# Document title is the Growing Child Safe Organisations in Queensland Decision Impact Analysis Statement.

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## A note on the content of this document

#### Content warning

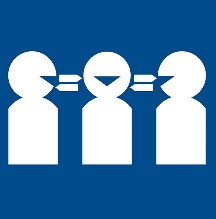
This paper deals with information about child abuse and its content may be distressing for readers.If the issues discussed raise concerns or cause distress to you, and you think you may need someone to talk to, you can contact one of the services listed below:

* Lifeline is a 24/7 telephone counselling and referral service across a range of support areas – ph. 13 11 14 and [www.lifeline.org.au](http://www.lifeline.org.au)
* Blue Knot supports adult survivors of childhood trauma and abuse, parents, partners, family and friends – ph. 1300 657 380 and <https://blueknot.org.au>
* Kids Helpline offers telephone and online counselling services for children and young people aged between 5 and 25 years – ph. 1800 551 800 and <https://kidshelpline.com.au>
* WellMob provides a safe online place made by and for Aboriginal and Torres Strait Islander peoples, bringing together wellbeing resources that are culturally relevant <https://wellmob.org.au/get-help/>
* MensLine Australia is a 24/7 telephone and online counselling and referral service across a range of support needs – ph. 1300 789 978 and <https://mensline.org.au>

#### About this document

The format of this Decision Impact Analysis Statement (DIAS) reflects the requirements of the regulatory impact assessment process in *The Queensland Government* *Better Regulation* *Policy* which is intended to ensure all regulatory impacts of proposed changes have been considered. We have worked to present distressing content sensitively within these requirements.

#### Translating and interpreting services

Readers who require translating or interpreting services can access these services for free from the Translating and Interpreting Service website <https://www.tisnational.gov.au>

#### Acknowledgements

The Queensland Government takes seriously its commitment to supporting people with lived experience of institutional child sexual abuse, redressing past wrongs, and taking action to ensure the mistakes of the past are never repeated. We acknowledge the courage and strength shown by those with lived experience of abuse who have shared their stories and who continue to engage in work to reform systems and cultures to ensure all children are safe in institutions.

The Queensland Government acknowledges everyone who provided input and feedback through the consultation process. The information we received through these consultations has been central to the development of the final policy recommendations outlined in this document.

We particularly thank the young people and Aboriginal and Torres Strait Islander community members who gave so freely of their time, sharing their wisdom and insights.

#### Acknowledgement of Aboriginal and Torres Strait Islander Peoples

The Queensland Government respectfully acknowledges Aboriginal and Torres Strait Islander peoples as the Traditional Owners and Custodians of lands across Queensland and recognises their connections to land, wind, water and community. We pay our respects to Aboriginal and Torres Strait Islander peoples, their cultures, and to Elders past, present and emerging.

We also acknowledge the enduring impacts of colonisation and dispossession and associated intergenerational trauma for Aboriginal and Torres Strait Islander peoples, including in relation to particular vulnerabilities to, and impacts of, institutional child abuse.

The Queensland Government is committed to respectfully journeying together to ensure cultural knowledge and values are critical factors in the development, implementation and evaluation of government actions that support Aboriginal and Torres Strait Islander peoples. We acknowledge and thank Aboriginal and Torres Strait Islander peoples who continue to inform our work to develop a child safe organisations system for Queensland.

#### Updates to Queensland’s regulatory impact analysis policy

This DIAS incorporates the results of consultation through the *Growing Child Safe Organisations in Queensland Consultation Regulatory Impact Statement* (CRIS). The CRIS refers to the development of a Decision Regulatory Impact Statement (DRIS), however, since the launch of the CRIS on 10 August 2023 the required regulatory review process has changed, as reflected in the updated *Queensland Government Better Regulation Policy*.

From September 2023, a DIAS is now required to reflect the results of consultation as well as Queensland Government’s decision about the best approach to implement a child safe organisations system. This decision was based on comprehensive analysis of consultation results and further impact analysis. The structure and core elements of the DIAS remain the same as a DRIS and build on the analysis in the CRIS.

## Executive summary

#### Background

Queensland is home to more than one million children and young people under the age of 18, many of whom will interact with various organisations throughout their childhood, including, for example, early childhood education and care, schools, health services, disability services, sport and recreation clubs and religious institutions.[[1]](#footnote-2) Organisations are an essential part of childhood, helping children learn, play and grow, and there is a strong community expectation that organisations are safe places where children can thrive.

Unfortunately, children and young people do not always experience organisations as safe and nurturing. The Royal Commission into Institutional Responses to Child Sexual Abuse (Royal Commission) found that tens of thousands of children were sexually abused in institutions and that the sexual abuse of children has occurred in almost every type of institution where children live or attend for educational, recreational, sporting, religious or cultural activities.[[2]](#footnote-3)

The Royal Commission concluded that many organisations entrusted with the care of children and young people failed to protect them and keep them safe, and it recommended state and territory governments require the implementation of 10 child safe standards (CSS) and establish nationally consistent reportable conduct schemes (RCS).[[3]](#footnote-4)

The Royal Commission’s 10 CSS act as the blueprint for organisations to become child safe and establish organisational cultures that value children, respect their rights and prevent institutional child abuse. An RCS provides independent oversight of organisations’ responses to allegations of child abuse and misconduct by staff and volunteers (‘reportable conduct’) and aims to ensure complaints are handled properly and information about people who may pose a risk to children is shared appropriately across organisations and sectors.

Figure 1 The Royal Commission’s Child Safe Standards[[4]](#footnote-5)



The CSS and RCS are complementary schemes that together comprise an integrated child safe organisations system which is preventative, responsive and has the capacity to detect risks.

Since the Royal Commission, many states and territories have progressed implementation of CSS and an RCS.

#### Child safe standards and a reportable conduct scheme in Queensland

Following consultation, and further analysis undertaken in this DIAS, the Queensland Government has decided to introduce a legislative framework to implement CSS and establish a nationally consistent RCS, as recommended by the Royal Commission. Our recommended approach to implementing both CSS and RCS is to establish an integrated child safe organisations system within a single oversight body. While the Royal Commission was focused on child sexual abuse in institutions, the Queensland Government’s child safe organisations system will also encompass other forms of child maltreatment in institutions and organisations: physical, sexual and emotional abuse and neglect.

The purpose of this DIAS is to:

* outline the feedback we received from stakeholders on the impact that regulation for CSS and a Queensland RCS will have on organisations, government and the community, with particular consideration for the children and young people that the regulation is intended to benefit;
* further assess the costs and benefits for Queensland of implementing CSS and RCS; and
* communicate the Queensland Government’s decision to stakeholders and the public.

For the purpose of assessing costs and benefits for Queensland, we have estimated an approximate prevalence rate of all types of institutional child abuse in Queensland, the financial impacts of institutional child abuse, and whether the proposals will create a net benefit for Queenslanders. However, we acknowledge that the impact of institutional child abuse is profound, lifelong and cannot be measured.

#### Objectives of government action

The Queensland Government’s goal is to prevent abuse and reduce the severity of harm children experience in Queensland institutions. To achieve this, there are two primary objectives of government action. The first objective is to ensure the safety and wellbeing of children accessing services or facilities in Queensland institutions, recognising that no amount of abuse is acceptable, and all children deserve to grow up safe from harm. However, as acknowledged by the Royal Commission, when abuse does occur, improper responses from institutions can exacerbate the harm experienced by children.[[5]](#footnote-6) The second objective is to ensure children who are at risk of experiencing, or have experienced, abuse in institutional settings are supported early, in a trauma-informed and appropriate way.

#### Overview of reforms

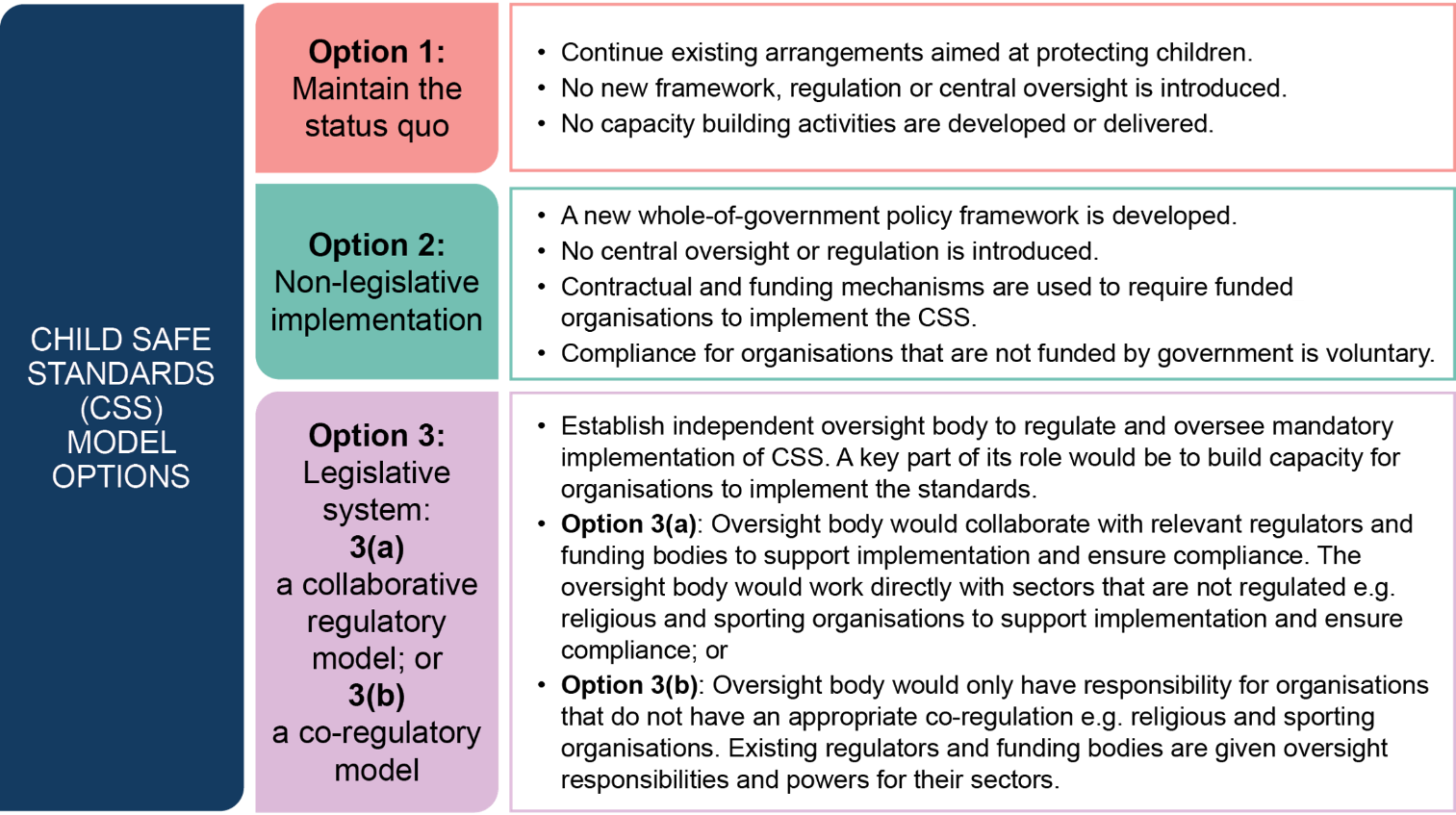
Queensland will establish an integrated child safe organisations system that requires and supports organisations to implement the CSS and provides oversight of institutional child abuse complaints and allegations through an RCS. Both functions will be integrated into the role of a single, independent oversight body.

In order to make this decision, we explored three options for CSS with the preferred option being a legislated scheme mandating compliance, implemented through a collaborative regulatory model with a key focus on capacity building for organisations (refer Figure 2, below). Two options were explored to assess the recommendation for an RCS (refer Figure 3, below), with the preferred option being implementing an RCS that is nationally consistent as recommended by the Royal Commission. The minimum scope of organisations recommended for inclusion in the RCS by the Royal Commission is narrower than the scope of organisations recommended for inclusion in the CSS. The Royal Commission recommended RCS only cover organisations that ‘exercise a high degree of responsibility for children’ and ‘engage in activities that involve a heightened risk of child sexual abuse, due to institutional characteristics, the nature of the activities involving children, or the additional vulnerability of the children the institution engages with’ (Royal Commission, Final Report recommendation 7.12). Further details and discussion on scope can be found in Part 3 of the DIAS.

#### Options for implementing child safe standards in Queensland

We considered several ways the CSS could be implemented in Queensland to help organisations better prevent, detect, and respond to child abuse and prioritise the safety and wellbeing of children in their care. The Royal Commission suggested states and territories should regulate, and support implementation of, CSS in a way that maximises the safety and wellbeing of children while minimising regulatory burden. To achieve this balance, the Royal Commission intended regulation to be proportionate to the level of organisational risk, flexibly applied, and leverage existing regulatory systems wherever possible. These considerations informed the options summarised below.

Figure 2 Options for child safe standards in Queensland



#### Impact on organisations

All options require efforts from relevant organisations to build a culture and adopt practices which prioritise the safety of children (child safe practices), in a way that is meaningful for each organisation’s unique operating environment. The CSS are not intended to set out prescriptive rules, but are intended to be flexible, principle-based and focused on outcomes. The difference between options is the support and resources provided (i.e. capacity building), the level of oversight, and the regulator.

Common strategies of implementing CSS include, but are not limited to, developing and maintaining organisational governance materials to ensure the CSS help influence the organisation’s practices, decision-making processes, risk management and transparency, such as:

* a statement of commitment to child safety;
* a child safe policy;
* a code of conduct for the organisation’s employees and volunteers;
* complaints management policies;
* a risk management plan; and
* reflecting the CSS in human resources policies and procedures (e.g. recruitment processes).

Under option 2, organisations in scope (i.e. organisations funded or regulated by government) would need to meet contractual obligations of demonstrating compliance and participate in capacity building activities delivered by funding or regulatory bodies. For organisations that are not in scope participation would be voluntary with no further support or capacity building beyond what is currently available.

Many of the impacts for Option 3(a) are the same as Option 3(b), with the key difference relating to potential increased costs of regulatory burden under Option 3(b) because of the possible involvement of multiple regulators. Organisations in scope of either Option 3(a) or (b) (see discussion of which organisations will be included in a legislated CSS system on pages 64-67) will be responsible for ensuring their organisations meet the CSS, including by:

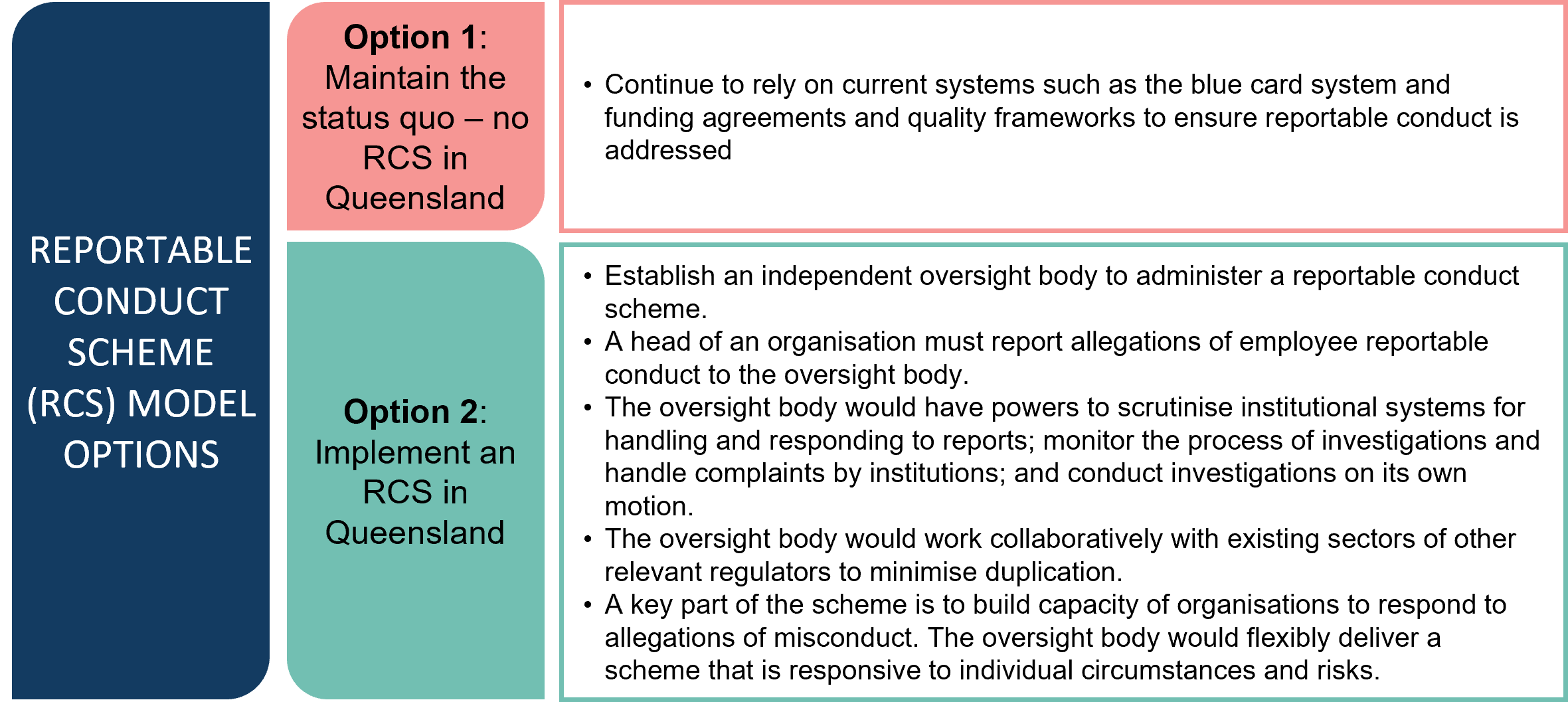
* identifying necessary requirements for how their organisation can best meet the CSS (with expert guidance and capacity building supports provided);
* participating in the oversight body’s capacity building activities and accessing supports as necessary, to assist the organisation’s ability to implement child safe practices;
* committing themselves to ongoing quality improvement in their child safe practices, as the risks of abuse in organisations are dynamic and changing, and child safe cultures must be consciously maintained;
* complying with any directions made by the oversight body (or a delegated CSS co-regulator, for Option 3(b)). This may include, for example, producing information relating to the organisation’s implementation of CSS (on request); and
* advising the oversight body of any barriers to compliance.

#### Recommended option for child safe standards

The recommended option for implementing CSS is Option 3(a), the establishment of an oversight body and legislation requiring organisations in scope to implement CSS, with the oversight body taking a collaborative approach with existing regulators supporting organisations to comply. For organisations already subject to existing regulation, the oversight body will work collaboratively with those regulators to establish a consistent and coordinated approach to building child safe organisations. This approach will leverage existing processes and help reduce any regulatory duplication or burden. The oversight body will adopt the role of regulator where there are no existing relevant regulatory arrangements for organisations. This option also enables flexible application of the CSS to each organisation in a way that is proportionate to the level of organisational risk and the nature and characteristics of each organisation.

#### Options for a Queensland reportable conduct scheme

Figure 3 Options for a Queensland reportable conduct scheme



#### Impact on organisations

For Option 1, organisations would remain subject to existing obligations such as the blue card system and existing reporting requirements, with no new obligations imposed. These are detailed further on pages 28-31.

For Option 2, organisations in scope (see discussion of scope on pages 77-80) will have obligations to:

* Ensure systems are in place for preventing, detecting and responding to reportable allegations and convictions of employees, volunteers and contractors. The oversight body will be able to request information from organisations about their systems and may make recommendations for action to be taken regarding those systems.
* Notify the oversight body of reportable allegations or convictions that they become aware of against their employees, volunteers and contractors.
* Investigate allegations having regard to the principles of procedural fairness and determine whether they have been proven.
* Provide information to the alleged victim and their parent/carer and, as requested by the oversight body, about allegations, progress of investigations, and findings and action taken.
* Ensure appropriate confidentiality of information relating to reportable allegations.
* Advise the oversight body of the outcome of investigations upon completion.
* Take appropriate action to prevent reportable conduct by employees.

#### Recommended option for a reportable conduct scheme

Option 2, implementing a Queensland RCS, is the recommended option. Over time, it is expected there will be earlier detection of risks and incidents of child abuse that will have positive impacts on children, organisations, government, and the wider community, including potentially fewer incidents of harm to children.

While there would be new obligations for all organisations, the impacts will be moderated by existing obligations on highly regulated sectors, such as early childhood education and care, child protection, youth justice, education, and services for children with disability.

Sectors that have fewer existing regulatory obligations, such as accommodation and residential services, health services for children and religious organisations may need to undergo more significant changes to their practices. However, this will be mitigated by the support and capacity building functions of the oversight body.

#### Impact analysis

To quantify the estimated costs and benefits that could be realised by implementing the various options for both CSS and a Queensland RCS, a financial analysis was performed on the options (aside from the status quo) to evaluate the required impact for each option to be cost-neutral. Table 1 summarises how different benefits and costs will accrue to different groups of stakeholders.

For the purposes of the cost-effectiveness analysis, the key benefit of creating safer environments for children is used to measure the costs for different options (see Part 4 for further detail). The other benefits identified in Table 1 contribute to this key benefit and inform the additional qualitative analysis for how options will affect stakeholders.

Table 1 Summary of expected impacts of both child safe standards and reportable conduct scheme

|  |  |  |
| --- | --- | --- |
| **Stakeholder** | **Costs** | **Benefits** |
| Children and young people | No direct costs | Safer environments for children who engage with organisations and sectors in scope and reduced risk of harm |
| Organisations | Costs to comply with CSS and RCS obligations such as engaging in capacity building; setting up policies and systems; reporting incidents to the oversight body and conducting investigations | Improved capability, understanding and frameworks to support institutional child safety; earlier detection of risks of harm and better reporting; support and guidance to respond to reportable allegations; may help reduce civil liabilities regarding child abuse, improved organisational culture; higher staff retention, improved public reputation, stronger ability to attract grants/funding |
| Government | Costs to fund oversight body to administer CSS and RCS; costs to government entities that must collaborate with oversight body; compliance costs to government entities in scope of CSS and RCS | Improved oversight of child safe practice in organisations; greater collaboration between oversight body and sector regulators; improved information sharing to identify child abuse and complement existing mechanisms to protect children; increased national consistency |
| Wider community | No direct costs | Greater community awareness and engagement in child safety; reduced incidents of child abuse in organisations; improved community confidence in organisations that deliver services to children; increased national consistency will benefit wider community to be aware of and avoid or reduce harm |

The key cost drivers and cost estimates for governments and organisations to establish and comply with CSS and RCS under different options are detailed in Tables 2 and 3 below, with further information on the assumptions and key drivers for these estimated costs, including the results of consultation through the CRIS process, explored in Part 4. It is expected there will also be additional costs faced by government agencies in establishing the necessary resources and processes to cooperate with the oversight body – these costs are expected to be largely the same across the options that require establishment of an oversight body and are detailed further in Part 4.

The estimates in Tables 2 and 3 have not changed from the estimated costs proposed in the CRIS.

Feedback from stakeholders on anticipated costs provided valuable insight into the individual cost for organisations to implement CSS and RCS, and will continue to be considered as the Queensland child safe organisations system is further developed and later implemented. However, we have not changed the estimated annual costs to organisations for the purpose of the impact analysis because the feedback we received (63 submissions in total) represents a small sample of a very large and diverse group of organisations (i.e. we expect CSS and RCS to reach approximately 40,000 organisations across Queensland). For more details on this rationale, see Part 4, page 89 and pages 96-98.

Table 2 Annual average costs to government to establish oversight body

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
| Option | | Cost (M) per Year | | | | | |
| Year 1 | Year 2 | Year 3 | Year 4 | Year 5 | Year 6 + |
| CSS | Option 2 | N/A | | | | | |
| Option 3(a) | $3.96 | $4.40 | $3.79 | $3.46 | $3.56 | $3.50 |
| Option 3(b) | $3.96 | $4.04 | $3.48 | $3.19 | $3.41 | $3.40 |
| RCS | Option 2 | $3.47 | $5.68 | $5.10 | $5.27 | $5.42 | $5.40 |
| Integrated Model[[6]](#footnote-7) | | $7.43 | $6.61 | $7.02 | $8.12 | $8.83 | $8.83 |

Table 3 Estimated annual average costs for organisations in scope to comply with CSS and RCS

|  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- |
|  | Annual costs to organisations | | | | | | | |
| Large School | | Religious Organisation | | Foster Care Provider | | Small Organisation | |
| Set-up | Ongoing | Set-up | Ongoing | Set-up | Ongoing | Set-up | Ongoing |
| **CSS** | $23,333 | $8,750 | $15,000 | $7,222 | $10,000 | $5,972 | $1,167 | $1,027 |
| **RCS** | $23,333 | $23,333 | $15,000 | $98,898 | $10,000 | $66,806 | $1,167 | $793 |
| **Integrated Model[[7]](#footnote-8)** | $24,333 | $26,667 | $16,000 | $101,620 | $11,000 | $69,028 | $1,353 | $1,391 |

It is expected that as CSS and RCS models are implemented in Queensland, two impacts will occur: a reduction in annual prevalence of child maltreatment in Queensland organisations, and a reduction in the average harm incurred where cases of child maltreatment continue to occur. Based on available analyses, it is estimated that on average, across all types of child maltreatment, each incident of maltreatment has a total cost to the child of approximately $400,000 in lifetime impacts. This cost comes from loss of quality of life and reduced lifespan related to increased risks for poor mental health, suicide and self-harm, as well as premature mortality directly arising from the maltreatment.[[8]](#footnote-9)

An additional cost to government of approximately $200,000 per incident of child maltreatment is estimated due to subsequent costs relating to the increased demands on the health, criminal justice, housing and homelessness, and child protection systems.[[9]](#footnote-10)

Therefore, every case of child maltreatment prevented represents approximately $600,000 in savings to society. The impact of maltreatment on every child is unique, and may be greater than these estimates, however, what is clear is that child maltreatment has an enormous impact on people’s lives, families and communities.

We note that the costs and benefits summarised above are indicative only and intended to best estimate the potential impact the options would have on government and society. The methodology and assumptions underpinning these estimates are outlined in detail in Part 4 of the CRIS. The conclusion of the impact analysis is that the recommended options would create significant net benefits for Queensland. The results of consultation on the CRIS generally supported the key findings of the impact analysis, agreeing that while there were associated costs for organisations, the cost of failing to act to protect children and young people was far greater.

The outcome of the impact analysis demonstrates that across all costed options, only a small reduction in prevalence of child maltreatment will be required to have an overall net benefit for Queensland. While it is difficult to forecast the precise impact each option will have, based on the evidence available to us and the expert recommendations of the Royal Commission, it is highly probable that the impact of the recommended options will reach the level required to have a net benefit.

#### Summary of consultation

The Queensland Government released the *Growing Child Safe Organisations in Queensland CRIS* for public consultation on 10 August 2023. The CRIS sought feedback on:

* the options for implementing CSS and an RCS in Queensland;
* the impact of proposed CSS and RCS regulation on organisations; and
* our analysis that implementing CSS and an RCS would reduce child maltreatment in Queensland institutions, resulting in an overall cost-benefit for Queensland.

The consultation period ran for a period of six weeks, closing on 22 September 2023. A total of 63 written submissions were received from members of the public, organisations, Queensland Government agencies, peak bodies and sector regulators. The list of submissions received is at Appendix G. Further detail on consultation activities is in Part 5.

##### What we heard during consultation

There was strong support for implementing CSS and RCS in Queensland. We heard it will demonstrate the Queensland Government’s commitment to child safe organisations and bring Queensland in line with other jurisdictions.

Most organisations told us they are already implementing the CSS or National Principles for Child Safe Organisations (National Principles) in some form, with different organisations and sectors at different stages of the process. Several large, national organisations already have dedicated safeguarding positions, while other, smaller organisations told us they will need additional support. Most organisations suggested they will need around 12 months to build organisational processes to comply with a legislated scheme.

Capacity building and cultural change was viewed as critical to successful implementation. We heard that stakeholders are genuinely committed to meaningful implementation, rather than a tick-box compliance approach or where child safety is seen as an add-on to existing service delivery demands. Stakeholders are committed to integrating a child safe organisations system into organisational leadership, culture and frontline service delivery, where staff fully understand what CSS means in everyday practice.

There was strong support for a balanced, flexible and proportionate regulatory framework focused on capacity building. Organisations told us the integration of CSS into existing regulatory frameworks is vital to avoid unnecessary duplication and an onerous regulatory burden. The importance of information sharing was recognised, with strong interest in understanding how the RCS will interact with existing regulatory compliance processes and authorities, how information will be collected, used and shared, and how duplication of reporting requirements will be minimised.

Stakeholders considered clear and comprehensive support from the oversight body essential. A wide range of support mechanisms were proposed including detailed and sector-specific guidance materials and resources (such as videos, templates and practice examples); training (including online training modules, pre-recorded seminars, live webinars); and access to a helpline or a relationship manager (also sector-specific) within the oversight body. Submissions noted this support needs to be broader than education on managing compliance and include other capacity building activities, including communities of practice, to help build child safe cultures within and across organisations.

Education of parents and families about what they should expect from an organisation was seen as an important component of a child safe organisations system. Many submissions suggested a shared culture of child safety needs to be promoted in the broader community through awareness raising activities and campaigns.

There was strong support to involve children and young people, Aboriginal and Torres Strait Islander people, survivors and people with diversity including people with disability, culturally and linguistically diverse communities and the LGBTQIA+ community in the design and implementation of the CSS and RCS.

When considering a child safe organisations system specifically for Queensland, submissions noted Queensland’s vast geography and spread of population in regional centres, rural and remote communities, as challenges for implementation. Stakeholders emphasised the importance of considering the needs of Aboriginal communities and Queensland’s Torres Strait Islander and South Sea Islander populations and communities.

Responses to estimated costings were mixed with some organisations that are already implementing CSS suggesting costs would be minimal, and others suggesting costs were significantly underestimated. There were a variety of reasons organisations expected higher costs than the estimates in the CRIS. This included greater costs for large and complex organisations given their scale; additional costs for organisations in rural and remote areas; and the need for continual capacity building and training in sectors with high turnover and more casual employment.

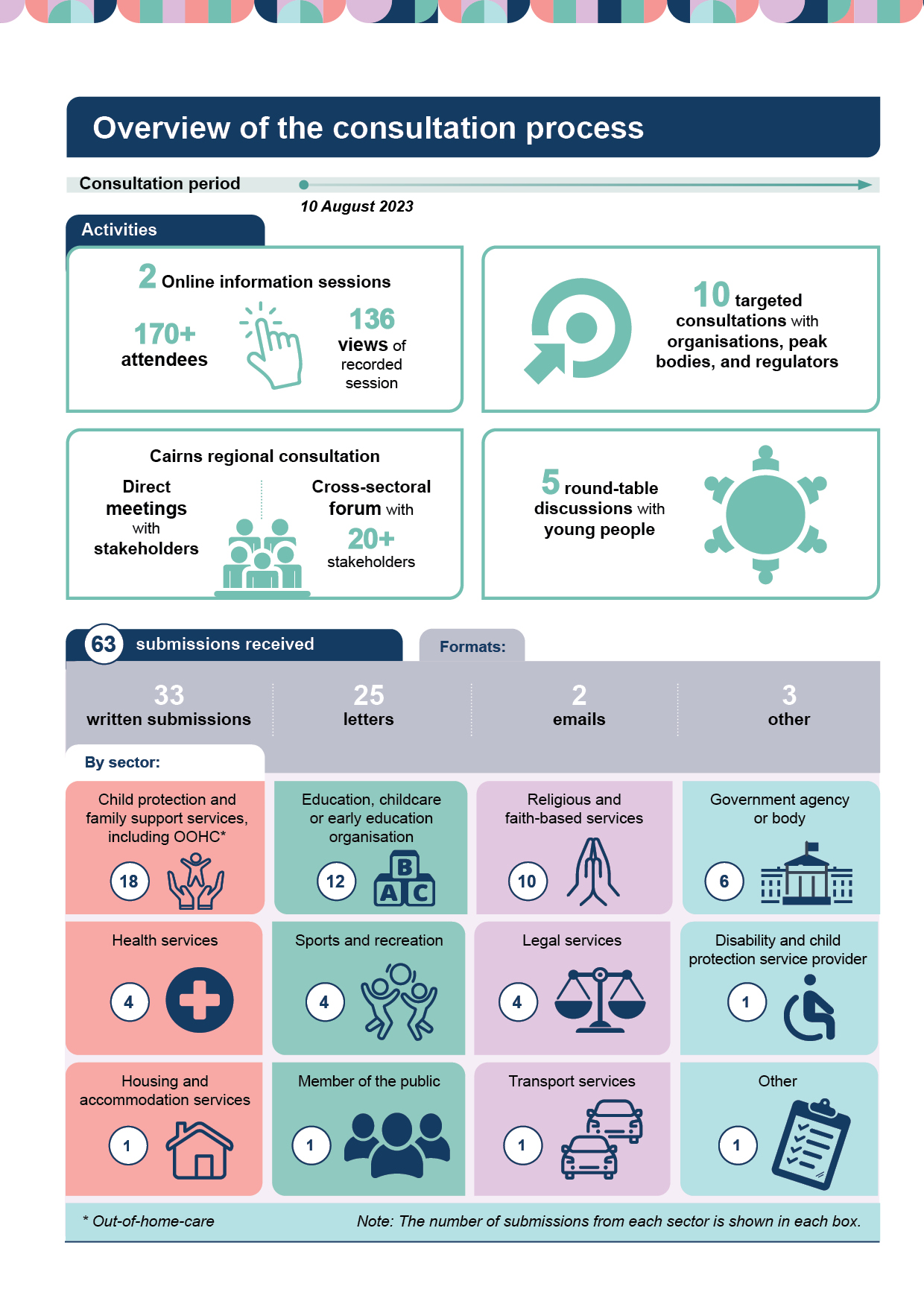
Stakeholders also raised concerns that an under-resourced and over-burdened oversight body would have a direct impact on compliance costs and service delivery if it did not have enough capacity to support organisations in implementation. The 2019 Victorian review of the CSS was cited as an example, because it found the oversight body, in managing the RCS was not able to provide ongoing sector-specific supports or advice.

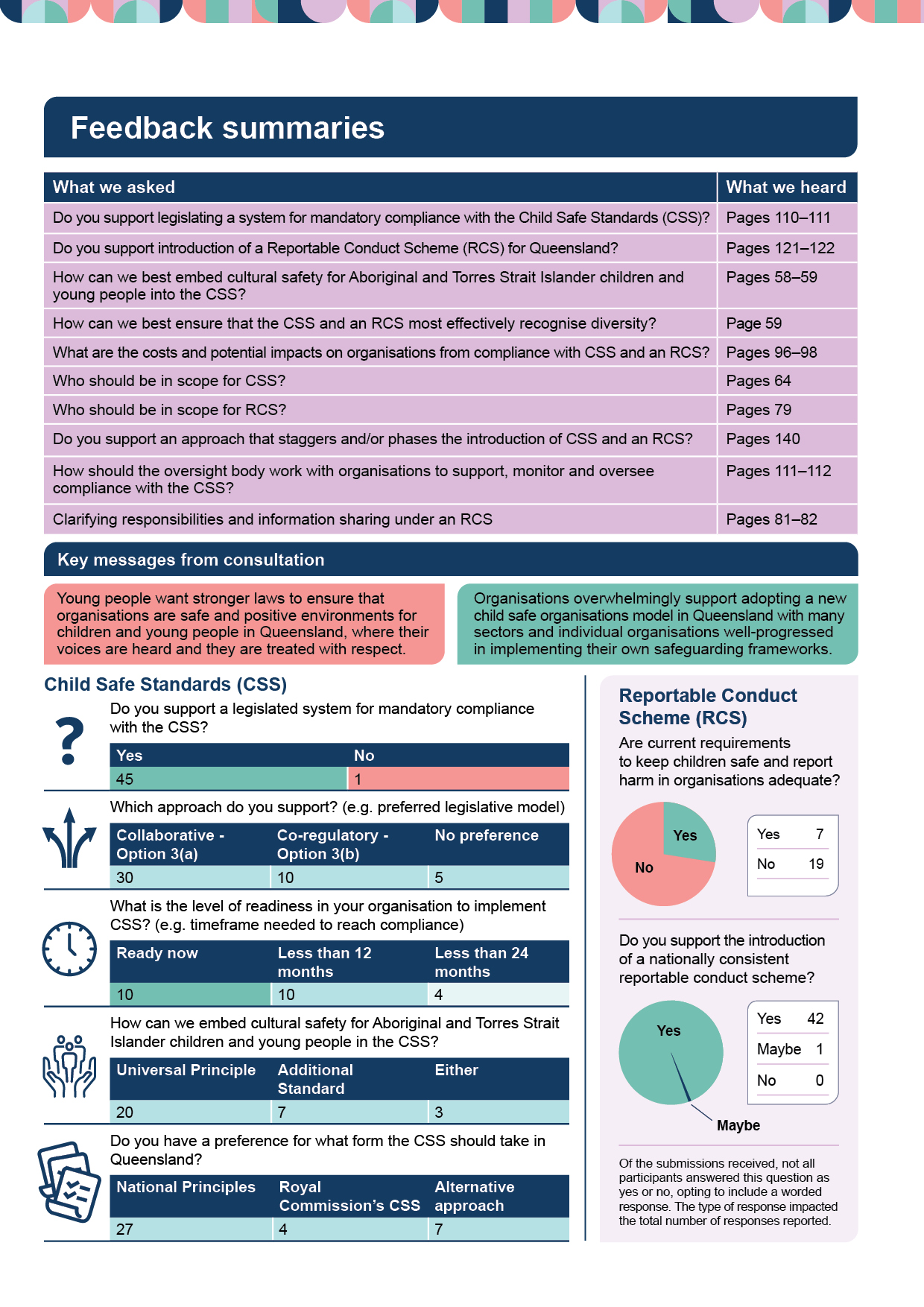
Young people told us that most organisations feel safe, although some feel safer than others. They said how their parents are treated in organisations is important because children will be reluctant to speak up if they feel their parents are not valued by an organisation. Young people said the community has the right to expect organisations are safe for children and that organisations should be accountable and transparent. They value the relationships they have with organisations, particularly when adults listen to them, understand them as individuals, and help them reach their goals.

Aboriginal and Torres Strait Islander peoples and organisations reinforced that a connection to culture is a protective factor for Aboriginal and Torres Strait Islander children. We heard that building culturally safe organisations requires the development of trusting relationships over time and needs to be led by Aboriginal and Torres Strait Islander peoples to ensure the work is underpinned by a deep understanding of local communities and contexts.

For a child safe organisations system to be culturally safe, Aboriginal and Torres Strait Islander stakeholders urged the Queensland Government to ensure that the design of systems, structures, resources and implementation is led by Aboriginal and Torres Strait Islander people through Aboriginal and Torres Strait Islander governance committees and by employing Aboriginal and Torres Strait Islander people in the oversight body.

Overall, consultation clearly supported the Queensland Government’s implementation of CSS and RCS, through a legislative framework, and overseen by a single oversight body. Key themes for implementation included a flexible and tailored approach that is culturally safe and focused on building capacity to ensure all Queensland organisations interacting with children are child safe.





## Introduction

Organisations that have the privilege of providing services to children and young people have a significant responsibility to make sure they are kept safe and supported to thrive. The Queensland Government, both in its service delivery roles and policy/law-making functions, is committed to creating the safest possible Queensland for children and young people.

The Royal Commission, through its five-year, in-depth inquiry, explored the devastating impacts of child abuse in organisations and recommended a wide range of measures to enhance systems that keep children and young people safe. The Queensland Government has made [substantial progress](https://www.cyjma.qld.gov.au/about-us/reviews-inquiries/queensland-government-response-royal-commission-institutional-responses-child-sexual-abuse?_sm_au_=iHVsStJTkvSRjqPf) in implementing the recommendations of the Royal Commission, but there is more to be done.

One of the next steps for Queensland in implementing the Royal Commission’s recommendations is to establish an integrated child safe organisations system that requires, and supports, organisations to implement the CSS and provide oversight of institutional child abuse complaints and allegations through an RCS. Both functions will be integrated into the role of a single, independent oversight body (the oversight body).

The intention of the Royal Commission in recommending CSS and nationally consistent RCSs was to prevent abuse in institutions; create safe spaces for children to thrive; better respond to abuse when it happens; and avoid compounding trauma for people with lived experience.

As there is a regulatory impact on organisations and government to achieve these objectives in the way the Royal Commission envisioned, the Queensland Government has undertaken [regulatory impact analysis](https://s3.treasury.qld.gov.au/files/Queensland-Government-Better-Regulation-Policy.pdf). The first part of this process was to develop and release the *Growing Child Safe Organisations in Queensland CRIS*. The CRIS set out the options available and sought community views on whether we assessed the impacts and benefits accurately, in order to make sure any new regulation is accompanied by a system that offers the greatest benefit to Queenslanders.

Following consultation on the CRIS, the next and final step of the regulatory impact analysis is the development of this DIAS. The purpose of this DIAS is to:

* outline the feedback we received from stakeholders on the impact that regulation for CSS and a Queensland RCS will have on organisations, government and the community, with particular consideration for the children and young people that the regulation is intended to benefit;
* further assess the costs and benefits to Queensland of implementing CSS and RCS; and
* communicate the Queensland Government’s decision to stakeholders and the public.

### Where to find more information

You can find more information, including the CRIS and supplementary material, at: [www.qld.gov.au/Growing-Child-Safe-Organisations](https://aus01.safelinks.protection.outlook.com/?url=http%3A%2F%2Fwww.qld.gov.au%2FGrowing-Child-Safe-Organisations&data=05%7C01%7CPieta.Sephton%40cyjma.qld.gov.au%7C9ad836b1568240009d2a08db9c88e912%7C95b907c2752b485088ad86939ce522f0%7C0%7C0%7C638275884088414542%7CUnknown%7CTWFpbGZsb3d8eyJWIjoiMC4wLjAwMDAiLCJQIjoiV2luMzIiLCJBTiI6Ik1haWwiLCJXVCI6Mn0%3D%7C3000%7C%7C%7C&sdata=brK1mtJIoJu3QrjRsDap5LHCunSKVsQOeRQmwjcRAq4%3D&reserved=0).

### If you have concerns about a child

If you have a reason to suspect a child in Queensland is experiencing harm, or is at risk of experiencing harm or being neglected, contact [Child Safety Services Centres](https://www.cyjma.qld.gov.au/html/dcsyw/contact-us/department/child-family/cssc/index.html) and talk to someone about your concerns:

* **During normal business hours** – contact the [Regional Intake Service](https://www.cyjma.qld.gov.au/contact-us/department-contacts/child-family-contacts/child-safety-service-centres/regional-intake-services); or
* **After hours and on weekends** – contact the Child Safety After Hours Service Centre on **1800 177 135**. The service operates 24 hours a day, 7 days a week.

## PART 1 – Why we are implementing a child safe organisations system

While many organisations across Queensland have done excellent work to improve the safety of children engaged with them, we know we need to do more. The Royal Commission, along with various other inquiries, has shown us that institutional risks to children do not only exist in the past, and that child abuse continues to occur in organisations today.

For clarity, when there is reference to child abuse in this document, we are referring to all forms of abuse that may occur in an institutional setting, including physical abuse, sexual abuse, emotional or psychological abuse, and neglect, experienced by children and young people under 18 years of age. We have defined this and other key terms in the Glossary on page 145.

**Terminology:  
‘children and young people’**

People under the age of 18. This paper references ‘children and young people’ throughout the document, but we also use the term ‘children’ to mean anyone under the age of 18.

Any harm to a child is unacceptable. It is critical that organisations providing services to children are safe. Organisations provide important social, educational and therapeutic services to children and young people that contribute to their development and wellbeing. Child safe organisations can also act as important protective mechanisms for children who might experience harm elsewhere.

### The nature of risks to children and young people in organisational settings

#### How abuse can occur

It is typical for children to be involved with all different kinds of organisations from early childhood, many of which provide essential supports to children and their families. This includes schools, hospitals, sport and recreational clubs, religious organisations, childcare services, and disability support services, for example.

Despite their differences and unique settings, all organisations that provide services or facilities for children share a responsibility for their safety and can at times be an additional source of risk of harm.

#### Who is affected, and who are the stakeholders?

Table 4 summarises the estimated number of children who are receiving care or services in different sectors, demonstrating the substantial population exposed to potential maltreatment.[[10]](#footnote-11)

Table 4 Queensland child population by service type

| **Service type[[11]](#footnote-12)** | **Number of children** |
| --- | --- |
| Education (schools) | 857,920 |
| Disability | 29,332 |
| Childcare | 28,000 |
| Child protection | 10,053 |
| Accommodation/residential | 4,689 |
| Justice and detention | 1,939 |

All children are vulnerable to harm through their interactions with organisations due to the inherent power imbalance that exists between adults and children, which can be amplified in certain environments.

The exact number of organisations that provide care or other services to children or otherwise interact with them in some capacity in Queensland is unknown, but is expected to be significant – the Victorian Government found over 50,000 organisations in Victoria fell within the scope of its Child Safe Standards scheme, and over 12,000 organisations under its Reportable Conduct Scheme.[[12]](#footnote-13) As at 30 September 2023, Blue Card Services in Queensland reported there were approximately 24,500 separate organisations with active blue card holders.

Queensland has had several independent inquiries about institutional harms to children in the last 25 years. The findings of these inquiries remain relevant to how government and organisations operate today and continue to shape our knowledge of the problem of institutional child abuse.[[13]](#footnote-14)

Some key commonalities among the abuses included an abuse of power, a betrayal of trust, a reluctance of people in authority to acknowledge or deal with the abuse, and an official response which showed more concern for the protection of the institution and the abusers than for the safety of the children

– Commission of Inquiry into Abuse of Children in Queensland Institutions, 1999 (Forde Inquiry) (pg. xii)

**Terminology: ‘institution’ or ‘organisation’**

The Royal Commission, when determining the scope of its inquiry, defined an ‘institution’ broadly, including any entity that ‘provides or has at any time provided, activities, facilities, programs or services of any kind that provide the means through which adults have contact with children’ (Royal Commission, Volume 1, page 17).

When we talk about children being safe in institutions, we are talking about organisations and businesses like: childcare, schools, churches, sports and facilities.

**Institutional context of child abuse:**

Happens on the premises of an institution, where activities of an institution take place, or in connection with the activities of an institution.

Is engaged in by an official of an institution in circumstances (including circumstances involving settings not directly controlled by the institution) where you consider that the institution has, or its activities have, created, facilitated, increased, or in any way contributed to (whether by act or omission), the risk of child sexual abuse or the circumstances or conditions giving rise to that risk.

Happens in any other circumstances where you consider that an institution is, or should be treated as being, responsible for adults having contact with children.

Concluding in 2017, the Royal Commission conducted an in-depth inquiry into the occurrence of institutional child sexual abuse, including examining new data and evidence relating to the nature and causes of child sexual abuse. While the Royal Commission’s terms of reference were limited to institutional sexual abuse, the Royal Commission’s findings are relevant to improving prevention of, and responses to, all forms of harm to children in organisations. They also echo the findings of other inquiries that extended to broader forms of institutional harm to children. Although the focus of our work on child safe organisations is on harm in institutional contexts, we acknowledge that creating child safe environments and raising community awareness may have beneficial flow-on effects such as reducing the prevalence of abuse of children and young people at home. However, the scope of the recommended integrated child safe organisations system is not intended to directly address these contexts.

#### Risk factors

The Royal Commission found a range of factors can influence the risk of harm to children in institutional settings, noting that some children can be more vulnerable to abuse than others. Such factors include gender, age and developmental stage, earlier experiences of maltreatment, disability, the nature of their engagement with an institution, social isolation, and their awareness of personal safety.[[14]](#footnote-15) For children with diverse backgrounds and needs, the Royal Commission noted inherent systemic and structural issues affect their safety:[[15]](#footnote-16)

We heard that Aboriginal and Torres Strait Islander children, children with disability and children from culturally and linguistically diverse backgrounds can face particular challenges. These children are not inherently more vulnerable to sexual abuse. Rather, they more often encounter circumstances that:

* place them in organisations with high risk;
* make it less likely they will be able to disclose or report abuse; and
* make it more likely they will receive an inadequate response to sexual abuse than other children.*[[16]](#footnote-17)*

Different organisations may also have varying levels of risk depending on a range of factors. The Royal Commission identified three broad types of risk factors that can occur in every institution: institutional, operational and environmental,[[17]](#footnote-18) as demonstrated in Table 5.

Table 5 Types of risk factors in organisations

| **Type of risk** | **Examples of risk factors** |
| --- | --- |
| **Institutional**  *Organisation attitudes and culture* | * Lacking understanding or awareness of child sexual abuse. * Failing to listen to children. * Failing to see prevention of child sexual abuse as a shared responsibility. * Prioritising the reputation of an institution over safety and wellbeing. * Failing to educate children about healthy and appropriate sexual development. * Cultivating secrecy and isolation. * A culture which normalises or tolerates harmful and abusive practices. |
| **Operational**  *Governance, policy and practices* | * Institutional hierarchy that enables abuse and inhibits identification of and responses to abuse. * Inadequate recruitment and screening policies and practices. * Ineffective and insufficient child protection policies and practices. * Roles that enable opportunities for abuse, such as physical contact (e.g. showering). * Children’s lack of access to a trusted adult. * Lack of effective supervision of adult-child interactions and external oversight. * Use of adults as role-models or mentors. |
| **Environmental**  *Inherent characteristics of organisations and services* | * Access to children in isolated or unsupervised locations. * Inappropriate placement of children in residential institutions. * Use of online environments or other potentially private, unaccountable communication avenues to groom and abuse children. |

Every institution is different in the risk factors that may exist in their organisation. Risks are also dynamic and ever-changing. Other factors such as staff turnover, shifting sector and market conditions, and major events such as the COVID-19 pandemic can be unpredictable and impact child maltreatment. While it is not possible to comprehensively map each organisation’s level of risk for the purposes of this regulatory analysis, we can estimate how different types of services and organisations within each sector may be more or less likely to demonstrate specific risk factors, noting some organisations will sit across multiple categories or service types. These risk factors are outlined in **Appendix E** which provides a non-exhaustive example of how operational and environmental risks may be different across sectors. As individual organisational and cultural risks can occur across all sectors and organisations and are not dependent on the nature of the organisation, they have not been included.

