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Queensland Protection Commission Bill 2026

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QUEENSLAND
Family & Child
Commission



Introduction

I welcome the introduction of the *Queensland Protection Commission Bill 2026*.

Leading the Review of System Responses to Child Sexual Abuse, which resulted in the *In Plain Sight* report, was one of the most significant responsibilities I have ever held. What the Review heard, examined and tested made one conclusion unavoidable: **our existing systems for protecting children have been inadequate.**

Behind the evidence were children and adults whose experiences demonstrated the devastating consequences of those gaps. The Review heard about grooming behaviours that were visible but not recognised, concerns recorded in one organisation but unknown to another, patterns of behaviour that only became apparent after significant harm had occurred, and children whose disclosures, distress or changed behaviour did not always lead to the protection they needed.

For victim-survivors, the consequences of child sexual abuse does not end when the abuse stops. Trauma can affect relationships, education, employment, parenting, mental and physical health, and a person's sense of safety for many years. I remain deeply conscious that victim-survivors and their families entrusted me and the Review with experiences that were often painful to recount. That trust carries an obligation. The value of *In Plain Sight* cannot be measured simply by the strength of its findings or recommendations, but by whether those findings lead to new systems that are more capable of recognising warning signs, connecting information and protecting children earlier.

That is why *In Plain Sight* placed such strong emphasis on proactive threat detection, stronger information sharing and centralised safeguarding leadership. **The Queensland Protection Commission Bill responds directly to those findings.** It provides the foundation for Queensland to move from a collection of important but separate safeguarding functions towards a more connected system capable of seeing the whole picture. It creates the opportunity to bring together systemic oversight, Worker Screening Services, the Reportable Conduct Scheme, Child Safe Standards, disability worker screening, the Child Death Register and child death prevention, and, in time, the Safeguarding Intelligence Hub and Intelligence Network. **Importantly the Bill creates centralised leadership for the protection of children.**

This is not simply an administrative consolidation. It is an opportunity to **change the architecture of government around the protection of children.** *In Plain Sight* found that Queensland's safeguarding arrangements were too fragmented. Responsibility was dispersed, information sat in separate systems, regulatory functions operated alongside one another, and no single entity held a clear leadership responsibility for bringing the safeguarding picture together. The Review therefore called for a new entity to provide a "central point of leadership, accountability, and coordination" and to move Queensland from fragmented responses to a "unified, proactive safeguarding system."

The Bill gives Queensland the opportunity to lead Australia in building that entity. The significance of the proposed Queensland Protection Commission is that each function being brought together sees something different:

- worker screening sees the individual;
- reportable conduct sees allegations, complaints and concerning behaviour;
- child safe standards see the organisations and the protective environments around the child;
- systemic oversight sees the performance of the broader child protection system;
- the child death register and child death review functions identify patterns, risks and opportunities for prevention;
- the Intelligence Hub will identify patterns across all of these functions; and
- the Intelligence Network will connect those patterns with the agencies and organisations across the State that have the power to act.

That is fundamentally different from a system in which each function operates separately.

The ambition of the Queensland Protection Commission is to become the proactive leadership entity envisaged by *In Plain Sight*: an organisation capable of aligning, connecting and elevating the work of others so that Queensland's safeguarding system becomes more than the sum of its individual parts. This matters because the problem confronting Queensland is not theoretical. *In Plain Sight* showed that child sexual abuse occurs at a scale and in places that the community consistently underestimates. Its central warning was that perpetrators can be visible to systems, organisations and communities while remaining unseen for the threat they pose.

The Review concluded: "A system that responds only after harm occurs is not one that protects children". The challenge for the Queensland Protection Commissioner is therefore not simply to respond better when something has already gone wrong. It is **to help Queensland see threats earlier**.

- To see when apparently isolated concerns form a pattern.
- To see when an organisation is repeatedly failing to recognise risk.
- To see when information held by one agency should change the decision of another.
- To see when a worker moving between organisations carries a history of concerns that no single employer can see.
- To see when emerging evidence demonstrates that policy, legislation or practice is failing children.

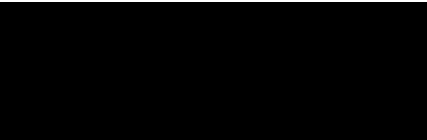
And then to ensure that somebody acts. That is the shift from administration to safeguarding, and from response to prevention.

The Bill preserves the vital role of systemic oversight of the child protection system and places that function within this broader safeguarding institution. This creates an opportunity to move oversight and the significant work reviewing child deaths closer to where it can contribute to change. That matters. An oversight body that isolates itself in an effort to demonstrate independence will struggle to influence reform. Modern oversight is not simply about being an advocate for change. It is about producing evidence and translating findings to improve practice, support better decisions and contribute constructively to solutions. That does not diminish independence. It gives purpose to it.

The Queensland Protection Commission will enable Queensland to become **better at identifying risk before children experience harm, better at connecting information before warning signs are lost, better at holding organisations and systems accountable for the safety of children, and better at turning knowledge into action that protects children**. That will require strong regulation. It will require credible oversight. It will require sophisticated intelligence. It will require transparent evidence and transparent processes. It will require leadership capable of working across government rather than simply observing it from the outside. And it will require an institution with the authority, integrity and courage to keep child safeguarding at the centre of its work.

In Plain Sight called for child safety to be elevated within the machinery of government and for safeguarding to become proactive rather than reactive. The Queensland Protection Commission Bill provides the opportunity to make that real. If implemented with ambition it can become the institution that **connects what Queensland knows, exposes what Queensland is missing, coordinates who must act and keep the protection of children visible across the architecture of government**. That is the transformative opportunity created by this Bill.

And ultimately, its purpose is simple: **to see risk earlier, act sooner and protect more Queenslanders from harm**.



Luke Twyford
Commissioner

Prevalence of Child Sexual Abuse in Queensland and the long delay before child sex offenders are detected

In Plain Sight confronted a fundamental misconception about child sexual abuse: that it is an uncommon event perpetrated by a small number of easily identifiable offenders. The evidence clearly demonstrated the opposite. Child sexual abuse is widespread, frequently hidden, and occurs across families, communities, organisations and online environments. The Review found that child sexual abuse is occurring at far higher rates, in more common places, and to children closer to us than the community generally expects or accepts.

A central evidence base for the Review was the Australian Child Maltreatment Study (ACMS), the first nationally representative study to measure the prevalence of all major forms of child maltreatment in Australia. The ACMS found that 28.5 per cent of Australians aged 16 years and over had experienced child sexual abuse before the age of 18 — more than one in four Australians. Prevalence was substantially higher among females, with 37.3 per cent reporting childhood sexual abuse compared with 18.8 per cent of males. These figures led *In Plain Sight* to characterise child sexual abuse as **a significant and persistent threat to Australian children**. Put simply, without further effective prevention, detection and intervention, the evidence suggests that one in four Australian and Queensland children will experience child sexual abuse. *In Plain Sight* also highlighted the frequency with which offending was becoming visible in Queensland, noting that a new offender was being identified in the media every 2.3 days. This pattern continued after the publication of *In Plain Sight*, and an updated analysis published in May 2026 indicated that this pattern had continued (**Attachment A**).

The scale of child sexual abuse demands a system designed around the reality that the risk facing our children is sufficiently prevalent to require prevention and detection to be embedded in everyday systems. The scale of prevalence means that a predominantly reactive system — one that waits for a child to disclose abuse, an allegation to be substantiated or an offender to enter the criminal justice system — will inevitably fail to keep children safe.

Research consistently indicates that child sexual offending may continue for many years before an offender is detected by authorities. Queensland's Project AXIS research found that offenders reported their first sexual contact with a child had occurred, on average, 8.6 years before their current conviction for intrafamilial offenders, 10.6 years for extrafamilial offenders and 11.5 years for offenders who abused both familial and extrafamilial victims.¹ Research into offenders operating in youth-serving organisations demonstrates that the delay can be even longer. An Australian Institute of Criminology study found that offenders who deliberately gained access to children through institutions had been associated with those organisations **for an average of 16.2 years before being caught**.² The practical challenge for the new Commission, is therefore to shorten the period between the emergence of concerning behaviour and effective intervention, rather than relying on criminal conviction as the first reliable indicator of risk.

¹ Cossins, A., THE BEHAVIOUR OF SERIAL CHILD SEX OFFENDERS: IMPLICATIONS FOR THE PROSECUTION OF CHILD SEX OFFENCES IN JOINT TRIALS, (2011), Melbourne University Law Review 821.

