Ombudsman
Western Australia

Beyond the behaviour

Systems responses to harmful sexual behaviours



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Acknowledgment of Country

We acknowledge Aboriginal and Torres Strait Islander people as the Traditional Custodians of this land. We recognise the continuing connection to land, waters, culture and community of all Aboriginal and Torres Strait Islander peoples. We pay our respects to their Elders past and present and recognise the strength, resilience and diversity of all Aboriginal and Torres Strait Islander peoples across this land.

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First published by Ombudsman Western Australia on 19 November 2026

Child safeguarding - Statement of Commitment

The Ombudsman is committed to promoting and protecting the safety, wellbeing and rights of all children and young people, their families and carers.

In exercising our functions, we place the safety, rights and best interests of children at the heart of our work. Our investigations are conducted with deep respect for the experiences of all children and young people. We work in a child-centred, trauma-informed way and seek to strengthen safeguarding practices, improve accountability and drive better outcomes that protect children and young people from harm.

We see the children and young people in this report. We see their families, carers, child protection workers, teachers, early childhood professionals, and the many other dedicated professionals who work to ensure they are safe and cared for.

We are equally committed to protecting the privacy and confidentiality of the children and young people who may be connected to our work. Consistent with the confidentiality obligations in section 28(2) of the *Parliamentary Commissioner Act 1971* (WA), we have taken all reasonable steps to ensure that information in this report does not identify, or enable the identification of, a child or young person.

Care has been taken to omit or modify information that may enable identification. Pseudonyms have been used throughout the report.

Content warning

This report discusses harmful sexual behaviours involving young children. Some readers may find this content distressing.

Find help and support

A range of child sexual abuse therapeutic services are provided throughout Western Australia. Information and contact details are available on the Department of Communities website.

Sexual Assault Resource Centre WA (08) 6458 1828 or free call 1800 199 888

A range of free services to people affected by sexual violence. It also supports children and young people who have engaged in harmful sexual behaviour.

Kids Helpline 1800 55 1800

Australia's free 24/7 hotline for youth aged 5-25.

Indigenous Healing Services

Yorgum Healing Services - 1800 469 371
Mackillop Family Services – (08) 6477 1000 (Perth Central Office)

13 Yarn 13 92 76

Aboriginal and Torres Strait Islander crisis support line. The first national crisis support line for mob who are feeling overwhelmed or having difficulty coping. It offers a confidential one-on-one yarning opportunity with a Lifeline-trained Aboriginal and Torres Strait Islander Crisis Supporter who can provide crisis support 24 hours a day, 7 days a week

Lifeline 13 11 14 24/7

Crisis support and suicide prevention. Provides all Australians access to crisis support and suicide prevention services.

Beyond Blue 1300 224 636

Free and confidential mental health counselling to anyone in Australia via phone, online chat, and email.

Executive summary

Every child has the right to be safe, heard and supported. Protecting those rights requires more than the efforts of any one professional, service or agency. It requires a system that recognises risk, shares information effectively and acts in the best interests of all children and young people.

Children who have experienced trauma, abuse or neglect do not always communicate their needs in obvious ways. Some act in ways that cause harm to others. Our safeguarding systems must be equipped to recognise early indicators of harm and respond with curiosity, coordination and urgency.

Our investigation arose from a sole complaint by a parent alleging that their child had been harmed by another child in an early learning centre. Through a **single case review**, our investigation examined whether systems and responses effectively identified, managed and prevented harm, revealing missed opportunities for assessment and intervention, weaknesses in information sharing and recordkeeping, and the risks of considering concerns in isolation rather than as part of a broader pattern.

As Western Australia's independent oversight body for the Reportable Conduct Scheme, we were able to **look beyond the individual complaint** to identify **broader systemic issues affecting child safeguarding practices** and **contribute to strengthening protections for children and young people**. This report is a powerful example of the unique role Ombudsman WA plays in strengthening child safeguarding across Western Australia.

Independent oversight is itself an important safeguard. It promotes accountability, transparency and public trust by ensuring that decisions, actions and systems are open to scrutiny. Through our work, we seek not only to understand what happened in individual instances of alleged harm, but also to strengthen the systems, practices and cultures that better protect children and young people and prevent harm.

This report is not about attributing blame. It recognises the complexity of the work undertaken by frontline caregivers, educators, practitioners and child protection staff. It also acknowledges the improvements made during this investigation, including strengthened information-sharing arrangements and enhanced practice guidance by the Department of Communities.

These are important developments. However, lasting improvement depends on practices being understood, applied and embedded in everyday decision-making. Effective safeguarding requires agencies and organisations to see the whole child, consider information cumulatively, and respond in a timely and coordinated way when concerns emerge.

I acknowledge the children and families whose experiences have informed this investigation, and the carers, educators, practitioners and other professionals who work every day to keep children safe. I am also grateful to the Ombudsman's Child and Family Safety Team for the expertise, care and thoughtfulness they brought to this important work.

Keeping children and young people safe is a whole-of-community responsibility. Preventing harm demands early action, transparent and ongoing accountability, and sustained commitment. By working together, we can strengthen safeguarding systems and improve outcomes for Western Australian children.

Bevan Warner
WA Ombudsman

How to read this report

Section 1 provides an overview of the investigation, including why and what we investigated.

Section 2 provides a chronological account of the case and explains what should have happened at critical junctures.

Section 3 provides a commentary on the key observations made, focussing on the themes of child-centred safeguarding practices, information sharing and departmental coordination, and regulatory oversight.

Section 4 outlines the Department of Communities' (Communities) response and what improvements are needed.

Appendices provide technical and background information including:

1. A demographic profile of children and young people in Western Australia (WA), agency context, responsibilities and expected practice of Communities;
2. A visual timeline of events;
3. An explanation of Harmful Sexual Behaviours (HSB) and the Reportable Conduct Scheme (the Scheme); and
4. Acronyms and useful terms.

What this investigation does and does not do

This investigation broadly considers whether systems and responses operated effectively to identify, manage and prevent harm arising from HSB in early childhood settings.

The investigation used a de-identified case to track the measures taken by Communities and analyse information sharing and record keeping practices.

Central to the review's methodology are the key principles of:

- paramount consideration of children's safety, rights and best interests,[1]
- child-centred, trauma-informed care,
- accountability and transparency; and
- timely and proportionate risk responses.

The review is not intended to assign blame or determine individual intent. This report is not intended to determine whether individual staff members, carers, educators, schools or education and care services acted appropriately in particular circumstances. References to these parties are included only where necessary to explain information that was available to Communities and to assess its administrative actions and system responses.

[1] Taking effect 27 February 2026, changes to the National Law will require all people involved in the operation and delivery of an education and care service (including approved providers, persons with management or control (PMCs), nominated supervisors, educators, staff, and volunteers (including students) to ensure that the safety, rights and best interests of children is the paramount consideration in all their decisions and actions (known as the 'paramount consideration). Extending beyond the existing Guiding Principle, it will now be a statutory duty to ensure the paramount consideration is applied.

Children and young people in Western Australia[2]



More than **1 in 5** people in WA is aged from 0-17 years

657,000 children and young people

22% of the state's population



75% Perth metro

16% regional

9% remote



7% of children and young people are Aboriginal

Family, home and safety

4,649 Children and young people who are the subject of substantiated abuse or neglect (2023-24)

5,189 Children and young people in out-of-home care (OOHC) (2025-26)

60% of children in OOHC are Aboriginal (significantly over represented)

Early childhood education and care



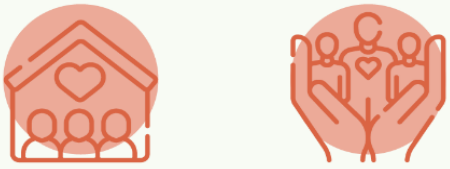
42% of children aged 0 to 5

16% of children aged 6 to 12

Attended an approved childcare service in 2024



1,508 approved childcare services



1,481 provided by Centre-Based Care

27 provided by Family Day Care

[2] Commissioner for Children and Young People, *Profile of Children and Young People in WA 2026*, retrieved from https://www.ccyp.wa.gov.au/media/wzbc3m3m/ccyp9552-profile-report-2026-web2.pdf; ACECQA (2026) *NQF Snapshot – Q2 2026 August 2026*. Retrieved from https://www.acecqa.gov.au/sites/default/files/2026-08/NQF%20Snapshot%20Q2%202026%20FINAL.pdfF; Government of Western Australia (2026) *Department of Communities Annual Report 2025-26*, retrieved from https://www.parliament.wa.gov.au/publications/tabledpapers.nsf/displaypaper/4211363aadfd45ad5e0f0b5648258e750029c25f/$file/tp+1363+(2026)+department+of+communities+annual+report+2025-26.pdf, OHC refers to care arrangements for children outside of their own family home including after-hours placement, district care, foster care, group homes and transitional high needs care https://www.wa.gov.au/organisation/department-of-communities/out-of-home-care-services

1. Our investigation

Harmful Sexual Behaviours
HSB refers to sexual behaviours by children and young people under the age of 18 that fall outside what is developmentally expected, appropriate or socially acceptable for their age and stage of development, and which cause harm or have the potential to cause harm to others.

The Royal Commission into Institutional Responses to Child Sexual Abuse (**the Royal Commission**) identified HSB in children and young people as a significant child protection issue requiring coordinated, trauma-informed and therapeutic responses.

Why we investigated

The Ombudsman's Child and Family Safety Team received information alleging that Yellow Early Learning Centre (**Yellow ELC**) did not adequately respond to known sexualised behaviours exhibited by a child in its care (**Quinn**). It was further alleged that, because of this, another child was harmed by Quinn.

Quinn was and remains in the care of the Chief Executive Officer (**CEO**) of Communities. This means that Communities holds legal responsibility for the care, welfare and key decisions affecting Quinn.

On the information available, it was necessary and reasonable to consider whether reportable conduct, in the form of significant neglect, may have occurred through a failure to protect children in care. Accordingly, an own motion investigation was commenced into the handling of the reportable conduct allegation by the head of the organisation. The investigation into Yellow ELC was subsequently closed after Yellow ELC committed to several improvement actions and implemented policy and operational changes in response to the matter.

The extensive information obtained during that investigation raised broader questions regarding Communities' systems and responses to HSB. These concerns led to the commencement of a further own motion investigation to examine Communities' administrative policies, practices and processes in identifying and responding to HSB, child protection concerns and other safeguarding risks in this case.[3]

Western Australian Framework for Understanding and Guiding Responses to Harmful Sexual Behaviours (the HSB Framework)
The HSB Framework recognises that children and young people's sexual behaviours occur along a continuum, ranging from developmentally appropriate and exploratory behaviours through to behaviours that are concerning, problematic or harmful.

The HSB Framework makes clear that determining whether behaviour meets the threshold of harm, and where it sits on the continuum, should underpin decisions about supervision, care arrangements, safeguards for other children, and the level and type of service response required. The HSB Framework positions the identification of HSB as a critical foundation for effective decision-making, harm prevention and system accountability.

