, youth justice, and child safety authorities but do not apply to schools or ECEC services. This is because they are intended to apply to only those agencies who have a specific role in the immediate response to people who have experienced sexual assault or child sexual abuse.

The Guidelines state that agencies should work collaboratively to coordinate the sharing of information to reduce the need for a child victim-survivor to share their story multiple times and require agencies to develop systems for sharing 'authorised information' with others.[82] They otherwise provide very little guidance on information exchange and the management of concerns around privacy and confidentiality.

Multiple submissions received by the Board called for strengthened practices to facilitate information sharing and provide greater clarification of what information can be shared under different legislative instruments. Lutheran Education Queensland called for proactive information sharing which is facilitated by the sharing of databases across jurisdictions, regulators and service providers. This would mean that if issues have been raised in one jurisdiction, it is known across all states and territories. This helps to close a loophole currently exploited by perpetrators, who may move across jurisdictions to continue their offending.

The Australian Childhood Foundation also highlighted the need for statutory guidance to help sector organisations and individuals understand responsibilities, thresholds, expectations, and requirements for information sharing, intervention, and proactive risk management stating that:

> *Queensland is well placed to lead in this area by producing detailed guidance for its own context, building on the Child Safe Standards and making clear how agencies and organisations should work together to keep children safe.*

In the United Kingdom (UK), the government issues 'statutory guidance' which agencies, employers, and individuals are required to comply with. This particularly applies to the social services sector. Statutory guidance, such as *Working Together to Safeguard Children 2023*, applies, in its entirety, to all education providers,[83] and childcare settings who have minimal authority to deviate from it.[84] This is a type of subordinate legislation unique to the UK and runs contrary to Australian and Queensland legislative practice. However, given the level of confusion and regulatory fatigue around information sharing and reporting which has identified throughout the Review, it may provide a useful model for the development of (non-binding) guidance by the Queensland Government.

What does best practice in information sharing look like?

- There is an oversight body which can enhance accountability, ensure organisations meet their obligations and provide additional safeguards.
- There is multi-agency cooperation which provides clarity around information-sharing access and practices.
- It should involve interjurisdictional cooperation and alignment in terms of best practice standards and processes.
- There should be training, support and guidance for those who will use the scheme.
- Mandatory periodic and comprehensive evaluations of its operation to ensure ongoing improvement of systems and it is effective in safeguarding children.[85]

Delays in implementation of a national information sharing scheme

Issues have also been identified with interjurisdictional information sharing arrangements, which are often reliant on informal cooperation and lack national alignment. These types of gaps can allow critical information to fall through the cracks and ensures that perpetrators are able to exploit jurisdictional differences to avoid detection and continue to pose a risk to children.[86]

International approaches to safeguarding children in ECEC settings provide valuable insights for strengthening regulatory safeguards in Australia. The Board heard of several leading international models, each demonstrating best practice in key areas such as worker screening, information sharing, and multi-agency collaboration. For example, the Australian Institute of Family Studies advised us that:

> *The United Kingdom's Disclosure and Barring Service (DBS) allows for greater discretion in information disclosure for high-risk professions. The UK system is further strengthened by the integration of Local Authority Designated Officers (LADOs), who coordinate investigations and facilitate information sharing among agencies. At the community level, Local Safeguarding Partnerships bring together ECEC organisations with other agencies, creating a coordinated and consistent approach towards safeguarding children.*[87]

and:

> *Ireland's Garda Vetting system addresses a critical gap by requiring overseas criminal record checks for applicants who have lived abroad. The Irish system, like the UK' s DBS, also considers a wide range of information, including police investigations and allegations to comprehensively assess suitability for working with children.*[88]

In its final report, the Royal Commission found that all Australian jurisdictions actively weighted decision making towards privacy and confidentiality when considering the merits of sharing information related to children and, combined with confusion about the scope of exemptions and obligations to adhere with privacy and human rights principles, this led to barriers to the sharing of critical information.[89] For this reason, the Royal Commission recommended the introduction of a national information sharing scheme to facilitate and mandate the exchange of certain information between government and private sector entities, within and between jurisdictions, for the purposes of protecting the safety of children.

> *Nothing is more important than children's welfare. Every child deserves to grow up in a safe, stable, and loving home. Children who need help and protection deserve high quality and effective support. This requires individuals, agencies, and organisations to be clear about their own and each other's roles and responsibilities, and how they work together.*[90]

To date, the recommendations of the Royal Commission have not yet been implemented. In November 2023, a Ministerial Forum on Child Safety met to discuss a coordinated response to the recommendations of the Royal Commission which have yet to be implemented, and declared that national consistency was required to progress this work:

> *This included… options to enhance sharing child safety and wellbeing information across sectors and jurisdictions. These options include possible legislation and administrative arrangements for an information sharing scheme as recommended by the Royal Commission into Institutional Response to Child Sexual Abuse.*[91]

Progress towards implementation has been sporadic and remains siloed, however there have been some developments which are discussed extensively in Part A of this report. For example, WWCC systems continue to improve in their interconnectedness, with the expansion of the National Reference Scheme and piloting of a National Continuous Checking Capability to share critical employment screening intelligence across borders. Additionally, the introduction of a Reportable Conduct Scheme in Queensland, alongside similar schemes in other jurisdictions, should ideally increase the visibility of sub-threshold indicators or persons of concern between regulators and other relevant entities to ensure this information is captured and shared where appropriate and necessary.

Throughout the reform process, we must be mindful that while information sharing schemes are carefully designed to ensure they are effective, they may still fail in practice. For example, in Victoria a comprehensive Child Information Sharing Scheme (the Scheme) operates under Part 6A and 7A of the *Child Wellbeing and Safety Act 2005*. This is intended to enable the sharing of information between organisations in the best interests of children and overrides other provisions in law that would inhibit this. However, the Scheme did not facilitate reportable conduct information being shared proactively with WWCC authorities in a recent high-profile matter.[92] As a result the Victorian *Rapid Child Safety Review* recommended that the Reportable Conduct Scheme and WWCC systems be brought together.

Regulatory frameworks, practices and mechanisms operating in isolation can mean that information is not shared in a timely and effective manner, leading to serious consequences for children.[93] Information about risks, incidents and inappropriate conduct is currently held across numerous departments and organisations. Without an adequate reporting scheme or information sharing mechanism this intelligence cannot be considered and acted upon in its completeness, enabling perpetrators to continue abusing children across different institutions, sectors and jurisdictions.[94]

More must be done in Queensland and throughout Australia. There remains no clear path to the sharing of reportable conduct information between jurisdictions, whether by Reportable Conduct Scheme regulators themselves or via other existing interconnected agencies. Privacy and industrial law issues continue to present barriers to private organisations sharing information between each other. There are opportunities for improved coordination and harmonisation between systems to prevent perpetrators from moving undetected within and between workplaces, industries, and jurisdictions.

Building a picture of risk, abuse and harm

Organisational and system structures that support the earlier identification of people who pose a risk of harm to children are critical. This has been a persistent issue identified in a multitude of previous reviews and inquiries, and one that has again been laid bare in this Review.

> *[A] multilayered approach is actually really quite crucial, and I think ensuring that you have systems speaking to one another is absolutely vital... A lot of the time, information sharing is probably the biggest inhibitor to child protection.*

For example, an independent analysis of case reviews of child sexual abuse in the UK from between 2017 and 2023 identified the following system weaknesses:

- **A lack of effective coordination or handover between services:** which highlights the need for clear and concise processes, transparent communication, supportive and trusting relationships and increased follow-ups and updates across agencies.[95]
- **A lack of understanding about where to refer risks:** professionals lacked an understanding of who to refer relevant information to, to ensure that risks were identified. In some cases, notifications were not made to relevant authorities.[96]
- **An absence of universal information sharing standards**: professionals were restricted by a lack of a centralised or standardised information sharing platform or system. Communication issues were also encountered with incompatible agency systems which highlighted the importance of a universally compatible system to achieve best practice information sharing.[97]
- **Lack of staff training or awareness:** privacy and data protection was prioritised above the sharing of safeguarding information because data protection legislation was often misinterpreted by staff.[98]

A lack of independent oversight in most jurisdictions limits system wide responses and means that critical information is not centrally coordinated and shared across relevant entities. Independent oversight can also help to address conflicts of interests when organisations investigate their own staff.[99]

For this reason, we need a conceptual shift. This is not just information, it is intelligence that can be used to build a picture of threats to children by persons of concern over time and across systems.

> *Potential intelligence on the alleged offender, their family, and their work history is siloed and disconnected rendering it almost useless in the identification of repeated concerning behaviours, dismissals, reports, warnings and all other WWC Balance of Probability suitability assessments.* - Hetty Johnston

In submissions received by the Board, the Advocate for Children and Young People New South Wales proposed the development of protocols for 'non-criminal' risk management which empower agencies to act on patterns of concern even where criminal thresholds are not met. This could include harmful behaviour to self and others, and other 'anti-social' conduct.

After the offender was detected, the external review of the policing response by the QPS found that more needs to be done to develop investigative methodologies and systems that connect disparate information sources to better identify escalating risk. Recommendations from the external review highlighted the importance of thinking differently about how information is collated, stored, used and understood within and across different agencies. This includes the need for:

- police officers to be empowered to consider a series of incidents holistically rather than individually
- the continued development of partnerships between QPS, AFP and other entities, that leverage technological advancements to enhance data access, storage, collation and search capabilities
- enhanced operating environments to more quickly develop intelligence so that evidentiary thresholds are reached more efficiently
- identifying and addressing existing barriers to all aspects of information collection, enhancement and sharing.

