Part D

# Responding to child sexual abuse

Chapter 17

# Complaint and reporting mechanisms

# Complaint and reporting mechanisms

## Responding to child sexual abuse

While prevention remains the ultimate goal, it is a sobering reality that some children will still experience sexual abuse. When this occurs, the quality and timeliness of the response is critical, both in terms of ensuring immediate safety and in shaping long-term outcomes for victim-survivors and their families.

***Perpetrators move across sectors. They identify and exploit system gaps, and they take deliberate and intentional action to prevent detection. When we solely focus on addressing the gaps in one system, we too often only serve to displace the problem elsewhere.***

The theory and practice of responding to child sexual abuse incidents is anchored in several interconnected systems. These include:

- complaint and reporting mechanisms, which act as the first gateway for children, families, and professionals to disclose concerns
- police investigations, which determine the scope and nature of the offence and safeguard others from ongoing risk
- court processes, which provide a forum for accountability and justice
- statutory reporting obligations, which ensure that all professionals who encounter risks to children act consistently to protect them.

Each element requires clarity, accessibility, and alignment with child-centred principles to be effective. Reporting obligations are a cornerstone of child safeguarding systems. Mandatory reporting frameworks, when clearly defined and consistently applied, create a culture of vigilance across health, education, justice, and community sectors.

Best practice includes not only legislative clarity but also sustained training, professional support, and clear organisational procedures to ensure that reporting is not a compliance exercise but a proactive act of safeguarding. Effective complaints and reporting systems emphasise accessibility, safety, and trust.

Research shows that children are more likely to disclose when they believe they will be listened to, taken seriously, and protected from retaliation. Too often adults refrain from raising concerns, or pressing issues, due to inherent politeness, because they are 'minding their own business' or treat behaviours as a 'one off' and because they do not want to be seen to criticise others.

Organisations must therefore design child-friendly reporting avenues, displace stigma, encourage people to speak up, provide multiple pathways for disclosure, and ensure complaints are met with immediate protective action.

***The devastation child sexual abuse causes for children and young people, their supporters, and those who help carry the burden of their experiences demands we keep our hearts and minds open and take action.***

> *It takes immense courage for victims and survivors to report child sexual abuse. Too often, they face significant challenges coming forward, including institutional and social barriers. It is our collective responsibility to make sure they are believed, protected and supported, and that perpetrators are held accountable.*[1]

## Known barriers to reporting

Victim-survivors face numerous barriers that prevent them from disclosing their abuse including a sense of shame, fear of not being believed, fear of the perpetrator, mistrust of government organisations, and other structural barriers. They may have also been threatened by perpetrators who tell them that they will not be believed or that they will be blamed for the abuse that has been inflicted upon them.

> *Child sexual abuse is a complex and difficult thing for us to talk, think or read about. It forces us to confront physical and mental abuse, and horrific sexual crimes. But our collective silence perpetuates suffering. Often, victims and survivors don't talk about their experiences for many years – if ever.*[2]

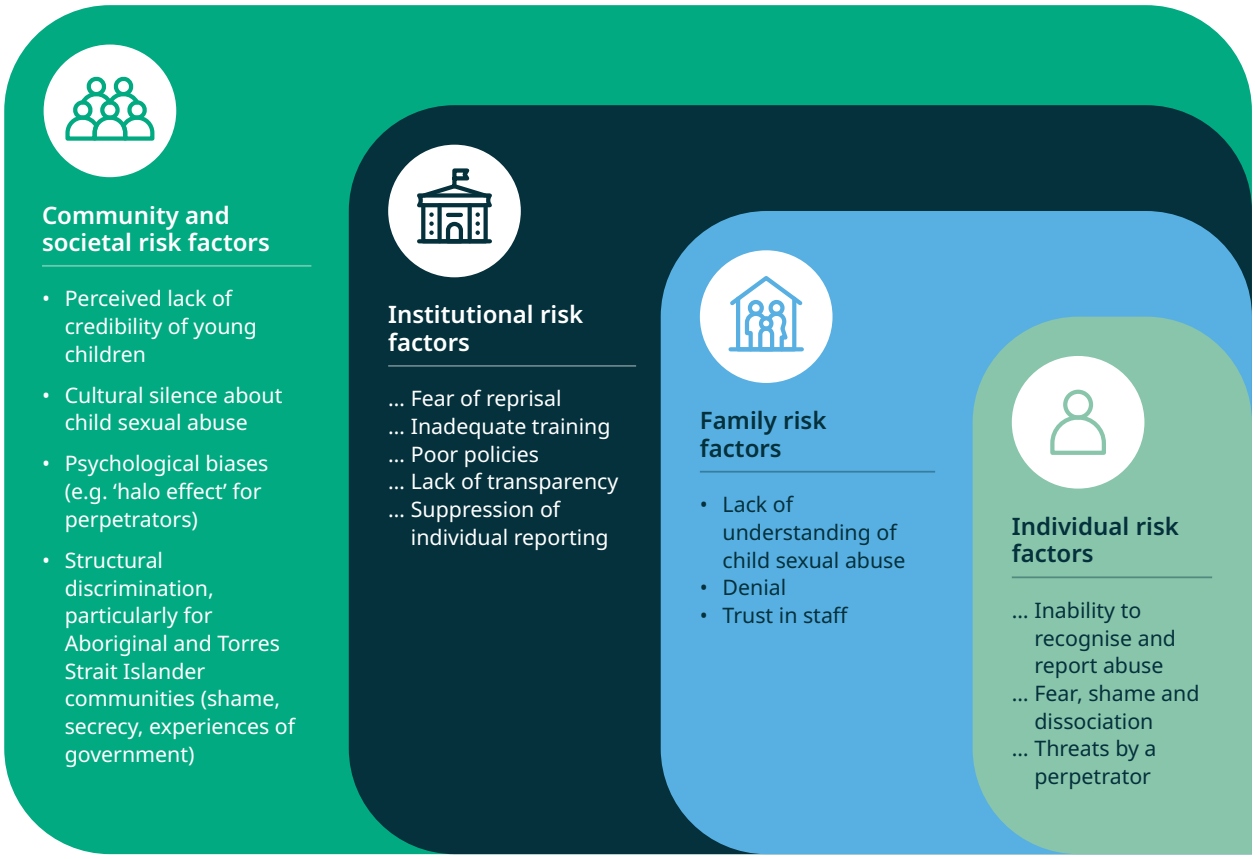
The Royal Commission into Institutional Responses to Child Sexual Abuse (Royal Commission) further highlighted that attitudes to gender, sexuality and masculinity, distrust of self, and difficulty communicating can prevent disclosure.[3] Organisational culture can be an additional barrier to reporting, where it involves:[4]

- cultural attitudes which promote loyalty and punishment
- reputational prioritisation
- personal relationships within the organisation.

Dependent on their developmental stage, children and young people may also not recognise, or be able to articulate, an experience as abusive until they are older.

**Table 1: Known barriers to reporting faced by victim-survivors of child sexual abuse**

*Source: University of New South Wales 2025*[5]




Multiple studies show that a large proportion of abuse remains invisible to statutory and professional systems, and that formal reports to child protection and police services represent only a small fraction of the true incidence.

***Data from the Australian Bureau of Statistics Personal Safety Survey (ABS PSS) shows that 84 per cent of women and 99 per cent of men who reported experiencing child sexual abuse never made a report to police.***[6]

***Data from the Australian Child Maltreatment Study (ACMS) shows that only 54.8 per cent of Australians who experienced child sexual abuse had ever told anyone about the abuse.***[7]

In a 2023 survey undertaken by the National Centre for Action on Child Sexual Abuse, participants reported that they lacked confidence in recognising the signs of child sexual abuse, having conversations about child sexual abuse, or being able to respond to the disclosure or discovery of child sexual abuse.[8]

> ***About 1 in 5 Australians report having discovered adult-perpetrated child sexual abuse or had a child disclose to them. 11 per cent have discovered a child or young person who had been harmed or was harming another child; or has had this disclosed to them.[9]***

Survey participants who reported that they had discovered child sexual abuse, or had this disclosed to them, stated that they most commonly responded by:

- having a supportive conversation with the child
- making a report to police or child protection authorities
- arranging professional support for the child
- discussing it with family, friends or another professional to get advice
- workplace reporting
- phoning a helpline or looking for advice online
- a combination of the above.[10]

# Reported child sexual abuse

## Australia

While there is known underreporting of child sexual abuse, police data shows ongoing increases in the number of reports received. The number of reports to police has steadily increased since 2014 in Australia, when the number of victim-survivors who reported child sexual abuse was 13,353.[11]

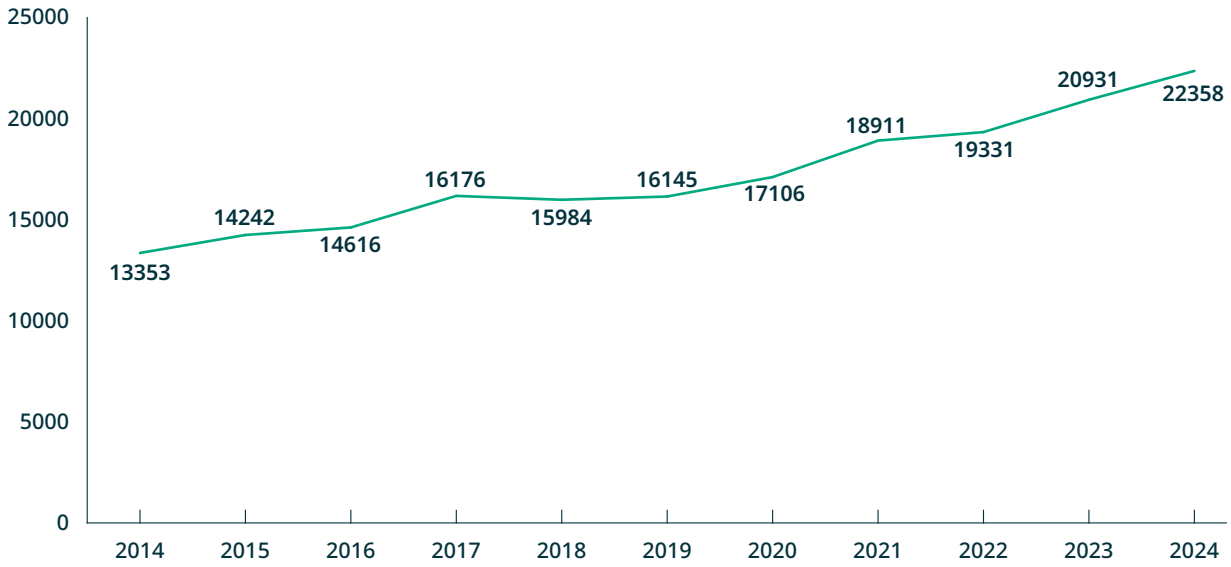
This increase is associated with a range of different factors including a growing population, community awareness, and strengthened reporting processes.

In 2023, 20,931 people were recorded by police as victim-survivors of sexual assault and were aged under 18 at the time of the incident.[12]

- 79.51 per cent (n=16,641) were female.
- 29.75 per cent (n=6227) were under the age of 10 at the time of the offence.
- 22.63 per cent (n=4739) reported the abuse as an adult.[13]

**Figure 1: Number of victim-survivors of sexual assault aged under 18 years at time of incident, as recorded by police in Australia, 2014–24**

*Source: Australian Bureau of Statistics [14]*



## Queensland

In 2023, 4566 people were recorded by police as victim-survivors of sexual assault and were aged under 18 at the time of the incident.

- 81.47 per cent (n=3720) were female.
- 34.32 per cent (n=1567) were under the age of 10.
- 14.50 per cent (n=662) were Aboriginal and/or Torres Strait Islander.[15]

There is no public information regarding the number of people subject to a report of child sexual abuse as an offender. Information from the Cyber Security Cooperative Research Centre does suggest that Australia is the third largest market for live-streamed abuse and that Australians are some of the most prolific consumers of CEM.[16]

In 2022–23, the Australian Centre to Counter Child Exploitation (ACCCE) Child Protection Triage Unit made 545 referrals to Australian law enforcement agencies. Referrals to local law enforcement agencies or support services may occur where an alleged perpetrator and/or suspected victim-survivor is identified by ACCCE.

# Navigating a complex complaints system

***A confronting reality of this Review has been the discovery that children, parents and other staff spoke up about the offender but were not heard.***

While multiple concerns and complaints were raised about the offender's conduct, responses to complaints varied greatly. Common issues included:

- concerns about the offender's conduct being minimised, dismissed or not responded to
- no or minimal action taken in response to the concerns raised, with no supporting documentation located to indicate that complaints had been recorded or responded to
- a lack of referral of complaints by centres to the Early Childhood Regulatory Authority (ECRA) (and its predecessor) despite there being a legislative requirement to do so
- limited investigations being carried out by the Queensland Police Service (QPS) or ECRA, including not interviewing all relevant parties
- internal investigations being conducted by centres into the complaint, with the outcomes subsequently being relied on by other agencies to finalise their investigations.

In undertaking this Review, the Board reflected that current complaints and reporting pathways are overly complex and unclear, including within individual centres, and to regulatory authorities or the police. There are also limited options for parents when making a report if the perpetrator is not a family member or caregiver, and if the police have assessed the report and determined they are unable to pursue charges. Difficulties also arise when the person subject to a complaint holds a senior role in a centre or may otherwise be involved in the investigation of a complaint.

This is only compounded for children, whose voices are often silenced, and their young age means that they are unable to articulate their experiences of abuse. For example, in one complaint the mother asked her child why they had not told her about the abuse before, and they said 'because I didn't have the words Mummy, I was only a baby... Mummy, I wanted to run away, run up the street, and find your work building'.

In another complaint, after the parents raised concerns about the offender getting angry at their child and squeezing his harm, one of the workers recorded the child's complaint as:

> *I said to [child] that he had told me something earlier about yesterday and asked if he would like to tell me more about it, [child] said "at rest time [Offender] got angry at me and grabbed my arm and squeezed it hard' I then asked [child] 'where on your arm" [child] indicated his upper left arm. I asked [child] if we could look at his arm, we looked at his upper left arm but there was no visible mark. I asked [child] if [the offender] had said anything to him when he grabbed his arm. [Child] said "he just got mad at me and squeezed my arm really hard, my dad is going to come and pick me up today and tell [the offender] that he is not aloud [sic] to grab anyone". I said "no he is not aloud [sic] to squeeze your arm" and that we would sort it out, [child] said "thank you, yesterday was a tough day". I thanked [child] for telling his parents and me about what had happened and asked if he would like to go off and play which he did.*

Another parent reported that when they tried to make a complaint about the offender threatening to smack a child, their first attempt was met 'aggressively'. This was after the parent approached her and requested a conversation about something 'sensitive in nature'. Although the parent expected to be taken to a private space, they recall that the Director/Owner stayed sitting at the desk.

In response to a question about whether the offender was still working at the centre as the parent had not seen him in a few days, they were told 'No'. After another question about whether this meant that the offender was no longer working in the Kindy room, or the whole centre, the parent reports that the Director/Owner 'abruptly stood up and put her hands on the desk and said "You got something to share?"'. 'Her demeanour and voice were quite aggressive, and I was taken aback so I just muttered "I guess there's no point if he's already gone" and I went to leave'. About a week later the parent reported that:

> *In the morning after dropping my daughters off, [the Director/Owner] yelled out for me to come into her office. She apologised for the other day saying that it must have taken courage for me to approach her about what I thought was a current employee. She asked what I wanted to tell her. I explained what I had seen and heard [the offender] say to [other child]. I told her that we weren't a smacking household and would be very upset if my children were being threatened with physical punishments at the daycare. I said I would want to know if this happened to my children and [other child]'s parents should be told. She said "Leave it with me" which I took to mean she would be informing the [family] and following through with my report to the relevant departments. The incident is never mentioned again.*

There is no record of this complaint in the centre's records. However, following the ECRA investigation in 2025, the centre was breached for failing to report this matter at the time and for failing to advise the parents of the child. This outcome is currently subject to an application for an internal review by the centre to ECRA. The centre owner also advised the Board they have no recollection of this report being made, and consider that it may have been responded to by the Centre Director/Nominated Supervisor. They further noted that a contemporaneous social media post at the time initially described the offender's comment as 'not said in an angry way at all, almost sing-songy...' Irrespective, of the way a complaint is made, all concerns by parents about the safety and wellbeing of children should be validated, taken seriously and fully investigated.

As part of the Board's call for public submissions, a parent of a child unrelated to this matter outlined their concerns with the current complaints system after they tried to raise a concern about persistent issues in an ECEC service their child attended. Notably this complaint was made while this Review was ongoing. This parent outlines that they were ignored despite their numerous attempts to make complaints to the Centre Owner. They reported that they found the system to be convoluted and hard to navigate, with no guidance on how to make a complaint.

> *Our entire time in the daycare we were at has been an issue – even when putting it in writing wasn't responded to and it got progressively worse. Don't believe that any parent who had the capacity to remove their child would have left them there.... There was no support from the management down.*

The parent explained that after attempting to contact the centre via email and not being able to find anything on their website, they attended the centre in person to obtain a copy of its complaints policy. The owner reportedly responded to the parent by saying 'you're no longer a parent or a family here I don't have to engage with you' before threatening to call the police. The parent reflected that 'the irony of this is that you would have more success getting the police to the centre than I would for what's happened to my daughter in the centre'.

This was based on the parent's previous interactions with QPS when making a complaint involving their child who stated that 'I tried to do everything by the book'.

> *I tried to follow up yesterday to see where it was up to, I got put through two different teams in the police and was met with the you don't have access to that information and would have to go through the Police Commissioner – when I asked how do I do that they told me to "look it up"... Police said you have nothing to say criminal offence happened so nothing for us to do.*

The parent further explained that they then called ECRA who advised of the phone number for the local office they needed to contact, which they did. Of this contact, the parent stated that:

> *I all but had to fabricate things for her [complaints person] to take it as a complaint, she said that if I didn't have exact dates and times the complaint wouldn't be able to occur. Having to reflect back her own logic to her - **"You're asking me to provide evidence from a child who doesn't speak".***

The parent also stated:

> *The only reason I sent the documents and the supporting evidence was because the woman on the other line said wouldn't be productive or considered. The complaints officer reportedly stated that the parent needed to have records of "dates and times".*

This parent also reported having been contacted by other parents from the centre to seek confirmation of dates and times given they could not lodge a complaint without these. While this parent received an automated response stating that their complaint was received by ECRA, they were not provided with any timeframes or expectations to follow.

# Clear and supportive complaint pathways for parents and children

Children and their parents need to be supported when raising concerns or making a complaint, to police, services, regulatory authorities or other professionals. They also need to be kept informed of any investigation that is undertaken and the outcome of their complaint, irrespective of what entity it has been made to.

***A poor or delayed response to sexual abuse compounds harm, while a compassionate, coordinated, and competent one can provide a pathway to justice, healing, and restoration of trust.***

In conducting this Review, the Board reflected on the lack of clarity on how parents can make a complaint, particularly for abuse in institutional settings. Currently children and parents can make a complaint to individual institutions, police, and the relevant regulatory authority. Each entity has:

- different procedures and processes for making a complaint
- different roles and responsibilities that set how they may or must respond to a complaint
- different systems to record complaints
- different legislative and regulatory frameworks which determine how they should respond
- different obligations or evidentiary thresholds that may need to be met to respond or address a complaint.

Responses to individual complaints will also differ dependent on the person who receives the complaint, and their knowledge, experience and understanding of the complaints process. This has resulted in a patchwork system of confusion, where parents are unclear of who to call, what to expect, and how to get help.

As part of its submissions to the Review, the Office of the Advocate for Children and Young People in New South Wales highlighted the need to strengthen complaint processes to ensure they are child friendly, accessible and responsive. This includes through the establishment of an independent complaints pathway. They also recommended the expansion of powers of independent oversight bodies to monitor compliance, investigate complaints and support continuous improvement.

The Aboriginal and Torres Strait Islander Legal Service called for improved awareness about how parents and responsible adults or other caregivers can escalate complaints about concerning conduct.

In a review of the Victorian Reportable Conduct Scheme, children and young people reported having varying levels of confidence to report incidents to the organisation and identified multiple barriers to reporting. This includes identified power imbalances, concerns about their reports being shared with staff and parents, and the belief that no action would be taken.[17]

Common themes were identified by Griffith University in research undertaken to inform the Board's understanding of best practices for the prevention of child sexual abuse. This study highlighted the necessity for an immediate response to safeguarding concerns, including reports from mandatory reporters, workers, and other stakeholders. Emphasis was also placed on reducing the burden of reporting pathways with options for anonymous reporting, allowing all individuals—whether parents, staff, carers, or mandatory reporters—to report concerns without fear of retaliation. A multi-agency and trauma-informed response is essential, involving collaboration between law enforcement and specialist services.[18] Mandatory reporters should be well-trained and supported in handling disclosures.[19]

Emphasis was also placed on system-wide accountability, to ensure concerns are acted upon quickly and thoroughly, with age appropriate, trauma-informed practices across all sectors, especially investigations, to protect the needs of the child and family.[20]

# Operational Recommendation 6: Dedicated support for parents and workers to navigate complaint and reporting processes

The case under review illustrates multiple instances where parents reported their concerns to the organisation and were dismissed or their matter was not adequately recorded, reported or investigated. Parents and carers continue to face challenges in reporting concerns, highlighting the confusion and lack of information on reporting pathways. While parents are directed to raise a complaint with their organisation and police regarding criminal matters, there are few alternative pathways.[21] **The establishment of a Reportable Conduct Scheme in Queensland provides an opportunity to strengthen and centralise complaint pathways for children, parents and staff whose concerns may otherwise fall through the gap of existing mechanisms.**

A strong Reportable Conduct Scheme is essential to ensuring that concerns about adults who harm or pose risks to children are properly examined and addressed. The Queensland scheme is still in its early stages and, as experience from other jurisdictions has shown, the demand for oversight and investigation is significant and continues to grow as awareness increases. If the Reportable Conduct Scheme is not sufficiently funded relative to its demand, the result will be delays, inconsistency, and lost confidence among families, workers, and organisations. Inadequate resourcing risks undermining the scheme's ability to achieve its central purpose: ensuring children are protected and unsafe adults are held to account.