[3] Australian Centre for Child Protection (ACCPFS) (2022) *Western Australian Framework for Understanding and Guiding Responses to Harmful Sexual Behaviours*, Department of Communities Western Australia. Retrieved from https://www.wa.gov.au/system/files/2022-07/Framework-Understanding-Guiding-Harmful-Sexual-Behaviours.pdf

What we investigated

Our investigation broadly focused on:

- How well the HSB Framework and Child Protection Guide (**the Guide**) are operationalised to enable child protection practitioners to make timely and informed decisions about children in the CEO's care, specifically when they enter early childhood and education settings.
- How information is shared within Communities, particularly between the Education and Care Regulatory Unit (**ECRU**) and Child Protection and Family Support (**CPFS**).
- How well Communities shared information with key stakeholders involved in the care and protection of Quinn and other children they interacted with.

Over the evidence-gathering period, we collected information from seven different sources. In total, 115 pieces of evidence were examined.

In addition to publicly available guidelines, policies and procedures, we also gathered extensive evidence in the form of internal case file documents, mandatory reports, Child Safety Investigations (**CSI**), HSB response mapping documentation,[4] interview transcripts, safety planning documentation, email correspondence, case data, incident reports and relevant school records.

During the evidence-gathering period, we sought information from the Department of Education in relation to the school Quinn attended. The Department of Education's actions do not form part of the scope of this investigation.

Similarly, while three early learning centres are part of Quinn's history and are mentioned in this investigation, they are not included in the scope of this investigation.

References to Yellow ELC are included only to the extent necessary to understand the information available to Communities and Communities' subsequent actions.

What is the Child Protection Guide?

The Guide is Communities' primary practice guidance for undertaking child protection work in Western Australia. It provides operational direction on responding to child safety concerns, including intake, assessment, investigation, safety planning and case management.

The Guide is aligned with the *Children and Community Services Act 2004 (WA)*, directing practitioners to take a child-centred, risk-based approach that focuses on the child's lived experience, safety and wellbeing.

The Guide was revised in February 2025 and is intended to support consistent, trauma-informed child protection practice within Communities.

[4] See Figure 2 on page 28 for more detail

2. Case review

A chronological account of events[5]

Background

Quinn entered the care of the CEO in infancy. A Protection Order was made for Quinn until the age of 18, and Quinn was placed with family carers. Since entering care, Quinn has had five different case managers.

Prior to commencing kindergarten, Quinn attended Purple Early Learning Centre (**Purple ELC**) for some time. Quinn's history at Purple ELC does not form part of the scope of this investigation.

2023: Emergence of concerns and initial responses

In 2023, Quinn commenced kindergarten at a primary school (**the school**) and also attended Teal Early Learning Centre (**Teal ELC**). Quinn's history at Teal ELC does not form part of the scope of the investigation.

In March 2023, Communities were first informed about concerning sexualised behaviours displayed by Quinn when the school notified Communities of frequent and escalating sexualised behaviours. These included repeated exposure of genitals, sexualised play during class, causing self-harm to genitals, and attempts to involve other children in sexualised play. These behaviours were occurring at least three to four times per class and could occur up to 10 times each day. At the same time, the school submitted a Mandatory Report of Child Sexual Abuse (**MR 1**) documenting these concerns.

The school staff reported that they had no prior knowledge of these behaviours and described them as 'outside of developmental norms', leading them to have concerns for Quinn.

What is a Mandatory Report of Child Sexual Abuse?

Section 124B of the *Children and Community Services Act 2004* stipulates that staff working with Communities—whether paid or unpaid—are legally required to report to the Mandatory Reporting Service (**MRS**) if, through their work, they have reasonable grounds to believe a child has been or is being sexually abused.

The MRS monitors its online portal and manages the triage and response to all mandatory reports received. MRS operates as a centralised, state-wide service, available 24 hours a day, and is part of the Statewide Referral and Response Service. The following professionals are designated as mandatory reporters:

- Doctor
- Midwife
- Nurse
- Teacher
- Police Officer
- Departmental Officer
- Early childhood worker
- Religious Minister
- OOHC worker
- Youth justice worker
- Psychologist
- School counsellor
- Assessor (someone who assesses the wellbeing, risk, needs or safety of children and young people)
- Boarding supervisor

[5] A visual timeline of key events is provided at **Appendix 2** on page 29

Actions taken by CPFS

In response to the concerns about Quinn, the following actions were completed:

- An Interaction[6] was recorded and progressed from Intake to an Initial Inquiry[7] to inform decision making about Quinn's needs and next steps.
- The District consulted the Duty of Care team[8] and recommendations were made to the Duty of Care team in response to the concerns.
- An urgent paediatrician appointment was arranged for Quinn in response to escalating concerns.
- Consultation was undertaken with Purple ELC and Teal ELC. Each reported concerns about Quinn's emotional regulation but also said that Quinn appeared healthy and happy.
- The District Psychologist met with Quinn's family carers to discuss their concerns. Following the meeting, the District Psychologist made recommendations to support the family carers with Quinn's care.

Despite the concerns raised by the school in MR 1, key child protection assessments were not completed and there is no evidence that Communities considered or applied the HSB Framework to inform its response.

A CSI was not undertaken, and there was no evidence that recommendations from the Duty of Care consultation or the District Psychologist were implemented.

What is a Child Safety Investigation?

A CSI is a statutory investigation conducted by Communities in response to serious concerns about a child's safety or wellbeing. This includes alleged or suspected abuse or neglect. According to the Guide, a CSI should be undertaken when Communities deem that a child has experienced or is likely to experience significant harm or there is a need to formally investigate and record harm, rather than managing these concerns through assessment or support services alone.

According to the Guide and assessment policy, a CSI may include:

- interviewing and engaging with the child, parents or carers and other relevant adults
- gathering information from schools, allied health professionals, police and other relevant agencies
- assessing the child's safety and general wellbeing
- recording findings about harm, risk and protective factors, and
- determining appropriate outcomes, including safety planning, court action, or referral to support services.

Further disclosures and concerns were then raised over a two-month period.

In April 2023, Quinn's family carer notified Communities of further sexualised behaviour that raised concerns. Additional Duty of Care consultations and meetings with the District Psychologist were held, resulting in

[6] **Interaction** - An electronic record on Assist (Communities' records management system) to document contact with the Department.
[7] **Initial Inquiry** - is not an investigation, rather an intake to gather additional information and to determine if there is a role for the Department to investigate and take actions to promote the safety of a child (Communities Child Protection Guide)
[8] **Duty of Care Team** – Operates through the Specialist Child Protection Unit (SCPU); available for complex case consultation and primarily responsible for:

- providing advice to Districts regarding responding to allegations of abuse in care, standard of care concerns and/or critical incidents for children in the care of the CEO;
- conducting carer investigations regarding allegations of abuse to children in care by approved foster carers, and;
- promoting the legal rights of children and young people in the care of the CEO who are significantly harmed or injured in care.

recommendations intended to support the family carers and manage risk. However, there is no evidence these recommendations were implemented.

CPFS recorded an intention to speak directly with Quinn, but this did not take place.

The family carer queried whether the school should be advised of the further concerns.

Records indicate that Communities did not share this information with the school. A file record of the response to the family carer's query could not be located.

In May 2023, the family carer again raised concerns about Quinn's sexualised behaviour and educators confirmed that Quinn was displaying similar behaviours at Teal ELC. There is no evidence that Teal ELC reported these behaviours at the time, and it is not known whether Communities had shared any information regarding Quinn's behaviours with Teal ELC prior to their commencement at the service.

The time period between April and August 2023 represents a significant missed opportunity during which Communities and Teal ELC could have shared relevant information or acted on concerns earlier.

In August 2023, Teal ELC submitted a Mandatory Report of Child Sexual Abuse (**MR 2**) following an incident where an educator observed Quinn engaging in sexual activity with another child (**Taylor**), while a third child (**Charlie**) witnessed the incident. When the educator asked Quinn about the incident, Quinn stated that Taylor "...does it to me in the [location at Teal ELC]".

At the time of MR 2, Taylor was also known to Communities.

Communities recorded an Interaction for Taylor, but the matter was closed as the concerns were deemed to not meet the threshold for further investigation.

Quinn was excluded from Teal ELC in August 2023, based on concerns they posed a risk to other children.

In September 2023, a further consultation with the District Psychologist in response to MR 2 again emphasised the need for a multidisciplinary approach, including timely information sharing between providers, carers and case managers, supported by regular meetings. There is no evidence that this approach was implemented in a timely manner.

Quinn commenced at Yellow ELC in September 2023. Although some informal discussions happened between the family carer and Yellow ELC, these were not documented. There is also no evidence that Communities shared any information about Quinn's history or their sexualised behaviours with Yellow ELC prior to their commencement.

In October 2023, Communities decided not to proceed with a CSI, citing insufficient grounds and favouring ongoing case management. While Communities indicated that an Initial Inquiry Outcome Report was prepared, records of the report, including documentation of speaking with Quinn, could not be located.

2024: Continued incidents

In 2024, Quinn was then involved in a series of incidents relating to concerning sexualised behaviour at Yellow ELC.[9]

In May 2024, Yellow ELC provided nine reports regarding four incidents to numerous business units within Communities, including the Statewide Referral and Response Service (SRRS), MRS, the relevant District office and ECRU.

In their incident reports, educators at Yellow ELC explicitly raised concerns about Quinn's welfare. Yellow ELC referred their concerns (via the Child Protection Concern Report) to the relevant District Office for actioning. In addition to the Child Protection Concern Report, one of the incident reports recorded concerns that Quinn may have been the subject of abuse, with educators noting sexualised language and behaviour withdrawal when questioned about the incidents that took place.

It is not known what action was taken by the District Office in response, or if follow-up occurred from the SRRS.

Actions undertaken by ECRU

ECRU assessed the four incidents, two of which included disclosures from children. Two incidents were serious enough to be categorised as an *"allegation of physical or sexual abuse"*.

ECRU found there were no relevant breaches in Yellow ELC's compliance history, and that there was insufficient evidence to conclusively determine if the incidents occurred as alleged or that the incidents were caused by a lack of supervision.

ECRU determined that because an educator had not witnessed the incident, and they did not take account of the child disclosures, they could not reliably say the Yellow ELC was in breach of section 165, which relates to active supervision of children. [10]

At this point, the cases were closed and 'no further action' was recommended. An alert was issued to review supervision practices during the next monitoring visit. ECRU also noted that Yellow ELC had undertaken several of its own preventative supervision measures.[11] Risk assessments were not undertaken at this time, and the cases were assigned a priority rating of 3 (Low).

While ECRU did not have access to Quinn's case file history, as it had not been shared by any other business units within Communities, they did receive disclosures from both adults and children, along with documented child protection concerns from educators.

> ECRU did not inform other business units within Communities of these notifications or its findings, nor had any other units within Communities shared any prior concerns with ECRU.

2025: Complaints and formal investigation

In May 2025, Communities received a third Mandatory Report from the school (MR 3). MR 3 followed allegations of *"child -on -child sexual abuse"* which was reported by a parent of a child who attended the school. The school advised Quinn's case manager that they had made MR 3.