The UK provides an example of a cross-agency database that permits the sharing of information about an individual without their consent if it is necessary to prevent abuse or harm.[100] This system is supported by the formation of Local Safeguarding Partnerships between agencies that require the provision of specified information to enable safeguarding of children in the area.[101]

Risk identification and assessment

The review received significant critiques of current protections:

> *While WWCC are a key part of keeping people who pose a risk to children out of child-focused settings, they are only able to restrict people who have previously been charged or convicted for an offence, or where relevant and concerning information has been provided to BCS which provides significant grounds to refuse a blue card.*
>
> *Strengthened recruitment screening strategies, induction and probationary processes are only effective if workers receive high-quality training on how to recognise, respond and report child sexual abuse, and to identify grooming and other problematic behaviours.*
>
> *Interagency collaboration is hindered by workforce turnover, as well as structural barriers that may impact information sharing where people or situations of concern are identified. This is particularly the case where there is insufficient evidence to substantiate a report of abuse to the requisite threshold due to a lack of evidence.*

What this Review makes clear is that we must fundamentally change our approach to safeguarding and develop an integrated approach across our systems that weaves together different information into a cohesive whole. This includes early warning indicators, problematic behaviour, disciplinary information, transiency in employment and complaints from children, families or others.

> *Recent alarming cases of child sexual abuse in ECEC are a critical reminder: the capacity of any one safeguarding mechanism or scheme to protect children in high-risk child related settings is, in isolation, limited.*[102]

We must also be able to analyse and act on this information swiftly and in a way that prioritises the safety of children and keeps people who pose a risk to our children out of our systems.

In submissions to the Review, Jesuit Social Services highlighted the importance of drawing on current research by the University of New South Wales to strengthen approaches to the detection and investigation of child sexual abuse, including to inform risk assessments and build perpetrator profiles. The Office of the Advocate for Children and Young People New South Wales also called for the expansion of risk assessment criteria to include behavioural indicators, patterns of concerns and unsubstantiated but credible complaints.

The Queensland Sexual Assault Network (QSAN) raised further concerns that grooming will not meet the criteria for reportable conduct under the new Reportable Conduct Scheme, and that they consider it is essential to include boundary transgressions that fall short of the defined 'sexual misconduct' or 'sexual offence' as per the definitions in the existing Act.

In Queensland, as part of the response by agencies after the offending was detected, both BCS and the Department of Education have advised that they are seeking to strengthen their processes through the developed and use of a risk analysis tool.

ECRA has advised that a Manipulation Process Assessment model is being developed by researchers at the Griffith Criminology Institute, which is due for completion in late 2025. The intention is to develop a tiered assessment model to guide decision-makers in interpreting and responding to allegations of 'sexual misconduct' within ECEC services. It is being developed using offender-based data and is informed by learnings from investigations into perpetrators, as well as other notifications of child sexual abuse that have been made to ECRA.

Three key evidence sources are being used to support the development of this framework:

- **Behavioural data:** analysis of the frequency and patterns of over 150 manipulative behaviours used by people who have sexually abused children in child serving organisations.
- **Victim-survivor and perpetrator characteristics**: a consideration of the characteristics of children targeted, perpetrator preferences and the types of relationships and sexual contact established.
- **Recent case evidence**: integration of findings from contemporary cases of 'sexual misconduct' in ECEC settings to ensure the model reflects current risks and tactics.

ECRA anticipates that this framework will:

- refine and structure decision-making by offering clear tiers of risk, ranging from 'low-concern' behaviours through to high-risk indicators of grooming and predatory intent
- integrate international research on offender patterns with local case studies to ensure that the model is both 'globally informed and contextually relevant' to ECEC settings
- provide consistency and transparency in the interpretation of notifications and reduce subjectivity and variation in regulatory or organisational responses
- support 'proportional responses' to ensure that regulatory interventions, investigations or prohibitions are aligned with 'the severity and evidentiary strength' of the reported conduct
- seek to align with existing child safe frameworks including the *National Principles for Child Safe Organisations* and the *Child Safe Organisations Act 2024*.

The model is also intended to be shared with other jurisdictional ECEC regulators, to foster consistency, strengthen safeguarding practices and provide an innovative approach to the safety of children in the ECEC sector.

The Department of Justice have further advised that they have contracted the same researchers to deliver a synthesis of offender-based research on people in youth serving organisations and develop an analysis tool based on this research. This tool has now been deployed, with training delivered to staff in May 2025. It is being used by BCS where behaviours of concern by adults towards children in youth serving organisations are identified during the risk assessment process.

> *…this tool will form an important part of the risk assessment process* ***where behaviours of concern by applicants engaged in child-related activities have been identified may not have resulted in charges or convictions for any offences****. It will assist BCS to make evidence-based findings* ***about behaviours of concern which do not reach a criminal threshold****, which in turn will ensure the risk assessment process in these cases is robust and informed.*

This tool and supporting research is intended to be used by BCS to conduct risk assessments for people seeking to work with children in regulated activities. In response to a request for a copy of the analysis tool to inform this Review, the Department of Justice advised that they would prefer not to provide the tool as they had received advice from law enforcement entities against sharing of the information. This is on the basis that access to the tool should be restricted as it provides an insight into the conduct of perpetrators of child sexual abuse, and its release may lead to misuse by perpetrators and diminishes its effectiveness.

They sought to further clarify that the tool is intended for use by assessing officers where an applicant or cardholder:

> *…is suspected of, or identified to have, exhibited inappropriate behaviour towards children in a setting that provides services directed at children, which is suggestive of child sexual abuse or manipulative behaviours, and which has not resulted in criminal charges. It assists officers to identify behaviours and patterns of behaviours, which on their own may not be sufficient to determine or establish that a person poses a risk to the safety of children, but when considered alongside offender-based research may support the issue of a negative notice in the absence of a substantiated finding against the person.*

It is understood that information about these behaviours of concern will be gathered by BCS from existing information it is provided with, namely a person's child protection, domestic and family violence or disciplinary history. As there were no known concerns about the offender with respect to a history of domestic and family violence or child protection concerns, it is considered unlikely that this tool, in practice, would have enabled the earlier detection of the offender by BCS.

This is because information still needs to be available to BCS to make this type of assessment, and there are limited provisions through which it can request information, and no mechanism through which information can be compelled from other agencies to support an assessment.

In an internal brief provided by the Department of Justice (dated 3 August 2023) reference was made to previous recommendations by the Queensland Family and Child Commission in its *Recommendation 28 supplementary review* that had yet to be implemented. This relates to a recommendation to provide QPS with the authority to share information about a suspect with BCS while an investigation is being finalised. Specifically the internal departmental brief notes that:

- *This is based on a review of police investigations involving blue card holders undertaken by the QPS which determined that the sharing of suspect information was unlikely to mitigate risks to children. This is because QPS advised that a person is usually informed they are a suspect on the same day the person is arrested and charged. In those limited cases in which there is a delay between a person becoming a suspect and being charged, risk management strategies are employed by the QPS to limit risks to children during the finalization of the investigation.*
- *QPS has developed a formalised policy which has been included in its Operational Procedures Manual to provide officers with a consistent approach for identifying and managing risks to children during an investigation…*
- *Further, while it is possible for the QPS to provide "investigative information" (as defined in paragraph 32) to BCS under the Working with Children (Risk Management and Screening) Act 2000, this can only occur in very strictly defined circumstances where a range of specific criteria are met…Given this high threshold, investigative information is shared in very rare circumstances by the QPS.*

It has also been well established that perpetrators share information about how to target children, how to create opportunities for abuse to occur, and how to prevent detection. They discuss this in online forums and through networks. Perpetrators work in our institutions, and in child-serving roles. When we train staff and seek to strengthen safeguarding practices, including through the use of risk assessment tools, it is a fundamental reality that some of the people who have access to that training and frameworks may have a sexual interest in or sexually abuse children. They will also use this knowledge to circumvent these institutional safeguards and use them to their advantage to prevent detection.

For example, the offender is known to have completed training in child safe standards, and to have worked within these safeguards. This includes when making a report about a female educator at the centre he was a Director at in late 2021. He was later convicted for offences against the child complainant and disclosed that the child may have been confused about the identity of the teacher the complaint was about.

Additionally, when community concerns were raised on Facebook in the centre that he was a director at, the offender assured parents that all staff held a blue card and completed child protection training to allay their concerns. Importantly:

> *…a Blue Card simply confirms that an individual does not have a known criminal conviction at the time of application. This can provide a deceptive feeling of safety for employers and families, because it cannot account for undetected offending, concerning behaviours, or the potential for future harm.*[103]

Understanding what risks can and cannot be assessed

It is almost impossible to predict if someone could potentially sexually abuse a child. This is particularly the case for people who abuse children who have not been detected for their offending, as most predictive risk factors are based on known past offending. Self-reporting biases also impact the quality and accuracy of the information used to inform a risk assessment process, if the information being relied upon is predominantly provided by a potential perpetrator.

For these reasons, when considering the development or use of any risk analysis or decision-making tool, it is important to be clear on what 'risk' is being assessed, how it will be managed or mitigated, and the limitations of any such approach. Risk assessment processes are largely dependent on the availability and accuracy of the information used to inform the assessment. An overreliance on perpetrator self-reports or a lack of known offending can mean that someone who poses a risk to children will not be identified through existing tools.

There is no typical profile of a perpetrator and their behaviours can change over time.[104]

Comprehensive sex offender risk assessment tools do exist, however they need to be completed by trained individuals who have experience in working with the relevant population, such as forensic clinicians and specialist corrective services officers. Although there are a range of actuarial risk assessment tools for sexual offenders, these have only been validated for use within the criminal justice system to manage convicted adult male sex offenders.[105] These include:

- **Risk Matrix 2000:** this tool was developed to assist in the management and supervision of sex offenders and is a statistically derived risk classification process used for assessing the risk of sexual recidivism among men aged over 18 years.[106]
- **Static-99R:** this is an actuarial risk assessment tool designed to evaluate the risk of sexual re-offending in men with a history of sexual offending.[107]
- **STABLE-2007:** this is an interview and desk-top review instrument designed to assess sexual recidivism factors which are potentially changeable in men.[108]
- **Sex Offender Risk Appraisal Guide (SORAG):** this actuarial scale is designed to predict violent, sexual recidivism among men who have committed at least one previous contact sexual offence.[109]

These tools all consider static and dynamic risk factors (such as criminal history, age and victim characteristics) and make predictions about re-offending.[110] Non-actuarial risk assessment approaches also exist where a clinician considers person-specific risk factors and makes a structured professional judgment.[111] Although these have some benefits by taking into account changing risk factors, they are open to clinician error and misinterpretation.[112]

Importantly, for a risk assessment tool to be effective it requires:

- training to ensure that those trained are able to interpret the results, which often comes with a monetary cost
- time to gather the necessary information
- in most cases, time to interview the person.[113]

There are currently no known validated risk assessment tools to assist in the early identification of persons with a sexual interest in children who do not have a relevant criminal justice system history. There are also no risk assessment tools developed for use with convicted female sex offenders.[114] As very little is known about those perpetrators who have not been caught there are some fundamental distortions in the tools and frameworks that are created to detect and disrupt any perceived threat.

