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Hear no evil, see no evil:

Understanding failure to identify and report child sexual abuse in institutional contexts

A report for the Royal Commission into Institutional Responses to Child Sexual Abuse

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Project team

The Royal Commission into Institutional Responses to Child Sexual Abuse commissioned and funded this research project. It was carried out by the following researchers: Professor Eileen Munro and Dr Sheila Fish.

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Preface

On Friday 11 January 2013, the Governor-General appointed a six-member Royal Commission to inquire into how institutions with a responsibility for children have managed and responded to allegations and instances of child sexual abuse.

The Royal Commission is tasked with investigating where systems have failed to protect children, and making recommendations on how to improve laws, policies and practices to prevent and better respond to child sexual abuse in institutions.

The Royal Commission has developed a comprehensive research program to support its work and to inform its findings and recommendations. The program focuses on eight themes:

1. Why does child sexual abuse occur in institutions?
2. How can child sexual abuse in institutions be prevented?
3. How can child sexual abuse be better identified?
4. How should institutions respond where child sexual abuse has occurred?
5. How should government and statutory authorities respond?
6. What are the treatment and support needs of victims/survivors and their families?
7. What is the history of particular institutions of interest?
8. How do we ensure the Royal Commission has a positive impact?

This research report falls within theme three.

The research program means the Royal Commission can:

- obtain relevant background information
- fill key evidence gaps
- explore what is known and what works
- develop recommendations that are informed by evidence, can be implemented and respond to contemporary issues.

For more on this program, please visit
www.childabuseroyalcommission.gov.au/research

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Executive summary

The failure to protect children from sexual abuse not only arouses shock and anger but also puzzlement: how could people who are employed to *care* for children fail to protect them when, with hindsight, the evidence of harm or danger seems all too obvious.

In the aviation and healthcare sectors, attributing failure simply to individual error is no longer seen as sufficient for encouraging safe practices in the future. Instead, attention has turned to seeking a deeper understanding of *why* errors occur. Failures are seen as consequences, not just causes. Solutions to failures are built on gaining a greater understanding of the factors that contributed to human error. Those factors lie in the nature of the activity being managed, the type of reasoning errors that people are prone to and the wider system in which workers operate.

Applying this approach to the two case studies available from the Royal Commission into Institutional Responses to Child Sexual Abuse when we began this study, it is possible to offer some speculative findings on individual and organisational factors that contributed to the failure to protect children in a timely and effective way.

The nature of the problem

The challenges posed by the problem of child sexual abuse are (1) that perpetrators seek to conceal their activities; (2) children and young people who are abused can be unable or slow to ask for help; and (3) many of the behavioural indicators of abuse and 'grooming' are ambiguous, requiring judgement or interpretation to decide if they are cause for concern. 'Grooming' involves actions by the perpetrator to increase their chances of abusing a child undetected..

Errors of human reasoning

Workers' judgements are vulnerable to cognitive biases. The current understanding of human reasoning is such that when we seek to understand the actions or inaction of those involved in the organisations where an abuser was operating, we should not imagine these people as cold, logical processors of data. A more apt image is of living, feeling human beings whose understanding and actions arise from the

interplay of their reasoning capacities, both logical and intuitive, and their emotions as they respond to the world around them.

Research has found that it is hard to eradicate biases, and especially hard for a person to eradicate their own biases. The strategies that have had some success involve a person trying to consider alternative perspectives or explanations, and this is best achieved with the help of others. Organisations have a major part to play in creating the conditions in which errors of reasoning can be quickly picked up and corrected. They can do this by providing mechanisms for staff members to talk through their judgements and encouraging a culture of critical reflection.

Organisational factors

The case studies examined in this report explore many of the organisational factors that influence how well children are protected: the recruitment process, training in recognising and responding to indications of abuse, and formal policies about what people should do both to prevent and react to abuse. Our study highlighted less tangible but equally influential aspects of organisations that were also evident in the case studies, including:

Local rationality: People do what they think is right or sensible at a given time, and inquiries such as this need to find out what local rationalities may have influenced their actions.

Organisational culture: This is partly created by the explicit strategies and messages of senior managers but is also strongly influenced by covert messages that are transmitted throughout organisations, influencing individual behaviour. These can significantly affect the rigour with which policies and procedures are implemented.