² Leclerc B & Cale J 2015. Adult sex offenders in youth-oriented institutions: Evidence on sexual victimisation experiences of offenders and their offending patterns. *Trends & issues in crime and criminal justice* no. 497. Canberra: Australian Institute of Criminology. <https://doi.org/10.52922/ti167904>

The *In Plain Sight* report identifies how multiple systems failed to identify and disrupt a prolific offender and it provides a detailed account of how these failures were not isolated, but systemic. This highlighted the need for a fundamental shift from a reactive, criminal justice-led response to a proactive, prevention-focused safeguarding model. A central finding of the report is that the offender's conduct remained undetected because relevant information was fragmented across agencies and institutions. Over a 20-year period, the offender's employment was terminated, he was made redundant or otherwise ceased at ECEC services due to behavioural or performance concerns, however, in the absence of any mechanism to share sub-threshold concerns, these responses occurred in isolation. This had the effect of moving the risk on to another unsuspecting centre, leaving future children exposed.

The report also highlighted significant deficiencies in information management practices. Critical intelligence was not effectively recorded or linked across systems. Regulatory limitations further compounded these risks, and the safeguarding system was overly reliant on downstream criminal justice responses. This created a significant protection gap in circumstances where allegations did not meet the evidentiary threshold required for prosecution. This reflects a systemic failure to recognise that behaviour may present an unacceptable risk to children even where it does not meet the threshold for criminal conviction. Finally, the report underscores the fragmented nature of reporting pathways for non-familial abuse. Parents and providers described being redirected between agencies, particularly between the QPS and the Department of Child Safety. This reflects a broader misunderstanding regarding the role of statutory child protection systems, which do not have a mandate to respond to risks posed by non-familial offenders. The absence of a clearly defined, coordinated response pathway created a regulatory gap in circumstances where police did not proceed with criminal charges.

Collectively, the findings of the *In Plain Sight* report demonstrates that effective safeguarding cannot rely on siloed systems or compliance-response approaches. It requires a shift toward an integrated, intelligence-led framework, including the establishment of a centralised Child Safeguarding entity and Intelligence Hub, the co-location of worker screening and reportable conduct functions, and the introduction of enforceable duties on organisations to proactively prevent harm to children.

The central implication of *In Plain Sight* was that Queensland's safeguarding architecture was inadequate Given the frequency of abuse, the diversity of perpetrators and settings in which it occurs, *In Plain Sight* argued for a safeguarding environment in which governments, regulators, organisations, professionals, parents and communities share information proactively with a dedicated safeguarding entity responsible for leading the system and recognising and responding to risk.

In *In Plain Sight* I said: "This absence of centralised leadership creates duplication in some areas, gaps in others, and ultimately leaves children less safe. The Board considers that unless we shift the paradigm of how government works in child safeguarding, Queensland will always be chasing crime rather than preventing threats".

Main purposes of the Queensland Protection Commission

The Queensland Protection Commission Bill gives legislative form to the central findings and recommendations of *In Plain Sight*. Its significance lies not only in establishing a new entity, but in reshaping how Queensland identifies, connects and acts on safeguarding risk. *In Plain Sight* called for a system that moved beyond reactive information sharing towards **proactive risk detection**, supported by a centralised safeguarding entity with integrated regulatory functions and a dedicated intelligence capability. The Bill gives effect to that architecture.

The Queensland Protection Commission (QPC) will be a **new statutory entity**. The Bill creates an institution that does not currently exist by bringing together new and transferred functions within a deliberately redesigned regulatory, oversight and safeguarding structure. The significance of that change is substantial. The new Commission will be established by law with defined statutory functions, powers, duties and accountability arrangements, providing clearer responsibility for the exercise of those functions, stronger legal foundations for regulatory and oversight action, and a more coherent system for identifying, responding to and preventing risks to children. The creation of the QPC is therefore not an administrative change in name or structure; it is the establishment of a new body with a distinct mandate to strengthen the protection of children in Queensland.

First, the Bill establishes a single Queensland Protection Commissioner and Commission. Proposed section 7 gives the Commissioner functions extending across systemic oversight, analysis and evaluation, child-safety improvement activities and, importantly, the exchange of information relevant to the **“proactive identification of, and protection from, threats”** to children, young people and other vulnerable persons. Section 7 also makes clear that the Commissioner will exercise functions under the *Child Safe Organisations Act 2024*, the *Working with Children Check Act 2000* and disability worker-screening legislation. That statutory design directly reflects one of the central propositions of *In Plain Sight*: **Queensland needs a body capable of seeing across systems rather than viewing each safeguarding mechanism separately.**

Second, the Bill delivers on Transformational Recommendation 4 by bringing worker screening, reportable conduct and Child Safe Standards into one regulatory entity. *In Plain Sight* recommended this co-location because it would eliminate information silos, support more consistent decisions about worker suitability and risk, strengthen collaboration through shared governance and leadership, and create a more integrated and proactive safeguarding system. The Review was explicit that the objective was a model in which **“intelligence is shared by design”** rather than through fragmented inter-agency processes. The Bill does more than place these functions under the same organisational roof. It changes how information can be used between them. For example, amendments to the *Child Safe Organisations Act 2024* allow the Protection Commissioner to use findings of reportable conduct for Working with Children Check functions. Proposed new section 54A goes further, allowing information obtained through administration of the Child Safe Organisations framework to be used for working with children and disability worker-screening functions where it is relevant to whether a person poses a safety risk. **This is a significant implementation of the *In Plain Sight* philosophy.** *In Plain Sight* repeatedly identified the limitations of systems that wait for a criminal conviction, substantiated allegation or other high thresholds before information becomes actionable. An unsubstantiated complaint or apparently isolated concern may not be sufficient on its own, but when considered alongside other allegations, screening information, employment history or organisational concerns it may reveal a materially different picture of risk. The Bill therefore begins to change the underlying question from: Has this individual piece of information crossed a particular

threshold? to: What does the information collectively tell us about risk to children? **That is a profound shift in safeguarding practice.**

Third, the Bill strengthens accountability around those functions. It increases penalties for important failures under the Reportable Conduct Scheme, including failures to notify the regulator and provide required reports. These amendments reinforce that reporting, and information obligations are substantive safeguarding duties rather than administrative requirements. That approach aligns with *In Plain Sight*, which recommended **stronger organisational duties and accountability** for the prevention, identification and response to child sexual abuse.

Perhaps the most important contribution of the Bill may be the platform it creates for the next stage of reform. *In Plain Sight* concluded that Queensland needed a Child Safeguarding Intelligence Hub capable of collating and analysing information below traditional criminal and regulatory thresholds, connecting information from multiple sources and identifying patterns of concern before they escalate into proven harm. The purpose was to shift safeguarding **from reactive investigation to proactive risk detection**. The Bill does not itself fully establish that Intelligence Hub, that work remains part of the next stage of implementation, however, it creates much of the institutional and legislative foundation required for it to succeed. Proposed section 7(1)(f) is particularly important because it expressly gives the Commissioner an information-exchange function directed at the proactive identification of threats. The co-location of worker screening, reportable conduct and Child Safe Standards then places several of Queensland's richest safeguarding information sources within the same statutory entity. This is the foundation upon which the Intelligence Hub can be built.

Together, those reforms respond to perhaps the most important finding of *In Plain Sight*: that the system must become capable of identifying the **breadcrumbs of risk** before another child is harmed. The architecture of this Bill enables us to move from **fragmented regulation to a safeguarding ecosystem**. Taken together, the Bill implements a coherent sequence of reforms contemplated by *In Plain Sight*. The importance of this architecture is that it connects **individual risk, organisational risk and systemic risk**. That is something Queensland's existing arrangements have not previously been designed to do. The Bill therefore represents much more than a machinery-of-government transfer. **It is a structural response to the central weakness identified in *In Plain Sight***: important safeguarding information existed, but the system was not always capable of joining it together and acting on what it revealed. If implemented with the ambition contemplated by the Review, the Queensland Protection Commission can move Queensland to a system in which information follows risk, concerns are considered collectively rather than in isolation, regulatory responses reinforce one another, and government becomes better able to intervene before another child is harmed. That is the safeguarding system *In Plain Sight* called for, and the Bill provides Queensland the substantial legislative foundation to build it.

Importantly, the proposed purposes of the Queensland Protection Commission in section 3 represent a **strong and logical evolution of the statutory purpose of the Queensland Family and Child Commission**. The current *Family and Child Commission Act 2014* establishes the QFCC to promote the safety, wellbeing and best interests of children and young people; promote and advocate the responsibility of families and communities to protect and care for them; and improve the child protection system. These purposes have provided the foundation for more than a decade of systemic oversight, evidence generation and advocacy.