Most studies are based on those perpetrators who have been caught, who are arguably less skilled at concealing their actions, who have left clearer evidence, and who have operated in a way that made detection more likely. This may result in an over-representation of certain offender types, an underestimation of institutional grooming, misleading risk profiles and system blindness which enables perpetrators to continue to hide in plain sight.

Transformational Recommendation 3: Create a Child Safeguarding Intelligence Hub: Enhancing early detection through integrated reporting and analysis

Child safeguarding remains one of the most critical challenges confronting society today. Despite significant progress in legislative reforms, regulatory oversight, and public awareness, children continue to be vulnerable to harm from perpetrators who seek to exploit or abuse them.

A major difficulty in prevention is that many concerning behaviours or risk indicators remain 'sub-threshold' - that is, they do not meet criteria for formal police investigation or action but nonetheless signal potential future risk. Moreover, reports and intelligence about such behaviours are often fragmented across agencies, organisations, and jurisdictions, limiting the capacity to connect dots and identify patterns early.

These threads leave a trail to an unseen threat, but it is currently no organisations role to systematically collect, follow or analyse these threads to identify any patterns and build a picture of harm.

The Board received contemporary submissions that continued to show the threshold issues, with one ECEC provider telling us:

> *There is increasing awareness among families, communities and early childhood professionals about the critical importance of identifying and reporting suspected grooming. It is generally understood that such concerns should be reported to the Queensland Police Service (QPS). However, [we] have encountered significant confusion and inconsistency during the reporting process, with referrals often redirected between QPS and the Department of Child Safety (Child Safety), Seniors and Disability Services, with each agency deferring responsibility to the other.*

> *A recent case illustrates this issue. Our organisation reported suspected grooming to QPS, supported by evidence consistent with multiple indicators of grooming behaviour. QPS declined to act on the report, advising that it must first be submitted to Child Safety. We then referred the matter to Child Safety. After three weeks, Child Safety responded that, because the matter involved an employee, it fell outside their remit and should be directed to QPS. When this was communicated back to QPS, they advised the report did not meet the threshold for investigation and referred the matter back to us to investigate.*

This lack of clarity around reporting thresholds, inter-agency communication, and agency responsibilities creates serious gaps in the system.

To ensure suspected grooming behaviour is consistently addressed, urgent improvements are required:

- *Improved training for frontline QPS and Child Safety officers on grooming indicators, thresholds for action, and inter-agency responsibilities.*
- *Clear, consistent and enforceable inter-agency protocols that outline which authority leads in various scenarios and ensure no report is dismissed or redirected without accountability.*

> *Without clear pathways and strong inter-agency coordination, organisations like [us] are placed in an untenable position, responsible for protecting children but unable to access the necessary system levers to act on serious concerns. Closing these gaps must be a priority if we are to effectively detect and respond to grooming behaviours and prevent child sexual abuse in Queensland.* - Anonymous ECEC provider, submission.

When the Board reviewed the evidence from the case study alongside broader research, it became clear that Queensland children face a tangible and serious threat. People within our communities are operating with motivations and intentions that are both profoundly harmful and deliberately hidden from view. In considering key challenges faced by the different systems under review, we noted:

1. **a limited ability to detect offending until significant harm has already occurred**
2. **perpetrators who are skilled at blending into everyday life, and who work together to remain hidden and cause harm**
3. **siloed law enforcement and reactive regulatory and justice responses**
4. **a community often uncertain about what to look for, and consequently how to protect itself.**

These observations naturally led us to draw parallels with, and examine, Australia's counter-terrorism framework following 9/11. This policy response demonstrated how proactive information sharing, investment in public awareness, and integrated operational approaches can improve early detection and intervention before harm occurs.

People who develop urges to harm children and those who develop urges to commit violent or extremist attacks may appear to inhabit vastly different domains of criminality. Yet, closer examination reveals striking similarities in how these behaviours form, are reinforced, and ultimately manifest as threats to society.

Both often begin in isolation, with people experiencing urges or beliefs that they may initially recognise as deviant or dangerous.

Over time, they seek validation and reinforcement, frequently finding it in online spaces where anonymity provides both safety and community. In these environments, harmful interests can be normalised, nurtured, and amplified. Within these digital communities, grooming and mutual encouragement play central roles. Just as extremist recruiters cultivate belonging and escalate commitment, people with sexual interests in children may groom newcomers by framing their urges as acceptable, inevitable, or misunderstood.

Both contexts provide training: for extremist groups, this may involve operational planning, tactical knowledge, and ideological reinforcement; for perpetrators against children, it may include sharing techniques to avoid detection, methods of grooming victims, or trading illegal child exploitation material.

In both cases, peer-to-peer reinforcement erodes inhibitions, emboldens participants, and increases the likelihood that deviant fantasies escalate to action.

The parallels extend further in terms of societal risk. Unlike many other crimes, where the primary harm may be limited, both child sexual abuse and extremist violence represent harms that reverberate across entire communities. They generate profound fear, trauma, and destabilisation. This scale of harm means that traditional reactive models of justice, i.e. waiting for an offence to be committed before intervening, is inadequate. The stakes are too high, the consequences too devastating, and the costs of failure too great.

For these reasons, society carries a heightened responsibility to detect threats before criminal acts occur. Just as intelligence and counter-terrorism agencies work proactively to identify signs of radicalisation or plots before they are realised, state governments can invest in child safeguarding systems that build mechanisms to detect grooming, identify emerging risk behaviours, and pinpoint concerning online activity.

This analogy underscores a critical principle: protection, in these contexts, is not a discretionary policy choice but a moral and practical necessity. It recognises that the significance of the harm - not just its likelihood - demands intervention at the earliest possible stage.

How Australia responded to the threat of terrorism

Following the attacks of 11 September 2001, Australia developed one of the most extensive counter-terrorism legal frameworks in the democratic world. Before 2001, Australia had no dedicated national counter-terrorism statutes. In the years following 2001, the Commonwealth Parliament enacted more than 90 federal counter-terrorism laws creating new offences, broadened investigative and intelligence powers, and established governance structures for information sharing across jurisdictions.

> *This transformation shifted Australia from a reactive, prosecution-driven model to a preventative, intelligence-led framework - one that allows authorities to act on suspicion and disrupt threats before they materialise.*

Australia's approach to counter-terrorism included:

1. **New laws that marked departure from traditional criminal justice principles and practices and that prioritised the mitigation of potential harm over the establishment of legal culpability:** In the ordinary criminal law framework, investigative powers are tightly constrained: authorities typically require reasonable suspicion and judicial authorisation before conducting searches, surveillance, or other intrusive actions. By contrast, counter-terrorism legislation allows agencies to intervene earlier, enabling pre-emptive action based on intelligence rather than confirmed criminal activity.[115]
2. **The adoption of a whole-of-community approach, that framing terrorism prevention as a civil responsibility:** The National Security Hotline was launched in December 2002 and became a key conduit for public reporting of suspicious activity. Calls to the hotline reportedly generated actionable intelligence and increased public confidence in counter-terrorism measures.[116] At the same time, campaigns encouraged vigilance with messages akin to 'If you see something, say something' and 'Be Alert but not Alarmed'. Awareness raising messages were deployed through television, radio, print, and online media, as well as on posters in public transport hubs and airports.
3. **The focus of criminal law became inherently preventative with new offences targeted on actions taken before 'traditional' offending occurred:** These laws criminalised preparatory acts, associations, and certain forms of travel. Intelligence-led operations sought to identify threats before they manifested as actual crimes, reflecting a fundamental shift in the balance between individual rights and collective safety.
4. **Enhanced powers of information sharing, information access and retention included lead roles for a multi-agency intelligence system:** The 2015 regime obliges telecommunications providers to store metadata—information about communications, not their content—for two years and enabled law enforcement agencies to access this data without a warrant in many cases.[117] This was a major departure from the warrant-based access model used in most ordinary criminal investigations. The Australian Criminal Intelligence Commission was established to facilitate the real-time exchange of intelligence between federal, state, and territory agencies, including biometrics, criminal histories, and operational intelligence.[118] This capacity surpasses the case-by-case information sharing common in non-terrorism criminal law. Joint Counter-Terrorism Teams were resourced to bring together the AFP, Australian Security Intelligence Organisation (ASIO), and state/territory police to integrate intelligence and coordinate operations, allowing for rapid detection and disruption of threats.[119]
5. **Central leadership:** The Department of Home Affairs (Centre for Counter-Terrorism Coordination) was established to set whole-of-government policy and coordinate the National Counter-Terrorism Plan. This architecture emphasised centralised threat assessment, interagency tasking, and a high degree of operational collaboration where necessary.[120]

The above elements highlight a distinct difference to our current approach to protecting children from suspected abuse and child safeguarding. Australia's legal, strategic and policy framework for preventing and detecting child sexual abuse can largely be characterised by:

- **Diffuse funding across portfolios:** Funding for child sexual abuse prevention and response is distributed across multiple Commonwealth and state portfolios, including social services, education, health, justice, and policing. This model supports cross-sectoral collaboration by embedding safeguarding responsibilities into the everyday work of frontline systems that interact with children. However, it also creates challenges: transparency is reduced, it is difficult to aggregate the total level of investment, and coordination across diverse funding streams can be complex. This stands in contrast to counter-terrorism, which benefits from clear, centralised budget allocations to national security agencies, enabling sharper accountability and visibility.