Communities recorded an Interaction which noted an unsuccessful attempt to speak with Quinn. Communities further noted that consultation

[9] **2024 incidents:**
3 May - Two incident reports (relating to one incident) were submitted to Communities (CPFS and ECRU);
13 May - One safeguarding incident report was submitted to Communities (CPFS and ECRU);
15 May - Five incident reports (relating to one incident) were submitted to Communities (CPFS and ECRU); and
30 May - One Child Protection Concern Report was submitted to Communities (SRRS).

[10] *Education and Care Services National Law Act* (WA)

[11] Including: Supervision plans for outdoor play area to be reviewed; Supervision plans for afterschool care sessions to be reviewed; Children are not to be playing unsupervised around the play area in question; Quinn to be supervised at all times when in attendance at Yellow ELC; Updated supervision training to be delivered for all staff; Protective Behaviour Training package was purchased.

between Quinn's family carers, the school, Yellow ELC and other Communities staff had occurred. Communities advised the school that there were no concerns for Quinn in relation to sexualised behaviours and no requirement for the school to undertake safety planning or any other additional work. They noted that information sharing had been difficult due to several changes in case management over a short period of time.

Ombudsman's investigation commences

In June 2025, the Ombudsman received a complaint from a member of the public that Quinn had perpetrated *"child-on-child sexual abuse"* against two other children.[12] These behaviours were said to have occurred at the school, at Yellow ELC and in the community.

The Ombudsman commenced an own motion investigation to examine how the service responded and whether children were adequately protected.

The information gathered during this stage raised concerns about how HSBs involving children were being identified and managed by Communities. This led to a subsequent investigation focused on Communities' administrative practices; namely its policies, operational guidelines and information-sharing protocols in relation to:

- decisions around when and on what basis an Interaction is progressed to a CSI or closed as an Initial Inquiry;
- how the HSB Framework and the Guide support decision-making processes outlined at the identification stage to trigger the use of the Response Mapping Tools; and
- how the Guide supports practitioners to ensure appropriate safeguarding measures are undertaken.

In July 2025, Quinn's family carer advised Communities that Quinn has exposed themself to another child in a public place.

Around this time, Quinn was withdrawn from Yellow ELC.

In September 2025, a fourth Mandatory Report of Child Sexual Abuse (**MR 4**) was made by Yellow ELC. The report followed a notification from another parent alleging that Quinn had engaged in historical sexualised behaviour toward their child in 2024.

Actions undertaken by CPFS

Three months after the Ombudsman's investigation had commenced, a CSI was initiated, Response Mapping Tools were completed and Quinn's behaviours on the sexualised behaviours continuum were identified as 'Concerning' and therefore classified as HSB. An explanation of the HSB continuum can be found at **Appendix 3**, on page 34.

In October 2025, Quinn was interviewed by child protection practitioners, two years and seven months after the initial concerns were raised and the first opportunity to conduct a CSI arose. It is the only interview that took place with any child during the investigation.

In November 2025, Communities finalised Quinn's CSI. The CSI found that Quinn's behaviours were not age appropriate, representing a disorganised style of attachment secondary to significant trauma. Communities substantiated the likelihood of psychological harm due to sexual abuse concerns.

> By this time, Quinn was seven years old. At least nine other children had been subjected to potential harm, in an early learning setting, not including those at the school.

[12] The complaint relates to MR 3.

Actions undertaken by ECRU

In response to our request for information to assist with the investigation, ECRU interviewed key staff and reviewed the compliance history of Yellow ELC. The review identified significant and recurring non-compliance matters, some of which had been identified in previous compliance monitoring activities.

In September 2025, ECRU issued Yellow ELC with a Compliance Notice and a Service Approval Amendment.

Compliance measures undertaken by ECRU

No Further Action – no formal enforcement action taken after assessment, used when non-compliance is not established or risk to children is assessed as low.

Compliance Notice – a formal, enforceable notice issued under the National Law, used when a breach is established but immediate suspension or cancellation is not warranted.

Additional monitoring – enhanced regulatory oversight where significant and recurring non-compliance is identified, resulting in increased frequency of compliance checks that enable ECRU to closely monitor risk.

Service approval amendment – a formal variation to provider or service approval conditions, issued where ECRU deems that restrictions are required to manage risk to children's safety, health or wellbeing. The amendment may restrict enrolments, staffing agreements or service operations.

2026: Evidence gathering continues

In 2026, the Ombudsman continued extensive information gathering from key agencies involved in the case.

We received multiple pieces of evidence in response to requests for information from relevant business units within Communities and from the school, via the Department of Education.

The evidence confirms a number of regulatory and operational concerns for Yellow ELC, which are being oversighted by ECRU. However, Yellow ELC, did raise early concerns about Quinn's welfare and their sexualised behaviours. For the purposes of this report, Yellow ELC is treated as a source of information and a stakeholder that raised concerns relevant to Communities' administrative response.

In January 2026, as a result of our investigation, ECRU implemented an internal policy which outlines a process for referring relevant information from ECRU to the CPFS directorate. It stipulates that any notification received by ECRU that includes HSB that raises a child protection concern involving a child in the care of the CEO, must be referred to CPFS.

This is now being expanded to apply to all children and young people, and to encompass all forms of abuse and neglect.

3. Key observations

Over the course of several years, multiple notifications and disclosures were made about Quinn's behaviours and wellbeing across various settings. Despite these repeated concerns, the timeline demonstrates a prolonged sequence of reported issues, with ongoing missed opportunities for timely assessment and intervention. Across multiple business units, systemic weaknesses were evident in information sharing and record-keeping practices and child-centred decision-making, which collectively hindered a coordinated safeguarding response.

Our investigation identified some key observations as shown in Table 1.

Table 1: Key observations

Child-centred safeguarding practices	Information sharing and departmental coordination	Regulatory oversight
1. Communities did not assess Quinn's behaviours along the HSB continuum despite receiving information from multiple sources indicating that such an assessment was required	3. Communities did not consistently share critical information with key stakeholders or within its own business units, which limited effective safeguarding responses	5. Communities' responses remained fragmented across business units and did not consistently draw together available information to assess cumulative risk
2. Communities did not escalate to a CSI in a timely manner, in circumstances where multiple notifications and disclosures were made across multiple settings over an extended period	4. Communities' recordkeeping gaps limited transparency and accountability	

Child-centred safeguarding practice

1. Communities did not assess Quinn's behaviours along the HSB continuum despite receiving information from multiple sources indicating that such an assessment was required

Our investigation found that Communities were first notified of Quinn's sexualised behaviours in March 2023. At that time, Quinn had already entered the CEO's care with an established history of adverse life events. Despite this, there is limited evidence that Communities considered the link between childhood trauma and HSB in shaping its response.

Over the following two years, Communities received eight further notifications about Quinn's sexualised behaviour, including an additional three mandatory reports, a family carer notification and five notifications from Yellow ELC. When viewed cumulatively, this information indicated recurring and escalating concerning behaviours that should have been assessed using the HSB Framework. This would have identified the need for immediate intervention.

Communities' own records acknowledged that further assessment was required to determine whether Quinn's sexualised behaviours were developmentally appropriate or constituted HSB. While the formal Response Mapping Tools were not incorporated into

practice guidance until 2025, Communities had access to earlier policies and resources requiring assessment of sexualised behaviours, associated risks, supervision needs and therapeutic responses. In addition, the HSB Framework was released in 2022.

This absence of timely assessment is significant. Research demonstrates a clear association between adverse childhood experiences and the development of HSB and emphasises that early identification and appropriate therapeutic intervention can reduce escalation.[13] In this case, the failure to assess Quinn's behaviours along the HSB continuum when concerns were first identified delayed safety planning and weakened risk management responses. This increased the likelihood of further incidents and compromised preventative measures intended to protect both Quinn and other children.

2. Communities did not escalate to a CSI in a timely manner, in circumstances where multiple notifications and disclosures were made across multiple settings over an extended period

Our investigation identified four clear points at which Communities could have commenced a CSI between March and October 2023. During this period, concerns about Quinn were increasing in frequency and seriousness. Quinn had been excluded from more than one ELC and Communities was receiving repeated notifications and disclosures from both adults and children, across school and early childhood settings. This occurred in the context of Quinn's known history of significant early trauma.

Communities did not initiate a CSI at any of these points. Records indicate that matters were assessed as having insufficient grounds for investigation or were managed through a case management approach. This assessment sat alongside consistent information indicating potential harm and the need to formally examine the underlying causes of Quinn's behaviours.

The Guide requires Communities to commence a CSI when it forms a belief that a child has experienced, or is likely to experience, significant harm, or where harm requires formal investigation to try and ascertain the underlying cause of behaviours. We found that the circumstances in this case, including repeated concerning sexualised behaviours, disclosures, and Quinn's vulnerability, met this threshold on multiple occasions.

We also found repeated opportunities and expectations for Quinn's views to be sought, documented and given weight. Quinn was not spoken to until October 2025, limiting Communities' ability to understand Quinn's experiences and inform a proportionate, child-centred response.

Communities ultimately completed a CSI and conducted an interview with Quinn in October 2025, after the Ombudsman's investigation had commenced. The CSI substantiated concerns of sexual abuse, relying on information that had been available to them much earlier.

A CSI is a critical tool for identifying patterns of prior harm and assessing future risk. By delaying the commencement of a CSI, Communities was unable to act decisively at critical junctures where risks could have been better understood and opportunities to reduce risk could have been taken. These actions highlight that the best interests of the child principle was not consistently applied in Communities' assessment, record-keeping or decision-making processes.

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[13] Royal Commission into Institutional Responses to Child Sexual Abuse (2017) *Final Report: Volume 10, Children with harmful sexual behaviours*, Commonwealth of Australia. Retrieved from https://www.childabuseroyalcommission.gov.au/children-harmful-sexual-behaviours; Commissioner for Children and Young People WA (2018). *Discussion paper – Children and young people with harmful sexual behaviours*. Retrieved from https://ccyp.wa.gov.au/media/u5cny0dt/discussion-paper-children-and-young-people-with-harmful-sexual-behaviours-may-2018.pdf; McPherson, L., Vosz, M., Gatwiri, K., Hitchcock, C., Tucci, J., Mitchell, J., Fernandes, C. and Macnamara, N. 2024, Approaches to Assessment and Intervention With Children and Young People Who Engage in Harmful Sexual Behavior: A Scoping Review, *Trauma, Violence, & Abuse*, vol. 25, no. 2, pp. 1585–1598, https://doi.org/10.1177/15248380231189293

Information sharing and departmental coordination

3. Communities did not consistently share critical information with key stakeholders or within its own business units, which limited effective safeguarding responses

Communities did not consistently provide key stakeholders, including early learning centres and the school, with information about known behaviours, risks and support needs that may have assisted safeguarding and supervision arrangements at key transition points, such as when Quinn commenced at new early learning centres or started school.