While understanding how organisations may experience different risks is useful, it is not possible to accurately compare organisations or make reliable predictions of the risks for any given organisation or sector. Two organisations may have roles that enable opportunities for abuse, but the organisations may have a different number of these roles and different opportunities for abuse to occur in each role. This limitation was considered in the development of options for CSS and RCS, as it means government action must broadly capture organisations engaged with children and cannot be limited to only ‘high-risk’ organisations.

A case study from the Royal Commission regarding abuse that occurred between 2009–2011 in the YMCA New South Wales (NSW) illustrates how institutional and operational risk factors led to the abuse of children by a staff member.

|  |
| --- |
| **Royal Commission case study: YMCA NSW[[18]](#footnote-19)**   * August 2009 – YMCA NSW employed Jonathan Lord as casual childcare assistant for outside school hours care services. * Over next two years, Lord worked in several roles including coordinator at two local YMCA centres. * September 2011 – Lord subject of allegations of sexual abuse of child on excursion. Immediately suspended and employment terminated two months later. * Early 2013 – Lord convicted of 13 sexual offences against 12 boys between six and 10 years of age, and sentenced to 10 years’ imprisonment, with a non-parole period of six years.   **The Royal Commission found that YMCA NSW:**   * Contributed to an organisational culture where Lord was able to groom and sexually abuse children for more than two years without detection. * Did not follow its own policies and procedures when recruiting Lord. These failures meant YMCA NSW did not know Lord had recently been dismissed from a YMCA role in the United States because of “questionable” behaviour with a child. * Staff regularly breached policies without consequence. For example, Lord and other outside school hours care staff, including a manager, frequently babysat and engaged in outside activities with children who attended YMCA services, despite a policy prohibiting this. * Did not have an effective system for giving parents information about its child protection policies. This meant parents were not aware of and did not understand these policies, preventing them from questioning Lord’s grooming behaviours. * Did not provide staff with adequate education and training about its child protection policies, the nature of sexual abuse, or how to identify risks and report concerns. This contributed to Lord’s behaviour going unreported. * Did not have an effective confidential reporting system in place. This left staff not feeling comfortable to raise their concerns about Lord’s conduct. |

#### Information-sharing to prevent ongoing abuse

The Royal Commission revealed many common problems with organisational responses to allegations of child sexual abuse that meant they were not properly investigated, and children were not adequately protected. These problems can continue today, even in sectors that are highly regulated. These problems include:

* lack of clear and accessible complaints handling policies and procedures;
* ignoring or minimising complaints;
* poor investigation standards;
* no assessment or management of risks to the safety of children in their care; and
* widespread under-reporting to authorities where abuse was known or suspected, noting the Royal Commission found under-reporting occurred regardless of whether there were obligations to report.

The Royal Commission highlighted cases where organisations transferred risk by moving perpetrators to another location or provided misleading employment references to help the person obtain employment elsewhere.

The Royal Commission noted that in Queensland, regulation and oversight of employee-related child safety matters differs between sectors and multiple bodies can have roles in the same sector. For example, for schools, the Department of Education, the Non-State Schools Accreditation Board and the Queensland College of Teachers all play a role in regulation and/or oversight. However, the absence of an oversight body with a view across all sectors has allowed people who are known or suspected to pose a risk to children to move between sectors and continue employment in roles where they have contact with children. Some sectors that work with children are subject to minimal regulation, with limited or no independent oversight of child safe practices, such as transport and commercial services, or sporting and recreation clubs.

Case studies examined by the Royal Commission highlighted examples of where there were missed opportunities to intervene and potentially prevent further abuse from occurring.

|  |
| --- |
| **Royal Commission case study: Brisbane Grammar School and St Pauls School**[[19]](#footnote-20)   * Examined Kevin Lynch, teacher and counsellor at Brisbane Grammar between 1973 and 1988, and counsellor at St Pauls, between 1989 and 1997, and Gregory Robert Knight, teacher at St Pauls between 1981 and 1984.   *Lynch*   * Lynch sexually abused a large number of students during employment at Brisbane Grammar, with a number of complaints against him made to senior staff and the headmaster. * He continued to sexually abuse students at St Pauls, where students made complaints, but no action was taken. * In 1997, Lynch was charged with 9 counts of offences committed against a St Pauls student. Lynch suicided the next day.   *Knight*   * During Knight’s employment, allegations were made that he sexually abused a number of students. * Two students made complaints of sexual abuse to headmaster of St Pauls regarding Knight, who accused them of lying and threatened to punish them if they persisted. * St Pauls responded to allegations by accepting his resignation. The headmaster gave him a favourable reference. * Knight went to teach at a high school in the Northern Territory. A student made allegations of sexual abuse, and school principal immediately referred matter to police. * Knight was charged and convicted of several counts of child sexual abuse and sentenced to eight years imprisonment.   **The Royal Commission found that:**   * The headmaster of Brisbane Grammar failed in his obligations to protect safety and wellbeing of the students, he did not investigate an allegation of sexual abuse made directly to him by a parent, and he did not report the matter to the police or board of trustees. * The culture at Brisbane Grammar was that boys who made allegations of sexual abuse were not believed and not acted upon. * During Lynch’s employment, Brisbane Grammar had no systems, policies or procedures in place for dealing with allegations of child sexual abuse of students. * St Pauls did not have a system for dealing with allegations that students made about child sexual abuse. * The headmaster of St Pauls failed in his fundamental obligation to ensure students under his care were safe by failing to act in response to notifications of child sexual abuse. |

#### Protective factors

While some factors contribute to added risk in organisations, protective factors reduce the risk of maltreatment occurring. These protective factors, as with risk factors, do not guarantee a certain outcome. However, their presence strengthens the safety of children and may decrease the likelihood of maltreatment, and where it does occur the overall harm may be lessened. The Royal Commission identified that strong connection to community and culture can be protective for children, as well as access to supportive and trustworthy adults and peers, and the ability for children to safely assert themselves (verbally and physically). Another protective factor can be a child’s adequate understanding of appropriate and inappropriate sexual behaviour, including sexual abuse and personal safety – this may enable a child to identify and resist abusive behaviour, although it is never a child’s responsibility to prevent or resist abuse.

It is not possible to meaningfully estimate the impact of protective factors on children. Similar to institutional risk factors, it is also not possible to reasonably estimate whether particular sectors and types of organisations may have more or less protective factors compared to others. Accordingly, protective factors were not incorporated into our impact analysis, but we acknowledge they have a role in reducing harm to children in Queensland.

#### Prevalence of institutional abuse

The Royal Commission concluded that it was not possible to determine the true incidence of child sexual abuse across Australian organisations due to limited data and under-reporting. However, the Royal Commission observed that the prevalence of child sexual abuse is significant.[[20]](#footnote-21) Child sexual abuse has occurred and continues to occur in nearly every type of institution where children live and learn.

People who spoke to the Royal Commission named 3,100 institutions in which child sexual abuse was reported to have occurred, of which 476 (15 per cent) were in Queensland. A breakdown of the types of Queensland institutions is outlined below.[[21]](#footnote-22)

Figure 4 Types of institutions in which sexual abuse was reported in Queensland (Royal Commission private sessions)

Work is ongoing to better understand the incidence of child abuse across Australian organisations following a key recommendation of the Royal Commission about improving data and establishing a national prevalence study.[[22]](#footnote-23)

In April 2023, the Australian Child Maltreatment Study (ACMS) published its landmark research into the national prevalence of child maltreatment in Australia, finding that 40.2% of Australians aged 16 – 24 years old have experienced more than one form of child maltreatment, and 62.2% of all Australians have experienced at least one type of maltreatment as a child.[[23]](#footnote-24)

This is supported by recent inquiries that also point to evidence of ongoing harm to children in organisations, for example, the 2020–21 Australian Human Rights Commission’s Independent Review of Gymnastics in Australia, the Commission of Inquiry into the Tasmanian Government’s Responses to Child Sexual Abuse in Institutional Settings (Tasmanian Commission of Inquiry), and the Royal Commission into Violence, Abuse, Neglect and Exploitation of People with Disability (Disability Royal Commission). In September 2023, both the Tasmanian Commission of Inquiry and the Disability Royal Commission delivered final reports referring to child safe organisations systems. The Tasmanian Commission of Inquiry noted implementation of CSS and RCS will be a key means for institutions to prevent and better respond to the risks of child sexual abuse. The Disability Royal Commission noted Queensland, South Australia and the Northern Territory are yet to establish RCSs and should do so urgently. A Queensland Government response to the Disability Royal Commission final report is yet to be considered by Government.

At this time, there is limited research available from which the rate of institutional child abuse in Queensland can be directly obtained. However, for the purpose of our impact analysis, we needed an approximate understanding of the baseline lifetime prevalence and annual prevalence of child abuse occurring in Queensland organisations.

**Terminology:   
*‘Lifetime prevalence***‘

the percentage of people who at any point in their lifetime experience one or more incidents of child abuse.

***‘Annual prevalence’***

an estimate of the average number of cases of child abuse each year.

The ACMS included exposure to domestic violence as a form of maltreatment and we note that exposure to domestic violence would not generally be categorised as a form of abuse that occurs in an institutional setting. Given this, while the ACMS provides a baseline for understanding the prevalence of maltreatment in Australia, the impact analysis used additional Australian research to estimate prevalence with a more institutional focus.

In 2016, Moore et al. undertook a systematic review of child maltreatment prevalence research in Australia to produce an estimated rate of total lifetime prevalence of four forms of child maltreatment: sexual abuse, physical abuse, emotional abuse and neglect. This study’s best estimate of lifetime prevalence of child maltreatment was 12.9% for men and 21.8% for women.[[24]](#footnote-25) It is noted that this is substantially lower than the lifetime prevalence estimated by the ACMS. This difference is partially owing to the inclusion of exposure to domestic violence in the ACMS as another form of maltreatment. Additionally, there is a significant gap in time between the ACMS and the studies that were reviewed by Moore et al. The ACMS indicates the figures used by Moore et al. may underestimate the lifetime prevalence of child maltreatment in Australia. While the more conservative figure provides the most suitable estimate for reasons outlined above, the evidence suggesting the true prevalence of child maltreatment is higher supports the need for government action.

To further refine these estimates to identify a lifetime prevalence of **institutional** child abuse, we adjusted these numbers using data from the Australian Bureau of Statistics (ABS) *Personal Safety Survey* (2016) (the survey). The data from the survey tells us the proportion of different types of abuse experienced by men and women that is perpetrated by a person known to them but who is not a family member/relative. This is referred to in the survey as **non-familial known person.**[[25]](#footnote-26)

For men, the survey results indicate approximately 65% of sexual abuse and 29% of physical abuse was perpetrated by a non-familial known person, and for women 47% of sexual abuse and 17% of physical abuse was perpetrated by a non-familial known person.[[26]](#footnote-27) Weighting these values by the number of respondents generates an estimated average percentage of child abuse perpetrated by a non-familial known person as 49% for men and 39% for women.

The ABS notes that non-familial known persons include foster carers, health professionals, teachers and school staff, childcare workers, recreational leaders, people associated with places of worship and corrective services personnel. Abuse perpetrated by these types of people would likely constitute examples of abuse in institutional settings. However, the category of non-familial known persons also includes perpetrators who are family friends, acquaintances or neighbours, which typically would not represent abuse in an institutional setting. Therefore, in the absence of more specific data that distinguishes institutional and non-institutional perpetrators, we adjusted the ABS figures down by 50% to account for the fact that the ABS data for abuse perpetrated by non-familial known persons likely captures some abuse perpetrated in non-institutional settings. Accordingly, it is estimated from the available data that the proportion of all child maltreatment that occurs in organisations is approximately 25% for men and 20% for women. By applying these proportions to overall lifetime prevalence calculated by Moore et al. it is estimated that 3.18% of men and 4.35% of women experience child abuse in an institutional setting, for a gender population weighted average of 3.74% for all people.[[27]](#footnote-28)

In 2016, McCarthy et al. extrapolated upon Moore et al. to produce a total estimated annual prevalence rate of 4.59%, which represents the expected percentage of the 0-17 year old population that will experience child abuse in a given year.[[28]](#footnote-29) Applying this to the most recent Queensland census population data[[29]](#footnote-30) produces an estimate of 54,352 annual cases of child maltreatment in any setting. By applying the values estimated above to indicate the proportion of child abuse perpetrated in institutional settings to Queensland population data by age and sex, the total estimated annual prevalence of child abuse in institutional settings in Queensland is approximately 12,148 cases per year.

It is important to emphasise again that this estimate was produced strictly for the purposes of providing an approximate Queensland baseline rate that could be used to analyse the impacts of the options for reform and is not intended to provide a true picture of institutional abuse in Queensland. Given the limited available data, this estimate should be taken as only a **rough approximation** of what the true prevalence might be. We know abuse is under-reported and that it can take many years for people with lived experience to disclose it, so it is likely we are under-estimating the rate of institutional abuse.

#### Impacts of child abuse

Experiences of child abuse, including poor institutional responses, have profound, lasting adverse impacts on people who experience it, as well as their networks, communities and broader society.

The impacts of institutional child abuse are devastating and can affect a person’s life in many ways including their: mental health; interpersonal relationships; physical health; sexual identity and behaviour; connection to culture; spirituality and religious involvement; and interactions with society.[[30]](#footnote-31) For Aboriginal and Torres Strait Islander peoples, these impacts are exacerbated by the ongoing impacts of dispossession and colonisation.

Childhood trauma can also negatively affect a person’s education, social participation, economic security, ability to secure and maintain employment and housing, and these impacts can be intergenerational.[[31]](#footnote-32)

The way an institution responds to abuse can contribute to the trauma for the person who experienced it. Inappropriate or inadequate responses by an institution can increase the harm experienced by the person subjected to the abuse, and also increase the risk and harm faced by their peers, i.e. other children. People who experience abuse and their families can feel betrayed by the organisations they trusted, resulting in an understandable fear and distrust of, and contempt for, organisations more broadly. This can be compounded when the institution is closely tied to the person’s communal and familial identity (e.g. church or sports clubs). In contrast, prompt and effective responses by organisations have helped keep children safe and promoted healing and a sense of justice for those who experienced abuse.[[32]](#footnote-33) Appropriate responses are those that are responsive, compassionate, transparent, and hold organisations accountable.[[33]](#footnote-34)

While people with lived experience of child abuse and their families are at the heart of our attention to this issue (and we acknowledge they experience the heaviest effects), it is important to also examine the ripple effects this abuse has on wider society. The Royal Commission heard from family members, including children, partners and siblings, about the tragic impacts child sexual abuse had on their loved one’s lives, and the complex and profound ways the abuse continued to adversely impact their own lives.

The Royal Commission found the estimated cumulative economic impact of child sexual abuse on wider society runs into the billions, with direct and indirect effects on social, cultural, public health and economic participation outcomes. The most significant costs to society relate to government expenditure on healthcare, increased need for government support and services, child protection, and crime.[[34]](#footnote-35)

**Annual prevalence vs annual incidence**

***Annual incidence***, the measure used by McCarthy et al., refers to the total number of children who experienced mistreatment **for the first time** in that year.

***Annual prevalence***, the measure used in this analysis, refers to the total number of children who experienced mistreatment in that year, including children who may be experiencing ongoing abuse over a period of years.

Annual prevalence will usually be a larger number than annual incidence – using annual prevalence aligns with the objectives of government intervention stated in Part 2, to improve safety and wellbeing for all children.

The limited data available supports the Royal Commission’s findings about the level of impact child harm has on health and wellbeing throughout people’s lives. The Australian Institute of Health and Welfare’s *Burden of Disease* study (2018) indicated that 2.2% of the total disease burden in Australia can be attributed to child abuse and neglect, and child abuse and neglect is the leading contributor to disease burden for Australians aged 15–44 years.[[35]](#footnote-36)

McCarthy et al. (2016) estimated the total financial cost of child maltreatment in Australia.[[36]](#footnote-37) Broadly, these are the costs that individuals, government and societies incur as a result of child maltreatment. The paper also produces an estimated non-financial cost, factoring in impacts such as loss of quality of life and reduced lifespan related to mental health and self-harm and premature mortality as a direct result of maltreatment (these are the costs incurred by individuals).

The total financial cost was estimated to be $214,545 per incident of child maltreatment, and a total non-financial cost of $399,764 per incident of child maltreatment, adjusted for inflation to December 2022 dollars.[[37]](#footnote-38),[[38]](#footnote-39) It is noted this estimate is based on incidence rather than annual prevalence, and it is reasonable to assume there would be a difference in the experience and impact on a child experiencing ongoing maltreatment over a period of years (which is not included in incidence) as opposed to maltreatment occurring for the first time in a given year.

In the absence of more recent and relevant data, McCarthy et al. provides a best-estimate of the cost for each case of child maltreatment for the purpose of determining the impact of child maltreatment at a population-level for Queensland. The lifetime cost figure is an average and should not be considered an accurate indicator of the impact of maltreatment on any one child, young person or person with lived experience of childhood maltreatment.

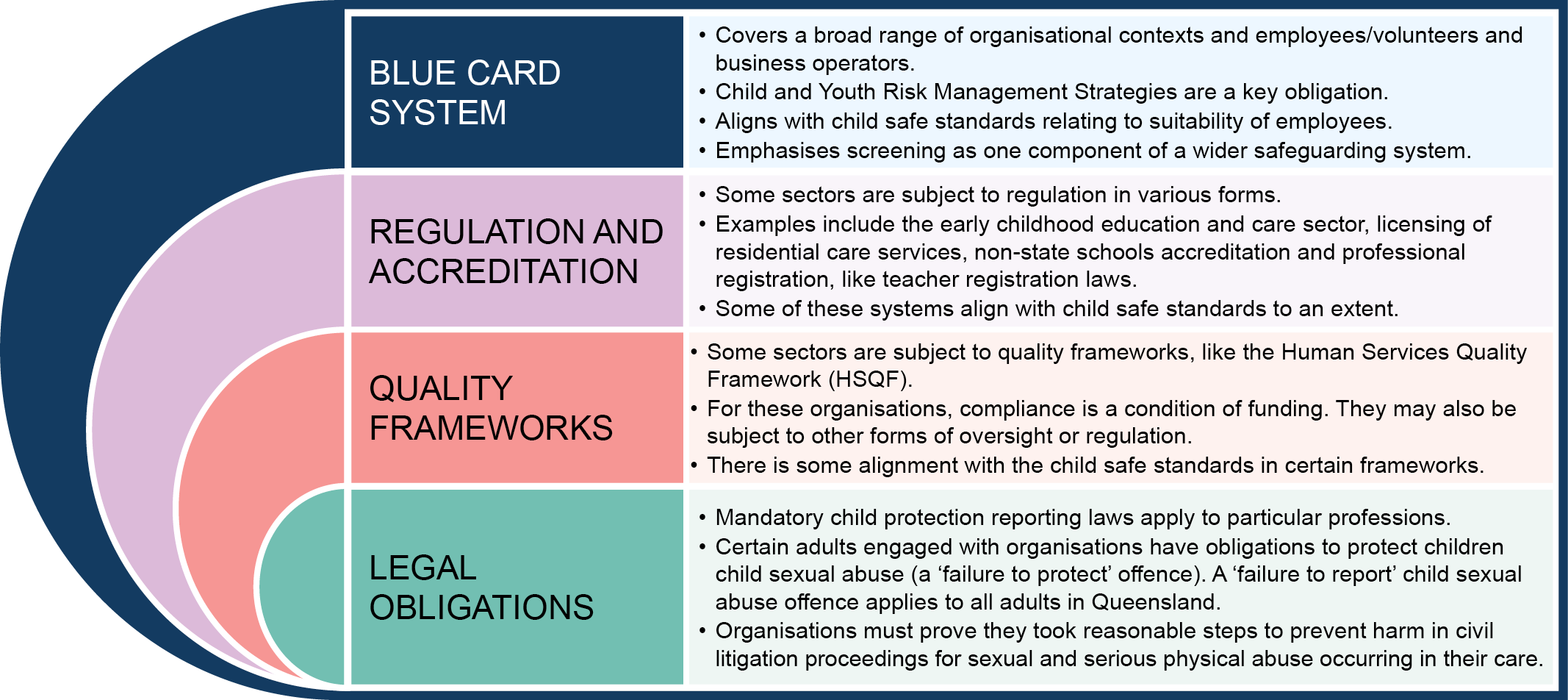
Applying the estimated number of annual cases of child maltreatment in Queensland organisations (approximately 12,148), it is estimated this is associated with annual financial costs totalling $2.61 billion and non-financial costs totalling $4.85 billion. The degree of harm that occurs in cases of institutional child abuse will be influenced by factors such as the seriousness of the abuse, the frequency of the abuse, how the organisation responds to the incident and whether further abuse is prevented due to earlier detection.

Evidence from the Royal Commission and other research also outlines the detrimental effects of abuse on communities and organisations, including loss of social cohesion and trust in community institutions that could potentially otherwise play a major role in people’s lives.[[39]](#footnote-40) Other potential impacts of child sexual abuse on organisations include adverse impacts on staff, loss of reputation, increased insurance costs (or the inability to obtain insurance), and the potentially significant costs of paying claims for redress and/or compensation.

### Existing systems for keeping children safe in organisations and where we can improve

The regulatory landscape in Queensland that covers organisations working with children is complex (see Figure 5). Organisations that work with children are subject to the following general child safety regulation, in addition to some sector-specific regulation.

**Figure 5 Overview of existing child safe requirements and regulation in Queensland**



We recognise most people working in organisations provide high quality and safe services to children. However, the nature of child abuse is such that organisations can lack the necessary knowledge and skills that assist in preventing, identifying, and responding appropriately to child abuse. The Royal Commission identified a need for improved awareness of child abuse and situational risk in organisations, and how to appropriately respond, at an individual, organisational and community level.

#### Working with children check – blue card system

Queensland’s Working with Children Check (WWCC) – the blue card system – regulates child-related services in Queensland under the *Working with Children (Risk Management and Screening) Act 2000* (WWC Act) and the *Working with Children (Risk Management and Screening) Regulation 2011*. The blue card system comprises employment screening, ongoing monitoring and a requirement for all regulated organisations to develop, implement and annually review a framework of child-safe policies and procedures referred to as a Risk Management Strategy. It applies to 16 categories of regulated employment and 12 categories of regulated business (see **Appendix F**). Whether an individual requires a blue card is determined by factors such as the environment in which the work is performed, the type of work and frequency of work.

Blue card screening assesses a person’s eligibility to work with children based on the welfare and best interests of a child being paramount, and that every child is entitled to be cared for in a way that protects the child from harm and promotes the child’s wellbeing. An assessment is informed by a range of information including a charge or conviction for any offence in Australia, disciplinary information from certain organisations, domestic violence information, adverse decisions about the person made by another working with children agency in Australia and any other information about the person that is relevant to deciding whether it would be in the best interests of children to issue a blue card (for example, child protection information). The strength of the WWCC scheme relies in part on information from other regulators and professional bodies.

#### Disability worker screening checks

In addition to a blue card, a person may also require a National Disability Insurance Scheme (NDIS) or State disability worker screening check under the *Disability Services Act 2006* (Qld) to be engaged to carry out disability work with children with disability. The disability worker screening system is a nationally consistent system that includes screening of criminal history, disciplinary and other assessable information relevant to whether a person poses an unacceptable risk of harm to people with disability, ongoing criminal history monitoring, and nationally portable clearances and exclusions. Disability worker screening only applies to people who are engaged by a NDIS registered provider in a risk assessed role, or a state-funded provider delivering disability supports or services – workers from unregistered providers do not require disability worker screening.

#### Failure to report and failure to protect offences

In 2021, amendments to the Criminal Code in Queensland introduced new offences of failure to report (that requires any adult to report child sexual abuse to police) and failure to protect (that applies to failing to protect a child from sexual abuse in an institutional context). Under section 229BC of the *Criminal Code Act 1899*, it is a criminal offence when any adult in Queensland fails to report to the Queensland Police Service a reasonable belief that a child sexual offence is being, or has been, committed against a child by another adult.[[40]](#footnote-41) The failure to protect offence applies if you are 18 or older and associated with an institution that has children in its care, supervision or control, and you:

* know there is a significant risk that another adult also associated with the institution (or who is a regulated volunteer) will commit a sexual offence against a child or children;
* have the power or responsibility to reduce or remove the risk;
* wilfully or negligently fail to reduce or remove the risk.[[41]](#footnote-42)

#### Public Sector Code of Conduct/Crime and Corruption Commission (CCC)

Public sector employees are also subject to a code of conduct, and suspected corrupt conduct can be reported to the Crime and Corruption Commission (CCC). The CCC may carry out a corruption investigation to determine whether disciplinary action or criminal action should be taken. While some child-related abuse or misconduct may be captured under the definition of ‘corrupt conduct’ (which may also be captured as reportable conduct under an RCS), corruption usually involves behaviours such as fraud, theft or unauthorised access to confidential information. Further, while the CCC has a broad corruption jurisdiction, its focus is on more serious cases of corrupt conduct and cases of systemic corrupt conduct within units of public administration.

#### Human Services Quality Framework (HSQF)

The HSQF provides a framework for assessing and improving the quality of human services. It applies to organisations funded to deliver human services under service agreements/other arrangements with certain Queensland Government departments including the Department of Child Safety, Seniors and Disability Services (DCSSDS), Department of Housing, Department of Justice and Attorney-General (DJAG), Department of Treaty, Aboriginal and Torres Strait Islander Partnerships, Communities and the Arts and Queensland Health.

#### Mandatory reporting

Some professionals that work with children have a legal responsibility to report to Child Safety where they form a reasonable suspicion that a child has suffered or is at an unacceptable risk of suffering significant harm caused by physical or sexual abuse and may not have a parent able and willing to protect the child from harm (under the *Child Protection Act 1999* (Qld)). Child Safety’s role is primarily focused on abuse within family settings.

In education settings, under the [*Education (General Provisions) Act 2006*](https://www.legislation.qld.gov.au/view/html/inforce/current/act-2006-039) (Qld) school staff members must immediately report to the principal or principal’s supervisor when they become aware of or reasonably suspect, in the course of their employment, the sexual abuse or likely sexual abuse of a student under 18 years. The principal or principal’s supervisor must immediately give a copy of the report to the Queensland Police Service.

Teacher registration is regulated under the *Education (Queensland College of Teachers) Act 2005* (Qld)*.* This Act requires the employing authority to notify the Queensland College of Teachers (QCT) when it starts to deal with an allegation of harm caused, or likely to be caused, to a child because of the conduct of a relevant teacher at the prescribed school. Note the teacher registration laws exempt teachers from also needing a blue card. Early childhood providers are not a ‘prescribed school’ under this Act and are not legally required to report allegations of child harm against a registered early childhood teacher to the QCT.

While mandatory reporting aims to ensure the protection of individual children, it does not trigger any oversight of the way an organisation has handled a complaint of child abuse that occurred within the organisation.

#### Other systems

Other regulatory mechanisms supporting the safety of children in organisations include accreditation and licencing systems (e.g. non-state schools accreditation and licencing of care services), quality frameworks and compliance requirements in funding agreements.

Some sectors that work with children are subject to minimal regulation, with limited or no independent oversight of child safe practices, such as transport and commercial services or sporting and recreation clubs. While many government and non-government entities have complaint-handling processes, which in some cases are overseen by independent bodies or sector regulators, there is no uniform quality standard for child safe practices and no central, independent oversight of complaints of child abuse in organisations that can look across sectors to identify and respond to patterns of concerning behaviour.

The existing regulatory framework provides inconsistent coverage of sectors that engage in child-related work, with each targeting specific aspects of organisations’ functions, employees and conduct. Despite these various protections, the Royal Commission found that harm still occurs to children in these settings and identified a lack of consistent oversight of child safety across sectors. The Royal Commission recommended models of regulation to comprehensively cover these sectors, while also flexibly targeting risk. Table 6 provides a high-level summary of existing regulation in Queensland as it intersects with child-related work across different sectors. For further detail, please see **Appendix C**.

Table 6 High level overview of existing Queensland regulatory environment for child-related work

| **Sector** (see Table 13 for further detail on sectors) | **Working with children check** | **Child and youth risk management strategy** | **Human Services Quality Framework** | **Public Sector Code of Conduct[[42]](#footnote-43)/ Crime and Corruption Commission[[43]](#footnote-44)** | **Failure to protect and report offences[[44]](#footnote-45)** | **Regulators and oversight bodies** |
| --- | --- | --- | --- | --- | --- | --- |
| **Accommodation and residential services** | ✓  *Applies to child accommodation service including homestays* | ✓ | ✓  *Specialist homelessness services only (largely via self-assessment)* | ✓  *Public sector social housing* | ✓ | * Department of Housing * National Regulatory System for Community Housing regulates community housing providers * Department of Justice and Attorney-General |
| **Child protection** | ✓  *Does not apply to provisionally approved carers[[45]](#footnote-46)* | ✓ | ✓ | ✓ | ✓ | * Department of Child Safety, Seniors and Disability Services * Queensland Family and Child Commission * Office of the Public Guardian * Queensland Ombudsman |
| **Disability services** | ✓  *Does not apply to certain consumers, volunteer relatives, secondary school students on work experience under direct supervision of a person who holds a blue card* | ✓ | ✓  *State-funded services* | ✓ | ✓ | * Department of Child Safety, Seniors and Disability Services * National Disability Insurance Scheme including NDIS Quality and Safeguards Commission (NDIS worker screening clearance or State disability worker screening clearance) |
| **State schools** | ✓  *Applies to boarding schools and employees other than teachers and volunteer parents* | ✓ | ✗ | ✓ | ✓ | * Queensland College of Teachers *(teachers only)* * Department of Education |
| **Non-state schools** | ✓  *Applies to boarding schools and employees other than teachers and volunteer parents* | ✓ | ✗ | ✗ | ✓ | * Queensland College of Teachers *(teachers only)* * Non-state Schools Accreditation Board |
| **Student exchange programs** | ✓  *Applies to homestays* | ✓ | ✗ | ✗  *State schools only* | ✓ | * Queensland Registration Authority |
| **VET and courses for overseas students** | ✗ | ✗ | ✗ | ✓  *University and TAFE employees* | ✓ | * Australian Skills Quality Authority * Queensland Training Ombudsman |
| **Childcare services** | ✓  *Applies to babysitting, nannying and other similar services* | ✓ | ✗ | ✗ | ✓ | * Department of Education, (Regulatory Authority – Early Childhood Education and Care) * Australian Children’s Education and Care Quality Authority |
| **Health services** | ✓  *Does not apply to registered health practitioners working in their professional capacity* | ✓ | ✓ | ✓ | ✓ | * Hospital and Health Services (public health) * Office of the Health Ombudsman * Australian Health Practitioner Regulation Agency * Australian Commission on Safety and Quality in Health Care * National Boards for the health professions |
| **Justice and detention** | ✓  *Applies to youth detention workers* | ✓  *Youth detention* | ✗ | ✓ | ✓ | * Department of Youth Justice, Employment, Small Business and Training * Office of the Public Guardian * Queensland Ombudsman * Inspector of Detention Services * Queensland Police Service * Queensland Family and Child Commission * Queensland Human Rights Commission |
| **Religious organisations** | ✓  *Does not apply to parent volunteers* | ✓ | ✗ | ✗ | ✓ | Some faith-based frameworks and oversight, for example:   * Australian Catholic Safeguarding/Professional Standards Office * Anglican Church of Southern Queensland – Central Diocesan offices |
| **Sport and recreation\*[[46]](#footnote-47)** | ✓  *Does not apply to parent volunteers* | ✓ | ✗ | ✓  *Department of Tourism, Innovation and Sport and Queensland Academy of Sport* | ✓ | * Sport Integrity Australia * State and National Level Sport and Active Recreation Organisations |
| **Private teaching, coaching\*\* or tutoring\*** | ✓  *Does not apply if employer is education provider* | ✓ | ✗ | ✗ | ✓ |  |
| **Transport services for children\*** | ✓  *Only applies for school crossing supervisors* | ✓  *Only for school crossing supervisors* | ✗ | ✗ | ✓ | * Department of Transport and Main Roads |
| **Commercial services for children, including entertainment or party services, gym or play facilities, photography services, and talent or beauty competitions\*** | ✓  *Applies to businesses providing childcare on commercial basis (e.g. gym that operates a child-minding service or hotel kid’s club). May also apply where these commercial services are offered as part of a church, club or association involving children* | ✗ | ✗ | ✗ | ✓ |  |

\*Note: These sectors were not recommended by the Royal Commission as part of the minimum scope of an RCS.

\*\*Coaching refers to organisations that provide instruction in a particular activity and are not already covered by clubs and associations category, such as tutoring, driving schools, private/personal athletic training.

The issue of child maltreatment in Queensland organisations is highly complex with a vast and interconnected scope of sectors, organisations, existing regulation and risk factors that frame the current environment for children accessing different services and facilities. As mentioned above, while broad estimates of the prevalence of child maltreatment in Queensland are possible, there is no reliable, contemporary data on child maltreatment in Queensland organisations. Key drivers of institutional child maltreatment, such as risk factors, and sector and market conditions are constantly changing over time, and major socio-economic events such as COVID-19 can have significant, unpredictable impacts on society and the safety and wellbeing of children at home and in organisations.

Accordingly, government action to address the issue of child maltreatment must avoid prescriptive approaches that do not account for the individual needs, capabilities and risks of different organisations. Responses must be flexible and adaptable to ensure all organisations providing care and services to children do so in a way that prioritises the safety and wellbeing of children while acknowledging the specific regulatory framework in which each organisation operates, and the individual institutional, operational and environmental risk factors they might experience.

### What we heard from young people

At the heart of the policy options assessed in this DIAS, and the ultimate objective of the final recommendation, is the wellbeing and safety of Queensland’s children and young people as they engage with organisations across the state.

In recognition of this, throughout the consultation period we met and spoke directly with several groups of young people with a broad range of backgrounds and experiences. More detail on consultation activities can be found in Part 5.

Through these discussions, we heard many perspectives about what it means to be safe in an organisation and what more needs to be done. Common themes from our conversations include:

* Some organisations feel less safe than others, and some do not feel safe at all for some young people. Young people told us that children are very aware of authority figures in organisations and how their behaviour flows through to how children experience organisations. Young people said that attitudes that children should be ‘seen and not heard’ are still present today and these messages stop children speaking up or disclosing harm.
* Young people thought in some communities there is a lack of awareness about how children and young people might feel in organisations. Young people said parents may not want to think about their children not feeling safe in organisations, and that most people are not even aware that organisations have responsibilities to be child safe.
* Young people strongly supported laws that require organisations to be child safe. Young people said that organisations, and their workers, need the right support and training to be safe and develop positive relationships with children and young people. They agreed that organisations might need time to become child safe, but after that period, they should face clear consequences if they are not safe.
* Young people said organisations should be transparent and accountable in how they deliver services and interact with children and young people. Young people told us that developing a trusting relationship takes time and the best relationships are those where workers listen to them, understand them as individuals, and know them well enough to understand what they are saying, even when they might struggle to share their feelings. Some young people said they also want to be encouraged to reach their goals.
* When we talked with Aboriginal and Torres Strait Islander young people, they told us that for them cultural safety means cultural understanding. They said they are more likely to share their concerns and feelings with Aboriginal and Torres Strait Islander people and were very positive about mentors and mentoring programs that they and their friends had experienced.
* Young people told us they know when someone is ‘just doing their job’ and they want workers to be genuine and engaged. They want organisations to prioritise them and their feelings and needs in a meaningful way, rather than go through the motions of ticking boxes.

## PART 2 – Objectives of government action

As highlighted in Part 1, children can experience abuse and neglect in contemporary organisations and more can be done to protect children and young people from harm. The ultimate goal of government action is to prevent maltreatment from occurring, and where it does occur, reduce the associated harm and trauma.

In exploring the objectives for policy addressing this problem, the Queensland Government considered:

* the Royal Commission’s findings about the need for enhanced **prevention**, **detection**, and **responses** to institutional abuse and its vision to create widespread cultural change, where organisations prioritise the safety and wellbeing of children, supported by well-informed communities;
* the nature of risks and benefits to children in organisational settings;
* the impacts of child abuse across an individual’s life and across generations;
* Queensland’s progress on implementing Royal Commission recommendations and other reforms that have contributed to improved safety of children; and
* the existing regulatory and quality frameworks that apply to organisations working with children in Queensland.

The Royal Commission emphasised the importance of leadership and organisational culture, recommending systems that are intended to drive widespread change. It also commented on organisations with limited resources or volunteer-based workforces, highlighting the need for flexibility in implementing child safe practices.

The policies that seek to achieve this objective must work with our existing laws, systems and processes that help keep children safe, to create a framework that will support leadership and organisational cultures that help protect children, and where situational risks of child abuse are minimised. This includes risks posed by employees who may target organisations that provide services to children and try to avoid detection by moving between sectors and jurisdictions. The following two primary objectives were developed to capture the key intent of the options we developed, supported by sub-objectives that contribute to one or more of the primary objectives (Table 7):

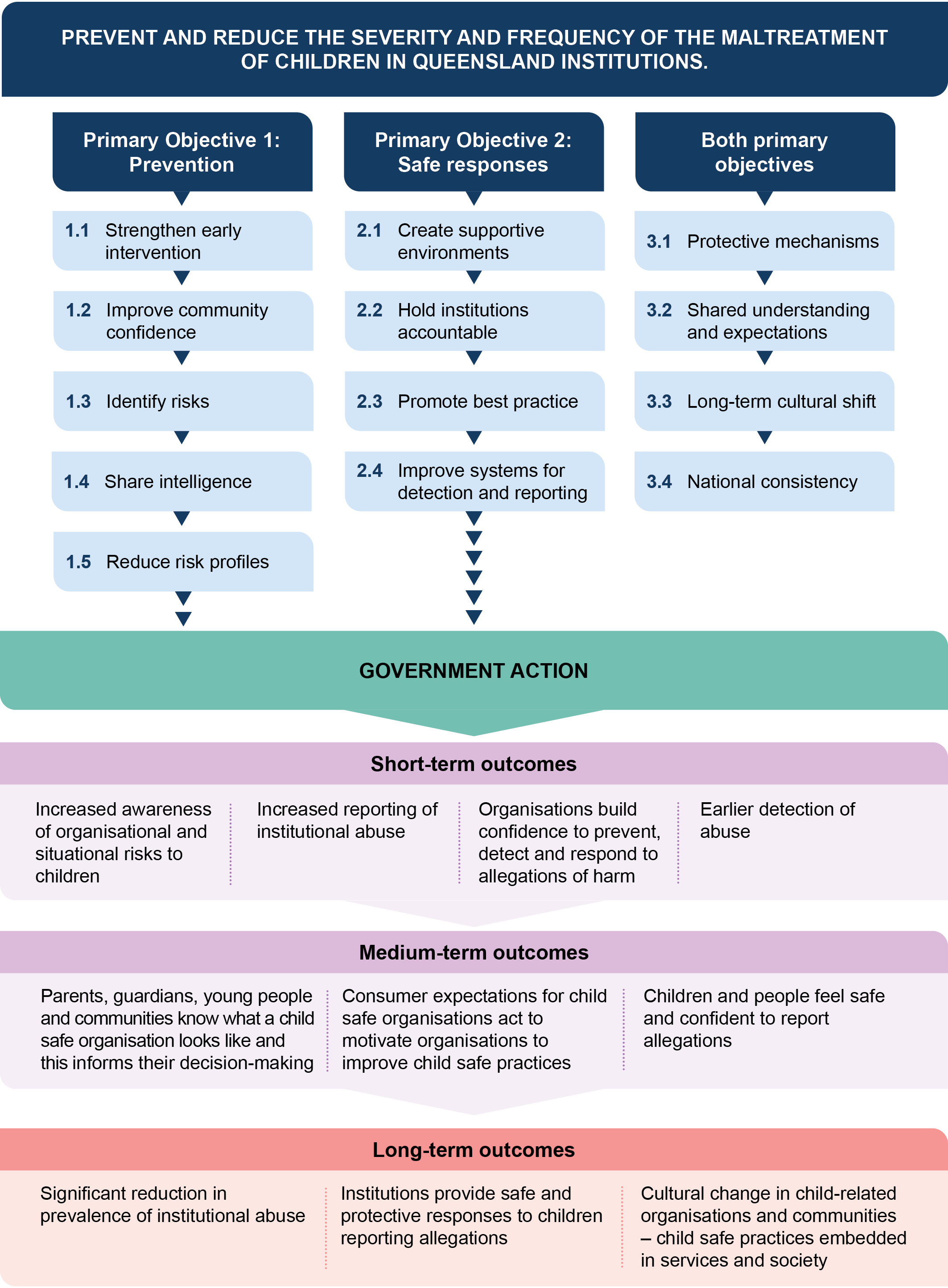
Table 7 Goal and objectives of government action

|  |  |
| --- | --- |
| **Goal: Prevent and reduce the severity and frequency of maltreatment of children  in Queensland organisations** | |
| *Primary Objective 1:* Prevention – Improve the safety and wellbeing of children receiving services and/or care in Queensland organisations | *Primary Objective 2:* Safe responses – Ensure children who are at risk of experiencing abuse or have experienced abuse in institutional settings are supported early, in a trauma-informed, appropriate way |
| * 1. Strengthen early intervention and prevention practices and frameworks to reduce prevalence of child maltreatment in Queensland organisations.   2. Improve community awareness and knowledge of what constitutes a safe organisation for children, motivating organisations to improve child safe practices.   3. Identify risks posed by organisational practices and individual employees, including concerning behaviour that might not meet the threshold for criminal conviction or is outside the scope of the child protection system.   4. Gather, monitor and share intelligence about risks posed by employees across sectors and jurisdictions, to reduce risks posed by predatory individuals who may otherwise avoid detection by moving around.   5. Reduce the risk profile of organisations that engage in child-related work, which may also reduce liabilities associated with civil litigation claims for both government and non-government entities. | * 1. Create environments and systems where people, including children and their families and staff and members of organisations, are supported to raise concerns and complaints and are taken seriously.   2. Ensure organisations are accountable and transparent in responding to complaints and allegations of abuse.   3. Promote best practice among organisations that provide services to children in responding to complaints of child abuse or child-related misconduct.   4. Improve systems for the detection and reporting of child maltreatment in Queensland’s organisations to an external independent body, with the ability to use this data to target prevention efforts. |
| (3) Contributing to both primary objectives | |
| * 1. Strengthen protective mechanisms that can help minimise harm to children that may occur in other settings (e.g. in the home) by creating safe spaces for children.   2. Develop a shared understanding and expectation of what it means to be a child safe organisation.   3. Drive long-term cultural change in organisations to ensure the safety of children is a shared responsibility and prioritised above organisational and individual reputations.   4. Contribute to national consistency to reduce gaps in child safety across jurisdictions and create consistent obligations for organisations that operate nationally. | |

### How do we expect these outcomes to be achieved?

Organisations will be required and supported to ensure their responses to reported child abuse are child-centred, prompt, accountable and transparent. Through better prevention of, and response to, institutional abuse, organisations will be better positioned to provide safe and responsive care and support to children. This will improve outcomes for children and young people both in institutional settings and at home with their families and communities by raising awareness and understanding of safety and wellbeing and ensuring that children have access to adults they can trust and to whom they can report harm. The program logic on the following page explains how objectives will guide government action and in turn drive the outcomes hoped to occur over different periods of time.

### Program logic



##### What we asked:

1. To what extent do you agree that action is needed to improve the safety of children in organisational settings in Queensland?
2. Do you broadly support the Queensland Government implementing the Royal Commission recommendations for the CSS and RCS?

### Consultation results – objectives

We heard strong support for taking action to improve the safety of children in organisational settings and implementing the Royal Commission’s CSS and RCS recommendations. Some submissions noted that existing arrangements in Queensland to safeguard children are complex and overlapping, and expressed support for a Queensland model that minimises duplication as much as possible.

Overwhelmingly, submissions shared the views that: the ongoing risks to safety and wellbeing experienced by children and young people in Queensland organisations must be addressed; the safety and wellbeing of children in organisations is the responsibility of every organisation; and reducing the incidence of child maltreatment must be at the centre of government’s reform goals.

## PART 3 – Options for child safe organisations regulation

The development of options for child safe organisations regulation in Queensland was guided by:

* Royal Commission recommendations and commentary (pages 42 to 44);
* approaches taken in other jurisdictions (pages 44-45 and **Appendix B**); and
* feedback received from stakeholders in our 2021 targeted consultation (Figure 7).

These sources informed the development of our design principles for a Queensland child safe organisations system. We heard during consultation on the CRIS that the design principles should be explicitly underpinned by a commitment to respect, protect and fulfill human rights. In response to this feedback, we have included a stronger emphasis on human rights in our design principles (Figure 6). We will continue to refer to our design principles as we develop legislation and plan for implementation of a child safe organisations system in Queensland.



## Figure 6: Our design principles for a Queensland child safe organisations system

The proposed options for how a child safe organisations system could be established in Queensland were designed around the following design principles:

* prioritising the safety and wellbeing of children and young people;
* a commitment to respect, protect and fulfill human rights;
* flexible and suitable for a wide range of organisations, and scalable and responsive to risk levels across varied physical and online environments;
* appropriate to the Queensland context and the needs of people with different economic, family, cultural, educational and health experiences;
* culturally safe;
* outlines clear objectives to promote understanding, certainty, and support implementation;
* recognises best practice and supports capacity building, promotes evidence-based methods;
* considerate of regulatory and cost impacts on organisations, avoids duplication, and contributes to national consistency;
* focuses on educating and guiding entities to improve their ability to prevent, identify and investigate reportable allegations;
* works collaboratively with regulators and recognises their knowledge and roles, including sharing information in relation to investigations; and
* promotes accountability, transparency, and procedural fairness while upholding individual privacy and confidentiality and protections for reporters.

### The Royal Commission’s recommendations – Child safe standards and reportable conduct scheme

Through over 8,000 private sessions with people with lived experience of institutional child sexual abuse and extensive commissioned research and consultations, the Royal Commission made 409 recommendations, the majority of which were directed towards state and territory governments. These comprise measures designed to work together to prevent, identify and respond to child sexual abuse, and strengthen the safety of children in organisations.

While its terms of reference were confined to institutional sexual abuse, the Royal Commission’s findings are relevant to improving prevention of and responses to all forms of harm to children in organisations and echo the findings of other inquiries which examined broader forms of institutional harms to children.

#### The Royal Commission – child safe standards

Throughout its inquiry, the Royal Commission examined what makes organisations safer for children. It found that organisational leadership and culture are crucial in growing safer environments. It identified that the majority of institutional child sexual abuse is opportunistic and can be minimised by addressing situational risks. The Royal Commission recommended states and territories legislatively require organisations engaged in child-related work (that is, organisations that have frequent or more than incidental contact with children and/or a degree of responsibility for children’s supervision and care) to comply with 10 CSS to create child safe organisations. The CSS have been adopted by various governments and organisations throughout Australia as the baseline approach to child safety and wellbeing in organisations (see further below, ‘Jurisdictional Comparison’ and **Appendix B**).

The 10 CSS (**Appendix D**), as set out in recommendations 6.5 and 6.6[[47]](#footnote-48) (Final Report) provide a flexible, outcomes-based framework for how to create a child safe organisation. CSS elements include promoting children’s voices, securing physical and online safety, ensuring reporting obligations are met, and ensuring appropriate responses to concerns. CSS are aimed at bringing about organisational cultural change to ensure the key priority is the safety and wellbeing of children and young people. The CSS are intended to apply to a broad range of sectors working with children in institutional settings, including schools, early learning and childcare, arts, sports and recreation, youth detention, child protection settings, transport and commercial services.

The Royal Commission made the following comment about the definition of a child safe institution:

‘We have adopted a definition of a child safe institution as one that consciously and systematically creates conditions that reduce the likelihood of harm to children, creates conditions that increase the likelihood of identifying and reporting harm, and responds appropriately to disclosures, allegations or suspicions of harm.’[[48]](#footnote-49)

The Royal Commission provided substantial commentary about the way states and territories should regulate to support implementation of CSS in a way that maximises the safety and wellbeing of children while minimising regulatory burden. CSS responses should be proportionate to an organisation’s risk and leverage existing regulatory systems wherever possible. The Royal Commission intended that the CSS be flexibly applied, to minimise regulatory burden in heavily regulated sectors, as well as sectors reliant on volunteer workforces. These considerations informed the development of the proposed options for a Queensland child safe organisations system.

#### The Royal Commission – reportable conduct scheme

The Royal Commission found systemic failings of organisations to properly deal with the conduct of their employees/volunteers where allegations of child abuse were not being properly investigated, and children not being protected. This occurred regardless of whether the organisations and associated adults were obliged to report, and where cultures of secrecy and organisational reputation were prioritised above the safety of children.

The Royal Commission concluded that independent oversight is important in addressing the way institutions handle complaints about child sexual abuse. It recommended, as articulated in recommendations 7.9 - 7.12,[[49]](#footnote-50) that states and territories establish nationally consistent reportable conduct schemes (RCS), similar to the NSW model, requiring heads of organisations to notify an oversight body of any reportable allegation, conduct or conviction involving any of the institution’s employees/volunteers. An RCS provides independent oversight of institutional responses to allegations of misconduct or abuse involving children as well as a central, cross-sectoral database to identify risks posed by individuals working with children. It identifies systemic risks in organisations and sectors and supports organisations to respond appropriately to risks, misconduct and abuse. An RCS can provide valuable information about institutional child safety and changes and trends that occur over time.

#### Queensland Government response to the Royal Commission child safe standards and reportable conduct scheme recommendations

In 2016, the former Council of Australian Governments (COAG) agreed in-principle to harmonise RCSs across jurisdictions, consistent with the NSW model. In 2019, COAG also endorsed the National Principles for Child Safe Organisations (National Principles), which incorporate the Royal Commission’s 10 CSS.

In its response to the Royal Commission’s Final Report in June 2018, the Queensland Government accepted, or accepted in principle, the majority of the CSS and RCS recommendations, with two remaining recommendations requiring further consideration (recommendations 6.8 and 6.12 relating to mandating compliance with the CSS and establishing CSS support in local governments).[[50]](#footnote-51) Both of these recommendations have now been accepted in principle by the Queensland Government.