This is not a new issue. *Strengthening the oversight of workplace child abuse allegations*, the special report following the New South Wales Government's 2016 review of its Reportable Conduct Scheme reported that:

> *The most significant challenge we currently face is the need to maintain, within existing resources, a high level of scrutiny over the handling of the most high-risk allegations of reportable conduct.*[22]

However, the issue continues to plague agencies administering the schemes. This was demonstrated in the *Rapid Child Safety Review* provided to the Victorian Government on 15 August 2025. The final report stated that:

> *Mandatory notifications to the Commission under the Reportable Conduct Scheme increased by 30 per cent between 2022–23 and 2023–24 but its base funding has not increased since 2018. The Commission for Children and Young People reports that 85 per cent of child abuse and harm investigations receive low or minimal oversight by the Commission.*[23]

In addition to resourcing the core investigative and oversight functions, the Reportable Conduct Scheme requires dedicated capacity to support parents, carers, workers, and volunteers to navigate complex complaint and reporting pathways. Families frequently encounter uncertainty about whether a concern should be directed to the relevant organisation, to police, or to regulators. Likewise, staff and volunteers can be unsure of their reporting obligations or where to seek advice when they are concerned about a colleague but are unable to clearly articulate the nature of their concerns. Without practical guidance and support, there is a real risk that concerns remain unreported or are handled inappropriately.

In research commissioned by the Board to inform the Review, the University of New South Wales advised that:

> *Even when staff or educators can identify indicators of CSA, they may not report their suspicions due to a lack of confidence in or knowledge of CSA reporting procedures. This can be exacerbated by inaccurate understandings of reporting obligations, processes, and consequences, including beliefs that:*
>
> - *they need evidence/proof to substantiate their reports*
> - *reports are to be made to their superiors rather than directly to authorities*
> - *before reporting their suspicions, they need to first ascertain the cause of the abuse by contacting the child's parents*
> - *instead of reporting, they should manage the abuse internally, as reporting may create further issues for the victim*
> - *they can be sued and become liable for damages if their reports are not substantiated*

> *More broadly, staff and educators' concerns about the potential consequences of reporting, including its implications for the perpetrator, the workplace environment, and their relationship with the victim and their parents, can hinder reporting. Additionally, fears related to the impacts on the institution's reputation may further disincentivise appropriate institutional responses.*[24]

Investment in a public-facing advice and navigation service within the Reportable Conduct Scheme would help bridge these gaps, providing clear, accessible guidance on complaint processes, ensuring referrals are properly directed, and reinforcing confidence that the system is working for children and families. This service should be available through multiple channels, including telephone, online platforms, and community outreach, to ensure accessibility across Queensland.

Ultimately, sustained and sufficient funding of the Reportable Conduct Scheme—both for demand-driven regulatory functions and for frontline guidance and support—is necessary to uphold community confidence, strengthen organisational accountability, and ensure the protection of children.

**Operational Recommendation 6:** Dedicated support for parents and workers to navigate complaint and reporting processes

That the Queensland Government ensure the Reportable Conduct Scheme is funded to meet demand, and that additional resources and authority is provided to enable the Reportable Conduct Scheme to establish dedicated support for parents, carers, workers, and volunteers to make and navigate complaints and reporting processes across organisations, regulators, and the police.

## Operational Recommendation 7: Transparent ECRA investigations that uphold a parent's right to know

Parents and caregivers have a right to know the outcomes of complaints they have made, and to be kept informed where an investigation is being undertaken into an institution that their child is involved with, or attends.

Parents who contributed to the Review expressed frustration at the lack of response from individual centres after the offending was detected, and the lack of publicity about the centres where the abuse occurred. In their view this means that parents are unable to make informed decisions about which centres to send their children to. A parent also reported being provided with misleading information by one centre after the offender had been stood down and were assured that the offender did not present a risk to their children.

Recent similar cases in New South Wales and Victoria have highlighted the importance of parents and caregivers being kept informed about what is happening in their centres. The recent *Rapid Child Safety Review* conducted by the Victorian Government identified that:

> *Open and timely conversations between parents and services are more likely to happen when processes for responding to complaints and concerns are clear and transparent. When an investigation occurs, parents need to be confident the matter will be handled in an appropriate manner, and that everything is being done to keep their children safe.*[25]

ECEC services play a vital role in children's lives, often being the first institution outside the family who is entrusted with a child's daily care and safety.

***Parents and carers must be able to place trust in these services not only to provide nurturing environments, but also to act with transparency and accountability when concerns arise. For this reason, there is a strong case to increase the regulatory expectation—and in time, the legal obligation—that ECEC services inform parents when a reportable conduct investigation is being undertaken that relates to their child's service.***

At present, parents may not always be notified, leaving them unaware of issues that may directly affect their child's environment. A modern safeguarding framework requires that parents have a right to know when serious allegations are being investigated, subject to appropriate safeguards around privacy and due process. This transparency empowers parents to make informed decisions about their child's care, reinforces accountability for services, and builds public trust in the integrity of the child safeguarding system.

More broadly, there is a need to shift societal attitudes around complaints and reportable conduct in the ECEC sector. Reportable conduct concerns are not rare events; they are an expected feature of any system where adults work closely with children. The existence of allegations or investigations should not automatically be viewed as an indicator of unsafe services, but rather as evidence of a mature organisation that takes safeguarding seriously by identifying, investigating, and reporting concerns appropriately. By contrast, services that claim to have no complaints or no reportable conduct concerns may in fact be failing to recognise risks or may not have a culture that encourages children, staff, or parents to raise issues.

> *I would be very worried about any organisation that claims to never have safety concerns.*[26]

Embedding a requirement for ECEC services to inform parents of reportable conduct investigations will help normalise transparency, support early resolution of issues, and send a strong message that the safety of children must always be paramount.

More importantly, transparency with children and parents transforms investigations from procedural, transactional exercises into holistic, child-focused inquiries. When families are informed and aware of the processes in place, centres are incentivised to examine the full context of concerns—patterns of behaviour, systemic issues, and environmental factors—rather than limiting their focus to isolated incidents. This approach ensures that investigations are genuinely about preventing harm and protecting children, rather than simply meeting compliance obligations.

Furthermore, increasing awareness among children and parents creates opportunities for earlier disclosures. Children, parents, and co-workers are more likely to speak up when they know their voices are not alone, and that they will be heard. By embedding transparency as a core expectation, organisations signal that raising concerns is important, safe and valued, fostering a culture where the identification of risk is proactive rather than reactive. This approach ultimately strengthens both the effectiveness of the Reportable Conduct Scheme and the broader safeguarding ecosystem.

This transparency is at odds with current practices where investigations are conducted behind closed doors, with minimal communication to parents or the broader community. Such an approach is often justified as a means 'to avoid panic' or because of procedural fairness for the person that is being investigated. While well-intentioned, this approach does very little to enhance the safety of children. It allows incidents to be treated as isolated events, limits the accountability of the organisation, and misses the opportunity to engage children and parents who may hold additional information. Worse, this secrecy can inadvertently protect perpetrators, giving them space to continue harmful behaviour undetected and perpetuating systemic risk.

By avoiding transparency, organisations reinforce a culture where concerns are hidden rather than addressed, undermining community trust and the principle that safeguarding children must be central to all decision making and actions. Evidence suggests that open, accountable processes—even when difficult or uncomfortable—are far more effective in preventing further harm, deterring potential perpetrators, and ensuring that organisations learn and improve from each incident.

### **Operational Recommendation 7:** Transparent ECRA investigations that uphold a parent's right to know

The Queensland Government should strengthen regulatory expectations and, where appropriate, legislated obligations, for ECEC services to inform parents and carers when a reportable conduct investigation is being undertaken that relates to a service provider or centre their child attends. This requirement should:

- ensure transparency while balancing privacy and procedural fairness
- encourage holistic, child-focused investigations that examine patterns, systemic issues, and environmental factors rather than treating incidents in isolation
- promote earlier disclosures from children, parents, and staff by fostering a culture where raising concerns is safe, valued, and acted upon
- replace practices that prioritise secrecy 'to avoid panic', which can limit accountability and inadvertently allow offenders to continue harmful behaviour.

Embedding this expectation will normalise transparency, reinforce organisational accountability, and strengthen the effectiveness of the Reportable Conduct Scheme, signalling that the safety of children is always paramount.

# Mandatory reporting requirements

In Queensland it is mandatory to make a report to police or child protection agencies where child sexual abuse is suspected or disclosed. This seeks to ensure that any concerns about a child's safety and wellbeing are quickly and appropriately addressed. While reporting obligations were initially in place for certain professions, such as health workers, they have continued to expand to different practitioners and sectors.

While mandatory reporting obligations may be established in legislation, workplace policies and procedures are needed to embed requirements into practice. Staff need to be aware of their obligations, know how to make a report, and be supported to do so. Reporting schemes can be strengthened by:

- focusing on cultural change where organisations encourage staff to report child sexual abuse or behaviour that makes them feel uneasy
- improving reporting pathways, with training and guides that assist staff understanding of when, how and what to report
- encouraging staff to report concerning behaviour which causes discomfort, even it does not meet a definition of child sexual abuse in and of itself.

### Mandatory reporting requirements

Since **1 October 2017,** approved providers of ECEC services have been required to make a report to ECRA of any physical harm or sexual abuse to a child or any allegation of physical or sexual abuse occurring while the child is being educated and cared for by the service.

Since **5 July 2021,** any adult in Queensland who reasonably believes that a child sexual offence is being or has been committed must report the information to a police officer as soon as possible, unless they have a reasonable excuse not to. This is known as the 'failure to report offence.' A reasonable excuse includes, but is not limited to:

- if the adult believes on reasonable grounds that the information has already been disclosed to a police officer
- if the adult gains the information as a relevant professional, such as a medical practitioner or a counsellor, in the course of a confidential professional relationship with the child in which there is an expressed or implied obligation of confidentiality between the adult and the child
- if the adult reasonably believes disclosing the information to a police officer would endanger the safety of the adult or another person, other than the alleged offender, regardless of whether the belief arises because of the fact of the disclosure or the information disclosed.

As of **1 July 2026,** all centres will be required to undertake an investigation as part of the implementation of a Reportable Conduct Scheme in Queensland (as discussed in more detail in Chapter 9) in addition to the obligations listed above.

Centres will also be required to notify the Queensland Family and Child Commission (the Commission) about the initial report and the outcomes of their investigation. The Commission will have a role in supervising these investigations, and conducting its own investigation if it believes that the centre has not adequately dealt with the report.

# A failure to report and to protect

Every adult in Queensland has a responsibility to act if child sexual abuse is suspected or disclosed to them. Additional obligations are also imposed on organisations to swiftly respond where there is a known risk of sexual offending associated with the institution. In Queensland these offences are commonly referred to as the:

- **Failure to report offence**: If an adult reasonably believes (or should reasonably believe) that a child is being or has been the victim of sexual abuse by another adult, they must report it to the police—unless they have a reasonable excuse not to (section 229BC of the Criminal Code).
- **Failure to protect offence**: This offence requires a person in a position of power or responsibility within an institution to reduce or remove a known risk of sexual offending against a child by an adult associated with an institution (Section 229BB of the Criminal Code).

These offences were implemented in response to the Royal Commission, which made a suite of recommendations to ensure that any person associated with an institution who knows or suspects that a child is being or has been sexually abused in an institutional context should report the abuse to police.[27] The Royal Commission also recommended that state and territory governments introduce legislation to create a criminal offence of failure to protect a child in a relevant institution from a substantial risk of sexual abuse by an adult associated with the institution.[28] In making these recommendations the Royal Commission found that:

> *The impact of child sexual abuse on individual victims may be lifelong, and the impact on their families and the broader community may continue into subsequent generations… unlike other categories of crime, child sexual abuse is often not reported and stopped at the time of the abuse because the child victims face such difficulties in disclosing or reporting the abuse. When a perpetrator is not discovered and stopped from abusing a child, they may continue to abuse that child and other children.*[31]

In contrast to the proportionately narrow scope of the failure to report offence recommended by the Royal Commission, which was initially intended to apply to child sexual abuse in institutional settings, the Queensland Government decided to extend the failure to report offence to all adults. This offence was expanded due to the complexity of having to establish the parameters of the offence if it was to apply only to institutional settings.[29] It also sought to ensure jurisdictional consistency and to send a message to the Queensland community 'that child sexual abuse is not something that can be ignored by any adult'.

The failure to report offence has not been without controversy. In the five years to 30 June 2025, only 10 charges have been laid, and five of these did not lead to conviction. Early on, stakeholders raised concerns about the broad operation and applicability of the offence, which was inconsistent with the intent of the Royal Commission's recommendations and the legitimate reasons victim-survivors have for not wanting to make a report of abuse. For older children, mandatory reporting obligations may act as a barrier to making a disclosure of abuse. This includes a fear of their parents finding out and because of the requirement for police to be told without them actively choosing to report an offence.[30]

At the time, the Queensland Government sought to respond to these concerns, by committing the former Department of Justice and Attorney-General to develop an appropriate communications strategy as part of implementation to 'help to mitigate the possible impact by ensuring the community clearly understands the operation of the new offence'.

Despite this commitment, submissions received by the Women's Safety and Justice Taskforce (the Taskforce) in 2022 highlighted that there was confusion around, and limited understanding of, the operation of this offence. Stakeholders also raised concerns that it acted as a barrier to victim-survivors engaging with support services, in circumstances where they did not wish to make a report of abuse to police.

At the time, the Taskforce was advised by the Department of Justice and Attorney-General that awareness had been raised about the offence by writing to stakeholders, convening a forum for specialist sexual assault providers and publication of fact sheets on the Queensland Government website. The Department of Education also advised that a factsheet had been developed for students who are over the age of 18 years about the failure to report offence and noted that school employees were subject to mandatory reporting obligations and therefore higher reporting obligations than adult students.

The Taskforce ultimately found that:

> *…the activities undertaken to explain the new offence have not addressed the concerns voiced at the time the offence was introduced and this was negatively impacting on victim-survivors…both the service sector and the community expected something more comprehensive than what was ultimately delivered.*[30]

As such, the Taskforce recommended that the Department of Justice and Attorney-General develop and implement a broad community awareness campaign with targeted messages for children's sexual assault and health services around the scope and intent of the failure to report offence to support its ongoing implementation. It further recommended that the 'reasonable excuse' provisions be reviewed to explicitly cover the provision of sexual assault counselling and medical care.

Legislative amendments to the operation of this provision have since been enacted, which provide greater clarity for community support services when working with victims-survivors about what can or must be disclosed.[31]

In the Second Annual Report 2023–24 of the Taskforce, the Department of Justice and Attorney-General advised that work had 'commenced' to deliver a community awareness campaign to clearly explain the scope and intent of this offence and would be informed by an overarching communication strategy, stakeholder consultation and market research.[32]

More recently, the National Review of Child Safety Arrangements called for national consistency in relation to the failure to report and failure to protect offences, along with a greater promotion of these laws to increase awareness about them. In making this recommendation it was noted that:

*…variations in obligatory reporting models mean that institutions have different obligations to externally report institutional child sexual abuse, depending on what sector and jurisdiction they operate in. These differences can result in varying levels of protection for children and the extent of potential underreporting.*[33]

In conducting its Review, the Board requested information from ECRA about its understanding of the operation of the failure to report and failure to protect offences who advised that:

*No specific awareness raising activities have been undertaken by the Department in relation to the requirements introduced in the Criminal Code (Child Sexual Offences Reform) and Other Legislation Amendment Act 2020. However, the Regulatory Authority's investigative protocols ensure that all allegations of child sexual abuse notified to the Department are reported to QPS.*

*The Department has conducted extensive awareness raising activities in relation to the mandatory reporting requirements of education and care staff under the Child Protection Act 1999, as well as in relation to approved providers' responsibilities to ensure specific roles receive child protection training (in accordance with Queensland's government protocol under s.162A of the National Law), to ensure all staff and volunteers working with children are aware of their obligations under current child protection laws (r.84 of the National Regulations), and to notify all incidents and allegations of child sexual abuse (r175(2)(d) and r(175(2)(e) of the National Regulations).*

A similar question about awareness of failure to report and failure to protect offences was also asked of those centres where the offender was known to have been employed. Responses indicated varied levels of understanding of the legal requirements and inclusion in their policies and procedures.

In their response, Centre WS acknowledged that at the time of the offender's employment they were subject to mandatory obligations under Section 13E of the *Child Protection Act 1999*, and the 'analogous obligation under the National Law and its subordinate regulation'. No reference was made to any knowledge of the failure to report and failure to protect offences. These were however included in recent training conducted by the service, which provides guidance to staff about what actions should be taken where abuse is reported or suspected:

- *Monitor child wellbeing.*
- *Refer directly to support services.*
- *Refer to family and child connect.*
- *Refer intensive family support.*
- *Refer to regional intake service and child safety.*

Changes in legislation were also noted by Centre MY. While the offender was employed in Centre MY prior to the legislation having been introduced, they have provided their updated child protection policies and procedures which include the failure to report and failure to protect offences.

Centre HN demonstrated advanced recognition of these offences in their policies and procedures. They provided material in relation to the offences which had been developed in 2021, when the initial amendments were introduced. This policy is clear in outlining the responsibilities of staff with respect to the new offences including through the use of case scenarios, additional considerations and further reading.

While some centres also confirmed that they had policies and training about mandatory reporting requirements, information provided in these documents was incorrect and referred to non-existent legislation.

For example, the entity that oversees Centre WN in its *Child and Youth Risk Management Strategy Considerations for Early Childhood Services* document dated 10 July 2018, incorrectly referenced the "Child Protection Act 2000" and referred to:

*Imminent legal responsibilities:*

*Criminal Code (Child Sexual Offences Reform) and Other Legislation Amendment Bill. These amendments include the creation of failure to report and failure to protect offences, regarding child sexual offences.*

The Board noted inaccuracies in the dates of the Child Protection legislation given the incorrect year referred to in the material as well as reference to the criminal code amendment bill in a document dated 2018, despite it not being introduced until 2019. This centre's updated *Protecting Children and Young People in (…) Education Guidelines and Procedures* dated December 2021, clearly outline the failure to report and protect offences, as well as the requirement to record and retain documentation.

Although the policies and procedures of Centre BS, outline comprehensive reporting guidelines, including visual prompts in the form of posters for their staff, there is no mention of the failure to protect and failure to report offences in them. Clarification around this point was sought in addition to the initial information, the response provided did not speak to these offences in their own right.

Information about the failure to protect and failure to report offences was sought from Centres EK and MT, however, was not received.

Some services where there was known offending have provided information about the changes they have made in response to the Board's request for information, including to ensure there is an increased awareness of, and compliance with, mandatory reporting obligations. This includes regular mandatory training and improvements to induction processes to ensure that staff are aware of their obligations. Services have advised that they have implemented:

- Reporting Serious Incident Procedures, to complement the existing Child Protection Policy
- visual reminders for staff
- regular reminders for staff around mandatory reporting obligations through multiple channels, including through a people and culture hotline, a compliance hotline, incident reporting system and whistleblower channel.

With the commencement of the Reportable Conduct Scheme in Queensland in July 2026, organisations will be required to report and investigate allegations of child abuse or misconduct by their staff and volunteers. Failure to report can result in the head of an organisation receiving a financial penalty of over $16,000.[33] While this goes toward addressing some gaps in reporting and provides strengthened oversight, the Board notes the low penalties associated with the failure to report to the scheme and recognises the need for additional safeguards.

Research conducted for the Board by the Australian Institute of Family Studies highlights that systems for reporting allegations of abuse can be strengthened in practice by:

- encouraging organisations to emphasise reporting through culture, guidelines and practices
- supporting staff to understand how and what to report, through rigorous and regular training and informational resources
- providing staff with a clear pathway to reporting, with systems that guide them to and through the reporting process
- enabling staff to feel comfortable to report concerning behaviour.[34]

## Operational Recommendation 8: Conduct a future evaluation of the reportable conduct and blue card schemes

From October 2025, Queensland's child safeguarding landscape has undergone significant reform with the commencement of the new Working with Children Check (WWCC) risk-based decision-making framework and the *Child Safe Organisations Act 2024*, followed by the launch of the Reportable Conduct Scheme in July 2026. Collectively, these three initiatives represent some of the most substantial advances in child safeguarding infrastructure in recent years. They signal a deliberate move toward more proactive, accountable, and systemic approaches to keeping children safe.

While their introduction is a major step forward, it is essential that these reforms do not end at implementation. The true measure of their success will lie in how effectively they operate in practice—whether they raise standards, strengthen accountability, reduce risk, and deliver on the expectations set by government, stakeholders, and the community. For this reason, a structured review of their operation after the first two years of operation is critical. Such a review would test whether the frameworks are functioning as intended, identify gaps or unintended consequences, and provide an evidence base for refinements and continuous improvement.

Only through ongoing scrutiny and review can we ensure that these reforms achieve their promise and that Queensland continues to build a safeguarding system capable of responding to contemporary challenges and preventing harm to children.

Specifically, the Reportable Conduct Scheme in Queensland represents a major step forward in safeguarding children within organisational settings. The Queensland legislation was based on the established frameworks in New South Wales and Victoria, however both of these have since been reviewed with proposals for amendment.

As a new initiative, the Reportable Conduct Scheme's operational effectiveness remains untested. Queensland's legislation adopts a broad definition of reportable conduct, and while this breadth is intended to capture a wide range of harmful behaviours and encourage organisational vigilance, it also creates potential challenges around practical implementation, clarity for organisations, and demand management. Swamping organisations with low-risk cases not associated with child sexual abuse may detract and limit the overall value of the scheme. Early engagement with the scheme, staff training, regulatory oversight, and the cultural acceptance of reporting mechanisms will all influence its uptake and overall impact. There is a genuine risk that, without close monitoring, the Reportable Conduct Scheme's broad legislative scope could result in diffused focus, inconsistent application, or administrative burdens that limit its intended value.