Balancing risks: Policies and actions that protect children can also create dangers. Workers who are fearful of being wrongly suspected of abuse may keep their distance from children and not provide the nurturing, healthy relationships that children need to have with adults. Organisations have to reach some conclusion as to what level of concern should be reported. Making it compulsory to report even a low level of concern will identify more cases of abuse but at the cost of including numerous non-abusive cases. Efforts therefore need to be made to create a culture that understands the ambiguity of the behaviour so that innocent people's reputations are not tainted by false reports.

Drift into failure: Organisations face the problem of maintaining vigilance and avoiding a drift into failure. For any one worker, the chances of working with an abuser are low and so they may not be as vigilant as they would be if they had recurrent experiences of detecting abuse. Indeed, if they are asked to report low-level concerns, they may experience so many false alarms that they become cynical about them. There is no quick fix to this problem. It requires that managers continually monitor and endorse protection policies to stress the importance of vigilance.

Organisations that achieve a very good safety level – known as High Reliability Organisations (Weick, 1987) – provide useful examples of what organisations can do to make themselves safer places for children. They share a fundamental belief that mistakes will happen and their goal is to spot them quickly. They encourage an open culture where people can discuss difficult judgements and report mistakes so that the organisation can learn. Organisations seeking to be safe places for children must encourage frequent, open and supportive supervision of staff to help counteract the difficulties people face in making sense of ambiguous information about colleagues. A shared acknowledgement of how difficult it can be to detect and respond effectively to abuse contributes to a culture that keeps the issue high on the agenda.

1 Introduction

When people hear about cases of institutional child sexual abuse that were not exposed at the time they occurred, it's difficult for them to fathom how others within the institution could have missed the signs or turned a blind eye to indications that a child was suffering harm. In his report on Case Study Two of the Royal Commission Professor Stephen Smallbone comments: '*It seems surprising that Ms Barnat remained unaware of the long list of ambiguous and clearly concerning incidents*' (Smallbone, 2014b para.85). Following these types of cases, efforts to improve practice tend to assume that the major problem lies in human error. Typically, solutions then take the form of providing additional training, emphasising the importance of being vigilant and creating more detailed policies on what people should or should not do. These are, of course, part of the solution but the case studies prepared by the Royal Commission show that these policies have not, to date, been sufficient to protect children. One option may be to do more of the same – increase the training, procedures and monitoring. However, this report argues that we should learn from the impressive progress made in other sectors where safety is a key concern. Industries such as nuclear power and aviation may seem remote from child protection but they have in common that they involve human beings and they seek to prevent adverse outcomes that are of low probability but can have a high impact when they do happen, such as plane crashes and child abuse. Progress in those fields has been achieved by looking beyond human error to study how their organisational factors help or hinder them in producing high-quality work.

Going beyond human error means analysing the skills needed for the tasks we want workers to do, considering the strengths and limitations of human beings in demonstrating those skills, and examining how organisational factors influence the level of skill achieved. Sometimes error is due to deliberate malpractice, but more often a series of weaknesses in the system produces the failure.

Our methodology involved analysing the two published case studies available when our work began – Case Study One and Case Study Two – and drawing on research into human errors of reasoning and on how organisational factors can contribute to human error. We are not duplicating the work of the hearings of the Royal Commission but using their findings to inform our analysis of the data from another theoretical approach to see whether drawing on lessons from other sectors can further illuminate systemic factors that contribute to failure in the care of children.

Nothing in this report should be read as disagreement with any of the findings of the Royal Commission but as offering additional understanding of *why* people acted as they did. The aim is not to exonerate workers from responsibility for their actions, or lack of action, but to seek a deeper understanding of how inaction or ineffective action occurs, with a view to formulating strategies to improve practices in sectors contributing to the care of children.

This report starts by detailing the methods we used, then discusses the challenges of suspecting, identifying and responding to grooming and abusive behaviour. Next, we summarise how and why other sectors instigated change in analysing human errors, and give a brief introduction to a system's approach to understanding behaviour. This provides the theoretical framing of the subsequent sections. We begin by presenting a selective review of research into the strengths and limitations of human reasoning, relevant to detecting and preventing child sexual abuse in institutions and with illustrations of weaknesses that can be detected in the case studies. This leads to consideration of selective research into how organisations can create an environment suitable for preventing and detecting child sexual abuse, allowing for known human cognitive tendencies. Again, illustrations are provided from the case studies.

