SUMMARY

Royal Commission Research Project

Hear no evil, see no evil: Understanding failure to identify and report child sexual abuse in institutional contexts

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This report was prepared for the Royal Commission into Institutional Responses to Child Sexual Abuse by Professor Eileen Munro (London School of Economics and Political Sciences) and Dr Sheila Fish (Social Care Institute for Excellence).

The report examines two case studies published by the Royal Commission and provides an analysis based on research into human errors of reasoning and the way that organisational factors can contribute to such errors. The authors use these conceptual frameworks to provide an analysis of the way that the persons concerned in the case studies failed to identify or to act effectively upon suspicions of child sexual abuse. Their work draws on the work of many researchers, including Professor Smallbone, who has produced reports for both case studies.[1]

The case studies examined are the first two case studies published by the Royal Commission. Case Study One relates to Steven Larkins, who was involved with Scouts NSW for 10 years. In 2012, Larkins pleaded guilty to and was convicted of a number of offences, including the aggravated indecent assault of two minors, aged 12 and 11 at the time of the offences, possession of child abuse material and dishonest offences perpetrated to avoid detection. During his time with the Scouts, various personnel observed Larkins' actions that made them concerned and they shared these concerns with people in more senior positions:

> The senior people took these concerns seriously and responded, though those responses were ineffective in stopping further abuse. This allowed Larkins to move on to work in a non-government agency charged with providing a safe place for children, to evade the state-run vetting process designed to expose him, and become the carer of a young person whom he was abusing. One senior staff member was aware of the rumours of previous incidents in the Scouts and also responded, but again ineffectively. More junior staff members identified new evidence that caused them serious concerns but this was not reported, on the advice of more senior staff members. (p.11)

Case Study Two relates to Jonathan Lord, who was employed by the YMCA in NSW in outside school hours care (OSHC) services from 2009. He groomed and sexually abused several boys aged between six and ten. He met many of them through his employment and committed many of his offences on YMCA premises and during excursions. He was suspended in 2011 when he was investigated because of allegations that he had sexually abused children. He was subsequently convicted and dismissed by the YMCA:

[1] See further Smallbone, S. (2014a). *Case Study One Report* (EXP.0001.001.0001_R). Retrieved from Sydney: Smallbone, S. (2014b). *Case Study Two Report*. Retrieved from Sydney.

> The account of this case study stands in stark contrast to Case Study One: the people involved did not 'see' what was in front of them. They saw the behaviours but did not recognise them as abusive. There was an initial missed opportunity for YMCA NSW not to employ Lord, because he had recently been fired from YMCA Camp Silver Beach in the USA due to 'questionable' behaviour with a youth camper (p.11).

The complexities of the nature of the task of preventing and detecting abuse and grooming

The report notes that detecting and preventing child sexual abuse is a complex task. It has a *reactive* dimension (seeking to identify and stop abusive behaviour) and also a *preventative* dimension (screening out job applicants who have a certain history and also aiming to identify and intervene early in relation to abusive behaviour).

Defining what behaviours count as sexual abuse is also a difficult task, although it is possible for the law to provide some parameters. Extending the definition to 'grooming' behaviour adds a significant level of complexity. The report notes that there is no generally agreed list of the specific behaviours that are evidence of grooming, making the task of identifying such behaviours quite problematic.

Further, as the report notes, 'even when definitions are agreed, it is difficult to turn them into precise rules about what behaviour is concerning' (p.12).

Some high risk behaviours are obvious (eg showering with children or sharing a bed), but other less obvious behaviours require a degree of judgment on the part of the observer. Policies tend to use words such as 'appropriate' or 'inappropriate', 'reflecting the fact that a description of the behaviour may be insufficient and judgment is needed to ascertain the meaning of some behaviours, taking account of the specifics of the people involved and the context.' (p.12)

The situation is complicated by the fact that many organisations are seeking to cultivate trusting adult-child relationships, and both benign and grooming behaviours can have the very same goals. As Professor Smallbone has observed, one of the observable grooming behaviours is creating a 'special' relationship with a child; however, 'many people have had a special relationship with a teacher or adult that has been hugely beneficial, raising their ambition, confidence and skills' (pp.12-13).

Observing the abusive or grooming behaviour can also be difficult because perpetrators seek to conceal their activity. The fact that child sexual abuse in institutions is relatively rare means that for many workers, the probability that they will have first-hand experience of working with a person who sexually abuses children is low and therefore it is unlikely that they will be required to identify and act on any suspicions of child sexual abuse (p.13).

Developments in understanding error

The limitations of a person-centred focus on reducing error

When accidents or failures occur in an organisation, investigations often focus predominantly on the events that occurred shortly before the incident, with a view to identifying a technical fault or a

human error. Once such a fault or error is identified, the investigation (usually) stops there. The report notes that 'human error has been blamed in 70-80 per cent of inquiries across a range of industries and professions from anaesthesia to aviation and child protection' (p.13).