Furthermore, Queensland's implementation comes at a time when national and international standards for child safeguarding are evolving rapidly, and the experiences of New South Wales and Victoria demonstrate that even well-designed schemes require ongoing refinement. Lessons from these jurisdictions emphasise the importance of reviewing operational practices, legal thresholds, and regulatory guidance to ensure schemes are both effective and sustainable over time.

During the course of the Review, stakeholders consistently reported that the blue card system can produce outcomes that are difficult to predict and, at times, appear inconsistent. Some participants described WWCCs as overprotective, restricting individuals from child-related work despite low levels of assessed risk, while others noted that decisions can feel arbitrary, with similar circumstances resulting in very different outcomes. In their submission one parent discussed a gap in WWCC as it relates to the traineeship and apprenticeship sector for young people. The parent emphasised that providers of traineeships and apprenticeships should be required to demonstrate that they are safe workplaces for children and young people, with the WWCC serving as a minimum safeguard. This parent outlined their own child's experience of harm during the course of traineeship and their child being manipulated to provide the perpetrator access to their friends (e.g., inviting their friends to celebrations and other occasions the employer organised).

This parent further observed that, as the government funds traineeships and apprenticeships to support the skill development and workforce participation of young people, there is a shared responsibility to ensure their safety and wellbeing. This includes ensuring that funded training environments meet child safe and workplace safety standards, and that appropriate mechanisms exist to monitor, regulate, and respond to risks of harm in these settings.

This feedback highlights the challenges inherent in balancing the protection of children with procedural fairness considerations and underscores the importance of monitoring and evaluating the operation of the Reportable Conduct Scheme as part of broader safeguarding reforms.

Given these considerations, it is imperative that Queensland establishes a formal, time-bound review mechanism. Such a review would examine the Reportable Conduct Scheme's uptake, assess how effectively it identifies and responds to child sexual abuse, and determine whether its broad legislative approach enhances the safety of children without creating unnecessary administrative burden or complexity. This approach ensures that the Reportable Conduct Scheme remains fit for purpose, evidence-informed, and responsive to emerging risks in the child protection landscape.

### **Operational Recommendation 8:** Conduct a future evaluation of the reportable conduct and blue card schemes

That the Queensland Government conduct a comprehensive review of the state's key child safeguarding frameworks—including the risk-based Working with Children Check (blue card) system, the Child Safe Organisations Act, and the Reportable Conduct Scheme—in 2028–29. This review should assess whether recent reforms are operating as intended, identify any gaps or unintended consequences to the operation of the new schemes, and provide evidence-based recommendations for improvements to strengthen accountability, reduce risk, and ensure that the child safeguarding system effectively protects children across all sectors. With specific reference the review must:

- consider the operation of the blue card system within the broader safeguarding system
- consider the operation of the Reportable Conduct Scheme and its effectiveness in preventing, detecting and responding to child sexual abuse.

The review should assess scheme uptake, operational challenges, and whether its broad legislative definition supports timely detection, intervention, and organisational accountability for preventing, detecting and responding to child sexual abuse.

Chapter 18

# Interviews and investigations

# Interviews and investigations

> *Maybe…the testimonies of children will get the attention they deserve, in their own right, not as an aside or a footnote. Maybe, just maybe, we can finally accept that the trauma caused by grooming, child sexual abuse and incest is unique and should be treated as such.* - Grace Tame

Effective police investigations require specialist training, multidisciplinary collaboration, and trauma-informed practice. Best practice approaches, such as the use of specialist child interviewers, joint investigative teams, and forensic interviewing protocols, minimise the need for children to repeat their story while maximising the quality of evidence. This strengthens both child safety and the integrity of the justice process.

The court process, long criticised for retraumatising children, has seen significant reform in many jurisdictions, including Queensland. Best practice now includes measures such as pre-recorded evidence, limits on cross-examination, the use of intermediaries, and closed court environments. These practices seek to protect children from further harm while maintaining the fairness and robustness of legal proceedings.

Together, these system improvements represent society's collective responsibility to respond to child sexual abuse and hold perpetrators to account through the criminal justice system. The measure of their effectiveness lies not in their existence on paper, but in the quality, consistency, and child-centredness of their application in practice. In the case of child sexual abuse, we must also ensure that the long-term consequences for victim-survivors are recognised and mitigated, and that parents and caregivers are recognised as secondary victims in the justice system.

This chapter examines investigative responses to child sexual abuse by police and the early childhood education and care (ECEC) system, highlighting both strengths and areas where further reform is required to ensure that every child who experiences abuse is met with a system that protects, supports, and delivers justice.

## Interviews and investigations into the offender's conduct

Across more than two decades, repeated concerns were raised about the offender's conduct in ECEC settings. Parents, children, and staff provided accounts of the offender's inappropriate behaviour, sexual misconduct and physical harm, yet the responses from centres, police, and regulatory bodies were fragmented and insufficient. Taken together, these events show a series of missed opportunities where decisive action could have brought the offender's conduct to light much earlier, by centres, by the Early Childhood Regulatory Authority (ECRA) and the Queensland Police Service (QPS).

Despite a clear legislative requirement to do so, centres failed to notify ECRA about complaints that indicated risk of harm to children. For example, a parent reported in 2019 that the offender had grabbed and squeezed their child's arm. Staff and parents also witnessed the offender threaten to smack a child (2018) and observed inappropriate physical contact with another child, including rubbing their shoulders and kissing their head (2019–2021). Each of these incidents should have triggered a formal regulatory response. Instead, they were dealt with internally or not acted upon at all, leaving the regulatory system blind to critical warning signs.

Three separate complaints were referred to QPS between 2009 and 2022, each presenting opportunities for intervention:

- **2009:** Police interviewed the child but not the offender or centre staff. No charges were laid, and there is no record of any action taken by the centre or the then-regulator, the Office for Early Education and Care.
- **2021:** Police interviewed the complainant staff member and the offender, but not the child. Again, no charges were laid. The centre conducted an internal review, identified a code of conduct breach and required the offender to re-familiarise himself with policies and procedures. ECRA accepted the centre's investigation and concluded there was no breach of the National Law.
- **2022:** Police interviewed the child but did not interview the offender. The centre collected staff statements, which were relayed to police. ECRA determined the matter did not meet its threshold for further investigation.

> *Across these complaints, investigative gaps were evident: children and potential witnesses were sometimes not interviewed, the offender was sometimes not interviewed, and regulatory oversight was limited to accepting the outcomes of narrow internal reviews.*

The shortcomings in these responses can be partly explained by the limits of police and regulatory capacity, alongside the relative immaturity of regulatory systems. Police investigations into child abuse are often constrained by the high evidentiary thresholds required to pursue criminal charges. Officers may make decisions not to interview every potential witness or suspect if they believe the initial available evidence is weak or if the complainant is very young, where reliability in court is considered difficult to establish.

While this approach reflects resource pressures and legal considerations, it risks narrowing the fact-finding process and overlooking important contextual information indicative of broader patterns of abuse and harm.

Similarly, given the timespan over which the offending occurred, regulatory authorities like ECRA were in the early stages of establishing systems for handling complex complaints and had limited specialist expertise in the investigation of reports of sexual or physical abuse. Regulators often relied on the outcomes of police investigations, in deference to law enforcement expertise and because of limited resourcing to conduct parallel inquiries. Where police found no grounds to proceed, regulators concluded there was no breach of the National Law, rather than independently assessing whether professional conduct standards or child safety obligations had been compromised.

***Each system appeared to treat the complaints in isolation, rather than recognising a pattern of concerning behaviour across years and settings.***

What emerges is a picture of siloed responses and lost opportunities. Centres withheld serious complaints from ECRA, QPS investigations were partial and inconclusive, and ECRA relied on the outcomes of others rather than exercising its own investigative powers. At no point were the multiple concerns consolidated, cross-referenced, or escalated to a level commensurate with the risks posed to children. The absence of a coordinated approach meant that credible reports of inappropriate and harmful conduct were repeatedly minimised or missed.

Ultimately, the offender was only identified when caught through digital evidence unrelated to these earlier complaints and investigations. The persistence of children, parents, and staff in speaking up contrasts starkly with the absence of decisive institutional action, highlighting systemic weaknesses in the mechanisms designed to protect children from harm.

**Three** complaints received by centres were not reported to ECRA, despite the legislative requirement to do so.

- One child told their parent that the offender had grabbed and squeezed his arm (2019).
- Two centres received reports from parents or staff that had witnessed the offender cause harm to a child or interact with them inappropriately. This includes the offender threatening to smack a child (2018), and stand behind a different child, rub their shoulders and kiss their head (between 2019 and 2021).

**Three** complaints received by police from parents or staff and referred to ECRA (or its predecessor).

### Complaint 1 (2009):

- **Police:** Interview with child. Offender and centre staff not interviewed. No charges laid.
- **Centre:** No information available about actions taken.
- **Office for Early Education and Care:** No information available about actions taken.

### Complaint 2 (2021):

- **Police:** Staff complainant and offender interviewed. Child not interviewed. No charges laid.
- **Centre:** Internal investigation by centre into complaint including staff interviews. Offender required to review policies and procedures due to code of conduct breach.
- **ECRA:** Requested centre undertake its own investigation which had been completed and requested information about the outcome. No breaches of the National Law by the approved provider were identified by ECRA.

### Complaint 3 (2022):

- **Police:** Interview with child. Offender not interviewed. No charges laid.
- **Centre:** Internal statements from centre staff taken about complaint. Statements shared with police.
- **ECRA:** Matter was determined not to meet the threshold for further investigation, following outcomes of the police investigation.

# Policing responses to child sexual abuse

Police are often the first point of formal contact for child victim-survivors following a disclosure of sexual abuse.[35] Their role is critical, not only in gathering evidence and progressing investigations, but also in shaping the child's experience of justice and recovery. The experiences victim-survivors have in their initial contact with police can determine the quality of their engagement in future processes, including in choosing to proceed with making a report. A trauma-informed, developmentally appropriate, and rights-based approach is essential to ensure that children are supported rather than re-traumatised during this process.[36]

> *A key challenge in the justice process occurs when police officers lack specialist knowledge of child development, trauma, and memory, factors which strongly influence a child's ability to disclose and be perceived as credible. Research shows that law enforcement can hold outdated or inaccurate beliefs about memory and trauma. Without appropriate training, there is a risk that police officers may misjudge a child's narrative, inadvertently undermining the child's credibility or causing re-traumatisation.*[37]

As a gatekeeper to the criminal justice system, QPS faces continued scrutiny in their responses to victim-survivors of child sexual abuse, and the way that it investigates these types of offences.

In 2003, the Crime and Misconduct Commission handed down its report *Seeking Justice: An inquiry into how sexual offences are handled by the Queensland Criminal Justice System*. This inquiry was established in response to public concern about the investigation, prosecution and discontinuance of charges against a swimming coach who had been arrested for offences against children. It noted that:

> *During the last decade, cultural and societal change has started to remove the veil of secrecy surrounding sexual abuse, encouraging more victims to come forward to report their experiences than in the past. It is, therefore, important that the criminal justice system responds appropriately to allegations of sexual abuse — the process must be seen both to encourage victims of abuse to come forward to report sexual abuse, and to help prevent the occurrence of such abuse… A key aspect, among many, in encouraging victims of sexual offences to officially report their victimisation clearly lies in their initial interaction and relationship with the police. The adequacy of the response by police to child sexual abuse allegations has been examined previously in Queensland and, importantly, a series of significant structural changes have been undertaken to enhance service delivery and improve effectiveness. An earlier review revealed a series of shortcomings in police investigations of child sexual abuse and identified the need to improve the coordinated service delivery model, to provide additional training support and to increase the selection and retention of specialist sexual offence staff.*[38]

Recommendations from this report sought to improve the collection and dissemination of evidence, including through interviews to support the prosecution of sexual abuse offences, and reduce the stress associated with engaging with criminal justice systems for victim-survivors. They also sought to enhance timeliness of decision-making, strengthen court proceedings and 'enhance community confidence in the fairness and objectivity of the process'.[39]

Twenty years on from the delivery of this report by the Crime and Misconduct Commission, the second report of the Women's Safety and Justice Taskforce (the Taskforce) in 2022 again reflected that:

> *The way police interact with victims can affect the likelihood of future reporting and whether victims continue with a complaint. Police interviewing techniques have been described in the research literature as invasive, traumatising and inappropriate. This may be because police must determine whether an offence has occurred, establish victim credibility, or decide whether sufficient evidence exists to proceed to charge an alleged offender. The Taskforce observed that this can sometimes be a result of police genuinely, although misguidedly, trying to protect a victim from the realities of the criminal justice process.*[40]

Over recent years, the Taskforce, the Royal Commission into Institutional Responses to Child Sexual Abuse (Royal Commission), and the Australian Law Reform Commission have made a multitude of recommendations that seek to improve policing responses to victim-survivors of sexual abuse and violence.

Implementation of these reforms by QPS is guided by the *Queensland Police Service Sexual Violence Response Strategy 2025–29.* This strategy establishes a vision of a victim-centric, trauma-informed sexual violence response that protects the community, strengthens public confidence and contributes to Queensland and National integrated action plans.[41]

*...the QPS is often the first point of engagement for victim-survivors within the criminal justice system. The lasting impact, trauma and devastation on victim survivors of sexual violence is well-established and it is imperative the response provided by law enforcement is appropriate, effective and supportive through victim-centric and trauma-informed practices.*[42]

QPS continues to implement a range of different programs and initiatives that seek to improve its responses to victim-survivors of child sexual abuse, including in institutional settings. This includes by providing training to build workforce capacity, capability and understanding.

The **Child Sexual Abuse Fundamentals Education** is a training program for QPS staff (sworn and unsworn) to improve responses to a report of child sexual abuse. The goal of the training is to help staff understand issues raised by the Royal Commission and better support victim-survivors of child sexual abuse, and sexual assault more generally. It is about listening to, understanding, and supporting survivors so they are better able to give their accounts of what happened to them. The learning objectives relate to:

- understanding institutional child sexual abuse
- understanding trauma and applying this to practice
- understanding the unique issues for survivors from diverse backgrounds
- understanding the implications of development throughout childhood
- how to communicate effectively**.**

The **Interdiction for the Protection of Children** (IPC) training program is a proactive, intelligence-led initiative aimed at detecting, disrupting, and preventing child sexual exploitation, child abuse and child abductions.[43] The IPC Program was initially developed by the Texas Department of Public Safety (TDPS). The QPS partnered with TDPS in 2019 to develop and implement IPC for the Australian environment.

It equips frontline officers with specialist training to identify subtle indicators of harm, even without prior intelligence, enabling real-time intervention and protection for vulnerable children. Officers are trained to identify:

- people who pose a high risk to children
- children who are being trafficked, exploited, or abused by one or more adults
- children who are at risk of various forms of exploitation.

The program effectively challenges officer bias relating to the behaviour of offenders and victim-survivors. It seeks to educate officers about perpetrator and victim typologies, trauma responses, child development, legislation and child protection frameworks. The program has proven that early detection and disruption are possible even when children are not able to seek help.

The Royal Commission also highlighted that misconceptions about the function of memory, particularly in cases of childhood abuse, may negatively impact how police collect evidence and the weight courts place on it at trial.[44] These misconceptions, coupled with approaches to investigation which are not child-centric and trauma informed, may cause additional harm to child victim-survivors and witnesses while also producing lower-quality evidence.

In Queensland, police are responsible for working within the Queensland Government Interagency Guidelines for responding to children, young people and adults who have experienced sexual assault or child sexual abuse (the Interagency Guidelines).

## The Queensland Government Interagency Guidelines for responding to children, young people and adults who have experienced sexual assault or child sexual abuse

The Interagency Guidelines outline key principles and a best practice framework for government agencies working with children, young people and adults who have experienced sexual assault and/or child sexual abuse, noting that people may have experienced both forms of violence.[45] The guidelines aim to ensure that individuals who have experienced sexual assault and/or child sexual abuse are provided with timely, sensitive, trauma-informed, victim-centric, high quality and coordinated service delivery responses appropriate to their needs, and appropriate to the role played by these agencies.[46]

The Interagency Guidelines were first developed in 2001 and are designed to promote whole-of-government interagency cooperation and service coordination with the aim of improving government agency responses to victim-survivors of sexual assault or child sexual abuse.[47] They aim to facilitate best practice, quality service and support to people who have experienced sexual assault or child sexual abuse. The Interagency Guidelines encompass consideration of a broad range of policies and legislation.

**Table 2: Legislation, policies and procedures relevant to sexual assault or child sexual abuse**

| Legislation relevant to and defining sexual assault or child sexual abuse includes, but is not limited to: | Policies and guidance documents that should be read in conjunction with internal agency procedures such as the: |
|---|---|
| • *Domestic and Family Violence Protection Act 2012*<br>• *Police Powers and Responsibilities Act 2000*<br>• *Criminal Law (Sexual Offences) Act 1978*<br>• *Criminal Code Act 1899* (Criminal Code)<br>• *Youth Justice Act 1992*<br>• *Human Rights Act 2019*<br>• *Mental Health Act 2016*<br>• *Public Guardian Act 2014*<br>• *Hospital and Health Boards Act 2011*<br>• *Victims of Crime Assistance Act 2009*<br>• *Public Health Act 2005*<br>• *Guardianship and Administration Act 2000*<br>• *Child Protection Act 1999*<br>• *Evidence Act 1977*<br>• *Health Act 1937* and associated regulations | • Health Service Directive: Caring for People Disclosing Sexual Assault<br>• Queensland Health Guideline: Guideline for the Management of care for people 14 years and over Disclosing Sexual Assault<br>• Ministerial Direction – Crisis Care Process<br>• Department of Health Guideline: Conducting Child Sexual Assault Examinations<br>• Office of the Director of Public Prosecutions Director's Guidelines<br>• Queensland Police Service Operational Procedures Manual<br>• Child Safety Practice Manual<br>• Queensland Child Protection Guide 2.1<br>• Victim Assistance Queensland Guidelines<br>• Youth detention operational policies<br>• QPS Sexual Violence Response Strategy 2025–2029 |

The Interagency Guidelines note that the initial information obtained from a child is critical in the prosecution process, and therefore it is best practice that only investigators who have completed Interviewing Children and Recording Evidence (ICARE) training should interview children to ensure admissibility of the statement.[48]

# Current practice and training

The offender is known to have perpetrated abuse against children in Queensland for almost two decades. He was found in possession of child exploitation material (CEM) dating back to 2000. The external jurisdictional review of the police response to complaints made to QPS about the offender prior to his arrest in 2022, identified opportunities for improvements in some of the responses and noted that there were 'obvious deficiencies' in the response by officers to the first 2009 report involving the offender. Officers interviewed as part of this review process, reflected that the current system of investigating child sexual abuse offending had 'vastly improved' since this first report.

While it is accepted that the QPS has made substantial improvements in its practices since the initial complaint was made, this should not stop the Board from considering what more could or should be done to strengthen current approaches, and ensure that victim-survivors are heard, and responded to.

In submissions made to the Board the Queensland Sexual Assault Network (QSAN) expressed:

> *...concerns about the conduct of some interviews with children and young people by the police, as their approach can be intimidating or their mannerisms may not create a safe space for young children to talk. Young children as young as 3 years old often do not make the statements that police require, even for older children such as primary school aged children there can be difficulties. Children [are] more likely to be open about an experience to parents, close family members etc over police, leading to cases not being proceeded with and being dropped which can result in a lack of protection for children. The burden of evidence is so high this makes it increasingly difficult in a criminal response. Children are not believed - individually or by systems, courts, police, workplaces and institutions. It can be easier for the system to not believe the child than to respond to the issue they are raising...As a result, children can be left effectively without protection as they are not believed by the criminal justice system or they do not make statements, in a way that is acceptable to the system.*

Submissions from the Office of the Advocate for Children and Young People New South Wales further emphasised the need for integrated victim-centric, co-located, trauma-informed responses by police and other services. They suggest that this would improve the capacity of police to respond to reports of abuse involving young children and for 'non-criminal' risk management, that is, measures that seek to enable agencies to act on disclosures of concerning behaviour even when criminal thresholds are not met.

In discussing the investigation of allegations of child sexual abuse by police, Bravehearts also stated that:

> *Central to these investigations needs to be the use of trauma-informed and developmentally appropriate forensic interviewing. Interviews with children should only be conducted by trained specialists, using structured techniques that are non-leading and sensitive to the child's emotional state and age. This may require upskilling of those police working in child protection units. Particularly when the victim is a young child, the use of specialist skilled forensic interviewers, trained on working with young children, should be prioritised.*

In submissions made to the Board, the Australian Centre to Counter Child Exploitation (ACCCE) advised that a skills audit undertaken in 2020 identified that members working in Australian Federal Police (AFP) child protection investigation did not receive any training specific to this crime type. A four-day Child Protection Induction Workshop was subsequently developed in response to this training gap. This training includes planning and evidence collection considerations, approaches to building rapport and interviewing offenders, and victim identification processes, however it does not specifically focus on interviewing techniques for child victim-survivors.

The NIVPP is an interactive program which is currently delivered by the ACCCE training team three to four times a year in various locations in Australia. This program seeks to develop the knowledge and skills of members who are likely to undertake investigative roles with a requirement for public engagement, witness and suspect management. It focuses on a trauma-informed approach and guides the conduct of Evidence in Chief Interviews for Commonwealth offences. The five-day interactive training program delivers training in the preparation, planning and conduct of best practice interviews and includes subject matter expert input on topics such as memory and vulnerability. The ACCCE considers that there is an ongoing need to develop AFP investigators with training in interviewing vulnerable persons, including children involved in specific proceedings, including slavery, trafficking and child sex offences.