Communities also did not consistently share information within its own business units. Specifically, CPFS did not consistently provide ECRU with relevant case history, prior concerns or emerging risk indicators. As a result, ECRU assessed notifications, disclosures and incident and safeguarding reports submitted by Yellow ELC in 2024 in isolation, with an emphasis on individual incidents and regulatory compliance, rather than forming a cumulative understanding of Quinn's behaviours and associated risks.

This occurred despite repeated concerns being raised to Communities. As early as 2023, Quinn's family carer identified escalating behaviours and raised the need for services to be informed. The case timeline also shows that on more than one occasion in 2023, the District Psychologist emphasised the need for information to be shared and recommendations be implemented. In 2024, Yellow ELC lodged a Child Protection Concern Referral, alongside an incident report outlining concerns for Quinn following an incident. The Child Protection Concern Referral was sent to the relevant District for follow up and actioning, but there is no evidence that any action was taken by Communities. Across the case's lifespan, while initial notifications and consultations were documented, there is limited evidence that this information was consistently shared across Communities' business units or with external service providers to inform appropriate safeguarding responses.

Notably, the *Children and Community Services Act 2004* (WA) expressly enables the CEO and authorised officers to disclose relevant information to support a child's wellbeing and the performance of statutory functions and provides protections for disclosure made in good faith. These provisions further support timely and appropriate information sharing within Communities and with other agencies.[14]

In the absence of consistent information sharing, the ongoing risks associated with Quinn's behaviours were not fully recognised or assessed cumulatively. Safeguarding and therapeutic responses were therefore inconsistent or delayed, meaning that opportunities for timely intervention were missed.

4. Communities' recordkeeping gaps limited transparency and accountability

Our investigation found that recordkeeping gaps within Communities limited transparency, accountability and effective risk management for Quinn. At multiple points, Communities could not locate records of key conversations, decisions or actions, which limited the ability to confirm what had been done and why.

There were numerous instances where discussions had taken place regarding Quinn's care and escalating concerns about their behaviour, but Communities did not consistently maintain corresponding file records. Key information could not be verified, including advice reportedly provided to family carers in April and May 2023 about managing escalating sexualised behaviours, whether information should be shared with the school, and the rationale for not escalating matters at that time. This absence of documentation meant that critical evidence could not be relied upon to understand decision-making or assess whether appropriate actions had been taken.

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[14] The *Privacy and Responsible Information Sharing Act 2024* (WA), which came into effect on 1 July 2026, establishes a clear legal framework to enable proactive and coordinated information sharing across public entities. Part 3 (Responsible information sharing) supports information sharing to guide risk assessment and improve service coordination and child protection efforts https://www.legislation.wa.gov.au/legislation

Concerns about the adequacy of information management were also raised by Quinn's family carer who expressed on more than one occasion that matters had been mismanaged, particularly in relation to how information about Quinn's behaviour and prior incidents were handled over time.

Records also show that Communities sought input from internal specialised teams, including the District Psychologist and Duty of Care teams and that these consultations resulted in recommendations. However, there is no evidence these recommendations were implemented or reviewed, and no documented rationale where actions did not proceed. For example, file notes indicated that Quinn was to be spoken to, but this did not occur and no explanation was recorded.

In 2024, additional concerns were escalated through formal reporting pathways, including incident reports and child protection concerns submitted by Yellow ELC to the MRS, ECRU and CPFS. Despite this, Communities' records do not clearly demonstrate what actions were taken by the District Office or whether follow-up occurred.

These recordkeeping gaps meant that Communities could not reliably demonstrate its actions, identify emerging patterns of harm, or reassess risk as concerns escalated. As a result, opportunities for timely escalation to a CSI, coordinated intervention, and earlier risk-reduction measures were compromised, increasing the likelihood that harm to Quinn and other children was not adequately addressed or effectively managed.

Regulatory oversight

5. Communities' responses remained fragmented across business units and did not consistently draw together available information to assess cumulative risk

Repeated concerns about Quinn's sexualised behaviours were raised with Communities from as early as 2023. However, Communities' responses remained largely at the stage of Initial Inquiry and did not move beyond a case management approach until after concerns had been repeatedly raised and external oversight had commenced. During that time, Quinn continued to interact with other children across early learning and school settings.

Throughout 2024, ECRU received multiple reports from Yellow ELC. At the time, ECRU's response focused on whether there was sufficient evidence to substantiate breaches, which relates to active supervision.[15] The cases were closed and an alert was issued to revisit supervision practices at a later stage. Stronger investigative and regulatory actions were not undertaken until the Ombudsman's investigation commenced in June 2025, which led to improvements, including the development of ECRU's internal information sharing policy with CPFS.

Rather than relying solely on evidence that demonstrated regulatory compliance, a proportionate, risk-based approach would have ensured that the system could respond to early warning signs for HSB that were well-documented and had a clear escalation pathway across Communities.

The case investigation shows that meaningful and collaborative interventions were delayed, despite repeated notifications, disclosures and concerns. Because concerns were not consolidated early or assessed with a child-safeguarding lens, incidents were assessed separately rather than cumulatively, which limited the ability to identify ongoing risk and respond in a coordinated way.

Many critical steps, including the identification of HSB, completion of safety planning, and strong compliance actions occurred after the commencement of the Ombudsman's investigation.

[15] *Education and Care Services National Law* (WA) s 165

4. What is needed

The Ombudsman acknowledges the complexity and scale of the work that Communities undertakes in exceptionally challenging circumstances. Their reach extends across a vast metropolitan area and to some of the most remote and diverse communities across the State.

Children and young people in the care of the CEO have similarly complex and diverse needs and there is now clear and compelling evidence, exemplified through the work of the Royal Commission, that displaying HSB as distinct from developmentally appropriate behaviours, can be a marker for children who have experienced trauma, abuse or neglect. The Royal Commission also highlighted that institutional responses have historically been inconsistent, punitive or poorly coordinated.

Emerging evidence suggests that HSBs among younger children are becoming more visible and more widely understood as a child safety issue. With many children attending early childhood settings, including children in the care of the CEO, these environments are critical for early identification and response.

However, this investigation has highlighted that an inconsistent understanding or application of Communities' assessment tools and guidance may limit timely detection and intervention. Systemic and operational challenges across the early childhood education and care sector may further affect the capacity of services to respond effectively to these behaviours.

From a regulatory perspective, ECRU should consider how its functions can be more closely integrated with child protection responses to support shared visibility of risk and coordinated safeguarding action. The recently developed information-sharing policy between ECRU and CPFS is a positive step.

There are several ways in which this case could have been more effectively managed to significantly improve outcomes for Quinn and other children they interacted with:

Early identification and assessment: strengthening processes to identify HSB in children at the earliest opportunity and mandating timely assessment, using the tools available, when concerns arise.

Consistency in information sharing: implementing robust, high-quality information-sharing protocols both within Communities and across agencies.

Timely escalation and decision-making: developing clear criteria and oversight for escalating serious concerns to a CSI to ensure potential harm is fully understood at the appropriate time.

Stronger focus on cumulative risk: adopting a cumulative risk approach in decision-making so that patterns of concerning behaviour trigger action even when singular incidents might seem inconclusive or not significant enough to progress.

Child-centred practice and the 'best interests' principle: embedding the 'best interests' principle as a tangible measure at all levels of decision making, including actively seeking the child's views where it is appropriate.

Integrated system coordination: establishing a multi-disciplinary, whole-of-system approach to HSB cases for children in the care of the CEO who are entering early childhood settings.

Robust recordkeeping and documentation: ensuring complete and accessible recordkeeping of interviews, consultations, key decisions, actions, and their rationale, to support oversight and accountability.

Recommendation

Communities ascertain the number of children in the care of the CEO who have displayed HSB in an early learning centre between 1 June 2026 and 1 September 2026; confirm whether appropriate information sharing with service providers has been undertaken, and report back to Ombudsman WA by the end of 2026.

5. Improvements made during our investigation

We acknowledge that during the course of our investigation, Communities has taken steps to strengthen its systems and practice.

New information sharing policy between ECRU and CPFS

In December 2025, Communities implemented a new internal policy and procedure, *Referring Relevant Information to Child Protection and Family Support*. The policy strengthens the process for referring relevant information from the ECRU to CPFS.

This improvement responds to the observations identified in this investigation that relevant information was not consistently shared within Communities, particularly where concerns about Quinn's HSB arose in an early learning setting.

The policy currently applies to children in the care of the CEO who are identified as exhibiting concerning, very concerning, or serious/extreme HSBs within an early learning or educational setting.

It supports earlier information sharing, better visibility of risk and more coordinated responses for children in the care of the CEO.

New guidance to support assessment of HSB

In July 2025, Communities introduced the HSB Response Mapping Tools[16] and amended the Child Protection Guide to strengthen requirements for identifying, assessing and responding to HSB.

This action responds to our observations that Quinn's behaviours were not consistently assessed against the HSB continuum, concerns were not escalated in a timely way, and key decisions were not always clearly documented. It supports earlier assessment of HSB, clearer escalation pathways, and more consistent recording of decisions and rationale.

[16] See Figure 2 on page 28 for more detail

6. Summary of Communities' response to our investigation

We provided Communities with an opportunity to respond to the investigation's key observations and, where appropriate, have addressed their comments in the report.

In a response dated 28 August 2026, Communities acknowledged opportunities to strengthen information sharing, recordkeeping and the consideration of risks in education and care settings.

In relation to the HSB Framework, Communities stated:

> *The Framework and the subsequent Response Mapping Tools set out the broad principles for understanding and responding to HSB and whilst they extend beyond the home environment, they do not contain specific guidance regarding Early Learning Centres, childcare services or education and care providers. Communities are of the view this could be strengthened in practice guidance...*

Communities also responded to our observations about the CSI, stating:

> *As a child in the CEO's care, Communities held parental responsibility for Quinn, to act in accordance with their best interests. Communities were already able to and did provide Quinn with therapeutic intervention, support to their carer and review by a Paediatrician, which did not require a CSI to initiate these service responses. Communities' Child Sexual Abuse Policy recognises the association between trauma and HSB and the importance of safety planning and therapeutic intervention for children displaying HSB. Whilst assessments and referrals for therapeutic intervention were undertaken, it is acknowledged that the responses at the time did not initially take into consideration risks in the education and care service context. Quinn's case file demonstrates regular stakeholder engagement and communication with Quinn's carers, service providers, medical and allied health services.*
>
> *Whilst Communities ultimately did undertake a CSI that commenced in September 2025, the CSI did not result in a disclosure from Quinn identifying a person responsible for alleged sexual abuse, or direct evidence that sexual abuse occurred. The CSI acknowledged that some allegations could not be independently verified and it was not determined as to whether Quinn had been sexually abused, concluding only that sexual abuse could not be ruled out. The rationale for substantiation of harm relied predominately on Quinn's sexualised behaviours, pattern of reports received over time, and clinical findings related to trauma, attachment and developmental vulnerabilities. All the available information at the time indicates Quinn's HSB were the result of trauma and indicated therapeutic intervention as the appropriate response.*
>
> *Communities acknowledge that there are further opportunities to strengthen information sharing and disclosure of relevant information about a child's HSB at the time of enrolment in an early childhood service...*

Communities acknowledged gaps in record keeping in Quinn's case file during 2023 and 2024, while noting improvements in 2026:

> *A review of Quinn's case file in 2026 demonstrates a significant improvement in records management with a large volume of documents saved and labelled in accordance with the naming conventions.*

Communities also referred to the development of an internal policy and procedure, implemented in December 2025, to strengthen referral of relevant information from ECRU to CPFS. It further noted that mandatory national training established as part of the

National Child Safety Reform agenda, will commence in WA when relevant legislative amendments occur.