The Bill substantially preserves these foundations while strengthening and modernising them. In particular, the proposed purposes:

- moves from “**promoting**” safety and wellbeing to “**protecting**” safety and wellbeing, providing a clearer and more active safeguarding purpose;
- elevates **oversight of the child protection system** from a statutory function undertaken in support of system improvement to an express main purpose of the legislation;
- preserves the important principle that **families and communities share responsibility for protecting and caring for children and young people**; and
- broadens the safeguarding remit to include **other vulnerable persons**, reflecting the expanded responsibilities of the new Commission.

This is an important progression. The current QFCC Act describes the QFCC's objective partly in terms of improving the child protection system, while its functions separately require it to provide oversight of that system. The Bill brings these concepts together more clearly by making oversight itself one of the principal purposes of the new statutory framework. This appropriately recognises that **oversight is not merely a mechanism for achieving another purpose; it is an essential public function in its own right**. However this value is only achieved if oversight is conducted effectively – **the value of the oversight role is not to critique, but to contribute to a better system**. The shift from *promoting* safety to *protecting* safety better reflects the considerably broader role proposed for the QPC, which will combine systemic oversight with safeguarding, regulatory and intelligence functions. The task of the QPC is not only to write reports and make recommendations, but also to take actions that protect children. This is a new burden of responsibility, and the formulation in the Bill provides a coherent statutory purpose under which these different functions can operate: **to identify risks and improvements, strengthen systems and ultimately protect people from harm**.

Importantly, the Bill also retains continuity with the philosophy that has underpinned the QFCC since its establishment. Protection is not framed solely as the responsibility of government or statutory agencies. The continuing recognition of the responsibility of families and communities acknowledges that effective safeguarding requires action across the environments in which children live, learn and participate. This provides a foundational role for the QPC to assist the community understand safety threats and risks, and empower them to put in place protections. In Plain Sight clearly showed that the experience of childhood is changing. Children spend more time online and in the care of private organisations – and less time with their parents and in public places. This demands us to reconsider the safeguarding system.

The Bill's articulated main purposes in section 3 **retains the strongest elements of the existing QFCC mandate while providing a clearer, more proactive and more contemporary foundation for the QPC's expanded responsibilities**. In doing so, the Bill provides an opportunity to carry forward the QFCC's established strengths in oversight and evidence-led recommendations while equipping the new Commission for a broader and more proactive safeguarding role.

The functions of the Queensland Protection Commissioner

The proposed functions for the Queensland Protection Commissioner preserve the core oversight responsibilities of the QFCC while providing a broader and more contemporary statutory basis for the expanded safeguarding, regulatory and intelligence role. There is substantial continuity between the two Acts. The Commissioner retains the QFCC's core functions to oversee the child protection system (7(1)(a)); promote the responsibility of families and communities (7(1)(b)); promote the safety and wellbeing of children (7(1)(b)); inform and educate the community (7(1)(c)); analyse policies and practices at a systemic level and assess agency performance (7(1)(d)); and report to the Minister (7(1)(g)). These have been central to the QFCC's oversight role since its establishment.

The Bill introduces several important enhancements.

1. First, the proposed functions extend beyond children and young people to include other vulnerable persons. This reflects the broader jurisdiction of the QPC, particularly through its proposed worker screening and safeguarding responsibilities, and provides a coherent statutory foundation for functions that will operate across different vulnerable cohorts.
2. Second, the Bill gives the Commissioner an express function to exchange information relevant to the proactive identification of, and protection from, threats to safety and wellbeing. This is a significant and positive development. The current QFCC Act contains no equivalent overarching function. The new provision recognises that modern safeguarding requires more than retrospective oversight: it requires the capacity to identify emerging risks, connect information across systems and to proactively intervene earlier. This function is particularly important to the future Child Safeguarding Intelligence Hub and **gives legislative expression to the preventative architecture recommended within *In Plain Sight*.**
3. Third, the Commissioner may perform functions under the *Child Safe Organisations Act 2024*, the *Working with Children Check Act 2000*, the *Disability Services Act 2006* and other legislation. This represents a substantial expansion from the current QFCC model. It brings systemic oversight, child safe regulation, reportable conduct, worker screening and intelligence functions under a single statutory office. In practical terms, this creates the potential to more effectively and efficiently identify and respond to safety risks for Queensland children. The significance of this change should not be understated. The Queensland Protection Commissioner will be accountable for Blue card decision making, worker screening decisions, the collection of revenue authorised by those Acts, and a key contributor to law enforcement intelligence.
4. The Bill simplifies the way several existing QFCC functions are expressed. The current Act separately identifies functions relating to workforce planning, research coordination, program evaluation, expert advice, collaboration and sector capacity building. These are not reproduced as separate standalone functions in the section 7 functions of the Protection Commissioner. Instead, the Commissioner will have a broader function to carry out, and support, activities to improve the safety and wellbeing of children and young people, together with the systemic analysis, oversight and incidental functions listed in section 7. This consolidation avoids an unnecessarily prescriptive statutory mandate and allows the Commissioner to determine the most appropriate means of performing the listed functions, rather than requiring particular methods (such as research) to be prescribed individually in legislation.

Overall, section 7 represents a **strong evolution of the current QFCC functions**. It retains the established foundations of systemic oversight and analysis, while adding an explicit preventative information function and bringing multiple safeguarding and screening responsibilities together. The effect of this new drafting is to shift from a model centred primarily on reviewing systems to one that is also capable of **proactively identifying threats and connecting information before harm occurs**.

The CSO scheme - building on current success

The commencement of the Child Safe Organisations (CSO) framework on 1 October 2025 has already represented a significant shift in Queensland's approach to safeguarding and the role of the current QFCC. It should not be lost in this debate that **as a result of that Act, the QFCC has already transitioned to a regulator of child safety.**

In its first year, the CSO scheme has demonstrated clear value in strengthening organisational capability, improving Queensland's awareness of child safety obligations, and establishing the foundations of a modern, prevention-focused regulatory system. The Commission has delivered a large-scale, statewide implementation program supporting approximately 40,000 organisations across 13 sectors to understand and implement their obligations. A comprehensive education and communications program has driven significant reach and engagement, with resources downloaded more than 74,000 times, web content viewed more than 665,000 times, and webinars attracting around 2,500 registrations. The Commission has also invested directly in building safeguarding capability across the sector. Through the \$4.8 million Child Safeguarding Grants Program, organisations have been supported to deliver locally tailored initiatives that strengthen governance, workforce capability and practical implementation of the Child Safe Standards. This investment recognises that sustainable safeguarding reform requires capability to be embedded within organisations and communities, not solely driven through regulation.

Operationally, from 1 July 2026 the scheme is active and fully functioning. A centralised enquiries function has improved accessibility and provides a clear "no wrong door" entry point for the community and regulated entities. In its first period of operation, the Commission received over 1,100 enquiries, with nearly half resolved at first point of contact, supporting timely advice and reducing the need for escalation. Matters raising child safety concerns are triaged and referred for regulatory assessment, ensuring that risks are identified and responded to early. The Commission has also commenced proactive and risk-based regulatory activities. Early compliance engagements with organisations across multiple sectors have tested regulatory processes and provided valuable insights into sector readiness. Through mechanisms such as the Collaborative Regulators Network, the Commission has worked with more than 14 regulatory and safeguarding bodies to align approaches to information sharing, triage and regulatory practice. This has reduced duplication, improved consistency and laid the groundwork for a more integrated safeguarding system. This reflects the scheme's early success in shifting organisational focus beyond compliance toward continuous improvement.

While still in its early implementation phase, the CSO scheme is already demonstrating its capacity to drive system-wide reform by strengthening shared understanding of child safety, lifting organisational practice, and establishing the foundations for more coordinated, intelligence-led regulation. In the first month of operation of the Reportable Conduct Scheme (from 1 July 2026), the Commission received 342 notifications of reportable conduct. More than 75 per cent of these related to ill-treatment of a child, physical violence, or behaviour causing significant emotional harm, and approximately 20 per cent concerning child sexual offences or alleged sexual misconduct. As at 31 August 2026, total notifications had increased to 666, of which 199 involved alleged criminal conduct and were referred to the Queensland Police Service (QPS). A total of 38 reportable conduct matters had been finalised, with just under 40 per cent substantiated; in the majority of substantiated cases, employment was terminated following investigation. A record of these cases now sits in the reportable conduct scheme database and can be used for future safeguarding intelligence, and decision making.