# Best practice approaches to interviewing victim-survivors

> *I went back to the same intimidating police station with the confidence to recall my abuse and the specific details, only to be met with new police officers. No familiar faces. Needless to say, the police interview was not successful. Some months later, I attended a final police interview. I was interviewed by the original police officer and was able to describe in detail what happened to me, when and where. After the interview, the officer told my mum that my recollection of details would have resulted in a confident prosecution had I have done so in my first interview. This was absolutely devastating. As a 5 year old I struggled to understand why the perpetrator was not going to be prosecuted. It felt like victim blaming in some sense - like my story didn't matter* - Lived experience advisor

Research demonstrates that when interviewing child witnesses, police interviews must prioritise emotional validation and procedural transparency. Children need to feel believed, respected, and safe. When interviewers demonstrate empathy and provide clear, accessible updates about the case, victim-survivors are more likely to engage with the justice system and experience improved psychological outcomes.[49]

For example the Queensland Intermediaries Scheme is a state-run initiative designed to improve communication within the criminal justice system for vulnerable complainants and witnesses in child sexual offence cases.

The scheme commenced as a pilot in Brisbane and Cairns in July 2021, as part of the implementation of recommendations from the Royal Commission.[50]

Queensland Courts Services employs intermediaries who are qualified professionals in speech pathology, psychology, occupational therapy, or social work to assess witnesses' communication needs and facilitate effective communication. These intermediaries are impartial officers of the court and do not act as support persons or advocates.[51]

Eligibility for intermediary support is currently limited to prosecution witnesses in child sexual offence matters who have one or more of the following characteristics:

- under 16 years of age
- have an impairment of the mind
- experience difficulty communicating.[52]

Intermediaries may be engaged during both police investigations and court proceedings. Their functions include conducting assessments, providing communication recommendations, attending interviews and hearings, and ensuring that questions and answers are understood by all parties. The Queensland Intermediaries Scheme is currently funded to operate until June 2029, with ongoing evaluation to determine its broader applicability and long-term impact.

Interviewing techniques should also be adapted to the child's developmental stage. For younger children, this includes:

- using open-ended, non-leading questions
- providing verbal affirmations and supportive comments
- limiting interview length to match attention span and cognitive capacity
- incorporating visual aids such as drawings or pictures to support communication
- supportive behaviours—such as warmth, proximity, and positive facial expressions—improve both the accuracy and completeness of children's responses, while reducing suggestibility and distress.[53]

Benefits can also be actualised when agencies work collaboratively and prioritise the best interests of the child. The Joint Child Protection Response Program (JCPRP) in New South Wales is a collective partnership between the Department of Family and Community Services, police, and the Ministry of Health which seeks to 'foster cooperation between the three agencies and provide the best outcomes for children and their families' following an allegation of harm.

The JCPRP explicitly makes the safety, welfare and wellbeing of children the paramount principle for agency responses to allegations of harm. It is an example of a collaborative effort between government bodies made without overarching legislative initiatives. The agencies have agreed via a memorandum of understanding (MoU) to conduct a joint intake and risk assessment of any allegation which may constitute a criminal offence against a child, conducted by a Joint Referral Unit. The agreement facilitates the identification and sharing of relevant information held by each agency and sets out clear coordination to avoid duplication or confusion in the response.

There are also a number of examples of international best practice approaches to interviewing children. For example, the Interview Guidance for Investigative Police Officers (IGIpop) in Cyprus focuses on leveraging the skills of officers proven to work well with children.[54] IGIpop operates on the basis that, rather than attempting to bring all policing personnel up to the same standard of trauma-informed interviewing, a small cohort of high-quality interviewers should be assigned to conduct all relevant interviews.[55] An evaluation of this approach in 2020 found that it reduced inappropriate interview techniques and increased effective techniques, without an increase in training costs.[56]

The Lundy Model of Participation in Ireland also ensures children's voices and rights are embedded in investigative processes. It conceptualises a child's freedom to express views and the right to be heard as requiring four concepts:[57]

- **Space:** children are given safe, inclusive opportunities to form and express their views.
- **Voice:** children are provided appropriate information and processes are designed to facilitate the expression of their views.
- **Audience:** children's views are communicated and listened to.
- **Influence:** children's views are taken seriously and acted upon as appropriate.

### Space

Have children's views been actively sought?

Was there a safe space in which children can express themselves freely?

Have steps been taken to ensure that all children can take part?

### Voice

Have children been given the information they need to form a view?

Do children know that they do not have to take part?

Have children been given a range of options as to how they choose to express themselves?

### Audience

Is there a process for communicating children's views?

Do children know who their views are being communicated to?

Does that person/body have the power to make decisions?

### Influence

Were the children's views considered by those with the power to effect change?

Are there procedures in place that ensure that the children's views have been taken seriously?

Have the children been provided with feedback explaining the reasons for decisions taken?

# Interviewing perpetrators

While it is important to strengthen policing practices when interviewing victim-survivors, it is also critical that police officers are appropriately trained in interviewing perpetrators of child sexual abuse and are aware of the strategic, manipulative and intentional tactics that perpetrators may use to avoid detection.

Police training for conducting investigative interviews usually focuses on relevant legislation, techniques and a range of evidentiary considerations to ensure that officers are able to prove an offence beyond a reasonable doubt. Given the intense focus on this, behavioural indicators representative of child sexual abuse perpetration, such as grooming and environmental manipulation, may be missed or skipped over.

As discussed in more detail in Part C, perpetrators of child sexual abuse engage in grooming not only of children but also of adults in positions of trust, including police, teachers, carers, and other professionals. Perpetrators may present as trustworthy, generous, and community-minded individuals, often described as 'pillars of the community'. They may also build relationships with professionals, including police, by:

- demonstrating helpfulness or volunteering in child-related roles
- being cooperative and respectful in interactions with authorities
- using charm, flattery, or shared interests to build rapport.

This creates a perception of credibility and reduces suspicion, making it less likely that concerns raised by children or others will be believed or acted upon. Perpetrators may also seek to influence how complaints are handled, by discrediting the credibility of victim-survivors and other complainants. These tactics are used to avoid detection, reduce suspicion, and maintain access to children.

The offender is known to have employed many of these tactics at the centres that he worked in, including by engendering trust because of his qualifications and experience, testing boundaries and ingratiating himself with others. It is considered likely that he may also have sought to employ these tactics when engaging with police. For example, when considering the 2021 complaint to police by a staff member who reported witnessing the offender kissing a child in an outdoor fort, records indicate that the staff member told QPS officers the following details:

> *She stated that when she walked out and looked through a window, she saw [the offender] on all fours with both of his knees and both hands on the ground on top of a female child who was asleep at the time. She further stated that she was shocked by this as she saw that [the offender's] face was super close to the girl's face. She stated that his face was about 2cm away from the girl's face and that his face was moving in a side to side motion. She stated his mouth was close to the girl's mouth. She stated that [the offender's] face was the only body part that was moving. She stated she then walked back into the classroom and paced around until she spoke to her coworker, (...). She told [other staff member] what she just saw. After about 3 minutes later, she then walked back out to the yard and still saw [the offender] in the same position on top of the girl. She called out to [the offender] three times and [the offender] looked up at her and responded angrily with a "What?" She asked [the offender] if he wanted a break and he replied to her with a "no". She stated she think [sic] he sat up when she walked back into the classroom. Five minutes later, [the offender] walked back inside and opened the door.*

During the offender's interview with police he provided his version of events stating that he was only crouched for 10 seconds with the child, that he did give her face a "nuzzle", and that some children were already awake and using iPads. He also explained this was a common way to wake up the children.

Based on the interview transcript, QPS officers did not challenge the offender with the details provided by the female childcare educator despite them being inconsistent with his version. They also did not consider the offender's way of waking up children as not being 'common' and considered inappropriate by other educators (hence the complaint). From the available QPS records, it appears officers did not believe an offence had occurred, which was substantiated by the internal review of this complaint following the offender's arrest.

This internal review ultimately found that the investigation was completed adequately. It was noted that while the conduct of the offender may have been 'professionally and morally unacceptable' no offence had been identified. Notably, a staff member later disclosed during an interview with ECRA in 2024, that the offender told her during a phone call that he had gone to stay in a hotel because he 'was worried police would go to his house' presumably because of the CEM he would have had in his possession at the time.

Being aware of the stages and indicators of grooming and perpetrator tactics supports improved detection of perpetrators particularly where there is no clear history of prior known offending. To gain expertise in this field, police should be trained in:

- understanding sexual offending pathways and theories of sexual offending (e.g. routine activity theory, the four pre-conditions to sexual abuse)
- understanding sexual behaviour (e.g. inappropriate, problematic, sexual deviancy) and sexual development across the life span
- understanding sexual abuse categories (e.g. female offenders, paedophilia, the role of technology) as well as specific populations (e.g. neurodiversity).

This type of training would also support officers during interviews with alleged perpetrators, by ensuring that they are alert to situations where:

- there are inconsistencies between the suspect, victim-survivor and witness's version of events and to challenge them about this
- the suspect expresses emotional congruence with children
- the suspect expresses unhealthy relationships, boundaries and attitudes towards children
- the suspect seeks to normalise behaviours towards children that others have raised concerns about
- there is evidence to suggest that the suspect may be exploiting policies and procedures at their place of employment or in other settings in order to gain access to children
- patterns are emerging suggestive of child sexual abuse perpetration, such as a person seeking to reduce guardianship by spending regular one-on-one time with a certain child or by circumventing institutional safeguards
- the police officer is being groomed by the perpetrator.

Having an awareness of what behaviours to look out for in perpetrators may prompt officers to consider other investigative steps that may need to be taken in response to a complaint, including by seeking access to a suspect's phone, laptop or other devices, where there is sufficient evidence to do so. Evidence could be further strengthened by ensuring that officers routinely undertake interviews with all relevant persons in response to a complaint, including child complainants, suspects and other potential witnesses.

# The standard of proof

When considering the system responses in this case, the Board discussed the complexity of undertaking investigations into a report of child sexual abuse, including for police in being able to reach the necessary threshold to prove beyond a reasonable doubt that the offence occurred. Data in relation to the outcomes of reported offences against children in the ten years to 30 June 2025 reflects these challenges.

**Table 3 Outcomes of reported offences against children, 2015-16 to 2024-25**

| | Did not proceed | Arrest/ Warrant | Notice to Appear/ Summons | Other outcome |
|---|---|---|---|---|
| **Rape and attempts*** <br> ***includes attempt to commit rape, and assault with intent to commit rape** | 6477 | 3833 | 390 | 643 |
| **Indecent treatment** | 10,367 | 7175 | 974 | 2093 |
| **Other sexual offence against a child** | 3799 | 1742 | 266 | 556 |
| **Queensland CEM offences** | 723 | 312 | 117 | 1195 |
| **Commonwealth CEM offences** | 133 | 172 | 24 | 16 |

*Source: Queensland Police Service*

A substantial proportion of contact sexual offences against children do not proceed to trial (57.10% for rape and attempts, 50.30% for indecent treatment, and 59.70% for other sexual offences). While most CEM charges do lead to an arrest (only 30.81% of Queensland and 38.55% of Commonwealth CEM offences do not proceed), many Queensland offences result in a non-trial outcome. Even considering those charges which do proceed to trial, a large number do not result in a conviction or serious penalty. Queensland Courts statistics indicate that over the 5 years to 30 June 2025, less than half (43.16%) of penalties imposed for child sexual abuse offences involved actual imprisonment, and more than half (52.23%) of contact offending did not result in conviction at all.

The Board also noted the apparent overreliance of the outcomes of the centre and police investigations by ECRA which meant that they did not take any further investigation into the complaints that came to their attention.

> *Prosecution is almost impossible without an immediate detailed account from an already traumatised child. In my opinion, securing testimony from child sexual abuse victims needs more time, a more consistent approach, and a much more supportive environment. Expecting children to disclose in the same way an adult does traumatises the victims further* - Lived experience advisor

In criminal courts, prosecutors must prove the elements of an offence beyond a reasonable doubt; that is, the evidence must exclude any other reasonable explanation other than that the accused committed the offence. A lower standard of proof exists in civil matters known as the balance of probabilities. This means that evidence must show that there is a greater than 50 per cent probability that the facts in contention are correct. The balance of probabilities is not static but is dependent upon the seriousness of the allegations. This is known as the Briginshaw principle—more serious allegations require more evidence.

Police investigations, and the evidence required by police and public prosecutors, are focused on securing a conviction, which means that the evidence gathered must support the beyond reasonable doubt standard of proof. Other regulators operating under their own legislation, however, are not limited at law by this high standard.

When abuse is disclosed, there can be a lack of decisive action taken because of evidentiary thresholds. The available information for this case suggests that regulators deferred to the decision by QPS to discontinue an investigation as positive evidence of a lack of harm or risk, when such investigations have a different standard of evidence and are conducted for a different purpose.

The young age and developmental stage of the children that the offender perpetrated abuse against also impacted the capacity of QPS to reach the evidentiary threshold to pursue further action.

After his arrest, the offender told officers that he targeted children under the age of five years, as they were 'easier' to offend against. The child victim-survivors in this case had no or limited vocabulary and limited capacity to recognise or report their experiences of abuse. They were sometimes asleep when the offending occurred. The offender also took deliberate steps to ensure children were distracted and occupied during some of the abuse or hidden from view from other witnesses.

Research by the University of New South Wales undertaken to inform the Board's review of this case highlighted multiple similar cases that have happened in ECEC settings including internationally, where children under the age of five years have been similarly targeted. This has been further amplified by recent cases in New South Wales and Victoria that have come to light while the Review was underway.[58]

The deliberate targeting of very young children by perpetrators to prevent detection has been harrowing for the Board to acknowledge, but it has also been something that has been known by law enforcement agencies for some time.

> *In 2015 the Queensland Organised Crime Commission of Inquiry was told with respect to child sexual abuse offending in online environments that 'offenders in Queensland are seeking out images and videos of younger and younger children, with many images of babies being offended against made available for viewing'.[59] Statements made to this inquiry also referenced two cases 'where offenders planned the abuse of children even before they were born, and took requests from offenders for the production of child exploitation material'.[60]*

Other research shows that men with a diagnosis of paedophilia are more likely to target very young children and use techniques to manipulate both their environments and victim-survivors to increase opportunities for abuse.[61]

Despite the increased vulnerability to sexual abuse of children in this age group, the Office of the Director of Public Prosecutions (ODPP) Guidelines currently place restrictions on prosecutors' authority to call a witness under the age of five years, unless their competency has been confirmed by an expert report. For children five years and over, a prosecutor may request an assessment of their competency 'if that is considered necessary or desirable'.

The ODPP guidelines are not law, but an expression of the Office's practice, based on caselaw, court benchbooks, and legislation. They are designed to assist the exercise of prosecutorial decisions to achieve consistency, efficiency, effectiveness and transparency in the administration of criminal justice.[62] One of the most fundamental decisions articulated in the guidelines, the decision to prosecute, is based on two questions:

- Is there sufficient evidence to secure a conviction?
- Is there a public interest in prosecution?[63]

These questions necessitate a cautious approach to the witnesses who may be called to give evidence.[64]

The Supreme and District Court benchbooks make very clear that children of all ages are presumed competent to give evidence, however this is only a starting point, and either party to a proceeding may request the court examine a child witness to assess: a) their competency to give evidence at all, and b) their competency to give sworn evidence. Expert evidence is admissible for this purpose.

Regardless of the difficulties of investigating reports of child sexual abuse, evidence can be strengthened by ensuring that perpetrators and other witnesses are consistently interviewed, and by assessing matters in a way that takes into account what is known about the particular offence (such as grooming).

While the capacity to meet the requisite threshold to pursue criminal charges in child sexual abuse cases is an enduring challenge, especially with very young children, the progress and outcomes of a police investigation may also provide invaluable intelligence to support robust system responses by other agencies with safeguarding responsibilities.

Even if a report is unable to substantiated due to a lack of evidence, there are opportunities for information gathered as part of a police investigation to be shared with Blue Card Services (BCS) to support assessments of a person's suitability to hold a working with children check, and with relevant regulatory entities so that they can consider what other action may be able to be taken to better manage or mitigate potential risks to children. QPS clarified to the Board that an offence still needs to have been substantiated but no action taken against the offender for this type of information to be shared.

ECRA have implemented a wide range of changes as part of Project Safeguard, which was established after the offender was arrested. They provided the following case study to the Board to demonstrate the role that regulatory agencies can play in responding to reports of child sexual abuse which are considered to have not met the relevant threshold for further investigation by police.

# Project Safeguard case summary

In 2024, ECRA's Child Safeguarding team investigated allegations of sexual misconduct against an educator at an Outside School Hours Care (OSHC) service. While QPS initially determined not to proceed with criminal charges, ECRA undertook its own investigation and determined that both the educator and the provider presented unacceptable risks to children.

ECRA took enforcement action, including prohibition of the educator, cancellation of the provider's approval, and prosecution under the National Law. The findings were referred to QPS, who reopened an investigation and later initiated criminal proceedings against the educator.

## Background

In late 2023, two children made independent disclosures of historical sexual misconduct by an educator employed at an OSHC service. In early 2024, ECRA received further information that two additional children had made similar disclosures about the educator prior to the other children coming forward.

ECRA disclosed all information to QPS, who investigated the reports but were not able to proceed with charges. ECRA commenced its own investigation into the educators' conduct, and whether the service met all obligations under the National Law.

## Investigation

ECRA took a comprehensive approach to its investigation, which included:

- systematically identifying all services where the educator had been employed in the years preceding the current allegations
- reviewing conduct, appraisal, and employment records across all services where the educator worked
- undertaking structured interviews with former staff and managers to examine the educator's behaviour, with particular emphasis on interactions with young girls and the exploration of any concerns previously reported
- examining service-level policies, staff files, and incident management responses
- conducting interviews with staff, parents, the educator and leadership personnel
- inspecting the service to assess supervision arrangements and environmental risks
- obtaining expert analysis on grooming behaviours and failed intervention points.

## Findings

The investigation identified:

- a sustained pattern of inappropriate interactions with pre-pubescent girls that included boundary-testing behaviours namely, inappropriate touching commonly framed as assisting or providing care, sexualised conversations and recommending age-inappropriate movies, shows and online viewing material
- persistent attempts to engage with young girls outside the regulated environment through activities such as babysitting and tutoring
- corroborated accounts from children and adults (including former colleagues and supervisors) supported by documentary records
- governance failures on behalf of the approved provider, including delayed responses to disclosures and inadequate follow-up of earlier staff concerns.

On the balance of probabilities, the educator was found to pose an unacceptable risk of harm to children. The Approved Provider was determined to have breached its statutory obligations and, as a result, was no longer considered fit and proper to hold provider approval to operate an ECEC service.

## Regulatory enforcement

ECRA exercised its statutory enforcement powers to mitigate risks and uphold safeguarding standards. Actions included:

- issuing a prohibition notice to the educator
- issuing a compliance notice to the provider
- cancelling the provider approval and transferring the service to new management
- commencing prosecution against the approved provider for offences under the National Law.

This case study highlighted the outcomes that can be achieved when relevant entities exercise their regulatory responsibility to act independently of criminal justice processes, ensuring that child safeguarding remains the primary focus.

## Criminal proceedings

ECRA's findings were referred to QPS, who reopened a criminal investigation and subsequently laid charges against the educator relating to his treatment of the four children. The proceedings were discontinued following the educator's death.

## Safeguarding significance

In ECRA's view this case demonstrates:

- the critical importance of prompt and appropriate responses to child disclosures
- the pivotal role of governance and leadership in recognising, assessing, and addressing risk
- the value of employing an integrated investigative methodology to systematically examine behavioural trends across contexts and timeframes
- the necessity of strong collaboration between regulators, law enforcement, and partner agencies to ensure comprehensive safeguarding outcomes
- the heightened risks posed by unsupervised educator access to children.

It further underscores that safeguarding extends beyond minimum compliance and requires a proactive culture of safety, disclosure, and accountability within services.

## Sector implications

ECRA also submitted that this case illustrates broader sector issues, including:

- the risks associated with educators who have a history of inappropriate child interaction
- the need for stronger cross-service information sharing and employment screening
- the importance of timely and effective service-level responses to disclosures
- the regulator's role in translating lessons from individual cases into improved sector-wide regulation.

## Conclusion

***This case highlights the need for timely and decisive regulatory intervention and reaffirms the role of ECRA beyond reliance on criminal justice outcomes. Where criminal proceedings do not progress, ECRA has the authority to continue to investigate allegations thoroughly and act to mitigate unacceptable risks to children.***

## Operational Recommendation 9: Enable the use of police intelligence material for child safeguarding

Current systems for responding to reports of harm to children often operate in silos, with police investigations and regulatory or organisational safeguarding mechanisms operating largely independently from each other. When a matter is reported to police but does not meet the threshold for a criminal investigation or prosecution, the information is often not systematically shared with child safeguarding entities. This creates significant gaps in the broader safeguarding system. Critical contextual information about patterns of behaviour, complaints, or potential risk may remain invisible to regulatory bodies, the Reportable Conduct Scheme, BCS, or other child protection agencies.

***Evidence from past inquiries highlights that perpetrators can continue to work with children if prior concerns are not visible across systems. A decision not to prosecute by police does not equate to an absence of risk; rather, it may reflect evidentiary limitations, legal thresholds, or procedural discretion. Without mechanisms to share key information with relevant safeguarding authorities, opportunities to detect emerging risks, patterns of misconduct, or grooming behaviours are lost.***

Police naturally maintain a protective approach to the information they collect. Investigative powers, legal obligations, and evidentiary rules constrain how information obtained during criminal investigations can be used or disclosed. These protections are essential to safeguard due process to preserve the integrity of investigations, and ensure that procedural fairness is maintained for all parties involved. The legal restrictions on using investigative material for purposes other than pursuing criminal matters are therefore both important and appropriate.