A [media release](https://statements.qld.gov.au/statements/84777) on 15 June 2018 by the Premier and then Minister for Child Safety, Youth and Women and Minister for the Prevention of Domestic and Family Violence, highlighted the commitment to introduce an RCS. In 2018, the Queensland Government directed that all Queensland Government agencies that provide services to children adopt the CSS as best practice. As a result, relevant Queensland Government agencies have been working to embed the CSS and National Principles in all levels of organisational leadership, governance, and culture.

The CSS and consideration of a Queensland RCS form part of a broader suite of reforms the Queensland Government has progressively implemented since the release of the Royal Commission’s final report in 2017. This includes changes to the civil and criminal justice systems to improve access to justice for survivors, enhance institutional accountability, and strengthen protections for children and young people in organisations. The CSS and RCS are intended to work alongside these and other reforms to improve the prevention and detection of, and organisational responses to, child abuse.

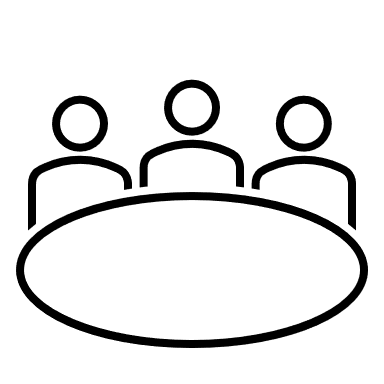
#### Jurisdictional comparison

States and territories are each at different stages of implementing the CSS and RCS. Each jurisdiction has tailored their approach to complement their existing regulatory environments. In developing options for Queensland, we considered other jurisdictions’ experiences to incorporate lessons learned and maximise opportunities for national consistency where appropriate. We thought that national consistency may also result in savings or cost efficiencies for interstate organisations subject to more than one CSS and/or RCS scheme, and this was confirmed through consultation. Table 8 provides a jurisdictional comparison, with greater detail in **Appendix B**.

Table 8 Interjurisdictional implementation of CSS and RCS[[51]](#footnote-52)

|  |  |  |
| --- | --- | --- |
| **State or territory** | **Child safe standards** | **Reportable conduct scheme** |
| New South Wales | ✓ | ✓ |
| Victoria | ✓ | ✓ |
| Australian Capital Territory | *Under development* | ✓ |
| Western Australia | *Under development* | ✓ |
| Tasmania | ✓ *from 2024* | ✓ *from 2024* |
| South Australia | ✓ | ✗ |
| Northern Territory | ✗ | ✗ |

### Results of 2021 consultation with stakeholders

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## Figure 7: What we heard from stakeholders in 2021

The options we developed for how CSS could operate in Queensland were informed by what we heard from stakeholders in targeted consultations in 2021. Key findings included:

* There was strong support for implementing the CSS in a way that promotes national consistency.
* There was considerable support for Queensland’s standards to address human rights obligations and cultural safety for Aboriginal and Torres Strait Islander children.
* There was strong support for a:
  + regulatory system that mandates compliance;
  + staged approach to implementation, with an initial focus on awareness raising and capacity building before regulation and oversight; and
  + responsive, risk-based approach to regulation.
* In terms of a regulatory approach to CSS, there was considerable support for:
  + a co-regulatory approach that minimises duplication and regulatory burden; and
  + a supportive, rather than punitive, approach to promoting compliance.
* Stakeholders also strongly supported ensuring the scope of organisations covered under the scheme includes at least all sectors recommended by the Royal Commission.
* In terms of how ready stakeholders felt for implementing the CSS:
  + 84% felt somewhat or very prepared to implement CSS; and
  + 88% would be able to implement CSS within two years.

#### Snapshot comparison of 2021 and 2023 consultations

The results from our 2023 consultation strongly align with what we heard in 2021. In summary, there remains strong support in Queensland for:

* nationally consistent CSS where the standards address human rights and cultural safety for Aboriginal and Torres Strait Islander children and young people;
* a legislative framework that mandates compliance;
* a broad scope which includes at least all the sectors recommended by the Royal Commission; and
* regulatory responses that focus on capacity building with enforcement powers used as a last resort.

Most organisations also said they would be ready to implement CSS within 12 months.

The most significant point of difference between 2021 and 2023 consultations is that our consultation on the CRIS has revealed more support for collaborative regulation than a co-regulatory approach. In part, this may be because the 2023 CRIS offered stakeholders more information about what collaborative regulation and co-regulation may look like in a Queensland system. More details about our 2023 consultation results are found throughout this document, and more information about our recommended approach to regulation is on pages 109-112.

### Summary of options developed to implement child safe standards in Queensland

Informed by the design principles (Figure 6), we developed a number of ways the CSS can be put into action in Queensland to help organisations better prevent, detect, and respond to child abuse and prioritise the safety and wellbeing of children in their care. We sought feedback on three options for CSS in Queensland as well as our impact analysis of each option (Part 4) through the CRIS consultation process.

The three options we presented in the CRIS are:

|  |  |
| --- | --- |
| **Options** | **Description** |
| Option 1 | No action and maintain the status quo. |
| Option 2 | Establish a non-regulatory model for CSS implementation, without legislation and with more limited application. |
| Option 3 | Implement a regulatory model requiring organisations in scope to comply with CSS, which could be:   1. collaborative regulatory model; or 2. co-regulatory model with multiple government entities and departments having oversight and regulatory responsibilities. |

Our models for how the CSS could work in Queensland considered the following key features:

* **Mode of regulation:**  
  should the CSS be mandatory for organisations in Queensland? Should an entity, or multiple entities, be responsible for overseeing and enforcing the CSS (should there be a CSS oversight body)? How should a CSS oversight body work with other regulators, government bodies and the non-government sector?
* **Capacity building approaches:**  
  how do we build the capability of organisations to become child safe and implement the CSS?
* **Tools for regulation:**  
  what monitoring and enforcement powers should a CSS oversight body have to regulate compliance with the CSS?
* **Oversight mechanisms:**  
  what oversight mechanisms would be available to monitor compliance with the CSS and help the oversight body target its activities to where they are most needed?

Alongside these key features, we also considered:

* alternative options unsuitable or unviable for further consideration;
* obligations for organisations who would fall under the scope of CSS;
* whether to adopt either the CSS from the Royal Commission, the National Principles, or amend either for Queensland’s specific context;
* how to ensure cultural safety in a Queensland system; and
* the appropriate scope of organisations subject to compliance.

#### Option 1 – Maintain the status quo

The Queensland Government would maintain the status quo for CSS in Queensland. This would mean no new framework or regulations to support implementation of the CSS, no new capacity building support, and existing child safe regulation and approaches would continue.

This would mean Queensland would continue the approach of:

* Queensland Government departments that have child-related responsibilities embedding the CSS internally, tailoring approaches to their unique service settings.
  + An example of this work can be seen with the Department of Education’s [*Aware. Protective. Safe Strategy*](https://alt-qed.qed.qld.gov.au/programs-initiatives/department/aware-protective-safe-strategy), and its associated commitments and ongoing child safety and wellbeing initiatives. The actions outlined in the strategy reflect the department’s response to the Royal Commission and additional initiatives to improve its culture of awareness, protection and safety for all Queensland children and young people.
* Organisations taking an ad-hoc and likely inconsistent approach to CSS implementation, with some sectors and organisations voluntarily implementing the CSS and others required to implement them under arrangements in other jurisdictions (e.g. an organisation operating in Queensland that receives funding from a federal government agency may be required by their funding contract to implement the National Principles). Organisations may continue to use freely available resources online to support implementation (e.g. guidance provided by Australian Human Rights Commission for implementing the [National Principles](https://childsafe.humanrights.gov.au/national-principles)) or pay for expert guidance by specialist organisations.

Existing child safe protections and regulations would continue to apply to organisations working with children such as those described in Figure 5 on page 28 and **Appendix C.**

#### Option 2 – Establish a non-legislative model for CSS implementation, with more limited application

An option that does not require legislation or setting up an independent oversight body to oversee CSS implementation was also considered.

Under this approach, implementation of the CSS would be supported by a whole-of-government policy framework. There would be no central oversight; CSS obligations would be the responsibility of Queensland Government agencies, and largely passed on to government-funded organisations via contracts and/or potentially incorporated into existing regulatory frameworks. Compliance would be voluntary for non-government organisations that are not funded by governments and implementation of CSS would not be subject to any central regulation.

The key features of this type of model are described in Table 9:

Table 9 Overview of key elements of a non-legislative option for CSS compliance (Option 2)

| **Key feature** | **Details** |
| --- | --- |
| Mode of regulation | * There would be no independent regulator or oversight body. * Queensland Government agencies that fund or regulate relevant organisations would partner under a whole-of-government policy framework to promote compliance with CSS. These government agencies would pass on CSS obligations to relevant funded and/or regulated organisations primarily via contractual mechanisms or possibly by embedding the CSS into relevant existing frameworks. |
| Capacity building approach | * Capacity building for organisations would be delivered by the government agencies that regulate/fund these services, supported by agency action plans which would outline how agencies promote CSS. |
| Tools for regulation | * CSS compliance would be dealt with via existing mechanisms that already respond to similar types of compliance issues. |
| Oversight mechanisms | * Information sharing between relevant government agencies and regulatory partners to identify risks and target capacity building activity to where it is most needed. * Existing mechanisms available to oversee relevant sectors (e.g. audit mechanisms in the HSQF). * Oversight of government agencies would be via existing oversight mechanisms (e.g. external audit). |

#### Option 3 – Establish a regulatory model legislatively requiring organisations in scope to comply with child safe standards

This option would involve setting up an oversight body that would have responsibility to regulate and oversee mandatory implementation of the CSS by relevant organisations in Queensland, supported by legislation. This would involve:

1. A collaborative regulatory model, with an independent authority providing centralised oversight of organisations’ mandatory compliance with the CSS. Other relevant regulators and funding bodies collaborate with the CSS oversight body by advising it when they become aware of indicators that organisations have issues with CSS compliance.
2. A co-regulatory model, in which CSS functions and powers sit with existing government regulators and funding bodies, with a CSS oversight body only having responsibility for organisations for which there is no appropriate co-regulator (e.g. religious and sporting organisations).

A collaborative regulatory model (Option 3(a)) would include the following key features:

Table 10 Key features of collaborative regulatory model for CSS implementation (Option 3(a))

| **Key feature** | **Details** |
| --- | --- |
| Mode of regulation | * A single, independent, central CSS oversight body is established (funded by the Queensland Government). * The oversight body collaborates with existing regulators and funding bodies to target oversight activities that support organisations to comply with the CSS. * Existing regulators and funding bodies collaborate with the oversight body by advising it of issues they become aware of that indicate organisations are experiencing challenges with CSS compliance. |
| Capacity building approach | * Delivery options include:   + capacity building delivered by one or more non-government providers with expertise in child safe organisations and/or tailored solutions for particular communities and sectors; and   + capacity building delivered by the oversight body. * The focus of capacity building in this model is both:   + as a proactive tool to support organisations to improve their child safe practice (proactive capacity building); and/or   + as a response to organisations experiencing issues with child safe practice/non-compliance with CSS (responsive capacity building). |
| Tools for regulation | * The oversight body could have a range of tools and remedies available to support organisations to comply and address non-compliance in a proportionate way, including for example:   + responsive capacity building;   + industry compliance plans;   + compliance notices;   + audit-related mechanisms (such as powers of entry and inspection, powers to request information and documents);   + civil monetary penalties; and/or   + publication of information about compliance issues. |
| Oversight mechanisms | * The oversight body could have a range of oversight mechanisms to inform itself about how well organisations are complying with CSS, which could include any or all of the following:   + information sharing;   + referrals from other relevant regulators, departments, funding bodies, and the community;   + self-assessments conducted by organisations; and   + audit program. |

A co-regulatory model (Option 3(b)) shares some similarities with the previous model, with the key difference being the higher level of responsibility and oversight powers given to existing sector regulators to ensure compliance with the CSS. Under this model, a central CSS oversight body would only have responsibility for direct regulation and oversight of organisations that do not have an existing, appropriate co-regulator (e.g. religious and sporting organisations).

Table 11 Key features of co-regulatory model for CSS implementation

|  |  |
| --- | --- |
| **Key feature** | **Options** |
| Mode of regulation | * A single, independent, central CSS regulator is established (funded by the Queensland Government). * Regulation and oversight of CSS compliance is formally shared between the central CSS oversight body and existing regulators and funding bodies:   + The central CSS oversight body has direct oversight of sectors that are not already funded or regulated by government.   + Relevant existing regulators/funding bodies are given CSS oversight responsibilities and powers for their sectors. |
| Capacity building approach | * The central CSS oversight body and its co-regulators undertake both proactive and responsive capacity building activities to support organisations to comply with the CSS. * Obligations to become a child safe organisation are supported by a range of guidance materials. * Delivery options are as described in Table 10 for Option 3(a). |
| Tools for regulation | As per Option 3(a). |
| Oversight mechanisms | As per Option 3(a). |

#### Alternative options

Several options were considered but were not proposed in the CRIS as suitable options for implementation, including:

**Co-regulatory approaches** that rely on sector peak bodies or other non-government entities to have oversight and regulatory responsibilities. It is important to ensure the well-established peak bodies in Queensland can maintain existing relationships with their sectors. If regulatory or oversight responsibilities sit with these bodies, these relationships would likely need to change so the peak bodies could have the independence and impartiality they would need to effectively regulate CSS.

**Approaches reliant on commercial accreditation** systems only. It is not considered viable to rely on commercial products given the wide range of sectors and types of organisations that could be in the scope of a CSS system. Only using commercial products would involve significant risk that only some organisations, with sufficient resources, could access the system and would likely create inequities for organisations and the children they serve.

**Self-regulatory approaches** wholly designed and determined by non-government sectors. Given the Royal Commission’s findings about the need for accountability and its emphasis on the way state and territory governments should mandate compliance with CSS, it is not considered appropriate that the non-government sector be entirely responsible for designing and determining the CSS system in Queensland. However, we recognise the expertise in these organisations and are committed to ensuring this expertise is used to inform a high-quality system.

#### Queensland child safe standards obligations for organisations

For individual organisations, how implementation of the CSS will look under each of the models will generally only differ in terms of the support and resources provided, the level of oversight they will be subject to, and who regulates the CSS (see further impact analysis in Part 4).

Common to all models is a set of CSS for Queensland which are intended to be flexible, principle-based and focused on outcomes. They are not intended to set out prescriptive rules to be followed in the same way for each organisation. The intent is that the CSS will empower organisations to create child safe practices that respond to their organisation’s nature, characteristics, and level of risk.

Some examples of how implementation of the CSS could look for organisations may include developing and maintaining governance materials to ensure the CSS help influence organisations’ practices, decision making processes, risk management and accountability mechanisms.[[52]](#footnote-53) This could include:

* a statement of commitment to child safety;
* a child safe policy;
* a code of conduct for organisations’ employees and volunteers;
* a complaints management policy;
* a risk management plan; and
* reflecting the CSS in human resources policies and procedures (e.g. recruitment processes).

Building a child safe culture in an organisation in scope of any of the options, regardless of type or size, will require an ongoing commitment to keeping children safe from abuse. It is about building long-term cultural change, and this means ongoing learning and continuous improvement.

Some further guidance about expectations for organisations under each of the CSS model options is set out below.

**For Option 2,** obligations in complying with the CSS for organisations may include:

* where required, meeting contractual obligations for demonstrating compliance with the CSS; and
* participating in capacity building delivered by relevant agencies.

Note Option 2 also allows for organisations not in scope to implement the CSS, which would not involve any centralised capacity building support or obligations to meet a standard of compliance.

**For Option 3(a) or 3(b)** obligations in complying with the CSS for organisations may include:

* identifying and implementing the necessary requirements for how their organisation can best meet the CSS (with expert guidance and capacity building supports provided);
* complying with any directions made by the CSS body (or a delegated CSS co-regulator, for Option 3(b)) in its regulation and oversight of CSS obligations. This may include, for example, producing information relating to the organisation’s implementation of CSS (see also other tools for regulation, detailed above);
* participating in proactive and reactive capacity building activities as necessary; and
* advising the oversight body/ies of any barriers to compliance.

These obligations would be similar irrespective of whether the CSS is overseen through a collaborative or co-regulatory approach. As implementation of CSS is intended to be flexible and tailored to each organisation based on its purpose, size, structure and characteristics, the activities used to implement the standards will be different for each organisation.

For the purpose of consultation through the CRIS, we listed in Table 12 below some examples of how small and large organisations could implement the CSS, noting there may be overlap between small and large organisations and not all examples would apply to every organisation given the range of different services and activities that are provided to children. We noted that these activities are examples only and do not indicate a minimum or expected standard for compliance with CSS. While we did not receive specific feedback on these examples, we did hear from organisations that change management and communication processes to implement CSS may be extensive.

Table 12 Examples of child safe activities (small and large organisations)

| **Standard** | **Small organisation – example activities** | **Large organisation – example activities** |
| --- | --- | --- |
| Standard 1: Child safety is embedded in institutional leadership, governance and culture | * Public commitment to child safety is displayed and reflected in Code of Conduct. * Code of Conduct includes guidance about how adults should behave in the organisation. * Child safe organisation resources are provided to staff and volunteers. | * Public commitment to child safety is displayed and reflected in a child safe policy. * Induction includes training in the Code of Conduct, child abuse and child safe organisations. * A dedicated position leads development of a child safe culture, policies and practices. * Governance meetings include child safety as a standing agenda item. |
| Standard 2: Children participate in decisions affecting them and are taken seriously | * Children are provided age-appropriate information on their rights and how adults should behave in the organisation. | * Children are involved in policy development e.g. student bodies, youth advisory groups, children representative committees. * Surveys seek feedback from children. |
| Standard 3: Families and communities are informed and involved | * Regular communication with parents includes information on child safe policies and practices. * Feedback is sought from parents on child safe policies and practices. | * Families are consulted on the development of child safe policies and practices. * Families are represented on governance committees. * Families are regularly surveyed about their experiences and perceptions of child safety in the organisation. |
| Standard 4: Equity is upheld and diverse needs are taken into account | * Information about child safe organisations includes consideration of children’s diverse needs, circumstances and vulnerabilities. * Code of Conduct includes expectations about equity and inclusion. | * Learning about diversity is incorporated into daily activities e.g. discussing upcoming events such as NAIDOC Week. * Cultural safety is clearly articulated in policies and procedures and staff engage in regular training. * Strategies are developed to support the participation of children with diverse needs including supporting individual children. |
| Standard 5: People working with children are suitable and supported | * Processes are in place for working with children check applications and renewals. * Selection processes consider why staff or volunteers want to work with children and discuss the organisation’s commitment to child safety. | * Selection processes include specific questions about child abuse and child safety. * References seek feedback on the candidates’ interactions with children. * Staff supervision includes a focus on child safety. * Managers are provided guidance on responding to concerns about staff behaviour. |
| Standard 6: Processes to respond to complaints of child sexual abuse are child focused | * Staff and volunteers have clear reporting processes in place. * Child-friendly resources which detail how to make a complaint are prominently displayed. * Processes are in place to ensure staff and volunteers are aware of how to respond to a complaint and have access to resources and guidance. | * Staff engage in regular training on reporting obligations and processes. * Data on reports of harm and complaints is collated and reviewed to identify improvements. * Children, young people and families are involved in the development of complaint processes. * Processes are in place to assist children who make a complaint to access support including external, professional support. |
| Standard 7: Staff are equipped with the knowledge, skills and awareness to keep children safe through continual education and training | * Induction includes information about child abuse, identifying child abuse and child safe organisations. * Guidance material on child abuse is readily available. | * Staff engage in regular training on child abuse, identifying child abuse and child safe organisations. * Training and guidance is regularly updated. * Supervision includes consideration of child safety. |
| Standard 8: Physical and online environments minimise the opportunity for abuse to occur | * Supervision of children is explicitly considered for all activities where an adult may be alone with children. * Clear guidelines established on the use of social media and digital communication with children. | * The physical and online environment is regularly assessed, and strategies developed to address risk e.g. enhancement to safety where adults are alone with children, development of social media policies. |
| Standard 9: Implementation of the Child Safe Standards is continuously reviewed and improved | * Policies, guidelines and access to resources are reviewed annually. | * Policies, guidelines, training and practices are reviewed and updated annually. * Children and families participate in annual review processes. * Action plans are developed to improve child safe responses. |
| Standard 10: Policies and procedures document how the institution is child safe. | * Policies and procedures are documented in writing. * Record-keeping processes are established to record reports of harm and complaints from children and families. | * Policies, procedures and reviews are clearly documented. * Robust record-keeping processes on reports of harm, complaints and incidents, as well as organisational responses, are developed and maintained. * Staff are trained in record-keeping. |

There is comprehensive information available to support CSS implementation in other jurisdictions[[53]](#footnote-54) and the role of a Queensland oversight body would also include developing guidance material for Queensland organisations. We heard strong support for guidance material and resources through the CRIS consultation process and we also heard that many organisations in Queensland have already implemented CSS or similar measures and practices into their everyday activities, policies and procedures.

### Child safe standards for Queensland

As part of designing a Queensland child safe organisations system, we sought feedback on whether to adopt the wording of the 10 CSS from the Royal Commission, the 10 National Principles (see **Appendix D**), or adapt either of these to respond to the Queensland context. Our approach in Queensland to date has been to refer to both the CSS and National Principles given their close alignment.

While broadly supporting national consistency, states and territories have taken different approaches. South Australia has adopted the National Principles, the NSW CSS closely reflect the Royal Commission’s 10 CSS, and Victoria’s approach aligns with the National Principles (but includes an 11th standard to establish culturally safe environments for Aboriginal and Torres Strait Islander children and young people).

##### What we asked:

1. Do you have a preference for what form the CSS should take in Queensland, and why? Would the form of CSS adopted in Queensland make a difference to your organisation? Options being considered include: the Royal Commission’s 10 CSS; the 10 National Principles; or a version adapted for Queensland.
2. Are there specific issues relevant to Queensland that need to be considered or reflected in the standards adopted in Queensland?

##### Consultation results – preferred standards

We heard from a wide range of stakeholders about what CSS should look like in Queensland. The majority of submissions advocated for the adoption of the National Principles for various reasons:

* the need for a nationally consistent approach given many jurisdictions, including the Commonwealth, have adopted the National Principles;
* the broadening of focus from child sexual abuse to all forms of child maltreatment, and the emphasis of the National Principles on child wellbeing;
* the acknowledgement of human rights and the rights of the child;
* availability of existing resources developed to guide organisations to implement the National Principles, including the SNAICC resource, *Keeping Our Kids Safe: Cultural Safety and the National Principles for Child Safe Organisations*;
* many organisations have already embedded the National Principles in their policies and practices;
* many organisations are required to comply with the National Principles by their regulatory body which has adopted the principles; and
* many organisations work across other jurisdictions and already comply with the principles in other jurisdictions.

The few submissions that supported the adoption of the Royal Commission’s 10 CSS did so on the basis that the Queensland CSS should align with and remain consistent with the recommendations of the Royal Commission.

Several submissions advocated for a set of standards adapted for the Queensland context on the basis that:

* Queensland’s unique geographic and demographic circumstances, particularly the needs of Aboriginal and Torres Strait Islander communities and rural and remote areas, should be considered;
* the standards need to account for the cultural safety of Aboriginal and Torres Strait Islander peoples; and
* the standards need to be compatible with Queensland’s existing regulatory frameworks.

##### Final recommendation

There was no preferred option for the form of Queensland’s CSS proposed in the CRIS, however, it was noted there was support for the National Principles expressed during previous targeted consultation.

Following the CRIS consultation process, it is recommended that Queensland adopts the 10 National Principles, reflecting the strong support expressed by stakeholders for the National Principles.

As suggested in consultation, implementing the National Principles has the following benefits:

* it will allow Queensland organisations to take a broad, holistic approach to protecting the safety and wellbeing of Queensland’s children;
* human rights and the rights of the child will be elevated in implementation; and
* Queensland’s child safe organisations system will be nationally consistent, noting the Commonwealth, Victoria, South Australia, and Tasmania have broadly adopted the National Principles.

The issues raised by stakeholders about the needs of rural and remote communities and the compatibility of the National Principle with existing Queensland regulatory frameworks will be considered and addressed as the Queensland child safe organisations system is further developed and later implemented. Cultural safety for Aboriginal and Torres Strait Islander children and young people remains a priority for the Queensland Government and is considered below.

#### Cultural safety and considering the diverse needs of children in a Queensland system

##### Cultural safety for Aboriginal and Torres Strait Islander children and young people

The Royal Commission found that a strong connection to culture is a protective factor against child sexual abuse for Aboriginal and Torres Strait Islander children because:

* it builds resilience in communities to help mitigate the negative consequences of past policies and contemporary racism;
* strong attachments with multiple caregivers, a high self-esteem and positive social connections act as protective factors against child sexual abuse; and
* racism and disconnection from culture heighten the vulnerabilities that Aboriginal and Torres Strait Islander children face in institutions.[[54]](#footnote-55)

The Royal Commission noted that the absence of cultural safety can compound the risk of abuse experienced by Aboriginal and Torres Strait Islander children in institutions by creating barriers to disclosure and inhibiting their access to appropriate support.[[55]](#footnote-56)

There are many definitions of cultural safety. We acknowledge that only Aboriginal and Torres Strait Islander peoples have the authority to define what is culturally safe for Aboriginal and Torres Strait Islander peoples, communities and children. We also acknowledge that what feels culturally safe for one person, may not feel culturally safe for another person.

Common elements of cultural safety include environments:

* where Aboriginal and Torres Strait Islander peoples are comfortable expressing their culture, identity and spiritual and belief systems;
* where the voices and needs of Aboriginal and Torres Strait Islander children, families and communities are listened to and respected; and
* that support Aboriginal and Torres Strait Islander children to embrace and maintain connection to their culture without fear or questioning.

Cultural safety is not just the absence of racism and is commonly recognised as being more than cultural awareness and cultural sensitivity.[[56]](#footnote-57) Cultural safety and cultural competence can go hand in hand, though some argue that cultural safety should replace cultural competence as a goal for organisations.[[57]](#footnote-58)

In our 2021 targeted consultation process, we heard strong support for Queensland’s CSS to address cultural safety for Aboriginal and Torres Strait Islander children. In the CRIS, we sought feedback on two key approaches to embed cultural safety in a Queensland child safe organisations system:

1. *Create an additional child safe standard*. The Victorian Government has introduced an 11th child safe standard: ‘Establish a culturally safe environment in which the diverse and unique identities and experiences of Aboriginal [and Torres Strait Islander] children and young people are respected and valued’. The benefit of this approach is that a specific standard puts cultural safety at the forefront, however, it could also mean organisations do not consider cultural safety fully in their application of the other standards.
2. *Include cultural safety as a guiding principle across all standards*: Tasmania will implement a universal principle that sits across all 10 standards to ensure the right to cultural safety of children who identify as Aboriginal or Torres Strait Islander is respected. The benefit of this approach is that a guiding principle could encourage consideration of cultural safety across all standards. However, a guiding principle could also be less obvious to organisations as it may not be clear the principle has legal status, or requirements for its compliance.

Embedding cultural safety in the CSS will also, by extension, apply to the systems that organisations put in place to prevent, detect and respond to reportable conduct.

##### Cultural safety for children from culturally and linguistically diverse backgrounds

Cultural safety also means appropriate consideration of the needs of children from culturally and linguistically diverse backgrounds. This is recognised in Standard 4 of the CSS and Principle 4 of the National Principles, both of which acknowledge that equity must be upheld and diverse needs embraced for the safety of children to be prioritised.

It is equally important that implementation of CSS, as well as the RCS, considers the diversity in Queensland communities and recognises that children from culturally and linguistically diverse backgrounds may face greater risk of abuse in organisations, and a greater risk that institutions may not respond in a safe and appropriate way if abuse occurs. The Royal Commission noted these risks could include:

* exposure to racism and discrimination;
* limited or no access to culturally tailored and adapted primary prevention programs;
* lower levels of awareness about child sexual abuse issues and child protection systems;
* different norms about how to discuss sex and sexuality; and
* limited access to skilled language and cultural translators within organisations.[[58]](#footnote-59)

We recognise that organisations will require support and guidance on incorporating cultural safety into implementation of CSS.

##### Recognising diversity in child safe organisations

The Royal Commission also identified other groups of children with diverse needs who must be considered when implementing child safe organisations, including children with disability, children from diverse religious and cultural backgrounds, very young children, children with previous experiences of trauma, and lesbian, gay, bisexual, transgender and intersex children.

In considering what helps keep children from diverse populations safe in organisations, the Royal Commission research[[59]](#footnote-60) highlighted the importance of consultation with children from diverse backgrounds and that approaches should be tailored to individual diverse groups. Other research findings indicated that:

* Interventions should acknowledge and account for structural barriers and discrimination that put those children at increased risk.
* When children from diverse populations are isolated and singled out from their peers, the risks of maltreatment in institutional settings increase.
* Organisational cultures of poor communication between children and adults charged with keeping them safe increases the risk of maltreatment. This risk was particularly apparent for children with disability and high support needs, as stereotypes and taboos about sex education and topics related to sexual abuse increased the risks of maltreatment for children with disability.
* Healthy, trusting relationships with adults are a protective factor for diverse populations of children. These relationships remove some of the barriers to disclosing and provide examples of appropriate adult behaviour.
* For children with disability, feeling seen, known and valued acts as a protective factor.

The Royal Commission created Standard 4 of the CSS, ‘Equity is upheld and diverse needs are taken into account’ and identified core components for implementation, which are similarly reflected in National Principle 4 and its key action areas:[[60]](#footnote-61)

National Principle 4 ‘Equity is upheld and diverse needs respected in policy and practice’ key action areas:

* *the organisation, including staff and volunteers, understands children and young people’s diverse circumstances, and provides support and responds to those who are vulnerable;*
* *children and young people have access to information, support and complaints processes in ways that are culturally safe, accessible and easy to understand; and*
* *the organisation pays particular attention to the needs of Aboriginal and Torres Strait Islander children, children with disability, children from culturally and linguistically diverse backgrounds, those who are unable to live at home, and lesbian, gay, bisexual, transgender and intersex children and young people*.

Through the CRIS consultation process, we sought feedback on how a Queensland child safe organisations system could most effectively recognise diversity and inclusion.

##### What we asked:

1. How can we best embed cultural safety for Aboriginal and Torres Strait Islander children and young people into the CSS? Do you prefer (and why):
2. an additional, standalone 11th CSS or
3. a guiding principle for cultural safety across the 10 CSS, or
4. an alternative approach?

**Note**: *We welcomed input from everyone on this question, and will continue to work with Aboriginal and Torres Strait Islander peoples to establish a culturally safe CSS system in Queensland*.

1. How can we best ensure the CSS embeds cultural safety for children and young people from culturally and linguistically diverse backgrounds?
2. How can we best ensure that the Queensland CSS and RCS most effectively recognise diversity and the unique needs of Aboriginal and Torres Strait Islander children, children with disability, children from culturally and linguistically diverse backgrounds, those who are unable to live at home, and lesbian, gay, bisexual, transgender and intersex children and young people?
3. What support would your organisation need to apply cultural safety and best consider the diverse needs of children and young people in implementing the CSS and RCS?
4. Is there anything else we need to consider to ensure cultural safety is appropriately embedded in a Queensland child safe organisations system as a whole (comprising CSS and RCS)?

##### Consultation results – cultural safety

We heard strong support for establishing a universal guiding principle in a Queensland child safe organisations system to ensure that cultural safety for Aboriginal and Torres Strait Islander children and young people is embedded in the application of each one of the 10 National Principles.

Some submissions supported an additional, stand-alone principle on the basis that organisations may find the obligation for a universal guiding principle confusing and, therefore, this requirement may be overlooked in implementation. Other stakeholders proposed we implement both a universal guiding principle and an additional stand-alone principle, and a few suggested that National Principle 4 (equity and diversity) was sufficient and could be further strengthened through guidance material.

Importantly, in undertaking this consultation, we recognised that the only authorities on what makes organisations culturally safe for Aboriginal and Torres Strait Islander children and young people are Aboriginal and Torres Strait Islander children and young people themselves, their families and communities. This was also acknowledged by several submissions from non-Indigenous organisations which supported embedding cultural safety within a child safe organisations system, but deferred to the expertise and cultural knowledge of Aboriginal and Torres Strait Islander stakeholders in providing feedback on the best approach for Queensland.

Aboriginal and Torres Strait Islander young people told us they feel safer and are more likely to raise issues, or disclose harm, when organisations are staffed by Aboriginal and Torres Strait Islander people. Similarly, we heard from young people that they feel safest when they feel represented in the organisations they interact with, and that means having diverse staff and workers, as well as ensuring that physical and online spaces are inclusive and accepting (e.g. posters and branding).

Our consultation with Aboriginal and Torres Strait Islander peoples and organisations reinforced that connection to culture is a protective factor for Aboriginal and Torres Strait Islander children. Aboriginal and Torres Strait Islander stakeholders strongly supported the emphasis in the CRIS on cultural safety for Aboriginal and Torres Strait Islander children and young people. We heard that the obligation in the CSS that will require all organisations engaged with children to consider cultural safety will create a foundation of cultural competence in Queensland.

We sincerely thank the Aboriginal and Torres Strait Islander peoples that spoke with us throughout consultation and shared with us the enduring and ongoing impacts that colonisation and intergenerational trauma has on Aboriginal and Torres Strait Islander peoples and communities. In this context, we heard that building culturally safe organisations requires the development of trusting relationships over a sustained period of time, and a deep understanding of local communities and contexts.

To build culturally safe organisations, we heard that the design of systems, structures, resources and implementation must be led by Aboriginal and Torres Strait Islander people through, for example, Aboriginal and Torres Strait Islander governance committees, and by employing Aboriginal and Torres Strait Islander people in the oversight body.

##### Final recommendation

Aligned with strong stakeholder support, the final recommendation is to include a universal guiding principle about cultural safety for Aboriginal and Torres Strait Islander children and young people in Queensland’s child safe organisations framework. Organisations will be required to consider the universal guiding principle and apply it to each one of the 10 National Principles. We acknowledge the concerns raised by stakeholders that the specific obligations to implement a universal guiding principle may be confusing, however, we believe the development of comprehensive and clear guidance and resources by the oversight body will help address these concerns.

As outlined in more detail later in the DIAS, we heard very clearly from stakeholders that the oversight body’s capacity building role will be key to successful implementation of CSS. A key focus for the oversight body will be supporting organisations to apply the universal guiding principle, in processes that are co-designed and led by Aboriginal and Torres Strait Islander peoples. Cultural safety will continue to be a key consideration as we progress our work on a Queensland child safe organisation system.

##### Consultation results – recognising diversity

Many submissions emphasised the importance of an inclusive child safe organisations system given the diverse needs and experiences of children in Queensland, with several submissions noting diversity is explicitly considered in National Principle 4. Key strategies proposed to ensure children and young people with diverse needs are included and safe in organisations include:

* reflecting diversity in representation on the oversight body and in the organisations that are in scope for the CSS;
* considering and embedding diverse needs in all CSS policies and practices;
* actively including diverse and vulnerable groups within organisations, balanced with recognising the individual needs of children and young people, i.e. building a system that avoids generalisations and understands that each young person is unique with different needs depending on their background, how they identify and their experiences;
* ensuring that communication is tailored and accessible e.g. through translating resources into diverse languages; and
* offering specialised training for staff and volunteers that recognises diverse needs and how practices can be inclusive and trauma-informed for all children and young people.

##### Final recommendation

There is clear support for a Queensland child safe organisations system that embraces diversity, with National Principle 4 as the vehicle to ensure the active inclusion of all children in organisations. Noting feedback in consultation that organisations will need guidance and support, the oversight body will have a key role in building the capacity of organisations to recognise diversity and implement National Principle 4.

#### Scope of organisations the child safe standards should apply to

The Royal Commission recommended that governments require all institutions that engage in ‘child-related work’ (i.e. institutions that have frequent or more than incidental contact with children and/or a degree of responsibility for children’s supervision and care) to meet CSS.[[61]](#footnote-62)

Several governments across Australia have either implemented or committed to implementing a CSS scheme. Both single regulator and co-regulator models have been implemented by governments, with NSW, Victoria and Tasmania also co-locating their oversight body for CSS and RCS schemes. With some exceptions, the scope of organisations to which CSS apply generally includes the following key sectors where care, supervision or services are provided to children as part of their primary functions:

* designated government agencies or related public entities;
* accommodation and residential services;
* religious institutions;
* childcare services;
* disability services (note, NSW does not include disability services under the scope of its CSS scheme);
* education services;
* health services; and
* justice and detention services.

Beyond these key sectors, the scope of organisations captured under other governments’ implementation of CSS differs slightly (see **Appendix B**):

* Victoria has the broadest scope, with 47 classes of organisations subject to its CSS, if they provide services specifically for children, provide facilities for use by children under supervision, or engage children as employees or volunteers.
* In NSW, organisations must adopt CSS if they are covered by the NSW Reportable Conduct Scheme, which applies to entities defined in Schedule 1 of the *Children’s Guardian Act 2019* (largely aligning with the above list) as well as local councils and recreational organisations that provide services to children.
* In South Australia, child safe regulation applies to all state government authorities, as well as any person or body defined under the *Child Safety (Prohibited Persons) Act 2016* which includes the above key sectors and other ‘child-related work’ such as coaching or tuition services for children.

Limited information is available on the number of organisations included under these different models, but the Victorian Government has estimated approximately 50,000 organisations fall under the scope of its CSS scheme.[[62]](#footnote-63)

Snapshot of 2021 stakeholder feedback about the scopeof a CSS regulatory system for Queensland:

* Stakeholders who made written submissions to targeted consultations in 2021 generally supported the Royal Commission’s recommended categories and thought a broad approach was preferable to a narrow one, with some suggesting sectors outside of the recommended list should also be included e.g. in organisations that do not deliver services directly to children but whose work otherwise impacts or involves contact with children.
* No stakeholder thought the Royal Commission’s recommended scope was too broad, although some emphasised the need for flexibility in how they are applied given the diversity of organisations.
* Some stakeholders also suggested more clarity was required about the types of organisations. that would be captured within the Royal Commission’s broad categories.

When we explored scope in the CRIS, we considered how the implementation and oversight of the CSS could be targeted most effectively to relevant sectors providing services to children and young people. We were cognisant that, while taking a broad approach to scope may reflect the principle that all organisations can benefit from implementing the CSS, the number of organisations covered by CSS impacts the costs and practicalities of a CSS oversight body effectively operating the scheme.[[63]](#footnote-64)

Given the importance of ensuring the regulatory approach has a positive impact on child safety and wellbeing without unnecessarily burdening organisations, our consideration of scope was informed by key factors such as:

* the nature and characteristics of services provided by the type of organisation;
* existing regulation;
* consistency with approaches taken in other jurisdictions;
* stakeholder feedback;
* Royal Commission commentary and research informing its recommended scope categories; and
* ensuring the CSS system can deliver an effective, targeted, and proportionate regulatory response.

#### Targeting scope to provide additional clarity

Consistent with approaches taken in other jurisdictions, Royal Commission commentary about proportionate regulatory burden, and to ensure the scope of the CSS scheme is effectively focused, we proposed in the CRIS that scope could be further targeted to organisations that:

* specifically provide services for children; or
* provide facilities specifically for use by children under the organisation’s supervision.

We also sought feedback in the CRIS on the approach that, in any potential CSS system, **obligations to comply would apply at a broad organisational level** (rather than applying only to specific service streams or parts of an organisation). The intent of this approach is to provide clarity for organisations that may deliver services to both adults and children, or different types of services to children. This would then be accompanied by the ability to implement the standards across various services, activities and environments in a flexible way that makes sense for the individual organisation’s circumstances.

In addition, we canvassed whether organisations that would be included in the scope of a mandatory CSS framework should include sole traders (individuals carrying on a business), as well as other usual business types (e.g. incorporated or unincorporated bodies and associations).

Table 13 sets out the sectors that the Royal Commission recommended[[64]](#footnote-65) be included in scope of a mandatory CSS scheme, along with some examples of what types of services this could include in Queensland (some organisations may deliver services across different sectors). Note ‘organisations’ is intended to mean both government and non-government organisations.

Table 13 Scope of organisations for CSS recommended by Royal Commission

| **Sector recommended by Royal Commission (CSS)** | **Examples of what this could include** |
| --- | --- |
| Accommodation and residential services for children, including overnight excursions or stays | * Domestic and family violence services that provide overnight beds or accommodation for children (noting children may be present with, or unaccompanied by, a parent/caregiver). * Providers of overnight camps/stays (for organisations that provide camps as part of their primary activity). * Housing and Homelessness Services (may include social housing (public and community housing)) and accommodation delivered by specialist homelessness services – noting children that access these services may in some circumstances be unaccompanied by a parent/caregiver/family). |
| Activities or services of any kind, under the auspices of a particular religious denomination or faith, through which adults have contact with children | * Religious bodies, such as churches and other congregational environments of religious and faith-based organisations where children have contact with adults. This would include all church services or activities, such as Sunday schools and youth groups. * Services provided by a religious body to children, such as community services and support services (including chaplaincy services, recreational services). |
| Childcare or childminding services | * Childcare services regulated under the Education and Care Services National Law (e.g. long day care, outside school hours care, and family day care) and the *Education and Care Services Act 2013* (Qld) (e.g. occasional care and standalone care). * Kindergarten programs. * Adjunct care services. * Professionally organised commercial babysitting/nannying/au pair/in home care services.   *Note: Does not include private babysitting, nannies and kids clubs.* |
| Child protection services, including providers of family-based care (foster and kinship care) and residential care, as well as family support/secondary services | * All child protection services delivered or funded by the Department of Child Safety, Seniors and Disability Services (DCSSDS), including organisations providing residential care, foster and kinship care or other tertiary support services (e.g. Family Intervention Services) and secondary child protection and family support services (e.g. Intensive Family Support, Family Wellbeing Services and Family and Child Connect). |
| Services for children with disability | * Registered and unregistered NDIS providers delivering services for children with disability. * Services for children with disability provided or funded by DCSSDS, including the Accommodation Support and Respite Service and disability advocacy services. |
| Education services for children | * State schools and non-state schools. * School boarding facilities (including student hostels). * TAFEs and other organisations registered or accredited to provide senior secondary education or training. * Organisations providing courses for overseas students or secondary student exchange programs under the *Education (Overseas Students) Act 2018* (Qld). * May include universities. |
| Health services for children | * Queensland Health and Hospital and Health Services. * Queensland Ambulance Service. * Private health facilities. * Mental health services that provide inpatient beds for children. * Drug or alcohol treatment services that provide inpatient beds for children. * Organisations funded by the State to provide community-based health services for children.   *Note: Does not include private practitioners unless covered by one of the sectors listed, such as a private hospital*. |
| Justice and detention services for children, including immigration detention facilities | * Youth detention centres (and organisations providing services within youth detention centres). * Services delivered or funded by Youth Justice. * Child and youth advocacy services. * Watch houses. * Community legal centres delivering services to children. * Queensland Police Service and related funded services. |
| Activities or services where clubs and associations have a significant membership of, or involvement by, children | * Sport and recreation organisations providing activities/services for children including dance, arts, music, cultural activities, indoor games, and outdoor recreation. * Active Recreation Centres (operated by the Department of Tourism, Innovation and Sport). |
| Coaching or tuition services for children | * Tutoring companies. * Organisations and owner-operated businesses that provide instruction/coaching/tuition in a particular activity (e.g. music/arts/recreation not covered by clubs and associations category, tutoring). |
| Commercial services for children, including entertainment or party services, gym or play facilities, photography services, and talent or beauty competitions | * Modelling/photography services for children. * Talent or beauty competitions in which children participate. * Entertainment or party services for children. * Gym or play services for children. |
| Transport services specifically for children | * Ride shares targeted towards children and families. * Driving schools. |
| Other organisational settings under consideration include:   * neighbourhood centres; * youth services; and * cadets.   It is also intended that relevant **Queensland Government entities** that provide services to children are included in the scope of a regulatory CSS scheme. This could include, for instance:   * government departments that provide services to children; * relevant statutory bodies; and * local governments. | |

Taking a risk-based approach to scope was also considered, where it would be mandatory for organisations identified as being high risk to comply with the CSS, and lower risk organisations would be encouraged to comply with CSS on a voluntary basis. However, we did not explore a hybrid of mandatory and voluntary participation in the CRIS because it is not possible to meaningfully compare the risk profiles of organisations given their diversity and the diversity of sectors. Our assessment was that different levels of risk in organisations can be managed with a proportional response by the oversight body to capacity building and enforcement measures where required. This approach also allows the oversight body to respond flexibly to the organisation’s existing regulation or regulators.

##### What we asked:

1. What do you believe are critical factors we should consider in determining the scope of the CSS scheme? Are any factors more important than others?
2. Do you have any views on the scope of organisations CSS should apply to, including any of the sectors we are considering?
3. What factors should be considered if we were to require CSS compliance for the whole organisation, with flexible and tailored implementation for each service or service stream, activity or environment?

##### Consultation results – scope

We heard strong support for a broad approach to scope and the majority of stakeholders agreed with the inclusion of their own organisation and sector. Some submissions supported an extended scope, similar to the approach taken by Victoria, which includes any organisation where children are being provided a service or care, and others supported adopting the scope as recommended by the Royal Commission. Aligning CSS scope with the obligations under the WWC Act was also supported, with submissions commenting that a new scheme should not exclude organisations already complying with the WWC Act, potentially weakening Queensland’s protections for children.

Some submissions noted that requirements to develop a Child and Youth Risk Management Strategy under the WWC Act as well as implement CSS was likely to be duplicative. Submissions also recommended clear guidance be provided on scope and the types of organisations that will be required to comply with CSS in Queensland.

##### Final recommendation

The final recommendation is that the Queensland CSS will apply to the sectors recommended by the Royal Commission as well as those already required to have a Child and Youth Risk Management Strategy under the WWC Act. Table 14 outlines the recommended scope for Queensland.

Table 14 Scope for Queensland CSS

| **Sector recommended by Royal Commission (CSS)** | **Sectors intended to be required to comply with CSS in Queensland**[[65]](#footnote-66) |
| --- | --- |
| Accommodation and residential services for children, including overnight excursions or stays | * Providers of overnight camps /stays /excursions. * Housing and Homelessness Services (may include social housing (public and community housing)) and accommodation delivered by specialist homelessness services. * Domestic and family violence services that provide overnight beds or accommodation for children (noting children may be present with, or unaccompanied by, a parent/caregiver). |
| Activities or services of any kind, under the auspices of a particular religious denomination or faith, through which adults have contact with children | * Religious bodies, such as churches and other congregational environments of religious and faith-based organisations where children have contact with adults. This would include all church services or activities, such as Sunday schools and youth groups. * Services provided by a religious body to children, such as community services and support services (including chaplaincy services, recreational services). |
| Childcare or childminding services | * Childcare services regulated under the Education and Care Services National Law (e.g. long day care outside school hours care, and family day care) and the *Education and Care Services Act 2013* (Qld) (e.g. occasional care and standalone care). * Adjunct care services. * Kindergarten programs. * Professionally organised commercial babysitting/nannying/au pair/in home care services. |
| Child protection services, including providers of family-based care (foster and kinship care) and residential care, as well as family support/secondary services | * All child protection services delivered or funded by the Department of Child Safety, Seniors and Disability Services (DCSSDS), including organisations providing residential care, foster and kinship care or other tertiary support services (e.g. Family Intervention Services) and secondary child protection and family support services (e.g. Intensive Family Support, Family Wellbeing Services and Family and Child Connect). |
| Services for children with disability | * Registered and unregistered NDIS providers delivering services for children with disability. * Services for children with disability provided or funded by DCSSDS, including the Accommodation Support and Respite Service and disability advocacy services. |
| Education services for children | * State schools and non-state schools. * School boarding facilities (including student hostels). * TAFEs and other organisations registered or accredited to provide vocational education or training. * Universities. |
| Health services for children | * Private hospitals. * Queensland Ambulance Service. * Hospital and Health Services (including public hospitals). * Mental health treatment and care services for children. * Drug or alcohol treatment services. * Organisations providing health services and facilities for children (whether privately or as part of funded community-based health services) – this is intended to cover things like GP clinics, allied health services, dental clinics, alternative therapies and others). |
| Justice and detention services for children | * Youth detention centres (and organisations providing services within youth detention centres). * Services delivered or funded by Youth Justice. * Child and youth advocacy services. * Community legal centres delivering services to children. * Watch houses. * Community justice groups providing services for children or facilities for use by children under their supervision. |
| Activities or services where clubs and associations have a significant membership of, or involvement by, children | * Sport and recreation organisations providing activities/services for children including dance, arts, music, cultural activities, indoor games, and outdoor recreation (includes dance schools, music programs, organisations like Scouts and Girl Guides, sports clubs, swimming schools etc.). * Active Recreation Centres (operated by the Department of Tourism, Innovation and Sport or Youth Justice). * Emergency services cadet program. |
| Coaching or tuition services for children | * Tutoring companies. * Organisations and owner-operated businesses that provide instruction/coaching/tuition in a particular activity (e.g. music/arts/recreation not covered by clubs and associations category, tutoring). |
| Commercial services for children, including entertainment or party services, gym or play facilities, photography services, and talent or beauty competitions | * Modelling/photography services for children. * Talent or beauty competitions in which children participate. * Entertainment or party services for children. * Gym or play services for children. |
| Transport services specifically for children | * An organisation providing a bus or other transport specifically for children (e.g. where buses are used to transport children specifically by a school, childcare facility or sport or recreation organisation or church). Examples include prescribed school services, specialist school transport for students with disability, school scheduled services or schools entering into chartered transport arrangements for school excursion. * School crossing supervisors. * Driving schools for learner drivers of motor vehicles. * Note – the word ‘specifically’ is important for this category. A transport services specifically for children means one that is particularly for use by children, such as a school bus. it is not intended to capture general public transport like buses, trams or trains, that children may use, nor ride share services like taxis or Ubers or similar. |
| Other categories | * Neighbourhood centres. * Government departments. It is anticipated this may include, at a minimum: * Department of Health. * Department of Education. * Department of Child Safety, Senior and Disability Services. * Department of Youth Justice, Employment, Small Business and Training. * Department of Treaty, Aboriginal and Torres Strait Islander Partnerships, Communities and the Arts. * Department of Tourism, Innovation and Sports (including active recreation centres and Queensland Academy of Sport). * Queensland Police Service (frontline service delivery includes children, but also children held under police supervision in a watch house). * Queensland Fire and Emergency Services (frontline service delivery includes children, but also emergency services cadet programs in partnership with PCYC). * Department of Transport and Main Roads (DTMR) (driver training and driver examiner services). * Relevant statutory bodies. (That are not already captured in the categories above). This may include, for example: * Arts Queensland bodies like the Queensland Theatre Company, Queensland Museum, State Library, Queensland Art Gallery and Gallery of Modern Art, Queensland Performing Arts Trust, and the Aboriginal Centre for the Performing Arts Pty Ltd. * Public Guardian. * Legal Aid Queensland. |

*Note: Scope may be further refined as legislation is drafted.*

In addition to these categories, our final recommendation is to further clarify and target scope with a requirement that organisations in scope also either:

* specifically provide services for children; or
* provide facilities specifically for use by children, under the organisation’s supervision.