When human error is seen as the main cause of accidents and incidents, solutions logically focus on reducing or controlling the human element of tasks. These three tactics are common:

1. Psychological strategies that use punishment and reward to encourage people to remember to do the right thing
2. Reducing the autonomous role and independent decision making of people as much as possible, including through increasingly detailed procedures about what to do
3. Increasing the surveillance of the workforce to check that procedures are being followed and to intervene and punish deviations (p.14).

Despite the appeal of such an approach, and the certainty and control that it seems to offer, in some high risk industries, the report notes that this approach started to be questioned when accidents kept occurring. The 'solutions generated through a person-centred inquiry were not working as expected and so were not preventing future incidents/accidents' (p.14).

There was also increasing concern that the solutions themselves, inadvertently, were contributing to new problems that could make accidents more, rather than less, likely. For example, due to increased regulation and recording requirements, child protection organisations in England found that their employees were spending so much time filling in forms they didn't have time to do home visits to check on the safety of children (p.14).

Individual errors of reasoning

In our Euro-American world view, the ability to think logically is considered supreme. Intuitive reasoning and emotions are seen as 'inferior influences and in some ways positively harmful' (p.18), or things to be eradicated, so as to make room for pure logic. The report notes however, that the latest work in psychology and neuropsychology 'undermines this view'. Instead, it is theorised that humans have two ways of processing information and of making sense of the world around us:

> 'Humans have two distinct minds within their brains: one intuitive and the other reflective. The intuitive mind is old, evolved early, and shares many of its features with animal cognition. It is the source of emotion and intuitions, and reflects both the habits acquired in our lifetime and the adaptive behaviours evolved by ancient ancestors. The reflective mind, by contrast, is recently evolved and distinctively human: it enables us to think in abstract and hypothetical ways about the world around us and to calculate the future consequences of our actions.' (p.18)

However, most cognitive tasks require the use of both analytic and intuitive reasoning skills. These should be considered part of a 'cognitive continuum' rather than in competition with one another. Current research has also altered our understanding of the role of emotions. Rather than considering them to be 'unwanted noise in the system' or a 'source of bias and distraction', or

something that can be eliminated, they should instead be considered valuable for the role they play as 'markers' in reasoning:

> In making a decision, for example, we face a potentially vast range of options and, if we were to consider them all, we would take so long that we would fail to make timely decisions. Our emotions help us identify which options look most probable and worth exploring more. Those patients who lacked such emotional hints could not find a way to limit the task and hence had great trouble coming to a decision. (p.19)

Intuitive reasoning is much faster than analytic skill and can process numerous items of information quickly. However, while relying on intuition may be good enough in many every day circumstances, it can lead to 'large and persistent biases with serious implications for decision-making'. Biases can contribute to faulty risk assessment and consequently faulty responses to suspicions of abuse, contributing to death or serious harm (p.19).

The report outlines different types of biases that can lead to faulty decision making:

- **Confirmation bias**: once we have formed an opinion about someone, we are slow to revise it; we are more likely to notice evidence that supports it and overlook or interpret ambiguous evidence in a way that confirms rather than challenges our opinion.

- **Representative heuristic**: people have a tendency to assess people or objects 'based on their similarity to the standard for that category.' For example, there is a tendency to think that because most people working in children's services are caring and well-motivated in their actions towards children, someone new starting in the organisation will also share these characteristics. A default position in the workplace is to think well of a new colleague. When this is combined with confirmation bias, this position will then persist (p.21).

- **Availability heuristic**: intuition tends to overlook information that is dull, abstract, emotion free and in the past, and instead pays most attention to information that is vivid, concrete, emotion-laden and recent (although first impressions have an enduring impact) (p.22).

- **Hindsight error**: Once we know what happened, we over-estimate how obvious it was (or should have been) to those involved at the time. This bias is most apparent in the responses of people looking at evidence after the perpetrators have been convicted. When you know that the behaviour was followed by abuse, it is far easier to classify it as evidence of grooming (p.24).

Reducing errors of reasoning

Considerable research has been conducted into finding ways of helping people detect and avoid biases in their thinking. One general conclusion is that this is hard to do. 'Biases' operate at an unconscious level and so cannot be avoided by a simple act of will.

- Availability bias can be counteracted by using checklists and frameworks so that a person can remember the information that tends not to spring to mind intuitively. A 'checklist should contain the items that people tend to forget, rather than being a list of everything relevant' (p.25).

- Confirmation bias is particularly difficult to counteract. 'Here, a "devil's advocate" who takes the opposing view can be helpful in looking at the evidence from a different starting point and seeing weaknesses or gaps that are not readily apparent to the other person' (p.25).