The effectiveness of the CSO scheme is underpinned by strengthened information-sharing arrangements between the Commission, QPS, and Queensland Worker Screening Services. Our approach has supported immediate protective actions, including the suspension of 39 blue cards as at 31 August 2026. Of the 220 discretionary suspensions issued by Worker Screening Services between 1 July and 31 August, almost one in five were informed by reportable conduct information provided through the Commission. While still in its early stages, the CSO scheme is already demonstrating its value as a catalyst for system-wide change. It is building shared understanding of child safety, improving organisational practice and establishing the infrastructure required for effective, intelligence-led regulation.

The early success of the CSO scheme should not be interpreted as evidence that Queensland's current institutional arrangements are sufficient. In many respects, it demonstrates the opposite. The scheme is already generating large volumes of safeguarding information, identifying alleged criminal conduct, contributing directly to worker-screening decisions, and creating new visibility of patterns of concern across organisations and sectors. Those results show that the regulatory model works. They also show how quickly the value of the model will be constrained if the information it generates remains confined within separate systems, agencies and legislative frameworks. The emerging challenge is therefore not simply to administer the CSO scheme well, it is to ensure that the information produced through reportable conduct, Child Safe Standards, worker screening, policing, child protection and other safeguarding systems can be **lawfully connected, analysed and acted upon as part of a broader picture of risk**. That is why the Queensland Protection Commission and the proposed Child Safeguarding Intelligence Hub are necessary. The QPC will provide the institutional architecture to bring complementary safeguarding functions together. The Intelligence Hub will provide the analytical capability to move beyond individual cases and identify relationships, patterns and emerging threats that no single scheme can see on its own. The Intelligence Network will extend that capability across the broader safeguarding system.

The experience of the CSO scheme gives confidence that Queensland can build and operate this next generation of safeguarding infrastructure outlined in the QPC Bill. The QFCC has demonstrated what can be achieved when information is acted on quickly and regulation is designed around prevention. The QPC Bill now provides the opportunity to extend that capability across the system. The lesson from the first months of the CSO scheme is that **when Queensland connects information and acts earlier, children are better protected**.

Strengthening accountability, and information sharing

The Bill strengthens the accountability, enforcement and information-sharing frameworks underpinning Queensland's child safeguarding system. A central lesson of *In Plain Sight* was that preventing child sexual abuse requires more than individual organisations having policies, conducting checks or responding to incidents in isolation. The Review identified circumstances in which concerns, complaints, employment history and other indicators of risk existed, but were fragmented across employers, regulators and systems. Information was not always visible to the people who needed it, and weaknesses in accountability meant opportunities to identify escalating risk could be missed. The Bill responds directly to this problem through three mutually reinforcing reforms:

- stronger consequences for non-compliance;
- clearer organisational accountability; and

- significantly improved capacity to use safeguarding information across regulatory schemes.

Stronger penalties reinforce that safeguarding obligations are central to good governance.

The Bill increases penalties for particular offences under the *Child Safe Organisations Act 2024* and the *Working with Children Check Act 2000*. These increases expressly respond to recommendations made in *In Plain Sight*. The significance of these amendments extends beyond the quantum of individual penalties. They send an important regulatory signal that obligations to report concerns, provide accurate information and cooperate with safeguarding systems are not administrative formalities. They are fundamental responsibilities attached to organisations and individuals entrusted with the care and safety of children. This is particularly important in the context of child sexual abuse. *In Plain Sight* demonstrated that seemingly administrative failures — an incomplete employment history, a concern that was not recorded, a complaint that was not escalated, or information that did not follow a worker between organisations — can collectively create the conditions in which risk remains undetected. The Bill appropriately strengthens the consequences attached to those failures.

Under the Child Safe Organisations framework, the Bill increases penalties associated with failures by reporting entities to meet important Reportable Conduct Scheme obligations. It also strengthens the offence relating to the provision of official false or misleading information, with a maximum penalty of 200 penalty units or two years imprisonment. Effective prevention requires systems capable of recognising patterns of concern before they develop into proven harm. The purpose of stronger accountability should therefore not only be understood simply as punishment after an organisation has failed. Its greater value lies in changing organisational behaviour beforehand. Clearer duties, credible regulatory oversight and proportionate penalties encourage organisations to:

- invest in prevention activities (training, procedures and governance);
- take concerns and allegations seriously;
- maintain reliable records;
- provide complete and accurate information;
- investigate appropriately;
- share relevant information with regulators and other entities; and
- recognise safeguarding as an organisational legal responsibility rather than solely a frontline practice issue.

The Bill also expands information-sharing and information-use provisions across the Child Safe Standards, Reportable Conduct Scheme, Working with Children Check scheme and disability worker screening functions. The structural decision to bring these functions together within the Queensland Protection Commission is important. However, **co-location alone does not create integration**. Corresponding provisions allow information obtained through worker-screening functions to be used across other screening and child-safe functions. The Bill therefore begins to establish a safeguarding system in which relevant information can follow risk rather than remaining confined within the legislative or administrative scheme through which it was first identified. This is a particularly important reform. **The value of information about a concern does not depend on which regulatory doorway it entered through.** A reportable conduct allegation, an adverse employment history, police information, a worker-screening concern or a pattern identified through regulatory activity may each provide only part of the picture. When considered together, however, those pieces of information may reveal a level or pattern of risk that would not otherwise be visible. That principle sits at the heart of the reforms recommended by *In Plain Sight*.

The combination of co-location, stronger penalties, enforceable accountability and expanded information sharing is substantially more significant than any one of those reforms viewed in isolation. The Bill brings these elements together and creates the legislative foundations for a Queensland Protection Commission that can see more of the safeguarding picture, connect information across functions and intervene on the basis of risk rather than waiting for harm to become established.

Why bringing worker screening and child safeguarding functions into one organisation matters

This Bill delivers on a reform expressly contemplated by *In Plain Sight*. Transformational Recommendation 4 recommended that Queensland “co-locate the Reportable Conduct Scheme, Child Safe Standards and the worker screening scheme (WWCC) within a single regulatory body” and enable their operational integration. The Review identified four principal benefits:

- eliminating information silos;
- enabling consistent risk decisions;
- strengthening collaboration through common governance and leadership; and
- improving efficiency, transparency and public trust.

The Bill gives legislative effect to that recommendation. **This is more than an administrative consolidation. It is a significant child safeguarding reform.** *In Plain Sight* concluded that the offending examined through its case study “could and should have been detected and disrupted earlier” had available concerns been connected and understood as part of a broader safeguarding picture. The underlying problem was that concerns about people working with children were received through multiple channels. Individually, complaints, boundary concerns or allegations may appear insufficient to justify action; collectively, they may reveal an escalating pattern of risk. This was the Review’s “breadcrumbs” problem: important information existed but no one could follow the trail because **different schemes hold different parts of that picture**. Worker screening considers whether an individual is suitable to engage in child-related work. The Reportable Conduct Scheme examines allegations, investigations and findings concerning people working with children. The Child Safe Standards consider whether organisations have the governance, culture and systems necessary to identify and manage risks to children. Each therefore provides a different lens on the same safeguarding question: **is there a risk to children, and what should be done about it?** Bringing these functions together creates the opportunity to connect those different sources of information and respond to risk more coherently. **The value lies in connecting information, not merely collecting more of it.** A concern that does not justify action under one scheme may nevertheless be relevant under another.

The model also allows **individual and organisational risk to be considered together**. *In Plain Sight* demonstrated that child sexual abuse risk can arise not only from individual conduct, but also from poor supervision, weak recruitment, inadequate recordkeeping, cultures that minimise concerns and failures to respond appropriately to complaints. A regulator administering worker screening, reportable conduct and child safe standards can therefore consider both **who may present a risk to children and what organisational conditions may allow that risk to emerge or persist**.

In Plain Sight also identified an organisational-design benefit it described as “**structural coupling**” — closely related functions reinforcing one another through shared governance, culture and

leadership. This creates the opportunity for common safeguarding doctrine, shared risk frameworks and more coordinated decision-making, while preserving the distinct statutory thresholds that apply to each scheme.

As evidence to *In Plain Sight* observed, **“You get a lot more strategic tools and choices when safeguarding functions are placed together.”** A single regulator should also provide a clearer point of accountability for families, workers and organisations, with a more coherent regulatory relationship and a lower risk that concerns fall between statutory responsibilities. It should also enable guidance, engagement, intelligence, compliance and enforcement activity to be coordinated across related safeguarding obligations.