- **Largely reactive system:** Child sexual abuse responses tend to occur after harm has already been alleged or identified. Law enforcement and regulators require sufficient evidence before proceeding, meaning intervention often comes late in the abuse trajectory. While this reactive orientation reflects the criminal justice and child protection frameworks within which these agencies operate, it also highlights a gap in proactive detection and disruption. Transparency and therapeutic needs for victim-survivors dominate, ensuring open processes, mandatory reporting, and trauma-informed practice. Counter-terrorism, by contrast, is explicitly proactive, with intelligence agencies tasked with identifying and neutralising threats before they manifest.
- **Fragmented and multi-jurisdictional structures:** The governance of child sexual abuse responses is inherently fragmented across states, territories, and the Commonwealth. Responsibilities are divided among child welfare agencies, schools, health systems, police, courts, and social services. This dispersal is necessary because safeguarding children requires multiple layers of intervention, but it also complicates coordination, slows responses, and risks duplication or gaps. Counter-terrorism, by contrast, is highly centralised, with Commonwealth agencies holding clear primacy and state police playing defined operational roles.
- **No analogue in the child protection domain:** By design, child protection frameworks lack covert intelligence powers. Instead, transparency, due process, and therapeutic support for victim-survivors is prioritised. Investigations are conducted within the bounds of criminal procedure. The emphasis is on responding to children, supporting survivors, and holding institutions accountable, rather than intelligence collection, threat disruption and harm minimisation. This creates a markedly different operational and ethical environment from national security work, and one which is largely failing to keep perpetrators visible and held them to account.

Noting this difference, there is, in the view of the Board, mutual learning potential between the two fields:

1. **Rapid, child-centred radicalisation/exploitation vectors.** Both violent-extremism prevention and sexual abuse prevention are grappling with younger cohorts being accelerated toward harm via the internet, social media and gaming platforms where children are targeted. These platforms also provide access to pornography, sexting, sextortion, and violent videos or imagery. This demands age-appropriate prevention, education and industry design changes.
2. **Data and capability pressures.** Rising volumes of online material and the technical sophistication of both extremists and perpetrators of child sexual abuse place pressure on digital-forensic, analytic and victim-survivor support capacity. Both sectors need scalable digital triage and cross-sector case management.
3. **Online platforms and industry cooperation.** Both prevention agendas hinge on rapid, substantive cooperation from global platforms. The *Online Safety Act 2021* gives Australia leverage in the child-safety domain; counter-terrorism also requires content takedowns and platform action. Recent public criticism of platform responsiveness by the eSafety Commissioner highlights common frustrations with the operation of these powers in practice.[121]

Table 3: Comparison table of Australia's counter-terrorism prevention efforts and its child sexual abuse prevention efforts

Dimension	Counter-terrorism prevention	Child sexual abuse prevention	Gaps / weaknesses in child sexual abuse response in comparison
National strategy	Comprehensive national Counter-Terrorism and Violent Extremism Strategy 2025, endorsed by all states and territories, with clear prevention, detection, and response pillars.	No single, unified national child sexual abuse prevention strategy covering all forms of abuse (online, contact, institutional, familial) with consistent state/territory buy-in. While there is a National Strategy to Prevent and Reduce Child Sexual Abuse responses are fragmented with notable delays in the implementation of key actions recommended by the Royal Commission.	Lack of a whole-of-government, whole-of-society national strategy endorsed and implemented across all jurisdictions.

Dimension	Counter-terrorism prevention	Child sexual abuse prevention	Gaps / weaknesses in child sexual abuse response in comparison
Dedicated legislation	Multiple federal laws (e.g. *Criminal Code Act 1995* Part 5.3), clear offence definitions, and prevention powers (e.g. control orders, preventative detention, passport cancellation).	Criminal laws exist at state/territory and federal level but focus mainly on post-offence prosecution. Preventative powers are narrow, siloed and unclear.	No equivalent pre-offence legal framework enabling early intervention before harm occurs.
Funding commitment	Record $106.2 million over four years for prevention initiatives under the Counter-Terrorism and Violence Extremism Strategy, plus ongoing security agency budgets in the billions.[122]	While there was a Commonwealth investment of $307.5 million for the first phase of implementing the National Strategy to Prevent and Respond to Child Sexual Abuse, funding for child sexual abuse prevention is relatively small and inconsistent; significant resourcing goes to crisis response and prosecution rather than upstream prevention.[123]	No sustained, ring-fenced prevention budget at comparable scale; heavy reliance on short-term grants provided to community organisations or other institutions, which are tied to specific funding requirements.
Prevention programs	National Support and Intervention Program, Step Together referral line, industry partnerships to detect and disrupt radicalisation, education sector involvement.	Ad-hoc programs run by non-government organisations (NGOs), limited early intervention services, no universal school education programs, online safety largely led by eSafety Commissioner without a unified prevention pathway.	No coordinated early-intervention referral system (like Step Together) for suspected child sexual abuse risk. Weaker integration of health, education, police, and community services.
Inter-agency coordination	High-level coordination through the Australia-New Zealand Counter-Terrorism Committee. Clear federal-state operational frameworks.	Multiple disconnected forums (police taskforces, eSafety Office, Standing Council of Attorneys-General, Education Ministers), but no standing inter-jurisdictional governance body solely focused on child sexual abuse or child safeguarding.	Absence of a permanent, formal national coordination mechanism with equivalent authority and accountability.
Intelligence and threat detection	ASIO, AFP, and state police have dedicated intelligence commands with legislative powers to collect and share information pre-offence.	Child sexual abuse detection relies on police cybercrime units, ACCCE, and individual reports from victim-survivors, NGOs, regulatory authorities or other entities. Intelligence sharing and threat detection powers are more limited and fragmented.	Fewer dedicated intelligence resources; limited capacity for proactive identification before offences occur.

Dimension	Counter-terrorism prevention	Child sexual abuse prevention	Gaps / weaknesses in child sexual abuse response in comparison
Community reporting pathways	National Security Hotline for public reports (24/7, anonymous, triaged to relevant agencies).	Reports made via police, Crime Stoppers, ACCCE online reporting tool or other entities. There is no single nationwide 24/7 public hotline for child sexual abuse prevention and early concern reporting.	Lack of a widely recognised, centralised, and promoted child sexual abuse prevention and reporting hotline.
Industry engagement	Strong engagement with technology platforms, finance sector, transport, and critical infrastructure to detect extremist activity. Legislative obligations to report suspicious material.	Engagement with tech sector through eSafety Commissioner and AFP but limited in other industries. Legislative duties for most industries are minimal, although they do exist for technology platforms. Child facing organisations have particular obligations that they must comply with under the CSO Act.	Weaker cross-industry mobilisation. While there are some obligations imposed these are not equivalent to counter-terrorism industry partnerships in breadth or enforcement.
Public education	National campaigns on radicalisation signs, 'Escape. Hide. Tell' armed attacker advice, online safety for gaming communities.	Public awareness campaigns are smaller, sporadic, and often issue-specific (e.g. ThinkUKnow, Stop It Now!). They are not continuous or nationally branded.	No long-term, consistent, high-visibility national public education campaign on child sexual abuse comparable to terrorism messaging.
Youth involvement	Youth and Mental Health Advisory Group informing policy, with direct investment to ensure youth perspectives in prevention.	Some youth consultation through NGOs and online safety programs but not embedded in government prevention planning.	No formal youth advisory mechanism consistently feeding into state, territory and national child sexual abuse prevention policy.
International partnerships	Active in Five Eyes intelligence sharing, United Nations counter-terrorism forums, and bilateral partnerships.	Australia participates in global child sexual abuse policing initiatives (e.g. INTERPOL, WeProtect Global Alliance), but partnerships are narrower in scope and lower profile.	Less political prominence and strategic weight given to child sexual abuse in international forums.
Evaluation and accountability	National strategies have defined measures of success, annual reporting, and parliamentary oversight.	Evaluation of child sexual abuse initiatives is inconsistent, fragmented, and often internal to agencies and levels of government.	System fragmentation and lack of transparent, national performance reporting against prevention goals.

To address these challenges, it is proposed that the Queensland Government establish a Child Safeguarding Intelligence Hub - a centralised, multidisciplinary intelligence unit that collects, analyses, and acts on sub-threshold indicators of concern about individuals working with or near children. By providing an accessible reporting pathway for parents, co-workers, and others, integrating intelligence techniques with law enforcement and regulatory information from entities like BCS and ECRA, and fostering collaboration across sector regulators, the Child Safeguarding Intelligence Hub could become a transformative tool for protecting children.

> *Someone needs to take leadership and ownership for the holistic assessment of risk. We see time and time again the thresholds of police and regulators being different, the purposes being divergent. There is a huge gap – and who actually steps in and puts it all together.* - Interstate Reportable Conduct Scheme manager

This is not a unique proposal. The *Review of Child Safety Arrangements* in 2023 by Australian Children's Education and Care Quality Authority (ACECQA) recommended the establishment of a national centralised mechanism which appropriately records and shares national intelligence between authorised entities to more effectively monitor and respond to suspected or alleged misconduct, including unsubstantiated notifications.[124] It also recommended the adoption of a risk-based approach that does not wait for an offence to occur, and gives precedence to a child's right to safety, while maintaining procedural fairness principles by including the right of reply to the person of concern.[125] Over the longer term this mechanism could link to WWCC, and applicable teacher or educator registers.