Our approach to scope will build on existing child safety requirements in Queensland, ensuring current protections under the WWC Act are maintained. However, as the requirements for organisations to develop a Child and Youth Risk Management Strategy in the WWC Act are aligned to the CSS, and likely to be duplicative, this obligation in the WWC Act will be repealed. There will be a transitional period where Child and Youth Risk Management Strategies remain in effect as CSS is rolled-out across Queensland.

This approach to scope will also ensure CSS aligns with the scope of schemes in other jurisdictions, contributing to overall national consistency.

To further understand what the transition from the Child and Youth Risk Management Strategy to CSS might look like in Queensland, our preferred approach to implementation and sector phasing is discussed in Part 8 of this DIAS.

### Options for a reportable conduct scheme

#### Consideration of options

We explored two options for implementing an RCS in Queensland in the CRIS including:

|  |  |
| --- | --- |
| **Options** | **Description** |
| Option 1 | Status quo. No changes and maintain current systems to protect children from harm. |
| Option 2 | Implement a nationally consistent, legislative reportable conduct scheme, as recommended by the Royal Commission. |

#### Alternative options (not proposed)

Alternatives to a full RCS were considered with a view to minimising the regulatory impacts and costs of the scheme. However as these were not considered feasible because they failed to meet the objectives of government action and the intent of the Royal Commission recommendations, we did not present them as options in the CRIS.

#### Reduced scope

We considered an option to implement an RCS with a reduced scope of organisations.

Options and their potential benefits included:

* Including only Queensland Government agencies – to remove any regulatory impacts on   
  non-government organisations and reduce the up-front cost to government of establishing and implementing the RCS.
* Including only sectors that do not have an existing independent regulator that can oversee and conduct investigations, e.g. religious organisations, non-state schools and accommodation and residential services. This would bridge a gap for these sectors, which are currently subject to less regulation and may require greater support to develop reporting and investigation systems.

However, the Royal Commission identified sectors for inclusion based on their risk profile and proportionate regulatory burden. An option of reduced scope does not provide national consistency in reporting obligations for organisations that deliver services to children, resulting in different treatment and safety standards for children depending on which services they engage with. It would also not deliver cross-sectoral oversight of organisations and employees. For example, the ability to gather and share intelligence regarding child abuse across sectors may be insufficient with a reduced scope. This would impact on the ability to detect and report abuse, including for individuals who may move across sectors and jurisdictions, and would also impact on the goal to reduce the risk profile of key organisations that engage in child-related work.

#### Voluntary reportable conduct scheme

Another option is a form of self-regulation, supported by a whole-of-government policy framework that provides education and guidance to support organisations to report allegations to an oversight body. Compliance would be voluntary for organisations. This option does not include legislative obligations to report or an oversight body to monitor or conduct investigations.

However, the Royal Commission found that without legal obligations, many institutions did not report child sexual abuse outside the institution. A voluntary option would not: promote best practice in improved accountability of organisations in preventing, identifying and responding to complaints of child abuse; improve detection and reporting of abuse to an external independent body; contribute to more complete gathering and sharing of intelligence regarding risks posed by employees; or contribute to national consistency in reporting obligations.

#### Option 1 – Maintain status quo (no action)

As a baseline, the CRIS explored an option where the Queensland Government maintains the status quo in Queensland which means maintaining current systems and obligations of organisations to protect children from harm. Regulation would continue to vary across different sectors, with no cross-sectoral oversight of institutional responses to allegations of harm against children. The key systems of existing regulation in Queensland are summarised under Part 1, pages 28-31 (and **Appendix C**).

The degree of enforcement and compliance within these existing systems varies as some requirements are contractual, legislative, required as a condition of employment, or are criminal offences. There is also limited publicly available data. Available data shows that in 2022-23, Blue Card Services assessed and finalised 2272 issues involving suspected non-compliance with blue card requirements and concerns reported by members of the public.[[66]](#footnote-67) In 2022, the Queensland College of Teachers assessed 103 compliance issues: in over half (57) no breaches of the general offence provisions of the Act were found; 28 warnings were issued to individuals, schools or employing authorities; no further action was undertaken on 18 minor breaches; and the remainder are to be addressed in 2023.[[67]](#footnote-68)

##### Consultation results – Option 1 Maintain the status quo

No stakeholders supported taking no action and maintaining the status quo – see Part 4 for further discussion.

#### Option 2 – Direct government regulation of a nationally consistent reportable conduct scheme

##### Consultation results – Option 2 reportable conduct scheme

There is overwhelming stakeholder support for implementing an RCS in Queensland, which is discussed broadly in Part 4.

This Part contains feedback on the core features of the model, and some descriptions of features have been updated in response to feedback on the CRIS.

##### Scope of core model

This option is to introduce an RCS which aligns with the model recommended by the Royal Commission (Final Report, recommendation 7.10). This requires direct government regulation to set up an independent oversight body that will have responsibility for administering the RCS, supported by legislation. This model is proposed to include the following key elements, with further details about their application and the variations across jurisdictions discussed in the paragraphs that follow:

Table 15 Key elements of a nationally consistent RCS

|  |  |
| --- | --- |
| **Core element of nationally consistent RCS (to be included in Queensland model)** | **Status and additional information** |
| Independent oversight body | Location to be determined by government. Funded by the Queensland Government. |
| Obligatory reporting by heads of organisations | Notification requirements, including timeframes to be determined.  While the obligation to notify the oversight body of an allegation remains with the head of an entity, any person may report directly to the oversight body.  Similar to other schemes, the Queensland scheme will contain ways to reduce duplication of reporting, such as providing a reasonable excuse for not reporting to the oversight body if it is believed another person has reported the allegation. |
| Definition of reportable conduct that covers any sexual misconduct committed against, with or in the presence of a child | Across other jurisdictions, reportable conduct also includes the following conduct, to be included in the definition for the Queensland scheme:   * a child sexual offence committed in relation to or in the presence of a child; * ill-treatment of a child[[68]](#footnote-69); * neglect of child; * physical violence or assault committed in relation to, or in the presence of a child; or * behaviour that causes significant emotional or psychological harm to a child; and * applies to conduct occurring outside the workplace. |
| Definition of reportable conduct that includes the historical conduct of a current employee | This will be included in the Queensland scheme and will apply to:   * conduct of a current employee that may have occurred prior to the commencement of the scheme; and * allegations made when the entity is covered by the scheme (allegations made before commencement of the scheme will not need to be reported to the RCS oversight body unless the allegation is re-made during the operation of the scheme).   *A past investigation may be sufficient to fulfil this requirement.* |
| Definition of employee that covers paid employees, volunteers, and contractors | A Queensland scheme will capture all employees, volunteers and contractors, regardless of whether they provide services to, or will have contact with, children. |
| Protection of persons who make reports in good faith | Protections for all persons making reports or complaints in good faith, whether to the oversight body or an organisation, will be included. Protections are from criminal or civil liability, reprisal or other detrimental action. |
| Oversight body powers and functions  It is proposed the Queensland RCS will incorporate the following functions and powers. The oversight body will have some discretion regarding how these are implemented. | |
| Scrutinising institutional systems for preventing reportable conduct and for handling and responding to reportable allegations, or reportable convictions | This will involve:   * proactive scrutiny of systems; and * reactive scrutiny of systems, such as upon receiving a notification. |
| Monitoring the progress of investigations and the handling of complaints by organisations | The level of monitoring will vary depending on the seriousness of the matter, the level of support needed by the organisation and the capacity of the oversight body (and any existing regulatory frameworks).  Will be supported by a range of investigative powers such as ability to request information or documents, interview witnesses or search premises. |
| Conducting, on its own motion, investigations concerning any reportable conduct of which it has been notified or otherwise becomes aware | As in other jurisdictions, the test for conducting an own motion investigation in Queensland will be that it is in the public interest, or the organisation is unable or unwilling to conduct the investigation, or to respond to an entity’s inappropriate handling of an investigation, or if the subject of the allegation is the head of an entity.  Will be supported by a range of investigative powers such as ability to request information or documents, interview witnesses or search premises. |
| Requesting a regulator undertake an investigation | The oversight body may request a relevant sector regulator to investigate a reportable allegation. If the regulator agrees to undertake an investigation, it must provide information about the investigation as requested by the oversight body and the findings. |
| Power to exempt any class or kind of conduct from being reportable conduct | The Queensland RCS will include this power for the oversight body.  For example, the oversight body may decide to apply an exemption to an entity that has demonstrated competence in complaint handling.  Based on experience of other jurisdictions, the RCS would need to be well established before such agreements could be entered with organisations. |
| Capacity building and practice development, through the provision of training, education and guidance to organisations | Capacity building is a central function of the oversight body. It could be provided directly by the oversight body or outsourced or a combination of both and could vary in the type and extent of support provided to organisations. Examples of capacity building activities include:   * online resources, such as fact sheets; * training; and * ongoing support and advice, upon request by organisations or in response to the monitoring of investigations. |
| Exchanging information | The scheme will provide for broad information sharing to relevant entities and regulators as well as other statutory bodies in Queensland and oversight bodies in other jurisdictions. The scheme will also provide specific information sharing provisions for the administration of the working with children check. |
| Public reporting, including annual reporting on the operation of the scheme and trends in reports and investigations, and the power to make special reports to parliaments | The oversight body must prepare an annual report on the operation of the scheme and may, at any time, prepare a special report on any matter relating to the performance of its functions. |

Functions and powers of the oversight body are generally consistent across jurisdictions, with all oversight bodies able to:

* monitor progress of investigations and handling of complaints by organisations;
* conduct their own investigations regarding reportable conduct;
* scrutinise and help develop institutional systems for preventing reportable conduct and for responding to reportable allegations, including through capacity building (not a requirement in Australian Capital Territory (ACT) and Western Australia (WA));
* publicly report on operation of the scheme and trends in reports and investigations; and
* share information with relevant agencies.

It is also consistent across jurisdictions that have implemented an RCS that people making reports are protected from civil, criminal liability and/or professional conduct obligations, although only some jurisdictions explicitly protect people making reports from dismissal, in the authorising legislation.

##### Consultation results – powers

A small number of submissions suggested additional powers for the oversight body:

* Powers to share information with organisations about employees of concern (including with organisations where an employee has moved to another organisation). Alternatively, consider providing additional legislative protections to allow organisations to share reportable conduct information directly with other organisations when it considers there is an unacceptable risk to children.
* Powers to suspend or step down people who are assessed as being an immediate risk of harm to children.

##### Final recommendation

The oversight body will have broad information sharing powers, including the ability to share certain investigation information with relevant organisations in scope, regulators or relevant statutory authorities – the extent and type of information that can be shared will depend on the nature of the body and its functions, and information sharing will be enabled only where it meets a certain purpose such as to promote the safety and wellbeing of a child, or relates to the entity’s investigation functions. This will be further consulted on during drafting of the legislation. The management of immediate workplace risks, including taking any disciplinary action against individual workers, will remain the employer’s responsibility, however information received from the oversight body may support their decision making.

It is recommended that broad enabling information sharing provisions will enable the oversight body, entities and regulators to share investigation and other relevant information regarding a reportable allegation or reportable conduct to other entities in scope, government departments (including QPS regarding criminal offences) and statutory authorities who may have relevant functions that overlap with the RCS, and equivalent oversight bodies in other jurisdictions.

**Consultation results – protections for reporters**

A small number of submissions commented on the fear of reprisal as a deterrent to reporting, particularly in locations with small populations, with suggestions that the identity of reporters must be protected, such as enabling anonymous reporting.

**Final recommendation**

As recommended by the Royal Commission, the scheme will include protections against civil or criminal liability or breach of professional ethics or standards, and protections from reprisals or other detrimental action for people that make reports or provide information under the scheme in good faith, whether to the head of an organisation, regulator or oversight body. The RCS will also enable a person to directly report to the oversight body, which may include anonymous reporting. These measures are intended to promote a culture in which people feel safe to report concerns about child maltreatment.

**Consultation results – false allegations**

A small number of stakeholders raised concerns regarding false allegations made against employees.

**Final recommendation**

It is proposed to include an offence against providing false or misleading information under the RCS.

#### Responsibilities of organisations under the reportable conduct scheme

The obligations for organisations under the RCS will include measures as set out below (some of which may be consistent with existing obligations such as reporting concerning behaviour). The obligations primarily sit with the head of the entity, but the legislative framework will enable heads of entities to delegate their functions within the organisation:

* Ensure systems are in place for preventing, detecting and responding to reportable allegations and convictions of employees, volunteers and contractors. This includes systems that enable notification of reportable allegations and convictions to both the head of an entity and the oversight body, and systems for their investigation. The oversight body will be able to request information from organisations about their systems and may make recommendations for action to be taken regarding those systems.
* Notify the oversight body of reportable allegations or convictions (obligation rests with the head of an organisation) when they become aware of reportable conduct by their employees, volunteers and contractors (within a prescribed period, e.g. NSW has a notification period of seven business days and Victoria has three business days). Any person may disclose a reportable allegation to the head of an entity or to the oversight body. An employee of an entity must disclose a reportable allegation in relation to another employee to the head of the entity, or if the subject of the allegation is the head of the entity, to the oversight body.
* Investigate allegations\*, having regard to the principles of procedural fairness, and determine whether the reportable allegation has been proven. As soon as practicable after the head of the entity becomes aware of a reportable allegation regarding an employee, they must investigate the alleged conduct or ensure it is investigated by a regulator or an independent investigator and notify the oversight body of the person undertaking the investigation.
* In the case of suspected criminal conduct, the head of an entity must notify the police as a priority. An RCS investigation may proceed concurrently to a police investigation unless the police advises that the RCS investigation may prejudice a police investigation or court proceeding and should be suspended.
* Provide information about allegations, the progress of investigations\* and the findings and action taken to the alleged victim and their parent/carer and as requested by the oversight body.
* Ensure appropriate confidentiality of information relating to reportable allegations and only disclose information about the allegations in circumstances permitted by legislation.
* Provide the oversight body with an interim report, detailing information about the reportable allegation and risk management strategy (action taken or proposed to be taken) within a prescribed period.
* As soon as practicable after completing an investigation, prepare a report which includes information about the facts and circumstances of the allegation or conviction, findings and reasons, details of disciplinary or other action the entity has taken, or proposed to be taken, in relation to the employee and reasons, and relevant information that was considered in the investigation, and any other action taken, such as to improve systems or the implementation of CSS.

\* An investigation is an inquiry into an allegation. The investigation should gather and assess all relevant evidence to establish a documented basis for a decision. The Royal Commission specified the investigations should be carried out by an impartial, objective, and trained investigator. This may be an employee of the institution or a contractor independent of the institution. Some may use a combination of internal investigation resources and external investigators. The investigations should be undertaken in a way that is proportionate to the seriousness of the complaint. Note an investigation may meet the requirements under multiple frameworks, including the RCS.

##### Consultation results – responsibilities

Stakeholders sought additional detail on their responsibilities under the RCS, some of which have been clarified in the list above and will be further clarified through guidance material and support from the oversight body.

Feedback also identified a range of measures they would need to support them to meet these obligations, including clear guidelines on conducting investigations (further explored in Part 8 of this DIAS).

#### Definition of reportable conduct

Reportable conduct captures conduct that falls below a criminal threshold and may not necessarily be reportable to police. The introduction of the RCS will not affect the requirements to report suspected criminal conduct to police, nor will it interfere with any police investigations.

The definition of reportable conduct differs slightly between the five jurisdictions with an RCS in place, as identified in Table 16:

Table 16 Definitions of reportable conduct across jurisdictions and proposed definition for Queensland scheme

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| **Definition of reportable conduct** | **NSW** | **VIC** | **ACT** | **WA** | **TAS** | **QLD** |
| A child sexual offence committed in relation to or in the presence of a child | ✓ | ✓ | ✓ | ✓ | ✓ | **✓** |
| Sexual misconduct (conduct in relation to or in the presence of a child that is sexual in nature but does not constitute a criminal offence) | ✓ | ✓ | ✓ | ✓ | ✓ | **✓** |
| Ill-treatment of a child | ✓ | ✗ | ✓ | ✗ | ✗ | **✓** |
| Neglect of child | ✓ | ✓\* | ✓ | ✓\* | ✓\* | **✓\*** |
| Physical violence or assault committed in relation to, or in the presence of a child | ✓  *Assault* | ✓  *Physical violence* | ✗ | ✓  *Physical assault* | ✓  *Physical violence* | **✓**  *Physical violence* |
| Any behaviour that causes emotional or psychological harm to a child | ✓\* | ✓\* | ✓ | ✓\* | ✓\* | **✓\*** |

\*Must be ‘significant’ neglect or cause ‘significant’ emotional or psychological harm.

#### Cumulative harm

Notifications of reportable conduct may be related to harm that occurs as either a single incident or a series or combinations of acts or omissions. For example, one incident of emotional or psychological abuse may not amount to reportable conduct, but a pattern of behaviour may cause significant emotional or psychological harm to a child and amount to reportable conduct.

#### Conduct outside the workplace

The Royal Commission Terms of Reference provide that child sexual abuse happens in an institutional context if, for example:

* it happens on premises of an institution, where activities of an institution take place, or in connection with the activities of an institution; or
* it is engaged in by an official of an institution in circumstances (including circumstances involving settings not directly controlled by the institution) where the institution has, or its activities have, created, facilitated, increased, or in any way contributed to, (whether by act or omission) the risk of child sexual abuse or the circumstances or conditions giving rise to that risk; or
* it happens in any other circumstances where an institution is, or should be treated as being, responsible for adults having contact with children.

All jurisdictions (NSW,[[69]](#footnote-70) Victoria, WA, ACT and Tasmania) provide for reportable conduct whether or not the conduct is alleged to have occurred within the course of the employee’s employment, as long as the person was an employee at the time the employer became aware of the allegation. The rationale for this is that if a person is abusive to a child in one environment, this may give rise to a risk in their employment environment *if they work with children.*

While investigations by police and child safety may also need to occur in such circumstances, the RCS investigation remains an important component in situations where the person comes into contact with children as part of their employment. The Queensland scheme will include the requirement to cover reportable conduct of an employee that may not have occurred during the course of their employment. This provision may be limited to employees who come into contact with children as part of their employment. It is expected that organisations would utilise the outcomes of investigations by police and child safety for the RCS investigation, as occurs in some other jurisdictions with an RCS. Therefore, organisations may be permitted to delay the completion of an RCS investigation until the outcomes of investigations by police or child safety are completed and shared with the organisation.

##### Consultation results – definition of reportable conduct

There was broad stakeholder support for the definition of reportable conduct as proposed in the CRIS, consistent with the Royal Commission recommendations and aligned with other jurisdictions.

We heard feedback that:

* clear guidance (including examples) will be required to ensure the definitions are widely understood, particularly in relation to sexual misconduct, significant harm, neglect of a child, and ill-treatment of a child – as these could be subjective and culturally misrepresented;
* increasing the threshold for ill-treatment to ‘serious ill-treatment’ should be considered;
* a broader scope of meaning of reportable conduct could include ‘inappropriate personal or intimate conduct relating to a child’;
* reportable allegations should focus on an employee’s behaviour, rather than only on the resulting harm to a child; and
* the threshold for making a reportable allegation should be based on ‘reasonable suspicion’, rather than ‘reasonable belief’ which may imply a proven fact is required before reporting.

##### Final recommendation

The definition of reportable conduct proposed in the CRIS will be retained in the interests of national consistency with further refinements to be informed by stakeholder feedback during the drafting of legislation. Additional guidance material will also be developed by the oversight body to assist organisations to understand the parameters of reportable conduct.

#### Excluded conduct

NSW, ACT and WA schemes clarify certain conduct is not reportable conduct, such as:

* conduct that is reasonable for the purposes of discipline, management or care of a child having regard to factors such as age, maturity, health, or other characteristics of the child and to any relevant codes of conduct or professional standards; and
* the use of physical force that is trivial or negligible following an investigation and recorded as part of a workplace procedure.

Specifying these exclusions is intended to reduce the potential for organisations and the oversight body to manage unnecessary allegations, and instead focus resources on matters that present serious risks to the safety and welfare of children. However, it may act as a deterrent to reporting possible misconduct if it is seen as falling into an excluded category such as disciplining or managing a child, which may also lead to cumulative harm being missed.

##### Consultation results – excluded conduct

Two submissions recommended that exclusions be considered to clarify the scope for decision-makers and reduce over-reporting, notably the exclusion of low-level physical force (trivial and negligible when being investigated and recorded, e.g. a push, pull or slap if no serious injury occurred).

##### Final recommendation

Further consideration will be given to whether a definition that excludes certain conduct as reportable conduct should be set out in the legislative framework. It is intended that guidance material will provide examples of low-level conduct that would not meet the threshold for reportable conduct. As part of its ongoing monitoring and operational review, the oversight body should monitor notifications to ensure the scheme is targeting the appropriate level of misconduct.

#### Definition of employee

In line with the Royal Commission’s recommendation, and consistent with other jurisdictions, a broad definition of employee will be included in the Queensland RCS, to capture paid employees, volunteers and contractors of organisations that are subject to the scheme, regardless of whether they provide services to, or will have contact with, children. Individuals are captured regardless of their employment relationship, and would include labour hire employees, secondees, trainees and work placements for students, apprentices, workers who perform work for an organisation subject to the scheme but are employed via another entity that is not subject to the scheme, and entities that comprise an individual, e.g. sole traders with no other employees.

Foster and kinship carers will be included in the definition of volunteers for the purposes of the scheme. Adult household members of people caring for children (including foster and kinship carers) and other childcare workers such as family day care providers, will also be included as volunteers.

This will create a focus on maintaining child safe environments and cover employees that may have incidental contact with children, such as a school cleaner.

Other jurisdictions cover all paid employees in a relevant organisation but vary as to how contractors and volunteers are treated. Victoria and Tasmania cover all contractors and volunteers whether or not they are engaged to provide services to children. By contrast, the NSW, ACT and WA reportable conduct schemes cover only those contractors and volunteers who provide services to children.

For a religious body, the scope would include a minister of religion, a religious leader, or an employee, including those who operate as sole traders and volunteers. It will not include a person only because they participate in worship.

It is not proposed to impose a minimum age for an employee.

##### Consultation results – definition of employee

The majority of stakeholders that commented are supportive of the proposed definition of employees. Other specific feedback from a small number of submissions included that:

* the inclusion of volunteers and contractors should be limited to those that provide services to children, as the broad inclusion of volunteers may deter people from volunteering and when combined with conduct outside the workplace becomes beyond the ability and authority of the organisation to manage; and
* the meaning of contractor is mixed in current legislation so will need to be clarified.

##### Final recommendation

The intent of including all volunteers and contractors within an organisation that is within scope is to create a child safe environment. The obligations under the scheme are focused on the head of the organisation in relation to people they engage to provide services in their organisation. Guidance material will provide further clarity, including examples, of contractors within scope.

#### Proposed reportable conduct scheme scope – types of organisations

The Royal Commission recognised that regulation and oversight should avoid placing unnecessary or excessive regulatory burden on organisations. Consistent with this approach, the Royal Commission considered two criteria that had to be met for organisations to be recommended for inclusion in the scope of an RCS:

* that the organisation exercises a high degree of responsibility for children; and
* that the organisation engages in activities that involve a heightened risk of child sexual abuse due to institutional characteristics, the nature of the activities involving children, or additional vulnerability of the children the organisations engage with.

Based on these criteria, the Royal Commission recommended a minimum scope of institutions and also recommended that governments continue to consider whether there are additional organisations that meet these criteria. Further detail regarding institutions which might be included in the scope of an RCS is set out below in Table 17 (both government and non-government) and the Royal Commission Final Report, Volume 7, pages 25 and 26.

The Royal Commission recommended a narrower scope for the RCS than for the CSS, considering that an ‘overly broad scope’ for the RCS might incur a disproportionate burden on government and organisations, and be ‘unsustainable and ineffective’.[[70]](#footnote-71) The Royal Commission’s proposed minimum scope for RCS does not include sport and recreation, private teaching, coaching or tutoring, transport services for children and commercial services for children. This was based on factors such as:

* limited evidence regarding these institutions;
* high membership base and low resources;
* often operating as sole traders or small businesses;
* large and diverse spread of institutions, making regulation impractical;
* the potentially limited capacity of an oversight body to engage with and support these additional institutions; and
* lack of coverage of these sectors in existing RCS at the time of the Royal Commission report.[[71]](#footnote-72)

As part of its RCS, Tasmania proposes to include clubs and associations and coaching or tuition services for children from 1 July 2024. Legislation for the Queensland RCS may enable the expansion of sectors in scope in the future.

The criteria used by the Royal Commission does not claim to provide an exact quantification of the risk-profile of different organisations. Rather, it establishes a sector-level view of organisations that should be included in the scope of an RCS. As noted on pages 20-21, it is not possible to meaningfully compare which organisations have more risk than others. In line with the intent of the Royal Commission recommendations, it is intended that an oversight body would have the flexibility to use regulatory tools as needed to address each organisation’s individual strengths, risks and capabilities.

Table 17 Organisations recommended for inclusion in RCS scope by Royal Commission

| **Sector recommended by Royal Commission (RCS)** | **Examples of what this could include** |
| --- | --- |
| Accommodation and residential services for children | * Domestic and family violence services that provide overnight beds or accommodation for children (regardless of whether the child is unaccompanied or with a parent/caregiver/family). * Providers of overnight camps/stays (where this is part of its primary activity). * Housing and Homelessness Services that provide overnight beds to children (regardless of whether the child is unaccompanied or with a parent/caregiver/family) such as specialist homelessness services. * School boarding facilities (including student hostels). |
| Activities or services of any kind, under the auspices of a particular religious denomination or faith, through which adults have contact with children | * Religious bodies, such as churches and other congregational environments of religious and faith-based organisations where children have contact with adults. * Activities and services provided by a religious body to children, such as community services and support services (including chaplaincy services, church youth groups, bible study groups, religious retreats and overnight camps, Sunday school programs and recreational services affiliated with a religious body). |
| Childcare (Early Childhood Education and Care) | * Childcare services regulated under the Education and Care Services National Law (for example long day care, kindergarten, outside school hours care, and family day care) and the *Education and Care Services Act 2013* (Qld) (for example, occasional care).   *Note: Does not include babysitting, nannies, adjunct care services, standalone care services and kids clubs.* |
| Child protection services, including providers of family-based care (foster and kinship care) and residential care, as well as family support/secondary services | * All child protection services delivered or funded by DCSSDS, including organisations providing residential care, foster and kinship care and secondary child protection and family support services (e.g. Intensive Family Support, Family Wellbeing Services and Family and Child Connect). |
| Disability services and supports for children with disability | * Registered NDIS providers delivering services for children with disability. * Disability service providers under the *Disability Services Act 2006* (Qld) e.g. providing Accommodation Support and Respite Service and disability advocacy services. |
| Education services for children | * State schools and non-state schools. * TAFEs and other organisations registered or accredited to provide senior secondary education or training. * Organisations providing courses for overseas students or secondary student exchange programs. * Universities.   *Note: This does not include home schooling.* |
| Health services for children | * Health and Hospital and Health Services (including public hospitals). * Queensland Ambulance Service. * Private hospitals (may include private health facilities). * Mental health services that provide inpatient beds for children. * Drug or alcohol treatment services that provide inpatient beds for children.   *Note: Does not include private practitioners unless covered by one of the sectors listed, such as a private hospital*. |
| Justice and detention services for children | * Youth detention centres (and organisations providing services within youth detention centres). * Services delivered or funded by Youth Justice. * Watch houses. * Community Justice Groups. * Queensland Police Service and related funded services.   *Note: Does not include immigration detention.* |
| Other government departments and entities | * Departments and entities that exercise care, supervision or authority over children as part of their primary functions or otherwise. * Government departments. * Local governments. * Statutory bodies and statutory offices. * Generally, a body that is established under legislation for a public purpose, whether incorporated or unincorporated. |

The scope of organisations subject to the RCS is broadly consistent across jurisdictions that have an RCS (NSW, Victoria, the ACT, WA and Tasmania), however there is some variation between jurisdictions. For example, the RCS in NSW, as with the NSW CSS, does not extend to disability services, and the ACT excludes private providers of mental health and related services with in-patient beds as well as providers of overnight camps and homelessness services.

The Disability Royal Commission recommended that states and territories establish RCSs, where not already in place, and ensure that disability service providers that deliver supports or services to children with disability, including NDIS providers, are included in their RCSs (Recommendation 11.17).

##### Consultation results – scope

Feedback generally supports the proposed scope of organisations, at a minimum, with some support for the RCS to go further, or to re-consider additional sectors after the schemes are road-tested:

* Six submissions expressed interest in exploring the inclusion of sporting organisations within the scope of the RCS.
* One submission recommended the inclusion of private residential treatment facilities (such as alcohol and other drugs treatment).
* One submission suggested that the scope of sectors should align with those regulated under the Blue Card System.
* Feedback from the transport sector indicated uncertainty as to how the CSS and RCS will apply in this setting.
* One submission (religious organisation) sought clarification as to whether overnight camps would be included if they are not a ‘primary activity’.

##### Final recommendation

It is recommended that the Queensland RCS apply to the sectors prioritised by the Royal Commission, as proposed in the CRIS. National consistency is a key driver for the success of the RCS, and at this stage, Tasmania is the only jurisdiction to propose a wider scope than recommended by the Royal Commission. Tasmania will include clubs, associations or cadet organisations that have a significant membership of, or involvement by, children; an entity that provides a coaching or tuition service to children; and an entity that provides commercial services to children.

It should be noted that if an organisation is brought into scope due to services it provides, the obligations will apply to the whole organisation and cover all employees, regardless of whether they have direct contact with children. This is intended to create child-safe environments. For example, if a religious organisation is brought into scope because they provide services to children (e.g. Sunday school), the whole organisation would be captured under the RCS. This may incidentally include the provision of activities that would not otherwise be directly in scope, such as sport and recreation services that are provided by the religious organisation. This may also apply to all Queensland Government departments and entities, which will be within scope if they provide care, supervision, or authority over children as part of their primary activities or otherwise. This may include for example, transport or sports and recreation activities provided by a local council.

While the legislation will provide broad parameters for the scope of sectors that will be required to comply with the RCS and CSS, some areas of service delivery will require further consultation and clarification.

Queensland understands that the scope of RCSs in other jurisdictions may change over time, and as such, periodic reviews of the operation of the scheme may occur. This could include consideration of an expansion of the scope of the sectors it applies to, and consider learnings from other jurisdictions and from implementation within Queensland. The capacity of the oversight body and any sectors it proposes to bring within scope will need to be carefully considered. It is proposed to allow flexibility in the legislation to prescribe through a regulation other sectors to be captured under the RCS.

The interest around including the sport and recreation sector (or clubs and associations that have a significant membership or involvement by children) in the RCS is noted. The Royal Commission considered that the inclusion of this sector in the RCS may present a disproportionate regulatory burden noting the high member/volunteer base and low resources, and large and diverse number of organisations involved. Feedback in the 2021 consultation confirmed that this sector may be less ready to comply with new regulation, and as such, the application of the CSS to this sector may be more appropriate to build capacity to provide child safe environments.

#### Other types of employers or organisations

Entities that comprise an individual may be included in the RCS if operating in a sector that is within scope. The CRIS proposed that third party employers, who are engaged by a relevant entity (i.e. in scope for the RCS) to provide services to children would also be in scope. This means they will be subject to the same obligations as other organisations in scope as previously set out. This includes ensuring there are systems in place for preventing, detecting and responding to reportable allegations or convictions, and reporting and investigating reportable allegations and convictions.

Further consideration will be given to whether third party employers should be captured, noting it will broaden scope beyond the core sectors recommended by the Royal Commission and impose a greater regulatory burden on organisations in scope.

#### Features to minimise regulatory impacts

The Queensland scheme will be designed to minimise duplication, including through the features outlined below.

#### Collaborative regulatory approach

The legislative framework will facilitate a **collaborative approach** between the oversight body and existing sector or other relevant regulators. The scheme will also be designed with the intent to avoid and minimise duplication with existing regulators. This will be achieved through mechanisms such as information sharing between the oversight body, regulators, and heads of organisations, to assist with investigations and minimise duplication in reporting and investigations. Another mechanism to achieve this includes the ability for the oversight body to establish agreements with sector regulators to facilitate a collaborative approach to investigations, or delegate certain functions in the future, where appropriate. For example, in Victoria and Tasmania, the oversight body may request that a regulator investigate a reportable allegation, which the oversight body may monitor. In Victoria, this is supported by information sharing provisions that allow information to be shared between the regulator, the organisation, and the oversight body. The *Child Wellbeing and Safety Act 2005* (Vic) requires the Commission to liaise with regulators to avoid unnecessary duplication in the oversight of investigations and sets out who is a regulator for the purpose of the Scheme.

This aims to harness the expertise and support of industry regulators, as well as reduce the regulatory burden on organisations who may continue to have other reporting obligations to sector and industry regulators, outside of an RCS.

The Tasmanian Commission of Inquiry emphasised the need for shared access to information between the oversight body and other government data systems such as police and child safety to enable systematic monitoring (recommendation 18.4c).

The Disability Royal Commission recommended that RCS operators and the NDIS Quality and Safeguards Commission should jointly develop guiding principles to support the efficient and effective handling of reportable incidents that are also allegations of reportable conduct, and develop broadly consistent guidance material to assist organisations to understand key issues relevant to notifying, managing and investigating allegations of reportable conduct and incidents involving children with disability (recommendation 11.18).

#### Minimising duplication of obligations – information sharing

Similar to other RCS schemes, the Queensland scheme will contain features that are intended to reduce duplication of reporting and investigating. NSW, Victoria, and WA provide for a ‘reasonable excuse’ to the obligation to notify the oversight body of a reportable allegation if the head of the entity believes the oversight body has already been notified. This may reduce duplication in circumstances where a contractor is employed by an entity that is in scope of the scheme, such that both the contracting entity and the third-party employer have reporting obligations.

NSW and WA schemes enable the oversight body to exempt organisations from commencing or continuing an investigation, if the matter is already being dealt with by another relevant entity (NSW) or another appropriate person or body (WA), such as another relevant entity, regulator or police. Victoria’s legislation places the highest priority on police investigations, such that an RCS investigation must not commence or continue if police are investigating the matter.

##### Consultation results – clarifying responsibilities and information sharing

There are some concerns about the RCS introducing additional obligations that duplicate existing requirements under other frameworks, and questions about how this will be managed.

There was strong support for the scheme to align with existing frameworks, and recognition of the importance of information sharing and for the oversight body to work closely with sector regulators.

Submissions highlighted the importance of the oversight body having access to key information that is proactively shared from a number of sources, including critical data systems such as QPS, Child Safety and the Queensland College of Teachers, in order to conduct its role. Submissions noted that the scheme will hold important information and it requires clear information sharing protocols between the scheme, other regulators and employers as to how this will be used to mitigate potential risks to children.

Organisations with experience in other jurisdictions noted that the overlap between WWCC and RCS and the dual responsibilities involved can be challenging to navigate. One national organisation noted that it works in partnership with police and the child protection authority to manage reportable conduct matters. This may involve delaying their investigation until police or child protection have completed their investigation, conducting interviews together or seeking and receiving interview transcripts and other evidence.

There was strong support to minimise the duplication of reporting and investigating, including in relation to interviewing children. For this to occur, clear authorities and protocols for reporting, investigating and sharing information need to be established along with clear guidelines for all parties. It was acknowledged that this will require a significant degree of knowledge, collaboration and a change in practice across several large service systems in Queensland. It was also suggested that other relevant legislation should be amended to reduce duplication in reporting.

The CSS and RCS are seen as an opportunity to create a clear authorising environment for information exchange and allow best practice information sharing arrangements between regulators. Priorities for the oversight body should be to ensure role clarity, consistency of processes, measures to streamline and maximise efficiency, to enable information exchange, and the flexibility to integrate with and build on existing frameworks.

##### Final recommendation

The RCS will be governed by a clear information sharing framework. The oversight body will work with sector regulators and entities to establish practical arrangements to facilitate collaboration and the exchange of information.

It is proposed that broad enabling information sharing provisions will enable the oversight body, entities and regulators to share investigation and other relevant information regarding a reportable allegation or reportable conduct to other entities in scope, government departments (including QPS regarding criminal offences) and statutory authorities who may have relevant functions that overlap with the RCS, and equivalent oversight bodies in other jurisdictions. This will be enabled only where it meets a certain purpose such as to lessen or prevent a serious threat to life, health, safety of an individual or the public.

The RCS will provide for some mandatory disclosures of information, including with police and in relation to a WWCC. Findings of reportable conduct must be shared with Blue Card Services for the purposes of the WWCC, and similarly, outcomes of WWCC assessments or reassessments for a person who has been subject to a reportable allegation should also be shared with the oversight body. It is proposed that police must notify the oversight body and the relevant head of an entity or regulator of any outcomes regarding any police investigations that overlap with the RCS.

#### Exemptions

The Royal Commission recommended the RCS should provide for the power to exempt any class or kind of conduct from being reportable conduct (Final Report, recommendation 7.10(g)(iv)).[[72]](#footnote-73) This exempts certain entities from requiring notification to the oversight body or to provide an entity report, in respect of a class or kind of conduct. The conduct is still reportable conduct, and the relevant entity is still required to investigate it, but without the oversight of the oversight body. It recognises that there are some entities and sectors that are competent to investigate certain classes or kinds of conduct. This helps to ensure that the oversight body can focus its efforts on the most serious matters, and on institutions or sectors that have less experience and have not demonstrated a satisfactory level of competence in complaint handling.

NSW, Victorian, ACT and WA schemes provide for class or kind exemptions. The Victorian, ACT and WA schemes also allow for an entity or class of entities to be exempt from the RCS, prescribed in regulation, however, there are currently no such exemptions in Victoria, ACT or WA. This may be because no organisations have yet been able to demonstrate the required competency to oversee reportable conduct investigations independently. Once jurisdictions’ respective schemes reach maturity, it is possible there will be an increasing number of exemptions as organisations have developed the operational experience to independently review and investigate allegations of reportable conduct.

The Queensland scheme will include the ability for the oversight body to exempt a class or kind of conduct for a particular entity or class of entities. In using such exemptions, the oversight body will need to carefully consider any risks that may arise from applying a lower level of scrutiny to certain organisations, such as reducing its ability to identify patterns of behaviour. The use of exemptions should only occur when organisations have demonstrated competence in investigating those classes or kinds of conduct and would therefore only be introduced as the scheme matures.

#### Capacity building and practice development

An important function of the oversight body will be to work with organisations to build their capacity to prevent harm to children through child safe systems, policies and practices through the provision of training, education and advice. In NSW, Victoria, WA and Tasmania, an object or function of the oversight body is to educate and provide advice to entities to assist them to identify reportable conduct and to report and investigate reportable allegations. In Victoria and Tasmania, this also includes education and advice to support regulators to promote compliance with the RCS. Queensland will include, as part of the legislative functions of the oversight body, providing education and advice to organisations and regulators to identify, report and investigate reportable conduct and allegations under the scheme.

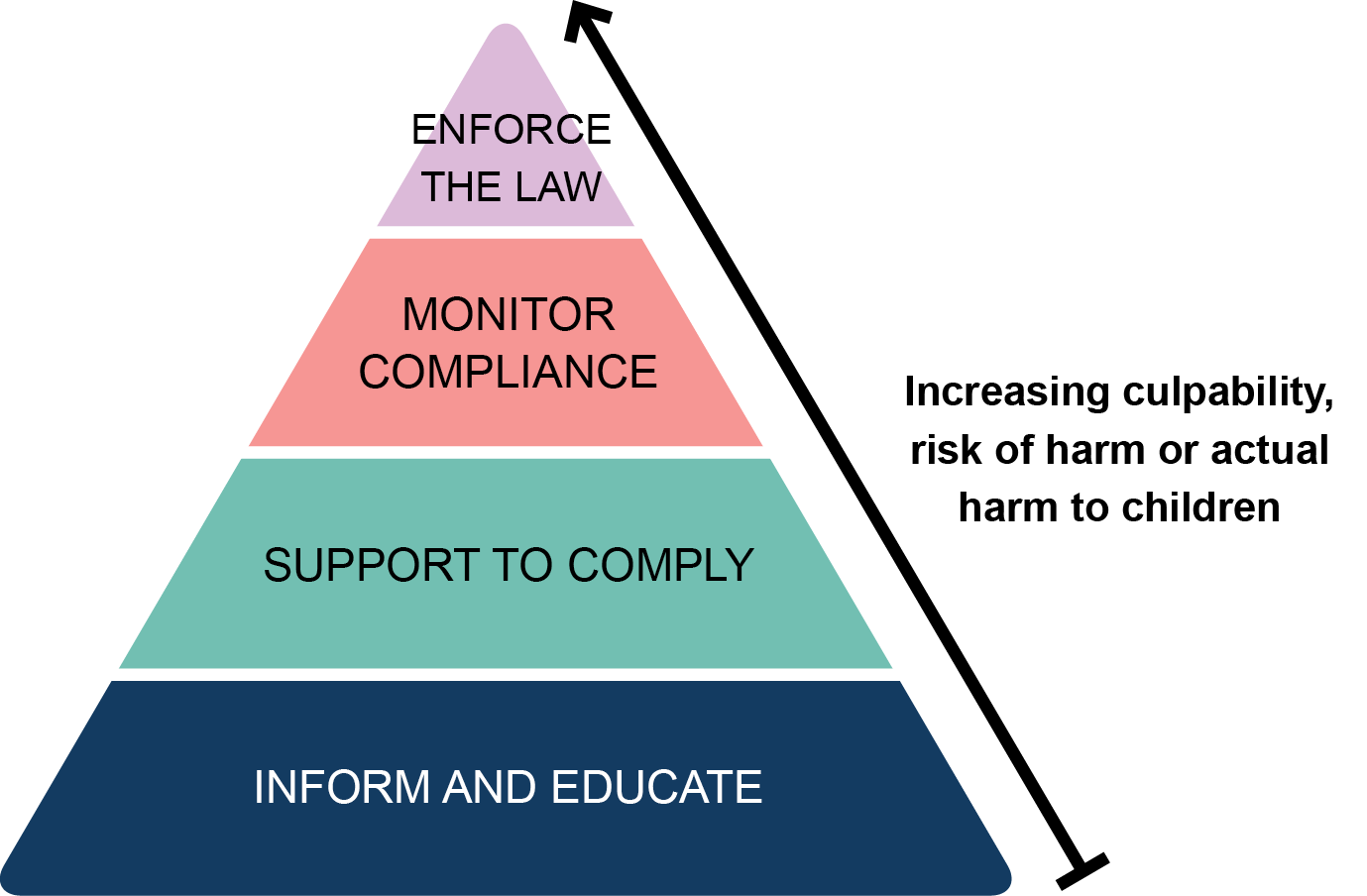
The Royal Commission found that the sectors most likely to require external advice and support are those that:

* are small or under-resourced;
* operate in new and emerging sectors;
* do not have the support of a peak body; and
* have little or no experience with handling complaints of child sexual abuse.

Capacity building will occur alongside the monitoring and enforcement functions of the oversight body to enable support to be targeted to organisations that need it the most.

In Victoria, the Commission for Children and Young People takes a risk-based approach as shown in Figure 8:

Figure 8 Commission for Children and Young People – Risk prioritisation approach



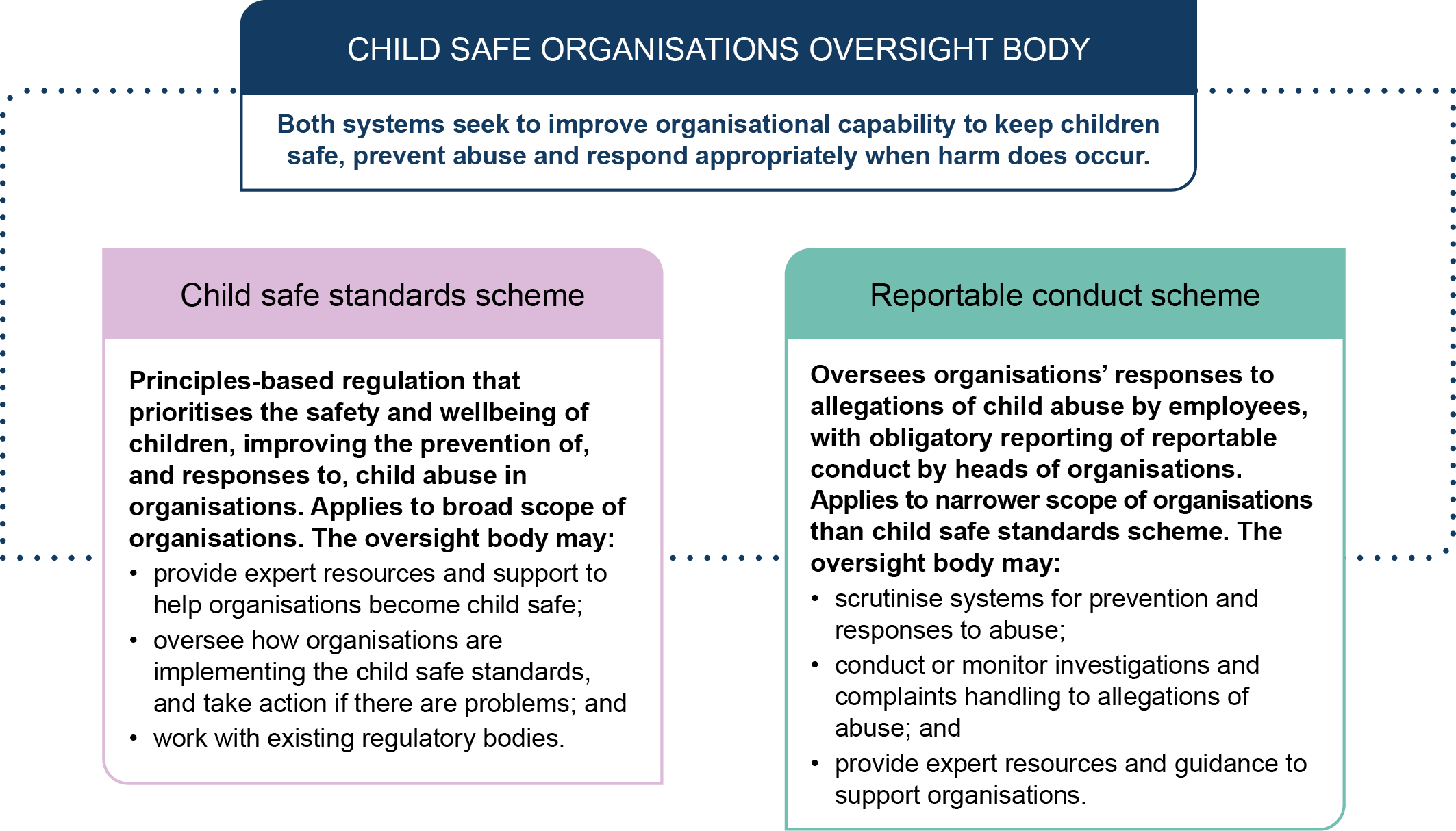
Experience in other jurisdictions suggests that under the RCS, the source of risk, the needs of organisations and the types of reportable conduct have evolved over time, warranting an approach that is dynamic and includes a focus on continuous improvement and maintenance of good practice for all organisations. The Queensland RCS will enable the oversight body to flexibly deliver a scheme that is responsive to individual circumstances and the characteristics of organisations and sectors.

Through the CRIS consultation process, several stakeholders recommended the establishment of communities of practice to support collaboration with other organisations. We heard that communities of practice have been used effectively in NSW in linking the oversight body with sector regulators and organisations for building relationships and improving compliance.

#### Implementing an integrated child safe organisations model

Both CSS and RCS seek to improve organisations’ ability to keep children safe and respond appropriately to allegations of child abuse. The Royal Commission considered that the oversight body for an RCS should also be responsible for monitoring and enforcing the CSS (which is the case in Victoria and NSW). In the CRIS, we explored the benefits to Queensland of establishing an integrated child safe organisations model consisting of CSS and RCS and sought stakeholder feedback on this approach.

Figure 9 Integrated functions of RCS and CSS into one independent child safe organisations oversight body



We proposed that integrating oversight of the CSS and RCS within one body has the potential to more effectively build child safe organisations and practices in Queensland because:

* the CSS and RCS are complementary schemes that together could comprise an integrated child safe organisations system in Queensland which is preventive, responsive and has the capacity to detect risks;
* the CSS could provide a foundation for organisations to develop child safe environments, while the RCS could provide a mechanism for transparent reporting of child abuse allegations and independent oversight of institutional responses to such allegations across sectors;
* an integrated model enhances the ability to identify and respond to risks posed by individuals working with children across sectors; and
* appointing a single oversight body to oversee both schemes allows costs to be shared, such as those relating to leadership resources, administration, information sharing, reporting, capacity building, and information and communications technology.

##### What we asked:

1. For organisations that work with the CSS and RCS in the same oversight body (i.e. Victoria and NSW), are there any other considerations we should be aware of regarding the schemes working together, based on your experiences?

##### Consultation results – an integrated model for Queensland

We heard strong support for an integrated CSS and RCS approach in Queensland. Organisations with experience operating in other jurisdictions, particularly NSW and Victoria, broadly indicated support for the integrated model proposed for Queensland, noting their experiences have generally been positive in other jurisdictions.

Key elements identified as important to the effectiveness of the integrated model included:

* cohesion and alignment between the administrative units implementing the two schemes, with streamlined internal processes to maintain the efficiency gains of co-location; and
* transparent and accessible lines of communication so organisations can easily access support and clarity when undertaking compliance activities.

