

CASEBOOK EDITION 1: 20 OCTOBER 2026

Reportable Conduct Scheme Case Studies

De-identified case studies for learning and practice guidance under Western Australia's Reportable Conduct Scheme.



How to read this casebook

Each case study uses the same structure — what happened, outcome and practice insight — so readers can quickly identify the safeguarding issue, the investigation response and the practical learning for their own organisation.

Who this casebook is for

This casebook is for leaders, human resources practitioners, child safe officers, investigators, governance and risk staff, and organisations that work with children.

It can be used for training, policy review, supervision, reflective practice and improving child safety systems.

Why these case studies are published

These case studies are published to support transparency and continuous improvement.

Details have been selected to highlight practice issues that may help other organisations prevent harm to children and young people, recognise warning signs and respond well when concerns are raised.



Public note

These case studies are for learning and practice guidance only.

They are not intended to revisit individual findings, identify any person, or replace legal, regulatory or organisational advice about a particular matter.

About this casebook

Purpose

To bring together de-identified Reportable Conduct Scheme case studies to support learning, reflection and improved practice across the Western Australia (WA) public sector.

The case studies involve adults in child-related work and the importance of organisations acting early, investigating fairly and completing investigations where possible and appropriate.



Key takeaway

Completing reportable conduct investigations supports child safety beyond the immediate workplace.

Clear findings strengthen organisational learning, help manage ongoing risk and enable relevant information to be shared where appropriate.

At a glance

Case study	Main issue	Practice learning
1. Investigation after stand down or departure	Boundary concerns and risk beyond the original workplace	Completing investigations and sharing relevant risk information
2. Sexual misconduct and misuse of trust	Boundary testing and overly familiar conduct involving a child	Professional boundaries, context and safeguarding obligations
3. Physical assault and patterns of behaviour	Physical handling, confidentiality breaches and parallel criminal proceedings	Prompt escalation, evidence-based findings and investigation integrity

How to use these case studies



Using the case studies in practice

Team learning: Discuss what early warning signs were present and how they should be escalated.

Policy review: Test whether current policies clearly address professional boundaries, reporting, confidentiality and information sharing.

Investigator training: Consider investigation scope, evidence, procedural fairness and the point at which external advice or notification is needed.

Governance assurance: Use the reflection questions and checklist to identify gaps in reporting pathways, recordkeeping and risk controls.

Case study 1: Continuing an investigation when the subject employee is stood down or leaves

What happened

A government organisation received concerns about a probationary employee working with children. The employee was directed away from the workplace while the matter was investigated. The timeline below summarises what happened, how concerns escalated and why continuing the investigation was important.

When	Stage	Event and significance
Dec 2024	Early concerns	Initial boundary concerns were identified after staff observed physical contact between the subject employee and young people. The employee was reminded of expected professional standards.
Jan 2025	Direction issued	The organisation issued a workplace direction about personal electronic devices and unauthorised items.
Feb - Mar 2025	Escalation	Further concerns emerged, including inappropriate communication and conduct captured in available footage and reported by staff.
April - May 2025	Investigation response	Matter was referred internally for investigation, Ombudsman WA was notified, and the employee was

		directed away from the workplace while the investigation progressed.
July 2025	Wider risk identified	A separate government organisation became aware that the person had sought child-related work elsewhere. A child voiced concerns about the person's conduct, which became relevant risk information.
Nov 2025 - Feb 2026	Finalisation	The employee's employment ended, but the investigation continued with a report finalised.

Outcome

The investigation continued after the employee was stood down and later left the organisation. The final report found that the conduct met the threshold for reportable conduct, including sexual misconduct. It also found that the person was not suitable to continue in the child-related role. Relevant information was shared with the Working with Children Screening Unit.

Practice insight

Standing an employee down, accepting a resignation or ending employment may reduce immediate workplace risk. However, it does not always resolve the wider risk to children. Completing the investigation creates a clear evidence base and supports lawful and appropriate information sharing where risk may extend beyond the original organisation.



Key insights

- ✓ **Do not stop at stand down.** Immediate workplace action may reduce current risk, but it does not determine what occurred or whether the conduct is reportable conduct.
- ✓ **Consider wider safeguarding risk.** A person may seek child-related work elsewhere, and other organisations may need relevant information to manage risk.
- ✓ **Keep assessing new information.** Later information, footage, staff reports and concerns raised by children may change the risk picture.
- ✓ **Record the rationale for information sharing.** Decisions to share information should be lawful, necessary, proportionate and connected to child safety.

Case study 2: Responding to sexual misconduct, boundary testing and misuse of trust

What happened

A child-related organisation delivering youth development and leadership programs received allegations about a contractor paramedic. The contractor was engaged to support young people during an overseas leadership trek.