The Victorian *Rapid Child Safety Review* in 2025 also recommended that its Reportable Conduct Scheme and WWCC systems be brought together with a new information and intelligence capability:[126]

> *To support these changes to the Working with Children Check and Reportable Conduct schemes, a new Shared Intelligence and Risk Assessment Capability must be established. That is, information and intelligence currently held in multiple places must come together. Staff must be resourced with the necessary expertise and evidence-based tools to make sound judgements around the level of risk an individual poses to a child, and provide that information to relevant decision makers so that they can act swiftly.*[127]

Submissions received by the Board also highlight the need for a centralisation of function. For example, the Halloran Morrissey Group submitted that:

> *Given the possible risks and harms associated with child-related employment, workplace investigations with a lower standard of proof are essential in safeguarding vulnerable people in organisations tasked with their care when conducted well. An RCS [Reportable Conduct Scheme] oversight body is also well placed to 'connect the dots' between notifications to identify patterns in alleged conduct that can be shared with relevant agencies to inform risk assessments and evidentiary considerations in workplace investigations such as tendency and propensity. Our view is that one agency governing the various safeguarding schemes (employment screening, RCS, child safe standards) is the ideal and most streamlined arrangement from the perspective of organisations needing to comply with the schemes.*

The implementation of a reportable conduct scheme in Queensland provides a critical opportunity to reflect on what type of cross-agency intelligence gathering and analysis capacity is needed to develop our systems of detection and disruption. Interviews with managers from interstate reportable conduct and WWCC schemes highlighted that:

> *We could do a whole lot more with data – with so many players we see risk shifting. The time bomb of information passes for the wrong reasons - Interstate Reportable Conduct Scheme manager*

The need for an intelligence hub in child safeguarding

Traditional child protection and policing frameworks rely heavily on threshold-based interventions—where clear evidence or allegations of harm trigger investigation and action. However, many indicators of potential risk appear as subtle or ambiguous behaviours, such as inappropriate comments, boundary testing, unexplained changes in behaviour, transient employment or repeated minor complaints. These sub-threshold indicators are often dismissed or unresolved because they do not meet criteria for formal action or there is insufficient evidence to substantiate that something had occurred. Research and expert consensus increasingly recognises that the early detection of these indicators is essential to prevent abuse and to remove threats. For instance, patterns of minor misconduct, when aggregated, can reveal grooming behaviour or unsafe individuals.

It can also show attempts by an offender to reduce guardianship and create opportunities for abuse to occur, by testing the strength of an organisations approach to safeguarding. The Australian Institute of Family Studies (AIFS) research conducted for the Board found that:

> *The evidence suggests that regulatory frameworks, mechanisms and bodies are most effective at safeguarding against CSA [child sexual abuse] when operating as a network, rather than as isolated entities. It is important for such a network to share common goals, language, practices and learnings to ensure consistency when sharing information or when implementing reporting schemes, policies and protocols. One potential feature of this may be a uniform information sharing database, which could provide critical insights that help safeguard against CSA* [child sexual abuse].[128]

Yet, there is currently no formal mechanism to collect, analyse, and act on these signals across agencies, sectors and regulatory bodies. Concerns about people working with children are reported through various channels: to human resource teams in individual agencies, regulators (such as blue card or WWCC systems), complaints mechanisms, and informal communications among co-workers or parents. These sources often operate in isolation, creating information silos. As a result, critical pieces of intelligence fail to be connected or escalated. For example, a person may receive informal complaints in one workplace, have concerning behaviour reported to a regulator in another, and show troubling social media or online activity elsewhere—but none of this information is linked to reveal an emerging risk. Without integrated intelligence sharing and analysis, these fragmented concerns remain invisible at a systemic level. As articulated in one interjurisdictional consultation session:

> *As a former police officer I never knew these schemes existed. I never turned my mind to the reporting of suspicious people working with children to a body outside of the police system. The relationships between police intelligence systems is critical to child safeguarding.* - Interstate police officer

The concept of intelligence-led safeguarding builds on established policing and security models where multiple information sources are integrated, analysed, and used proactively to detect threats before harm occurs. An intelligence hub dedicated to child safeguarding would adopt such a model—collecting a broad spectrum of concerns, applying analytical techniques to identify risk patterns, and enabling coordinated responses.

Core Functions of the Child Safeguarding Intelligence Hub

The Child Safeguarding Intelligence Hub would serve multiple critical functions designed to overcome current gaps and enhance the safeguarding system's effectiveness:

- **Integration of existing regulatory and organisational data:** The hub would link with existing regulatory systems databases, capturing data on approvals, suspensions, investigations, and complaints. This would include:
    - BCS
    - ECRA
    - Disability Services
    - Reportable Conduct Scheme
    - Child Safe Standards
    - Vulnerable persons employee registers and regulatory information
- **Cross-organisational intelligence sharing:** Legislation will enable information sharing with schools, childcare providers, sports clubs, and other child-related organisations with relevant behavioural and disciplinary information securely and confidentially. Strict data governance frameworks would ensure the hub complies with ethical standards and procedural fairness requirements, maintains the confidentiality of reports and safeguards individuals' rights to information privacy to the extent that it does not jeopardise the safety of children.
- **Centralised collection of sub-threshold reports through an accessible reporting portal**: The hub would provide an easy-to-use, confidential online platform where parents, co-workers, volunteers, educators, and others can report concerns or behaviours that may not meet formal thresholds but warrant attention. This would include observations, feelings of discomfort, minor incidents, and contextual information. To maximise accessibility, the hub would support reports via telephone, email, and potentially in-person support for those needing assistance.
- **Feedback mechanisms:** Reporters would be provided with appropriate feedback and support, reinforcing trust and encouraging ongoing reporting. Public education and training programs would accompany the hub's launch to encourage a culture of vigilance and transparency among communities and organisations.
- **Analytical risk assessment and intelligence techniques*:*** Using advanced data analytics and machine learning, the hub would identify patterns of behaviour or connections between reports that suggest escalating risk or grooming behaviour. Risk scoring models would prioritise individuals and cases for further assessment or intervention, ensuring resources focus on the highest risk profiles. Analysts would consider contextual factors such as organisational culture, previous employment history, and environmental stressors to interpret data accurately.
- **Coordination, referral and multi-agency collaboration:** The hub would operate as a coordination centre, sharing relevant intelligence with child protection services, law enforcement, regulatory bodies, and organisational safeguarding leads. Clear protocols would guide referrals for further investigation, support services, or regulatory action based on risk assessments.
- **Continuous learning and reporting:** The hub would produce regular intelligence reports on emerging safeguarding trends, risk hotspots, and systemic issues to inform policy and practice. Insights from the hub would underpin workforce training and resource development to improve frontline detection and response and strengthen workforce and sector capability.

By capturing and analysing sub-threshold concerns, the hub will enable earlier identification of people who pose a risk to children, potentially before harm occurs or escalates. This proactive approach enhances prevention and the safety of children. Key benefits would include:

- **Enhanced accountability and transparency:** Providing a formal, centralised reporting mechanism for concerns creates a culture of accountability. Staff, parents, and community members gain confidence that their concerns are heard and addressed appropriately.
- **Breaking down silos and improving information sharing:** The hub facilitates integrated intelligence sharing across agencies and organisations, overcoming traditional barriers that limit systemic risk detection.
- **Better regulatory oversight and decision-making:** Access to rich, integrated intelligence supports regulators in making more informed decisions about worker suitability, license suspension, or investigation prioritisation.
- **Increased community trust and engagement:** Transparent communication and visible action reinforce community trust in child safeguarding systems and encourage greater reporting and vigilance.

- **Systemic insights for policy and practice:** Aggregated data and analysis provide valuable insights into emerging risks, systemic weaknesses, and effective interventions, informing continuous improvement in child safeguarding policies.

> *Our schemes have an inherent reliance on other schemes to do their bit. And when one doesn't do it correctly the butterfly effect touches all the other schemes.* - Interstate police officer

Operationalising the Intelligence Hub

The design and implementation of a Child Safeguarding Intelligence Hub would represent a critical evolution in protecting children from harm. By providing a centralised, integrated, and proactive platform to collect and analyse sub-threshold indicators and other concerns, the hub would overcome the current system fragmentation that hinders early detection of risk and improve the visibility of potential threats. Accessible reporting avenues for parents, co-workers, and communities empower those closest to children to contribute to safeguarding efforts.

Integrating intelligence methodologies with regulatory systems such as the blue card and reportable conduct schemes will enhance oversight and decision making, while coordinated referrals ensure that concerns translate into timely, effective action. The hub would foster a culture of vigilance, accountability, and transparency that is essential for preventing child abuse and exploitation.

The establishment of a Child Safeguarding Intelligence Hub will require a clear and deliberate investment in infrastructure, capital expenditure on information and communication technology capability, and the recruitment of dedicated specialist staff. A secure digital platform will be needed to integrate data from multiple schemes, support real-time data exchange and access, and ensure compliance with strict privacy and security requirements. Specialist analysts, data scientists, and safeguarding professionals will also be essential to interpret and operationalise the intelligence, ensuring it translates into practical prevention and protection measures.

While these costs are not insignificant, they must be understood in the context of the current system's inefficiencies. At present, multiple parallel schemes—such as working with children checks, reportable conduct, professional registration, and various regulatory databases—operate in isolation, each with its own infrastructure, staffing, and administrative burden. This duplication generates cost without delivering a coherent or complete safeguarding picture. By bringing these schemes together in a single intelligence hub, government can reduce overlap, streamline processes, and create a platform that not only enhances the safety of children but also delivers long-term efficiency gains.

In this sense, the investment in a Child Safeguarding Intelligence Hub should not be seen as an additional cost layered on top of existing systems. Rather, it represents a rational consolidation; an opportunity to reallocate resources currently dispersed across fragmented schemes, while at the same time building the capacity required to meet contemporary and future safeguarding challenges. The efficiencies created will, over time, offset the initial capital expenditure, while the improvements in system performance and the reduction in harm to children provide benefits that cannot be measured in financial terms alone.

Ultimately, investing in such an intelligence hub aligns with best practice in public safety and child safeguarding, and offers significant benefits to children, families, and communities by identifying and responding to risks before harm occurs.