The concluding chapter summarises the key messages.

2 How we conducted the study

2.1 Methods

This study draws significantly on the expertise and previous work of the authors – Professor Eileen Munro and Dr Sheila Fish – including the formulation of a case review method for child protection based on a systems approach (Fish, Munro, & Bairstow, 2008). It also draws on the reports produced by Professor Smallbone for both case studies (Smallbone, 2014a, 2014b).

The literature falls into two main areas: research on human errors of reasoning and research on organisational factors that contribute to human error. We used the two conceptual frameworks this literature provides to analyse how the people in the two work settings mentioned in the case studies failed to identify or to act effectively upon suspicions of child sexual abuse. The first framework, on human reasoning, builds on Professor Munro's 'Common errors of reasoning in child protection work' (Eileen Munro, 1999). Specifically, we selected four types of error that arise from the

heuristics[1] people use – the shortcuts in reasoning to save time that have been found to have led to faulty risk assessment and consequently faulty responses to suspicions of abuse, contributing to death or serious harm to a child (Munro, 1999). These errors include the confirmation bias, the representativeness heuristic, the availability heuristic and the hindsight bias. The second framework draws on the joint work of Professor Munro and Dr Fish in adapting a systems approach to analysing performance in child protection (Fish, Munro, & Bairstow, 2008). We focused on certain prominent issues from the safety management literature that our experience has shown tend to be relevant to child protection: local rationality, organisational culture, balancing risks and drift into failure.

The hearings from which these case studies were prepared had a different task and different methodology from us, so not surprisingly they did not ask all the questions we would have asked. The transcripts and witness statements provided useful information yet there is still insufficient data on many issues that are of interest to us. This limits our ability to explain people's behaviour. Moreover, while we offer analyses of factors influencing people's behaviour, these should be treated as speculative. Nonetheless, this study does suggest that evidence in the case studies can be explained in terms of psychological and organisational factors that appear to have played a significant part in the failures to protect children.

2.2 Summary of case studies

The case studies were nominated because they were the contemporary cases published at the time this report was commissioned. They also raised questions about why people within institutions failed to suspect child abuse or act effectively on what they knew at the time. The case studies held promise for showing how using a different analytic framework to that used in the hearings might add to our understanding of how failures happened. For the purposes of this report, only a very brief summary of the two case studies is needed.

[1] Heuristics: These rule-of-thumb strategies shorten decision-making time and allow people to function without constantly stopping to think about their next course of action

Case Study One relates to Steven Larkins. 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 dishonesty offences perpetrated to avoid detection. The minors he assaulted were scouts, and the assaults occurred in 1992 and 1997 while Larkins was a scout leader. The case study reports that at various times during the 10 years that Larkins was involved with Scouts NSW, different scout personnel observed actions of Larkins that made them concerned that he was abusing children 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.

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 10. 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. 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 young camper. Thereafter, and over a two-year period, he managed to abuse numerous boys without coming under any suspicion from parents or workers, despite his behaviour breaching the organisation's policies on appropriate behaviour when interacting with children. The situation was only brought to an end when one of Lord's victims disclosed his abuse to his parents, who informed the YMCA as well as the police.

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

Achieving a state where a particular institution can reliably protect children from sexual abuse is challenging in part because of the very nature of the task. It has a reactive dimension – seeking to identify abusive behaviour and stop it – and also a preventive dimension. This involves screening out job applicants who have a certain history and also aiming to identify abusive behaviour and intervene in the early stage of 'grooming' a child that many abusers go through so they can have the opportunity to abuse the child undetected.

Defining what behaviours count as child sexual abuse is not without controversy (Haugaard, 2000; Wolfe & Birt, 1997). However, it is possible to reach a workable level of consensus (Finkelhor, 1994). Extending the goal from identifying instances of abuse to identifying grooming behaviour adds a significant level of complexity. Specifying the behaviours that are evidence of grooming is even more problematic, with no generally agreed list (Bennett & O'Donohue, 2014).