However, this necessary caution must be balanced against the overarching goal of the safety and protection of children. Police investigations are typically focused on meeting the high evidentiary threshold required for criminal prosecution, which means that much potentially relevant information about risks to children may not result in charges or convictions. While such information may not meet legal standards for criminal action, it can nonetheless be invaluable for identifying emerging threats, concerning patterns of behaviour, or sub-threshold indicators of harm to children. QPS reflected to the Board that:

> *'The role of QPS as investigators of criminal matters is always a blurred line and we accept we seem to be the 'go to' agency. As this review at times has highlighted our high legislative threshold is used by other entities disregarding their own lower thresholds. While highlighting QPS it should not be lost that the information was also known to the service provider and ECRA, and there were parents willing and able to protect the children.'*

Past reviews have highlighted this gap. *Keeping Queensland's children more than safe* was critical of QPS failures to share relevant information with BCS in a timely manner, noting that early sharing could have supported preventative interventions and better protected children.[65] This Review has demonstrated similar shortcomings: QPS collected information that, had it been considered for its protective value rather than solely its evidentiary potential for prosecution, would have allowed more children to be safeguarded.

There is therefore a compelling case for police to adopt a dual perspective: while information must continue to be protected and used in accordance with legal obligations for criminal investigations, there is a concurrent responsibility to recognise when collected intelligence could inform child safeguarding systems.

> *By enabling appropriate, lawful sharing of risk-relevant information, police can contribute to proactive protection measures, support regulatory and organisational oversight, and prevent further harm.*

The Australian Institute of Family Studies research for the Board on best practice responses to safeguard children from child sexual abuse advised that:

> *A best practice WWCC model should also give police the power to disclose a sufficiently wide range of information to facilitate informed decision making by regulators. The UK DBS [Disclosure and Barring Service] model allows for greater discretion among relevant local police forces in disclosing information for applicants to high-risk professions, including ECEC. Police forces and law enforcement agencies can provide any information on file, including allegations, investigations or any court orders to the DBS if it is deemed by the Chief of Police or the agency to be relevant to the applicant's desired profession and position. Although the effectiveness of this model is subject to police force attitudes towards, and understanding of, CSA [child sexual abuse] and the importance of allegations… it can lead to greater scrutiny of individuals with some suspicious behaviours, even where no formal investigation has occurred.66*

Establishing a clear obligation for police to provide key contextual information from investigations that do not result in prosecution would ensure that at least one safeguarding body has access to the full picture of potential risk. This would allow regulatory and oversight entities to take preventive or supervisory action, strengthen intelligence-led safeguarding, and improve system-wide protection for children.

A centralised approach—through BCS, the Reportable Conduct Scheme, or a dedicated child safeguarding entity—would ensure that such information is collected, assessed, and acted upon, rather than remaining in isolated records. By integrating police intelligence into child safeguarding frameworks, Queensland can move from reactive to proactive protection, reducing the likelihood that harmful individuals evade oversight simply because there is insufficient information to meet criminal thresholds.

### **Operational Recommendation 9:** Enable the use of police intelligence material for child safeguarding

The Queensland Government should legislate a clear obligation for police to share key contextual information from investigations that do not lead to a prosecution with a relevant child safeguarding authority (WWCC, reportable conduct or the child safeguarding body). This information should include details of complaints, observed behaviours, investigative findings, and other relevant contextual data. This obligation should ensure that:

- a decision not to prosecute does not result in lost intelligence or missed opportunities to identify threats and emerging risks
- a centralised safeguarding body—either BCS, the Reportable Conduct Scheme, or a dedicated child safeguarding entity—can assess risk, detect patterns, and take protective action
- police information, especially the information gained from child interviews, witness interviews and suspect interviews, is used to protect children.

Implementing this requirement will strengthen Queensland's safeguarding system, close information gaps, and ensure that all available intelligence contributes to keeping children safe.

Chapter 19

# At the policing frontier – emerging threats and spiralling demand

# At the policing frontier – emerging threats and spiralling demand

> *Child sexual abuse has transcended cultural normalisation: it has become a commercial enterprise. Law enforcement and legislators are struggling to keep pace. Meanwhile, governments and regulators worldwide continue to languish in a digitally dependent economy that demands buy-in. The need for specialised, multidisciplinary child sexual abuse prevention, intervention and response methods has never been more urgent. We're in a tech arms race with offenders that we can't afford to lose. This is a global crisis of public health, but before we can even hope to address it, we must first understand it.*[67]

Child exploitation material (CEM) has become one of the fastest-growing forms of online criminal activity. Originally confined to physical media, its proliferation has been accelerated by the internet, social media platforms, encrypted communication channels, and rapidly evolving technologies which enable perpetrators to navigate online environments undetected.

These developments have enabled perpetrators to produce, distribute, and consume CEM at an unprecedented scale. Law enforcement agencies worldwide are grappling with the dual responsibility of prosecuting offenders and identifying and safeguarding victim-survivors. This task is made more difficult by the vast volume of offending, technological barriers, and the hidden nature of online abuse networks.

Conversely, once an offence has been detected and perpetrator identified, the prosecution of offences is comparatively more straightforward in cases of CEM, as the material provides law enforcement with the evidence they need to pursue criminal charges.

Over the past two decades, the global availability of CEM has surged. In 2024 alone, the National Center for Missing and Exploited Children (NCMEC) received nearly 20 million reports of suspected CEM via their CyberTipline.[68] Europol noted a dramatic increase in reports related to online child sexual abuse during the COVID-19 pandemic, attributed to perpetrators and children spending more time online during mandatory isolation and lockdowns.[69] A particularly troubling development is the rise of live-streamed child sexual abuse, often involving cross-border financial transactions, which adds further complexity to victim identification and perpetrator prosecution. This is because once the live streaming ceases, the evidence disappears.

***Australians are some of the largest consumers of CEM globally. Perpetrators in our homes, our communities, and in our institutions are driving this scourge.***

The rise of artificial intelligence (AI) also presents risks and opportunities. It diverts scarce and specialist resources away from the difficult task of victim identification, but it also provides an opportunity for law enforcement to continue to automate and evolve their processes.

Victim identification is a critical priority for law enforcement and often represents a race against time and over continents, where global forces work together to locate the children in the pictures, and the perpetrators that offend against them.

At times this seems like an insurmountable task. Agencies must sift through millions of files, many of which are duplicates, or AI generated, making it difficult to detect new victim-survivors. Perpetrators increasingly use the dark web, TOR networks, VPNs, and end-to-end encryption to conceal their identities and locations. The global distribution of perpetrators, victim-survivors, and service providers complicates jurisdictional cooperation. Additionally, many images lack contextual clues, making it hard to determine who the victims are or where they are located. When victim-survivors are identified, engaging them safely requires trauma-informed approaches and specialist counselling and support.

Despite these challenges, law enforcement has made significant strides through technology and international collaboration. INTERPOL's International Child Sexual Exploitation (ICSE) database enables global comparison of seized material, helping identify overlaps and generate investigative leads. As of July 2024, ICSE contained 4.9 million images and videos, and had contributed to the identification of 42,300 victim-survivors and 18,300 perpetrators.[70] AI and image analysis tools are increasingly used to detect unique objects, backgrounds, or digital fingerprints that can aid investigations. Cross-border taskforces like the Virtual Global Taskforce (VGT), which includes the Australian Federal Police (AFP), facilitate coordinated efforts and intelligence sharing among multiple countries. The VGT seeks to work with non-government organisations and industry partners to deliver a program of coordinated activity to help protect children online, no matter where they are in the world.

Progress is still hindered by systemic issues. National legal frameworks often lag behind technological developments, leaving legislative gaps related to live-streamed abuse and anonymising tools. Resource constraints mean that specialist law enforcement units are frequently understaffed relative to the scale of the problem, which is compounded by the specialist nature of the roles. The relentlessness of the task means that few people can do this work and even fewer for long periods of time.

In some jurisdictions, online platforms are not legally required to report CEM, resulting in inconsistent global detection and reporting. Australian law enforcement entities receive vast volumes of referrals from agencies like NCMEC and Europol, much of which consists of duplicative data or are informational reports. The sheer scale of incoming intelligence makes it extremely difficult to identify new Australian victim-survivors or perpetrators. Critical triaging decisions must be made on what fleeting image to follow or lead to track down.

State and territory police have limited capacity to chase down referrals while also responding to existing workloads and victim-survivor complaints. This leads to delays, backlogs, and the potential for urgent threats to children to be missed. Victim-survivors and families who report abuse often feel ignored when their complaints do not result in visible police action, discouraging future reporting and allowing perpetrators to continue to offend. This is not unique to Queensland or Australia, similar pressures are reported in the United Kingdom, Canada, and the United States of America.

To restore effectiveness and public confidence, urgent reforms are needed. This includes investing in victim identification capabilities and frontline responses, developing smarter triage tools to filter known CEM, and resourcing police and regulators to manage both online and offline intelligence. A child safeguarding system that prioritises digital files over children who make a report of abuse cannot succeed. Balancing technological tools with improved responsivity to victim-survivors is essential to safeguarding children and disrupting offender networks.

# An arbitrary distinction

Acknowledging criminal justice system complexities, the offender's case gives the perception that the rise of online child sexual exploitation has reshaped law enforcement priorities. Digital evidence, including images, videos, and chat logs, has become central to successful prosecutions, as it is less vulnerable to credibility challenges than victim-survivor testimony. Multiple recent reviews and inquiries have highlighted how community disclosures from children, parents, carers, and workers may be sidelined because of challenges in conducting investigations into these types of offences and the lack of apparent prosecutable evidence. This means that potential witnesses are not spoken to, and other evidence is not tested. The failure to listen to children and their parents, and the neglect of other organisational and community intelligence, risks missing early intervention opportunities to detect and disrupt perpetrators and undermines public trust in the justice system.

***In undertaking this Review, a clear delineation has emerged that distinguishes between the complexities of policing responses to victim-survivors who make a report of abuse to police, and the extraordinary investigative techniques and resources allocated to online offending.***

The QPS informed the Board that there are different challenges that are present during an investigation that involves online (digital evidence) and other child abuse investigations which are usually reliant upon witness recollection and limited corroborating evidence.

For children, there is limited distinction between the two forms of crime—online depictions and contact offending. While arbitrary distinctions can sometimes be drawn between 'contact' and online offending, each CEM image or video represents a crime scene involving a real child. Emerging research also shows that where a person is found in possession of CEM, there is a significant likelihood that they have committed a contact offence against a child.[71]

As set out by the Queensland Organised Crime Commission of Inquiry in 2015:

> *While an offender may be only involved in either online child sex offending or offences relating to child exploitation material, it is not uncommon for an offender to be involved in both types of offending. For example, an offender may make contact with a victim over the Internet and, in the course of communication, direct the child to touch himself or herself, or touch other people, in a sexual way. The offender may then record this conduct and upload the images to the Internet. In this scenario, the offender has not only committed sexual offences against a child, but has also made and distributed child exploitation material. The same offender may also have a collection of child exploitation material which has come into his or her possession quite separately from the sexual offences committed against the child. In another example, an offender may come to police attention through downloading child exploitation material from the Internet. When the offender's computer or devices are analysed by police, it may be discovered that he or she has recorded himself or herself committing sexual offences against a child.*[72]

A recent joint law enforcement *Parliamentary Committee Inquiry into Child Exploitation* explored the relationship between contact and online offending. While this inquiry noted that there were some differences between the two, it accepted evidence that highlighted the close links between contact and online offending.[73] The final report of this inquiry noted that online CEM networks can influence members to commit contact offences and that 'technology can blur the distinction between these two types of crime, as both live online child sexual abuse and sexual coercion can involve an offender directing abuse from afar'.[74]

In submissions made to the Board, the Australian Centre to Counter Child Exploitation (ACCCE) sought to clarify that perpetrators who commit online child sexual abuse offences 'are not always or automatically contact offenders'. They also note that:

> *Contact offending is harder for law enforcement to detect as it occurs behind closed doors in circumstances where the victims are typically not able to come forward to seek help or support.*

Notably, ACCCE's role is focused on combating online child sexual abuse and exploitation, which limits the extent to which they directly engage with victim-survivors who seek to report abuse. It is their experience that where they identify cases involving contact offending in Australia, it is often intrafamilial, happening in homes, and conducted by someone who is related or known to the victim-survivor.

# Resourcing, priorities and decision-making

What has emerged from this Review is a story of resources, priorities and decision-making. Of police persistence in identifying victim-survivors in online CEM over nearly a decade, but where concerns raised about the offender by children, parents and staff were filed because of an apparent lack of evidence to substantiate that an offence has occurred.

Underpinning this challenge is a critical systemic issue. Online child sexual exploitation offences are often more easily progressed to prosecution on the basis of digital evidence, including images, videos, and files, rather than through complaints raised directly by victim-survivors or their families. This reflects the structural reality of the criminal justice system: cases underpinned by tangible digital material are often viewed as more evidentially reliable, less contested in court, and more likely to secure a conviction.

While the evidentiary strength of cases of online offending has become central to successful prosecutions, it may have consequences for the way resources are allocated, and investigations are prioritised. The QPS advised the Board that "in terms of assessing sufficiency of evidence, digital evidence such as photographs or text messages that are direct evidence of the crime are difficult for an offender to dispute. In contrast a personal recollection by a witness, without digital evidence, can be challenged by an offender. This presents challenges when prosecuting such offences". As a result, the voices of victim-survivors, families, and frontline workers—those who raise early concerns and complaints—may be minimised. Where investigations are delayed or closed early, potential witnesses are not spoken to, and leads are not chased down. This dynamic risks further silencing victim-survivors and eroding trust in already fragmented reporting pathways and complex court processes.

As so aptly articulated in the external jurisdictional review of the QPS contact prior to the offender's arrest, child protection notification reports are causing a demand management pressure 'that can only be met if local police streamline responses' and that:

***The online child sexual offending environment is exploding with new creators and new viewers. Resources are thin.***

This pressure is also acknowledged in the QPS's *Sexual Violence Response Strategy 2025–29* which aims to improve policing responses, prevention processes, and victim-survivor safety.[75] The strategy also identifies four 'victim-survivor principles', highlighting the need to keep victim-survivors at the forefront of responses.

While responses specifically tailored to victim-survivors of child sexual abuse are not mentioned, the strategy raises a number of identified risks to achieving this goal including:[76]

- a declining confidence in police responses by victim-survivors and the community
- victim-survivors being unsupported and burdened by the criminal justice system
- lack of consideration of factors leading to attrition at key stages in the investigative process
- inability to deliver consistent responses amid increasing demand and evolving community expectations.

# The offender's detection

***The detection of the offender through uploaded CEM, that he posted years before his arrest, was remarkable. It is evidence of the determination of the police and specialist victim identification staff in the AFP and Argos to track down every possible lead, to leave no stone unturned and to remain focused on the task at hand.***

However, while the timeline of detection is a story of persistence, it is also a cause for reflection. It took police nine years to identify the offender from the CEM he uploaded online. They experienced delays in obtaining critical information from private providers, and in analysing the information they obtained. As soon as the offence location was identified, police were able to swiftly arrest the offender. From there, police faced an almost insurmountable task of identifying the children in the CEM the offender had created, and notifying their families.

It is impossible not to question the impact of the delays encountered by police in obtaining critical information from the private bedding supplier or to ask oneself whether, if more resources had been allocated to victim identification, the offender would have been located earlier and less children harmed.

These types of investigation delays are not unique to Queensland. A recent *Parliamentary Committee Inquiry into Child Exploitation* noted concerns raised by Victoria Police in obtaining information from agencies to inform its investigations including that wait times can vary dramatically. It was further noted that:

> *Delays in receiving information can mean that children may be accessible to offenders whereby contact offending may be occurring. By understanding if the offenders have access to children consideration can allow resourcing to be prioritised to those investigations whereby children are being harmed.*[77]

# Responding to the threat of online environments

Much has changed for law enforcement over the nine years that it took to locate the offender, following the uploading of CEM onto The Love Zone. Legislative frameworks have strengthened to enable police to more effectively respond to online threats, and they have continued to evolve their approach to combat the task at hand.

Queensland has also led the way in responding to threats in online environments. Initially established as a multi-disciplinary taskforce in 1997 focused on historical and institutional sexual abuse of children, Argos (formally known as Taskforce Argos) shifted to technology-facilitated offences against children, commencing in 2000. It consists of sworn officers, victim identification experts and administrative staff that support the unit's purpose of protecting children. The unit now provides a specialist statewide response to the investigation of networked paedophilia, child exploitation and technology facilitated crimes against children. Their principal focus in any investigation is the identification and rescue of children from harmful environments.

In 2018, ACCCE was established in the AFP. It seeks to provide a connected and collaborative capability to ensure cohesion by using the expertise of federal, state and territory, non-government agencies and private industry, and by allowing a cross-pollination of resources, knowledge and skillsets between stakeholders.

Collaborative operational partnerships between law enforcement, community organisations, technology companies and private providers are key to disrupting online child sexual abuse offending, both within Australia and internationally. No one entity can address this issue in isolation of others. The Board is cognisant of the insurmountable task ahead, and the need to ensure the appropriate mix and level of resourcing is available for law enforcement to continue to counter online threats, and act swiftly when new ones emerge.

# Australian Centre to Counter Child Exploitation

ACCCE received a total of 82,764 reports of CEM from NCMEC in 2024–25, which represents a 44 per cent increase over the previous year. According to the AFP, these reports 'typically involve the upload, download, or distribution' of CEM.

The significant number of reports received by ACCCE requires a triaging process to identify children at the highest and most immediate risk. Prioritisation is generally given to the identification of 'first generation' CEM which is material that has not previously been detected by law enforcement. Reports that do not fall within the triaging classification criteria, have duplicate content or have an incident date or upload date older than two years, are classed as 'informational reports' and are used for crosschecking in future investigations.

Triage processes within ACCCE are supported by a Triage Referral Investigation Support Tool (TRIST) which supports consistent and risk-informed decision making during the triage process. A review of this tool is currently underway because of new and emergent methodologies, technological developments and the extensive nature of the data available, comparative to when this tool was initially developed. Every actionable report that comes into ACCCE is reviewed, to ensure that professional judgement is applied when triaging reports.

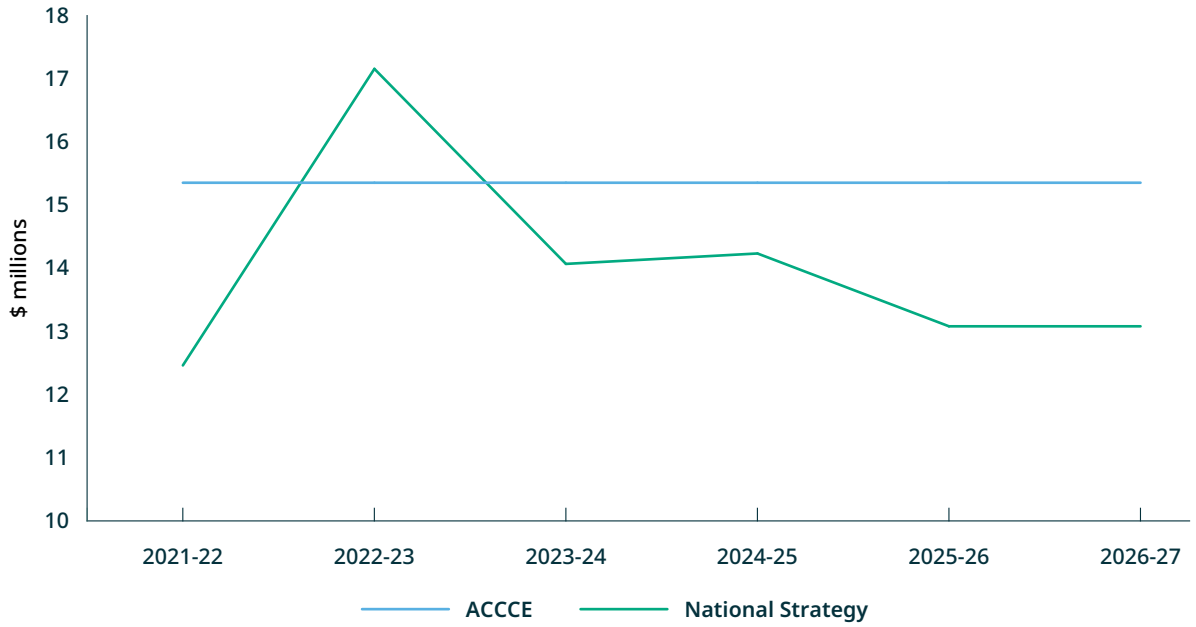
Multiple teams contribute to the goals of ACCCE:

- **Child Protection Triage Unit:** receives and assesses reports of child sexual abuse which come in from various agencies and triages them to determine what further action is required.
- **Covert Online Engagement Unit:** works in online environments to target, infiltrate and dismantle child sex offender networks.
- **Intelligence Fusion Cell:** provides intelligence support and monitors emerging threats.
- **Technical Capability Unit:** provides on-site support for frontline investigators and intelligence analysts through their technical expertise.
- **Partnerships and Outreach Team**: is responsible for leading outreach initiatives and stakeholder engagement.
- **Online Child Safety Team:** leads the national delivery of online safety education, prevention, and outreach initiatives across Australia.
- **Operations Development and Disruption Unit:** coordinates national operations between ACCCE, State and Territory Joint Anti Child Exploitation Teams (JACETs), and overseas law enforcement such as Interpol and Europol.
- **Victim Identification Unit:** leads the national coordination and de-confliction of victim identification efforts, operating as the conduit between Australian law enforcement and the International Child Sexual Exploitation database.

The AFP also provides funding for the NCMEC to employ a dedicated analyst for reported CEM which involves Australian victim-survivors or perpetrators.

The Human Exploitation Command of the AFP, incorporating ACCCE, has approximately 100 full-time equivalent staff. The AFP received $68.6m over four years in the 2018–19 budget for the establishment of the ACCCE (ongoing at $15.35m annually). The AFP also received funding under the National Strategy to Prevent and Respond to Child Sexual Abuse of $109.8m over four years from 2021–22. From 2025–26, AFP will receive $13.1m ongoing until 2030 to continue to deliver National Strategy commitments.