This represents a deliberate move away from separate regulatory schemes operating alongside one another towards a connected safeguarding system in which intelligence is shared by design and regulatory responses reinforce one another. **The central lesson of *In Plain Sight* is that safeguarding effectiveness is not determined by how much information a system collects, but by whether it can connect that information, understand what it means and act before warning signs become evidence of harm.** The Bill gives legislative effect to that recommendation.

The QPC provides the governance and institutional platform for the safeguarding intelligence hub

The Queensland Protection Commission Bill is particularly significant when considered alongside the Queensland Government’s commitment to implement *In Plain Sight* Transformational Recommendation 3 — the establishment of a Child Safeguarding Intelligence Hub — and Operational Recommendation 4 — the establishment of a legally authorised Child Safeguarding Intelligence Network. Those recommendations responded directly to one of the Review’s central findings: Queensland must become substantially better at identifying risk before conduct reaches the point of proven abuse or criminal offending. *In Plain Sight* described **threat detection** as the “frontline defence” of child safeguarding and concluded that systems can better disrupt perpetrators by bringing together fragments of information that may otherwise appear insignificant when viewed individually. This is particularly important in child sexual abuse because the grooming behaviours that precede offending are often ambiguous, dispersed and below conventional regulatory or criminal thresholds. The Review identified precisely this problem in relation to **“sub-criminal-threshold” behaviour**: concerning conduct that may not meet the threshold for formal police investigation or another regulatory response but may nonetheless signal future risk. It found that reports and intelligence of this kind are often fragmented across agencies, organisations and jurisdictions, limiting the capacity of the system to “connect dots and identify patterns early”.

The QPC Bill provides the right institutional platform for the next step in intelligence led safeguarding. Its significance lies not only in the functions it immediately transfers, but in the architecture, it creates for the intelligence hub and network. The establishment of the QPC, the integration of complementary safeguarding functions and the strengthening of information-sharing provisions are important first steps. The next step is to ensure the QPC can turn that information into actionable intelligence and connect that capability to the broader network of agencies that collectively safeguard Queensland children.

The Queensland Government has already committed to establishing both the Child Safeguarding Intelligence Hub and Intelligence Network. Taken together, these reforms reveal **a deliberate architecture**:

- Child Safe Standards strengthen the responsibility of organisations to prevent harm.
- The Reportable Conduct Scheme increases visibility of concerning conduct.
- Worker screening assesses the suitability of individuals to work with children.
- The QPC brings those functions together.
- The Intelligence Hub connects and analyses the information they generate, and
- the Intelligence Network extends that capability across government, law enforcement, regulators and other safeguarding organisations.

Each layer strengthens the next.

The result is a system capable not only of regulating organisations and responding to allegations, but increasingly of identifying threats, anticipating risk and intervening earlier. That is the fundamental shift contemplated by In Plain Sight: from fragmented information and reactive investigation to connected intelligence and earlier prevention. The QPC Bill provides the institutional platform for that shift; the Intelligence Hub and Intelligence Network will be essential to realising its full preventative potential.

The value of the QFCC's oversight functions

Importantly, the Bill retains oversight functions of the child protection system, meaning the QPC will continue to produce reports and recommendations that create public value. For more than a decade, the QFCC has provided oversight and analysis of Queensland's child and family systems. It has identified emerging risks, tested assumptions, exposed weaknesses and recommended practical changes to policy, legislation and service delivery. Since commencing in 2014, the Commission has produced more than 100 significant reports, reviews and major analytical outputs. Key examples include:

- When a child is missing: Remembering Tiahleigh (2015–16)
- A systems review following the death of Mason Jet Lee (2016–17)
- Keeping Queensland's children more than safe: Review of the blue card system (2017–18)
- Seeing they are safe (2019–21)
- Principle Focus (2021–22 onward)
- Lessons from the life-story timelines of 30 Queensland children who have died (2022–23)
- Exiting youth detention (2023–24)
- Who's responsible (2023–24)
- A System that Cares (2023–24)
- Too Little Too Late (2024–25)
- In Plain Sight (2025–26)

The value of the existing QFCC oversight function lies not simply in the reports it produces, but in **what happens because of the evidence those reports create**. Over time, the evidence produced by the QFCC has contributed to changes in legislation, funding, service models, regulatory practice and the way Queensland understands risks to children. While major reform is rarely attributable to one report alone, and governments must consider evidence alongside operational, financial and policy considerations, there are numerous examples where reforms implemented by government directly reflect evidence produced through the QFCC's oversight work. For example:

- Queensland introduced 12 months of rehabilitation support for young people leaving detention after the Commission recommended a comprehensive post-release support model in *Exiting Detention*.
- Queensland Police publicly report information about the number of young people in watch houses after the Commission recommended greater transparency in *Who's Responsible: Understanding why young people are being held longer in Queensland watch houses*.
- Queensland is progressing dual-carer models, secure care and alternative care arrangements after the Child Death Review Board recommended these in its 2021–22 annual report.
- Queensland introduced professionalised foster care after the Child Death Review Board and the Commission repeatedly recommended it including in *A System that Cares*.
- Queensland increased financial support for carers after the Commission's *Carer Allowances* analysis and submission to the Foster, Kinship and Permanent Carers Payment Review.
- Queensland extended post-care support to age 21 following the Commission's sustained advocacy that the State's responsibility should not end when a young person turns 18.
- Queensland improved the identification of paediatric sepsis in death certificates and autopsy reporting after the Commission's *Paediatric Sepsis Mortality Study*.
- Queensland invested in 85 behaviour specialists in primary schools, and expanded access to free kindy, following recommendations in the Commission's 2023 *Life Trajectories* report.
- Queensland invested \$65 million in sustained health home visiting and antenatal support, including the Pepi-Pod® Program, after the Child Death Review Board recommended stronger responses to prevent sudden unexpected deaths in infancy in its 2023-24 Annual Report.
- Queensland reviewed its home education accreditation scheme after the Child Death Review Board identified concerns about the visibility and safety of children registered for home education.
- Queensland introduced a minimum age of 16 years for riding e-scooters after the Commission recommended changes in *Improving safety when young people ride e-scooters and e-bikes*.
- Queensland strengthened the Blue Card system following the QFCC's *Review of Blue Card System*.

These examples demonstrate what effective oversight can achieve. The QFCC does not make government policy, or unilaterally advocate for predetermined positions, its role is **to find the evidence that allows better decisions to be made, to make problems visible when they might otherwise remain unknown, and to identify practical opportunities for reform**. This is the practical value of evidence-led oversight and the QPC Bill preserves that function. Section 83 maintains the Commissioner's responsibility to assess the performance of Queensland's child protection system, examine progress over time, compare Queensland with other jurisdictions, and publish findings and recommendations through an annual report to Parliament. Requiring the Minister to table that report within 14 sitting days preserves a direct line of accountability to the Legislative Assembly. Together with the separate parliamentary reporting arrangements for the Child Death Register and Child Death Review Board, **the Bill preserves an important feature of the existing QFCC oversight model: the capacity of a statutory officer to generate evidence, form an assessment of system performance, make recommendations and ensure that those findings are placed transparently on the public record (before Parliament)**.

Child Death Register

Under Part 3, the Bill preserves the Child Death Register and its associated prevention, research and information-gathering functions. It carries forward the existing statutory framework while transferring responsibility from the QFCC Principal Commissioner to the Queensland Protection Commissioner. Specifically, the Commissioner will continue to be required to maintain the Register, classify and analyse child deaths, identify patterns and trends, undertake and support research, identify areas requiring further investigation and make recommendations about laws, policies, practices and services to reduce the likelihood of future child deaths. The Bill also preserves the Commissioner's dedicated power to seek information from public entities where that information is necessary to perform the Child Death Register functions. This is critical to maintaining the Register as more than an administrative record.

The Child Death Register is far more than a record of children who have died. It is a longitudinal evidence base that brings together information about every child death registered in Queensland and enables patterns in mortality, circumstances and risk to be examined over time. The Bill also continues the researcher-access provisions of the QFCC Act. Proposed section 33 is, in substance, the continuation of existing section 28. Over recent years, more than 100 researchers, government agencies and other legitimate users have accessed data from the Register to support research, policy development, program design and child death and injury prevention initiatives. In 2024–25 alone, the Commission responded to 29 external requests for data, following 25 requests in 2023–24. Access is provided at no cost to genuine researchers and can include both aggregated information and, where justified, confidential unit-record data. The QPC Bill retains a deliberately broad definition of “genuine researcher”, including a person approved to access health information under the *Public Health Act 2005*, a member of an approved quality assurance committee, or another person whom the Commissioner considers to be conducting genuine research.

Queensland's Child Death Register demonstrates the value that can be created when government information is deliberately structured, preserved and made available for prevention.