The concerns involved interactions with a teenage participant, including private treatment, physical contact, boundary issues, conversations about sexual matters and drugs, and the administration of prescription medication.

Outcome

An independent investigation substantiated three allegations of sexual misconduct on the balance of probabilities. The investigator found that the contractor crossed professional boundaries and engaged in overly familiar conduct that did not meet child safe expectations.

The matter was reported to Ombudsman WA. Relevant information was also shared with the Working with Children Screening Unit to support broader child safety decision-making.

Practice insight

Professional boundaries must be clear, visible and reinforced. Conduct may be reportable conduct even where criminal conduct is not established. This is especially important where an adult uses their role, access or position of trust in a way that creates risk for a young person.



Safeguarding focus

Private interactions, secrecy, overly familiar physical contact and misuse of authority should be assessed in context and escalated promptly.



Key lesson

Boundary testing, secrecy and misuse of a position of trust should be assessed together. Organisations should not wait for conduct to escalate before reviewing risk, reinforcing expectations and taking protective action.

Case study 3: Responding to inappropriate physical conduct towards children and completing an investigation after criminal proceedings

What happened

An early childhood education provider received concerns from employees about a room leader. The allegations included physical restraint, inappropriate physical handling of children and inappropriate behaviour guidance practices. The organisation stood the employee down, notified relevant oversight bodies and started an investigation.

More concerns were raised later. Some allegations were temporarily removed from scope while the WA Police Force considered criminal matters. After those proceedings finished, the remaining allegations were investigated and finalised.

Outcome

The investigation considered allegations about physical interactions with children and confidentiality breaches during the investigation. Most allegations were substantiated, and the organisation formed the view that reportable conduct had occurred.

Findings were reported to Ombudsman WA and the Education and Care Regulatory Unit. Relevant information was also referred to the Working with Children Screening Unit.

Practice insight

Criminal processes and workplace or reportable conduct processes have different purposes and thresholds. Organisations should coordinate with relevant agencies, avoid compromising criminal processes and assess any remaining allegations when it is appropriate to do so.



Investigation integrity

Confidentiality, witness independence and careful coordination with external agencies help protect the reliability of findings.



Key lesson

Where criminal processes are involved, organisations should protect the integrity of those processes while ensuring any remaining workplace or reportable conduct issues are finalised when it is appropriate to do so.

Common themes across the case studies



Common themes

- ✓ **Child safety risk can extend beyond one workplace.** Organisations should consider wider safeguarding risks when a person seeks child-related work elsewhere.
- ✓ **Complete investigations where possible.** Clear outcomes support findings, action, learning and information sharing.
- ✓ **Fair process strengthens findings.** Procedural fairness helps test allegations and supports reliable findings.
- ✓ **Confidentiality protects integrity.** It reduces the risk of bias, collusion, witness influence and compromised evidence.
- ✓ **Patterns matter.** Boundary breaches, new information and repeated conduct should be assessed together, not in isolation.

Questions for reflection



Questions for reflection

- 1. Immediate response:** What immediate steps should an organisation take when concerns are raised about an adult's conduct towards children and young people?
- 2. Continuing the investigation:** How should an organisation decide whether an investigation should continue after a person resigns or is dismissed?
- 3. Broader risk:** What information may be relevant to assessing risk beyond the original organisation?
- 4. Fairness and safety:** How can an organisation maintain procedural fairness while prioritising child safety?
- 5. Investigation integrity:** What controls help protect confidentiality and the integrity of an investigation?
- 6. Information sharing:** When should relevant information be shared with other screening, regulatory or oversight bodies?

Practical checklist for organisations



Practice checklist

Check that reporting pathways are clear. Staff, volunteers and contractors know how to report concerns and who to contact.

Check that risk is managed early. Immediate protective steps are taken without prematurely closing the investigation.

Check that investigation scope is clear. Allegations, evidence sources and decision points are defined and recorded.

Check that procedural fairness is built in. The subject person has a fair opportunity to respond to relevant allegations and evidence.

Check that confidentiality is protected. Information is shared only with people who need it to perform their role or manage risk.

Check that records explain key decisions. Reasons, evidence and information-sharing steps are documented.

Check that information sharing is lawful and appropriate. Relevant information is shared with oversight, regulatory or screening bodies where needed to manage risk.



Ombudsman
Western Australia

Level 2, 469 Wellington Street Perth WA 6000
PO Box Z5386 St Georges Terrace Perth WA 6831

Call us 08 9220 7555 or Freecall 1800 117 000

Email us mail@ombudsman.wa.gov.au

ombudsman.wa.gov.au