Figure 2: AFP funding for ACCCE and National Strategy measures 2021–22 to 2026–27




While recognising the triaging processes they have implemented that prioritise children at the highest risk of harm, the AFP advised the Board that frontline police would be able to do more with additional resources. With the increasing number of reports to the ACCCE, processes are constantly being reviewed to identify innovative new ideas and best practice. Technological solutions are also being enacted to increase efficiency and limit the psychosocial impacts for staff.

# Queensland Police Service

As the number of sexual offences reported to authorities has increased, so have the demands on policing services. In response, QPS has increased its resourcing across all key operational areas related to the investigation of child sexual abuse offences and management of convicted perpetrators.

The period over which the offender committed abuse was characterised by significant demands on police in Queensland and Australia, both in terms of the novel and rapidly changing impact of the Covid-19 pandemic from 2019, several reviews and inquiries which identified inefficiencies in QPS resourcing and operations, and changes in senior leadership.

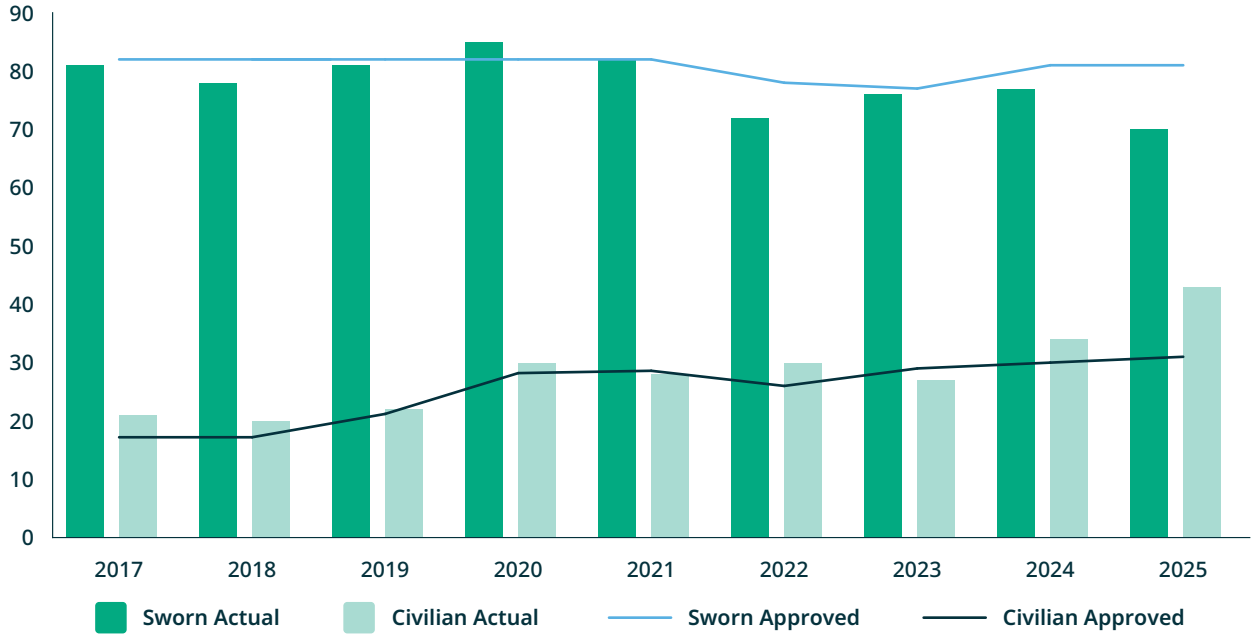
> *[During Covid-19] the QPS has maintained business as usual policing operations with some adjustments to certain activities to reduce the risk of potential transmission of Covid-19. To prioritise the allocation of frontline resources to the Covid-19 response, the QPS deferred police attendance for some standard operational duties…*
>
> *The rapid and frequent changes to public health measures in Queensland have required unprecedented levels of responsivity and scalability from QPS…*[78]

The deployment of police officers to frontline roles instead of support, coupled with a general focus on recruitment to these roles, contributed to a general decrease in the number of officers available to do this work.

> *The data also shows that the organisation was tired and overworked and angry, because we're into the second year of COVID, and they honestly believed that the senior executive could not appreciate that the pressure was - what they were under. And on top of that… that they couldn't meet demand already from two, three previous years, and here we were putting 12, 1,300 some days to COVID, and on top of that we were going through massive reform, and particularly also in areas like [the Service Delivery Redesign Project] that had even more negative responses about leadership in that regard.*[79]

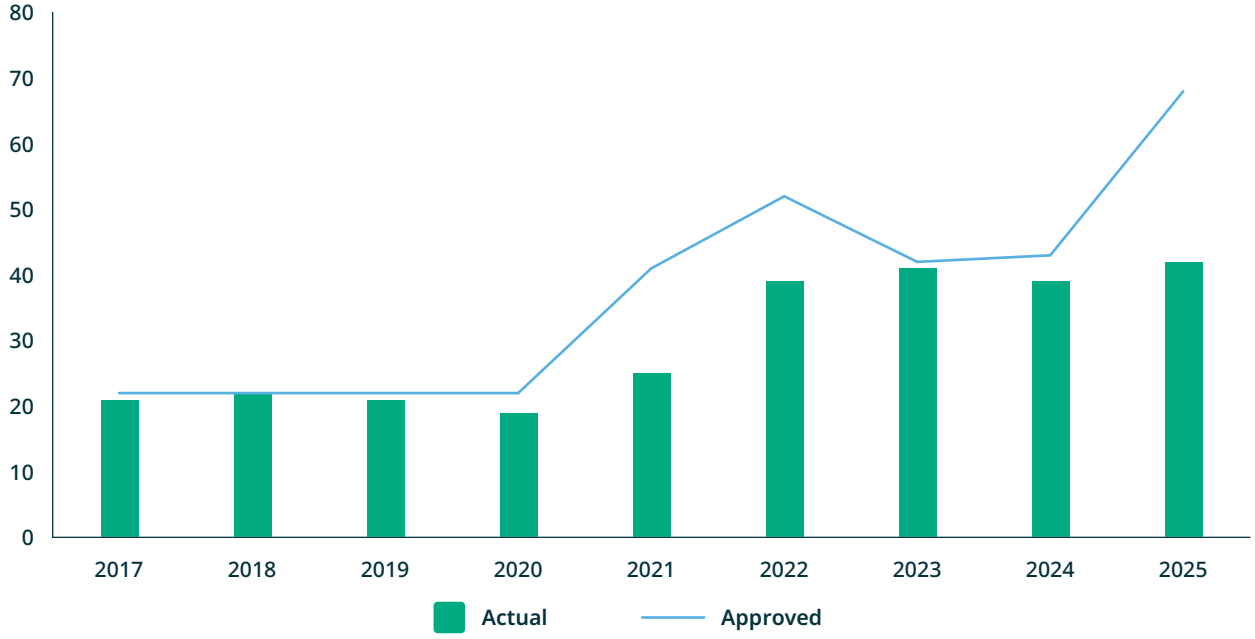
Data shows that the Child Abuse and Sexual Crime Group (CASCG) has experienced a shortfall in sworn officer allocations since 2020 despite largely consistent funding levels for over 80 full time equivalent (FTE) roles. Conversely, the proportion of civilian staff in CASCG has been steadily increasing since 2017, in excess of funded FTE positions.

**Figure 3: Child Abuse and Sexual Crime Group (CASCG) Approved and Actual FTEs 2017–25**




Within CASCG, CPOR has significantly increased its sworn officer FTE positions. In 2025, significant additional resources have been allocated to CPOR in response to a demand model request for growth.

**Figure 4: Child Protection Offender Registry (CPOR) Sworn officers approved and actual FTEs 2017–25**

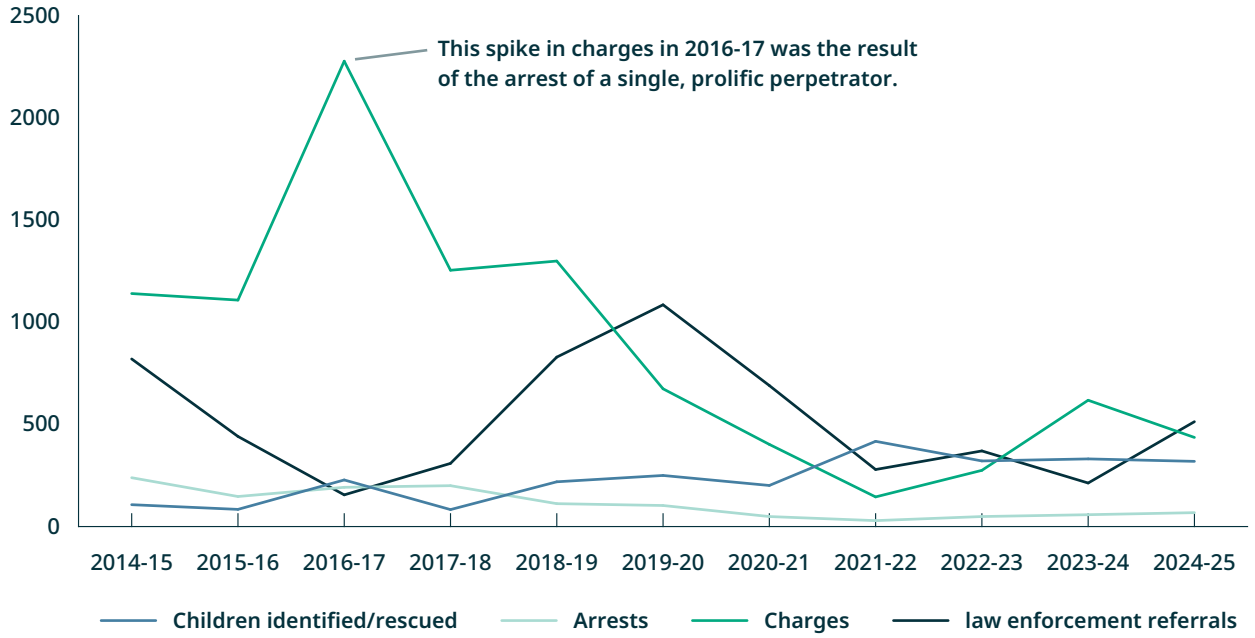



QPS also provided advice to the Board that funding for national responses to online offending has not been shared equally across jurisdictions, resulting in demand-management pressures between Commonwealth and Queensland law enforcement entities:

> *The First Commonwealth Action Plan [to Prevent and Respond to Child Sexual Abuse 2021–2024] focused on Federal agency responsibilities, including increased funding and resourcing for the Australian Federal Police (AFP) to enable them to better triage and on-refer NCMEC files. To date, no additional funding has been allocated to state- or territory-based policing agencies. As a result, all states and territories are now experiencing a significant increase in NCMEC files referred from the AFP. The QPS estimates it has experienced and is continuing to experience an increase of approximately 90–96% in NCMEC referrals.*

While the recognition that an increase in offender management at CPOR has led to a commensurate increase in staffing allocation within that unit from 2020, the general decrease in personnel in CASCG may have adversely contributed to a reprioritisation of child sexual abuse and CEM efforts within the Argos unit.

**Figure 5: Argos activity outcomes 2014–15 to 2024–25**



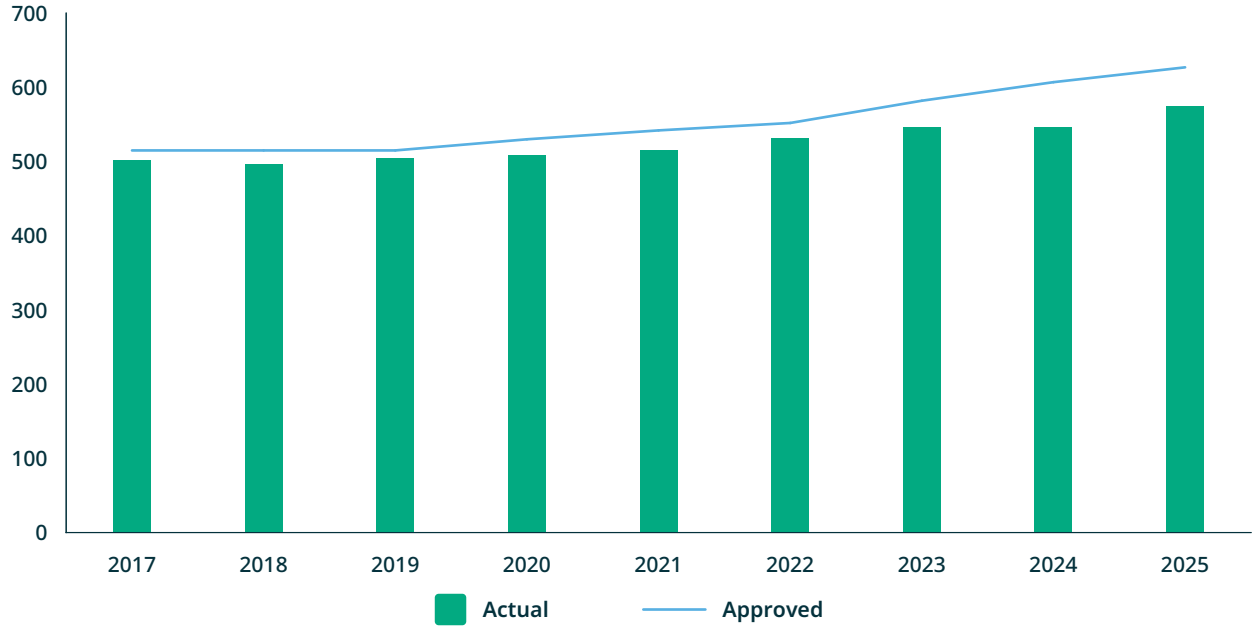

*Source: QPS Annual Reports 2014–15 to 2024–25.*[80]

Data on Argos activities indicates that the number of arrests and charges made against perpetrators sharply fell off with the commencement of the pandemic. QPS expects the Argos workload to continue to significantly increase as CEM becomes more prevalent and new threats emerge:

> *The Argos Taskforce is responsible for triaging and 'packaging' (organising the necessary groundwork in identifying perpetrators and organising warrants) for referrals out to the District CPIUs. In light of the district workloads, Argos reports managing as many of these files as possible to alleviate the strain on districts already under pressure from other child protection matters. Based on the increase in NCMEC referrals being received, the QPS anticipates an increase in offences relating to online child sexual exploitation over the next several years.*

In comparison to CASCG, resourcing for sworn officers in Child Protection Investigation Units (CPIU) across the state has been slowly but steadily increasing. However, the actual number of assigned CPIU officers has failed to keep pace with this increase in resourcing:

**Figure 6: Statewide CPIU Sworn officers approved and actual FTEs 2017–25**



QPS have advised that it anticipates it will experience further resourcing pressures associated with the implementation of Child Safe Standards and the Reportable Conduct Scheme in Queensland.[81] In particular, they consider that the Reportable Conduct Scheme will impose great demands on QPS, both as an investigatory body and custodian of vast amounts of information that may relate to incidents of reportable conduct.

QPS has estimated that an additional 45 detective constables will be required by CPIU teams statewide to address the increased demands on police to investigate allegations of criminal reportable conduct, rapidly increasing to an additional $10 million in required funding. They anticipate that significant demands will be placed on QPS civilian staff units to comply with information sharing requests, including flow on impacts to CPIUs, and the Child Abuse and Sexual Crime Group.

Key challenges faced by QPS include a rising volume of notifications placing strain on specialist investigators and contributing to case backlogs. QPS have advised the Board that staffing shortages, particularly in regional areas, have led to a junior workforce with limited access to training and development. Filling CPIU roles is challenging, with these positions being unattractive to many personnel due to the nature of the work (which, in a problematic and contradictory arrangement, involves both protecting and policing children).

***Staffing shortages leading to sustained high work demand, and limited access to training or development opportunities, especially in remote and regional areas, has impacted CPIU workforce recruitment and retention. As a result, the CPIU workforce in some locations is relatively junior, with a reduction in the number of experienced senior detectives and investigators available.***

Investigators are also burdened with non-core responsibilities and face infrastructure and technological limitations, such as inadequate interview facilities and digital forensic tools. Additionally, the complexity of historical abuse cases and the surge in online child sexual exploitation offences have increased demand on specialist units.

***QPS advises that there has been an increasing reliance on police to carry out non-core functions on behalf of other agencies. This includes activities that fall outside conventional law enforcement but have, over time, been taken up by the QPS, particularly when responsible agencies are not available to meet community safety expectations. This extension of policing responsibilities is impacting on the QPS to meet its core functions including conducting criminal investigations.***

To address these issues, QPS reports that it has:

- initiated the CPIU Workload Management Project to assess and alleviate workload pressures
- allocated new positions to CPIUs and Child Protection Offender Register teams in anticipation of legislative changes and the rollout of the Reportable Conduct Scheme
- expanded training programs to include trauma-informed and victim-centric approaches, with specialist courses for investigators handling cases involving very young children
- supported broader systemic reforms, including improved information-sharing protocols, community education on grooming behaviours, and legislative changes that facilitate the prosecution of serial offenders
- continued to partner with external support services and initiatives like the Queensland Intermediary Scheme and PACT to further enhance support for victims and improve investigative outcomes.

## Operational Recommendation 10: Prioritising law enforcement resourcing—both personnel and technological

Queensland has set an international benchmark in policing child sexual abuse through its specialised units and collaborative initiatives. These units demonstrate profound levels of resilience, dedication, and strategic innovation. From meticulous digital investigations to global collaboration, the work of CPIU's, Argos, ACCCE, and JACETs showcases the state's commitment to keeping children safe and has positioned Queensland and Australia as a global leader in child protection law enforcement. Argos, based in Brisbane, is recognised globally for its innovative, proactive approach to online child exploitation. Its work has directly rescued hundreds of children, dismantled complex networks of perpetrators, and prosecuted high-profile cases with exceptional precision.

ACCCE and JACETs exemplify the power of collaborative, cross-jurisdictional operations. ACCCE has coordinated responses to hundreds of complex cases nationally, while JACETs have enabled rapid identification, arrest, and prosecution of offenders by combining federal and state expertise. ACCCE and Argos are internationally recognised for best practice methodologies in victim identification, digital forensics, and offender disruption. This includes in the case under review by the Board. Despite its other failings, the policing work done to track the origins and owners of bedding in an image shows the remarkable policing feats victim identification staff do to bring perpetrators into the light, and into justice.

This global best practice leadership is at risk. Officers involved in child protection and exploitation investigations are operating under significant and growing pressures. Interviews with frontline officers highlighted the extraordinary demand placed on their time and expertise, particularly in relation to managing and analysing electronic evidence and CEM.

The Board is concerned that many of the individuals that have made these units a success are working in small teams with growing demand pressures. The ability to build capability, transfer experience and 'pass on the baton' does not appear strong. This work is relentless and exposes officers and staff to the worst acts of depravity.

***Officers we spoke to as part of this Review described spending weeks categorising and reviewing seized electronic files, noting that they typically execute two to three warrants per week, but believe that their workload could realistically support two to three warrants per day if resources were sufficient.***

Similarly, victim identification staff—whose role involves painstakingly examining CEM to identify victim-survivors, locations, and perpetrators—reported frustration at months spent reviewing material that is already dated, often from previous arrests. They spoke about meticulous coding processes, which while essential for evidentiary purposes, is extremely time-consuming. Officers noted that with appropriate technology, including AI-assisted analysis, much of this work could be performed instantly, freeing their time for higher-value investigative activity.

> *While law enforcement has historically focused on prosecuting offenders, victim identification remains under-prioritised, despite being critical to rescuing children from active abuse. A shift towards victim-centred policing is essential. This includes greater investment in tools that can rapidly identify victims within AI-generated content, and support proactive interventions.*

This issue was similarly considered by the Queensland Organised Crime Commission of Inquiry in 2015, which recognised that the classification of CEM takes an 'enormous amount' of time for police and staff in law enforcement agencies.[82] The final report of the Inquiry noted that this 'task takes resources away from victim identification and the priority of rescuing those children from further harm' and that 'the time taken by police to classify the images and video files often means delays in prosecuting offenders'.[83]

These issues are not new, but we do have emerging technologies that could assist in addressing them, while also minimising the extent of exposure to CEM faced by officers in categorising such material.

Recent decisions have impacted the capacity for law enforcement to explore the use of this type of technology. For example the Australian Information Commissioner made a determination on 3 November 2021 that Clearview AI Inc 'breached Australians' privacy by scraping their biometric information from the web and disclosing it through a facial recognition tool'.[84] The Board is concerned that decisions of this nature are limiting the ability of police to effectively respond to online child sexual offending.

The Board has heard from experts that the lack of a centralised database of victim-survivor images inhibits the process of identifying victim-survivors who appear in CEM found online. While privacy concerns inherent to gathering biometric data of children are legitimate and acknowledged, these must be weighed against their rights to safety and security. The Board considers that Australian privacy laws are currently not sufficient to empower law enforcement with the tools they need to locate and protect victim-survivors of child sexual abuse in an increasingly digital world.

Another recurring theme from discussions with frontline officers was the lag between police capabilities and the technological sophistication of perpetrators. Both federal and state government procurement processes were cited as key barriers: police often find themselves two to three years behind in understanding and accessing the latest technology that perpetrators exploit to commit crimes and hide evidence. This technological gap exacerbates delays, limits investigative effectiveness, and can hinder timely identification of at-risk children.