Importantly, at Section 34 the Bill continues to require the Commissioner to prepare an annual report on the analysis of child deaths that may include recommendations arising from the evidence. The Bill also requires the Minister to table that report in Parliament within 14 sitting days of its receipt (s36(4)). This preserves a critical element of the existing framework: the Commissioner's independent ability to place evidence, analysis and recommendations directly before the Parliament and the Queensland public. The Register is not simply a repository of mortality data; it is an independent prevention mechanism.

Queensland's Child Death Register represents a mature and nationally significant evidence capability, and its preservation ensures that more than two decades of Queensland child mortality data, research and prevention work can continue within the broader safeguarding mandate of the new Commission.

The Child Death Review Board

In July 2026 the Queensland child death review model was recognised as best practice at the *International Society for the Prevention of Child Abuse and Neglect*. Part 4 of the QPC Bill provides for the continuation of the Child Death Review Board including its systemic and preventative purpose, independent status, research and analytical functions, power to make and monitor recommendations, capacity to determine the scope of its reviews, and ability to report publicly on systemic issues arising from the deaths of children connected to the child protection system. Specifically proposed section 39 expressly **continues the existing Child Death Review Board in existence**, rather than establishing a replacement body. This provides important institutional continuity. The Board's core functions remain materially unchanged. Under proposed section 42 it will continue to:

- carry out systemic reviews following relevant child deaths;
- analyse data and apply research to identify patterns, trends and risk factors;
- undertake or commission research;
- recommend improvements to systems, policies and practices;
- recommend legislative change; and
- monitor implementation of its recommendations.

These functions closely reproduce the existing section 29D framework. The current statutory requirement that the Board act **independently and in the public interest** is retained. Proposed section 41 expressly provides that the Board is not subject to direction by the Minister or anyone else about how it performs its functions. Under the QPC Bill the Board will continue to examine the provision of services to children and families by government and non-government entities, identify opportunities for continuous improvement in systems, legislation, policies and practices, and identify preventative mechanisms capable of protecting children and preventing avoidable deaths.

Importantly, the Bill provides a clearer **and stronger statutory basis for the Board to obtain information**. Under the current Act, the existing model is framed predominantly as an authority to request and disclose information, rather than as an enforceable obligation to produce it. At sections 60 and 61 the Bill provides **a more explicit statutory mechanism for compulsory information production**. Importantly, a prescribed entity is required to comply unless it has a reasonable excuse. This represents a significant improvement in legislative clarity and practical effectiveness, because the Board's systemic role depends on its ability to reconstruct the full service history surrounding children and families. A clearer statutory obligation to provide relevant information therefore strengthens both the quality and independence of the Board's analysis.

The Board's annual reporting role is also preserved under sections 56 and 57. Under the current QFCC Act, the Board must report annually to the Minister, may include recommendations and information about implementation of previous recommendations, and the Minister must table the report in the Legislative Assembly within 14 sitting days. This public reporting requirement is an essential element of independent child death review.

Commissioner and Deputy Commissioner structure

The Bill introduces a clearer statutory leadership structure for the Queensland Protection Commission, comprising a Commissioner and two Deputy Commissioners. This differs from the current QFCC model, which provides for a Principal Commissioner and a second Commissioner with overlapping statutory responsibilities and unclear reporting arrangements. The Bill's structure more distinctly clarifies the reporting arrangements and roles of the statutory offices and provides a more readily understood framework of accountability for a Commission that will have substantially broader oversight, regulatory, screening and safeguarding powers. This addresses issues in the scope and mandate of the Commissioner roles identified in the *2022 Independent Review of the QFCC*.

Compared with the current QFCC Act, the Bill is less prescriptive about First Nations representation. This creates greater discretion to appoint office holders whose combined expertise reflects the breadth of the QPC's functions and the communities affected by its work, however it raises concerns that the Commission's leadership team need not include a First Nations representative. I have previously advocated for a dedicated First Nations Commissioner, reflecting the over-representation of Aboriginal and Torres Strait Islander children in the child protection system. Diversity of representation is important within any leadership group and contributes directly to effective governance, sound decision-making and institutional legitimacy. A leadership group that brings together different gender, generational, cultural, professional and lived perspectives is better placed to identify institutional blind spots and make decisions that reflect the communities the Commission serves. Because the Bill provides for less prescription and greater flexibility in the composition of the QPC's statutory leadership, greater importance is placed on each individual future appointment process. Each of those processes will need to ensure that the three office holders collectively bring the expertise, experience and perspectives necessary across child protection, safeguarding, First Nations children and families, disability and other cohorts relevant to the Commission's functions.

Accountability and Transparency

The establishment of the Queensland Protection Commission provides an opportunity to be precise about what is meant by the independence of a statutory Commissioner, and how independence should operate alongside appropriate public, Ministerial, administrative and financial accountability. These definitions are particularly important in considering the QPC because the Bill creates a materially different institution from the existing QFCC. The QPC Commissioner will not only exercise systemic oversight functions. The Commissioner will also administer major regulatory and screening schemes, exercise coercive information-gathering powers, make decisions affecting whether individuals may work with children or vulnerable people, regulate and take legal action against organisations, collect government revenue, and exchange information for the proactive identification of threats that may otherwise engage or override the privacy and reputational interests of individuals and corporate entities. **These are substantial public powers.** It is therefore appropriate that their exercise be accompanied by clear performance expectations, Ministerial accountability, transparent reporting and consequences for misuse, mistake and poor performance.

The relevant question is not whether the Commissioner should be entirely separated from government, but whether the accountability arrangements are proportionate to the powers being exercised and whether sufficient transparency is in place to preserve confidence in the Commissioner's judgement and performance. The Bill reflects this accountability through a number of mechanisms. Section 28 provides for Ministerial direction over specified functions which is

narrower than current section 22 of the QFCC Act which applies to all functions. Furthermore, new section 29 permits a published statement of expectations for the Commissioner's child-safety improvement activities (under section 7(e)) and requires the Commissioner to publish these expectations and keep the Minister reasonably informed about those activities. **A degree of closer Ministerial accountability is understandable in the context of the Commissioners expanded regulatory and operational responsibilities.**

Financial and administrative accountability is also changed for clear reasons. Proposed section 84 makes the departmental chief executive the accountable officer for the Commission for the purposes of the *Financial Accountability Act 2009* and the chief executive for the Commission's staff under the *Public Sector Act 2022*. The scale and nature of the QPC will be materially different from the existing QFCC. The new entity will administer major regulatory schemes, collect government revenue, and require substantially greater investment in technology, data, cyber security, information management and digital infrastructure. These requirements will increase further as Queensland develops the Child Safeguarding Intelligence Hub. The ambition is not a small analytical function attached to an existing regulator, but a sophisticated intelligence capability able to connect personal and confidential information across regulatory and government systems. This will require secure cross-government data integration, strong privacy and governance arrangements, and infrastructure capable of supporting trusted information exchange. This infrastructure is best housed within a Departmental structure, noting that the important distinction is between **administrative accountability and substantive statutory judgement**. The Department should be accountable for the integrity of the financial, workforce, ICT, cyber security and administrative systems that support the Commission, while the Commissioner must remain accountable for the exercise of statutory powers, regulatory decisions, evidence production, analysis and conclusions. ability of the Commissioner, preserved in the QPC Bill, to report publicly on the Commission's performance provides an important protection against those administrative arrangements fettering, or being perceived to fetter, statutory judgement. **This is not a novel model. Comparable arrangements already operate for statutory offices such as the Office of the Public Guardian and the Director of Public Prosecutions, where departmental administrative accountability coexists with independent statutory decision-making.**

A final point is that **independence should not be confused with criticism**. A Commissioner's role is neither to agree with any government policy, or to oppose any government policy. It is to produce credible evidence. Sometimes that evidence will affirm system performance, sometimes it will identify areas requiring improvement. Sometimes it will directly contradict prevailing policy assumptions. Integrity requires the Commissioner to treat each of those circumstances in the same way. The central quality required of the QPC Commissioner is not performative independence but integrity of judgement and integrity of process. Integrity means exercising oversight powers proportionately, distinguishing evidence from opinion, being transparent about methodology and limitations, and ensuring that neither proximity to government nor distance from government becomes an end in itself. The independence of a statutory office should be assessed by the whether the office can independently form conclusions from evidence and place those conclusions transparently before Parliament. That has always been an essential part of the QFCC's oversight role, and it will remain essential to the credibility of the QPC. This is particularly important because the QPC will occupy several roles simultaneously. It will be an oversight body. It will advocate for the safety of children. It will be a regulator. It will administer worker screening. It will increasingly become an intelligence organisation. Those functions require different relationships with government. An oversight function requires intellectual independence. A regulatory function requires consistency, procedural fairness and accountability. An intelligence function requires lawful authority,

strong governance, trusted relationships and close engagement with operational agencies. A major public administration function requires financial, workforce and infrastructure accountability. None of these are contradictory – but they speak to a new organisation identity and culture. The QPC Commissioner **must be capable of working across government to improve child safety, accept legitimate accountability for substantial public powers, and place evidence before Parliament regardless of the reaction.** None of that is a contradiction. It is the proper work of an effective statutory Commissioner.