- Overall, people find it difficult to police their thinking. Identifying grooming and abusive behaviour is challenging because it is so often ambiguous.

The report thus highlights the importance of the *environment* created by organisations, which can either make errors of reasoning easier to pick up quickly or more likely to go undetected. (p.25)

Systemic contributions to human error

Local rationality

A key assumption in systems thinking is that human behaviour is understandable: people are likely to do what they thought was right or sensible at the time. This is referred to as the 'local rationality principle':

> People's behaviour is rational, though possibly erroneous, when viewed from the locality of their knowledge, attentional focus and trade-offs' (p.25).

The report notes that 'local rationalities are not seen as unique to each individual but as created within the work group and lead to a shared understanding of the meaning of their actions' (p.25).

An example of a local rationality is provided in the report in relation to Case Study Two:

> …it is apparent that the local rationality that had developed in the YMCA service included assumptions about the unimportance of strictly following procedures, which allowed Lord to groom and abuse children without appearing strikingly different from colleagues. There are numerous examples in the YMCA of people with varying levels of seniority breaching procedures in their interactions with children; for example, in babysitting and allowing children to sit on their laps, and consequently Lord's behaviour did not arouse concern. (p.25)

When a local rationality develops within a workplace, the individuals within the workplace have generally been influenced in adopting this attitude by the behaviour of the colleagues around them.

The report notes that it 'is also important to look beyond the local group and consider whether wider organisational factors helped this cultural norm to develop' (p.26). In particular, it is important to examine both the overt messages provided by an organisation (such as those in formal

statements on policies) and the 'covert' messages that are often conveyed by the actions of those in leadership rather than in official documents. For example, it is important to ask 'what covert messages were received about the importance of adhering to the policies on babysitting and physical contact with children? Did senior management seek to find out if there were transgressions? Did they punish transgression? Did they seek to reinforce policies through ongoing training?' (p.26).

In relation to Case Study One, the report notes that:

> …it appears that the local rationality developed in the Scouts included assumptions that a very high standard of evidence of grooming or abuse perpetrated by a scout leader was needed before decisive action could be taken to suspend that leader. (p.26)

Also in relation to Case Study One, when a senior member of the Scouts was asked why Larkins wasn't suspended when he was told about Larkins buying lollipops for children at the local swimming pool (against the backdrop of other incidents), the response that was provided was as follows:

> '… at the time our procedures I don't think would have allowed me to suspend him, and reading into our procedures where it specified a number of steps we had to go through before we could suspend a leader […] there was no proof of anything that I was aware of at that time, and I just – again, probably inexperience, just did not know what to do about the lack of proof.' (p.26)

Organisational culture

Drawing upon the 'systems' approach, the report highlights the need for organisations to:

> …create an environment conducive to allowing staff to perform the tasks required of them, including implementing the necessary safeguards and defences against failure. In terms of child sexual abuse, this would include having the right policies, guidance and training … but this alone is not sufficient. The culture within which these factors operate has a major impact on their effectiveness in ensuring the safety of children'(p.27).

Organisational culture is partly created by explicit messages from the leadership, but is also strongly influenced by the 'covert' messages that permeate the organisation and influence the behaviour of personnel:

> Workers need not only a formal mechanism for making reports but some guidance on the threshold for action. Thresholds are rarely explicitly put in writing; workers tend to develop an understanding of them through the feedback they get themselves or the feedback they see given to others who report concerns. This feedback can either encourage or discourage workers to report concerns. (p.27)

The report refers to the facts as presented in Case Study Two as an example. One of the witnesses outlined that she 'did not feel comfortable raising her objections or concerns about Lord with her manager because she didn't trust her and thought that if she raised an issue with her, that she

wouldn't take it further. She also didn't use the YMCA 'communication book' where staff could write thoughts, concerns or information to be shared, because Lord would have access to anything she wrote in the book. (p.27)

The messages that an organisation sends to its staff (both overt and covert) are key factors in determining whether the organisation will be a child safe friendly organisation:

> The degree to which workers trust that senior personnel in their organisations will respond well to a report and, importantly, keep the name of the reporter confidential, influences the number and nature of the reports (p.28).

The report highlights the importance of staff being engaged in a 'culture of extended guardianship', so that prevention of child sexual abuse is seen as an ordinary responsibility of all adults within the organisation. This should create an environment conducive to people being alert to suspicious behaviour and ready to share concerns' (p.28).