##### Final recommendation

The final recommendation is to establish an integrated child safe organisations system in Queensland with CSS and RCS co-located in a single oversight body. The feedback we received about strengthening and clarifying the relationship between CSS and RCS will be considered as we continue to progress this work and as we prepare for implementation.

## PART 4 – Impact analysis of the options

This Part of the DIAS builds on our work in the CRIS by incorporating the results of consultation into our analysis and presenting a final impact analysis to government. In the CRIS we compared each option for CSS and RCS implementation in Queensland to maintaining the status quo, and we have used the same process in this DIAS.

#### Impact analysis

This Part details the expected impacts of the options developed to implement the CSS and RCS in Queensland. This is informed by what we have heard in consultations, lessons learned in other jurisdictions and actuarial analysis.

This Part includes government’s decision about the best option for Queensland to implement a child safe organisations system.

The cost estimates in this Part are intended to inform government’s decision about whether implementation of CSS and RCS will have an overall positive impact on the whole of Queensland. We heard feedback from organisations about their expected costs to comply – this feedback has been considered and has not changed the overall cost-effectiveness analysis.

Financial impacts for organisations will continue to be considered as this work progresses and we prepare for implementation.

There is inherent value in safeguarding children in Queensland, upholding their human rights and helping them grow up in a supportive, enriching environment that prioritises their wellbeing.

However, to help government invest in the most effective actions to prevent and respond to child maltreatment, in this Part we explore the risks, benefits and impacts of each option compared to the ‘base case’ of taking no further action to implement the CSS or RCS.

Quantifying the cost benefits of social policy initiatives that aim to improve the safety and wellbeing of children and young people is a challenging and sensitive exercise, and we have outlined the limitations in the existing data related to child abuse (see pages 23-28).

Based on the data available, we cannot accurately cost the expected benefits of regulatory changes that aim to reduce risks to children in organisations and, in the long-term, lower the prevalence and impacts of institutional child abuse. Data and information currently available to support the limited quantitative analysis in this Part are focused on cost impacts for organisations and government and are based on what is known from consultations in 2021 and 2023, experiences in other jurisdictions, independent actuarial analysis, and the extensive research of the Royal Commission.

The figures presented in this document are indicative only. The quantitative analysis is supported by qualitative discussion and comparative analysis which is also informed by these sources.

The following analysis examines the comparative risks, costs (where possible to estimate) and benefits of each option. This analysis has informed the recommended option for CSS and RCS in Queensland outlined in this document, which is an integrated child safe organisations system consisting of CSS and RCS.

It is important that the benefits and impacts of implementing the recommended option are monitored and evaluated, to inform future best practice and continuous improvement.

The impact analysis is delivered with respect to four key stakeholder groups:

* **Children and young people** – as the intended beneficiaries of regulatory reform.
* **Community at large** – including wider social impacts arising from reforms.
* **Government** – in its capacity as central oversight body/regulator and also being subject to compliance requirements.
* **Organisations and the sector** – as being subject to compliance requirements.

### Methodology

To quantify the estimated financial impact of costs and benefits that could be realised by implementing the various options, a financial analysis was performed on the options (aside from the status quo) to evaluate the required impact for each option to be cost-neutral.

In the CRIS, this impact was quantified as a reduction in the annual prevalence of child maltreatment in Queensland institutions, which was estimated to be approximately 12,148 cases per year at baseline, as outlined on page 26. In the CRIS, we used the estimated value of the lifetime costs of a single case of child maltreatment to an individual, as established in McCarthy et al. (2016) i.e. approximately $614,309.16, adjusted to December 2022 dollars.[[73]](#footnote-74) We have continued to use both these figures for the purpose of our impact analysis in the DIAS. Based on these estimates, total annual cashflow ‘benefits’ can be estimated as the savings accrued to society by reducing the prevalence of child maltreatment. For example, a 5% reduction in annual prevalence is equal to a reduction of approximately 607 cases per year, which results in an annual equivalent savings of approximately $373 million. These savings were used to develop a ‘benefits’ cash flow.

It is expected that as CSS and RCS models are implemented in Queensland, two impacts will occur: a reduction in annual prevalence of child maltreatment in Queensland institutions, and a reduction of the average harm incurred in cases of child maltreatment that continue to take place. Theoretically, for the purposes of the analysis in this DIAS, a reduction of the level of harm incurred would also impact the estimated ‘benefits’ cash flow by increasing the effective savings for society realised by preventing one case. In the absence of reliable data to estimate what the value of the reduction in average harm from implementing the options is, we have not incorporated this into the analysis, and only use ‘avoided incidents’ as the measure. However, it is reasonable to expect that the actual number of ‘avoided incidents’ required for an option to be cost-effective is lower, as benefits accrue more broadly from reduced harm to all children who experience maltreatment.

To develop a costs cash flow, we drew on independent modelling by Finity Consulting as contracted by DCSSDS, which produced cost estimates for both an oversight body regulating CSS and/or RCS, and cost estimates for organisations complying with the two policies. Note the key assumptions and limitations involved in the modelling performed by Finity Consulting, and the additional impact analysis which informed this part of the CRIS, are summarised below in Tables 18, 19, 20, 21 and 22.

The cost estimates in this Part are intended to inform whether implementation of CSS and RCS will have an overall positive impact for Queensland. We heard feedback from organisations about their expected costs to comply – this feedback has been considered and has not changed the overall cost-effectiveness analysis.

For establishing the oversight body, approximate annual cost estimates were provided for both the set-up period (spanning the first five years of implementation), and an ongoing annual cost once the option was fully implemented (year six onwards).

Table 18 Annual average costs to establish oversight body

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
| Option | | Cost (M) per year | | | | | |
| Year 1 | Year 2 | Year 3 | Year 4 | Year 5 | Year 6+ |
| CSS | Option 2 | N/A | | | | | |
| Option 3(a) | $3.96 | $4.40 | $3.79 | $3.46 | $3.56 | $3.50 |
| Option 3(b) | $3.96 | $4.04 | $3.48 | $3.19 | $3.41 | $3.40 |
| RCS | Option 2 | $3.47 | $5.68 | $5.10 | $5.27 | $5.42 | $5.40 |
| Integrated model[[74]](#footnote-75) | | $7.43 | $6.61 | $7.02 | $8.12 | $8.83 | $8.83 |

The cost estimates for the oversight body will be reviewed in consultation with the oversight body both before and after the commencement of the schemes. Feedback through the CRIS consultation highlighted the need for the oversight body to be adequately resourced to fulfill its functions. This was reinforced by the Tasmanian Commission of Inquiry recommendation (18.4b) that the oversight body be sufficiently resourced to enable it to effectively perform these regulatory functions.

For organisations, costs were distinguished as the initial set-up costs and ongoing costs once the organisation has fully complied with either CSS, RCS or both. Estimated costs are in Table 19.

#### A note on assumptions and limitations underpinning modelling for organisational costs

The cost estimates for organisations, modelled by Finity Consulting (Table 19) were based on the following key assumptions:

* Average annual remuneration for staff (including superannuation) was taken to be $125,000 for larger organisations and $70,000 for smaller organisations, for the purpose of deriving equivalent hourly costs from time requirements.
* Several activities were identified as applying only to large organisations, such as large-scale change management processes or ranges in cost for different sizes of organisation (small vs large) such as for training. The reference to organisation size is indicative only and may apply on a per-site basis – as such, costs may need to be multiplied for very large, multi-site organisations.

The cost estimates for organisations, modelled by Finity Consulting (Table 19) were also subject to the following limitations:

* Actual costs will likely vary significantly depending on the size, structure, operational practices, workforce profile and risk factors for each organisation.
* Individual and total organisational costs were developed before the final model was recommended, and Finity Consulting noted that final policy positions on matters such as the regulatory toolset available to the oversight body and the scope of organisations would have an impact on exact costs for organisations.
* Organisational costs do not consider potential offsets from existing obligations under current regulation – e.g. it may cost organisations less to set up policies and systems to comply with CSS and RCS if they already comply with existing obligations that align (see Table 22).

Table 19 Estimated average annual total costs for organisations in scope to comply with CSS and RCS

|  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- |
|  | Annual costs to organisations | | | | | | | |
| Large school | | Religious organisation | | Foster care provider | | Small organisation | |
| Set-up | Ongoing | Set-up | Ongoing | Set-up | Ongoing | Set-up | Ongoing |
| CSS | $23,333 | $8,750 | $15,000 | $7,222 | $10,000 | $5,972 | $1,167 | $1,027 |
| RCS | $23,333 | $23,333 | $15,000 | $98,898 | $10,000 | $66,806 | $1,167 | $793 |
| Integrated model[[75]](#footnote-76) | $24,333 | $26,667 | $16,000 | $101,620 | $11,000 | $69,028 | $1,353 | $1,391 |

The costs summarised in Tables 18 and 19 reflect the independent modelling undertaken by Finity Consulting and are indicative only. The cost estimates for organisations (Table 19) are based on estimates of the labour needed to perform the administrative duties of complying with CSS and RCS, as detailed in Part 3.

Tables 20 and 21 detail the costs for specific compliance activities that Finity Consulting used to form its estimates in Table 19. Following consultation, we have updated Tables 20 and 21 with feedback from organisations about estimated costs to comply with CSS and RCS. Updates are in **bold blue** text, with original estimates in the CRIS noted in brackets where relevant.

As Table 19 represents an average cost for types of organisations, it has not been updated to reflect the results of consultation through the CRIS process because:

* While helpful in providing a clearer picture for individual organisations to implement CSS and RCS, the feedback we received represents a small sample of organisations in Queensland (we estimate 40,000 organisations will be in-scope for CSS and/or RCS - see page 95).
* We received mixed feedback on costs where organisations suggested our estimates were adequate, too low or too high which indicates a wide variety of costs across organisations.
* Many of the submissions which said they would expect higher costs than the estimates in Tables 20 and 21 are very large, multi-site organisations, some with thousands of employees, while most organisations in Queensland are small, with less than 20 people employed or earning total revenue less than $1 million.[[76]](#footnote-77),[[77]](#footnote-78)

For the purpose of the cost-effectiveness analysis, the average costs in Table 19 are used to estimate the total costs for all organisations in Queensland, i.e. it represents the average cost for an individual organisation which has then been multiplied by the approximately 40,000 Queensland organisations in scope (see page 95).

Updating the average estimated costs was unlikely to be more accurate for estimating the total costs to all organisations in Queensland that would be required to implement CSS and RCS. However, we updated Tables 20 and 21 because it may provide a clearer picture for individual organisations about the potential cost for CSS and RCS compliance. The results of the cost-effectiveness analysis are presented in Tables 28, 30, 32 and 36.

Table 20 Estimated costs for organisational compliance with CSS

| **Activity** | **Time requirement** | **Cost (small – large)** | **Frequency of activity** |
| --- | --- | --- | --- |
| Participate in initial capacity building run by regulator | 2–6 people, 5 hours each | $467 – $2,500 | Year 1 only |
| Participate in ongoing capacity building by regulator | 2–6 people, 5 hours each | $467 – $2,500 | Every second year |
| Set up/revise policies and systems | 15–50 hours | $700 – **$5,244** ($4,167) | Year 1 only |
| Maintain policies and systems | 5–20 hours | $233 – $1,667 | Annually |
| Annual self-assessment | **1-4 people,** 10 hours | $467 – **$3,332** ($833) | Annually |
| Participate in responsive capacity building if required | 2–5 people, 10 hours | $933 – $4,167 | As required |
| **Engagement and involvement of children and families** | **2-6 people, 5 hours** | **$467-2,500** | **Variable** |
| Large organisations only | | | |
| Run internal capacity building – initial cost | **Per** 50 people, 2 hours each | $8,333 | Year 1 only |
| Run internal capacity building – ongoing cost | **Per** 25 people, 2 hours each | $4,167 | Every second year |
| **Dedicated project oversight** | **1 person, full-time** | **$125,000** | **Annual** |
| **Marketing materials** | **Variable** | **$5,000** | **Year 1 only** |

Table 21 Estimated costs for organisational compliance with RCS

| **Activity** | **Time requirement** | **Cost** | **Frequency of activity** |
| --- | --- | --- | --- |
| Participate in initial capacity building run by regulator | 2–6 people, 5 hours each | $467 – $2,500 | Year 1 only |
| Participate in ongoing capacity building by regulator | 2–6 people, 5 hours each | $467 – $2,500 | Every second year |
| Set up/revise policies and systems | 15–50 hours | $700 – **$5,244** ($4,167) | Year 1 only |
| Maintain policies and systems | 5–20 hours | $233 – $1,667 | Annually |
| Report incidents | 2 people, 5 hours each | $233 – $833 | Dependent on external factors |
| Investigate incidents | 2 people, 20 hours each or outsourced (for larger organisations) | $1,867 – **$60,000** ($30,000) | Dependent on external factors |
| **1 - 3 dedicated investigators and 0.5 FTE coordinators (only required to extremely large organisations)** | **$144,000 - $492,000** | **Annual** |
| Participate in responsive capacity building if required | 2–5 people, 10 hours | $933 – $4,167 | Where required |
| **Backfilling labour during ongoing investigation requiring employee is stood down with pay** | **Variable** | **Variable** | **Subject to the nature of allegations, role of subject of allegations and length and complexity of investigation** |
| **Engagement and involvement of children and families** | **2-6 people, 5 hours** | **$467-2,500** | **Variable** |
| **Large organisations only** | | | |
| Run internal capacity building – initial cost | **Per** 50 people, 2 hours each | $8,333 | Year 1 only |
| Run internal capacity building – ongoing cost | **Per** 25 people, 2 hours each | $4,167 | Every second year |
| **Dedicated project oversight** | **1 FTE** | **$125,000** | **Annual** |
| **Marketing materials** | **Variable** | **$5000** | **Year 1 only** |

Consultation confirmed that the actual costs for an organisation will be highly dependent on its size, complexity and existing operational and reporting practices, as well as factors such as how many reportable conduct incidents (RCIs) occur.[[78]](#footnote-79) The actual number of RCIs in each sector and organisation is likely to vary and fluctuate year to year. As the compliance requirements for CSS Options 2, 3(a), and 3(b) are the same, we have not differentiated estimated costs for individual organisations to comply with CSS. The key difference between Options 2, 3(a) and 3(b) relates to the number of organisations in scope, and the relationship between the oversight body and existing regulators.

Costs for organisations may also be offset by integrated implementation of CSS and RCS, as demonstrated in Table 22, as well as by existing regulatory obligations. Table 22 provides examples of some of the existing obligations and activities an organisation may be undertaking that could reduce the real cost of engaging in activities to comply with the CSS and RCS:

Table 22 Cost offsets for organisations complying with CSS and RCS

| **Activity** | **Offset – examples of existing obligations and activities** |
| --- | --- |
| Participate in capacity building with oversight body | * Blue card system, including requirements to develop and implement Child and Youth Risk Management Strategies – policies on handling disclosures or suspicions of harm. * Registered NDIS providers supported by NDIS Quality and Safeguards Commission to prevent and respond to incidents of harm. * Queensland Public Service Code of Conduct – training and development. * Department of Education – mandatory annual student protection training for staff who have contact with students or children. |
| Run internal capacity building for staff (large organisations only) | * Blue card Child and Youth Risk Management Strategy – policies on handling disclosures or suspicions of harm. * Queensland Public Service Code of Conduct – training and development. |
| Set up/revise and maintain policies and systems for preventing, detecting and responding to reportable allegations | * Blue card Child and Youth Risk Management Strategy – policies on handling disclosures or suspicions of harm. * HSQF requirements to have processes to prevent, identify, and respond to harm. * Reportable incidents management obligations of registered NDIS providers. * Early childhood services under the National Quality Framework must have policies and procedures for responding to complaints. * Department of Education – allegations against employees in the area of student protection procedure (including failure to report and protect offences). |
| Report incidents to the oversight body (within a prescribed period) | * Build on processes for mandatory reporting obligations for certain professions including school staff members, teachers, doctors, registered nurses, police officers with child protection responsibilities, and early childhood education and care professionals. * Reportable incidents management obligations of registered NDIS providers. * Criminal Code offence of failure to report sexual offences against children. * Employing authority for school must notify Queensland College of Teachers of allegations of harm. |
| Investigate, or arrange for investigation of, incidents and report findings to the oversight body | * Registered NDIS providers may be required to carry out an internal investigation of reportable incidents, or engage an independent expert to investigate. * Queensland College of Teachers investigations into professional conduct of teachers. * Australian Health Practitioner Regulation Agency and the Office of the Health Ombudsman manage complaints about conduct of individual health practitioners. * Civil liability legislative requirements to take all reasonable steps to prevent the abuse of a child by a person associated with the organisation under their care, supervision etc. |
| Participate in responsive capacity building if required (liaising with oversight body to implement improvements/recommendations if issues arise) | * HSQF requirements to have processes to prevent, identify, and respond to harm. * Registered NDIS providers supported by NDIS Quality and Safeguards Commission to prevent and respond to incidents of harm, including being directed to take specific remedial action. |

#### Methodology of the cost-effectiveness analysis

The other cost considered in the overall cost-effectiveness analysis was additional costs to government faced by agencies in working with the oversight body. These costs to agencies were estimated to arise from an increased need for staff to manage required activities for complying, reporting and communicating with the oversight body and meeting relevant obligations (see Part 3). An estimate of the net annual cash flow was produced by deducting the costs from the benefits cash flow. The chosen timeframe to analyse these forecasted cash flows was 10 years, which allows sufficient time for implementation of each option to reach maturity. Expanding the forecast beyond 10 years increases the risk that estimated costs and benefits are significantly different from the actual costs and benefits following a decade of economic change, policy reform and technological advancement.

Over this total cash flow, a net present value (see glossary) of the total cash flow of implementation was estimated. In line with the Australian Government Office of Best Practice Regulation,[[79]](#footnote-80) a discount rate (see glossary) of 7% was used to estimate what percentage of the existing annual prevalence of child maltreatment in Queensland institutions would have to be reduced for each option to be cost effective. As can be seen in Tables 28, 30, 32 and 36, the key outcome of this analysis is that all options assessed are expected to have a positive net impact if they achieve a relatively low impact toward the objectives of this regulation. It is expected that all assessed models will likely produce outcomes beyond the cost-neutral level (see ‘expected effectiveness’, pages 94-95).

It is important to note that financial outcomes for government are not the ultimate objective of proposed regulation – the safety and wellbeing of all children who receive care or services from institutions in Queensland is paramount and any regulation that improves this is inherently worthwhile. Nonetheless, the analysis demonstrates that, CSS Options 2, 3(a) and 3(b) and RCS Option 2, and an integrated implementation of CSS and RCS, are overall highly likely to be beneficial and cost-effective. This analysis must be considered holistically with the qualitative assessments of the impact of both options on various stakeholder groups, chief among them children and young people. To further test the reliability of these findings, key assumptions were adjusted to evaluate the impact they had on the result, including the discount rate and the number of organisations in scope. The results of this sensitivity analysis demonstrated that even if assumptions about certain costs and benefits are somewhat inaccurate, the options continue to be highly cost effective (see **Appendix A).**

#### Expected effectiveness

Forecasting the specific impact, a given option will have on the prevalence of maltreatment is not possible with existing available data. For this reason, the cost-effectiveness analysis used for the impact analysis establishes a minimum break-even impact required for each option to have a net benefit for Queensland. It is then possible to make broad assumptions as to whether it is likely for the options to exceed that minimum level.

The key evidence to the effectiveness of the CSS Option 3(a) and Option 3(b) and RCS Option 2 is established in the Final Report of the Royal Commission, particularly Volumes 6 and 7 which recommend implementation of CSS and RCS.[[80]](#footnote-81) Building on the work of many previous inquiries, and drawing on insights from over 8000 private sessions, 338 written accounts and 12 community forums with people who had been affected by child sexual abuse, the Royal Commission was able to establish for the first time a fulsome and informed view of the key risk factors and drivers of child sexual abuse in institutions.

This evidence was supported by the Royal Commission’s comprehensive policy and research agenda which produced 33 policy and research papers, that informed its final recommendations. One example of the many sources drawn on to inform the Final Report was a scoping review on evaluations of employment screening practices to prevent child sexual abuse, which summarised the findings of 25 evaluations with evidence that criminal-history checks are more effective when paired with other human resources checks.[[81]](#footnote-82)

There is also evidence from the implementation of CSS and RCS in other jurisdictions that can be drawn on to estimate the potential impact of CSS and RCS on prevalence of child maltreatment in Queensland institutions. By applying data on RCIs from other jurisdictions to Queensland population data, it is estimated there will be approximately 1200 total RCIs every year across all in-scope organisations (see Table 35). If we estimate that of 1200 reports, only 240 (20%) result in the prevention of a future incident of child maltreatment, we can estimate an impact of a reduction of approximately 2% (of the estimated 12,000 total annual cases of child maltreatment in Queensland institutions) (see Part 1). This value provides an approximate benchmark for impact to use in this impact analysis for the RCS.

Acknowledging the evidence base of the Royal Commission balanced against evidence from other jurisdictions, 2% is also used as the conservative estimate of reduced prevalence of child maltreatment in Queensland institutions as a result of fully implementing CSS Option 3(a) or 3(b). Therefore, the expected impact for implementing an integrated child safe organisations model which combines CSS Option 3(a) and RCS Option (2) is taken to be 4%. Given the significantly reduced scope compared to other jurisdictions and the Royal Commission recommendations, for CSS Option 2 the expected effectiveness is taken to be substantially less, with approximately a quarter of the impact at 0.5%.

It is noted that these estimates for effectiveness at reducing prevalence of child maltreatment are intended for use in comparing and evaluating the options considered in this impact analysis and are intentionally conservative to provide confidence in the outcomes of the cost-effectiveness analysis. Clearly, it is the intention that government action reduce the prevalence of child maltreatment in institutions substantially more than a 0.5–4% reduction, and our ultimate goal is to prevent child maltreatment in institutions altogether. However, these estimates allow the evaluation of each option and give an indication of whether it is likely to provide a net benefit for Queensland.

#### Key assumptions in cost-effectiveness analysis

* To account for the required time for implementation, benefits were estimated to begin after the first year. In reality, it is likely there will be a more incremental realisation of benefits as more organisations reach full compliance beginning from initial implementation.
* Costs for organisations in scope were based on scaling up from approximately one third of the cost in Year 1, two thirds of the cost in Year 2 and full costing in Year 3. This represents a phased approach to implementation, rather than incorporating all organisations in scope immediately.
* The estimated number of organisations in scope was based on estimates produced by the Victorian Government in developing its CSS and RCS schemes, and data about specific types of Queensland organisations, with adjustments made to reflect the difference in population between Victoria and Queensland. The estimated Victorian numbers were 50,000 organisations subject to CSS and 12,000 organisations subject to RCS. [[82]](#footnote-83) The estimates for Queensland are approximately 40,000 organisations subject to CSS and approximately 10,000 organisations subject to RCS.
* The estimates used for ‘additional costs to government’ for CSS Option 3(a) and 3(b), RCS Option 2 and a co-located integrated child safe organisations model are the same, noting that it is expected the costs for agencies to collaborate with an oversight body are likely to be generally consistent whether the oversight body is solely administering either of the schemes, or both. Furthermore, the sensitivity analysis demonstrates that significant shifts in the estimated total cost to government have a limited effect on the results of the impact analysis.
* For Option 2 of the CSS model, estimated costs for organisations in scope are taken to equal approximately 10% of total costs for all organisations in scope of Options 3(a) and 3(b), noting that Option 2 would have a significantly reduced scope of organisations mandated to comply.

#### Variables not costed in cost-effectiveness analysis

* Separate analysis was not performed to estimate the specific impact on costs for different parties resulting from a decision on the use of the framework of ‘child safe standards’ or ‘National Principles’– it is highly unlikely that the associated impact on costs would be significant as the major costs for implementing CSS are not sensitive to which framework is adopted in Queensland.
* There are Queensland organisations that have already implemented a form of CSS and/or RCS, including those that operate across multiple jurisdictions that already have the CSS and/or RCS, Queensland Government departments which have begun implementing the CSS since 2018, and other organisations that have voluntarily implemented additional measures aligned with the CSS. This will impact the actual cost-effectiveness of implementing the schemes in Queensland, because there may already be an existing level of compliance in some sectors. Additionally, some organisations may have already voluntarily implemented additional measures aligned with the CSS and RCS, which means that the costs and benefits for the non-status quo options would be lower compared to the status quo.

|  |
| --- |
| What we asked:  1. Are the costs detailed in Tables 19, 20 and 21 regarding costs for organisations, relatively accurate approximations of the costs your organisation may face in complying with CSS and RCS? If not, is the actual cost likely to be substantially higher or lower, and why? 2. Will there be any other costs associated with the implementation of CSS or RCS from activities not sufficiently captured by the estimates in Tables 20 and 21? Examples of possible CSS compliance activities are included in Table 12 in Part 3. |

#### Consultation results

Approximately half the submissions received through the CRIS consultation process provided specific feedback on our estimated costs in Tables 20 and 21 in the CRIS. Most of these organisations indicated that their expected costs to comply with both CSS and RCS are likely to be higher than estimated in the CRIS, however, the reasons for higher costs varied significantly. This is to be expected given CSS and RCS will apply to a wide range of diverse organisations.

Table 23 is a snapshot of the submissions we received which specifically provided feedback on costs, noting that organisations generally expect costs to be higher than estimated in Tables 20 and 21.

Table 23 – Snapshot of feedback on cost estimates

|  |  |
| --- | --- |
| Submissions | Feedback summary – key messages |
| Lower costs:   * CSS – 2 submissions | * Organisations have already implemented the CSS, National Principles or have other safeguarding policies and procedures in place. |
| Adequate estimates:   * CSS – 6 submissions * RCS – 6 submissions | * Cost estimates are reasonable, however, organisations noted several factors may impact costs for individual organisations including size and complexity and need for specialised training and investigations. |
| Higher costs:   * CSS – 18 submissions * RCS – 20 submissions | * Volunteer based organisations will likely require more time to complete tasks than was estimated. * Costs for organisations in regional and remote areas, including Aboriginal and Torres Strait Islander Community Controlled Organisations, are likely to be high e.g. to fly in investigative expertise. * The underlying average hourly rate for estimated costs is too low. * Additional costs which may not be taken into consideration in the estimates include the recruitment of staff, ongoing training, data management systems, updating accreditation systems and potentially legal fees in cases of non-compliance. * Level of resourcing of the oversight body and its capacity to support organisations could have a substantial impact on the costs for organisations. |

Building on the assumptions we used in the CRIS analysis (refer pages 95-96), the feedback from organisations through the consultation process has informed the development of further assumptions:

* Large organisations may have additional costs associated with setting up governance arrangements, training senior leaders and board members, and acquiring labour and resources for large-scale organisational consultation, communication and change management processes.
* Organisations operating in rural and remote areas may experience greater costs compared to central or urban locations, including the additional expense of bringing in outside expertise for investigations and auditing (such as travel and accommodation costs).
* Sectors and organisations that experience high staff turnover and a greater share of casual employees in the workforce (e.g. early childhood education and care) may have increased costs associated with training and capacity building for staff.
* Organisations that lack the required skill-base and labour resourcing to implement the CSS and RCS due to shortages of qualified staff, may face added costs to hire the necessary staff.
* The cost associated with investigations will have a significant impact on the total costs faced by organisations required to comply with the RCS – some submissions noted that the amount of labour required to complete an investigation is highly variable and is often substantially greater than the estimated figures.
* Adapting resources to be culturally safe and inclusive represents another potentially significant cost for organisations, e.g. translating resources into other languages.
* Very large or multi-site organisations may face larger costs given their scale e.g. providing multiple training sessions to 400 employees across multiple locations costs more than a single site organisation providing a single training session to a staff of 50 employees.
* For the many organisations already compliant with the National Principles, the alignment of the adopted standards in Queensland with the National Principles can be a significant cost offset.

The results of consultation provided further insight into the potential impacts on organisations in complying with the CSS and RCS. These impacts will continue to be considered as this work progresses and we prepare for implementation. Consistent with the intent that the Queensland child safe organisations system is implemented in a flexible manner that is sensitive to overburdening or duplicating the work of organisations, there will be a role for the oversight body to consider the impact of compliance on organisations.

Overall, the consultation results support the finding of the impact analysis proposed in the CRIS; that implementing CSS and RCS will have a cost for organisations and for government, but that the cost of failing to act to protect children and young people is far greater. In undertaking the impact analysis, we also developed a sensitivity analysis (see Appendix A) to test whether large changes in our estimates would substantially change the expected net impact of implementing CSS and RCS. This analysis found that even if the total cost for all organisations in scope to comply with the CSS and RCS was much higher, it is still expected that the implementation of an integrated model would create a significant net benefit for Queensland. This means we can be confident that the recommended options will have a net benefit even if the total average cost for organisations complying with the CSS and RCS is higher than estimated.

Based on the results of consultation and the further impact analysis conducted for the purpose of this DIAS, our conclusion is that the recommended integrated child safe organisations model will be cost-effective and produce a significant net benefit for Queensland while contributing to the primary objectives of improving safety and wellbeing for children, and ensuring appropriate responses if children are at risk of, or experience, harm.

The final recommendation reflects our preferred approach in the CRIS. However, the consultation process has reinforced key elements of the preferred model including the integration of a flexible and proportionate approach to compliance that minimises duplication and regulatory burden; and the central role of the oversight body to support and build the capacity of organisations to be child safe.

### Child safe standards

#### Option 1 – No action and maintain status quo

If no further action was taken by the Queensland Government to implement the CSS, existing protections for children in organisations would continue via the current regulatory safeguards in Queensland, such as the blue card system, sector-specific regulation and quality frameworks (e.g. early learning regulatory frameworks or non-state schools accreditation processes). An ad hoc and inconsistent approach to CSS implementation across the sectors providing services to children and young people may be the result. As the status quo option, Option 1 represents the base case against which the other options are compared. As this option entails no further government action, it has no cost, produces no additional benefit and does not respond to risks currently experienced by children in Queensland. Table 25 demonstrates the strengths and weaknesses of continuing to take no action, however for the purposes of the cost-effectiveness analysis, the costs and benefits are nil.

Costs and benefits are broken down by impacted stakeholders below:

Table 25 CSS Option 1 – Costs and benefits of maintaining status quo on stakeholder groups

| **Stakeholder** | **Risks from inaction** | **Benefits from inaction** |
| --- | --- | --- |
| Children and young people | * Children and young people in Queensland will not be afforded the same level of safety in organisational environments that their peers in other jurisdictions with the CSS receive. | * None specific to children and young people. |
| Organisations | * Continued uncertainty for organisations in how to best apply the CSS in their context. * This option is unlikely to be effective in driving cultural change in organisations to prioritise the safety and wellbeing of children and young people. | * This option incurs no regulatory burden as it implements no additional regulation. |
| Government | * Government organisations delivering services to children will continue to have limited independent oversight of child safe practice – risks of liabilities relating to child abuse continuing to grow. * The CSS were intended by the Royal Commission to complement other reforms. By taking no further action to embed the CSS in Queensland, the vision of the Royal Commission to reduce child abuse and ensure effective institutional responses is only partially achieved. * This may mean investment in other reforms is less valuable and effective. | * Cost savings will accrue to government in terms of the limited compliance and monitoring responsibility associated with the current, ad hoc approach to CSS compliance in funded and non-funded sectors. |
| Wider community | * Not an approach that supports national consistency, one of the key aims of which is to build a baseline understanding of what minimum expectations are for organisations to be ‘child safe’. * Loss of opportunity to build community awareness. * Continuation of costs of institutional child abuse accruing to wider community. | * Government expenditure on establishing a system to implement CSS in Qld could be redirected elsewhere in the community. |

##### Summary of impact analysis for Option 1

This option does not meet the intent of the core objective (in Part 2) of government action to seek to minimise the risks and impacts of child abuse in organisations working with children and young people in Queensland. While there are some existing measures to protect children in Queensland institutions, there is a clear case for exploring additional measures that cut across all sectors working with children to support a consistent approach to child safe practice. Further, as safeguarding strengthens through the implementation of the CSS and RCS in a growing number of other states and territories, the risk to Queensland children may increase as perpetrators seek organisations with less safeguards compared to other states and territories. It is not recommended to pursue this option further.

##### What we asked:

1. Do you support the Queensland Government taking no further action to implement the CSS in Queensland, with organisations able to choose whether to adopt the CSS? Why or why not?
2. What are the current challenges for your organisation/sector in supporting the safety and wellbeing of children in organisations? Do you think adopting the CSS in Queensland could help address these?

##### Consultation results

Stakeholders did not support the status quo in Queensland. Where specific reasoning was given, stakeholders shared the view that there is an urgent need for meaningful improvements to child safe organisation cultures in Queensland to ensure the safety and wellbeing of children. There was strong agreement that continuing with the status quo was not acceptable, with further input on how adopting CSS could address current challenges for child safety in organisations summarised in Table 26:

Table 26 Suggestions for how CSS could address current challenges in supporting child safety in organisations

| Current challenges to supporting child safety | How CSS could help address |
| --- | --- |
| * Equipping carers and child protection staff to manage the complexities of working with children and young people who have experienced harm. * Lack of community understanding of the nature, causes and impacts of child maltreatment. * Lack of adequate resourcing, training and professional development. * Difficulties gaining clarity around, and access to, information and requirements regarding CSS. There are a number of regulatory bodies that do not have the capacity to give practical advice and assistance. * Lack of detailed research and information on trends in risks factors relating to perpetrators and risk factors for organisational settings. * Non-reporting of abuse and failure to respond appropriately to allegations of abuse. * Lack of a shared language and understanding of children’s safety across sectors and organisations. | * Standardises training to ensure staff are equipped with the knowledge, skills and awareness to keep children safe through continual education and training, and to understand expectations and requirements about reporting abuse. * Supports government and non-government organisations implementing CSS in a mutual relationship. * External oversight to not only non-government organisations meeting CSS, but also public entities and others working with children and young people. * Reinforces a culture both in organisations and the communities they serve, that seeks to understand the rights of children and the nature of child maltreatment. * Provides a baseline for what is required for an organisation to present as safe. * Considers compliance when funding programs. * Provides clear standards and practical assistance to organisations. * Requires people in child-related roles to report abuse. * Provides a nationally recognised framework and shared language between organisations, sectors and government. * Shifts cultural understanding to child protection being everyone’s responsibility, not only that of leaders and administrators or external agencies. |

#### Option 2 – Non-legislative approach to implementing the child safe standards

This option involves no central oversight body for CSS. CSS obligations would largely be passed on via contracts to funded non-government organisations and could be incorporated into existing regulatory frameworks. Compliance would be voluntary for non-funded organisations or organisations that have minimal government regulation (e.g. sport and recreation organisations and religious organisations).

Table 27 Impacts on stakeholder groups – CSS Option 2 – non-legislative approach

| **Stakeholder** | **Costs and risks (compared to status quo)** | **Benefits** |
| --- | --- | --- |
| Children and young people | * Inconsistent implementation of CSS within and across sectors will mean that only some children will obtain the benefits of this model. * Potential for organisations in scope to pass on additional costs of complying with CSS through membership fees. | * Children who receive services from relevant funded organisations that are required to embed CSS via contracts or regulatory frameworks will experience benefits to their safety and wellbeing as the organisations work to embed the CSS into organisational culture and practices. |
| Organisations | * Any introduction of new regulatory measures will mean organisations need resources to meet new requirements. This may result in organisations needing to redirect resources from other parts of the service. * Competition impacts – unequal application of CSS regulatory requirements depending on whether an organisation is funded or regulated by government may lead to adverse competition impacts for organisations required to be child safe. For example, some organisations provide multiple services, and while only some of an organisation’s service delivery streams may require CSS compliance, costs may still increase for embedding CSS in the organisation even across the service delivery streams that do not require CSS implementation. An organisation may need to increase its fees for service delivery across all streams to cover these costs. This may in turn make it less competitive than organisations delivering the same out-of-scope services that are not required to become child safe. * Organisations out-of-scope that wish to implement the CSS will be doing so without centralised supports and capability building activities. * While out-of-scope organisations may save money by not being required to comply with CSS and may be able to offer cheaper services, there is a risk especially for smaller, volunteer-run organisations that may not have the capacity to implement the CSS themselves, their service offering may in time be seen as less valuable as they will not be considered a child safe organisation. | * This option has a comparatively low level of regulatory burden for organisations, given obligations will be incorporated into existing regulatory frameworks and contracts. It also does not feature the same level of oversight that a legislative regulatory system would involve. * Additionally, the total regulatory burden for organisations will be lower than other non-status quo options, as the number of organisations subject to mandatory compliance is lower than Options 3(a) or 3(b). * For organisations in scope of CSS regulation, they may be able to tap into existing relationships with their funders/regulators to access tailored capacity building support to become a child safe organisation. * Organisations in scope of the CSS regulation will be able to hold themselves out to be child safe organisations, over time potentially gaining a competitive edge as community awareness and expectations regarding the CSS increase. |
| Government | * Consultation with agencies to date has demonstrated that agencies will experience cost impacts associated with this proposal. Using contracts to mandate compliance would have impacts on contract manager workloads. * Using contracts as an oversight mechanism may lead to adverse outcomes for communities with limited access to services (i.e. should funding be affected). * Over the long term, unlikely to be the most cost-effective option for government, given the resource-intense nature of capacity building by individual agencies who would likely be duplicating work across sectors. This is in comparison to having a centralised repository of CSS resources and dedicated subject matter experts who have a focus on delivering training and capacity building (as for Option 3). | * Compared to legislatively mandating compliance with the CSS and establishing an oversight body, some cost savings may accrue to government in terms of the limited compliance and monitoring responsibility. However, these savings would be balanced by the flow on effects from the increased workloads of contract management and related program support staff. |
| Wider community | * Given the limited application to only certain organisations of this option, there is a loss of some opportunity for building wider community awareness of institutional child abuse and child safe practices in organisations. * The limited scope of this option is likely to mean some continuation of costs of institutional child abuse passing to the wider community. | * Government expenditure on establishing a system to implement CSS in Queensland could be redirected elsewhere in the community. |

Table 28 Cost-effectiveness analysis – CSS Option 2 – non-legislative approach

|  |  |  |
| --- | --- | --- |
| **Option costs** | **Cost effectiveness** | **Evidence for effectiveness** |
| **Costs to oversight body**  Nil.  **Organisations in scope**  Net present value of total cost to organisations to comply with CSS over 10 years is **$63.46M.**  **Additional costs to government**  Net present value of additional costs for government agencies to comply and administrate compliance with CSS over 10 years is **$9.09M.** | Total net present value of cost for Option 2 over 10 years is **$72.55M.**  **To be cost effective this model would need to reduce annual prevalence of child maltreatment in Queensland institutions by approximately 19 cases.** | The non-legislative approach will have a smaller scope of organisations who are mandated to adopt the CSS, with other organisations able to participate voluntarily, and therefore likely have a smaller impact than Options 3(a) and 3(b).  However, it is highly probably this option can reduce the number of cases of maltreatment by 19 each year, only 0.16% of total annual prevalence, based on the 0.5% reduction estimated for effectiveness of this option. |

##### Summary of impact analysis for Option 2 – non-legislative approach

Under this approach, children and young people accessing services from organisations in-scope may experience improved safety and wellbeing as the organisations work to embed the CSS. There would also be some cost savings to government and lower regulatory burden for the organisations in scope, compared to Option 3 involving establishing the oversight and regulation of the CSS. However, without a legislative mandate to oversee and regulate the CSS, this option can apply only to those organisations and sectors funded or regulated by government. This leaves key sectors that provide services to children out-of-scope. Organisations out-of-scope would comply with the CSS on a voluntary basis only, likely without the same level of support provided to funded and regulated services. This does not meet stakeholder feedback or achieve the objectives set out earlier in this document. This option is unlikely to be the most effective (including cost-effective) for government and organisations in terms of achieving long term cultural change and reduction in risks of harm to children in organisations.

##### What we asked:

1. Do you support the Queensland Government using contractual/funding arrangements to require compliance with the CSS, supported by a policy framework, instead of legislation?
2. To what degree will this option contribute to the objectives for government action, i.e. to ensure the safety and wellbeing of children accessing services or facilities in Queensland institutions? (See Part 2 – Objectives of government action.)
3. Do you consider there are additional potential impacts or benefits of this option?
4. What support would organisations in scope of this option need to effectively implement the CSS?
5. What is the level of readiness in your organisation to implement Option 2?
6. Are there any other issues about this option you wish to raise for your sector/organisation?

##### Consultation results – CSS Option 2

The majority of submissions did not support CSS implementation through contractual/funding arrangements (Option 2), preferring a legislative approach (Option 3) as the most effective mechanism to establish a clear child safe organisations framework and drive cultural change.

While some submissions did support Option 2, on the basis it would contribute to the objectives for government action, they preferred a legislative approach as its scope is broader and would have a greater impact on the safety and wellbeing of more children in more organisations.

The few submissions that supported Option 2 alone did so out of concern that regulation under Option 3 may be overly burdensome and restrictive. All submissions that supported Option 2 indicated they would be ready for implementation within a year.

Given the majority of submissions did not consider Option 2 went far enough, and acknowledged the potential benefits were reduced compared to Option 3, feedback on Option 2 supports the conclusion in the CRIS that Option 3 is the preferred model. Concerns raised about burden and restrictive regulation are significant issues of consideration for the legislative framework and implementation, noting the intent is that CSS are applied flexibly, tailored to the organisational context and that organisations are supported by the oversight body.

#### Option 3(a) – Collaborative regulatory approach

This option involves government establishing an independent oversight body that will have responsibility to regulate and oversee the mandatory implementation of the CSS by relevant organisations in Queensland, supported by legislation. This body would take a *collaborative regulatory approach* (as distinct from a formal *co-regulatory approach*, in Option 3(b) below) to support, monitor and oversee compliance with the CSS, in collaboration with existing regulators and funding bodies. These existing bodies would collaborate with the CSS oversight body by advising it of issues they become aware of that indicate organisations are experiencing challenges with CSS compliance.

Table 29 Impacts on stakeholder groups – CSS Option 3(a) – collaborative regulatory approach

| **Stakeholder** | **Costs and risks** | **Benefits** |
| --- | --- | --- |
| Children and young people | * No direct costs. May result in increased costs of service delivery if organisations pass on administrative costs to clients (if applicable). | * Organisations become safer spaces for children and young people, with benefits to their safety and wellbeing. * Children and young people benefit from improved:   + participation in organisational decisions and activities that affect them;   + cultural safety, with respect for difference and diversity promoted in the organisation; and   + overall quality of services, with a renewed focus on child safety and wellbeing. * The improvements above are likely to extend across a wider range of settings compared with Options 1 and 2. * Children and young people in Queensland enjoy equal protections in relation to the CSS as children in other jurisdictions with CSS regulation. |
| Organisations | * Any introduction of new regulatory measures will mean organisations need resources to meet new requirements. This may result in organisations needing to redirect resources from other parts of the service. * It is anticipated that organisations may experience increased costs associated with the following activities:   + participating in capacity building activities run by oversight body;   + conducting internal capacity building;   + establishing/revising policies and systems;   + maintaining policies and systems; and   + undertaking self-assessment of CSS. * There is limited available data to indicate how many organisations exist in each tier, noting that the forecast costings are highly dependent on the size and structure of the organisation. For subsequent cost-effectiveness analysis purposes, data from Victoria was applied to the costs for small organisations to provide an approximation of the total cost, noting that Victoria has a larger economy and population compared to Queensland, and that some organisations’ costs will be under-estimated by the expected cost for small organisations. * These costs are associated with staff and volunteers taking time to participate in training/awareness activities, ensure policies and procedures are appropriately maintained, conducting self-assessments of compliance, etc. | * Clear CSS compliance obligations for organisations, providing certainty of their responsibilities, and how they should be met, in relation to child safety and wellbeing. * Organisations will benefit from access to a central repository of child safe resources to improve child safe practice. This will reduce the burden on organisations seeking to become child safe. * CSS implementation may help to reduce insurance premiums and reduce the risk of civil liability/payouts over the longer term.[[83]](#footnote-84) * The proposed focus on capacity building in organisations of the CSS oversight body will promote positive cultural change and increased awareness amongst in-scope organisations. * Organisations will be able to hold themselves out to be a child safe organisation, increasing services’ marketability as a preferred provider, as community awareness and expectations regarding the CSS increase. * Compared to Options 2 and 3(b), this Option has the most streamlined approach to regulatory compliance for organisations already subject to regulation and quality frameworks that feature CSS alignment. By leveraging existing frameworks and collaborating with regulators, the risks of regulatory duplication are minimised. This lowers the overall regulatory impacts for organisations. * Costs may be partially offset for some organisations by existing regulatory obligations that align with the CSS. |
| Government | * There will be costs for government associated with establishing and operating the CSS system from an independent oversight body – including the following key activities:   + referrals and notifications;   + responsive capacity building;   + audits;   + enforcement and penalties;   + information sharing;   + reporting;   + self-assessments;   + industry compliance plans;   + advice and communications; and   + capacity building. * Preliminary indications of the types of costs for other government agencies include the following considerations, which will be relevant for some core agencies:   + collaboration with the CSS oversight body, including reporting matters to the oversight body;   + information sharing arrangements; and   + enabling the new system, including where agencies may not be directly participating in the CSS system, but which administer systems that could be leveraged to enable collaborative regulation. * Compliance costs for government agencies being subject to oversight of their child safe obligations in their service delivery to children. This includes costs associated with ensuring they meet the CSS, any impacts flowing from additional awareness and reporting of abuse matters, and any system/capacity issues that may arise in existing regulatory/quality systems as a result of collaborating with the CSS oversight body. * Compliance costs for local governments/councils to be subject to oversight of their child safe obligations in the delivery of services to children. For smaller local councils that operate in rural or remote communities, there is a risk that compliance costs may be greater as they often provide a diversity of services, including last resort services, to their community relating to working with children, while also having fewer resources than larger, metro councils. | * This option provides a scalable and flexible model of regulation which minimises regulatory burden on government as well as organisations. The range of tools available to the oversight body to regulate compliance with CSS can be expanded and reduced to fit within available resources and established priorities. * Leveraging existing regulatory arrangements would capitalise on existing relationships between sectors and regulators, and existing functions and strengths of sector regulators, including sharing information about risk that regulators are already collecting. This also provides opportunities to boost oversight capacity. Cost efficiencies are produced from leveraging existing systems to target oversight activities. * Related regulatory systems could either introduce CSS compliance into their own frameworks; and/or refer issues arising in compliance assessments at a particular threshold, to boost oversight capacity for the CSS oversight body. * Compared to Option 3(b), it is assumed that the government regulators and funding bodies that collaborate with the CSS oversight body will likely experience lower costs, as they will not be absorbing costs associated with the devolved functions and powers of CSS oversight. The intention with this option is to leverage these existing regulatory relationships, while centrally maintaining CSS powers in the oversight body, thus allowing existing regulators to largely continue their usual functions. * The Royal Commission identified that CSS implementation may help to reduce insurance premiums and protection against civil liability/reduced payouts over the longer term.[[84]](#footnote-85) * Some of the costs to government agencies will be offset by existing work to embed the CSS into policies and processes. * Implementation of a CSS system that specifically embeds and requires consideration of cultural safety for Aboriginal and Torres Strait Islander children supports and aligns to the Queensland Government’s commitments and obligations regarding reframing the relationship with Aboriginal and Torres Strait Islander peoples and the Queensland Government. It may also help strengthen implementation of related government policies, action plans, strategies and legislative requirements (e.g. the *Our Way: A generational strategy for Aboriginal and Torres Strait Islander children and families 2017-2037* and its *Breaking Cycles 2023-2031* action plan.). |
| Wider community | * No direct costs. May result in increased costs of service delivery if organisations pass on administrative costs to clients (if applicable). | * Increased awareness of child safe practice and how to select a child safe organisation for consumers. * Expected that over the long term, the prevalence of child abuse and poor institutional responses to abuse, will be lowered. This would result in a net benefit for the community not only in terms of the improved safety and wellbeing of children and the adults they become, but also the costs to the community associated with the impacts of abuse. |

Table 30 Cost-effectiveness analysis – CSS Option 3(a) – Collaborative regulation

|  |  |  |
| --- | --- | --- |
| **Option costs** | **Cost effectiveness** | **Evidence for effectiveness** |
| **Costs to oversight body**  The estimated cost to establish and maintain the oversight body is **$26.05M.**  **Organisations in scope**  Net present value of total cost to organisations to comply with CSS over 10 years is **$281.39M.**  **Additional costs to government**  Net present value of additional costs for government agencies to comply and administrate compliance with CSS and RCS over 10 years is **$18.18M.** | Total net present value of Cost for Option 3(a) is **$325.61M.**  **To be cost effective this model would need to reduce annual prevalence of child maltreatment in Queensland institutions by approximately 87 cases.** | It is highly probably this option can reduce the number of cases of child maltreatment by 87 each year, only 0.72% of total incidence, based on the 2% reduction estimated for effectiveness of this option. |

#### Option 3 (b) – Co-regulatory approach

Like Option 3(a), this option involves setting up an oversight body that would regulate and oversee the mandatory implementation of the CSS by relevant organisations, supported by legislation. Under Option 3(b), the oversight body would use a formal co-regulation approach with existing sector regulators. This involves existing government regulators and funding bodies having responsibilities and powers relating to CSS for their sectors, with the CSS oversight body only having responsibility for organisations for which there is no appropriate co-regulator (e.g. religious and sporting organisations).

Table 31 analyses the impacts of this option, many of which are the same for Option 3(a), with a few key differences.