Even when definitions are agreed, it is difficult to turn them into precise rules about what behaviour is concerning. Some high-risk behaviour can be clearly described and banned, such as showering with children or sharing a sleeping bag, to take two examples relevant to the Scouts. Applying other rules about unacceptable behaviours requires some degree of judgement. Policies tend to contain words such as 'appropriate' or 'inappropriate', reflecting the fact that a description of the behaviour may be insufficient and judgement is needed to ascertain the meaning of some behaviours, taking account of the specifics of the people involved and the context. With grooming behaviour in particular, its purpose may not be clear not just to the observer but even to the victim. For example, in Case Study One, Larkins was seen giving out sweets to children at a local swimming pool and encouraging them to join the Scouts. This was reported at the time as suspicious but can also be seen as a well-meaning, if misplaced, marketing strategy – as was noted at the time.

The situation is further complicated by the fact that benign and grooming behaviours can have some of the very same goals, and go to the very heart of what the institution is trying to achieve, such as cultivating trusting adult–child relationships. One of the observable grooming behaviours Professor Smallbone describes is creating a 'special' relationship with a child. But many people have had a special relationship with a

teacher or other adult that has been hugely beneficial, raising their ambition, confidence and skills.

Additionally, observing the abusive or grooming behaviours is difficult because perpetrators seek to conceal their activity, and, as the case studies show, are often extremely cunning in how they go about this and neutralise any emerging suspicions. This includes manipulating the children and young people they abuse so that they are unable or slow to ask for help, and manipulating the adults so that they are often slow to understand or believe what it is they are seeing.

Finally, the relative rarity of institutional child sexual abuse is an issue. While the work of the Royal Commission shows that it is far too common, for any institution it remains a rare occurrence. This means that for an individual worker, the probability of working with a person who sexually abuses children is low and first-hand experience of identifying and acting on suspicions extremely rare. The vast majority of people who might play a key role in this important task are therefore novices, yet the task they are faced with involves making sense of only glimpses of the full extent of a colleague's abusive behaviour that may be ambiguous in nature.

4 Developments in understanding error

4.1 The limitations of a person-centred focus on reducing error

Organisations have always been seen to play some part in the skill levels achieved by their employees. Providing training, equipment and guidance are basic steps in creating a workforce capable of doing the required tasks. Yet investigators into accidents or failures have traditionally focused on the events shortly before those incidents. They have tracked back through the chain of events only until a technical fault or human error could be found that could explain the incident – and the investigation stopped there. The mistake or fault closest to the end has been taken to be the cause of the accident. 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 (Blom-Cooper, 1996; Boeing Product Safety Organization, 1993; Cooper & Kitz, 1984; Eileen Munro, 1999; Wright, Mackenzie, Buchan, Cairns, & Price, 1991). If only the worker had taken the correct action then the accident would not have happened.

In this approach, human error is seen as the main cause of accidents and incidents. Therefore solutions logically focus on reducing or controlling the human element of tasks. Woods, in relation to patient care in the health system states: *'erratic people degrade a safe system so that work on safety is protecting the system from unreliable people'* (Woods, 1994). 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.

These tactics are frequently seen in efforts to improve the quality of child protection services (E. Munro, 2005). There is a strong appeal in the certainty and control that this approach seems to offer; the problem is clear and those at the top know what has to be done to address it. However, it began to be questioned in high-risk industries because accidents were still occurring. The solutions generated through a person-centred enquiry were not working as expected and so were not preventing future incidents/accidents. There was also increasing concern that the solutions themselves were, inadvertently, contributing to new problems that could make accidents more rather than less likely. Alarm mechanisms were introduced; for example, to reduce the reliance on human judgement to identify and deal with mechanical failure. These were very useful with isolated problems but not in a situation of crisis. After the Apollo 12 spacecraft was struck by lightning, one space controller in mission control made the following comment:

> *'The whole place just lit up. I mean, all the lights came on. So instead of being able to tell you what went wrong, the lights were absolutely no help at all.'* (Cited in (Woods & Hollnagel, 2006 p.88)

In a similar way, increasing proceduralisation and recording requirements in child protection in England led to workers spending up to 80 per cent of their time in front of their computers and so failing to do the home visits needed to check on the safety of children – the primary concern of the organisation (Broadhurst et al., 2009; E. Munro, 2011).