Finally, Communities stated that:

> *As an agency we are committed to continuous improvement and to learning from investigations where opportunities to strengthen practice are identified. We value our workforce and know that they bring intelligence and compassion to this difficult work.*

Appendices

Appendix 1: Background

1.1 What do we know about our children and young people?

Our children and young people are diverse; in their cultural backgrounds, their family compositions and their health and development outcomes. To support their needs, they move through a range of institutions and interact with a variety of services and systems before they reach adulthood.

Family, home and safety

While most children and young people live in safe, supportive family environments, there is a significant number who are the subject of substantiated abuse of neglect each year, as well as children and young people in OOHC.

Research consistently shows that children and young people who experience OOHC face elevated risks of sexual abuse and experience significantly poorer health and wellbeing outcomes than children and young people who do not. These outcomes can include lower educational attainment, poorer physical and mental health and increased behavioural issues. They reflect the cumulative impacts of trauma, abuse, neglect and instability.[17][18]

1.2 Child safeguarding in WA

Across Australia, there has been growing recognition of the need for stronger institutional accountability for the safety and wellbeing of children. The Royal Commission identified numerous instances in which children reported abuse and were not believed, or no action was taken. [19] In its recommendations, the Royal Commission made clear that effective safeguarding requires prevention, through child-safe systems and cultures, and accountability, through independent oversight to scrutinise how organisations respond when harm occurs.[20]

To address the systemic failures of institutions to keep children safe, the Royal Commission recommended that all States and Territories establish reportable conduct schemes to hold organisations accountable for the conduct of their staff and to strengthen safeguards for children. It also recommended the implementation of Child Safe Standards (CSS) for all institutions engaging in child-related work. The CSS are a best-practice framework to create child-safe organisations and cultures to make institutions safer for children and reduce the likelihood or harm occurring. The CSS align to the National Principles for Child Safe Organisations.[21]

Child Safe Standards and the Reportable Conduct Scheme

Child safeguarding in WA is supported by a framework of legislated oversight, regulatory standards and independent scrutiny. The Ombudsman is the independent oversight body for the Scheme. In October 2025, the Western Australian Government announced that the Ombudsman will be the independent oversight body for CSS once legislation is passed.

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[17] The Royal Commission into Institutional Responses to Child Sexual Abuse (2017), *Final report, Contemporary out-of-home care*. Commonwealth of Australia. Retrieved from https://www.childabuseroyalcommission.gov.au/sites/default/files/final_report_-_volume_12_contemporary_out-of-home_care.pdf; Lima, F., Maclean, M., & O'Donnell, M. (2018) *Exploring outcomes for young people who have experienced out-of-home care.* Telethon Kids Institute. Retrieved from https://www.thekids.org.au/contentassets/0a827e30fcaa481ead96fafe42aa5c82/dCPFSfs-outcomes-report-final.pdf

[18] Commissioner for Children and Young People WA, 2026, *Disconnected, Unprotected: What happened to the best interest of the child?"* Commissioner for Children and Young People, WA

[19] The Royal Commission into Institutional Responses to Child Sexual Abuse (2017), *Final report*. Commonwealth of Australia. Retrieved from https://www.childabuseroyalcommission.gov.au/final-report

[20] Royal Commission into Institutional Responses to Child Sexual Abuse. (2017). *Final Report: Volume 7, Improving institutional responding and reporting* (Recommendations 7.9–7.12). Commonwealth of Australia

[21] Australian Human Rights Commission (2018), *National Principles for Child Safe Organisations,* Council of Australian Governments. Retrieved from https://www.childsafety.gov.au/system/files/2024-04/national-principles-for-child-safe-organisations.PDF

Reportable conduct schemes are intended to ensure that allegations of child abuse are reported to an independent body, are investigated thoroughly, and are addressed in a way that protects children and reduces the risk of further harm.

The Scheme commenced in WA on 1 January 2023 and is a key mechanism for strengthening child safety within institutions. The Scheme compels heads of organisations that exercise care, supervision or authority over children to notify the Ombudsman of allegations or convictions for child abuse by their employees and to investigate those allegations.

The Ombudsman monitors, oversees and reviews investigations undertaken by organisations into allegations of, and convictions for, abuse of children involving any of the organisation's employees. The Ombudsman may also at any time investigate matters of their own motion.

The Scheme applies to a wide range of organisations across WA, including government departments and authorities, child protection and OOHC services, childcare and early childhood services, education and health services, justice and detention services, religious institutions and other organisations that provide care or accommodation to children. These entities play a critical role in the daily lives of children and young people and carry significant responsibility for ensuring safe environments and responding appropriately to concerns about abuse or harm.

What is reportable conduct?

Reportable conduct captures a broad range of behaviours that pose a risk to children. Upon commencement, the behaviours included sexual offences, sexual misconduct and physical assault. From 1 January 2024, significant neglect and conduct causing significant emotional or psychological harm were included in the Scheme. This broad definition reflects an understanding that harm to children may arise in different ways, and that early identification and response is critical to preventing escalation.

1.3 The Department of Communities

Communities is the legal guardian of children and young people in OOHC in WA. It is also a central agency covered by the Scheme due to the nature and scale of its responsibilities in delivering critical human services across, including child protection, community services and the regulation of the early childhood sector through ECRU. Communities employs more than 7,000 staff across 91 locations and is responsible for the care of thousands of vulnerable children.

Communities' engagement with the Scheme spans key Directorates and business units. These responsibilities frequently intersect with external OOHC providers operating under formal care and placement agreements.[22]

Since the commencement of the Scheme:



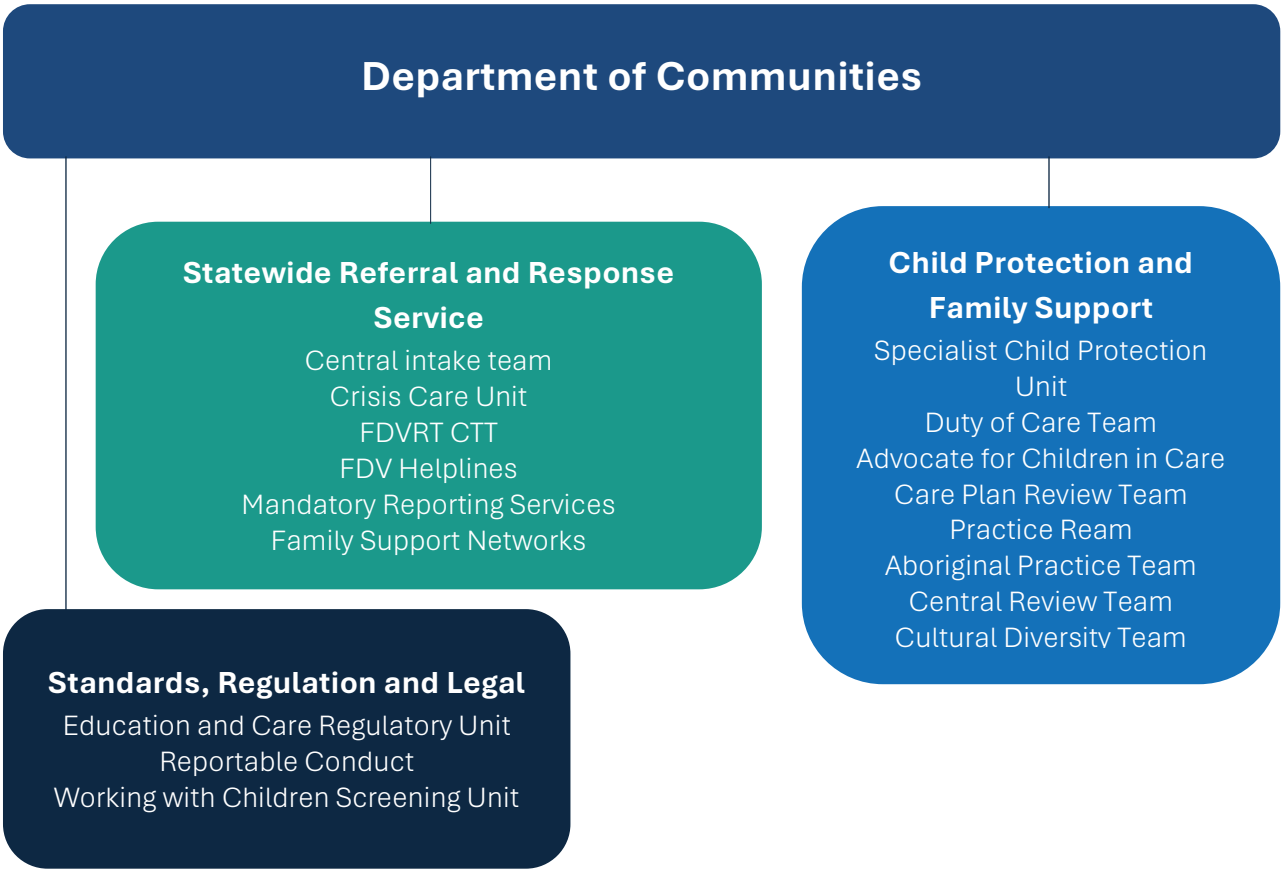
2,888
notifications received

624
(22%)
of total notifications are from Department of Communities

760
(26%)
of total notifications are from approved childcare services

[22] Pursuant to the *Children and Community Services Act 2004*.

Figure 1: Department of Communities organisational structure relevant to the Scheme



In 2025–26, more than 5,000 children were in the care of the CEO. Many of these children experience overlapping vulnerabilities, and their safety depends on coordinated and effective responses across multiple parts of the system. Communities therefore holds direct responsibility for the care, safety and wellbeing of children in the care of the CEO. This includes responsibility for identifying, assessing and responding to behaviours that may pose a risk to children in their care, including behaviours involving other children, where a failure to appropriately identify and respond may result in harm.

1.4 Harmful sexual behaviours

The Royal Commission identified HSB in children and young people as a significant child protection issue requiring coordinated, trauma-informed and therapeutic responses. The Royal Commission highlighted that many children displaying HSB have themselves experienced trauma, abuse or neglect, and that institutional responses were historically inconsistent, punitive or poorly coordinated.