Awaiting Commonwealth response

The Queensland Government has formally responded to *In Plain Sight*, supporting the majority of recommendations and commencing a significant reform program centred on the Queensland Protection Commission and child safeguarding intelligence hub. These reforms are described as **nation leading**. This is an important point. *In Plain Sight* was not solely a review of Queensland systems. The sexual abuse of children is a national occurrence and people who pose a risk to children move across organisational and jurisdictional boundaries. Online offending is inherently borderless. Consequently, there are 10 recommendations in *In Plain Sight* that require action by the Australian Government. They are:

1. Operational Recommendation 1 — Produce a public response to the report.
2. Transformational Recommendation 1 — Create a national child safeguarding training program.
3. Transformational Recommendation 2 — Prevent threats to children from entering the workforce, including amendments to the *Fair Work Act 2009* and related laws so that employers acting reasonably on child-safety concerns are better protected.
4. Operational Recommendation 10 — Prioritise law-enforcement resourcing, including both personnel and technology.
5. Transformational Recommendation 5 — Strengthen child safeguarding duties and introduce corporate and personal accountability and liability.
6. Transformational Recommendation 7 — Increase the rights of victim-survivors in child exploitation material cases.
7. Operational Recommendation 11 — Invest in the tracking and takedown of images of Australian victim-survivors.
8. Operational Recommendation 13 — Empower children through consistent and contextual safety education.
9. Operational Recommendation 16 — Allocate funding and services to prevent and address behaviours that may lead to offending.
10. Transformational Recommendation 8 — Establish robust and centralised national and state governance for child safeguarding, including clear Commonwealth ministerial accountability and a permanent Ministerial Council on Child Safeguarding as a committee of National Cabinet.

Following the release of *In Plain Sight*, I wrote to the Prime Minister and relevant Commonwealth Ministers seeking a formal response to the national recommendations. I acknowledged that the Commonwealth had taken steps to strengthen safeguarding in early childhood education and care, however, strengthening one sector alone is insufficient.

Queensland is progressing an integrated model through the QPC, the Intelligence Hub and the proposed Intelligence Network, however, many safeguarding levers sit in Commonwealth law. A formal Commonwealth response would clarify which recommendations are supported, what action is already underway, where further reform is accepted, and how implementation will be coordinated across jurisdictions.

In Plain Sight made clear that child sexual abuse is not confined by jurisdiction, location, postcode or organisation. A clear national response to the recommendations requiring Commonwealth action would provide greater transparency, coordination and accountability for the broader safeguarding reform agenda.

Conclusion

The establishment of the Queensland Protection Commission is a significant change....and change inevitably invites attention to what may be different, displaced or lost. But there is another way to assess this reform: by asking what Queensland will gain.

The Queensland Protection Commission is a new entity, with broad statutory responsibility and a clear purpose. It is a significant change to the architecture of government.

This Bill matters because the status quo is not good enough. When one in four Australian children experience sexual abuse, the greater risk is not that our systems change too much - it is that they change too little.

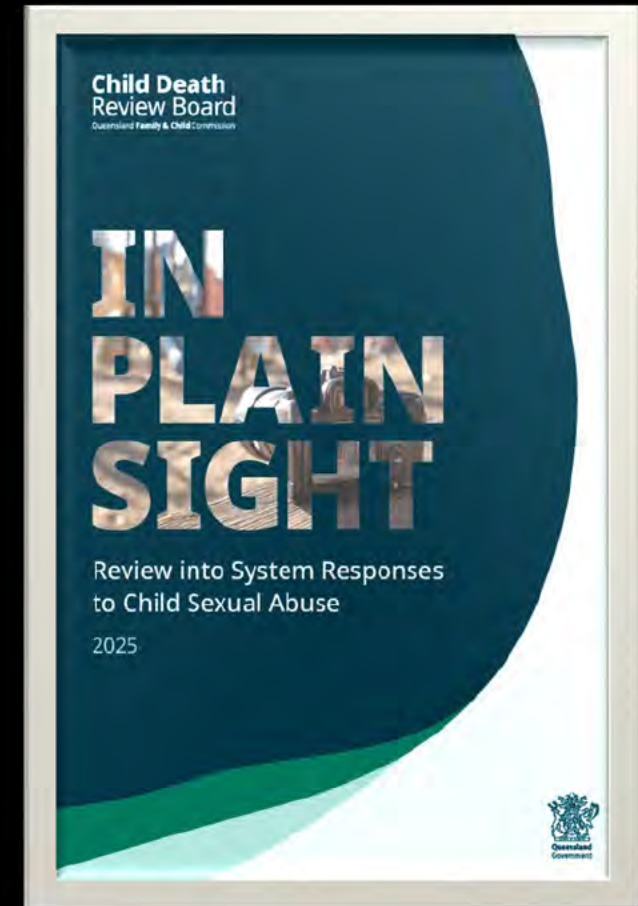
We can focus on the structures, practices and arrangements that will be different under the QPC, or we can focus on what this reform makes possible: **seeing risk earlier, connecting information sooner, acting more decisively and preventing more children from experiencing harm.**

The QPC Bill creates the opportunity for stronger safeguarding leadership, more connected regulation, better use of information, earlier identification of risk and a clearer line of accountability for protecting children. It provides the platform for a system that can see across individual workers, organisations, regulatory functions and emerging threats rather than continuing to rely on fragmented parts operating separately. In doing so it maintains the child death register, child death review board and oversight of the child safety system.

I support the Bill because I believe Queensland should choose the opportunity that change presents.

In a world where too many children continue to experience sexual abuse and exploitation our current response needs to change.

“Child sexual abuse is occurring at far higher rates, in more common places, and to children closer to us than the community expects.”



Reporting on QLD offenders since the report was released
4 December 2025

Central Qld teacher suspended over past posing disturbing sexual questions to overseas pupils

Photos have emerged of a Qld teacher suspended for asking disturbing questions to students, including “how long would you wait to have sex with a dead girl?”.

Emma McBryde

3 mins read · March 23, 2026 12:14pm
Gladstone Observer

Former private school groundskeeper charged with creating child abuse website among 150 offences

A former groundskeeper at a prestigious Brisbane girls’ school has been charged with more than 150 child sex abuse offences including allegedly creating a website.

Shayla Bulloch and Nicola McNamara

2 mins read · April 20, 2026 4:09pm
The Courier-Mail

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Brisbane carpenter accused of creating child abuse website denied bail

A Brisbane carpenter has been refused bail on 155 child exploitation material offences, including allegedly creating a website encouraging parents to abuse their own children.

Nicola McNamara

2 mins read · April 14, 2026 3:02pm
The Courier-Mail

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OnlyFans star pleads guilty to making and distributing violent child abuse videos

An OnlyFans star with thousands of followers has walked from court after pleading guilty to making disturbing videos of child abuse at a Brisbane apartment.

Vanda Carson and Nicola McNamara

1 min read · March 26, 2026 5:30pm
The Courier-Mail

[Listen to this article](#) 1 min



“Too often those who harm children are operating openly in our community, visible to systems, neighbours, and institutions, yet unseen for who they truly are”.

One new offender every 2.3 days

Woman saw childcare worker accused of rape touching tongues with three-year-old child, court hears

By Lucy Loram Sexual Offences

11h ago



Queensland man jailed for 15 years after live-streaming child abuse

Courts

11h ago



Ex-TV reporter hit with four new child abuse material charges

A former high-profile TV journalist has been charged with more child abuse material offences, as a court heard his lawyers are still reviewing “thousands of pages” of evidence from chat rooms and social media.

Nicola McNamara



“By understanding this duality: the respectable facade and the predatory core - we begin to unravel the central paradox of child sexual abuse: that harm often comes, not from those society teaches us to fear, but from those it teaches us to trust.”

One new offender every 2.3 days

'Very disturbed' miner allegedly filmed child victim, court hears

Police have discovered encryption apps and "very disturbing" material on devices allegedly belonging to a FIFO miner who faces a maximum of 20 years in prison if found guilty.