In progressing such an integrated intelligence function, the Queensland Government should consider the following design principles.

Table 4: Design Principles for the Child Safeguarding Intelligence Hub

Domain	Key elements
Governance and leadership	Established under statutory or government authority with clear legislative mandate and independence to ensure credibility. Guided by a multidisciplinary advisory board including child safeguarding experts, law enforcement, regulators, community representatives, and legal experts.

Domain	Key elements
Technology infrastructure	Secure, user-friendly digital platform to facilitate reporting, data integration, and analytics. Interoperability with regulatory databases and organisational systems via application programming interfaces and data-sharing agreements. Robust cybersecurity to protect sensitive information.
Workforce and expertise	Skilled analysts trained in behavioural risk assessment, data analytics, and child safeguarding. Dedicated liaison officers to coordinate with organisations, regulators, and law enforcement. Training and support staff to assist reporters and stakeholders in using the system.
Legal and ethical frameworks	Privacy, data protection, and human rights safeguards embedded in operations. Clear policies on data retention, access, and reporting thresholds. Ethical oversight committees to ensure procedural fairness and due process.
Community and organisational engagement	Partnerships with schools, childcare services, sports clubs, and community groups. Education campaigns to promote the hub and clarify reporting responsibilities and protections. Feedback loops to engage communities in continuous improvement.
Integration with child protection and law enforcement	Formal protocols for referral and information sharing with child protection authorities and police. Joint training and exercises to strengthen inter-agency understanding and cooperation.

Transformational Recommendation 3: Create a Child Safeguarding Intelligence Hub

The Queensland Government establish a Child Safeguarding Intelligence Hub: a centralised, integrated platform to collect, analyse, and act on sub-threshold indicators of concern about individuals working with children. By linking organisational, regulatory, and community reports, applying analytical risk assessment techniques, and coordinating referrals with child protection and law enforcement, the hub will enable earlier identification of potential risks, enhance transparency and accountability, and break down information silos that currently impede proactive safeguarding. The government should ensure the Child Safeguarding Intelligence Hub is resourced with sufficient staff and technological capability to link, match and analyse data across the information silos relevant to child safety.

The operation of the Child Safeguarding Intelligence Hub should transform child safeguarding from a reactive investigation to proactive risk detection approach by integrating data from regulatory systems (blue card, Reportable Conduct Scheme, sector regulators, and other vulnerable persons registers), provide accessible reporting pathways for parents, staff, and volunteers, and apply advanced analytics to identify patterns of concern and threats to children. By doing so, it will enable earlier interventions, strengthen oversight, improve community trust, and prevent harm before it escalates.

The Child Safeguarding Intelligence Hub, should be designed to sit within a statutory or government-authorised entity with robust governance, secure technology infrastructure, skilled analysts, and clear ethical and legal frameworks. The hub would:

- collect and centralise sub-threshold reports from organisations, regulators, and communities
- analyse patterns of behaviour to detect emerging risks
- coordinate referrals to child protection and law enforcement
- provide feedback and training to reporters and stakeholders.

This integrated approach will seek to overcome fragmented information flows, strengthen systemic safeguarding, and enable proactive, intelligence-led protection of children.

Transformational Recommendation 4: Co-locate the reportable conduct and WWCC schemes into one entity

The establishment of a Reportable Conduct Scheme in Queensland from 1 July 2026, and the amendments made to shift the blue card system into a risk-based decision making framework, mean that Queensland will soon have two universal (i.e. cross-sector) schemes that collect intelligence and assess risk. In New South Wales, the Reportable Conduct Scheme sits alongside the WWCC system within the Office of the Children's Guardian. The Victorian Rapid Review of its reportable conduct scheme has also recommended that both schemes be brought together in this state:

> *Currently the Working with Children Check and Reportable Conduct schemes sit in 2 separate entities. The Review recommends that they be brought together (along with the Child Safe Standards) into a single entity with a new Shared Intelligence and Risk Assessment Capability. Together, these changes will significantly strengthen the safety net around children.*[129]

The Board considers that, from an organisational design perspective, co-locating the Queensland Reportable Conduct Scheme and the WWCC within a single regulatory body provides a significant advantage in terms of efficiency, collaboration, and impact.

Organisations are designed to facilitate coordination. When teams with closely aligned functions sit under the same structure, they benefit from shared governance, unified strategy, and streamlined decision-making. Organisational design theory shows that co-located teams reduce 'transaction costs'—the delays, duplication, and information loss that occur when separate entities must negotiate formal agreements and boundaries. This is especially important in safeguarding, where timely information-sharing and coordinated responses can prevent harm to children.

Our review heard:

> *Our view is that one agency governing the various safeguarding schemes (employment screening, RCS, child safe standards) is the ideal and most streamlined arrangement from the perspective of organisations needing to comply with the schemes.*[130]

Like this Review, the Victorian review 'heard multiple times that "breadcrumbs" of information about a person—including information which does not meet the relatively high thresholds for substantiated conduct, but which is nevertheless still concerning—is rarely able to be seen and acted upon because no one can see the whole picture.'[131]

Co-locating the blue card system and Reportable Conduct Scheme is not a new idea. The Queensland Family and Child Commission submission to parliament on the Child Safe Organisation Bill 2024 stated:

> *...in the QFCC's response to the CRIS, the QFCC recommended that the Working With Children Check (WWCC) functions be consolidated and align under the independent oversight regulatory body (similar to the NSW model).*[132]

Currently the blue card system and Reportable Conduct Scheme sit in two separate entities, the Department of Justice and the Queensland Family and Child Commission respectively. However the WWCC and Reportable Conduct Scheme share a common purpose: to identify and manage risks posed by individuals working with children. Both rely on collecting, assessing, and acting on information about behaviour, allegations, and findings. When they are housed in different organisations, valuable intelligence can remain siloed, with each team working to its own mandate, timelines, and information systems. Integration in one regulator allows for the seamless flow of intelligence, joint analysis, and coordinated risk assessments. Advice from New South Wales staff where the Reportable Conduct Scheme and WWCC sit within the one regulator included:

> *When we are co-located there is better understanding and less reservation. Everything became easier to work collaboratively.*

and:

> *You get a lot more strategic tools and choices when safeguarding functions are placed together - a much more strategic approach to risk and intelligence.*

The Victorian Rapid Review came to the same position in saying:

> *...there is benefit in consolidating the Reportable Conduct Scheme functions of the Commission for Children and Young People (which currently holds the most extensive information about individuals through reportable conduct notifications) and the Working with Children Check screening authority (which has powers to assess, suspend or cancel a Working with Children Check and prevent a person from engaging in child-related work) into one place. The Review considers the administration of the Child Safe Standards should also be included in this consolidation.*[133]

Similarly, the AIFS advised the Board that best practice approaches to WWCC should:

> *…have a strong and proactive review system, where once a certain number of allegations are made against an individual or the severity of the reports reaches a certain level – even when the individual allegations or reports were deemed as having too little evidence to formally investigate – their WWCC is immediately placed under review.*
>
> *ACECQA's 2023 review of Australia's child safety arrangements recommended the creation of a secure mechanism for regulatory authorities to record and share information about 'persons of interest' who may be subject to unsubstantiated allegations, or potential concerns for the safety, health or wellbeing of children, with other regulators.*

A similar recommendation was made following the review of the Tasmanian Education department's response to CSA [child sexual abuse], i.e. to ensure data collection of all allegations of CSA [child sexual abuse], whether substantiated or not (Smallbone & McCormack, 2021). Such an information register would need to be linked to the WWCC system to facilitate the level of proactivity required for best practice. This would enable screening processes to flag and scrutinise individuals who have not yet offended but present a reasonable and significant risk of offending, or individuals who have already offended but with little or insufficient compelling evidence.

> *Creating an information register to record unsubstantiated and/or weak allegations (i.e. with limited evidence) can raise concerns around privacy. Therefore, significant protections would need to be in place for employees to avoid data being released in case of malicious or other reports.*[134]

Collaboration within a single organisation also leverages what organisational design scholars call 'structural coupling': the ability of related functions to reinforce each other through proximity, shared culture, and common leadership. This ensures that thresholds for risk are interpreted consistently, that decisions on worker suitability are aligned, and that learning from one scheme informs practice in the other. For example, an unsubstantiated complaint captured by the Reportable Conduct Scheme may not meet disciplinary thresholds on its own, but when considered alongside WWCC data, it can provide a more complete picture of risk.

Finally, co-locating the schemes enhances accountability and public trust. Families, organisations, and professionals benefit from a single point of contact and consistent guidance, rather than navigating multiple regulators with overlapping but separate responsibilities. In system design terms, this reduces complexity and strengthens transparency.

By embedding both the Reportable Conduct Scheme and WWCC within one organisation, Queensland can create a safeguarding system where intelligence is shared by design, collaboration is the norm, and the detection of risk is proactive rather than fragmented.

Transformational Recommendation 4: Co-locate the reportable conduct and worker screening (WWCC) schemes into one entity

That the Queensland Government co-locate the Reportable Conduct Scheme, Child Safe Standards and the worker screening scheme (WWCC) within a single regulatory body and enable operational integration. Placing these schemes together in one organisational structure is intended to:

- eliminate silos by ensuring intelligence about individuals is shared seamlessly, reducing the risk of fragmented information
- enable consistent decision making on risk thresholds and worker suitability, as both schemes are interpreting and acting on the same evidence base
- strengthen collaboration by leveraging shared governance, culture, and leadership, which organisational design theory shows is far more effective than coordinating across separate entities
- improve efficiency and trust by giving families, organisations, and professionals a single point of contact, creating clarity and transparency in safeguarding oversight.

By embedding these functions within one organisation, Queensland will create a more integrated, accountable, and proactive safeguarding system that maximises the value of both schemes.