HSB refers to sexual behaviours by children and young people under the age of 18 that fall outside what is developmentally expected, appropriate or socially acceptable for their age and stage of development, and which cause harm or have the potential to cause harm to others.[23]

The HSB Framework,[24] released in 2022, recognises that children and young people's sexual behaviours occur along a continuum, ranging from developmentally appropriate and exploratory behaviours through to behaviours that are concerning, problematic or harmful. HSBs are distinguished not simply by the presence of sexual

[23] See **Appendix 3** on page 34

[24] Australian Centre for Child Protection (ACCPFS) (2022) *Western Australian Framework for Understanding and Guiding Responses to Harmful Sexual Behaviours*, Department of Communities Western Australia. Retrieved from https://www.wa.gov.au/system/files/2022-07/Framework-Understanding-Guiding-Harmful-Sexual-Behaviours.pdf

nature, but by characteristics such as the use of power or coercion, lack of consent, persistence despite redirection, significant age or developmental differences, or behaviours that cause distress, fear or physical harm to others.

According to the HSB Framework, assessment of whether a sexual behaviour is harmful requires consideration of multiple factors, including the child or young person's age, developmental stage, context, intent, frequency and pattern of behaviour, and the impact of the behaviour on others. Behaviours cannot be reliably categorised as harmful or non-harmful in isolation, as the same behaviour may have different implications depending on developmental and situational factors.

Accurate identification of HSB is necessary to inform risk assessment and safety planning. The HSB Framework makes clear that determining whether behaviour meets the threshold of harm, and where it sits on the continuum, should underpin decisions about supervision, care arrangements, safeguards for other children, and the level and type of service response required. Identification further supports consistent and coordinated system responses by enabling shared understanding and clearer decision-making across child protection, care services and other involved agencies, reducing fragmented or inconsistent responses in complex cases.

The HSB Framework positions the identification of HSB as a critical foundation for effective decision-making, harm prevention and system accountability. The HSB Framework therefore emphasises a continuum-based approach to understanding and assessing behaviours, rather than reliance on single indicators or labels.

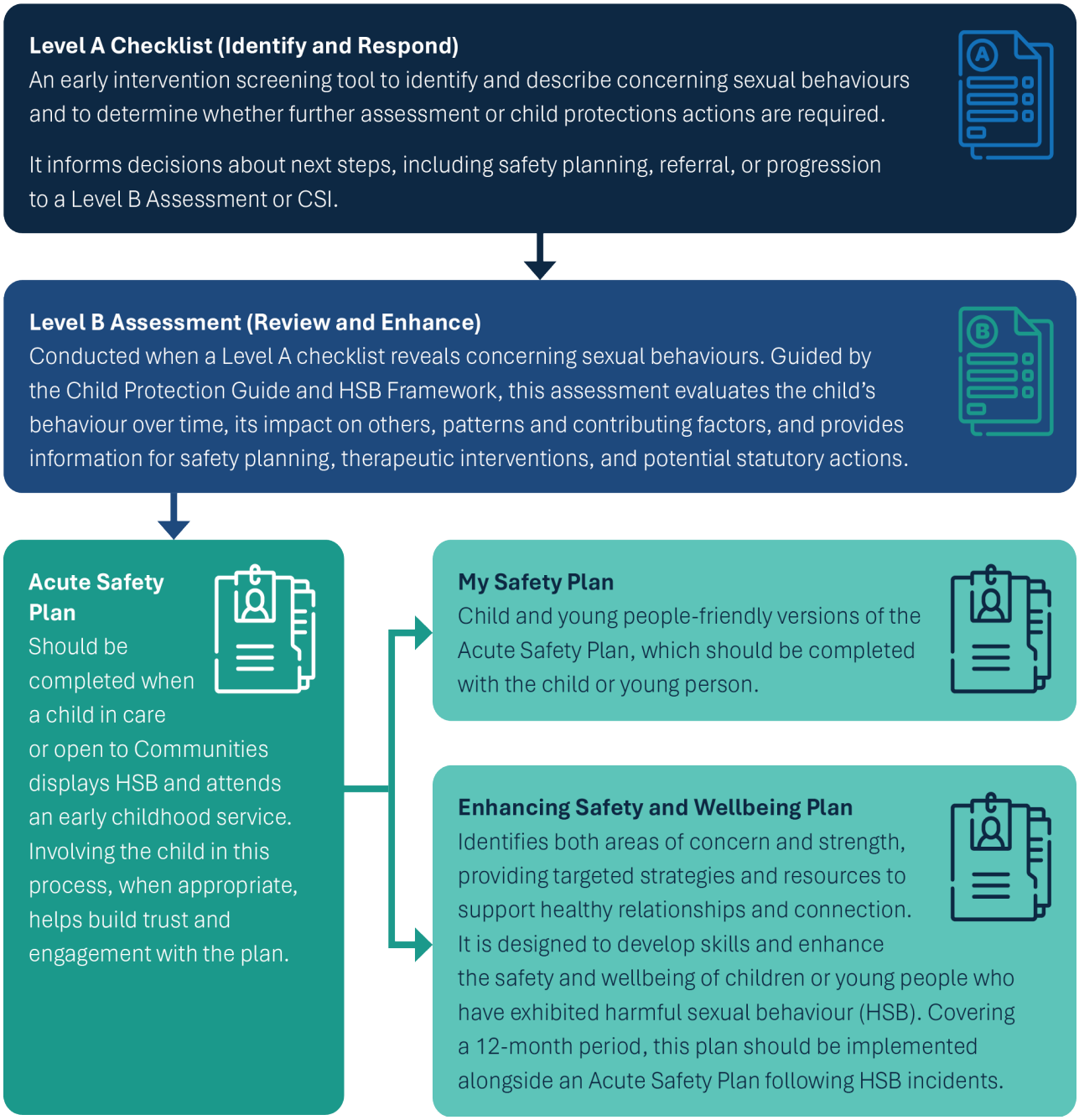
Communities' response when children display HSB

The process for responding to HSB for children in the care of the CEO is operationalised though the Guide.

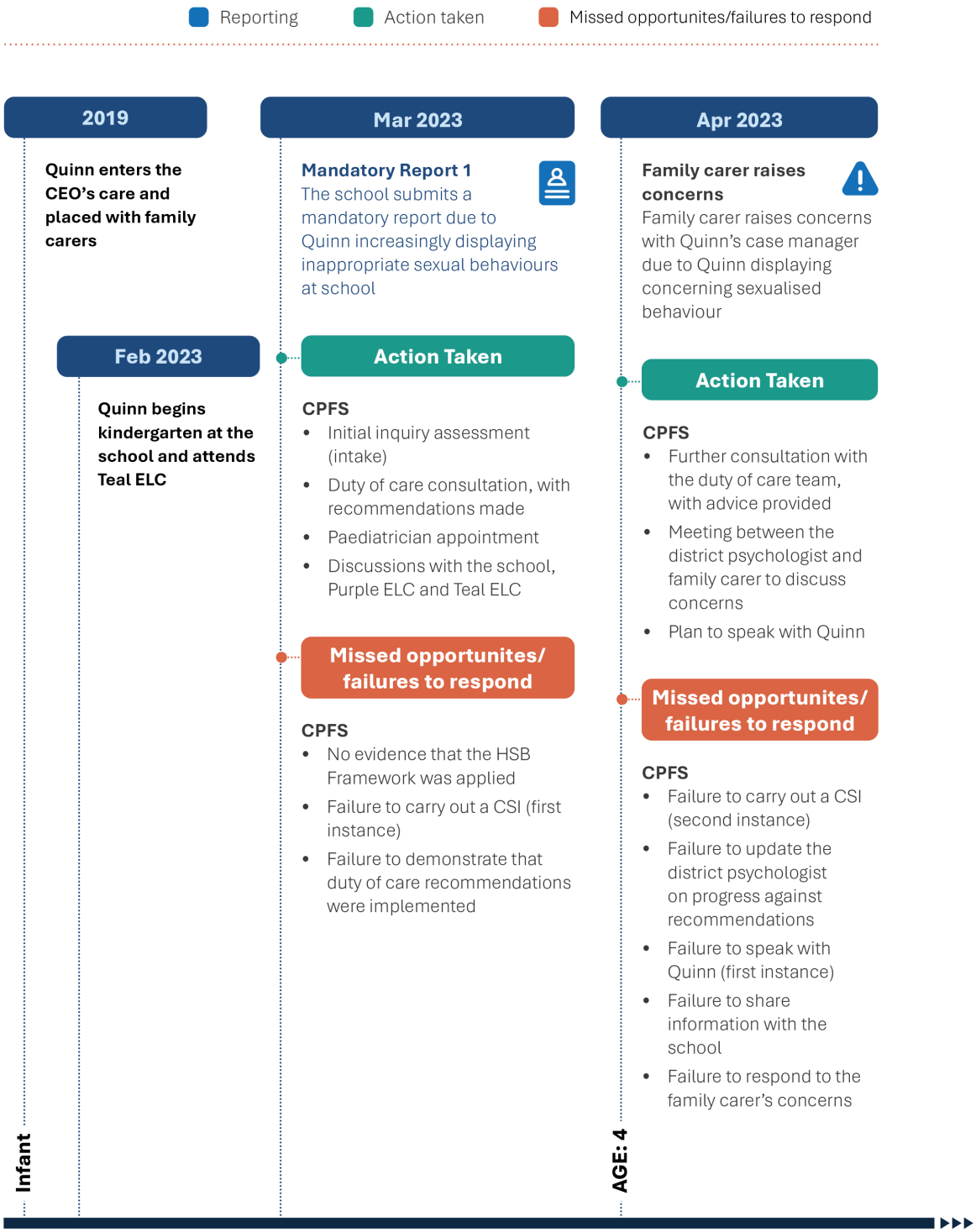
The Guide stipulates that where a child in the care of the CEO displays sexualised behaviours, Communities must assess whether those behaviours are harmful to the child exhibiting the behaviours and/or the child who the behaviours are directed to. This assessment should utilise the Response Mapping Tools.

The assessments should be completed by the Case Worker and Team Leader in consultation (where appropriate) with the Aboriginal Practice Leader, the Specialist Child Protection Unit (SCPFSU) Cultural Diversity team, the district psychologist and the Care Team.