> *Law enforcement agencies are also constrained by limited access to the specialised tools, training, and infrastructure needed to address AI-enabled child sexual abuse. At the same time, the absence of reliable data on the prevalence and nature of AI-generated child sexual exploitation material significantly impedes policy development and prevention efforts. Without investment in these foundational areas, Australia risks falling behind in its capacity to protect children from rapidly evolving digital threats.*

A submission to the review advised:

> *Australia's current legislative and regulatory frameworks are not yet aptly equipped to address the growing risks posed by AI in the context of child protection. There is no unified, enforceable AI legislation, leaving significant gaps in accountability and platforms can avoid responsibility for harmful outcomes. Information-sharing across agencies remains fragmented, with no standardised national or international protocols to support coordinated responses to AI-facilitated exploitation.*

These insights demonstrate that ensuring the safety of children requires properly resourcing law enforcement — not only in terms of personnel, but also in ensuring that they have access to advanced technology, training, and procurement agility. Without adequate investment, police will continue to operate reactively, constrained by outdated tools and overwhelming demand, rather than being proactively equipped to counter threats and address harm. A well-resourced police service is a critical component of a comprehensive child safeguarding system, complementing regulatory, oversight, and intelligence mechanisms across government.

> *An obvious first step in deciding what recommendations are appropriate is to look at how the system has operated in the past… The only way that perpetrators of sexual abuse can be brought to justice is through the machinery of those who investigate, prosecute and have the charges determined by relevant Courts. Anything which detracts from the efficiency of that process must be eschewed.*[85]

### **Operational Recommendation 10:** Prioritising law enforcement resourcing—both personnel and technological

The Queensland and Australian Governments take immediate action to ensure that law enforcement agencies have the resources, tools, and capabilities necessary to proactively protect children from sexual abuse and exploitation. Specifically:

1. **Resourcing frontline investigations:** The Australian Federal Police (AFP) and Queensland Police Service (QPS) should increase the capacity for Child Protection and Investigation Unit (CPIU), Joint Anti-Child Exploitation Teams (JACET) and Victim Identification Units to ensure timely and effective investigations, including the ability to execute more warrants and analyse electronic evidence without delay.
2. **Technology parity:** The Queensland and Australian governments should review and reform procurement, policy, and funding arrangements to ensure police have rapid access to technology and analytical tools equivalent to, or ahead of, those used by perpetrators of child sexual abuse. This must include AI-assisted analysis, digital forensics software, and secure cloud storage solutions.
3. **Integrated safeguarding approach:** These measures should be part of a broader, coordinated strategy to embed law enforcement as a fully supported pillar within Queensland's child safeguarding system, complementing regulatory, oversight, and intelligence mechanisms.

Both governments should publish this resourcing to ensure that organisational drift does not occur and that the public can monitor changes in resourcing over time.

Chapter 20

# Structural impediments to safeguarding our children

# Structural impediments to safeguarding our children

It goes without saying that law enforcement agencies are not the only entities with a responsibility to act when a report of child sexual abuse is made. An enduring challenge noted by the Board in undertaking this Review is the consideration of what actions could or should be taken by agencies in response to a report of abuse, where there is a lack of evidence to substantiate that it occurred.

Given the hidden nature of child sexual abuse, the barriers to reporting faced by victim-survivors and the challenges in meeting the relevant evidentiary thresholds, it is critical that proactive and protective action is taken even in circumstances where complaints have not been proven beyond reasonable doubt. Although the matter of vexatious complainants was raised with the Board as a reason for regulatory entities and agencies to take no further action where a complaint is not able to be substantiated, it is likely that such matters should be identified early on in an investigation and dealt with accordingly.

Importantly just because a report of abuse is unable to be substantiated, does not mean that the abuse did not occur.

***Perhaps the most complex challenge arises when safeguarding allegations are credible but cannot be substantiated to a criminal or civil threshold. In these cases, employers face a stark dilemma: allowing the individual to continue working despite concerns, potentially exposing children or vulnerable people to risk; or terminating employment and facing significant exposure under Fair Work legislation, including the risk of uncapped general protections claims or unfair dismissal damages.***

# Challenges addressing employee behaviours

The prioritisation of an organisation's reputation, a fear of defamation and legal risks to organisations and individuals may act as a deterrent to raising or sharing concerns about a person of concern, particularly where complaints have not been substantiated. As discussed in more detail in Part C, there were multiple instances where the offender did not pass probation in the centres that he worked in, or where he was terminated, offered a redundancy, asked not to return and/or dismissed immediately. In most centres there was very limited information available as to why the offender's employment was ceased.

The Board identified that this was potentially indicative of centres seeking to 'move a problem on' rather than taking decisive action against the offender.

In submissions made to the Review, one centre where offending is known to occur submitted that changes to employment law are required to enable employers to terminate educators without risk to an organisation if credible allegations of abuse have been made. This should be founded on a risk-based approach which operates in the best interests of a child and enables employers to take action.

Employees in Australia are protected from unfair dismissal under Part 3–2 of the *Fair Work Act 2009* (Fair Work Act). Generally, any employee who meets the minimum employment period and is covered by a modern award or enterprise agreement is protected from unfair dismissal. The Fair Work Commission (FWC) may be asked to make a ruling on whether the dismissal of an employee was unfair. To make a determination, it must find that 'the dismissal [was] harsh, unjust or unreasonable.' A dismissal must be for a 'valid reason'. It must be objectively defensible or justifiable on the relevant facts.[86]

The employer bears the burden of proving to the civil standard that the valid reason existed. For allegations of misconduct, the employer must:

- carry out an investigation
- give the employee reasonable opportunity to respond to the allegations (procedural fairness)
- form the view, based on evidence, that the employee is guilty of misconduct
- form the view that, based on all the circumstances, dismissal is justified by the misconduct.

Within the early childhood education and care (ECEC) sector, there is no provision in the *Education and Care Services National Law (Queensland) Act* 2011 (National Law) or *Education and Care Services National Regulations* (National Regulations) to dismiss an educator for allegations of misconduct or which places responsibility for adherence to the National Law or Regulations above industrial law. By comparison, when providing for employers' compliance with a requirement to end a person's employment (or to not begin it), the *Working with Children (Risk Management and Screening) Act 2000* explicitly provides protection for the employer by stating that 'The employer must comply with the provision despite another Act or law or any industrial award or agreement'.[87]

The Board heard from employers who face challenges in addressing allegations of inappropriate conduct by employees which do not meet the threshold for reporting.

> *We need a really good, robust, code of conduct. It needs to focus on things like crossing professional boundaries with children and what that looks like in a particular setting and it needs to be explicit.*[88]

In the absence of evidence to support an allegation which would warrant a report to a regulator or the Queensland Police Service (QPS), or which is sufficient enough to substantiate a breach of a staff code of conduct, employers are left with having to face the industrial consequences of dismissing a worker or allowing them to continue, potentially in close contact with children. The Board also became aware of cases where employers find themselves in this situation even after having reported their concerns to police, as the complaint was unable to be substantiated.

One solution that avoids legal action under the Fair Work Act by the employee is to bind them and the employer to a deed of release, which often includes a significant lump sum payment to the employee for their agreement to resign voluntarily. These deeds of release frequently have non-disclosure clauses, preventing the employer from advising others of their concerns.

The 2019 FWC case of *Horan v Tren Trading Pty Ltd* dealt with immediate dismissal on the basis of allegations of physical abuse, and the employee was found to have been unfairly dismissed. This is discussed in detail below.

## Horan v Tren Trading [2019] FWC 3249

### Background

An educator was employed as an Early Childhood Teacher. She resigned in May 2018 to take a job at another service but was subsequently stood down pending investigation of a complaint alleging she yelled at and forcibly isolated a child. She was dismissed a few days later for alleged serious misconduct. The email in which she was advised of her dismissal stated:

> *I need to ensure that we meet the requirements of the Education and Care Services National Law Act 2010 and Education and Care Services National Regulations to ensure the safety, health and wellbeing of children. Your actions have put our service approval at risk, consequently, you have been summarily terminated due to gross misconduct effective immediately.*

She filed an application under s 394 of the *Fair Work Act 2009* for unfair dismissal.

### Allegation and Dismissal

An anonymous complaint alleged the educator forcibly removed a child and yelled at him. The employer alleged this breached the National Law and Regulations. The employee was asked to attend a disciplinary meeting but requested 24 hours' notice and written details. Her request was refused. The employer immediately dismissed the educator by email. She considered that the meeting was to 'ambush' her about the allegations. The employee did not attend the meeting due to lack of proper notice and details, as advised by their union.

### Investigation and Evidence

Several staff provided statements supporting aspects of the allegations. There were conflicting accounts on whether the educator had used force or raised their voice. The employer claimed dismissal was necessary to meet regulatory obligations and protect the service's licence under the National Law. The educator denied yelling, being aggressive, or using force. They said the child was misbehaving and that they followed standard procedure to remove him to calm down.

This employee had no prior warnings or disciplinary issues and claimed the investigation was biased and flawed.

The employer argued that, as they had an obligation to inform ECRA within 24 hours of an incident involving a child, and to advise what steps they had taken to prevent a repeat of the incident, they were under a positive obligation to take immediate action against the educator. The employee had left them no other choice when she refused to attend a meeting.

### Key Findings by the Fair Work Commission

The FWC found there was no lawful reason for dismissal. The evidence did not conclusively support the allegation, and the allegations of serious misconduct had not been substantiated to the required standard. Further, the accounts of staff used to support the dismissal were inconsistent and lacked reliability.

The FWC also found that the employer's investigation lacked procedural fairness and demonstrated a disregard for natural justice. Some staff were not interviewed until after the employee's dismissal. The dismissed educator was not given a reasonable opportunity to respond, and the FWC found her refusal to attend a meeting without proper notice was not unreasonable. It was ultimately determined that the employer's regulatory obligations under the National Law did not excuse their failure to follow process under the Fair Work Act.

### Conclusion

The FWC found the dismissal to be both substantively and procedurally unfair. Role reinstatement was not deemed appropriate, but compensation was awarded. Procedural fairness is critical, especially in cases of serious misconduct which must be proven, not merely alleged. A valid reason for dismissal must be 'sound, defensible or well-founded' and dismissal by email in the absence of procedural fairness is prima facie unacceptable.

## Insurance and civil liability

Under the legal principle of vicarious liability, an employer will generally be liable for torts (civil harms) committed by its employees. The *Royal Commission into Institutional Responses to Child Sexual Abuse* (Royal Commission) heard from many victim-survivors and institutions about the challenges of securing redress for child sexual abuse, particularly historical cases, due to a) officials of some institutions not being considered 'employees' at law and b) the harm caused by child sexual abuse not being considered to be done 'in the course of employment'. The Royal Commission ultimately recommended that states and territories should take action to address this legal technicality.[89] In Queensland, amendments to the *Civil Liability Act 2003* in 2019 ensured that victim-survivors are able to sue institutions and receive compensation even when these barriers exist.

> *"There is no deeper responsibility for institutions liable for child sexual abuse than to shoulder the burden of making reparations to the children they so terribly failed."*[90]

Civil liability payments can be a significant and potentially debilitating cost to institutions. Other financial costs incurred by organisations in the course of addressing child sexual abuse include investigation and legal costs, costs to address environmental risks, or payments made to impacted employees (such as those made under deeds of release).

The Royal Commission also recommended that all state and territory governments must require organisations which receive funding to deliver services for children to hold appropriate insurance to cover the impact of abuse. This was intended to ensure that a victim-survivor would not be prevented from accessing redress where services are delivered by non-government entities which may lack significant assets or be in an unincorporated structure that limits their ability to control or access funds.

The National Quality Framework also requires that all ECEC providers must take out and maintain public liability insurance of $10 million or greater as a condition of service approval.[91]

The Royal Commission further recommended changes to the civil liability statutes in each jurisdiction to introduce a statutory duty of care for organisations to take all reasonable steps to prevent the abuse of a child by a person associated with the institution while the child is under the institution's care, supervision, control or authority of the institution, as well as a 'reverse onus' on the institution to prove it met the duty of care when a claim is brought against them by a person alleging abuse. These changes were enacted in Queensland through amendments to the *Civil Liability Act 2003* which came into effect in March 2020.

Although limitation periods on civil action for child sexual abuse claims have largely been eliminated in Queensland as part of the implementation of recommendations by the Royal Commission,[92] uncertainty remains in these types of proceedings particularly against larger institutions. For example, a defendant may petition the court for a permanent stay on proceedings where they suggest a lawsuit is an abuse of process. In a significant recent case, the High Court overturned a decision to grant a permanent stay in favour of the State of Queensland in a historical child abuse lawsuit, on the basis that such a decision should only be a last resort in exceptional cases because of the removal of limitation periods.[93] As discussed elsewhere in this report, most victim-survivors may disclose their abuse many years after it occurred. This interpretation therefore provides certainty for victim-survivors who are not able to bring an action for compensation within the prompt timeframes insisted upon by the courts prior to the Royal Commission.

The insurance market has experienced challenges in this space due to the increasing number of historical child abuse claims being made, particularly against religious institutions.[94] This reached a point in 2023 when the Queensland Government began to indemnify institutions for abuse payouts, to ensure that victim-survivors could continue to receive fair payments despite the failure of the market.[95]

Conversely, this has opened new opportunities for specialist insurers to enter the Australian market, providing safeguarding packages to reduce institutional risks and respond to claims efficiently. For example, Ansvar Insurance has developed a Physical and Sexual Abuse policy in consultation with Hetty Johnston AM to provide specialised insurance to organisations, which incorporates safeguarding and risk mitigation measures.[96]

The above insurance and civil liability pressures, in concert with the difficulty and expense of removing employees who are subject to allegations of abuse, creates a perverse financial incentive on institutions not to report and/or to cover up instances of abuse, further endangering children.

The implementation of Queensland's Child Safe Standards represents a critical opportunity to keep children safe by embedding child safety in every aspect of an organisation's operations, including leadership, governance, staff conduct and service delivery. They must be implemented by businesses or organisations working with or providing spaces and facilities for anyone 17 years and under. This includes small volunteer and community groups, sole traders, as well as established organisations, such as hospitals, schools and churches. The Reportable Conduct Scheme places a further responsibility on organisations to report and investigate allegations of harm to children by their employees or others associated with the organisation and gives the Queensland Family and Child Commission power to conduct its own investigations when this is in the public interest to do so. Failure by an entity head to notify the Queensland Family and Child Commission of reportable allegations is an offence attracting a fine of over $16,000.

Recent legislative amendments have been enacted in other jurisdictions to ensure that regulators and organisations place the rights and best interests of children first. For example, in September 2025 changes to the National Law legislation in New South Wales (NSW) were introduced into the NSW parliament. This followed a review into the regulation of ECEC services in NSW which 'found the regulator was significantly constrained by the National Law.[33] The amendments have brought forward changes to the National Law recommended by the Review of Child Safety Arrangements under the National Quality Framework which are yet to be enacted nationally. Changes to the National Law in NSW include:

- creating a paramount obligation for the sector regulator and providers to place the rights and best interests of children first
- empowering the regulator to suspend or revoke quality ratings during or in response to an investigation, and to suspend individual educators
- significantly increasing financial penalties against providers for breaches of the national law, including a 900 per cent increase for large operators, and a broadening of the scope of breaches liable to penalty
- introducing a new power for the Minister or the regulator to issue a binding direction to the sector where they perceive there is an unacceptable risk to child safety.

# Economic and governance concerns in for-profit early childhood education and care

The early childhood education and care (ECEC) sector has experienced sustained growth in profitability, particularly among large for-profit providers. Market consolidation and increasing private equity involvement have driven strong financial returns, with many providers reporting significant margins. However, these profits have not consistently translated into higher quality or improved child safety outcomes. Despite high and rising fees for families, there is limited evidence that additional revenue is being reinvested into frontline quality, workforce capability, or safeguarding systems.

From an economic perspective, this reflects a market failure in quality signalling. Parents are price-takers in a complex market where information asymmetry prevents them from accurately assessing the safety or safeguarding quality of a service. In this context, accreditation and regulatory compliance are treated as proxies for safety, but current frameworks, including the National Quality Framework, do not adequately measure or communicate safeguarding performance. As a result, financial incentives are misaligned: providers can capture revenue and market share without proportionate investment in the systems and workforce that ensure the safety of children.

A stronger policy and regulatory approach is needed to realign financial incentives with safety outcomes. Owners, boards, and executive management of ECEC providers must bear clear accountability for child safety breaches, supported by statutory obligations and transparent governance standards. The introduction of enforceable duties, similar to those in workplace health and safety law, would ensure that safety is treated as a board-level responsibility, not a compliance burden delegated to front-line staff.

Liability and insurance settings should also be recalibrated to reinforce these incentives. Where safety breaches result in tangible financial exposure through liability, reputational, or insurance consequences, rational economic actors will internalise these costs and reinvest more systematically in safety governance and safeguarding infrastructure. Over time, this would create a virtuous cycle of reinvestment, where maintaining high safety standards becomes not only an ethical imperative but also a financially prudent strategy.

In short, while for-profit ECEC providers play an important role in service provision and innovation, the current market configuration carries inherent risks. Without stronger governance, transparency, and accountability mechanisms, the pursuit of profit may continue to outpace the sector's investment in the very systems that protect children from harm.

> *There may be leaders and members of some institutions who resent the intrusion of the Royal Commission into their affairs. However, if the problems we have identified are to be adequately addressed, changes must be made to the culture, structure and governance practices of institutions. A failure to act will inevitably lead to the continuing sexual abuse of children, some of whom will suffer lifelong harm. That harm can be devastating for the individual. It also has a cost to the entire Australian community.*[96]

# Reframing the approach required

Over the last half-century, Australia has fundamentally transformed the way it thinks about protecting workers. What began as fragmented, inconsistent, and largely reactive occupational health and safety regimes has evolved into a harmonised national system of Work Health and Safety (WHS) laws. These laws now span across sectors, industries, and state borders, providing a consistent framework that holds organisations accountable for creating safe environments and preventing foreseeable harm.

In contemporary Australia, worker safety is no longer a peripheral compliance issue—it is a core responsibility of CEOs, boards, and shareholders. The Australian approach has elevated employee safety from being an operational concern to a central matter of corporate governance and liability. Today, directors can be held personally accountable for breaches, insurers price risk based on safety performance, and shareholders expect transparent reporting on workplace harm. This transformation did not occur by chance. It was driven by a recognition that worker safety is a systemic duty of care that organisations owe, not an optional extra. The legislative framework reinforced this by imposing positive obligations, ensuring consistency across sectors and states, and creating enforcement powers that made negligence not only reputationally damaging but legally and financially untenable.

The parallels with child safeguarding are unmistakable. Just as workers in the past faced unacceptable risks due to piecemeal regulation and organisational priorities that did not regard safety, children today remain exposed to preventable harms because our institutional safeguarding systems are fragmented, inconsistent, and unevenly applied across settings.

***Child safeguarding now stands at the same crossroads. Despite growing awareness of the risks children face in organisational settings, safeguarding is often treated as an administrative exercise rather than a core corporate responsibility.***

Boards do not yet treat child safety with the same urgency as worker safety, and senior executives rarely face the personal accountability that they do under WHS law. This disparity is striking: society rightly demands that a factory floor be safe for employees, but an ECEC centre, residential care home, sports club, or school is not held to the same expectations for vulnerable children.

As so aptly articulated in the 1999 Report of the Commission of Inquiry into Abuse of Children in Queensland Institutions:

> *Children are our most precious resource. They are our future. Their experience as children will determine what kind of adults they become and what kind of society there will be. One act of abuse or mistreatment towards a child is one act too many. Repeated acts of abuse that have gone unrecognised and unaddressed are inexcusable. Although there have been many reasons presented to the Commission as to how and why the abuses took place, none excuse the abuse, nor do they excuse the failure of those in authority in government, churches and society in general to effectively deal with complaints of abuse. We have failed these most disadvantaged and powerless children in the past. It is vital that we do not continue to do so.*
>
> *Adequate accountability systems are not in place, in institutions or on the part of the Department, to ensure that children are protected, and to ensure that where abuse occurs it is appropriately dealt with. Improving monitoring and accountability is the centrepiece of our recommendations for the future. In making our recommendations we conclude that although it was individuals who perpetrated each act of abuse, they alone cannot shoulder the whole responsibility.*
>
> *Some measure of responsibility must be taken by those to whom the abuses were reported and who did not act, those in charge of the institutions who did not have sufficient safeguards in place to protect the children, those members of religious organisations who turned a blind eye, the staff and the management of the Department of Children's Services who did not adequately monitor the children in their care, successive State Governments that have not sufficiently valued children to adequately resource the Department entrusted with their care, and society, which ignored or accepted what happened to children in the care of the State. As a State, we must face up to past wrongs and make proper redress, and ensure that when children are in our care we do them no harm.*[97]

# A 50-year journey to harmonise how organisations are responsible for worker safety

WHS laws in Australia have evolved over many years to create a safer working environment for employees and employers. Before the 1970s, there were limited and varied regulations around workplace health and safety across Australia. Each state had its own legislation, and safety standards were not uniform. Most of the laws focused on specific industries (such as mining, construction, etc.) and were often reactive rather than proactive in addressing health and safety risks.

In the 1900s industrial safety laws began to emerge but they were often focused on specific hazards such as machinery, fire safety, and hazardous substances. By the 1930s–1940s industrial safety was still treated as an issue of personal responsibility rather than something that required systemic management. Regulations were often inadequate, and workplace accidents were common.

The 1970s saw significant changes in how WHS was approached in Australia, largely driven by international movements, growing industrial advocacy, and increased awareness of workers' rights. In the 1970s there were attempts to implement more comprehensive safety standards in various industries, however, these were still largely irregular, with different standards across states and territories.

The 1980s marked a significant shift towards more consistent regulation, particularly with the introduction of national standards and codes of practice. During this time, safety standards were enforced more rigorously, with the establishment of specific health and safety authorities at the state level.

By the 1990s, the need for a unified approach to WHS laws became increasingly clear. Australia's economy was becoming more integrated, and there were growing calls for a national approach to industrial safety standards. Different state and territory laws created confusion, particularly for businesses operating in multiple jurisdictions. In 1991 the National Occupational Health and Safety Commission (NOHSC) was established to provide national leadership on occupational health and safety issues. Its role was to develop national guidelines, codes of practice, and technical standards. In 1995 the Model WHS Act was first developed by NOHSC to create a uniform framework across the country. It provided a model for states and territories to follow, though not all states and territories adopted it immediately.