Operational Recommendation 4: Establish a legally authorised Child Safeguarding Intelligence Network

The ability for relevant organisations to share information of concern is crucial to informing decision making and actions that keep Queensland children safe. The Board has collected sufficient evidence throughout this review to highlight a growing recognition within government departments that no single agency has adequate information to address issues alone. Consequently, interventions and responses to issues must involve collaboration between different organisations and disciplines.[135]

The sharing of information and intelligence across agencies is crucial to the successful safeguarding of children. In this context, information can be understood as the raw data and material that is used to create intelligence.[136] Information can come in many forms, is often from multiple sources and is collated and analysed to inform and provide intelligence. As such, data and information are characterised and understood as being building blocks for intelligence.

There are many benefits to the sharing of information or intelligence among agencies, and within an established network. A network refers to a group of individuals or organisations that work collaboratively to achieve a common goal or set of goals, they can be established formally or informally. Research suggests that for information sharing networks:

- many practitioners are reluctant to share information even when they have the legal authority to do so
- the protocols for sharing information can be considered complex
- there are too many organisations, regulators, enforcement agencies and oversight bodies to successfully understand 'who needs what when', and more importantly whose job is it to give it to them
- many agencies have a risk-averse attitude to information sharing even when this may be in the interests of clients.[137]

It is also apparent that information sharing can often be passive rather than active; where agencies respond to information requests rather than proactively deciding that another agency should be provided with particular information.

An intelligence sharing network (being broader than just information sharing) may present opportunities to share information in such a way that is purposeful, driven by clear objectives, and can inform decisions to address issues of concern. This will support cross departmental collaboration, with the ultimate purpose of keeping children safe and preventing harm.

The AIFS went some way to highlight the need for this network when it advised the Board:[138]

> *...regulatory safeguards should unite as a network to share common goals, language, collaborative practices, and learnings from successes and mistakes. This may include mechanisms like reporting schemes and information sharing schemes, as well as cultural frameworks like policies and protocols which ensure a consistently child safe culture across the social ecology.*[139]

It also said:

> *Although Australian information-sharing schemes explicitly articulate the prioritisation of children's wellbeing over privacy concerns, a database such as this one would require stringent privacy and data-sharing protocols– whether this is a specific ECEC sector regulator or a government agency. Further, it would have to be very carefully and sensitively managed in order to balance competing rights and protect individuals from malicious or incorrect reports of concern.*
>
> *The UK provides several examples to consider for this type of sensitive data collection and sharing, such as Local Safeguarding Partnerships and the NHS information sharing model. Queensland does not currently have such a model of a broad information database, and the information it holds/shares is limited to what is prescribed by the Child Protection Act 1999 (Qld) (i.e. only information (facts or opinions) that a person reasonably believes may help support a child who is currently in need of protection or may become in need of protection if support is not provided).*[140]

The *Child Safe Organisations Act 2024* (the Act) provides a broad framework to allow the sharing of relevant information under the Child Safe Standards and Reportable Conduct Scheme among prescribed entities (s48-49). Relevant information may be disclosed for the purposes of lessening or preventing a serious risk or threat to the life, health or safety of a child or class of children. The Act provides confidentiality requirements for information gained and disclosed under the Act, and it is important the Queensland Family and Child Commission, child safe entities, reporting entities, sector regulators and any other persons involved in administering the Act, can access and disclose relevant information. However, the Act also requires that information entities receive, including confidential information, is protected from disclosure unless prescribed circumstances apply.

The Act also enables the Queensland Family and Child Commission to disclose confidential information obtained under the Act to an entity performing functions under a law of another state or the Commonwealth with substantially the same functions, for a matter relevant to the performance of a function by that other entity (for example, to disclose information to the Office of the Children's Guardian in New South Wales). The Board was advised by operators in New South Wales and Victoria that:

> *An intelligence function would best sit under a reportable conduct scheme, because it is an information gathering scheme. You need to carefully distinguish between an investigation and an information gathering role*
>
> *- Interstate Reportable Conduct Scheme manager*

Drawing from lessons learned across other jurisdictions and other information sharing schemes, there are a number of interrelated factors that affect information sharing between organisations. These factors can be grouped into three overarching categories of barriers: technological, organisational/cultural, and political/legislative.

Political and legislative barriers:

- individual and agency interpretations of policy documents and legislation
- governance structures.

Technological barriers:

- technical factors such as compatibility of computer system and data types
- training and support
- oversharing of data which inhibits meaningful analysis and use of information shared.

Organisational and cultural barriers:

- organisational structure and culture (relating to need-to-know mentalities, competition, culture of secrecy and ego)
- trust, rewards, incentives and other social factors
- individuals' beliefs about information sharing.[141]

A significant task

It is recognised that maintaining and transmitting information securely is a significant task, which requires trusting that recipient agencies handle and share information securely - this means that those operating within an information sharing network are expected to abide by a common set of security standards governing the storage and dissemination of information.[142]

In recognising the barriers that are often experienced in sharing information across agencies, research shows that effective and appropriate information sharing can only take place in a context where the following exist:

- **Legislative framework:** there is a clear legislative and policy framework that guides the sharing of information, which may be further developed through a cross-agency or cross-organisational agreement.
- **Processes:** policies and procedures specify the appropriate processes but are flexible enough to allow for these processes to be tailored to individual situations.
- **Culture of sharing**: organisational cultures facilitate appropriate information sharing and collaborative practice while taking into account individual rights to privacy and confidentiality.

- **Training**: the workforce understands the legislative and policy framework and is trained and supported in delivering good practice.
- **Relationships of trust:** workers and agencies trust each other to use the information appropriately.[143]

Research shows that the key to effective information exchange, and collaborative practice more generally, is that individuals and agencies trust each other to use information appropriately.[144] This relates to the importance of creating a culture of information sharing, which is a critical factor in determining the success of an information sharing network. In this context, culture can be defined as the rituals, values and behaviours of the network that give rise to the overall framework and arrangement, which shapes the willingness of individual entities or agencies to share information.[145]

Learnings can be drawn from the creation of networks, or communities of practice which provide a platform to share and enhance knowledge and are built for collaborative advantage - they are founded on the understanding that more can be accomplished by working together, than by working alone. This recognition of collaborative advantage underpins the intent of the Act, and the intended approach to implementation. Networks have both informal and formal underpinnings. Networks are often characterised by objectives and have formal underpinnings that facilitate the networking process.[146] However, networks are also highly complex where members of networks learn and adapt it shared but not entirely controlled ways.

Key questions that can be considered when designing or shaping a network include:

- **Functions:** What roles and functions does the network carry out, i.e., filtering, amplifying, investing and providing, convening, community-building, and/or learning and facilitating?
- **Governance**: What are the behaviours and processes in place within the network that govern its short and long-term functioning?
- **Localisation and scope:** Where are the network and its members located both physically and thematically?
- **Membership**: Who are the network's members and how are they related to each other?
- **Capacity and skill.** Does the network, including its members, have the capacity and skills necessary to carry out its functions?
- **Resources:** Does the network have access to the inputs necessary to its functioning?
- **Communications:** Does the network have appropriate communication strategies to carry out its functions, thus amplifying messages outwardly or sharing messages and information within the institution?
- **External environment:** What are the external influences affecting the network?
- **Strategic and adaptive capacity:** Is the network capable of managing changes and shocks in its internal and external environment? Can it manage those changes on its own or does it depend on others, e.g., partners, networks, donors?[147]

While considering these characteristics in the process of designing a network, there are also key factors that will dictate the effectiveness of establishing a network:

- **Time:** Investing time in building a relationship that involves regular and open communication is likely to lead to a sustainable, long-term relationship.
- **Common goals or objectives:** It is important to ensure that members of a partnership or network have a shared understanding of the goals and objectives they are working together to achieve.
- **Defined roles:** Clearly defining the role of other members of the partnership or network will ensure that each member is accountable and clear on their responsibilities. For a network, this includes agreeing on which organisations or individuals will help to keep the network running, for example by arranging and chairing meetings and taking minutes, if this is applicable. For a partnership, the specific roles and responsibilities of each partner organisation are clearly defined.
- **Formal agreements:** While partnerships and networks can be informal arrangements, it can be useful to have a formal cross-agency agreement in place (such as a Memorandum of Understanding) to ensure mutual understanding of roles and responsibilities, particularly if there are changes in personnel.
- **Strengths and gaps**: Each stakeholder will have particular strengths and challenges. Acknowledging and building on the strengths of members of a partnership or network and exploring how to address any gaps together can lead to a positive, collaborative relationship.
- **Transparency:** Ensure all members of the partnership and network agree on key actions and decisions. This will ensure that partnerships or networks lead to concrete actions and investing time in working together feels worthwhile.[148]

An information sharing matrix was developed by the Australian Institute of Criminology to show information sharing for criminal intelligence purposes based on two dimensions—the level of interaction and the level of connectivity.[149]

In this matrix, ***interaction*** refers to how the provider and recipient of information relate to each other, which can range from no interaction beyond the transmission of the information through to regular, direct interaction.[150] At some point, there needs to be a degree of processing applied to information before it can inform decision making, the term interaction situates the processing of information at the time the information is shared or at some later point. ***Connectivity*** refers largely to the method of sharing, ranging from at its simplest, an exchange between two entities through to a 'free market' of information exchange, where agencies can access the information held by another agency. An explanation of the categorisations can be found below.[151]

Types of interaction:

- **Connected interaction**: delivery of information from one agency to another. This may be associated with a 'push' or 'pull' approach. A key feature of connected interactions is limited communication between entities beyond the sharing of information, which may generally result in a one-way transfer of information. Communication between entities may include limited context about how or why the information was collected, and there may be limited joint activity between the two entities.
- **Collaborative interaction**: intelligence sharing that is characterised by greater reciprocity among two or more agencies. Information may lead collaborating agencies to ask new questions that require additional intelligence gathering, creating an iterative process of collection and analysis.