Figure 2: Response Mapping Tools

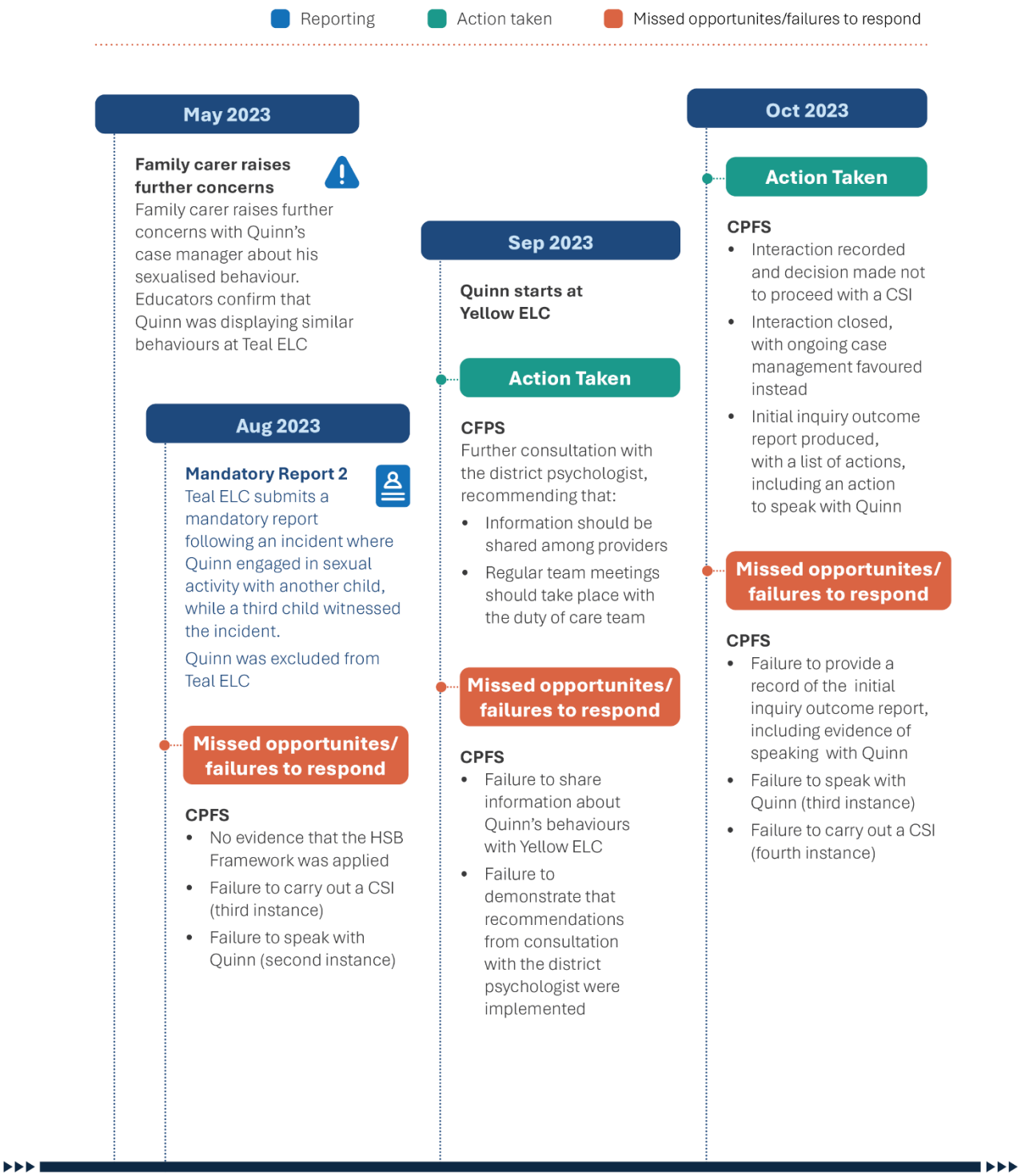


Appendix 2: Timeline of events



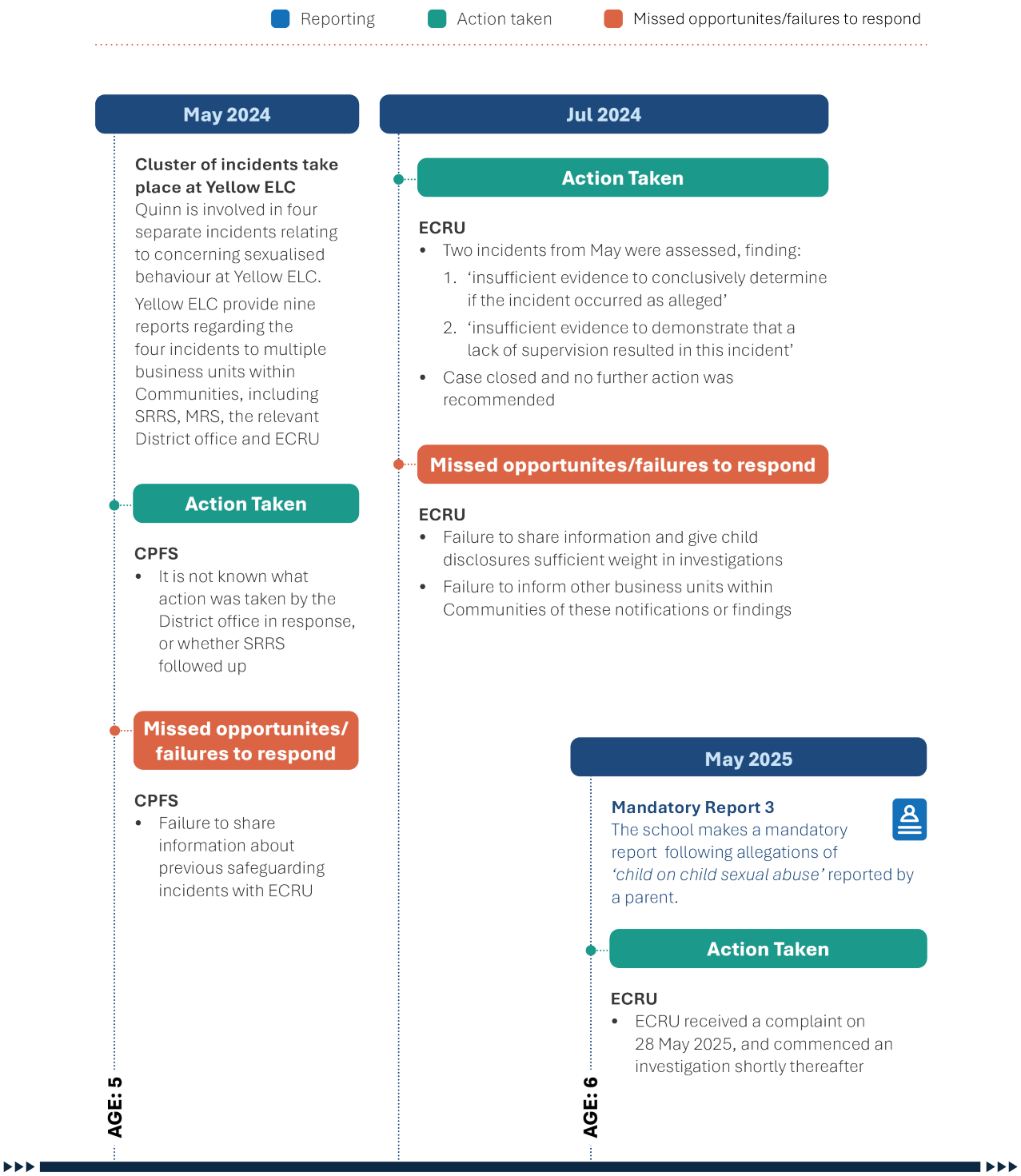
Acronyms:

Department of Communities (**Communities**) / Child Protection and Family Support (**CPFS**) / Education and Care Regulatory Unit (**ECRU**) / Child Safety Investigation (**CSI**) / Early Learning Centre (**ELC**) / Statewide Referral and Response Service (**SRRS**) / Mandatory Report (**MR**) / Mandatory Reporting Service (**MRS**)