The most significant reform in Australian WHS law came in the early 2010s when a process was launched to harmonise workplace health and safety laws across the country. This reform aimed to create consistent regulations, simplify compliance for businesses, and enhance protection for workers. Safe Work Australia was established and the *Workplace Health and Safety Act 2011* (WHS Act) was passed as a model law for Australian jurisdictions. The WHS Act was designed to be adopted by all states and territories, with only minor variations based on local circumstances.

Key features of the WHS Act included:

- a focus on risk management rather than prescriptive rules
- clear duties of care for employers, workers, contractors, and suppliers
- the introduction of workplace health and safety representatives and health and safety committees in larger businesses
- greater accountability and penalties for non-compliance, including the introduction of personal liability for officers (e.g. company directors) who fail to ensure compliance.

Child safeguarding in Australia sits at a point very similar to occupational safety in its early decades of reform in the 1970s and 1980s. At present, while there is strong intention, it is characterised by:

- **Fragmented systems**: Child safeguarding responsibilities are distributed across multiple regulators and oversight bodies, each with different mandates, definitions, and thresholds for action.
- **Sector-specific rules**: Requirements for safeguarding differ across sectors, education, sport, health, disability, and residential care, without a unifying framework.
- **Inconsistent accountability**: Some organisations face strong oversight (for example, through reportable conduct schemes), while others operate with minimal scrutiny.
- **Reactive models**: Too often, safeguarding efforts begin only after children are harmed, rather than addressing the early warning indicators and sub-threshold signals of risk that could help to prevent abuse.
- **Jurisdictional variation:** State-based Working with Children Checks, reportable conduct schemes, and standards create inconsistency, allowing risks to migrate between states or sectors.

The result is that much like the pre-reform WHS system, our current approach to child safeguarding is prone to failure at the points where children most need protection. The WHS journey demonstrates that meaningful change is possible, but only when governments are prepared to step back from siloed approaches and commit to a unified national framework and ongoing continuous improvement.

> *…15 years since the establishment of Australia's national system for regulating early childhood education and care services and the national law, and despite its many successes, we must acknowledge, confront and address the harsh realities of its failings. In large part, the national system has been reliant on goodwill. It has not required good behaviour at all times by law. Slowly, forces have crept into the sector—I would say nefarious forces—that have sought and been able to exploit the safeguards that were intended to protect wrongfully accused childcare providers or workers. Whilst only a small number across the system have sought to exploit these safeguards, they have harmed children, families and workers by focusing on profits over safety, leaving children vulnerable where the law should have better protected them.*[98]

The lessons are clear:

- **Shared responsibility**: Just as every employer is now accountable for workplace safety, every organisation that interacts with children must be accountable for safeguarding. However, WHS does not just place responsibility with one role or person. Every board member, CEO and employee has a duty such that everyone has a clear responsibility and role in ensuring a safe workplace.
- **Positive duty of care**: WHS laws introduced a legal obligation on organisations, their leaders, and their boards, to eliminate or minimise risks 'so far as reasonably practicable'. A similar positive duty to prevent harm should underpin child safeguarding law.
- **Harmonisation**: Workers should not be less safe depending on their industry or state, and neither should children. Safeguarding protections must be universal and consistent.
- **Prevention as the organising principle**: Both WHS and safeguarding must be grounded in risk management, hazard and threat identification, and early intervention—not crisis response.
- **Central leadership with shared enforcement**: WHS reform only succeeded because governments agreed on a harmonised model law, with regulators empowered to enforce it. Child safeguarding requires the same resolution.

> *Valuing children and their rights is the foundation of all child safe institutions. Improving child safe approaches in institutions will reduce the risk of sexual abuse. The best interests of children must be the primary consideration.*

# Transformational Recommendation 5: Strengthen child safeguarding duties and introduce corporate and personal accountability and liability for the safety of children

The history of WHS reform shows that fragmented, inconsistent, and reactive systems eventually give way to harmonisation when the public and governments recognise the human and social costs of failure. For child safeguarding, that moment is now. The evidence is overwhelming: without a unified, legally enforceable, and prevention-focused safeguarding framework, Queensland and Australia will continue to respond to crimes rather than prevent them.

A long-term strategy for child safeguarding must therefore chart the same course that WHS has taken: from fragmented and reactive to harmonised, preventative, and universally accountable. This is not only possible, but necessary if we are to create a society where children are as safe in their communities, schools, and organisations as workers are now expected to be in their workplaces.

Central to prioritising child safety will necessarily be new penalties for organisations and leaders who oversee processes that lead to harm. Severe consequences for non-compliance are central to shifting organisational behaviour, including leadership accountability, board oversight, insurance costs, and preventive systems. Significant cases and statistics from the WHS system stand in stark contrast to the current penalties available to organisations with weak safeguarding practices, who fail to detect, and respond to perpetrators of child sexual abuse, and prevent their employment.

> *Between 2020–2024, there were 1,373 WHS prosecutions nationally, accumulating $164.22 million in financial penalties.[99] In 2023 alone, there were 293 prosecutions for WHS law breaches; total penalties approached $40 million.[100] The average financial penalty per case over the four years to 2024 was $122,920.[101]*

The enforcement of WHS laws in Australia has shown that strong penalties, applied consistently, are powerful levers for changing organisational behaviour. Recent cases illustrate how fines, custodial sentences, and leadership accountability transform workplace safety from a compliance exercise into a core governance concern.

**Table 4: Recent WHS case examples**

| Case | Jurisdiction | Outcomes |
|---|---|---|
| **SafeWork NSW v A1 Arbor Tree Services Pty Ltd and Anor [2023] NSWDC 256** | New South Wales | Despite repeated opportunities to address serious safety concerns, the company failed to act. The court imposed a penalty of over $2 million on the business, alongside a personal fine exceeding $100,000 for its director.[102] This case is significant not only for the size of the penalty but also for its clear message: senior leaders cannot escape personal accountability when systemic safety failures cause harm. |
| **WorkSafe (WA) v MT Sheds (WA) Pty Ltd (Unreported, Magistrates Court of Western Australia, Esperance, 2021)** | Western Australia | This case was prosecuted under the old *Occupational Safety and Health Act 1984* (WA), rather than the post-2011 WHS model law. After a worker was killed and another seriously injured due to gross negligence, the company director was sentenced to more than two years in prison. This custodial penalty underscores that WHS duties are not optional, and when lives are lost through blatant disregard for safety, directors face the same level of accountability as in other forms of criminal negligence. |
| **Agius v Metal Manufactures Pty Ltd and Jack Platt [2024] ACTMC 16** | ACT | A site manager left heavy cable racks unanchored, leading to serious injury when one toppled onto a worker. The company received a substantial fine of $500,000 while the manager himself was personally fined. This dual approach ensures that accountability is shared: both the organisation and its leaders are responsible for creating safe systems of work. |

Taken together, these cases demonstrate the escalating seriousness with which regulators and courts approach workplace safety. The penalties are not symbolic: they are large enough to impact company viability, executive careers, and industry reputation. They influence insurance settings, shape boardroom discussions, and encourage proactive investment in prevention. Most importantly, they signal to all organisations that failing to prevent foreseeable harm carries consequences of the highest order. These high-profile penalties function as powerful levers for change:

1. **Leadership and board accountability:** When fines are large or when individual directors are penalised (financially or with imprisonment), it forces boards and executives to take safety seriously. Safety becomes a matter of governance, reportable KPIs, and reputation not just compliance documents.
2. **Insurance and liability costs:** With major penalties recorded publicly, insurers adjust risk ratings and premiums. Organisations without robust safety systems face higher insurance costs, loss of coverage, and reputational risk, creating financial incentives to prevent incidents.
3. **Preventive systems over reactive responses:** When penalties include damages for foreseeable risks that weren't addressed, organisations learn that prevention (risk assessment, safe systems, maintenance, training) is cheaper than litigation and fines.
4. **Regulatory deterrence and culture:** The visibility of large penalties sends a message across industries: non-compliance has serious consequences. This spreads into sector-wide culture: better audits, safer work practices, more internal reporting, and better leadership oversight.
5. **Encouraging reporting and transparency:** Organisations that know they can be held accountable—especially senior leadership—are more likely to invest in transparent reporting, worker consultation, and hazard identification rather than hiding or minimising problems.

> *Protecting children and promoting their safety is everyone's business. It is a national priority that requires a national response. Everyone—the Australian Government and state and territory governments, sectors and institutions, communities, families and individuals—has a role to play in protecting children in institutions.*

**Transformational Recommendation 5:** Strengthen child safeguarding duties and introduce corporate and personal accountability and liability for the safety of children

That the Australian Government commences a national reform to strengthen and harmonise child safeguarding laws across jurisdictions, embedding corporate responsibility and liability for child safety in the same way that Work Health and Safety laws now apply to worker safety so that Commonwealth laws include enforceable corporate duties of care for child safeguarding, and significant penalties for organisations, their board and their leaders where safeguarding failures result in sexual abuse or exploitation or expose children to serious risk of harm. Such a scheme is to include the appointment of child safeguarding officers in medium sized organisations and above, and the explicit inclusion of child safeguarding within risk management plans and performance reporting.

While this occurs the Queensland Government should strengthen its own state-based legislation, including *the Child Safe Organisations Act 2024*, to introduce the above corporate and personal liabilities, duties and incentives for boards, owners, and workers to implement safeguarding practices as a requirement for operating a child-related business.

# Endnotes

1 National Office for Child Safety (NOCS), *'National Strategy to Prevent and Respond to Child Sexual Abuse 2021–2030'*, Australian Government, 2021, p15.
2 NOCS, *National Strategy to Prevent and Respond to Child Sexual Abuse 2021–2030*.
3 Commonwealth of Australia, *Final Report: Royal Commission into Institutional Responses to Child Sexual Abuse.*
4 Commonwealth of Australia, *Final Report: Royal Commission into Institutional Responses to Child Sexual Abuse.*
5 Childlight (East Asia and Pacific Hub) & Gendered Violence Research Network, *International Best Practice for Protecting Children from Child Sexual Abuse - Project 3: Identifying Perpetrators and Children at Risk* [unpublished report], University of New South Wales, Sydney, 2025.
6 Australian Bureau of Statistics, *Personal Safety, Australia, 2021–22 financial year*, Australian Government, 15 March 2023, accessed 16 September 2025.
7 B Matthews, H Do, *Prevalence of child sexual abuse in Queensland: Results from the Australian Child Maltreatment Study* [research report], Queensland University of Technology, Brisbane, 2025.
8 National Centre for Action on Child Sexual Abuse (National Centre), *The Australian child sexual abuse attitudes, knowledge and response study,* October 2025.
9 National Centre, *The Australian child sexual abuse attitudes, knowledge and response study.*
10 National Centre, *The Australian child sexual abuse attitudes, knowledge and response study.*
11 Australian Bureau of Statistics (ABS), *Recorded Crime - Victims, 2024* [data], Australian Government, 2025.
12 ABS, *Recorded Crime - Victims, 2024.*
13 ABS, *Recorded Crime - Victims, 2024.*
14 ABS, *Recorded Crime - Victims, 2024.*
15 ABS, *Recorded Crime - Victims, 2024.*
16 Parliament of Australia, Chapter 7 - Conclusions and committee view – Parliament of Australia, Parliament of Australia, November 2023, accessed 16 September 2025.
17 Department of Families, *Review of Victoria's Reportable Conduct Scheme*, Fairness and Housing Victoria, Victorian Government, 2024, p72.
18 D Harris, J Ogilvie, B Jenkins, A Bodker, L Buzza, *Best practices for prevention of institutional child sexual abuse and exploitation* [research report], Griffith University, Brisbane, 2025.
19 Harris et al., *Best practices for prevention of institutional child sexual abuse and exploitation.*
20 Harris et al., *Best practices for prevention of institutional child sexual abuse and exploitation.*
21 Parliament of Victoria, *Review of Victoria's Reportable Conduct Scheme Final Report*, Department of Families, Fairness and Housing, State of Victoria, 2024.
22 New South Wales Government, *Strengthening the oversight of workplace child abuse allegations,* Ombudsman New South Wales, State of New South Wales, 2016.
23 J Weatherill AO, P White PSM, *Rapid Child Safety Review*, Department of Premier and Cabinet, State of Victoria, 2025, accessed 12 September 2025.
24 Childlight, *Identifying Perpetrators and Children at Risk*, p28.
25 Weatherill and White, *Rapid Child Safety Review.*
26 Luke Twyford, Principal Commissioner, QFCC.
27 Commonwealth of Australia, *Final Report: Royal Commission into Institutional Responses to Child Sexual Abuse.*
28 Commonwealth of Australia, *Final Report: Royal Commission into Institutional Responses to Child Sexual Abuse.*
29 Second reading speech, Criminal Code (Child Sexual Offences Reform) and Other Legislation Amendment Bill 2019, Queensland Parliament, 27 November 2019
30 Women's Safety and Justice Taskforce, *Hear her voice, Report Two*, Women's Safety and Justice Taskforce, State of Queensland, 2022.
31 See Criminal Law *(Coercive Control and Affirmative Consent) and Other Legislation Amendment Act 2024* s.9
32 Women's Safety and Justice Taskforce, *Second Annual Report 2023–24*, Department of Justice and Attorney-General, State of Queensland, 2024.
33 *Child Safe Organisations Act 2024*, s 34.
34 Wall et al., *Safeguarding children from child sexual abuse.*
35 L Dodds, D Moritz, D Mitchell, S Price, *Responding to Allegations of Child Sexual Abuse* [research report], Sexual Violence Research and Prevention Unit, University of the Sunshine Coast, 2025.
36 Dodds et al., *Responding to Allegations of Child Sexual Abuse.*
37 Dodds et al., *Responding to Allegations of Child Sexual Abuse.*
38 Crime and Misconduct Commission, *Seeking Justice: An inquiry into how sexual offences are handled by the Queensland Criminal Justice System*, CMC, The State of Queensland, 2003.
39 CMC, *Seeking Justice: An inquiry into how sexual offences are handled by the Queensland Criminal Justice System.*
40 Women's Safety and Justice Taskforce, *Hear her voice, Report Two.*
41 Queensland Police Service, *Sexual Violence Response Strategy 2023–2025*, QPS, Queensland Government, 2023.
42 QPS, *Sexual Violence Response Strategy 2023–2025.*
43 M Bourke, D Prestridge and MB Malterer, 'Interdiction for the protection of children: Preventing sexual exploitation one traffic stop at a time', *Aggression and violent behavior*, 2016, 30:68-75.
44 Commonwealth of Australia, *Final Report: Royal Commission into Institutional Responses to Child Sexual Abuse.*
45 Queensland Government, *Interagency guidelines for responding to children, young people and adults who have experienced sexual assault or child sexual abuse,* 2024, accessed 11 September 2025.
46 Queensland Government, *Interagency guidelines for responding to children, young people and adults who have experienced sexual assault or child sexual abuse*.
47 Queensland Government, *Interagency guidelines for responding to children, young people and adults who have experienced sexual assault or child sexual abuse*.
48 Queensland Government, *Interagency guidelines for responding to children, young people and adults who have experienced sexual assault or child sexual abuse*.
49 Dodds et al., *Responding to Allegations of Child Sexual Abuse.*
50 Queensland Courts, *Queensland Intermediaries Scheme,* Queensland Government, 1 July 2025.
51 Queensland Courts, *QIS General Factsheet*, Queensland Government, September 2023.
52 Queensland Courts, *Supreme Court Benchbook 63A Intermediaries*, Queensland Government, February 2025.
53 Dodds et al., *Responding to Allegations of Child Sexual Abuse.*.
54 M Kyriakidou, M Blades, J Cherryman, S Christoforou, A Kamperis, 'The impact of investing in the good interviewers policy of practice (IGIpop) on police interviews with children', *Police Practice and Research* 2020, 22(1), 1046–1057.
55 Kyriakidou et al., 'The impact of investing in the good interviewers policy of practice (IGIpop) on police interviews with children'.
56 L Lundy, *The Lundy model of child participation*.
57 L Lundy, *The Lundy model of child participation*, European Commission, 2018.
58 Childlight, *Identifying Perpetrators and Children at Risk.*
59 Commissioner M Byrne QC, *Queensland Organised Crime Commission of Inquiry*, Queensland Organised Crime Commission of Inquiry, State of Queensland, 2015.
60 Commissioner M Byrne QC, *Queensland Organised Crime Commission of Inquiry.*
61 A Talmon, J Ditzer, A Talmon and N Tsur, 'Maltreatment in Daycare Settings: A Review of Empirical Studies in the Field', *Trauma, Violence & Abuse*, 2024, 25(1), 512–525.

62 Department of Justice and Attorney-General, *Director of Public Prosecutions guidelines*, Queensland Government, Brisbane, 2022.
63 Department of Justice and Attorney-General, *Director of Public Prosecutions guidelines*.
64 Department of Justice and Attorney-General, *Director of Public Prosecutions guidelines*.
65 Queensland Family & Child Commission, *Keeping Queensland's children more than safe: Review of the blue card system*, The State of Queensland, 2017.
66 L Wall, R Moody, L Kling, T Pappu, S Rattambige, P Bosher, *Safeguarding children from child sexual abuse* [research report], Australian Institute of Family Studies (Australian Government), Melbourne, 2025, p53.
67 G Tame, *The numbers don't lie: Australia needs grooming prevention education*, Grace Tame Foundation, 5 September 2025.
68 National Center for Missing and Exploited Children, 'Our impact: 2024 – Every child deserves a safe childhood', 2025.
69 Europol, 'Exploiting Isolation: Offenders and victims of online child sexual abuse during the COVID-19 pandemic', 19 June 2020.
70 INTERPOL, 'International Child Sexual Exploitation Database', 2025, accessed 19 September 2025.
71 ML Bourke, L Fragomeli, PJ Detar, MA Sullivan, E Meyle, and M O'Riordan, The use of tactical polygraph with sex offenders. *Journal of Sexual Aggression,* 2015, 21(3), 354–367. https://doi.org/10.1080/13552600.2014.886729
72 Commissioner M Byrne QC, *Queensland Organised Crime Commission of Inquiry.*
73 Parliamentary Joint Committee on Law Enforcement, *Law enforcement capabilities in relation to child exploitation*, Parliament of Australia, 2023, ch 7.
74 Parliamentary Joint Committee on Law Enforcement, *Law enforcement capabilities in relation to child exploitation*.
75 Queensland Police Service, *Sexual Violence Response Strategy 2025–29*, 2025, accessed 14 November 2025.
76 Queensland Police Service, *Sexual Violence Response Strategy 2025–29*, 2025, accessed 14 November 2025.
77 Parliamentary Joint Committee on Law Enforcement, *Law enforcement capabilities in relation to child exploitation.*
78 Queensland Police Service, *2019–20 Annual Report: QPS Response to COVID-19*, Queensland Government, 2020.
79 Independent Commission of Inquiry into Queensland Police Service responses to domestic and family violence, *Report: A call for change*, Queensland Government, 2022.
80 Queensland Police Service (QPS), *Reports and publications*, Queensland Government, 2025.
81 *Child Safe Organisations Act 2024* schs 1 and 2.
82 Commissioner M Byrne QC, *Queensland Organised Crime Commission of Inquiry.*
83 Commissioner M Byrne QC, *Queensland Organised Crime Commission of Inquiry.*
84 Office of the Australian Information Commissioner, *Clearview AI breached Australians' privacy* [media release], Australian Government, 3 November 2021.
85 Board of Inquiry into past handling of complaints of sexual abuse in the Anglican Church Diocese of Brisbane, Report, Parliament of Queensland, 2003.
86 Fair Work Commission, What makes a dismissal unfair?, Australian Government, accessed 12 September 2025.
87 *Working with Children (Risk Management and Screening) Act* 2000 s356(2).
88 Harris et al., *Best practices for prevention of institutional child sexual abuse and exploitation.*
89 Commonwealth of Australia, *Redress and Civil Litigation Report*, Royal Commission into Institutional Responses to Child Sexual Abuse, Commonwealth Government of Australia, 2015.
90 Senate Community Affairs Committee Secretariat, *Commonwealth Redress Scheme for Institutional Child Sexual Abuse Bill 2017*, Community Affairs Legislation Committee, Commonwealth of Australia, 2018.
91 ACECQA, 'Guide to the National Quality Framework', Australian Government, 2020, p43.
92 These were in enacted in Queensland in 2018 via the *Limitation of Actions (Child Sexual Abuse) and Other Legislation Amendment Act 2016.*
93 *Willmot v State of Queensland* [2024] HCA 42.
94 L Lohnberger, 'Catholic Church-owned insurer says 'high volume' of abuse claims is putting it out of business - ABC News', *ABC News*, 29 October 2023, accessed 16 September 2025.
95 C Knause, 'State governments forced to indemnify church bodies for child abuse due to insurance 'market failure' | Australia news | The Guardian', *The Guardian*, 11 May 2023, accessed 16 September 2025.
96 D Wood, 'Beazley launches safeguard product in Australia', Insurance Business, 21 July 2022, accessed 16 September 2025; Ansvar Insurance Limited, *Our ERM Solutions - Safeguarding Vulnerable People*, Ansvar Insurance Limited, 2025, accessed12 September 2025.
97 L Forde, J Thomason and H Heilpern, *Report of the Commission of Inquiry into Abuse of Children in Queensland Institutions*, Families, Youth and Community Care, Queensland Government, 1999.
98 S Whan, Second reading speech, Children (Education and Care Services National Law Application) Amendment Bill 2025, New South Wales Legislative Assembly, 10 September 2025.
99 Australian Institute of Health & Safety, *WHS prosecutions climb as Safe Work Australia tracks $164 million in penalties*, AIHS, 2025, accessed 16 September 2025.
100 D Tilo, 'Financial penalties from WHS prosecutions hit nearly $40 million in 2023 | HRD Australia', *Human Resources Director*, 2 August 2024, accessed 16 September 2025.
101 Safe Work Australia, *WHS prosecutions* [data], Australian Government, 2024, accessed 16 September 2025.