Kerri-Anne Mesner

X [@kalm80](#)

1 min read · March 20, 2026 5:00am
Rockhampton Morning Bulletin

Listen to this article 3 min

Central Qld teacher suspended over past posing disturbing sexual questions to overseas pupils

A Qld school has suspended a veteran educator the same day it made a disturbing discovery about his past dealings with students.

Emma McBryde

3 mins read · March 19, 2026 2:12pm
Gladstone Observer



UPDATED

Permanent ban: Teacher barred from classroom after sex with student

A teacher has been permanently banned from the profession after a tribunal found she had sex with a Year 10 student in her car before school.

Queensland Young Australian of the Year charged over child exploitation material allegations

A youth worker who is employed by a Queensland council has been charged with eight counts of possessing child exploitation material allegedly on work devices.

Thomas Chamberlin

X [@tomchamberlin](#)

1 min read · March 17, 2026 6:10pm
The Courier Mail



"Every society tells itself comforting lies about child abuse. That it is rare. That it is perpetrated only by monsters lurking in dark alleys. That the danger exists 'out there', beyond the family home, beyond the school gates, beyond the places we attend and consider safe."

One new offender every 2.3 days

Queensland Police's Taskforce Argos helps charge soccer coach with human trafficking

Queensland police have helped Mexican authorities arrest a soccer coach accused of sexually abusing children and selling footage online for a decade.



Shayla Bulloch

2 mins read · April 15, 2026 3:35pm
The Courier-Mail



Petford Training Farm founder found guilty of child sexual abuse



By Christopher Testa

ABC Far North

Chi

1h ago



99, has been found guilty of child sexual abuse charges which date back to the 1970s. (ABC Far North: Sharnie Kim)



“These lies obscure the truth: that those who abuse children are often ordinary in appearance, adept at camouflage, and deeply strategic in the way they infiltrate families, institutions, and communities.”

One new offender every 2.3 days

Child sex charges

A Queensland man has been charged after allegedly offering \$700 to procure children overseas for sexual activities.

The 49-year-old man arrived at Sydney Airport on a flight from China on Tuesday when Border Force examined his luggage following intelligence-led screening.

Australian Federal Police will allege child abuse material and conversations

with third parties in the Philippines discussing procuring children for sexual activity were located on his electronic devices.

The man allegedly asked a third party to find minors for him to adopt and engage in sexual activity with in exchange for about A\$730.

He was refused bail and his matter was adjourned to Downing Centre Local Court on April 22.

UQ's academic Dean and Head of the School of Economics

**54,
charged with possessing
child exploitation
material**

The University of Queensland's academic Dean and Head of the School of Economics is in custody on a charge of possessing child exploitation material.

Teacher avoids lifetime ban after having child with 17-year-old student

A Queensland teacher who had a child with a student will be back in the classroom in just 18 months despite calls for an indefinite ban.

Patrick Billings

2 mins read • March 1, 2026 1:40pm
The Courier-Mail

Child sex offender worked as Milne Bay Aquatic Centre lifeguard

A Queensland AFL player who sexually penetrated a 14-year-old girl after luring her away from a party worked as a lifeguard at a community pool for years after the hideous act.

Michael Nolan, Alexander Blain

3 mins read • March 4, 2026 2:53pm
Toowoomba Chronicle



“Too often, child sexual abuse is viewed as rare, exceptional, or confined to particular settings, rather than recognised as a significant and systemic issue...This warped understanding has consequences: it dulls the urgency of reform, diminishes support for victim-survivors, and allows the conditions that enable abuse to remain insufficiently challenged.”

One new offender every 2.3 days

Logan Central man accused of trying to sexually assault child

A Logan man accused of trying to molest a child while already a registered sex offender, wants to live with his mother in a Brisbane aged care unit, a South Burnett court has heard.



Celeste Müller

1 min read • February 14, 2026 2:41 pm
South Burnett Times

Parents association fined after allowing alleged sexual offender to keep working at care centre



By Emily Anderson

Courts

28m ago



'No one was looking or asking where I was.'

KIDS IN CARE TRADED FOR DRUGS AND SEX: INQUIRY

Peta McEnchery

"I'd up and hold a rap in a bathroom by a group of men, a girl under the 'cave' of the state went missing from her residential placement for 11 days."

No missing person's report was made until the 16-year-old South West Queensland girl had no contact with her mother for 11 days.

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inquiry went to evaluating the Department of Child Safety to effectiveness "as a response to allegations of sexual abuse against community organisations."

Ms Sweet said as of June 2023, one in six South West children were being placed in home care and that the South West region had the second highest number of children in state care across Queensland.

"Of those 273 children, 477 are in residential care, and 144 of those children are under 12 - a system that is not designed for children under the age of 12," she said.

She said there was a call for the re-examination of child safety services in the region.

Through the Department of Child Safety (CS) and the Department of Youth Justice (YJ).

"We identified... that while children's caseworkers are approximately one quarter of the youth justice cohort as of March 2023," she said.

However, when it came to children's caseworkers, it was not just about the number of caseworkers but also the quality of the casework.

Ms Sweet said the figure was much higher.

Over a 12-month period, ending in December 2023, she said there were 140 South West juveniles with standard criminal charges, and 200 with "youth justice charges."

Ms Sweet said in an investigation, YJ had 241 juveniles and children under supervision.

Around the same time, there were 800 juveniles in YJ custody, and an average of about 200 juveniles would be in custody.

The Queensland findings began with the "community sector" annual meeting, before Sweet KC, saying the

children identified in state. In per cent had unstable housing, 10 per cent were disadvantaged from education, 10 per cent were affected by domestic and family violence, and 10 per cent had a parent's drug use.

"We know that more than half of the youth... have at least one disability, including mental health, autism spectrum disorder," she said.

Ms Sweet introduced a new role, creating the "youth justice caseworker" only a former child under the care of CS, but was also referred to the YJ department.

It is the story of the system - often, indeed, interviews - and, indeed, a

opportunity to report of a child who was falling through the cracks in full view," she said.

"That day, however, was a long day to tell for story in a state of the system, and to be honest."

CS fails to protect five-year-old from sexual abuse, did

Processing a youth justice case, and working in a CS residential care facility, Anne said the system was not working.

From legally dragging and throwing children to hospitals and sexual abuse at the hands of CS residential care workers, Anne said the system was not working.

After at home with her father who sexually abused her, and her grandmother, who, according to her, was in the state "care."

The court was told the first case to the attention of CS and the Queensland Police Service when she was five years old, having come from

UPDATED

23,000 files, 459 victims: Qld man who allegedly groomed hundreds of kids NAMED

A Queensland man allegedly used social media and gaming platforms to collect thousands of images and videos of 450 children in one of Australia's worst alleged cases child sexual abuse.



“Systems that only respond once abuse has occurred inevitably fail to prevent the profound trauma, lifelong consequences, and intergenerational impacts that child sexual abuse leaves behind.”

One new offender every 2.3 days

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The public servant with two decades experience was arrested on Wednesday.



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abuse material charges**



“Grooming can occur in any context. It can be challenging to identify as it often looks like the behaviour of a caring adult.”

One new offender every 2.3 days

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Two Queensland brothers have been charged with child abuse material offences after Australian Federal Police received a tip-off from an international agency.

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A teen predator who filmed sex with a 15-year-old girl has been released from custody – but more punishment now looms.

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“These motivated offenders are older, better resourced, more socially integrated, and more strategic in their offending. Their apparent ‘normality’ and seniority in both professional and community settings can act as powerful camouflage.”

One new offender every 2.3 days

Former PE teacher and sports coach, 68, unmasked as serial child sexual offender

A PE teacher who committed unspeakable acts against children in his care has had his identity protected for years. Now, we can finally unmask

charged with child exploitation offences

Renowned Australian author has been charged with child exploitation offences after police allegedly found him engaging with other offenders online.

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NewsWire

Predatory Queensland teacher banned for life for grooming vulnerable student

A teenage student, who was a virgin and high achiever, was flown across state lines for shocking drug-fuelled sexual acts with her teacher and her trans partner including threesomes, a tribunal has heard.

Janessa Ekert

“Grooming can be challenging to identify as it often looks like the behaviour of a caring adult. Perpetrators groom other adults in a child’s life, including parents, carers, colleagues and organisations. Grooming is interpersonal but also institutional and structural. Adults who deliberately harm children can continue to hide behind a shield of confusion.”

One new offender every 2.3 days



Find out more:

<https://www.qfcc.qld.gov.au/monitoring-and-reviewing/system-responses-child-sexual-abuse>