Types of connectivity:

- **Bilateral connectivity**: the provision of information is often between two entities. This may be based on a request for specific information, or it may be unsolicited information that is sent out to a receiving agency.
- **Centralised connectivity**: an information sharing structure in which multiple agencies send information to a central storage facility where it can be combined and analysed. By joining together data from multiple sources, it may help to address the linkage blindness that can result from siloing. The supplier of the data will typically deposit the data in advance for use by the end user. The information supplied may be a set of data agreed with the central agency (warehouse sharing), or information may be provided in the expectation that it will be of use to others, known as volunteer sharing.
- **Networked connectivity**: networked arrangements in which each agency in the network stores its own information but allows other agencies in the network to access its holdings, essentially creating a 'free market' in information exchange between agencies. This could involve any agency in the network accessing data holdings of other agencies to view information that is relevant to its own operational requirements.

Using this information sharing matrix, it would be appropriate for the Queensland Government to aim for establishing and maintaining an information or intelligence sharing model that ranges between collaborative-networked and collaborative-centralised. It is anticipated that information may be shared more than bilaterally (shared one-on-one between two entities), but it may not be appropriate to establish an information sharing structure that works as a central storage facility of information (centralised connectivity). The intention of sharing information in a way that addresses blindness associated with siloing should be a goal of the network to be established. For example, it may be that intelligence is shared in a way that resembles bilateral connectivity but is shared between numerous relevant or appropriate entities rather than just one-on-one, and that this is shared in a collaborative manner that enables an iterative process of collection and analysis (collaborative interaction).

This highlights the considerations required for establishing an intelligence sharing network, as opposed to an information sharing network, the burden associated with sharing and analysing potentially large volumes of raw data (referred to in this context as information) may prove detrimental to the intent of the network. By contrast, an intelligence network shares insights that align with established objectives of the network as a result of processed information that is collected by a member while performing member functions. Collaborative intelligence sharing underpins the regulatory approach to safeguarding children.

Operational Recommendation 4: Establish a legally authorised Child Safeguarding Intelligence Network

That the Queensland Government progress amendments to the *Child Safe Organisations Act 2024* to establish an effective Child Safeguarding Intelligence Network. This network should provide a formal legal framework and compulsion for cross-agency intelligence sharing that:

- transforms information into intelligence by empowering agencies to collate, analyse, and share insights that reveal patterns of risk and harm to children, overcoming the current fragmentation of raw data
- provides a legal foundation for proactive, not just reactive, sharing of relevant intelligence,
- overcomes existing barriers—technological, organisational/cultural, and political/legislative—by setting common security standards, developing consistent protocols, and mandating interoperability of systems
- embed collaborative practice through clear governance arrangements, defined roles and responsibilities, and formal agreements between members
- foster a culture of trust and transparency where agencies are supported and incentivised to share intelligence in the interests of the safety of children, underpinned by workforce training and professional development
- enable networked or collaborative-centralised sharing models so that intelligence is accessible across multiple relevant entities, reducing 'linkage blindness' and silo effects
- give safe access to police intelligence, especially for cases that police have determined do not reach a criminal threshold, to decision makers in the WWCC and reportable conduct schemes.

A legislated Child Safeguarding Intelligence Network will provide Queensland with the capability to identify emerging threats, connect otherwise isolated threads of information, and ensure agencies can act on a shared, accurate picture of risk. It will transform the current information-sharing environment into a proactive intelligence system that strengthens the capacity of government and non-government organisations to protect children.

Operational Recommendation 5: Enable the integration of worker registers

Across Australia, worker registers are increasingly recognised as critical infrastructure for both professional regulation and child safeguarding. Registers provide a mechanism to verify whether individuals are eligible to work with children or in other sensitive roles, and to ensure that risks identified in one setting do not simply migrate into another. At present, the architecture of registers is fragmented, with each sector maintaining its own system, and only limited capacity for cross-checking.

- **The NDIS Worker Screening Database:** The National Disability Insurance Scheme (NDIS) has established the NDIS Worker Screening Database (NWSD), administered by the NDIS Quality and Safeguards Commission. This database records whether a worker has been granted a clearance or has been barred following a worker screening check. It is a centralised, national record, ensuring that a person who is barred in one jurisdiction cannot simply move to another and obtain clearance. Access to the NWSD is limited to NDIS providers, plan managers, and self-managed participants. The database is not publicly searchable, reflecting its function as a safeguarding tool rather than a professional register.
- **Professional Registers – Teaching and Nursing:** Other sectors operate long-established, publicly accessible professional registers. For example, the Australian Health Practitioner Regulation Agency (AHPRA) maintains the register of health practitioners, including nurses, and state-based teacher registration boards maintain registers of teachers. These systems allow members of the public to search by name to confirm whether a person is registered, suspended, or subject to practice conditions. They serve not only a safeguarding purpose but also promote professional accountability and public confidence.
- **Early Childhood Education and Care – Emerging registers:** The early ECEC sector is now moving towards its own worker register. This reflects a recognition that those working with very young children require an additional level of oversight, and that professionalisation of the sector depends on transparent registration. As this register matures, it will join the broader landscape of occupational registers that overlap with child safeguarding responsibilities.
- **Working with Children Checks – A Cross-Sector Register:** In addition to sector-based registers, Australia operates the WWCC scheme. Administered separately by each state and territory, WWCCs function as a universal screening system for employees and volunteers across all sectors who engage in child-related work. While systems vary in detail, each maintains a database of cleared and barred persons. Some jurisdictions operate searchable public registers of WWCC card holders, while others restrict information to employers. The WWCC scheme is not a professional register as such, but rather a clearance register that cuts across industries, creating a baseline child-safeguarding mechanism.
- **Reportable conduct register:** An emerging register of individuals and organisations who have been reported for engaging in 'reportable conduct' will be established in Queensland from 1 July 2026. This will be similar to existing registers in NSW and Victoria.
- **Residential care worker register:** There have been previous recommendations to the Queensland Government to establish a residential care worker register by the sector, similar to the registers in place in New South Wales.[152] Youth workers in residential care settings have significant access to children including infants, and there is currently no worker screening beyond WWCC. A Commission of Inquiry into Queensland's child safety is currently underway, which will examine the protection and abuse of children in residential care. It is possible a worker register may emerge as a solution from this process.
- **Aged care worker register:** The Australian government is developing a Personal Care Worker registration scheme for people working in aged care. This was an outcome of the Royal Commission into Aged care Quality and Safety. This is separate to the provider register.

While these systems all contribute to safeguarding of vulnerable persons, they are not currently designed to 'speak to each other', either across sectors or jurisdictions. A person may be barred in one register but still be able to hold clearance in another if information has not been shared or matched between registers. For example, a disability support worker barred under the NDIS screening process could, in theory, still apply for work in early childhood education or outside the NDIS unless their status was proactively checked in other systems. Similarly, a teacher who loses registration due to misconduct may still hold a valid WWCC card unless the relevant agency updates the WWCC authority. These gaps create inefficiencies for employers and, more critically, provides opportunities for unsafe individuals to re-enter child-related work under a different guise.

There is an emerging picture of fragmented but converging registers. The NDIS, health, teaching, ECEC, and WWCC systems are all developing greater sophistication in their approach to worker registers. However, the next logical step is to design interoperability of these registers, either through shared data standards, centralised coordination, or a dedicated safeguarding agency with responsibility to scan across registers. This type of reform would not only increase efficiency but significantly strengthen Australia's ability to prevent individuals who pose risks to children and other vulnerable persons from moving between sectors undetected.

Substantial efficiency and safeguarding improvements could be achieved if existing and planned registers were designed to interact. Ensuring information flows between systems presents both legal, technological and operational issues, however the benefits to safety through improved threat detection and the minimisation of gaps are immense.

Ultimately fragmented and siloed employee registers create loopholes that allow unsafe individuals to move between sectors or jurisdictions undetected. By leading with structural reform in Queensland while also embedding interoperability and national coordination, the Queensland Government can deliver the strongest protections for children, greater efficiency for employers, and a system capable of learning from patterns of risk across workforces and sectors.

The Board holds significant fears that commitments and actions taken by agencies after the offender was detected may serve to strengthen the early childcare sector's protections but will perversely displace the risk elsewhere resulting in perpetrators moving to other sectors with less safeguards.

An integrated or interoperable system would allow a single clearance decision, suspension, or adverse finding in one register to be automatically considered in others. Employers across different sectors could be confident that their checks were drawing on the full risk picture, not just the slice relevant to their industry. From an efficiency perspective, integration would reduce duplication of screening processes, minimise administrative burden, and streamline verification for employers. It would also help governments avoid the cost of maintaining parallel, siloed systems.

From a safeguarding perspective, integration would close loopholes that currently allow persons of concern to move across sectors undetected. If a single agency was tasked with monitoring risks across al registers, it could identify patterns—such as an individual facing multiple low-level concerns in different contexts—that would not be visible within a single system. This would mirror the lessons of past child protection and abuse inquiries, which consistently find that siloed information held across different databases and agencies contributes to missed opportunities to intervene earlier. These types of issues have again been laid starkly bare in the Board's review of this case.

Operational Recommendation 5: Enable the integration of worker registers

That the Queensland Government lead structural reform by consolidating employee registers and enabling linkage or matching with the Working with Children Check (WWCC) register and the reportable conduct register. Existing state and federal employee registers should be incorporated into the scheme where possible, including the early child care worker register, disability worker register, teacher worker register and the proposed residential care worker register. This will provide a central point of accountability for worker screening and safeguarding intelligence. This reform should be supported by two critical sub-elements:

- **Interoperability standards:** Develop and adopt shared data standards and interoperability protocols across all worker registers relevant to child and vulnerable person safeguarding. This will enable timely information flow across systems and jurisdictions, ensuring that risks identified in one setting are visible to all others.
- **National coordination mechanism:** Advocate for, and actively participate in, the creation of a national safeguarding register clearinghouse with authority to reconcile clearance and misconduct information across states, territories, and sectors. This clearinghouse would ensure that adverse findings or suspensions in one jurisdiction or sector are automatically recognised and acted upon in others, eliminating loopholes and enabling intelligence-led prevention.

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