Table 31 Impacts on stakeholder groups – CSS Option 3(b) – co-regulatory approach to CSS

| **Stakeholder** | **Costs and risks** | **Benefits** |
| --- | --- | --- |
| Children and young people | * As for Option 3(a), no direct costs. Additional regulatory burden on organisations that serve children and young people may impact service delivery. | * As for Option 3(a). |
| Organisations | * As for Option 3(a), with the following additional considerations:   + Based on lessons from Victoria’s review of the operation of its CSS regime (which features a co-regulatory approach), an inherent risk in this type of regulation is that organisations may experience some confusion and duplication in regulation/oversight of CSS implementation by multiple regulators.   + There is also a potential for regulatory tools to be applied for non-compliance with CSS under multiple frameworks.   + These risks carry potential increased costs as regulatory burden increases. | * Clear CSS compliance obligations for organisations, providing certainty in what organisations’ responsibilities are, and how they should be met, in relation to child safety and wellbeing. * With the oversight body becoming a central repository for child safe resources developed by experts, organisations will benefit from access to these resources to improve child safe practice. This will reduce the burden on organisations seeking to become child safe. * The benefits of increased clarity in obligations and availability of tailored capacity building resources regarding child safe practice in organisations is particularly important in the context of increased institutional accountability for child abuse, as a result of civil litigation and criminal justice reforms in recent years. The Royal Commission identified that CSS implementation may help reduce insurance premiums and protection against civil liability/reduced payouts over the longer term.[[85]](#footnote-86) * The proposed focus on capacity building in organisations as the core function of the CSS oversight body will promote positive cultural change and increased awareness among in-scope organisations. * Organisations will be able to hold themselves out to be child safe, increasing services’ marketability as a preferred provider, as community awareness and expectations regarding the CSS increase. |
| Government | * Largely as for Option 3(a), noting the key difference in impacts for government relates to costs for:   + the oversight body; and   + the existing regulators who will have CSS regulatory functions and powers devolved to them. * Costs to existing regulators and funding bodies of the additional devolved CSS functions have not been independently costed. However, preliminary indications of the types of costs for these entities have been considered in the cost-effectiveness analysis. | * Like Option 3(a), this option is a scalable model of regulation which aims to minimise regulatory burden on government and organisations. * In terms of costs to set up and operate the oversight body, there will be cost efficiencies produced from leveraging existing systems and devolving CSS powers to other existing regulatory bodies. However, this will mean the other bodies will absorb any additional costs associated with these new CSS functions. |
| Wider community | * As for Option 3(a), no direct costs. May result in increased costs of service delivery if organisations pass on administrative costs to clients (if applicable). | * As for Option 3(a). |

Table 32 Cost-effectiveness analysis – CSS Option 3(b) – collaborative regulation

|  |  |  |
| --- | --- | --- |
| **Option costs** | **Cost effectiveness** | **Evidence for effectiveness** |
| **Costs to oversight body**  The estimated cost to establish and maintain the oversight body is **$24.87M.**  **Organisations in scope**  Net present value of total cost to organisations to comply with CSS over 10 years is **$281.39M.**  **Additional costs to government**  Net present value of additional costs for government agencies to comply and administrate compliance with CSS and RCS over 10 years is **$18.18M.** | Total net present value of Cost for Option 2 over 10 years is **$324.44M.**  **To be cost effective this model would need to reduce annual prevalence of child maltreatment in Queensland institutions by approximately 86 cases.** | It is highly probably this option can reduce the number of cases of child maltreatment by 86 each year, only 0.71% of total annual prevalence, based on the 2% reduction estimated for effectiveness of this option. |

|  |
| --- |
| What we asked: for Options 3(a) and 3(b) **Legislative mandate to implement the CSS:**   1. Do you support the Queensland Government legislating a system for mandatory compliance with the CSS? Why or why not? 2. Do you consider there are any additional potential impacts or benefits of a legislative approach? 3. Has your organisation already implemented measures that align with the CSS that may reduce the costs for compliance and/or the potential benefits from complying?   **How the CSS oversight body should work with existing bodies to reduce regulatory burden and duplication:** **Questions for organisations and sector regulators**   1. If an independent CSS oversight body was established, which approach do you support:  * **Option 3(a)**: Existing sector regulators should work collaboratively with the CSS oversight body to maximise effectiveness of the scheme for their sectors, with the main regulation and enforcement of the CSS resting with the CSS oversight body? or * **Option 3(b)**: Existing sector regulators should have a formal role in regulating and enforcing compliance with the CSS, with potential powers and functions delegated to them in legislation?  1. Do you see any likely barriers or challenges to either approach in regulating the CSS? 2. What do you estimate the costs or other impacts would be for your organisation to comply with the CSS under either option? 3. For existing sector regulators, what are the estimated costs or other impacts to you for either option? 4. Do you have suggestions as to how the CSS oversight body could collaborate (or co-regulate) with sector regulators, to streamline and support the operation of the CSS?   **Oversight body working effectively with organisations to support CSS compliance:**   1. How should the CSS oversight body work with organisations to support, monitor and oversee compliance with the CSS? Does this change based on factors such as existing sector regulation and peak bodies, an organisation’s size and resources, and the risk profiles of particular sectors and organisations? 2. What sorts of powers and functions should the CSS oversight body have to be most effective in supporting CSS compliance? Are some powers and functions more important than others? 3. What support would organisations need to effectively implement the CSS under Option 3? 4. What is the level of readiness in your organisation to implement Options 3(a) or 3(b)?   **Driving cultural change and raising awareness in organisations and communities:**   1. How can the CSS oversight body best help create cultural change to prioritise the safety and wellbeing of children and young people in organisations as well as the community? 2. How should the CSS oversight body best support families and communities to build their child safe knowledge and help drive organisations to be child safe? |

##### Summary of impact analysis for Option 3 (a) and 3(b)

In considering how to implement the CSS in a way that will achieve the greatest net benefit for Queenslanders, the balance of risks, cost impacts and benefits of the proposed options indicate a legislative, regulatory system would be preferred (Options 3(a) or 3(b)). This is consistent with stakeholder feedback from targeted consultations in 2021 (see page 110-112 for results of consultation through the CRIS process) that showed strong support for a mandatory approach to CSS. A mandatory approach has regard to national consistency as well as the unique needs of the Queensland context. Constraints of this kind of model include additional cost to government through the establishment of a CSS oversight body, and to existing regulators and the non-government sector to realign with CSS. However, it is expected that in the longer-term, a robust system of CSS regulation supported by a legislative mandate, as set out in Options 3 (a) and 3(b) will contribute to mitigating the very costly impacts of child sexual abuse. The Royal Commission identified benefits to organisations required to comply with CSS, including: potentially reduced insurance premiums, protection against civil liability/reduced payouts over the longer term, increased business reflecting the organisation’s child safe approach and status as a preferred provider, and a fairer competitive environment.[[86]](#footnote-87) It is challenging to quantify the anticipated benefits noting they may not be fully realised for a number of years. However, given the evidence base contributing to the development of CSS and what we know about the devastating and life-long impacts of child sexual abuse and other forms of harm, it is reasonable to anticipate that embedding child safe practices on a broad scale will have a positive impact on the lives of Queenslanders into the future.

Having established that a regulatory system would be preferred for CSS implementation, the key question is whether Option 3(a) (collaborative regulation) or Option 3(b) (formal co-regulation) would work best for the Queensland context and achieve the greatest net benefit.

The key difference between Option 3(a) (collaborative) and Option 3(b) (formal co-regulatory) is whether the central oversight body takes a collaborative approach to regulating the CSS with existing regulators or uses formal co-regulation arrangements with sector regulators. Both types of approaches exist in the jurisdictions that have CSS regulation. Victoria’s CSS system features a formal co-regulatory approach, which has recently been amended following a review of its operation in 2022, to address some of the challenges and regulatory duplication experienced in the original system. NSW, on the other hand, has a CSS regulatory system more akin to the collaborative approach proposed in Option 3(a).

Estimated costs for government to establish the CSS oversight body under Options 3(a) and 3(b) are comparable, with Option 3(a) potentially costing marginally more in total over a five-year period (reflecting that the oversight body would be devolving much of its regulatory activities to existing sector regulators under the co-regulatory Option 3(b)). However, the cost-effectiveness analysis demonstrates that the difference in costs is negligible and both options generate net benefits if they achieve approximately 84 or 85 fewer cases of child maltreatment per year in Queensland institutions. Compared to Option 3(b), the collaborative regulatory approach of Option (3)(a) makes it more flexible, scalable, and responsive to risk, and more responsive to significant stakeholder feedback to avoid duplication in regulation. It is also considered that Option 3(a) has the capacity to reliably address some of the identified challenges with formal co-regulation due to assurance of consistency in regulatory approaches and responses to non-compliance (as this power rests with the oversight body, rather than being decentralised to other existing regulators); and increased clarity for organisations about roles and responsibilities (particularly for those that work across sectors).

##### Consultation results – Option 3(a) and 3(b)

There was strong support for the recommendation in the CRIS for a legislative approach to implementing the CSS, through a collaborative regulatory model. The vast majority of stakeholders preferred collaborative regulation (Option 3(a)) over co-regulation (Option 3(b)), and a few submissions indicated no preference for either model.

Submissions that preferred Option 3(a) suggested that collaborative regulation would limit inconsistency in applying the CSS, ensuring a single entity holds the expertise on implementing and complying with CSS. Collaborative regulation was supported on the basis that the oversight body could provide support and guidance in circumstances where the regulator does not have the knowledge or capacity to support the organisation. A collaborative relationship between the oversight body and sector regulators was also seen as promoting transparency and a focus on continuous learning and improvement.

Support for a co-regulatory model (Option 3(b)) was generally based on the following:

1. Co-regulation would generate a lower risk of duplication and conflicting advice between the oversight body and sector regulators.
2. Co-regulation would allow the CSS to be better embedded into existing frameworks with a focus on improving outcomes for children rather than diverting funds to administrative compliance activities.
3. In sectors where organisations are already subject to multiple regulators, stakeholders suggested that communication and information sharing between regulators is already limited, and the subsequent need to communicate with multiple regulatory bodies has a significant cost implication.

In considering this feedback, we understand the appeal for organisations to interact with one regulator rather than a regulator and the CSS oversight body. However, the experience of other jurisdictions generally suggests that collaborative regulatory approaches are less likely to duplicate requirements and add to regulatory burden. Further complexity emerges where organisations are regulated by more than one body and each regulator has powers and functions to enforce compliance with the CSS. In a collaborative regulatory model, the oversight body provides centralised oversight which is consistent and informed by its expertise in CSS. However, to ensure a collaborative regulatory model is successful, the oversight body will work closely with sector regulators on an approach to collaboration that is best suited to each sector and regulator.

Most submissions that provided an estimated timeframe for complying with a legislative CSS model advised they would be ready within 12 months (see Part 8 for more information).

##### Final recommendation

Noting the strong support for a collaborative regulatory model, the consultation results clearly support the conclusion in the CRIS that Option 3(a) is the preferred model for regulating CSS in Queensland. There is a strong theme of concern from stakeholders that CSS regulation, even under Option 3(a), has the potential to be duplicative and add to administrative and regulatory burden. The intention remains to minimise regulatory burden as much as possible and we will continue to consider these issues as work progresses and we prepare for implementation. In Part 8 we consider implementation in more detail.

##### Consultation results – functions and powers of the oversight body

###### Objectives of the oversight body

The vast majority of stakeholders submitted that the oversight body should operate under a culture of positive, supportive action, rather than a focus on punitive compliance. Many of the functions and powers, roles and responsibilities noted in submissions emphasised the importance of capacity building and awareness raising with organisations and the broader community.

###### Capacity building

The majority of submissions discussed the need for comprehensive and ongoing capacity building by the oversight body, with sector-specific activities a common theme. There was strong support for the oversight body to provide a wide range of capacity building activities including guidelines and tools (such as a self-assessment tool); free training (online and face-to-face); webinars; videos and podcasts; and other resources (such as fact sheets). Several submissions also advocated for helplines and a relationship manager, information portals and communities of practice to provide further support to organisations. Some suggested the oversight body take a lead role in raising awareness with parents, families and the broader community.

There was strong support for capacity building resources being culturally responsive and accessible to culturally and linguistically diverse communities, and available in a wide range of languages. In addition, it was highlighted that resources and the support provided to organisations to implement cultural safety for Aboriginal and Torres Strait Islander children and young people must be led and co-designed with Aboriginal and Torres Strait Islander peoples. Direct engagement with diverse groups including people with lived experience of institutional abuse, people with disability and the LGBTQIA+ community was also seen as essential to ensure Queensland’s child safe organisations approach appropriately responds to diversity.

###### Collaboration with existing regulators

We heard considerable support for the oversight body to collaborate with regulators and for CSS to be embedded in existing regulatory frameworks to reduce regulatory burden and duplication.

Submissions suggested the benefits of collaborative regulation include facilitating the oversight body’s understanding of a sector and its existing regulatory landscape; and helping the regulator understand CSS and CSS compliance. Submissions also identified collaboration between the oversight body and regulators on guidance and capacity building materials would be essential.

Several submissions noted the importance of information sharing between the oversight body and sector regulators. Close collaboration and efficient information sharing with sector regulators by the oversight body would ensure information is disseminated to organisations via existing regulatory channels.

###### Compliance, enforcement and penalties

Stakeholders strongly supported capacity building as the first response to indicators of non-compliance with CSS. Compliance activities suggested included self-assessment tools, random yearly audits and the establishment of a register of organisations required to comply with CSS and RCS.

A range of enforcement methods and penalties were proposed including letters of warning or notices of breach/non-compliance as a first-line enforcement method. Some advocated for financial penalties (imposed on organisations, not individuals) or withdrawal of funding. Other submissions suggested the oversight body should have the capacity to instigate criminal and/or civil proceedings in cases of serious, ongoing non-compliance.

While clearly defined consequences for non-compliance, and enforcement measures for repeated non-compliance, were strongly supported, stakeholders agreed that punitive enforcement methods should be used as a last resort after efforts to build capacity have failed.

###### Powers of the oversight body

The submissions received during consultation recommended a range of powers for the oversight body. These included the authority to request documents from organisations; conduct unannounced site visits; initiate own motion investigations; and compel organisations to stand down people of concern. Several submissions highlighted the importance of the oversight body conducting regular reviews of the functioning of the child safe organisations system.

##### Final recommendation

The feedback we received has informed our understanding of the functions and powers needed by the oversight body. There is a clear role for the oversight body to engage in ongoing and comprehensive capacity building with organisations and within the broader community. It is also clear the oversight body needs monitoring, compliance and enforcement powers that are flexible, responsive and can effectively address ongoing non-compliance when necessary. A range of functions are proposed for the oversight body to educate and support organisations to implement the CSS, as well as to monitor and enforce compliance. A broad range of powers is proposed for the oversight body to support its functions and as part of its graduated suite of regulatory tools, such as the power to require documents or information to be produced, and the power to issue notices to comply when required.

### Reportable conduct scheme

#### Option 1 – Maintain status quo (no action)

If the Queensland Government does not take any action to implement an RCS, existing systems and obligations will continue to apply to protect children against harm in institutional settings. As the base case, this option presents the lowest cost as no changes will be required. This option also offers no potential to improve child safe practices that may lead to a reduction in incidence of harm. Further, it is possible that harm may increase if Queensland is considered to have lower safeguards in place for child-related work compared with a growing number of other states and territories that have or are implementing the CSS and RCS.

This option also presents key risks, as existing frameworks vary in scope and the extent of oversight provided, which results in an ad-hoc and inconsistent approach to how organisations respond to allegations of harm towards children by their employees. This presents key limitations in regulation, particularly:

* Some sectors that work with children have minimal regulation, such as religious groups, non-state schools, and accommodation and residential services for children, with limited or no independent oversight over how they respond to allegations of harm. This lack of independent oversight is also associated with a lack of external support for organisations to implement child safe practices.
* Regulated sectors are subject to different oversight powers and treatment. For example, there are limited powers in the non-state schooling sector to take action in respect of apparent instances of unsafe practice, and unregistered providers under the NDIS (which can provide services to children) are not subject to the same oversight or screening obligations as registered NDIS providers (although unregistered NDIS providers are still subject to the blue card system in undertaking work with children with disability to which the WWC Act applies).
* Funding agreements with organisations offer a broad tool to enforce compliance with quality frameworks where funding can be withdrawn for non-compliance, resulting in a reduction of services for vulnerable children and young people.

The RCS will focus on employees in child-related organisations and capture a wider range of concerning behaviour than other reforms or frameworks, that serve another purpose, and have different thresholds and scope of conduct to the RCS. For example:

* The child protection framework focuses on child abuse within family settings and is unlikely to be useful in institutional contexts. Mandatory reporting obligations under the *Child Protection Act 1999* are triggered when a parent is not able and willing to protect a child from harm.
* Mandatory reporting under the *Child Protection Act 1999* relates to significant harm caused by physical or sexual abuse while reportable conduct captures other concerning behaviour, such as sexual misconduct, neglect, ill-treatment and emotional and psychological abuse.
* Distinct mandatory reporting obligations for all Queensland schools under the *Education (General Provisions) Act 2006*, and criminal responses such as the failure to report and protect offences under the Criminal Code are also limited to sexual abuse.
* Current reporting continues to place the onus on reporting on the individual (e.g. mandatory reporting, failure to report offence) instead of the head of an organisation, and does not trigger oversight of how the organisation responds to reports of harm.
* The Working with Children Check (blue card) assesses a person’s eligibility to work at a point in time based on a person’s criminal and disciplinary history. Even though blue card holders are subject to criminal history monitoring, the check does not gather and monitor intelligence to identify patterns of behaviour that may indicate risks of future harm.
* Child and Youth Risk Management Strategy obligations under the blue sard system, while intended to help identify potential risks of harm to children and young people, are not supported by capacity building with the sector or an active monitoring and enforcement framework.
* Accreditation and licensing requirements and quality frameworks vary depending on sectors and roles and do not provide insight or consistency of standards into how organisations across different sectors respond to reports of abuse.

Table 33 Impacts of RCS Option 1 (maintain the status quo)

| **Stakeholder** | **Costs and risks** | **Benefits** |
| --- | --- | --- |
| Children and young people | * Subject to current levels and risks of institutional child abuse, including inconsistent protection depending on sector and organisation. * Concerns that do not meet the threshold for criminal conduct may go unreported to an external body/authority. * Subject to lesser degree of safety in organisations than those in jurisdictions with an RCS. | * Current service levels and costs likely to remain. |
| Organisations | * Subject to current fragmented and inconsistent regulation across sectors. * Exposed to greater risks and liabilities associated with child abuse, including financial liabilities and challenges to sustainability of operations through increased insurance premiums and payouts, and reputational damage. * No dedicated, independent oversight body providing support and guidance on child safe practices and ways to prevent or respond to reportable conduct. * May not be alerted to live risks posed by employees, unless the employee has a criminal record. * Lack of national consistency creates confusion and complexity for national organisations. | * No additional costs of compliance with RCS obligations, which varies according to current level of regulation that applies in that sector – those with minimal regulation will maintain a lower compliance burden. * No reduction in current levels of service provision. |
| Government | * Limited or no oversight into how organisations handle reports of abuse, particularly where it does not reach criminal conduct threshold. * Lack of transparency and access to data/information on rates of abuse and responses to reports. * The ongoing (and at times, lifelong) impacts of institutional child abuse will continue to place high economic demand on government through provision of health and welfare support services. * Risks of liabilities relating to child abuse may continue to grow. | * Does not require up front funding for an independent oversight body and no new compliance requirements for government agencies that deliver services to children. |
| Wider community | * Costs of institutional child abuse will continue to affect wider society such as potential reduced social participation and employment of victims/survivors, and greater demand for housing services, public health services etc. * Greater distrust of particular organisations or sectors that deliver services to children leading to reduced opportunities for families to access social connection and support services. | * Government expenditure on establishing a system to implement RCS in Queensland could be redirected elsewhere in the community. |

##### What we asked:

**Feedback on Option 1 (RCS) (no action):**

1. Do you support this option? Why or why not?
2. What are the strengths and benefits of the current system?
3. What are the challenges of the current system?

**Current impacts on your organisation:**

1. What are your current costs relating to preventing, detecting and responding to allegations of child abuse/maltreatment by staff? (If possible, please set out a breakdown of these costs, such as the costs for an activity like maintaining a complaints policy or conducting an investigation.)
2. Do you consider the current requirements that apply to you/your organisation or sector, to keep children safe and report harm in organisations, are adequate? This includes, for example, the blue card system, mandatory reporting and other measures listed on pages 28 to 31.

##### Consultation results – Option 1

There was no support for Option 1 – to retain the status quo, with one submission noting uncertainty about how the RCS is different from current reporting requirements.

Strengths of current system include:

* Queensland’s child protection framework has clear legislation, policies and procedures that guides the response to harm for children and young people. It gives anonymity to notifiers, defines harm and the processes to determine and investigate harm, including clear timeframes.
* Blue card system – Blue Card Services are easy to communicate with, the online portal is useful with information and resources, and there is no fee for cards for volunteers.
* The flexibility of system and organisational autonomy allows organisations to tailor child safety measures to their specific needs.

Challenges of current system include:

* The variance in existing reporting requirements (who they apply to and the reporting thresholds) highlights a gap in how some concerning conduct, which may not constitute criminal offences or result in significant harm, is reported or dealt with.
* There is a lack of accountability and lack of external, independent oversight.
* Repeat perpetrators may persist due to matters not being investigated, reported or minimised.
* It does not enable the detection and investigation of individuals who manage to avoid detection within the criminal justice or child protection systems, but who present a risk to children.
* There is no oversight or tracking of individuals of concern. An example was provided in the early childhood education and care sector where incidents are reported and investigated, but the alleged perpetrator may resign and gain employment elsewhere, even if harm is substantiated.
* There is an over-reliance on the Blue Card system to determine whether staff are suitable, noting the blue card process does not identify all individuals who are a risk to children as it only reviews those charged or convicted of certain offences. Unless there are other overlapping licencing or regulatory frameworks that apply to certain sectors or professionals (as with teachers), employers have limited options for action in cases where no criminal charges are involved, but there are concerns of risks to children.
* There is no obligation for an unregulated sector such as religious organisations to address allegations about the conduct of their staff.
* There is a lack of consistency across organisations and sectors, including some that are not covered by child safety regulations and reporting mechanisms are fragmented.
* There is an inability to link potential perpetrators across organisations where they have engaged in suspicious conduct.
* Investigation timeframes can be prolonged and require significant resourcing.
* There are gaps in regulation such as schools having no external oversight of non-teaching staff.
* Reporting suspected sexual abuse focuses on whether it meets a criminal threshold, rather than identifying risks to children.
* Organisations may be unclear how to undertake robust and independent investigations and respond to historical claims of abuse.
* Existing arrangements are not focused enough on prevention.
* Professional boundary violations are not adequately captured in the current reporting regime for education authorities.
* There is inconsistency in the information sharing arrangements with the Queensland College of Teachers (QCT) between state authorities (who can receive information on a teacher’s conduct) and non-state schools (who can only receive information on the registration status of a teacher).
* Mandatory notifications to QCT are limited to prescribed schools, and do not include early childhood education centres. Further, any person undertaking practicums in prescribed schools is not an approved teacher and therefore does not fall under the jurisdiction of QCT.

#### Option 2 – Nationally consistent reportable conduct scheme (requires direct government regulation)

This option will introduce obligations across sectors for the reporting and investigation of complaints of misconduct and abuse involving children in institutional environments. This will be supported by an independent oversight body which will provide capacity building support and monitor investigations in response to allegations of abuse.

Organisations will be supported by a dedicated, independent oversight body to improve institutional responses to reports of harm to children and drive cultural change that will benefit the organisations themselves, their employees and children. In the longer term, it is expected that there will be earlier detection of risks and incidents, which will have positive impacts on children, organisations, government, and the wider community including potentially fewer cases of harm to children. Community confidence in child-related services is likely to grow, which may enhance demand for services.

The key impact for organisations is the costs associated with compliance.

#### Impacts of core model

Table 34 sets out the expected impact of the core model for RCS, for different stakeholders. The core model includes costs estimates for government to operate an independent oversight body and for non-government organisations, based on independent cost modelling from Finity Consulting. These costs estimates are also based on estimates of the average number of RCIs that will be reported to the oversight body, across different sectors.

While several Queensland Government agencies have provided estimates of the resourcing impacts to fulfil their obligations under the RCS (and CSS), this consultation provides an opportunity to test these cost estimates for non-government organisations. This includes the cost of key activities that organisations will need to undertake. Anecdotal experience from other jurisdictions suggests there is no evidence of significant adverse impacts on organisations in complying with the RCS.

Table 34 Impacts of RCS Option 2 (nationally consistent scheme) model

| **Stakeholder** | **Costs and risks** | **Benefits** |
| --- | --- | --- |
| Children and young people | * No direct costs. May result in increased costs of service delivery if organisations decide to pass on administrative costs to customers (if applicable). | * Safer environments when engaging with organisations and sectors where children spend a substantial time away from parental care and supervision. * Reduced risk of harm in an institutional context due to earlier detection of risks, which may reduce the impact of the abuse and prevent abuse of other children by the identified perpetrator, greater transparency in reporting allegations of abuse, and improved institutional investigations and appropriate responses to actual, or potential risk of harm from employees or volunteers. |
| Organisations | * Resourcing implications for undertaking activities to fulfil RCS obligations which includes new tasks as well as existing tasks for organisations already subject to other reporting/investigation requirements. * Costs vary depending on the size of an organisation. Costs may be partially offset by existing regulatory obligations that align with RCS (see Table 22). | * Organisations will receive dedicated expert source of information, support and guidance about how to handle complaints and investigations of child abuse by employees and volunteers. * Improved understanding of institutional child safety and a framework that supports reporting of concerns, such as clearer pathways, obligations and protections for reporters. * Earlier identification of risks of harm and more complete reporting of, and responses to, incidents of abuse (through education, capacity building and penalties for serious non-compliance). * Increased national consistency in way organisations in scope respond to reports of abuse which helps minimise compliance costs for organisations that operate across jurisdictions with RCS. * Strong compliance will yield benefits of improved community confidence and reputation of organisations. This may lead to stronger ability to attract grants and funding. * May reduce liabilities associated with civil litigation claims regarding child abuse. * Improved organisational culture, which may lead to greater staff retention and ability to attract high quality staff. |
| Government | * Queensland Government will need to fund an oversight body to administer an RCS. * Independent modelling provided cost estimates (see cost-effectiveness analysis), for an oversight body to conduct the following key tasks:   + review incidents and investigations;   + oversee investigations;   + perform investigations;   + review findings;   + responsive capacity building;   + enforcement actions;   + monitor systems;   + information sharing;   + reporting; and   + advice and communications. * Administrative costs to government entities participating (collaborating) in the system by making referrals and notifications to the oversight body. * Compliance costs for government agencies that are in-scope (deliver services to children). * Increased awareness of child maltreatment may have potential flow-on effects of increased reporting to DCSSDS. There may be increased reports to the Queensland Police Service by the RCS body. | * Improved oversight of child safe practice in organisations and ability for regulators and government agencies to identify risks. * Greater collaboration between oversight body and sector regulators to harness their skills and experience in complying with RCS. * Improved information sharing between oversight body, organisations and regulators will improve data identifying trends in child abuse and complement existing mechanisms to protect children from harm. * Increased national consistency for jurisdictions with an RCS, and associated improvements to intelligence sharing across jurisdictions. * Reduced financial liabilities associated with child abuse, such as lower insurance premiums and civil litigation liabilities. |
| Wider community | * No direct costs associated with the establishment of an RCS. | * Reduced annual prevalence of institutional child abuse which may have long term impact of reducing demand on support and welfare services that are attributed to this abuse. * Improved community confidence in organisations that deliver services to children. * Increased national consistency in the RCS will result in increased efficiency and effectiveness of regulation which benefits the wider community. |

#### Estimates of reportable conduct incidents (RCIs)

Table 35 provides estimates for minimum RCIs across different sectors per year, based on Finity Consulting’s analysis. This was based on benchmarking against the Victorian RCS, using the number of RCIs for each sector published in Victoria between 2015 - 16 and 2019 - 20. This was adjusted by the relative size of the child population in the equivalent sector in Queensland. This does not include estimates for RCIs from government departments and entities.

The majority of estimated RCIs are within the child protection, childcare and education sectors. The child protection and justice and detention services sectors are likely to experience the highest volumes of RCIs relative to the size of the population they serve. It is expected the impact of the RCS on highly regulated sectors will be moderated by existing obligations. Sectors already subject to regulatory frameworks that align with the obligations imposed by the RCS will experience less impact than those with minimal existing regulation. For example, they should already have appropriate systems in place to report and investigate allegations of abuse or misconduct, which may be leveraged to capture a wider range of abuse or misconduct, and to make reports to a separate independent oversight body. A single investigation could meet obligations under existing frameworks and the RCS (noting that the thresholds that trigger an investigation may differ). In these cases, the RCS will provide a new level of oversight to ensure organisations are fulfilling these obligations.

Sectors that have less existing regulatory obligations aligned with the RCS will mean new obligations for organisations. However, it is expected that the number of reportable incidents in these sectors may be lower than heavily regulated sectors. These sectors may include accommodation and residential services, including providers of overnight camps, health services for children and religious organisations.

While volumes of notifications have remained relatively stable during the life of existing RCSs, the experience in NSW suggests that the nature of reported incidents has changed over time. These changes appear to be at least in part impacted by preventative strategies and systems in place under the RCS but have occurred alongside other environmental and social factors such as changes to technology and the impacts of the COVID-19 pandemic.

Table 35 Estimated annual number of reportable conduct incidents (RCIs) by sector in Queensland

|  |  |  |  |
| --- | --- | --- | --- |
| **Sector** | **Reportable conduct incidents (RCIs) estimate per year\*** | | |
| Number | Percentage of total RCIs (%) | Percentage of client population\*\* |
| Accommodation and residential services for children | 2 | 0 | 0.04% |
| Activities or services of any kind, under the auspices of a particular religious denomination or faith, through which adults have contact with children | 60 | 5 | N/A |
| Childcare services | 255 | 21 | 0.91% |
| Child protection services, including providers of family based care (foster and kinship care) and residential care, as well as family support/secondary services | 519 | 44 | 5.16% |
| Disability services and supports for children with disability | 20 | 2 | 0.07% |
| Education services for children | 223 | 19 | 0.03% |
| Health services for children | 7 | 1 | N/A |
| Justice and detention services for children | 95 | 8 | 4.9% |

*\* These estimates were produced by Finity Consulting using data from the Victorian Government, adjusted to Queensland population statistics*

*\*\* This figure represents the number of RCIs proportionate to the number of children accessing that service or sector. For example, from 1939 children involved in the justice and detention system as at 2021, 95 notifications represents 4.9% of this population. Where data was not available – N/A*

Table 36 sets out a cost-effective analysis of Option 2 for an RCS. The total net present value (see glossary) of cost is based on the total projected costs to the oversight body, organisations in scope and additional costs to government over a period of 10 years. The benefits are based on the saved lifetime costs of a single case of child maltreatment referenced in the methodology, with a reduction of 1% representing 121 less cases annually, based on the above annual estimate of 12,148 cases of child maltreatment in Queensland.

Table 36 Cost-effectiveness analysis – RCS Option 2 – nationally consistent RCS

| **RCS Option 2 costs** | **Cost effectiveness** | **Evidence for effectiveness** |
| --- | --- | --- |
| **Costs to oversight body**  The estimated net present value of cost to establish and maintain the oversight body over 10 years is **$36.04M.**  **Organisations in scope**  Net present value of total cost to organisations to comply with RCS over 10 years is **$166.85M.**  **Additional costs to government**  Net present value of additional costs for government agencies to comply and administrate compliance with CSS and RCS over 10 years is **$18.18M.** | Total net present value of Cost for Option 2 over 10 years is **$221.07M.**  **To be cost effective this model would need to reduce annual prevalence of child maltreatment in Queensland institutions by approximately 59 cases. (0.49% of total incidence).** | It is highly probable this option can reduce the number of cases of child maltreatment by 59 each year based on the 2% reduction estimated for effectiveness of this option. |

Noting the likelihood that Option 2 would achieve outcomes beyond a 0.49% reduction in annual prevalence, it is reasonable to conclude the net benefits of implementing Option 2 will be greater than those realised by maintaining the status quo in Option 1. Continuing the status quo would result in an ongoing high cost to government and to individuals who have experienced child maltreatment, with no expected reduction in annual prevalence.

##### What we asked:

1. Do you support Option 2, to introduce an RCS for Queensland? Why or why not?
2. What are your views on the core elements of the RCS, as set out in Part 3? For example, do you consider that the following is appropriate or should be modified: scope of sectors; definition of reportable conduct; capturing cumulative harm; and including third party employers?
3. Do you expect the RCS to change your organisation or sector’s culture, or individual employee behaviour, regarding responses to allegations of child abuse? Why or why not? Alternatively, if you have experience of an RCS in another jurisdiction/s, what changes in behaviour and culture have you observed with the introduction/presence of the reportable conduct scheme?
4. Have the potential impacts of an RCS been accurately captured? (see Table 29) Please also consider (and if applicable, as part of your experience of an RCS in another jurisdiction/s):
5. If there are any other benefits to the RCS?
6. What are the challenges that exist for you/your organisation or sector to comply with the RCS?
7. How could organisations be supported to address these challenges?
8. Has your organisation already implemented measures that align with the RCS that may reduce the costs for compliance and/or the potential benefits from complying?

**For sector regulators:**

1. How does the scope of your existing functions as a sector regulator align with the obligations under the RCS?
2. Do you have suggestions as to how the oversight body could collaborate with sector regulators, to streamline and support the implementation of the RCS?

##### Consultation results – Option 2

There was strong support for Option 2 – to introduce an RCS in Queensland.

Reasons for support include the RCS:

* Provides a structured way for organisations to respond to complaints of child abuse.
* Creates more accountability for employers and employees as expectations are made clear.
* Builds capacity and capability in child facing organisations by conducting high quality investigations.
* Creates a systemic response to people engaged in organisations who have harmed children, complementing existing systems that address risk to children and criminal behaviour.
* Identifies misconduct that falls below criminal threshold and may therefore improve the identification of risks to children.
* Supports the sharing of intelligence between regulators, employers and across jurisdictions to prevent harm to children as information about people who have harmed children in organisational settings can be shared appropriately to identify risks.
* Better tracks staff wanting to move between services and organisations who work with children, who may not be suitable to do so.
* Identifies trends and emerging issues of child abuse within systems.
* Builds greater awareness of child abuse/maltreatment in institutional settings.
* May strengthen employers’ ability to take action against employees in cases of misconduct, but where there is no criminal charge, and for this information to be shared with an oversight body or other potential employers.
* Will complement the CSS as the final point of safeguarding to ensure institutional responses to allegations of misconduct are appropriate.
* May raise the baseline standards for organisations and allow for greater consistency in programs/services for children across states and territories, which a national organisation noted legislated schemes in other jurisdictions have done.

##### Concerns and questions with RCS

Overall, submissions indicated strong support for the proposed key features of the RCS to align with other jurisdictions as much as possible. Many submissions emphasised the importance of information sharing, with strong interest in understanding how the RCS will interact with existing regulatory compliance processes and authorities, how information will be collected, used and shared, and how duplication of reporting requirements will be minimised.

To be most effective, we heard from stakeholders that the model for RCS would need to go beyond overseeing how organisations manage incidents of misconduct to cover the broader management of conduct across organisations involving the same person, and the subsequent implementation of risk-based approaches for individuals of concern.

Stakeholders with experience complying with the RCS in other jurisdictions highlighted:

* There is still duplication of reporting and at times confusion about who leads or supports investigations.
* Interviewing children can be further traumatising, so care needs to be taken for them to be done correctly and minimised.
* In cases of police involvement, organisations’ investigations are necessarily delayed.
* During the period of implementing the RCS, the oversight body provided training and supports to assist organisations to embed the RCS, including training on conducting investigations. However, after this period there was less training and support available to new organisations entering the sector. Stakeholders suggested the oversight body continue training and support to organisations to embed the RCS, beyond the initial implementation period.
* The need for national consistency for organisations that operate across jurisdictions and reporting across all jurisdictions.
* A desire for the oversight body to be able to share pending RCS allegations/investigations with Blue Care Services and other relevant authorities as there is a current loophole where an employee suspected of abuse may resign prior to an official investigation and commence a role with another organisation, but this information cannot be shared.
* Small organisations are already stretched, and the oversight body would need to provide significant support to build knowledge and capacity of organisations.
* Ongoing support and training to organisations is essential due to high staff turnover in many sectors.
* Employees who are the subject of allegations can be impacted which may result in workers compensation processes and associated costs to employers, including increased insurance premiums.
* Costs and shortages of independently accredited investigators.

Stakeholders noted that successful implementation of an RCS would be dependent on the detail around how compliance and oversight will work in practice, including:

* the interface with existing regulatory compliance processes;
* how information will be collected and used under an RCS, such as how it will feed into employment screening and recruitment processes, with some employers seeking access to information about persons of concern from the RCS;
* how duplication of reporting requirements will be reduced;
* how disputes regarding outcomes will be managed (for example between oversight body and Child Safety);
* how investigations will impact licensing agreements to provide out-of-home care services;
* how concerns will be managed regarding the potential impact of introducing policy options that could exacerbate the existing issue of organisations being unable to obtain insurance for physical and sexual abuse;
* clarification of the minimum investigation standards required, such as the Australian Government Investigation Standards 2022; and
* how organisations can access an approved list of accredited investigators.

##### Sector regulators

Several submissions and consultation activities were undertaken which sought feedback from sector regulators. The following themes emerged:

* support for a streamlined approach that reduces duplication and regulatory burden;
* requests for more clarity and guidance around jurisdiction and responsibilities and a clear authorising environment for information exchange and collaboration; and
* an expectation of increased costs associated with:
  + an expected increase in notifications and inquiries and need to support stakeholders to implement the CSS and RCS; and
  + establishing new systems and arrangements to interface with the new system.

It is intended that further consultation will occur with sector regulators regarding the details of information sharing arrangements under the RCS.

### Integrated child safe organisations model

To understand the net impact of implementing both CSS and RCS in Queensland, below is a cost-effectiveness analysis for a joint implementation of CSS, assuming that for CSS, Option 3(a) is selected, and for RCS, Option 2 is selected. The timing model used takes the following form, with CSS acting as a foundation. The organisations which fall under each phase could be based on a number of factors, including sector readiness (e.g. education may be included under phase 1 and sports and recreation (including the arts sector) could be included under phase 2 or 3, noting there is no government decision regarding how sectors would be phased in at this stage). Further detail on implementation, timing and phasing is provided in Part 8, including feedback from stakeholders through the consultation process.

Table 37 Example for staged approach to implementing CSS and RCS in an integrated model

|  |  |
| --- | --- |
| **Period** | **Implementation milestones** |
| Year 1 | Implementation set-up, initial capacity building. |
| Year 2 | CSS implementation commences, rolling out to phase 1 and phase 2 sectors. |
| Year 3 | RCS implementation commences, rolling out to phase 1 sectors.  CSS rolls out to remaining phase 3 sectors and reaches maturity. |
| Year 4 | RCS roles out to phase 2 and 3 sectors.  CSS fully operational. |
| Year 5+ | CSS and RCS fully operational. |

It is noted this timing option is indicative only and does not reflect a government position. The cost-effectiveness analysis built from this implementation approach also makes assumptions on the proportion of costs associated with different phase sectors. The real distribution of costs will be subject to the number, size and complexity of organisations that fall under each sector.

Table 38 Cost-effectiveness analysis – integrated child safe organisations example model

| **Option costs** | **Cost effectiveness** | **Evidence for effectiveness** |
| --- | --- | --- |
| **Costs to oversight body**  The estimated net present value of cost to establish and maintain the oversight body over 10 years is **$56.76M.**  **Organisations in scope**  Net present value of total cost to organisations to comply with CSS and RCS over 10 years is **$407.58M.**  **Additional costs to government**  Net present value of additional costs for government agencies to comply and administrate compliance with CSS and RCS over 10 years is **$18.18M.** | Total net present value of Cost for a co-located Integrated Child Safe Organisations model over 10 years is **$482.52M.** Cashflow benefits per case prevented are estimated to be $614,309.16 (inflation adjusted[[87]](#footnote-88)).  **To be cost effective this model would need to reduce annual prevalence of child maltreatment in Queensland institutions by approximately 129 cases (1.06% of total incidence).** | It is highly probable this option can reduce the number of cases of child maltreatment by 129 each year based on the 4% reduction estimated for effectiveness of this option. |

Noting the expected impact, it is likely that an integrated child safe organisations model as described above would achieve outcomes beyond a 1.06% reduction in annual prevalence, and it is reasonable to conclude the net benefits of implementing an integrated child safe organisations model will be greater than those realised by maintaining the status quo. Continuing the status quo would result in an ongoing high cost to government and to individuals who have experienced child maltreatment, with no expected reduction in annual prevalence. Implementing a child safe organisations system will strengthen safeguards for children in line with the majority of other states and territories in Australia. The views of stakeholders on an integrated model are highlighted in Part 3 on page 85-86.

## PART 5 – Consultation

### Previous work including 2021 targeted consultation

The Royal Commission’s recommendations for CSS and RCSs were supported by an extensive consultation process over five years, which included over 8,000 private sessions with people with lived experience of institutional child sexual abuse. In March 2021, targeted consultation on CSS and an RCS led by DCSSDS and DJAG commenced. It focused on peak bodies and other representative organisations in sectors identified for potential oversight and regulation by the Royal Commission.

In 2021, our first consultation paper, *Growing Child Safe Organisations in Queensland*, was sent to more than 170 stakeholders across more than 10 sectors with 29 written submissions received. A series of information sessions were also held for key stakeholders, attended by more than 60 representatives, between 12 and 26 March 2021.

A consultation report outlining the results of this targeted consultation, *Growing Child Safe Organisations in Queensland: child safe standards and a reportable conduct scheme* was published in August 2023. Overall, the consultation process heard strong support for the implementation of the CSS and an RCS in Queensland. While organisational readiness for implementation varied, consultation indicated a solid foundation to build on to create safer organisations for children.

Throughout 2021 - 2022, consultation continued with government stakeholders via a dedicated cross-government working group, established in June 2021, as well as direct consultation with relevant Queensland government agencies to understand the impacts of CSS and RCS. During development of CSS and RCS options, DCSSDS and DJAG also consulted with the NSW Office of the Children’s Guardian and Victoria’s Commission for Children and Young People, regarding learnings from their established CSS and RCSs. Cross-jurisdictional consultation continues, further informing Queensland’s approach.

We have also continued to bring proposals for CSS and an RCS to the Truth, Healing and Reconciliation Taskforce. The Taskforce was established to provide the views of those who have experienced institutional child abuse, support services and organisations to the Queensland Government on implementing the reforms arising from the Royal Commission.

### Current work including the consultation regulatory impact statement

Building on the targeted consultation in 2021, the *Growing Child Safe Organisations in Queensland CRIS* was released on 10 August 2023, with the consultation period closing on 22 September 2023. An optional response template was provided to stakeholders to aid in the preparation of submissions, however written submissions of all forms were accepted. A total of 63 written submissions were made. We also held two online information sessions attended by more than 170 people to inform organisations and members of the public about the proposed options.

In addition to written submissions, consultation activities were undertaken to support organisations in preparing submissions, receive verbal feedback and discuss potential impacts for specific stakeholders.

At the core of the policy proposals evaluated in this DIAS is the objective of improving the wellbeing and safety of children in organisations in Queensland. For this reason, representatives from the Queensland Government met and spoke with young people across the state to develop an understanding of the contemporary experience of children and young people in Queensland, focused on what it means for them to feel safe in organisations. A total of five roundtable discussions with young people were facilitated by officers from DCSSDS, including with the CREATE Foundation and Queensland Family and Child Commission’s Youth Advisory Council, Queensland Youth Parliament, Queensland Indigenous Youth Leadership Program and young people from Youth Empowered Towards Independence (YETI) in Cairns. We thank all the young people and organisations for their participation and acknowledge the support we received from the Office for Youth in the Department of Treaty, Aboriginal and Torres Strait Islander Partnerships, Communities and the Arts.

Acknowledging the unique experiences of organisations in regional locations, officers from DCSSDS and DJAG also travelled to Cairns, undertaking direct meetings with three key stakeholder organisations: Innisfail Youth and Family Centre, Deadly Inspired Youth Doing Good and YETI. We also led a cross-sectoral consultation forum with over 20 key stakeholders in attendance, predominantly from the early childhood and child protection sector. We thank all the organisations in Cairns who gave generously of their time to speak with us and describe the challenges in regional service delivery.

Over the course of the consultation period, DCSSDS and DJAG also met directly with several organisations from a variety of sectors, in order to provide further information on the CRIS; the policy options being considered; and hear about the impact on their organisations and sectors including:

* Independent Schools Queensland;
* Ausdance;
* Translink;
* Aruma;
* Royal Australian College of General Practitioners;
* Queensland Foster and Kinship Care;
* Non-State Schools Accreditation Board;
* Queensland Schools Bus Alliance;
* Creche and Kindergarten Association; and
* Housing stakeholders including QShelter.

### Future consultation

We will continue to engage with stakeholders as this work progresses and we prepare for implementation including non-government organisations, government agencies and regulatory bodies. We will also continue to seek advice from Aboriginal and Torres Strait Islander stakeholders as we progress work on a child safe organisations system that is culturally safe for Aboriginal and Torres Strait Islander children and young people.

## PART 6 – Conclusion and final recommendation

### Final recommendation – Growing Child Safe Organisations in Queensland

The final recommendation to Government is to establish an integrated child safe organisations system which includes:

1. a collaborative regulatory model to implement mandatory CSS and ensure compliance by in-scope organisations (CSS Option 3(a)); and
2. oversight of institutional child abuse complaints and allegations through a nationally consistent RCS (RCS Option 2).

It is recommended that both functions are integrated into the role of a single oversight body.

### Consideration of options

#### Child safe standards

Three options were considered for implementation and regulation of CSS as described below:

Figure 10 CSS model options[[88]](#footnote-89)

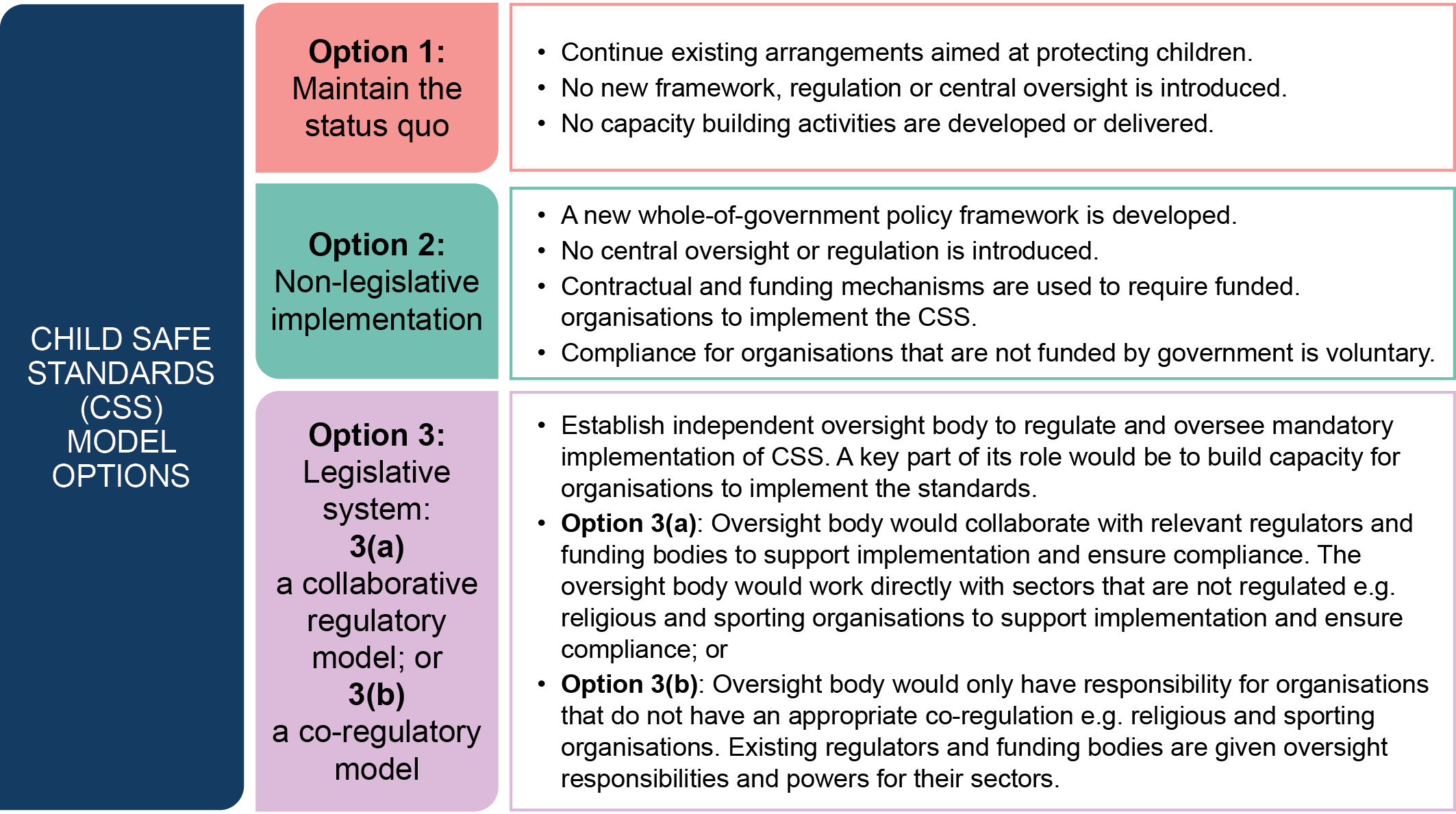


Table 39 summarises the comparative evaluation of the options for implementing CSS:

Table 39 Comparative analysis of the CSS model options

|  |  |  |
| --- | --- | --- |
| **Option** | **Required reduction in annual prevalence for cost-effectiveness** | **Overall analysis** |
| 1 | 0% | This option would impose no additional regulatory burden for organisations. However, this approach would fail to meet the objectives of government action, in particular by having negligible impact on preventing child maltreatment in Queensland institutions. |
| 2 | 0.16% | Limited additional regulatory burden for organisations (only government funded organisations) and substantially lower cost to implement. This approach has limited alignment with the objectives of government action, by having a significantly restricted scope of influence on organisations, meaning the net benefit for child wellbeing is likely to be reduced compared to broader scoped options. |
| **3(a)** | **0.72%** | **The highest cost option, however, it offers a greater scope of influence on Queensland organisations, consistent with objectives of government action, and therefore is likely to generate the greatest net benefit for Queensland. This option also limits burden on sectors with existing regulators/regulation compared to co-regulatory approaches.** |
| 3(b) | 0.71% | Equal highest cost option. It offers a greater scope of influence on Queensland organisations than Option 2, consistent with the objectives of government action, and is likely to generate a higher net benefit for Queensland. However, there is a risk of duplicating and complicating regulatory burden for organisations in scope with existing regulators/regulation. |

Option 3(a), a collaborative regulatory model supported by legislation, is the final recommendation because it will establish a consistent and coordinated approach to building child safe organisations and will best streamline compliance for organisations already subject to regulation. While it presents a high cost for implementation, it is only marginally greater than Option 3(b), and its benefits are greater as it will enable a more consistent approach and limit potential duplication of regulatory burden on organisations. Where there are no existing relevant regulatory arrangements, the oversight body will adopt the role of regulator. Implementation of the CSS will be flexible and tailored to the nature and characteristic of each organisation; and proportionate to the level of organisational risk. It is our conclusion, following our initial analysis in the CRIS, consideration of feedback from stakeholders through the CRIS consultation process and further analysis as we developed this DIAS that Option 3(a) provides the most effective means for achieving the primary objectives of government action and contributing to the overall goal of preventing maltreatment and reducing harm to children in Queensland. While it is the (marginally) highest cost option, its broad scope means it will have significantly greater impact on the total population of children in Queensland who are accessing services and facilities in Queensland organisations, reducing the lifelong effects of trauma and harm resulting from maltreatment. Option 3(a) was strongly supported through the CRIS consultation process by organisations, which preferred collaborative regulation, and young people, who advocated for clear laws to implement CSS.