In ascertaining how workers assess and compare goals, particular attention must be paid to the 'covert' organisational signals and messages they receive:

> The goals that drive practitioner behaviour are not necessarily those of written policies and procedures. Indeed, the messages received by practitioners about the nature of an institution's goals may be quite different from those that management acknowledges. Many goals are implicit and unstated. These covert factors are especially insidious because they shape and constrain behaviour and, in politicized and risky settings, because they are difficult to acknowledge. (p.28)

After an adverse outcome, senior managers may assert the overt goals and procedures of the organisation and fail to appreciate how these may have been subtly distorted by daily practices. (p.28)

The report then outlines some important features of healthy child safe organisations:

Effective implementation of policies and procedures

In healthy organisations, it is important that policies and procedures are clear, disseminated, understood and implemented by the workforce, and monitored by senior managers. 'At all these points, weaknesses can reduce the effectiveness of policies and procedures in achieving intended goals' (p.28).

Reactive vs preventive policies

To be child safe, an organisation needs to focus its policies and procedures on ways of preventing abuse in the first place. Sexual abusers often proceed by stages, starting by grooming the children to give them a greater chance of being able to commit abuse. If grooming can be detected at an early stage, the perpetrator can be stopped before any harm is done.

Specifying what behaviour is banned

Because of the judgment that is often required in interpreting policies about appropriate and inappropriate behaviour, training is extremely important. In particular, it can provide context about why certain rules or policies are in place.

However, whilst training is necessary for ensuring safety in relation to child sexual abuse, it is not in itself sufficient. The report argues that employees should also be provided with access to such things as advisory or referral services. Such services can provide an avenue for those thinking of raising concerns via a formal internal reporting system as well as for those running that system. It offers a kind of support and supervision of their risk assessment. Talking through their concerns with someone more experienced may help workers to more accurately interpret the observed behaviour in its context or to work out what additional information could help them make sense of what is worrying them.

The report states that it is important that if such services are provided, they be external to the organisation. This is primarily because discussions amongst personnel can be affected by the internal relationships within the organisation. Discussing matters of concern with an 'expert' in the organisation may be problematic if the expert's judgment is distorted by their opinions of both the reporter and the suspect (p.30). There are also rare cases where the person charged with providing the 'expert' advice may themselves be an abuser and will be keen to cover up their actions.

Applying policies and procedures

The report acknowledges that in some situations, procedures may need to be adapted, or, in fact, deviated from. 'Applying procedures is not simple rule-following … applying procedures is a substantive cognitive ability' (p.31).

The report notes that those organisations that have a 'high level of reliability in terms of their safe functioning' (p.32) don't penalise employees for non-compliance but rather treat non-compliance as an opportunity to learn more about the realities of the work environment.

High reliability organisations continually invest in their understanding of the reasons beneath the gap. 'This is where they try to learn – learn about ineffective guidance; learn about novel, adaptive strategies and where they do and do not work' (p.32):

> Seeking a better understanding of why people deviate from procedures in any organisation requires not just that senior managers keep a close eye on what is happening but a culture where people feel safe to admit to having breached a procedure. If compliance is monitored in a punitive manner, it encourages people to hide deviations and so block the opportunity for organisational learning (p.32).

The challenges of balancing risks

The authors acknowledge that it is challenging to devise rules that prohibit dangerous behaviour but allow nurturing and constructive adult-child relationships. The current (widespread) fear of false accusations can make people, especially men, reluctant to work with children. A further issue is that in some organisations, those who report concerns can face severe reprisals for drawing attention to an unwanted problem.

For children’s organisations, implementing a child protection policy will also have resource implications. Training in implementing policies and managing the implementation consumes money and time.

Drift into failure – the challenge of maintaining a safe organisation

Finally, the report notes that maintaining a high level of organisational performance remains the challenge for every organisation. Establishing good policies, providing good training and creating a constructive organisational culture are important elements of a safe workplace, but it is the ‘dynamic nature of many systems that means that continual vigilance is needed for them to function with high reliability’ (p.34) The task is an ongoing one for organisations.

The report quotes the phrase ‘drift into failure’ as one of the biggest challenges to maintaining a safe organisation. The phrase refers to the phenomenon that can occur in organisations where departures from the expected standard or required processes occur gradually and become routine. The change becomes embedded over time, especially when no incidents or disasters occur. ‘The adaption seems like a safe and efficient way to manage competing demands, and hence there is drift into failure. When there is finally an adverse outcome and the practice is reviewed by others, the extent of the deviant culture becomes visible’ (p.34):

> Given the rarity of child sexual abuse in any particular institutional setting, maintaining a safe organisation is a huge challenge. Staying vigilant against this abuse is difficult, and the chances of any organisation cutting corners on key safety operations and making them less of a priority than other functions are high. That means the possibility of drifting into failure is very real. The danger can be reduced if outside forces keep up the momentum by monitoring performance and checking that safety policies are kept high on the agenda – in practice as well as in theory (p.35).