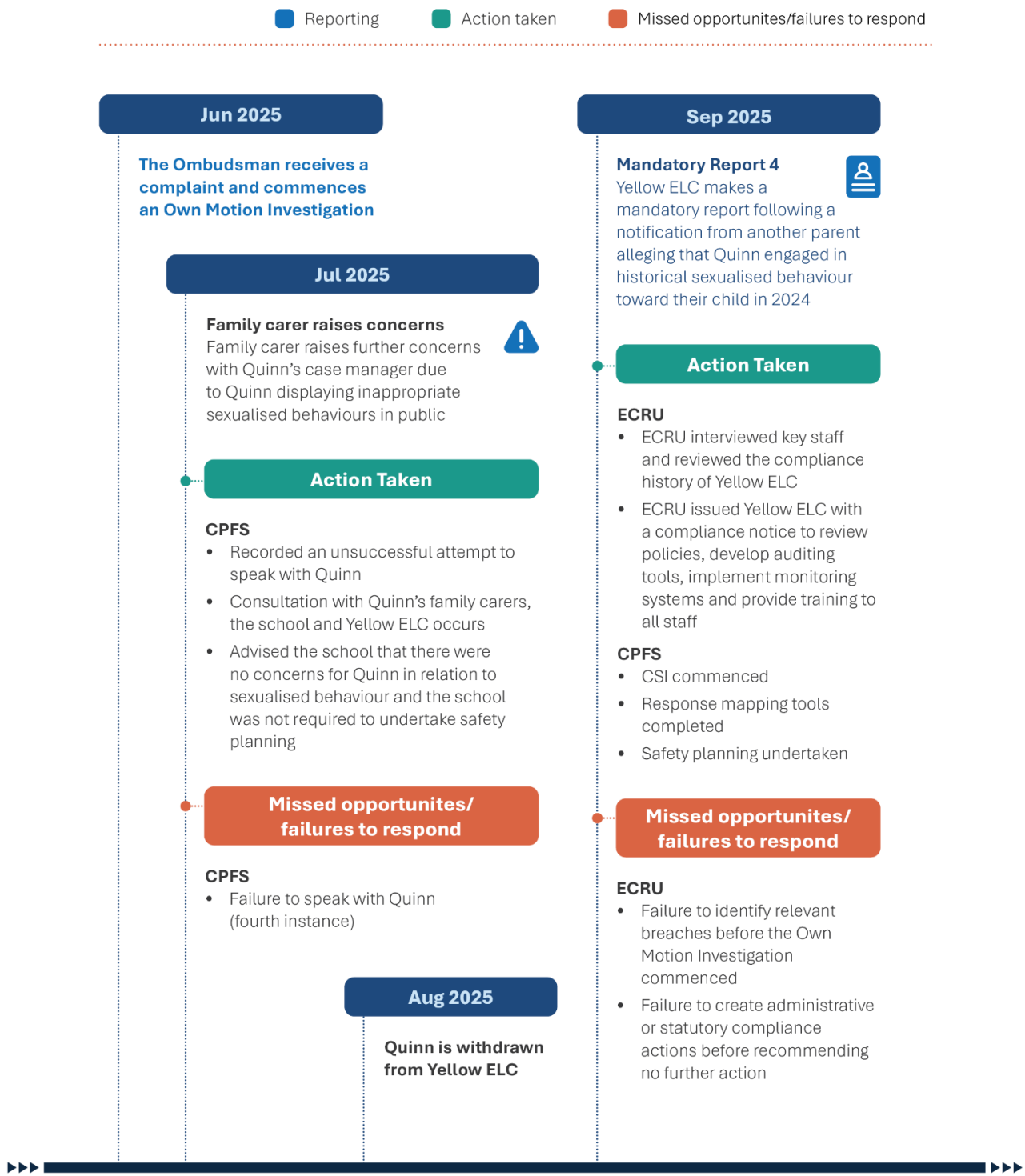
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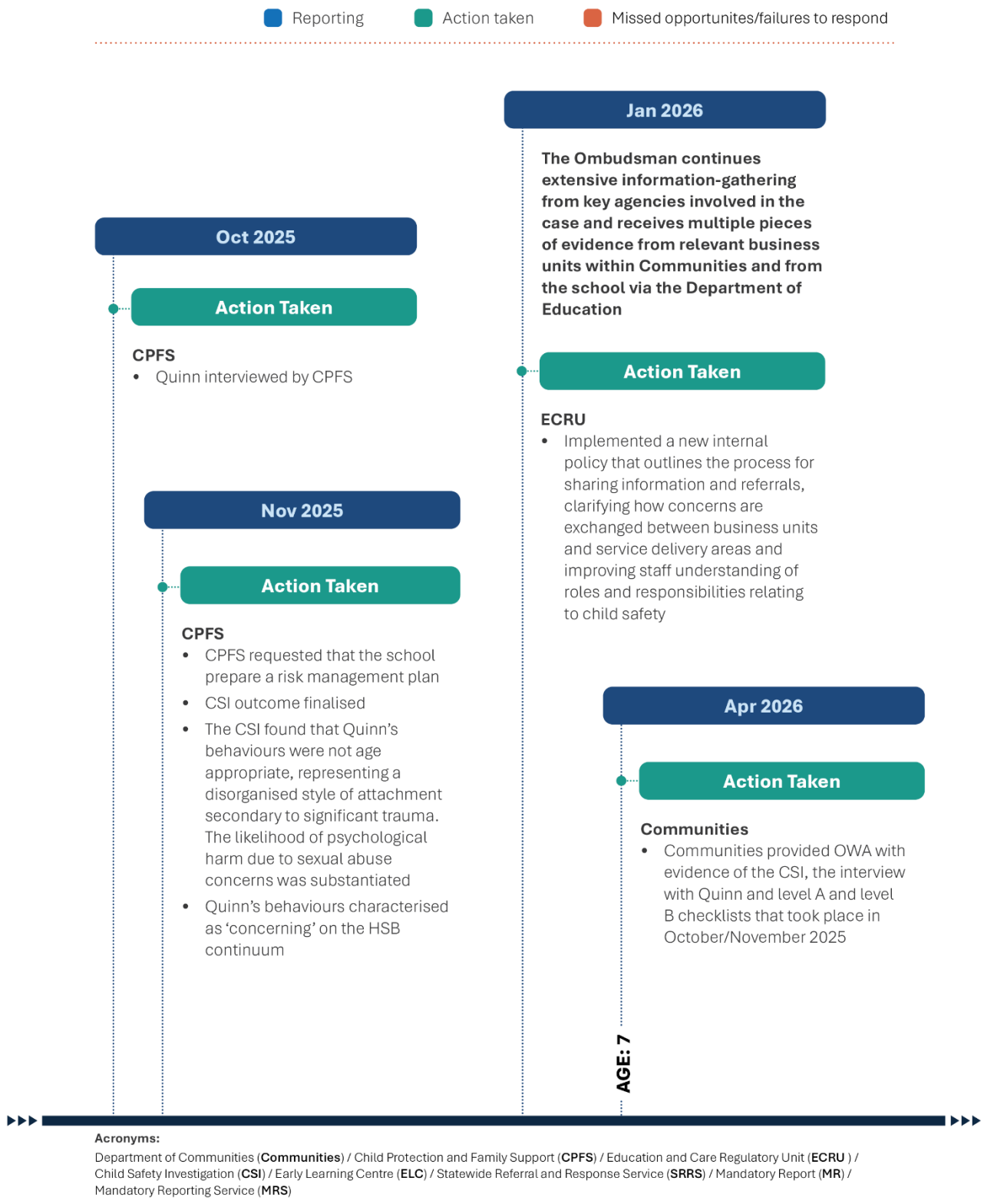
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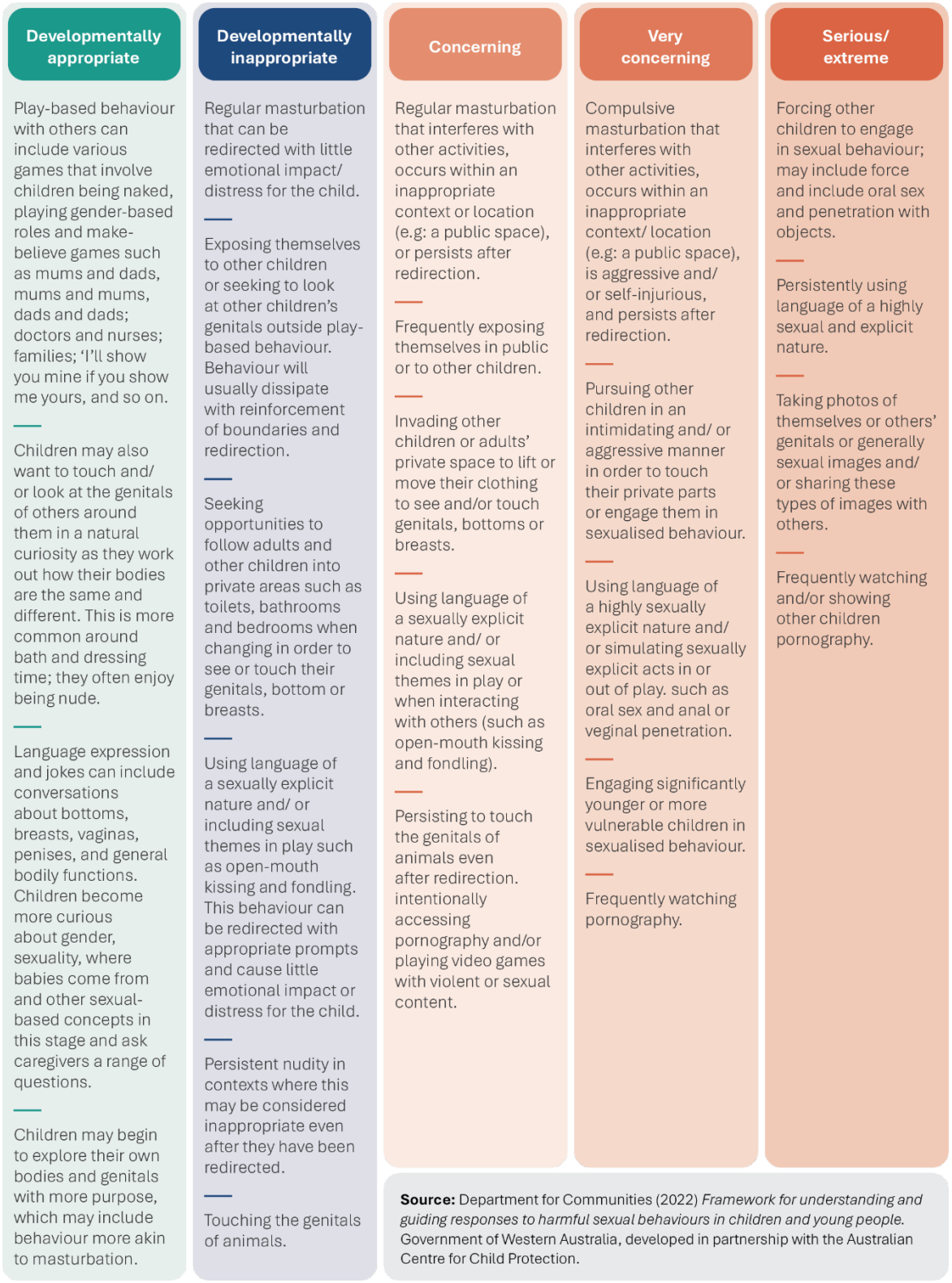


Acronyms:

Department of Communities (**Communities**) / Child Protection and Family Support (**CPFS**) / Education and Care Regulatory Unit (**ECRU**) / Child Safety Investigation (**CSI**) / Early Learning Centre (**ELC**) / Statewide Referral and Response Service (**SRRS**) / Mandatory Report (**MR**) / Mandatory Reporting Service (**MRS**)

Appendix 3: The HSB continuum

Quinn's sexualised behaviours were assessed as 'Concerning' and therefore classified as HSB.



Source: Department for Communities (2022) *Framework for understanding and guiding responses to harmful sexual behaviours in children and young people.* Government of Western Australia, developed in partnership with the Australian Centre for Child Protection.

Appendix 4: Acronyms and useful terms

Term or acronym	Definition
Care of the CEO	Refers to children and young people under the statutory care of the Chief Executive Officer (CEO) of the Department of Communities, including those in out-of-home care arrangements
CSI	Child Safety Investigation A statutory investigation undertaken when there are concerns a child has experienced, or is likely to experience, significant harm. It involves gathering information, assessing risk, and determining outcomes
CPFS	Child Protection and Family Support The Department of Communities directorate responsible for intake, assessment, investigation and case management of child protection concerns
ECRU	Education and Care Regulatory Unit The unit within the Department of Communities responsible for regulating education and care services under the National Law and National Regulations
ELC	Early Learning Centre A regulated education and care service providing early childhood education and care
FDV	Family and Domestic Violence Violence or abuse occurring within a family or intimate relationship, including physical, emotional or psychological harm
HSB	Harmful Sexual Behaviours Sexual behaviours in children or young people that are outside what is developmentally expected and which cause, or may cause, harm to themselves or others
HSB continuum	A framework-based approach that places children's sexual behaviours along a spectrum from developmentally appropriate through to harmful, used to inform assessment and response
Interaction	An electronic record in Communities' system used to document contact, concerns or actions relating to a child or case
Initial Inquiry	An intake and assessment process used to gather information and determine whether further investigation, including a CSI, is required
MR	Mandatory Report A report made by mandated professionals who are legally required to report suspected child sexual abuse to Communities
MRS	Mandatory Reporting Service The central service within Communities that receives and manages mandatory reports and forms part of the intake system

Term or acronym	Definition
National Law	The *Education and Care Services National Law* (WA), which provides the legal framework for regulating education and care services
National Regulations	The Education and Care Services National Regulations, which set out detailed operational requirements supporting the National Law
OOHC	Out-of-home care Care arrangements for children unable to live with their families, including foster, kinship and residential care
Reportable Conduct	Conduct by an employee that may involve harm to a child and must be notified and investigated under the Reportable Conduct Scheme
Reportable Conduct Scheme (the Scheme)	A statutory oversight scheme administered by the Ombudsman that requires organisations to report and investigate allegations of child-related misconduct by employees
Response Mapping Tools	Structured tools used by Communities to assess and respond to HSB, including Level A screening and Level B assessment
RFI	Request for Information A formal request issued during an investigation to obtain information or documents from agencies
SRRS	Statewide Referral and Response Service A central intake service within Communities that receives child protection concerns, including mandatory reports
The HSB Framework	The Western Australian Framework for Understanding and Guiding Responses to Harmful Sexual Behaviours, which guides assessment and response using a continuum-based approach
The Guide	Communities' Child Protection Guide, the primary operational document guiding child protection practice, including responses to HSB

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