#### Reportable Conduct Scheme

Two options were considered for a Queensland reportable conduct scheme as described below:

Figure 11 RCS model options[[89]](#footnote-90)

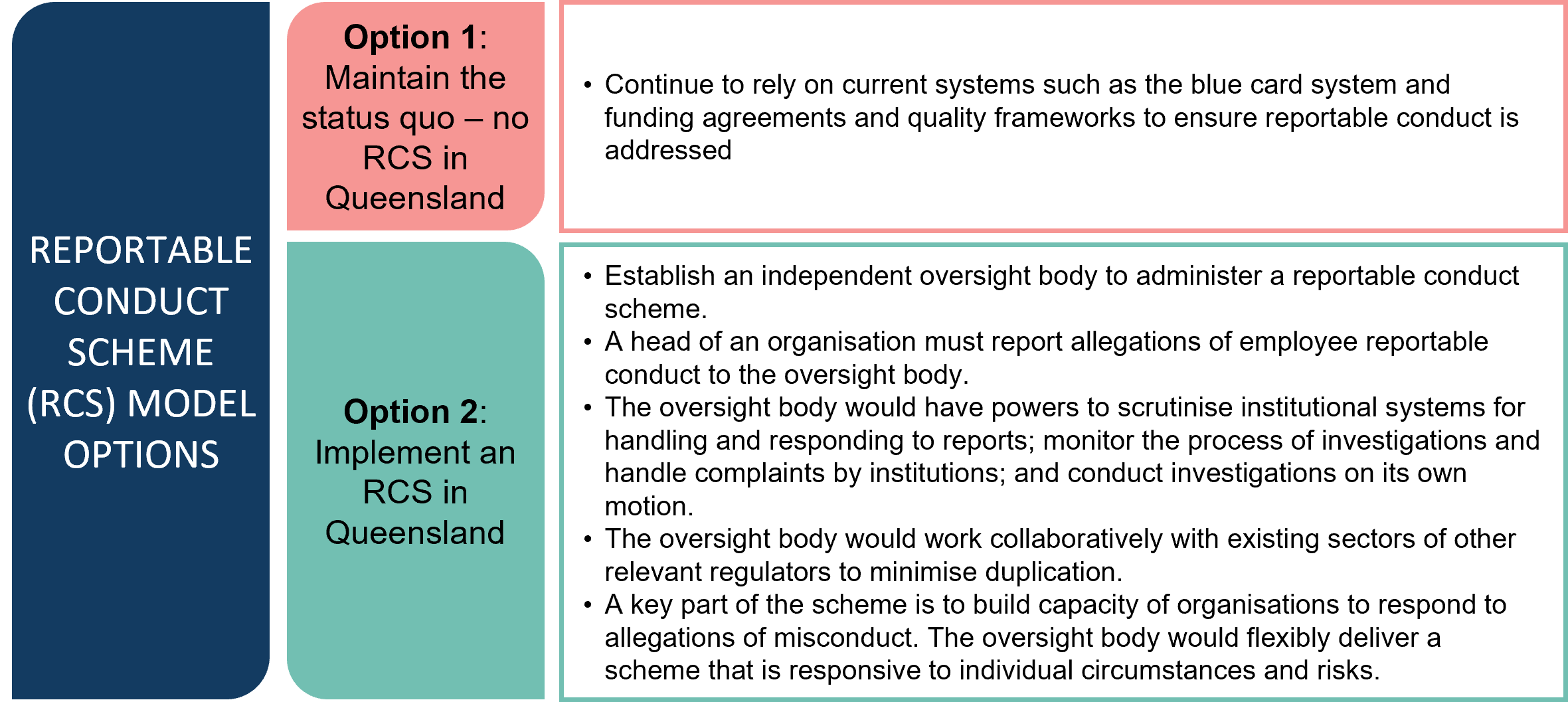


Table 40 summarises the comparative evaluation the options for implementing RCS:

Table 40 Comparative analysis of the RCS options

|  |  |  |
| --- | --- | --- |
| **Option** | **Required reduction in annual prevalence for cost-effectiveness** | **Overall analysis** |
| 1 | 0% | This option would impose no additional regulatory burden for organisations. However, this approach would fail to align with the objectives of government action, and have no additional impact on identifying, reporting and responding to child maltreatment in Queensland institutions. |
| **2** | **0.49%** | **The highest cost option, however, it offers a greater scope of influence on Queensland organisations, consistent with the objectives of government action, and therefore is likely to generate the greatest net benefit for Queensland. This option also enables capacity-building and supports readiness for sectors in scope.** |

Option 2, a nationally consistent reportable conduct scheme, is the final recommendation. Over time, it is expected that there will be earlier detection of risks and incidents of child abuse, which will have positive impacts on children, organisations, government and the wider community. Introducing a Queensland RCS will produce the greatest benefits for children and young people and their families by creating safer environments. Supported by stakeholders in consultation, direct government regulation will establish a nationally consistent RCS which delivers against the objectives of government action. The Royal Commission noted that, in Australia, an RCS is the only model for independent oversight of institutional responses to complaints of child abuse and neglect across multiple sectors.

#### Impact analysis

The analysis of all available information leads us to several main conclusions. Given the devastating and lifelong impacts of institutional child abuse (including poor institutional responses) for survivors, and the ripple effects to their family, friends and wider society, there is a clear case for government to take further action to better prevent, respond and detect institutional child abuse.

In quantitative terms, the recommended options for both CSS and RCS will need to deliver a relatively small impact on the total annual prevalence of child maltreatment in Queensland institutions in order to be cost neutral. An integrated model of both recommended options under a single oversight body would need to reduce the annual prevalence of child maltreatment in Queensland institutions by only 1.06% (approximately 126 cases) to be cost effective. Based on the expert recommendations of the Royal Commission and the reporting on implementation of CSS and RCS in other jurisdictions, it is reasonable to expect that implementation of the recommended options in Queensland would surpass a 1% impact.

Noting that a small impact of preventing institutional child abuse will at a minimum be cost-neutral, our analysis demonstrates that both recommended options have the greatest net benefit for Queenslanders. While we make these conclusions through a cost-benefit lens, we acknowledge that the impact of preventing child abuse in an organisational setting on every individual child, their family and the wider community cannot be overestimated.

Consultation on the CRIS supported our analysis that alternative options with reduced scope for influence will limit the potential of a Queensland approach to significantly reduce child maltreatment and prevent the lifelong effects of harm and trauma. The significant individual and societal costs of institutional child abuse will persist, failing to meet the objectives of government action. The Royal Commission identified many problems with institutional responses to child sexual abuse by employees, and these problems are likely to remain unless organisations are subject to external oversight.

New obligations for organisations were widely supported in consultation on the basis that there is more to do in Queensland to make organisations child safe. Stakeholders agreed a more contemporary, consistent and stronger safeguarding regime can be established in Queensland with the introduction of a mandatory CSS scheme and an RCS. Consultation also reinforced the need for the oversight body to support organisations to become child safe through comprehensive capacity building activities. Young people told us that organisations should not strive for a minimum standard but should do everything they can to ensure children are safe.

Queensland’s recommended approach follows legislative regulatory models of CSS and RCS that have been implemented successfully in other jurisdictions without substantial negative impacts on organisations in scope. The NSW Office of the Children’s Guardian reported that independent oversight promotes ongoing improvement and the maintenance of good practice, and is important, even for more experienced organisations.

The introduction of an integrated child safe organisations system will enable government, organisations, communities, and families to have greater awareness of the practices of organisations which provide services to Queensland children, and improved confidence that their children will be safe and well supported. In line with the ultimate goal of policy options considered through this impact analysis, the CSS and RCS will contribute to preventing children from experiencing harm and help to ensure that where they are exposed to maltreatment, they are supported in a trauma-informed and wellbeing-focused way.

#### Consistency with objectives for government action

Implementing an integrated child safe organisations system is consistent with the key government objective to prevent and reduce the severity and frequency of the maltreatment of children in Queensland institutions by:

* increasing the identification and reporting of institutional child abuse;
* strengthening organisations’ capacity, accountability, and transparency in accordance with best practice complaint handling;
* supporting organisation and institutional practices that facilitate safer environments for children receiving services or using facilities;
* raising community awareness for the nature and risks of child maltreatment in institutional settings;
* encouraging national consistency in approaches to supporting child wellbeing in institutional settings;
* providing direct and independent support to organisations, with the greatest benefits to smaller organisations – assisting smaller organisations with limited resources to handle complex and serious allegations, and managing conflicts of interest;
* providing cross-sectoral oversight of employee-related complaints of, and responses to, child abuse, across sectors that largely operate in isolation (in the current environment), promoting more consistent standards and rigor of complaint handling; and improving the ability to detect and respond to risks;
* providing an avenue for any person to notify the oversight body directly of a reportable allegation against an employee (compared to reporting directly to the organisation, which may be the only option in the current environment);
* detecting a wider range of concerning employee behaviour than other mechanisms that have the threshold of a criminal offence, which may lead to earlier detection and a reduction in the severity of the harm perpetrated on an individual child and the prevention of harm occurring to multiple other children;
* reducing the risk of potential offenders moving between sectors to evade detection, or travelling to jurisdictions that do not have RCSs, thus contributing to the equal protection of children regardless of their circumstances or geographical location;
* sharing intelligence with other regulators, authorities and jurisdictions, which will have flow on benefits for other regulatory systems, e.g. worker screening processes, as the RCS may provide access to additional information; and
* allowing for and contributing to collection and analysis of local and national data on institutional child abuse and neglect.

## PART 7 – Consistency with Fundamental Legislative Principles and Human Rights

### Fundamental legislative principles

The fundamental legislative principles (FLPs) under the *Legislative Standards Act 1992* (LS Act) require legislation to have sufficient regard to the rights and liberties of individuals and the institution of Parliament. We considered the FLPs as we developed the options for CSS and an RCS that were presented in the CRIS, as well as in our final impact analysis where we concluded the recommended approach for Queensland is an integrated child safe organisations system.

It is considered that the recommended options to implement CSS and an RCS in Queensland have sufficient regard to the rights and liberties of individuals and the institution of Parliament. Potential departures are identified and considered below.

#### Expansion of information sharing (child safe standards and reportable conduct scheme)

Section 4(2)(a) of the LS Act provides that legislation must have sufficient regard to the rights and liberties of individuals. The establishment of a collaborative regulatory model for the CSS (Option 3(a)) and nationally consistent RCS (Option 2) may affect this FLP as both CSS and RCS will require the expansion of information sharing powers between the oversight body, sector regulators, heads of entities and relevant Government agencies, to assist with investigations and minimise duplication in reporting and investigations. This will enable information obtained under the RCS, which may include personal information, about individuals to be shared between relevant entities.

This is justified as broad information sharing, for the purposes of administering the CSS and RCS, is critical to ensure the safety and wellbeing of children, and their protection from harm. This justification is also based on the principle that the protection and care needs of children take precedence over the protection of an individual’s privacy. Safeguards may be put in place to protect against unauthorised disclosure of information, and restrictions are provided to ensure confidential information (i.e. information that may identify a child) must be protected.

#### Offences (child safe standards and reportable conduct scheme)

As noted above, section 4(2)(a) of the LS Act provides that legislation must have sufficient regard to the rights and liberties of individuals. This may include regard to whether a penalty is proportionate to the offence noting a person’s rights may be infringed upon breach.

Under the recommended model for CSS and RCS, new offences are proposed with regards to non-compliance with the legislative framework, to ensure the effective administration and regulation of CSS and RCS in Queensland. Similar offences are provided in Tasmania, Victoria and NSW legislative schemes, and are also provided under other similar Queensland legislation.

Having regard to the impact of non-compliance on the safety of a child, and the risk to a child’s or other persons’ privacy from a breach, any offences that may be proposed are considered justified.

#### Entities in scope to comply with CSS (child safe standards)

Section 4(3)(a) of the LS Act provides that whether legislation has sufficient regard to rights and liberties of individuals depends on whether, for example, the legislation makes rights and liberties, or obligations, dependent on administrative power only if the power is sufficiently defined and subject to appropriate review.

Under the preferred CSS model, it is intended that certain entities and persons must comply with CSS in Queensland. This may represent a potential departure from the FLP where it creates obligations on entities, including sole traders. The establishment of these obligations is considered appropriate and essential to supporting the Royal Commission’s recommendation for implementing CSS in child-related work sectors. The intent of the scheme and obligations is to ensure institutions are child safe, thereby reducing the risk of harm and abuse of children in contexts which may give rise to vulnerability.

The potential departure may be mitigated where CSS obligations are consistent with existing obligations for entities under sections 171 and 172 of the *Working with Children (Risk Management and Screening) Act 2000* (Qld) that require organisation-wide risk management strategies.

#### Powers of the oversight body (child safe standards and reportable conduct scheme)

Section 4(3)(a) of the LS Act requires consideration of whether, for example, the legislation makes rights and liberties, or obligations, dependent on administrative power only if the power is sufficiently defined and subject to appropriate review. Additionally, section 4(3)(e) of the LS Act provides that whether legislation has sufficient regard to the rights and liberties of individuals depends on whether it confers power to enter premises, and search for or seize documents or other property, only with a warrant issued by a judge or other judicial officer.

To administer the CSS and RCS effectively under the recommended models, the oversight body must have appropriate investigative powers (for example, the power to request information or documents from an entity, and enter and inspect or search premises) to investigate actual or potential non-compliance with CSS or investigate reportable conduct allegations under an RCS. It is considered that the oversight body would need a range of enforcement tools to meet this objective, consistent with other jurisdictional oversight bodies in Victoria, NSW and Tasmania. These powers may be justified based on the essential purpose of investigations and audits under CSS and RCS to protect children from harm and promote their safety and wellbeing.

#### Delegations (child safe standards and reportable conduct scheme)

Section 4(3)(c) of the LS Act further provides that whether legislation has sufficient regard to rights and liberties of individuals depends on whether, for example, the legislation allows the delegation of administrative power only in appropriate cases and to appropriate persons.

Under the recommended models for CSS and RCS, it may be considered appropriate for the powers of the oversight body to be delegated by the head of the oversight body to employees or office holders of the oversight body. This would be for the purpose of enabling the oversight body to administer the CSS and RCS.

Under the RCS, it may also be considered that the head of an entity may delegate their functions to an employee of that entity.

The potential departure from this FLP is mitigated where delegations are limited only to another employee of the entity, or for the oversight body, their employees or office holders where they would be public service employees under the *Public Sector Act 2022*. This ensures that, for the oversight body, decisions made in performing the functions or exercising the powers of the oversight entity may be subject to government scrutiny. Delegation by the head of an entity within their organisation may also be required to manage the day-to-day operations of the RCS.

#### Protections from liability (child safe standards and reportable conduct scheme)

Section 4(3)(h) of the LS Act provides that whether legislation has sufficient regard to the rights and liberties of individuals depends on whether it does not confer immunity from proceedings or prosecution without adequate justification.

To support the effective implementation of the recommended models for CSS and RCS, it is proposed to provide that a person does not incur civil or criminal liability where they provide information or documents to the oversight body, head of an entity or an existing sector regulator in good faith.

This potential departure from the FLP is considered justified and necessary to ensure the effective administration and regulation of the CSS and an RCS, where the oversight body is empowered to perform its intended role in ensuring compliance with CSS by receiving information from a range of sources. It also provides a mechanism for risks to a child to be proactively identified and addressed. As noted above, the extent of the departure may be mitigated by providing that disclosure must be made in good faith to identified bodies.

#### Requirement for head of entity to report reportable conduct to the oversight body (reportable conduct scheme)

Section 4(2)(a) of the LS Act provides that legislation must have sufficient regard to the rights and liberties of individuals.

Under a nationally consistent RCS (Option 2), this FLP may be affected as legislation will require the head of an entity, and enable any other persons, to notify the oversight body of an allegation of reportable conduct. This is considered justified for matters of child protection based on the object of an RCS which includes the paramount principle to protect children from harm. There are also safeguards that may be considered to surround this obligation under the recommended model, including, for example, protection from criminal or civil liability, reprisal or detrimental action for reports made in good faith reflecting Royal Commission recommendations (7.5 and 7.6, Final Report Volume 7).

#### Reportable conduct to include historical conduct (reportable conduct scheme)

Section 4(3)(g) of the LS Act provides that whether legislation has sufficient regard to the rights and liberties of individuals depends on whether it does not adversely affect rights and liberties, or impose obligations, retrospectively.

For the recommended model for an RCS, this FLP may be affected where a definition of reportable conduct includes the historical conduct of a current employee. This would affect an individual’s liability to be investigated and a report made regarding conduct that occurred prior to the commencement of an RCS in Queensland, particularly for conduct that does not meet the threshold for criminal conduct. This is justified for matters of child protection based on the purpose of an RCS: that it protects children from harm. Also, reportable allegations may only be reported to an oversight body for entities proposed to be in scope of the scheme, so historical conduct would be captured if an allegation is made or re-made during the operation of the scheme.

### Human rights assessment

#### Overview

A regulatory approach to CSS and the establishment of a nationally consistent RCS are both likely to have human rights implications. Queensland’s *Human Rights Act 2019* (HR Act) protects 23 human rights in law. Queensland Government departments and agencies are required to act and make decisions which are compatible with human rights. This includes considering human rights implications in the development of policy and legislative proposals. While human rights may be limited, the limitations must be reasonable and demonstrably justifiable in a free and democratic society based on human dignity, equality and freedom.

The recommended model seeks to establish an integrated CSO system, co-locating a CSS scheme and an RCS within the same oversight body. To give effect to this recommendation, legislation would need to be introduced that required compliance by prescribed entities with 10 CSS, including a universal principle related to cultural safety for Aboriginal and Torres Strait Islander children and young people (Universal Principle). Additionally, it is intended that the oversight body would be enabled to share and receive information relating to CSS compliance with and from entities, including existing sector regulators, heads of entities and agencies with investigative functions relating to the protection of children and workers. It is proposed the legislation may include offences for non-compliance and unauthorised information sharing.

#### Human rights promoted by the recommended models

Overall, the recommended models for CSS and RCS promote and support human rights, primarily through the right to protection of families and children (section 26, HR Act). Both CSS and an RCS will promote and protect the rights of children in Queensland. At the core, these recommended models are about preventing harm to children by improving organisational practices. They promote the right for children to have the protection they need, and is in their best interests, because of being a child (section 26(2), HR Act). The CSS and RCS may also promote the following rights:

* ***Right to recognition and equality before the law* (section 15)** – this is promoted through the CSS standard that equity is upheld and diverse needs are taken into account for all children.
* ***Right to protection from torture and cruel, inhuman or degrading treatment* (section 17)** – the RCS and CSS are intended to prevent and protect children from harm, particularly in institutional settings.
* ***Cultural rights of Aboriginal peoples and Torres Strait Islander peoples* (section 28)** – CSS is proposed to be implemented in a way that embeds cultural safety for Aboriginal and Torres Strait Islander children.
* ***Right to liberty and security of person* (section 29)** – the RCS and CSS place positive obligations on entities to ensure their services are safe settings, to ensure not only the physical but emotional safety of children.

#### Human rights limited by the recommended models

A regulatory CSS and RCS may also limit the following human rights. These limitations are considered reasonable and demonstrably justifiable, as these are essential mechanisms to achieve the overarching policy purposes of the CSS and RCS to protect children from harm in institutional environments.

Thehuman rights under the HR Act that may be limited by a legislative framework supporting the recommended models are:

* ***Right to freedom of thought, conscience, religion and belief* (section 20)** – under an RCS, heads of religious institutions will be required to notify the oversight body of reportable allegations or conduct, even where it is obtained during religious confession and religious practice would require that to remain confidential. However, the need for children to have safe spaces from all types of harm outweighs the necessary and limited intrusion on religious confession. In line with the Royal Commission’s conclusion, the right to practise religion cannot prevail over the safety of children, and religious institutions that are tasked with caring for, or providing services for children, must provide an environment where children are safe from harm. Therefore, this proposal is considered compatible with human rights.
* ***Freedom of expression (section 21)*** – for CSS and RCS, it is proposed to include offences within the legislative framework for information sharing that prohibit a person from disclosing information other than for prescribed purposes, and create an offence for such unauthorised disclosure. This may limit the right by limiting the kind of information that a person may impart. However, it is considered information sharing under the recommended model is essential for effective regulation and administration of the schemes (and the safety and wellbeing of the child), and the impact of unauthorised disclosure on a person’s privacy outweighs the limitations on freedom of expression.
* ***Property rights* (section 24)** – for both CSS and an RCS, the oversight body is proposed to have powers to enforce compliance with the CSS and conduct investigations into reportable allegations, or conduct audits of organisations in scope. This would be supported by investigative powers, such as the ability to compel documents and information and enter and search premises. This may deprive a person of their right to exclusive possession of their property. It is considered that the safety and wellbeing of the child outweighs the limitations on property rights that may result when the powers of the oversight body are exercised, especially noting exercise of these powers may be subject to reasonable limitations within a legislative framework, consistent with other jurisdictions.
* ***Right to privacy and reputation* (section 25)** – for both CSS and RCS, this right will be limited by the oversight body’s ability to collect and share information about an individual with relevant entities, such as other government bodies or sector regulators. For the RCS, this may include for the purpose of facilitating investigations (e.g. for seeking information regarding a reportable allegation including historical conduct), or for CSS this may include for identifying and addressing non-compliance by entities in scope of the scheme. This may also be for a broad purpose such as ensuring the safety, wellbeing and welfare of a child under the recommended CSS or RCS models. For this reason, it is considered a reasonable limitation noting safeguards may be put into place to protect personal information consistent with other jurisdictions.

## PART 8 – Implementation and evaluation

### Implementation of an integrated child safe organisations model

As noted earlier in Part 6, the final recommendation is that Queensland establishes an integrated child safe organisations system, comprising CSS and RCS, in the same independent oversight body. This is consistent with the Royal Commission’s view that the same oversight body for an RCS should also be responsible for monitoring and enforcing the CSS (as in Victoria and NSW, and to be implemented in Tasmania).

An integrated system of CSS and RCS located in the one oversight body aims to deliver:

* a clear and coordinated way for organisations to engage with their child safe obligations;
* a system which is preventive, responsive and has the capacity to identify risks of abuse;
* holistic child safe capacity building and education activities for organisations, that is responsive to identified issues and risks and provides targeted support and guidance;
* shared expertise and intelligence to enable targeted and efficient oversight activities from the two schemes; and
* cost efficiencies for government arising from shared leadership resources, administrative staff, information sharing, reporting, capacity building, ICT and other operating costs.

An integrated child safe organisations system, including establishment of an oversight body would commence through legislative amendment.

#### Staggering child safe standards and reportable conduct scheme vs concurrent implementation

There is potential to stagger the introduction of the CSS and RCS, or to introduce the CSS and RCS to sectors simultaneously. A staggered commencement would involve the CSS providing the ‘foundational phase’ of building child safe environments, with RCS introduced at a later stage. This would allow organisations to embed the standards into their leadership, governance, and culture, which may improve their capacity to comply with an RCS by establishing processes and cultures targeting child safety. Alternatively, a concurrent implementation of CSS and RCS may be simpler and clearer to communicate to sectors that are within scope.

Various approaches to timing RCS and CSS have occurred in other jurisdictions. For example, the RCS was established ahead of the CSS in NSW (because the RCS existed in NSW before the Royal Commission conceived the CSS). Victoria established the CSS slightly ahead of the RCS. WA is establishing an RCS ahead of a CSS, and Tasmania is proceeding with a concurrent implementation of CSS and RCS.

#### Establishment period and capacity building

The Royal Commission noted that an RCS has administrative and cost implications for institutions and governments, and it will take time for governments to mobilise the necessary machinery for implementing their schemes. The Royal Commission noted that institutions will need time to understand what is required and how they can implement the RCS in their context, and should be provided with training and education in this regard.

Targeted stakeholder consultation in 2021 showed there is substantial support for implementation of the RCS to involve a capacity building or awareness-raising phase prior to the commencement of mandatory compliance, with supports targeting smaller or less regulated sectors to assist them to prepare for the scheme.

#### Phasing of sectors

The Royal Commission recommended a staged approach for introducing CSS and RCS to sectors to assist both government and organisations to prepare.

This acknowledges that some sectors will be more ready to comply with CSS and RCS, while others may require more time and support. This is the approach that was taken in Victoria, which introduced sectors to their RCS in three phases over an 18-month period from July 2017 to January 2019.

A phased implementation has a number of advantages:

* provide the oversight body with time to establish necessary processes and resources to implement the schemes and build its capacity over time;
* provide more time to those sectors that have less well-developed child protection policies and complaints handling processes to prepare;
* enable the oversight body to provide more targeted support to sectors as they are brought into the scheme; and
* distribute the costs to government over a longer period of time.

Sector phasing would attempt to balance the following factors:

* the level of risk inherent in the activities provided by the sector and the vulnerabilities of the population it serves, indicated in part by the number of reportable allegations for sectors in the Victorian scheme;
* the approximate number of children receiving services, and the overall volume of services received by children, by each sector;
* the complexity and degree of existing regulation which applies to each sector;
* the anticipated length of time needed by sectors to prepare; and
* staggering the sectors (giving consideration to the size of sectors and the support/intervention required) to enable the oversight body to provide more focused support to sectors as they are introduced at each phase.

As identified in Part 1, different sectors may be subject to relatively more or less risk factors that contribute to the overall risk of child maltreatment occurring. There is very limited data on the number of organisations in each sector, the number of organisations within different service types, and the number of children who interact with that organisation, so it is not possible to accurately estimate how different phasing approaches will have different impacts on overall cost-effectiveness. Accordingly, phasing was not evaluated extensively in the impact analysis, though the actuarial costing model we used does assume that there is some degree of phasing with not all organisations commencing in year 1.

However, there are broad elements of the various sectors that can be used to develop an approximate schedule for a phased approach. Table 41 provides an example of how a potential phased approach may occur. Note that the example phases below do not represent overall timing – as discussed in Part 4, under a foundational CSS timing approach, Phase 1 of the CSS would be implemented before Phase 1 of the RCS is implemented. In this example, the schemes commence with more mature sectors that are expected to require less time to prepare for compliance, with sectors that will require more support included at a later stage. This approach also addresses sectors that are expected to have a greater number of RCIs based on comparative data drawn from Victoria’s implementation of RCS. The key principle behind considering a phased approach was to ensure that sectors are properly supported to be ready for compliance.

Table 41 Example of sector phasing

|  |  |  |
| --- | --- | --- |
| **Phase** | **Sector phasing CSS** | **Sector phasing RCS** |
| 1 | * Education * Child protection * Childcare * Justice/detention | * Education * Child protection |
| 2 | * Religious organisations * Health * Disability * Accommodation (e.g. housing and homelessness services) | * Childcare * Justice/detention * Disability |
| 3 | * Clubs and associations * Coaching * Commercial * Transport * Other | * Religious organisations * Health * Accommodation (e.g. housing and homelessness services) * Other |

#### Additional considerations for implementation

There are potential negative impacts resulting from implementation, beyond the costs identified in this DIAS. It is possible that when costs of delivering a service or part of a service are increased, some organisations may need to manage increased costs which could lead to non-compliance, undermining the effectiveness of the regulations. Alternatively, organisations may need to exit the market or stop delivering services if the costs to comply are too great. In both circumstances there is a risk that children are exposed to more harm either due to hidden non-compliance or reduced availability and quality of services.

For these reasons, it is critical that the oversight body has the necessary flexibility to work with different sectors and organisations in applying the CSS and RCS. The intention of the Royal Commission recommendations is that the implementation of CSS and RCS can be adapted to the needs, resources and nature of every organisation’s unique circumstances. As there is no evidence of significant rates of non-compliance or organisations exiting the market in other jurisdictions where CSS and RCS are fully implemented, we think it is unlikely these risks are significant. However, it will be important to continue to monitor the impacts of compliance on organisations when implementation commences and as it matures over time.

##### What we asked:

1. Are there any factors specific to your organisation and/or sector that should be considered as part of implementation of an integrated child safe organisations scheme? (RCS and CSS)
2. Do you support an approach that staggers the introduction of CSS and RCS (such that CSS is introduced ahead of the RCS) or should the CSS and RCS be introduced to sectors at the same time? Why or why not?
3. Do you support a phased approach to introducing sectors to the CSS and RCS, or should the schemes apply to all organisations in scope at the same time? Why or why not?
4. Do you have suggestions for any supports or measures that could help with successful implementation of CSS and RCS in Queensland and/or which might minimise any unintended outcomes?

#### Consultation results - implementation

##### Readiness to implement CSS

The vast majority of submissions indicated their organisation could implement a legislative model of CSS within one year, noting most organisations have already made significant progress implementing the CSS in some form. A small number of large and complex organisations, predominantly in education settings, suggested implementation of a new regulatory regime may take up to two years.

##### Implementation approach

We heard a mixed response from submissions about whether to stagger the introduction of CSS and RCS; implement both schemes simultaneously; and/or take a phased approach to introducing each scheme into different sectors over time. There was strong support for an establishment period for the oversight body to set up solid systems and develop resources, including sector-specific resources, and a transition period where organisations can access resources and support before regulatory obligations commence.

Some submissions suggested a staggered roll-out would allow agencies and the oversight body to prepare for change and focus on the substantial work required to implement each individual scheme, helping ensure successful implementation. There was some support for establishing CSS as the foundation for child safe environments, with CSS supporting the introduction of RCS at a later stage. For some organisations, staggered implementation was seen as more practical because limited resources could focus on one scheme at a time, supporting service continuity.

Some organisations suggested that, while they were ready for simultaneous implementation, they could see the benefit of staggered implementation for organisations that were not as ready. Some also expressed concern for the capacity of the oversight body to manage simultaneous implementation, noting a lack of resources in the oversight body could impact the roll-out of the schemes and, potentially, community acceptance.

Submissions that supported a staggered approach to implementation often also supported phasing in sectors over time, beginning with the sectors with highest risk and/or the sectors with the least regulation. In addition to putting further protections in place for children at most risk, phasing was seen as providing flexibility in implementation where improvements can be incorporated as the schemes are progressively rolled out across sectors.

We heard from other submissions that simultaneous implementation best supports the protection of children because it has an immediate impact; prioritises the safety and wellbeing of children; and builds public confidence. Some organisations preferred simultaneous implementation because of the strong linkages between both schemes and suggested simultaneous roll-out would be less confusing for organisations because they would come online at once. Some organisations also suggested simultaneous implementation would be more streamlined and allow organisations to pool their resources. Some submissions that favoured simultaneous implementation also expressed concern for the capacity of the oversight body to manage a wide scale roll-out and provide adequate support to organisations at the same time.

Submissions in favour of phased implementation, i.e. phasing sectors in at different times, saw benefits in allowing the oversight body to focus on specific sectors to give them all the support they need to get implementation right. Again, the opportunity to identify and address implementation issues as different sectors come online was seen as a benefit to phased implementation as was the capacity of the oversight body to focus its resources on particular elements of implementation (i.e. CSS or RCS), as well as particular sectors, scaling up its regulatory functions over time.

Regardless of the implementation approach preferred, submissions stressed that implementation should focus on awareness raising and education to promote child safe organisational cultures rather than compliance measures.

##### Final recommendation

The feedback received in submissions has been immensely helpful in considering the way forward for Queensland. The approach that will best support organisations to implement CSS and RCS seems to be staggered implementation, with CSS forming the foundation of child safe environments, and RCS building on protections at a later stage. This allows smaller organisations with less experience in CSS to focus on implementation activities for one scheme at a time and allows larger organisations time to manage the change required for more complex organisational structures.

Much of the feedback on phasing implementation, with different sectors commencing at different times, was focused on the ability of the oversight body to support both sectors and individual organisations in capacity building. Noting many submissions called for sector-specific guidelines, resources and support, a phased approach to both CSS and RCS seems the best strategy to boost the capacity of the oversight body to develop resources and provide the level of support organisations require for successful implementation.

However, we acknowledge the oversight body is likely to have views on the best approach for implementation, and the implementation approach for Queensland as described above may change based on further consultation with the oversight body.

#### Consultation results - measures to support successful implementation

Many submissions offered practical suggestions to support successful implementation including:

* clear communication to foster support and understanding of the system from all stakeholders and the wider community;
* time and support for training and capacity building;
* clear guidance, resources, and training provided by the oversight body to organisations including training videos, example and scenario testing to assist organisations to understand how the system operates;
* an information technology platform to track incidents (including automatic notifications) and enable two-way communication between organisations and the oversight body;
* a dedicated contact point or helpline within the oversight body and clear channels of communication;
* support for organisations to conduct investigations including targeted training by the oversight body and the establishment of a register of approved/accredited external investigators to support smaller organisations that do not have in-house skills or resources;
* adequate funding and resourcing of the oversight body, with some stakeholders noting that stretched oversight bodies in other jurisdictions have had a direct impact on service delivery;
* staffing of the oversight body should be diverse and representative of the population of children who may be a greater risk of abuse in organisations;
* children and young people should be supported by organisations and the oversight body to make complaints and to access supports if they have experienced abuse or trauma;
* financial support to organisations based on organisation size and/or income, in particular, not for profits and other organisations that rely heavily on volunteers will need support for implementation and compliance;
* government tender/grants processes should require demonstration of how CSS and RCS requirements will be met;
* the definition of reportable conduct will need to be clearly explained and widely understood, particularly in relation to ‘ill-treatment’ and the meaning of ‘significant’;
* children and young people and survivors of child abuse should be engaged in the design of the new oversight body and the implementation of the system;
* further targeted consultation is required with stakeholders including people with lived experience of child abuse, Aboriginal and Torres Strait Islander communities, people with disability, people from culturally and linguistically diverse communities, the LGBTQIA+ community and regional and remote locations;
* consideration of how regional services will be supported during the rollout and have access to training and resources;
* clear protocols for managing the intersection with other regulatory frameworks and authorities e.g. Queensland Police Service, and clear information sharing protocols with employers;
* establishment of sector practitioner working groups or communities of practice; and
* support for frontline staff to understand and apply the CSS and RCS, including:
* identifying concerning behaviours of themselves, colleagues and others;
* understanding professional boundaries; and
* resources to support reflective practice and supervision of staff, students and volunteers.

This feedback from stakeholders will continue to be considered as this work progresses and as we prepare for implementation.

#### Monitoring and evaluation

The Queensland RCS and CSS will be evaluated as required, to:

* establish a baseline of information to measure and assess changes over time;
* determine the effects/impacts of the schemes to assess whether the expected benefits are being delivered; and
* improve the design and performance of the schemes.

Evaluation activities will need to occur at different stages:

* Collection of baseline data prior to the commencement of the scheme. This may occur during the education and establishment phase. Such data may include levels of confidence in existing child safe systems within the organisation, data on support needs emerging from different sectors and the impacts of complying with the new schemes.
* Ongoing data collection during the operation of the scheme that can be used for continuous improvement and annual/public reporting. ICT systems should be built to capture data such as:
  + number of notifications of reportable allegations and convictions received;
  + the circumstances of a reportable allegation or conviction;
  + information about the subject of the allegation or conviction (both victim and alleged perpetrator), such as age, gender identity, Aboriginal and/or Torres Strait Islander identity, cultural and linguistic identity, religion and disability status;
  + the findings (substantiated, unsubstantiated, unfounded, outside scope of scheme) and reasons;
  + any disciplinary or other action the entity has taken, or proposed to be taken, in relation to the employee and reasons; and
  + if no action is proposed and reasons.
* Ongoing engagement with organisations through training and capacity building activities will also provide the oversight body with valuable information on the effectiveness of the schemes. Reviewing such information can identify trends, including sectors and organisations that might not be meeting their obligations under the schemes. This can guide the oversight body to target its capacity building efforts. It will also contribute to public reporting on the schemes, through annual reports, and recommendations for changes to the scope or operation of the schemes over time.
* Evaluation after the schemes have been in operation for some time. The Royal Commission recommended that governments periodically review the operation of RCS’, including to determine whether the schemes should cover additional institutions and to adapt to changing dynamics and new challenges relevant to employee-related child abuse. The Queensland child safe organisations system will undergo periodic operational review. The oversight body will be required to review the operation of the system as part of its annual reporting. The annual report must include information about:
  + the performance of its functions under the CSS and RCS;
  + trends in the reporting and investigation of CSS compliance, reportable allegations and/or reportable convictions; and
  + trends in outcomes as a result of investigations.
* Broader operational reviews may occur as needed and may be initiated by the oversight body (via its ability to prepare special reports) or by the relevant Minister.

The oversight body will undertake data collection as part of the monitoring and evaluation of the child safe organisations system. This could include data on various cohorts and how they are impacted, including systemic data on:

* Aboriginal and/or Torres Strait Islander identity;
* gender and sexuality diversity;
* cultural and linguistic diversity; and
* religion and diversity of belief.

During the CRIS consultation process, stakeholders were supportive of a review of the RCS taking place early enough to capture developing improvements as it evolves and matures. Stakeholders also emphasised that evaluation should look beyond levels of organisational compliance and seek to understand and measure issues such as the level of system support and how closely the compliance of organisations aligns with the intended outcomes and objectives of government policy.

#### Measures

Table 42 provides a summary of possible measures which could be used to evaluate performance of a Queensland child safe organisations system against the primary and secondary objectives outlined in Part 2.

Table 42 Possible measures

| **Primary objective** | **Secondary objective** | **Measures** | **Expected/intended outcomes** |
| --- | --- | --- | --- |
| 1,2 | 1.1, 1.2, 1.3, 2.1 | Number of organisations compliant with CSS. | Expect to see steady increase of up-take across sectors as capacity building and rollout continues.  Expect no reduction in services and facilities. |
| 1,2 | 1.1, 1.2, 2.1, 2.2, 2.3, 3.1 | Downloads of online CSS and RCS guidance material. |
| 1,2 | 1.1, 1.2, 2.1, 2.2, 2.3, 3.1 | Level of participation in training opportunities (seminars etc.) across organisations and sectors. |
| 1,2 | 1.1, 1.2, 1.3, 2.1 | Number of organisations seeking exemptions from CSS/RCS requirements, reducing scope of operations or exiting the market. |
| Short term (6 months – 5 years) | | | |
| 2 | 1.4, 2.1, 2.4 | Reports of child-related misconduct. | Aimto see an increase in reports of child-related misconduct during the early years of rollout of the RCS, which demonstrates the system is effectively working to detect and report these incidents (which have previously been underreported). |
| 2 | 1.3, 1.4, 2.1, 2.2 | Types of reportable conduct incidents and sectors in which they occur. | Expect to see different trends in types of incidents across sectors, which reflects the experience in other jurisdictions that this can be influenced by changing environmental and social factors. |
| 2 | 1.1, 1.3, 1.4, 2.2, 2.3 | Time for organisations to respond to allegations. | Expect response times to trend downwards as organisations understand obligations and are supported to respond to reported incidents. |
| 2 | 1.3, 1.4, 2.3, 2.4, 3.3 | Intervention by the oversight body, e.g. number of times the body has taken over or conducted a direct investigation; provided advice, resources, research; or provided recommendations following an organisation’s investigation. | Aim for more highly regulated, well-resourced organisations to conduct thorough investigations; oversight body will still need to monitor to ensure compliance across all organisations and provide greater support to new, less regulated or smaller organisations. |
| Long term (5 years+) | | | |
| 1, 2 | 1.2, 1.2, 1.4, 1.5, 2.1, 2.4 | Severity of reports of child-related misconduct, e.g. number of reports made against a single perpetrator; ratio of incidents vs perpetrators. | Aim for a long-term reduction in the severity of reports, e.g. the ratio of reportable incidents to alleged perpetrators will reduce so there is less reporting of repeat offenders (i.e. a single perpetrator being responsible for multiple reportable incidents). Once implementation of CSS and RCS has reached maturity and expanded to all organisations within scope, this will improve practices and systems to reduce opportunities for misconduct, and ensure reports are made earlier to prevent the occurrence, or escalation, of abuse. |
| 1, 2, 3 | 1.2, 3.1, 3.2 | Community trust in organisations. | Expect communities to report greater trust and understanding of child safe organisations and standards through government feedback pathways to the oversight body, community surveys, related public discussion or consultation papers. |
| 1, 2, 3 | 1.2, 3.2, 3.3, 3.4 | Level of understanding of organisations. | Organisations report greater understanding of what it means to be a child safe organisation. This includes regulators, agencies, peak bodies and the oversight body hearing from organisations that they understand their obligations as a child safe organisation by:   * understanding the role, purpose and how to comply with CSS; and * develop confidence in preventing, detecting and responding to allegations of misconduct. |

## Glossary

|  |  |
| --- | --- |
| **ABS** | Australian Bureau of Statistics |
| **ACMS** | Australian Child Maltreatment Study |
| **Blue card / blue card system** | The blue card system is Queensland’s Working With Children Check-It regulates child-related services under the Working with Children (Risk Management and Screening) Act 2000 and the Working with Children (Risk Management and Screening) Regulation 2011. |
| **CCC** | Crime and Corruption Commission |
| **Children / children and young people** | A person under the age of 18. Although this document references ‘children and young people’ throughout the document, the term ‘children’ is generally made in reference to children and young people. |
| **Child abuse and child maltreatment** | The terms ‘child abuse’ and ‘child maltreatment’ are used interchangeably throughout this document to refer to all forms of abuse including physical abuse, sexual abuse, emotional or psychological abuse, and neglect, experienced by children and young people under 18 years of age.  In different academic and government documents, child abuse and child maltreatment can sometimes be defined in different ways to include a more or less conservative measure of the different forms of abuse. |
| **Child safe standards (CSS)** | Throughout this document, CSS refers generally to organisational child safe principles, examples of which include the Royal Commission’s CSS and the National Principles for Child Safe Organisations. See **Appendix D** for the full text of the Royal Commission’s CSS and the National Principles for Child Safe Organisations. |
| **Consultation Regulatory Impact Statement (CRIS)** | A Consultation Regulatory Impact Statement (CRIS) was used to assist government decision-making where government proposals for regulation will impact organisations or the community. The CRIS assisted government to gather feedback from stakeholders about these impacts and hear their views on the proposals under consideration. Since September 2023, the previous Queensland Government Guide to Better Regulation has been replaced by the [Queensland-Government-Better-Regulation-Policy.pdf (treasury.qld.gov.au)](https://s3.treasury.qld.gov.au/files/Queensland-Government-Better-Regulation-Policy.pdf). |
| **DCSSDS** | Department of Child Safety, Seniors and Disability Services |
| **Discount rate** | A discount rate is applied to costs and benefits, or cash inflows and cash outflows, that are expected to occur in the future. The discount rate (for example 7% used in this CRIS’ impact analysis) is used to adjust these future cash flows to estimate their value in the present day. |
| **DIAS** | A Decision Impact Analysis Statement incorporates the results of consultation from a Consultation Impact Analysis Statement (formerly referred to as a Consultation Regulatory Impact Statement), and makes a final recommendation to government on a decision about new regulation which may impact organisations or the community. For more information see [Queensland-Government-Better-Regulation-Policy.pdf (treasury.qld.gov.au)](https://s3.treasury.qld.gov.au/files/Queensland-Government-Better-Regulation-Policy.pdf). |
| **DJAG** | Department of Justice and Attorney-General |
| **HSQF** | Human Services Quality Framework |
| **Institution / organisation** | Any public or private body, agency, association, club, institution, organisation or other entity or group of entities of any kind (whether incorporated or unincorporated), however described, and:   * includes, for example, an entity or group of entities that provides activities, facilities, programs or services of any kind that provide the means through which adults have contact with children, including through their families; * includes an individual who is carrying on a business or entity as above; and * does not include the family. |
| **Lifetime prevalence and annual prevalence** | Lifetime prevalence is the proportion of a particular population with a specific characteristic or condition (in this DIAS, experience of child maltreatment) at any point in their life. This means the lifetime prevalence of institutional child maltreatment in Queensland is the total proportion of Queenslanders of any age who at any point in their life experienced child maltreatment in an institutional setting.  In contrast, annual prevalence is a type of period prevalence figure. This means that the annual prevalence is the proportion of a population with a specific characteristic or condition within a given year. In this DIAS, annual prevalence of institutional child maltreatment in Queensland means the total proportion of Queenslanders who are experiencing or experienced child maltreatment in a given year. |
| **Misconduct** | Reportable conduct committed against, with or in the presence of a child, that does not necessarily constitute a criminal offence. Includes sexual misconduct, which may include crossing professional boundaries and sexually explicit comments or other overtly sexual behaviour with or towards a child. |
| **National Principles** | The National Principles for Child Safe Organisations |
| **NDIS** | National Disability Insurance Scheme |
| **Net present value (NPV)** | NPV is a tool used in investment planning and cost benefit analysis to compare the current values of different possible investment or funding decisions. It is equal to the sum of the cash inflows and cash outflows over a period of time, which are discounted by a ‘discount rate’. This is to represent that costs and benefits are less valuable if they will only be received after a long time period. In general, investments with a higher or positive NPV are better investments than those with a lower or negative NPV. |
| **Oversight Body** | The body is proposed to provide independent oversight of the CSS and RCS. The oversight body would have powers prescribed under the associated legislation which allow it to coordinate with other sector regulators and interact directly with organisations. The type of regulatory powers, degree of oversight and scope of organisations it regulates are subject to outcomes of this CRIS and further government consideration. |
| **Reportable conduct scheme (RCS)** | A scheme that provides independent oversight of institutional responses to complaints of child abuse and child-related misconduct across sectors. It requires reporting of misconduct and abuse of children by employees of designated organisations that provide services to children, to an external oversight body. References to RCS may apply to the schemes in other jurisdictions or more specifically to the model proposed for Queensland. |
| **Reportable conduct** | Conduct which heads of relevant entities are required to report to an oversight body under a reportable conduct scheme. This includes a child sexual offence committed in relation to, or in the presence of, a child; sexual misconduct; ill-treatment of a child; neglect of a child; physical violence or assault, committed in relation to, or in the presence of a child; or behaviour that causes significant emotional or psychological harm to a child. |
| **RCI/s** | Reportable Conduct Incident/s – notification of conduct that is reportable under the scheme. |
| **Royal Commission** | Royal Commission into Institutional Responses to Child Sexual Abuse |
| **Royal Commission Final Report** | The Final Report of the Royal Commission into Institutional Responses to Child Sexual Abuse (2017, 17 volumes) |
| **Sensitivity analysis** | Where variables have been estimated or are based on assumptions, sensitivity analysis is used to evaluate whether the predicted net present value is impacted significantly if the ‘real’ value is different from the forecasted value used in the analysis. Undertaking sensitivity analysis helps us understand the risk of different options if the conditions of the real world are different from those predicted in the original analysis. |
| **WWC Act** | *Working with Children (Risk Management and Screening) Act 2000* |

## Appendix A – Sensitivity analysis

To test the strength of analysis used to determine the required reduction in cases of child maltreatment to generate a positive net present value for CSS options 2, 3(a) and 3(b) and RCS Option 2 in Part 4 of this DIAS, a number of scenarios were considered. Detailed below are the results of this analysis, and the evaluation of its results.

For the purposes of the sensitivity analysis, a base scenario was developed below which also incorporates the 3% and 11% discount rates recommended for sensitivity analysis by the Australian Government guidelines.[[90]](#footnote-91) To enable comparison between the impact of different scenarios, the respective number of cases and associated percentage of total annual prevalence was calculated for each option. It is noted that there is ongoing discussion about the appropriate discount rate for evaluating social impacts – e.g. a reduction in prevalence of child maltreatment in Queensland institutions, given the ethical implications of discounting the welfare of society in the future. However, the CRIS and this DIAS accepts the advice of the Australian Government Office of Impact Analysis, which is that the discount rate should not be adjusted as there is no acceptable means of adjusting the discount rate for the quantifying of the ‘relative value of different generations’ welfare’.[[91]](#footnote-92)

It is also important to note that for the purposes of the cost-effectiveness analysis, estimated costs produced by Finity Consulting have been used to produce an estimate of total costs to government and organisations in-scope. However, this modelling is noted to include significant uncertainty and actual outcomes may deviate substantially. For this reason, the below sensitivity testing is important to understand of the potential risk if estimated costs, benefits and underlying assumptions are demonstrated to be inaccurate when implementing.

Table 43 Base case scenario (with 3% and 11% discount rates for risk analysis)

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
|  | CSS | | | RCS (Option 2) | | |
| Discount rate | 3% | 7% | 11% | 3% | 7% | 11% |
| Option 2 | 24 (0.2%) | 19 (0.16%) | 16 (0.13%) | 73 (0.6%) | 59 (0.49%) | 49 (0.4%) |
| Option 3(a) | 107 (0.88%) | 87 (0.72%) | 72 (0.59%) |  |  |  |
| Option 3(b) | 106 (0.88%) | 87 (0.71%) | 72 (0.59%) |  |  |  |
|  |  |  |  |  |  |  |
| **Co-located integrated model**  **(CSS Option 3(a) and RCS Option 2)** | | | | **3%** | **7%** | **11%** |
| 160 (1.31%) | 129 (1.06%) | 106 (0.87%) |

### Total cost of compliance for organisations in scope

This scenario evaluates the impact on the cost-effectiveness analysis if the total cost for all organisations in scope is greater than estimated in the core scenario. This could be because of several variables changing from the core assumptions used in Part 4 of this DIAS:

* there is a significantly different number of organisations that fall under the scope of either the CSS or RCS;
* the pool of organisations in scope has relatively more complex organisations for whom it is costlier to comply; and
* the expected average cost for organisations to comply is substantially different to the expected costings.

To represent these possible impacts, two scenarios were considered where the total cost of compliance for organisations in scope was either higher or lower by 50% than the expected value.

Table 44 Increased cost of compliance for organisations in scope (+50%)

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
|  | CSS | | | RCS (Option 2) | | |
| Discount rate | 3% | 7% | 11% | 3% | 7% | 11% |
| **Option 2** | 51 (0.42%) | 41 (0.33%) | 33 (0.27%) | 101 (0.83%) | 81 (0.67%) | 67 (0.55%) |
| **Option 3(a)** | 153 (1.26%) | 125 (1.03%) | 103 (0.85%) |  |  |  |
| **Option 3(b)** | 153 (1.26%) | 124 (1.02%) | 103 (0.85%) |  |  |  |
|  |  |  |  |  |  |  |
| Co-located integrated model  (CSS Option 3(a) and RCS Option 2) | | | | 3% | 7% | 11% |
| 227 (1.87%) | 183 (1.51%) | 151 (1.24%) |

Table 45 Decreased cost of compliance for organisations in scope (-50%)

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
|  | **CSS** | | | **RCS (Option 2)** | | |
| **Discount rate** | **3%** | **7%** | **11%** | **3%** | **7%** | **11%** |
| **Option 2** | 8 (0.07%) | 7 (0.05%) | 6 (0.05%) | 45 (0.37%) | 37 (0.3%) | 30 (0.25%) |
| **Option 3(a)** | 60 (0.5%) | 49 (0.41%) | 41 (0.34%) |  |  |  |
| **Option 3(b)** | 60 (0.49%) | 49 (0.4%) | 41 (0.34%) |  |  |  |
|  |  |  |  |  |  |  |
| **Co-located integrated model**  **(CSS Option 3(a) and RCS Option 2)** | | | | **3%** | **7%** | **11%** |
| 92 (0.76%) | 75 (0.61%) | 62 (0.51%) |

Based on the Tables 44 and 45, it is clear the overall cost-effectiveness of the options analysed have a low level of sensitivity to the total cost of compliance for organisations in-scope, with only marginal changes to the required reduction in annual prevalence of child maltreatment for each option to break even. All values remain significantly below the expected 2% minimum impact for implementation of Option 3(a) for CSS and Option 2 for RCS or a 4% reduction predicted under an integrated model.

### Average cost per incident of child maltreatment

This scenario evaluates the impact on the cost-effectiveness analysis if the average cost per incident of child maltreatment is different to the estimate in the core scenario. This could be because of several variables changing from the core assumptions used in Part 4 of this DIAS:

* the financial cost to government resulting from incidents of child maltreatment is significantly different, as a result of added costs or efficiencies not captured in the impact analysis; and
* the impact of harm is inaccurately captured through the method used to identify a monetary cost of said harm.

To represent these possible impacts, two scenarios were considered where the total cost per incident of child maltreatment was either higher or lower by 50% than the expected value.

Table 46 Increased cost per incident of child maltreatment (+50%)

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
|  | **CSS** | | | **RCS (Option 2)** | | |
| **Discount rate** | **3%** | **7%** | **11%** | **3%** | **7%** | **11%** |
| **Option 2** | 16 (0.13%) | 13 (0.11%) | 11 (0.09%) | 49 (0.4%) | 39 (0.32%) | 32 (0.27%) |
| **Option 3(a)** | 71 (0.59%) | 58 (0.48%) | 48 (0.4%) |  |  |  |
| **Option 3(b)** | 71 (0.58%) | 58 (0.48%) | 48 (0.39%) |  |  |  |
|  |  |  |  |  |  |  |
| **Co-located integrated model**  **(CSS Option 3(a) and RCS Option 2)** | | | | **3%** | **7%** | **11%** |
| 106 (0.88%) | 86 (0.71%) | 71 (0.58%) |

Table 47 Decreased cost per incident of child maltreatment (-50%)

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
|  | **CSS** | | | **RCS (Option 2)** | | |
| **Discount rate** | **3%** | **7%** | **11%** | **3%** | **7%** | **11%** |
| **Option 2** | 48 (0.4%) | 39 (0.32%) | 32 (0.26%) | 146 (1.2%) | 118 (0.97%) | 97 (0.8%) |
| **Option 3(a)** | 214 (1.76%) | 174 (1.43%) | 144 (1.19%) |  |  |  |
| **Option 3(b)** | 213 (1.75%) | 173 (1.43%) | 144 (1.18%) |  |  |  |
|  |  |  |  |  |  |  |
| **Co-located integrated model**  **(CSS Option 3(a) and RCS Option 2)** | | | | **3%** | **7%** | **11%** |
| 319 (2.63%) | 258 (2.12%) | 212 (1.75%) |

It is evident from Tables 46 and 47 that the break even point for all tested options are reasonably sensitive to the value used for cost per incident of child maltreatment. However, in all scenarios, the required reduction in annual prevalence of child maltreatment remains relatively low, in all cases below a 2% reduction which is expected to be achieved for implementation Option 3(a) for CSS and Option 2 for RCS or a 4% reduction predicted under an integrated model, even under a worst case scenario of a 50% decreased cost per incident and a 3% real discount rate.

### Total cost to government (establishment of oversight bodies and agency compliance costs)

This scenario evaluates the impact on the cost-effectiveness analysis if the total cost to government for implementing the various options is different to the estimate in the core scenario. This could be because of several variables changing from the core assumptions used in Part 4 of this DIAS, including:

* the expected cost of establishing the oversight body is substantially different from the estimated cost; and
* the expected additional costs to government, for agencies to establish collaboration with the oversight body, is substantially different from the estimated cost.

To represent these possible impacts, two scenarios were considered where the total cost to government was either higher or lower by 50% than the expected value.

Table 48 Increased cost to government (oversight body and other agencies) (+50%)

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
|  | **CSS** | | | **RCS (Option 2)** | | |
| **Discount rate** | **3%** | **7%** | **11%** | **3%** | **7%** | **11%** |
| **Option 2** | 25 (0.21%) | 21 (0.17%) | 17 (0.14%) | 82 (0.67%) | 66 (0.55%) | 55 (0.45%) |
| **Option 3(a)** | 114 (0.94%) | 93 (0.77%) | 77 (0.64%) |  |  |  |
| **Option 3(b)** | 113 (0.93%) | 92 (0.76%) | 77 (0.63%) |  |  |  |
|  |  |  |  |  |  |  |
| **Co-located integrated model**  **(CSS Option 3(a) and RCS Option 2)** | | | | **3%** | **7%** | **11%** |
| 176 (1.45%) | 143 (1.17%) | 118 (0.97%) |

Table 49 Decreased cost to government (oversight body and other agencies) (-50%)

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
|  | **CSS** | | | **RCS (Option 2)** | | |
| **Discount rate** | **3%** | **7%** | **11%** | **3%** | **7%** | **11%** |
| **Option 2** | 23 (0.19%) | 18 (0.15%) | 15 (0.12%) | 64 (0.53%) | 52 (0.43%) | 42 (0.35%) |
| **Option 3(a)** | 100 (0.82%) | 81 (0.67%) | 67 (0.55%) |  |  |  |
| **Option 3(b)** | 100 (0.82%) | 81 (0.67%) | 67 (0.55%) |  |  |  |
|  |  |  |  |  |  |  |
| **Co-located integrated model**  **(CSS Option 3(a) and RCS Option 2)** | | | | **3%** | **7%** | **11%** |
| 146 (1.2%) | 118 (0.97%) | 97 (0.79%) |

Based on the Tables 48 and 49, it is clear that the overall cost-effectiveness of the options analysed have a low level of sensitivity to the total cost to government, with only marginal changes to the required reduction in annual prevalence of child maltreatment for each option to break even. All values remain significantly below a 2% minimum impact for implementation of Option 3(a) for CSS and Option 2 for RCS or a 4% reduction predicted under an integrated model.

## Appendix B – Jurisdictional analysis

### Implementation of child safe standards – interjurisdictional comparison

| Symbol | Represents | | | |
| --- | --- | --- | --- | --- |
| ✓ | Implemented / in-scope | | | |
| ⭘ | Under development / unconfirmed / partially applicable | | | |
| ✗ | Not implemented / not applicable | | | |
| Implementation of child safe standards (CSS) | | | | | | | | | | |
| Key elements | | NSW | VIC | SA | | CWTH | ACT | TAS | WA | NT |
| Implementation of CSS | | ✓ | ✓ | ✓ | | ✓ | ⭘ | ⭘ | ⭘ | ✗ |
| Oversight body | | *Office of the Children’s Guardian (OCG)* | *Commission for Children and Young People (CCYP)* | *Department of Human Services (DHS)* | | *National Office for Child Safety* | *ACT Human Rights Commission (HRC)* | *N/A* | *N/A* | *N/A* |
| CSS and RCS schemes co-located in oversight body | | ✓ | ✓ | ✗  *No RCS established yet* | | *N/A* | ✗ | ✓ | *N/A*  *Information not yet available* | *N/A* |
| Mode of regulation | | *Single regulator* | *Co-regulatory* | *Single regulator* | | *Non-regulated* | *Single regulator* | *Single regulator* | *Under development* | *Non-regulated* |
| Summary of regulatory approach | | *OCG regulates the implementation of CSS in all organisations under the scope of the legislation in collaboration with govt agencies having existing regulatory or funding relationships with in-scope organisations* | *Organisations fall into categories which are prescribed a ‘sector regulator or ‘integrated sector regulator’. CCYP will be default regulator without a prescription.* | *DHS has oversight of child safe environment compliance, which represent the application of the National Principles. Primary oversight mechanism is compliance statements lodged by organisations.* | | *The Commonwealth Child Safe Framework includes discretion for agencies to pass on the framework to funded organisations through contractual mechanisms.* | *Proposed model would engage the HRC to take a responsive regulatory approach, building capacity, and cooperatively monitoring compliance* | *A Child and Youth Safe Organisations framework is under development in consultation with stakeholders. The framework will comprise legislatively mandated CSS and RCS and is scheduled to commence on 1 January 2024.* | *CCYP has developed capacity building resources for organisations to embed the National Principles.*  *Officer level advice indicates a mandatory CSS framework is under development.* | *Available information on proposed reform indicates CSS to be reflected in existing quality systems (child protection, sport and recreation agencies)* |
| Authorising Act | | *Children’s Guardian Act 2019* | *Child Wellbeing and Safety Act 2005; Commission for Children and Young People Act 2012* | *Children and Young People (Safety) Act 2017* | | *N/A* | *Under development* | *Child and Youth Safe Organisations Act 2023* | *N/A* | *N/A* |
| Scope of organisations to which CSS apply | | | | | | | | | | |
| Designated government agencies or other public entities that exercise care, supervision or authority over children as part of its primary functions | | ✓ | ✓ | ✓ | | \* | *Under development* | ✓ | *N/A* | *N/A* |
| Accommodation and residential services for children | | ✓ | ✓ | ✓ | | \* | *Under development* | ✓ | *N/A* | *N/A* |
| Religious institutions providing activities or services of any kind, through which adults have contact with children | | ✓ | ✓ | ✓ | | \* | *Under development* | ✓ | *N/A* | *N/A* |
| Childcare services which include approved early childhood education and care (ECEC) services | | ✓ | ✓ | ✓ | | \* | *Under development* | ✓ | *N/A* | *N/A* |
| Disability services and supports for children with disability | | ✗ | ✓ | ✓ | | \* | *Under development* | ✓ | *N/A* | *N/A* |
| Education services for children, including State and non-State schools; TAFES, and other registered institutions | | ✓ | ✓ | ✓ | | \* | *Under development* | ✓ | *N/A* | *N/A* |
| Health services for children, including government health departments, statutory bodies or affiliated health organisations | | ✓ | ✓ | ✓ | | \* | *Under development* | ✓ | *N/A* | *N/A* |
| Justice and detention services for children, including youth detention centres | | ✓ | ✓ | ✓ | | \* | *Under development* | ✓ | *N/A* | *N/A* |
| Out of home care | | ✗\* | ✓ | ✓ | | \* |  | ✓ | *N/A* |  |
| Other | | *\*Adoption services and services providing substitute residential care for children are included. Statutory out of home care is not currently in scope, pending review of accreditation framework.* | *All organisations must comply with CSS if they: provide services specifically for children, provide facilities for use by children under supervision, engage child as employee or volunteer.* | *All organisations that require a WWCC*  *Commercial services, such as recreational or entertainment services (play gym, bouncy castle hire)*  *Coaching or tuition services* | | *\*Commonwealth Govt agencies have discretion about passing on Child Safe obligations via contracts, so scope varies.* | *Under development* | *Commercial services, such as recreational or entertainment services (play gym, photography)*  *Coaching or tuition services*  *Neighbourhood houses*  *Transport services* | *Child Safe Organisations WA guidelines are un‑enforced but are intended to support all organisations to prioritise safety of children and young people* | *N/A* |
| Scope of regulator’s powers and functions | | | | | | | | | | |
| Capability building:   * Training * Support for implementation | | ✓ | ✓ | ✓ | | *N/A* | ✓ | ✓ | *Under development* | *N/A* |
| Monitoring:   * Access upon request to organisations facilities, systems, policies | | ✓ | ✓ | ✓ | | *N/A* | ✓  *Non-coercive* | ✓ | *Under development* | *N/A* |
| Investigation   * Review organisations records, systems, policies | | ✓ | ✓ | ✓ | | *N/A* | ⭘  *Non-coercive* | ✓ | *Under development* | *N/A* |
| * Inspect organisation’s premises | | ✓ | ✓ | ✓ | | *N/A* | ✗ | ✓ | *Under development* | *N/A* |
| * Require relevant authorities to answer questions/provide information | | ✓ | ✓ | ✓ | | *N/A* | ✗\* | ✓ | *Under development* | *N/A* |
| Enforcement   * Issue a compliance notice to organisations deemed to not satisfactorily reflect CSS | | ✓ | ✓ | ✗ | | *N/A* | ⭘  *Enforcement powers intended for use only in exceptional circumstances* | ✓ | *Under development* | *N/A* |
| * Issue penalty units/fines | | ✓ | ✓ | ✓ | | *N/A* | ⭘  *Enforcement powers intended for use only in exceptional circumstances* | ✓ | *Under development* | *N/A* |
| * Apply to the court for injunctions or issuing penalty units/fines / other enforcement | | ✗ | ✓ | ✓ | | *N/A* | ⭘  *Enforcement powers intended for use only in exceptional circumstances* | ✓ | ✗ | *N/A* |
| * Accept an enforceable undertaking to organisations to take action | | ✓ | ✓ | ✗ | | *N/A* | ⭘  *Enforcement powers intended for use only in exceptional circumstances* | ✗ | ✗ | *N/A* |
| * Publish information and report on non-compliant entities | | ✓ | ✓ | ✗ | | *N/A* | ⭘  *Enforcement powers intended for use only in exceptional circumstances* | ✓ | ✗ | *N/A* |
| * Other | | *N/A* | *N/A* | *N/A* | | *N/A* | *N/A* | *N/A* | *N/A* | *N/A* |

### Nationally consistent reportable conduct scheme – interjurisdictional comparison

| Symbol | Represents |
| --- | --- |
| ✓ | Implemented / in-scope |
| ⭘ | Under development / unconfirmed / partially applicable |
| ✗ | Not implemented / not applicable |
| Nationally consistent state and territory reportable conduct schemes (RCSs)[[92]](#footnote-93) | | | | | | |
| Key elements | | NSW | VIC | ACT | WA | TAS[[93]](#footnote-94) |
| **Independent oversight body** | | *Office of the Children’s Guardian* | *Commission for Children and Young People* | *Ombudsman* | *Parliamentary Commissioner (Ombudsman)* | *To be confirmed – Governor will appoint an independent regulator* |
| **Authorising Act** | | *Part 4,* [*Children’s*](https://www.legislation.nsw.gov.au/#/view/act/1974/68) *Guardian Act 2019* | *Part 5A,* [*Child Wellbeing and Safety Act 2005*](http://www.legislation.vic.gov.au/domino/Web_Notes/LDMS/LTObject_Store/ltobjst10.nsf/DDE300B846EED9C7CA257616000A3571/F0EDCDF8366CFA41CA2582410080158A/$FILE/05-83aa023%20authorised.pdf)  [*Child Wellbeing and Safety Regulations 2017*](http://www.legislation.vic.gov.au/Domino/Web_Notes/LDMS/LTObject_Store/LTObjSt10.nsf/DDE300B846EED9C7CA257616000A3571/B60910779EE85FD1CA25814F000D7A19/$FILE/17-62sra001authorised.pdf) | *Part 2, Division 2A,* [*Ombudsman Act 1989*](http://www.legislation.act.gov.au/a/alt_a1989-45co/default.asp)  [*Ombudsman Regulation 1989*](http://www.legislation.act.gov.au/sl/1989-9/default.asp) | *Division 3B,* [*Parliamentary Commissioner Act 1971*](https://www.legislation.wa.gov.au/legislation/statutes.nsf/law_a572.html) *(PCA)* | *Part 4*[*, Child and Youth Safe Organisations Act 2023*](https://www.legislation.tas.gov.au/view/html/asmade/act-2023-006)  *As introduced 22/11/22* |
| Scope of organisations | | | | | | |
| Public entities or functional public entities, that exercise care, supervision or authority over children as part of its primary functions | | ✓ | ✓ | ✓ | ✓ | ✓  *Includes Parliament of Tasmania* |
| Accommodation and residential service for children, including housing or homelessness services that provide overnight beds and some providers of overnight camps | | ✓ | ✓ | ⭘  *Includes residential care organisations. Providers of overnight camps and homelessness services not included* | ✓ | ✓ |
| Religious institutions providing activities or services of any kind, under the auspices of a particular religious denomination or faith, through which adults have contact with children | | ✓ | ✓ | ✓ | ✓ | ✓ |
| Childcare services which include approved early childhood education and care (ECEC) services under the Education and Care Services National Law (such as kindergartens, long day care, family day care or outside school hours care) | | ✓ | ✓ | ✓ | ✓ | ✓  *Includes professional babysitting or au pair services* |
| Child protection services including child protection authorities and agencies; providers of foster care, kinship or relative care; providers of family group homes; providers of residential care (includes support entities/secondary services) | | ✓ | ✓ | ✓ | ✓ | ✓  *Includes community-based intake services, adoption and contact services* |
| Disability services and supports for children with disability, including state disability service providers and registered providers under the NDIS | | ✗ | ✓ | ✗ | ✓ | ✓ |
| Education services for children, including State and non-State schools and may include TAFES, and other institutions registered to provide senior secondary education or training; courses for international students or student exchange programs | | ✓  *Includes TAFE. Other institutions registered to provide senior secondary education not included* | ✓  *Includes organisations providing overseas student exchange program* | ⭘  *Includes government and non-government schools. TAFE and other training not included* | ✓ | ✓  *Includes tertiary education providers* |
| Health services for children, including government health departments and agencies, and statutory corporations; public and private hospitals; providers of mental health; and drug or alcohol treatment services that have inpatient beds for children and young people (excluding private practitioners) | | ✓  *Does not include private hospitals except in limited circumstances (an affiliated health organisation or as part of a Public Private Partnership)* | ✓ | ✓  *\*Private providers of mental health and other services with in- patient beds not included* | ✓ | ✓  *Includes counselling services* |
| Justice and detention services for children, including youth detention centres (excludes immigration detention facilities) | | ✓  *Limited to government departments* | ✓  *Limited to government departments* | ✓  *Limited to government entities* | ✓  *Includes state-funded community justice services providers* | ✓  *Includes youth justice services* |
| Other   * Clubs and associations * Coaching or tuition services for children * Commercial services for children * Transport services for children | | ✗ | ✗ | ✗ | ✗ | ✓  *Includes a club, association or cadet organisation that has a significant membership of, or involvement by, children*  *Includes an entity that provides a coaching or tuition service to children* |
| Scope of reportable conduct | | | | | |  |
| A child sexual offence committed in relation to or in the presence of a child | | ✓ | ✓ | ✓ | ✓ | ✓ |
| Sexual misconduct (conduct in relation to or in the presence of a child that is sexual in nature but does not constitute a criminal offence) | | ✓ | ✓ | ✓ | ✓ | ✓  *(Also includes ‘Grooming’ category)* |
| Ill-treatment of a child | | ✓ | ✗ | ✓ | ✗ | ✗ |
| Neglect/significant neglect of child | | ✓ | ✓ | ✓ | ✓ | ✓ |
| Physical violence or assault committed in relation to, or in the presence of a child | | ✓ | ✓ | ✗ | ✓ | ✓ |
| Any behaviour that causes significant emotional or psychological harm to a child | | ✓ | ✓ | ✓ | ✓ | ✓ |
| Who and when is in scope | | | | | |  |
| Employees, volunteers and contractors are within scope | | ✓ | ✓ | ✓ | ✓ | ✓  *Includes a person elected to a role in an entity, such as alderman, councillor or member of Parliament* |
| Historical conduct, where a fresh allegation is made, is within scope | | ✓ | ✓ | ✓ | ✓ | ✓ |
| Reportable conduct, whether or not it occurs in the course of an employee’s employment, is within scope | | ✓ | ✓ | ✓ | ✓ | ✓ |
| Obligations of organisations within scope | | | | | |  |
| Must have systems and procedures in place for preventing and detecting reportable conduct | | ✓ | ✓ | ✓ | ✓ | ⭘  *Not an explicit obligation, but is encompassed in the Child and Youth Safe standards* |
| Head of organisation must report initial notification of reportable conduct to the oversight body | | ✓ | ✓ | ✓ | ✓ | ✓ |
| Must investigate, or arrange to investigate, allegations of reportable conduct | | ✓ | ✓ | ⭘  *Not an explicit obligation, however entities must have practices and policies in place for dealing with a reportable allegation or reportable conviction* | ✓ | ✓ |
| Head of organisation must provide a report of any investigation to the oversight body | | ✓ | ✓ | ✓ | ✓ | ✓ |
| Protections for persons making reports | | | | | |  |
| Persons making reports are protected from civil, criminal and/or professional conduct obligations | | ✓  *Includes civil and criminal liability and disciplinary obligations* | ✓  *Includes civil and criminal liability and disciplinary obligations* | ✓  *Includes civil liability, authorisation to disclose applies despite any contrary law* | ✓  *Includes civil and criminal liability and secrecy or duty of confidentiality obligations* | ✓  *Includes civil and criminal liability and professional standards and ethics* |
| Persons making reports are protected from dismissal | | ✓ | ✗  *Not explicitly included in legislation* | ✗  *Not explicitly included in legislation* | ✓ | ✗  *Not explicitly included in legislation* |
| **Functions and powers of the oversight body** | | | | | |  |
| Scrutinising institutional systems for preventing reportable conduct and for handling and responding to reportable allegations, or reportable convictions | | ✓ | ✓ | ✓ | ✓ | ✗  *Not explicitly included in legislation* |
| Monitoring the progress of investigations and the handling of complaints by institutions | | ✓ | ✓ | ✓ | ✓ | ✓ |
| Conducting, on its own motion, investigations concerning any reportable conduct of which it has been notified or otherwise becomes aware | | ✓ | ✓ | ✓ | ✓ | ✓ |
| Power to exempt any class or kind of conduct from being reportable conduct | | ✓ | ✓ | ✓ | ✓ | ✗ |
| Capacity building and practice development, through the provision of training, education and/or guidance to institutions | | ✓ | ✓ | ⭘  *Not a legislative requirement* | ✓ | ✓ |
| Public reporting, including annual reporting on the operation of the scheme and trends in reports and investigations, and/or the power to make special reports to parliaments | | ✓ | ✓ | ✓ | ✓ | ✓ |
| Information sharing with other relevant agencies | | ✓ | ✓ | ✓ | ✓ | ✓ |

## Appendix C – Intersection with existing regulation

* Note: Some organisations will sit across multiple categories.
* Existing regulators may have either regulatory or funding relationships with sector organisations.
* Other mechanisms and frameworks may apply – the following table is intended to illustrate, at a glance, the types of existing frameworks relevant to the CSS, to help indicate the level of existing relevant regulation in these sectors.
* Note: Categories and example service types do not represent a government position on the scope of organisations to which CSS will apply – this table is illustrative of the types of organisations working with children and their relevant regulation/regulators and is not intended to act as a comprehensive overview of scope.

| **Sector of organisations (as recommended by Royal Commission)** | **Example service types in this sector** | **Regulatory/quality framework relevant to child safe standards and reportable conduct scheme** | **Existing regulators and oversight bodies** |
| --- | --- | --- | --- |
| Accommodation and residential services, including overnight excursions or stays | Homelessness services. | Human Services Quality Framework (HSQF) (largely via self-assessment). | Department of Housing as funding agency. |
| Community housing. | National Regulatory System for Community Housing (NRSCH) or Queensland State Regulatory System for Community Housing (QSRSCH). | Queensland Registrar and Department of Housing as funding agency. |
| Domestic and family violence services (e.g. shelters). | HSQF. | DJAG as funding agency. |
| Activities or services of any kind, under the auspices of a particular religious denomination or faith, through which adults have contact with children | Churches and other types of faith-based institutions. | Child and Youth Risk Management Strategy (CYRMS) obligations in the *Working with Children (Risk Management and Screening) Act 2000* (Qld). | DJAG (Blue Card Services) with limited oversight capacity.  Individual faith bodies, such as the Australian Catholic Safeguarding/Professional Standards Office. |
| Childcare or childminding services | Early childhood education and care (registered or regulated under state or national law) – e.g. kindergarten, outside school hours care, standalone care services. | National Quality Framework for early childhood/educationand *Education and Care Services Act 2013* (Qld). | Department of Education (DoE) as regulator.  Australian Children’s Education and Care Quality Authority. |
| Adjunct care services (e.g. care in shopping centres/holiday resorts | CYRMS. | DJAG (Blue Card Services) with limited oversight capacity. |
| Professionally organised child minding / babysitting / in home care services. | CYRMS. | DJAG (Blue Card Services) with limited oversight capacity. |
| Child protection services, including providers of family based care (foster and kinship care) and residential care, as well as family support/secondary services | Tertiary child protection services. | HSQF.  Statutory framework and internal controls. | DCSSDS as funding agency. |
| Secondary child protection services. | HSQF. | DCSSDS as funding agency. |
| Advocacy services. | HSQF. | DCSSDS as funding agency. |
| Advocacy and community visiting. |  | Office of the Public Guardian. |
| Activities or services where clubs and associations have a significant membership of, or involvement by, children | Sporting and recreational clubs/organisations or centres. | CYRMS.  National Integrity Framework. | DJAG (Blue Card Services) with limited oversight capacity.  Sport Integrity Australia.  Department of Tourism, Innovation and Sport (DTIS) as a funding provider.  Arts Queensland as funder for some commercially focused arts organisations. |
| Coaching or tuition services for children | Private tutoring services. | CYRMS. | DJAG (Blue Card Services) with limited oversight capacity. |
| Commercial services for children | Entertainment or party services, gym or play facilities, photography services, and talent or beauty competitions. | CYRMS for some (not all) in this category. | DJAG (Blue Card Services) with limited oversight capacity. |
| Services for children with a disability | NDIS registered services. | NDIS Quality and Safeguarding Framework. | NDIS Quality and Safeguards Commission. |
| Unregistered providers. | CYRMS. | DJAG (Blue Card Services) with limited oversight capacity. |
| Services for children with disability provided or funded by state Disability Services, including the respite services and disability advocacy services. | HSQF. | DCSSDS as funding and/or delivering agency. |
| Education services for children | State schools. | Statutory and internal controls. | DoE.  Queensland College of Teachers. |
| Non-state schools. | Non-State Schools Accreditation framework. | Non-State Schools Accreditation Board. |
| Health services for children | Hospital and Health Services. | Statutory frameworks and internal controls.  Australian Health Service Safety and Quality Accreditation. | Department of Health (DoH).  Office of the Health Ombudsman.  Australian Health Practitioner Regulation Agency (AHPRA). |
| Private health services and hospitals. | Australian Commission on Safety and Quality in Health Care.  Office of the Health Ombudsman.  AHPRA. |
| Limited funded health organisations. | HSQF. | Queensland Health as funding agency. |
| Justice and detention services for children | Youth detention centres. | Statutory and internal controls.[[94]](#footnote-95) | Department of Youth Justice, Employment, Small Business and Training as administering agency, with independent oversight – including by:   * Office of the Public Guardian. * Queensland Ombudsman. * Inspector of Detention Services. * Queensland Family and Child Commission. * Queensland Human Rights Commission. |
| Youth advocacy. | CYRMS. | DJAG (Blue Card Services) with limited oversight capacity. |
| Funded non-government services working in the youth justice sector.  Community justice groups. | CYRMS.  Contractual requirements. | DJAG (Blue Card Services) with limited oversight capacity.  Department of Youth Justice, Employment. Small Business and Training. |
| Watch houses. | Statutory and internal controls.[[95]](#footnote-96) | Queensland Police Service.  Inspector of Detention Services.  Office of the Public Guardian.  Queensland Human Rights Commission.  Queensland Family and Child Commission. |
| Transport services for children | Ride shares targeted towards children and families. | Nil relevant, except for school crossing supervisors (CYRMS). | Department of Transport and Main Roads (operator accreditation and driver authorisation).  Department of Education.  School crossing supervisors (DJAG (Blue Card Services) with limited oversight capacity). |
| Driving schools for learner drivers of motor vehicles. | Driver trainers are accredited and regulated under the *Transport Operations (Road Use Management—Accreditation and Other Provisions) Regulation 2015*. | Department of Transport and Main Roads (driver trainer accreditation). |

## Appendix D – Child safe standards and the National Principles for Child Safe Organisations

The table below summarises the 10 Child Safe Standards as recommended by the Royal Commission, and the 10 National Principles for Child Safe Organisations, as endorsed by the Council of Australian Governments in 2019. Additionally, next to each standard and principle are the core components recommended to form the basis of implementation, which provides context for the general alignment, with minor differences, between the intent and scope of both sets of principles.[[96]](#footnote-97) [[97]](#footnote-98)

| **Child Safe Standards**  Royal Commission into Institutional Responses to Child Sexual Abuse | | **National Principles for Child Safe Organisations**  Community Services Ministers and Council of Australian Governments | |
| --- | --- | --- | --- |
| Standard 1: Child safety is embedded in institutional leadership, governance and culture | * The institution publicly commits to child safety and leaders champion a child safe culture. * Child safety is a shared responsibility at all levels of the institution. * Risk management strategies focus on preventing, identifying and mitigating risks to children. * Staff and volunteers comply with a code of conduct that sets clear behavioural standards towards children. * Staff and volunteers understand their obligations on information sharing and recordkeeping. | (1) Child safety and wellbeing is embedded in organisational leadership, governance and culture. | * The organisation makes a public commitment to child safety. * A child safe culture is championed and modelled at all levels of the organisation from the top down and the bottom up. * Governance arrangements facilitate implementation of the child safety and wellbeing policy at all levels. * A Code of Conduct provides guidelines for staff and volunteers on expected behavioural standards and responsibilities. * Risk management strategies focus on preventing, identifying, and mitigating risks to children and young people. * Staff and volunteers understand their obligations on information sharing and recordkeeping. |
| Standard 2: Children participate in decisions affecting them and are taken seriously | * Children are able to express their views and are provided opportunities to participate in decisions that affect their lives. * The importance of friendships is recognised and support from peers is encouraged, helping children feel safe and be less isolated. * Children can access sexual abuse prevention programs and information. * Staff and volunteers are attuned to signs of harm and facilitate child-friendly ways for children to communicate and raise their concerns. | (2) Children and young people are informed about their rights, participate in decisions affecting them and are taken seriously. | * Children and young people are informed about all of their rights, including to safety, information, and participation. * The importance of friendships is recognised and support from peers is encouraged, to help children and young people feel safe and be less isolated. * Where relevant to the setting or context, children may be offered access to sexual abuse prevention programs and to relevant related information in an age-appropriate way. * Staff and volunteers are attuned to signs of harm and facilitate child-friendly ways for children to express their views, participate in decision-making and raise their concerns. |
| Standard 3: Families and communities are informed and involved | * Families have the primary responsibility for the upbringing and development of their child and participate in decisions affecting their child. * The institution engages in open, two-way communication with families and communities about its child safety approach and relevant information is accessible. * Families and communities have a say in the institution’s policies and practices. * Families and communities are informed about the institution’s operations and governance. | (3) Families and communities are informed and involved in promoting child safety and wellbeing. | * Families participate in decisions affecting their child. * The organisation engages and openly communicates with families and the community about its child safe approach and relevant information is accessible. * Families and communities have a say in the development and review of the organisation’s policies and practices. * Families, carers and the community are informed about the organisation’s operations and governance. |
| Standard 4: Equity is upheld and diverse needs are taken into account | * The institution actively anticipates children’s diverse circumstances and responds effectively to those with additional vulnerabilities. * All children have access to information, support and complaints processes. * The institution pays particular attention to the needs of Aboriginal and Torres Strait Islander children, children with disability, and children from culturally and linguistically diverse backgrounds. | (4) Equity is upheld and diverse needs respected in policy and practice. | * The organisation, including staff and volunteers, understands children and young people’s diverse circumstances, and provides support and responds to those who are vulnerable. * Children and young people have access to information, support and complaints processes in ways that are culturally safe, accessible and easy to understand. * The organisation pays particular attention to the needs of Aboriginal and Torres Strait Islander children, children with disability, children from culturally and linguistically diverse backgrounds, those who are unable to live at home, and lesbian, gay, bisexual, transgender and intersex children and young people. |
| Standard 5: People working with children are suitable and supported | * Recruitment, including advertising and screening, emphasises child safety. * Relevant staff and volunteers have Working with Children Checks. * All staff and volunteers receive an appropriate induction and are aware of their child safety responsibilities, including reporting obligations. * Supervision and people management have a child safety focus. | (5) People working with children and young people are suitable and supported to reflect child safety and wellbeing values in practice. | * Recruitment, including advertising, referee checks and staff and volunteer pre-employment screening, emphasise child safety and wellbeing. * Relevant staff and volunteers have current working with children checks or equivalent background checks. * All staff and volunteers receive an appropriate induction and are aware of their responsibilities to children and young people, including record keeping, information sharing and reporting obligations. * Ongoing supervision and people management is focused on child safety and wellbeing. |
| Standard 6: Processes to respond to complaints of child sexual abuse are child focused | * The institution has a child-focused complaint-handling system that is understood by children, staff, volunteers and families. * The institution has an effective complaint-handling policy and procedure which clearly outline roles and responsibilities, approaches to dealing with different types of complaints and obligations to act and report. * Complaints are taken seriously, responded to promptly and thoroughly, and reporting, privacy and employment law obligations are met. | (6) Processes to respond to complaints and concerns are child focused. | * The organisation has an accessible, child focused complaint handling policy which clearly outlines the roles and responsibilities of leadership, staff and volunteers, approaches to dealing with different types of complaints, breaches of relevant policies or the Code of Conduct and obligations to act and report. * Effective complaint handling processes are understood by children and young people, families, staff and volunteers, and are culturally safe. * Complaints are taken seriously and responded to promptly and thoroughly. * The organisation has policies and procedures in place that address reporting of complaints and concerns to relevant authorities, whether or not the law requires reporting, and co-operates with law enforcement. * Reporting, privacy and employment law obligations are met. |
| Standard 7: Staff are equipped with the knowledge, skills and awareness to keep children safe through continual education and training | * Relevant staff and volunteers receive training on the nature and indicators of child maltreatment, particularly institutional child sexual abuse. * Staff and volunteers receive training on the institution’s child safe practices and child protection. * Relevant staff and volunteers are supported to develop practical skills in protecting children and responding to disclosures. | (7) Staff and volunteers are equipped with the knowledge, skills and awareness to keep children and young people safe through ongoing education and training. | * Staff and volunteers are trained and supported to effectively implement the organisation’s child safety and wellbeing policy. * Staff and volunteers receive training and information to recognise indicators of child harm including harm caused by other children and young people. * Staff and volunteers receive training and information to respond effectively to issues of child safety and wellbeing and support colleagues who disclose harm. * Staff and volunteers receive training and information on how to build culturally safe environments for children and young people. |
| Standard 8: Physical and online environments minimise the opportunity for abuse to occur | * Risks in the online and physical environments are identified and mitigated without compromising a child’s right to privacy and healthy development. * The online environment is used in accordance with the institution’s code of conduct and relevant policies. | (8) Physical and online environments promote safety and wellbeing while minimising the opportunity for children and young people to be harmed. | * Staff and volunteers identify and mitigate risks in the online and physical environments without compromising a child’s right to privacy, access to information, social connections and learning opportunities. * The online environment is used in accordance with the organisation’s Code of Conduct and child safety and wellbeing policy and practices. * Risk management plans consider risks posed by organisational settings, activities, and the physical environment. * Organisations that contract facilities and services from third parties have procurement policies that ensure the safety of children and young people. |
| Standard 9: Implementation of the Child Safe Standards is continuously reviewed and improved | * The institution regularly reviews and improves child safe practices. * The institution analyses complaints to identify causes and systemic failures to inform continuous improvement. | (9) Implementation of the national child safe principles is regularly reviewed and improved. | * The organisation regularly reviews, evaluates and improves child safe practices. * Complaints, concerns and safety incidents are analysed to identify causes and systemic failures so as to inform continuous improvement. * The organisation reports on the findings of relevant reviews to staff and volunteers, community and families and children and young people. |
| Standard 10: Policies and procedures document how the institution is child safe. | * Policies and procedures address all Child Safe Standards. * Policies and procedures are accessible and easy to understand. * Best practice models and stakeholder consultation inform the development of policies and procedures. * Leaders champion and model compliance with policies and procedures. * Staff understand and implement the policies and procedures. | (10) Policies and procedures document how the organisation is safe for children and young people. | * Policies and procedures address all national child safe principles. * Policies and procedures are documented and easy to understand. * Best practice models and stakeholder consultation informs the development of policies and procedures. * Leaders champion and model compliance with policies and procedures. * Staff and volunteers understand and implement policies and procedures. |

## Appendix E – Potential risk factors by organisational type

| Category of organisations | Potential risk factors  Note: The risk factors identified below will not necessarily apply to all organisations and do not identify all possible risk factors – indicative only of risk | | | | | |
| --- | --- | --- | --- | --- | --- | --- |
| Access to children in isolated or unsupervised locations | Roles that enable opportunities for abuse | Children’s lack of access to a trusted adult due to nature of placement | Overnight stays and residential settings | Less regulated recruitment and screening policies and practices | Focus of service delivery is to more vulnerable client population |
| Accommodation and residential services | ✓ | ✓ | ✓ | ✓ |  | ✓ |
| Religious organisations and services | ✓ | ✓ |  | ✓  *Overnight camps* | ✓ |  |
| Childcare or childminding services\* | ✓ | ✓ |  |  |  |  |
| Child protection services, including providers of family-based care (foster and kinship care) and residential care, as well as family support/secondary services | ✓ | ✓ | ✓ | ✓ |  | ✓ |
| Clubs and associations with a significant membership of, or involvement by, children \* | ✓ | ✓ |  | ✓  *Overnight camps* | ✓ |  |
| Coaching or tuition services for children \* | ✓ | ✓ |  | ✓  *Overnight camps* | ✓ |  |
| Commercial services for children\* | ✓ | ✓ |  |  | ✓ |  |
| Services for children with a disability | ✓ | ✓ | ✓ | ✓ |  | ✓ |
| Education services for children | ✓ | ✓ |  | ✓  *Boarding schools/camps/ student exchange programs* |  |  |
| Health services for children | ✓ | ✓ | ✓ | ✓  *Inpatient services* |  | ✓ |
| Justice and detention services for children | ✓ | ✓ | ✓ | ✓ |  | ✓ |
| Transport services for children\* | ✓ | ✓ |  |  | ✓ |  |

\* Recommended by the Royal Commission for inclusion in the child safe standards only (not the reportable conduct scheme)

## Appendix F – *Working with Children* – Regulated employment and business

***Working with Children (Risk Management and Screening) Act* 2000, Schedule 1 Regulated employment and business for employment screening**[[98]](#footnote-99)

**Part 1 – Regulated employment**

1 Residential facilities

2 Schools – boarding facilities

3 Schools – employees other than teachers and parents

4 Education and care services and similar employment

4A Childcare and similar employment

5 Churches, clubs and associations involving children

6 Health, counselling and support services

6A Disability work

7 Private teaching, coaching and tutoring

8 Education programs conducted outside school

9 Child accommodation services including home stays

10 Religious representatives

11 Sport and active recreation

12 Emergency services cadet program

13 School crossing supervisors

14 Care of children under the *Child Protection Act 1999*

15 Regulation about usual functions of employment

**Part 2 – Regulated business**

16 Health, counselling and support services

16A Disability work

17 Private teaching, coaching and tuition

18 Education and care services and similar businesses

18A Child care services and similar businesses

19 Educational programs conducted outside of school

20 Religious representatives

21 Child accommodation services including home stays

22 Sport and active recreation

23 Hostel for children other than residential facility

24 Business relating to licensed care and service under the *Child Protection Act 1999*

25 Non-State schools – directors of governing bodies and authorised persons

## Appendix G – List of submissions

| **#** | **Submitted by** |
| --- | --- |
| 1 | CONFIDENTIAL |
| 2 | Queensland Foster and Kinship Care |
| 3 | CrossLife - A Baptist Church |
| 4 | The Centre for Women & Co. |
| 5 | CONFIDENTIAL |
| 6 | CONFIDENTIAL |
| 7 | Dollys Dream |
| 8 | Alannah and Madeline Foundation |
| 9 | Townsville Catholic Education |
| 10 | CONFIDENTIAL |
| 11 | CONFIDENTIAL |
| 12 | Queensland Council of Social Services |
| 13 | Uniting Church Queensland |
| 14 | CONFIDENTIAL |
| 15 | 54 Reasons |
| 16 | Queensland Indigenous Family Violence Legal Service |
| 17 | Infinity Community Solutions |
| 18 | yourtown |
| 19 | Anglicare North Queensland |
| 20 | CONFIDENTIAL |
| 21 | Life Without Barriers |
| 22 | Ideagen CompliSpace |
| 23 | CONFIDENTIAL |
| 24 | Ethnic Communities Council of Queensland |
| 25 | Busy Bees Early Learning |
| 26 | Micah Projects |
| 27 | Maurice Blackburn Lawyers |
| 28 | Creche and Kindergarten Association |
| 29 | CONFIDENTIAL |
| 30 | National Association for Prevention of Child Abuse & Neglect |
| 31 | CONFIDENTIAL |
| 32 | Queensland Office of the Health Ombudsman |
| 33 | IFYS |
| 34 | Shine Lawyers |
| 35 | Knowmore Legal Service |
| 36 | Anglicare South Queensland |
| 37 | CONFIDENTIAL |
| 38 | Queensland Catholic Education Commission |
| 39 | CONFIDENTIAL |
| 40 | Act for Kids |
| 41 | Auscycling |
| 42 | The Benevolent Society |
| 43 | CONFIDENTIAL |
| 44 | Queensland Family and Child Commission |
| 45 | Relationships Australia -Queensland |
| 46 | Family Day Care Queensland |
| 47 | Queensland Network of Alcohol and Other Drugs Agencies |
| 48 | Scouts Queensland |
| 49 | Queensland School Bus Alliance |
| 50 | Junior Adventures Group |
| 51 | Bravehearts |
| 52 | Edmund Rice Education Australia |
| 53 | Office of the Public Guardian |
| 54 | Anglican Church Southern and Northern Queensland |
| 55 | QATSICPP |
| 56 | Archdiocese of Brisbane |
| 57 | Queensland College of Teachers |
| 58 | CONFIDENTIAL |
| 59 | Royal Australian College of General Practitioners |
| 60 | CONFIDENTIAL |
| 61 | Queensland Department of Transport and Main Roads |
| 62 | Ausdance Queensland |
| 63 | Non-State Schools Accreditation Board |

1. Australian Bureau of Statistics, *2021 Queensland Census All persons QuickStats*, Australian Bureau of Statistics, 2022 [↑](#footnote-ref-2)
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3. Royal Commission into Institutional Responses to Child Sexual Abuse, *Final Report: Recommendations,* Sydney, 2017, pages 6–12, 19–21, 42, 44, 45. [↑](#footnote-ref-4)
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5. Royal Commission into Institutional Responses to Child Sexual Abuse, *Final Report Volume 7: Improving institutional responding and reporting,* Sydney, 2017, page 13 [↑](#footnote-ref-6)
6. See pages 123-124 for further detail on the assumptions and options selected to represent an integrated model of CSS and RCS co-located within the same oversight body [↑](#footnote-ref-7)
7. See pages 123-124 for further detail on the assumptions and options selected to represent an integrated model of CSS and RCS co-located within the same oversight body [↑](#footnote-ref-8)
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13. For example, the *Commission of Inquiry into abuse of children in Queensland institutions* (Forde Inquiry) (1999); *the Crime and Misconduct Commission Inquiry into the Abuse of Children in Foster Care in Queensland* (2003-2004); and the *Queensland Child Protection Commission of Inquiry* (2013). [↑](#footnote-ref-14)
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15. Royal Commission into Institutional Responses to Child Sexual Abuse, *Final Report Volume 6: Making institutions child safe,* Sydney, 2017, page 3. [↑](#footnote-ref-16)
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22. Royal Commission into Institutional Responses to Child Sexual Abuse, *Final Report Volume 2: Nature and cause,* Chapter 3, Sydney, 2017, page 78. [↑](#footnote-ref-23)
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26. Australian Bureau of Statistics, *Personal Safety Survey: Experience of abuse before the age of 15,* Australian Bureau of Statistics, 2017. [↑](#footnote-ref-27)
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42. Applies to employees of Queensland Government agencies including departments, TAFE institutes, administrative offices of a court/tribunal or other entities prescribed by regulation. [↑](#footnote-ref-43)
43. Has broad jurisdiction to deal with corruption including State Government departments (incl QPS), statutory bodies, local governments, government-owned corporations, universities, prisons, courts, tribunals and elected officials. [↑](#footnote-ref-44)
44. Failure to report offence applies to all adults. Failure to protect offence applies to adults, other than regulated volunteers, associated with an entity that provides services to children or operates a facility for or engages in activities with children under the entity’s care, supervision, or control [↑](#footnote-ref-45)
45. The *Working with Children (Risk Management and Screening) Act 2000*, schedule 1 section 14(2), provides that an adult member of a provisionally approved carer’s household is not required to hold a blue card before a child can be placed with the provisionally approved carer. However, if an adult household member does not currently hold a blue card or exemption, they are required to lodge an application and be granted a blue card or exemption before the provisional approval of the carer expires. [↑](#footnote-ref-46)
46. This category may include clubs and associations dance, arts, music, cultural activities, indoor games, outdoor recreation, etc. [↑](#footnote-ref-47)
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51. See Appendix B for further detail on other jurisdiction’s implementation of CSS and RCS, and Appendix D for further detail on the 10 recommended Child Safe Standards and National Principles for Child Safe Organisations [↑](#footnote-ref-52)
52. These types of activities are common to Royal Commission commentary about implementation, as well as the National Principles and approaches taken in other jurisdictions. [↑](#footnote-ref-53)
53. See for example, [Guide to the Child Safe Standards | Office of the Children's Guardian (nsw.gov.au)](https://ocg.nsw.gov.au/resources/guide-child-safe-standards) and [CCYP | Resources and support for the Child Safe Standards](https://ccyp.vic.gov.au/resources/child-safe-standards/). [↑](#footnote-ref-54)
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57. See, for example, Ruth DeSouza, *Wellness for All: The Possibilities of Cultural Safety and Cultural Competence in New Zealand,* 2008, 13(2) Journal of Research in Nursing 125, 125. [↑](#footnote-ref-58)
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63. Royal Commission into Institutional Responses to Child Sexual Abuse, *Final Report: Volume 6*, *Making Institutions Child Safe*, Sydney, 2017, page 261. [↑](#footnote-ref-64)
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65. [↑](#footnote-ref-66)
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68. The Disability Royal Commission recommended that ‘ill-treatment’ be included in the definition of reportable conduct (recommendation 11.17c) [↑](#footnote-ref-69)
69. For employees of public authorities (e.g. local councils), contractors and sub-contractors if they engage in child-related work (hold a WWCC). [↑](#footnote-ref-70)
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74. See Page 123-124 for further detail on the assumptions and options selected to represent an integrated model of CSS and RCS co-located within the same oversight body. [↑](#footnote-ref-75)
75. See Page 123-124 for further detail on the assumptions and options selected to represent an integrated model of CSS and RCS co-located within the same oversight body [↑](#footnote-ref-76)
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88. Note this figure is identical to Figure 2 but is duplicated here for ease of reference. [↑](#footnote-ref-89)
89. Note this figure is identical to Figure 3 but is duplicated here for ease of reference. [↑](#footnote-ref-90)
90. Department of Prime Minister and Cabinet Office of Best Practice Regulation, *Guidance Note: Cost-benefit analysis,* Australian Government, 2020. [↑](#footnote-ref-91)
91. Department of Prime Minister and Cabinet Office of Best Practice Regulation, *Guidance Note: Cost-benefit analysis,* Australian Government, 2020. [↑](#footnote-ref-92)
92. South Australia and the Northern Territory do not have Reportable Conduct Schemes in place. [↑](#footnote-ref-93)
93. Tasmania’s Act is scheduled to commence from 1 January 2024. [↑](#footnote-ref-94)
94. Note *Inspector of Detention Services Act 2022* will commence in full on a date to be fixed by proclamation. [↑](#footnote-ref-95)
95. As above [↑](#footnote-ref-96)
96. [Final Report - Recommendations (royalcommission.gov.au)](https://www.royalcommission.gov.au/system/files/2021-08/final_report_-_recommendations.pdf) [↑](#footnote-ref-97)
97. [National Principles for Child Safe Organisations (humanrights.gov.au)](https://childsafe.humanrights.gov.au/sites/default/files/2019-02/National_Principles_for_Child_Safe_Organisations2019.pdf) [↑](#footnote-ref-98)
98. [Queensland Government, *Working with Children (Risk Management and Screening) Act 2000.*](https://www.legislation.qld.gov.au/view/pdf/inforce/current/act-2000-060) [↑](#footnote-ref-99)