4.2 The alternative systems approach

An alternative approach to explaining adverse incidents began to emerge through work on improving safety in the US military forces, and particularly the Air Force. Here research started to reveal how features of the work environment made human error more or less likely. Initial efforts tended to focus on how human beings interacted with tools and to study whether the latter were well designed to fit the strengths and limitations of human abilities. For example, in the Second World War, pilots often confused the flap and landing gear handles and raised the flap gear on approaching landing, damaging the propellers, engines and air frame and leading to a crash. This error became more understandable when looking at the task and tools at hand. Rather than random individual failings, this showed how they were made more probable by the design of the aircraft because the gear handles looked and felt the same and were located next to each other. This made the likelihood of operating the wrong one high, particularly given the amount of other tasks demanding a pilot's attention during landing.

Since the early focus on technology, there has been a gradual expansion in the issues considered to merit investigation so that nowadays teamwork, the work environment and work culture, management issues and socioeconomic factors, both internal and external to the organisation, may come into the frame. Moreover, there is a focus on the interactions and interdependencies among these factors and not just on the factors themselves. A basic tenet of a systems approach is that change in one part of the system can have unpredictable and unintended consequences in another part.

There has been a fundamental shift from the traditional view that human error provided a satisfactory explanation of a failure, to treating error as just the starting point of an inquiry. The assumption is that '*errors are consequences not just causes*' (Reason & Hobbs, 2003 p.9).

> *'Research results reveal systemic factors both in the organisation and the technical artefacts that produce the potential for certain kinds of erroneous actions and assessments by people working at the sharp end of the system. In other words, human performance is shaped by systemic factors, and the scientific study of failure is concerned with understanding how these factors lawfully shape the cognition, collaboration and ultimately the behaviour of people in various work domains.'* (Reason & Hobbs, 2003) (Woods, Johannesen, Cook, & Sarter, 2010 p.7)

This is described as an organisational model of accident causation, or a 'systems' approach. When a mistake is found to have been made, the inquiry explores not just

the knowledge and skills of the person concerned, but all the many factors that interact to create the situation in which they were operating. The goal becomes to identify how mistakes are made more or less likely depending on factors not just concerning the individual but more importantly concerning the task environment. Solutions no longer seek to reduce the role of fallible people; instead they aim to '*to make it harder for people to do something wrong and easier for them to do it right*' (Institute of, 1999). An example is redesigning the fighter plane flap and landing handles referred to earlier.

There are various models for conceptualising a system and the range and the relationship of causal factors that contribute to any outcome. Figure 1 below depicts complex systems as having both a 'sharp end' where the front line workers manage their tasks, and a 'blunt end' comprising the management and organisational factors.

Figure 1 Woods & Hollnagel, 2006

Systems investigations, they state, have shown that the story of both success and failure is:

- How sharp-end practices adapt to cope with the complexities of the process they are dealing with (in this case, identifying and responding to child abuse), and

- How the strategies of the people at the sharp end are shaped by the resources and constraints provided by the blunt end of the system. (Woods, Johannesen, Cook, & Sarter 2010: 8)

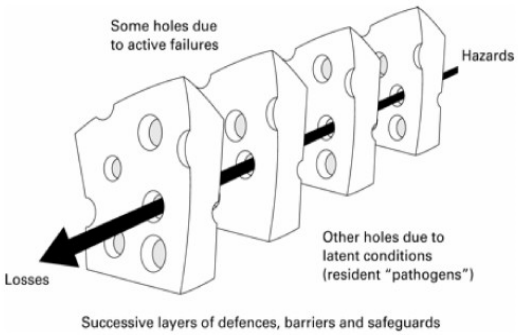

Figure 2 Reason, 1997

Another way to think about any system and the factors that influence individual behaviour within it is in terms of successive layers of defence against possible failure. Here the dominant analogy is James Reason's 'Swiss cheese' model (Figure 2), often used to analyse medical errors and patient safety incidents. Each slice of cheese represents a particular kind of defence, barrier or safeguard – some are engineered (alarms), others rely on humans (teamwork), and others on procedures and administrative controls. However, none are perfect; they have holes. These holes in the defences can arise due to 'active failures' – the mistakes of workers The impact of this type of failure on the functioning of an organisation is usually short-lived. Otherwise, holes are created by 'latent conditions': weaknesses in how the organisation operates that can make errors more likely. They can be created in numerous ways. They may arise from strategic decisions and actions such as procedure writing, IT system choice, workforce strategy and organisational priorities. An organisation's safety procedures and mechanisms may be poorly designed and implemented in the first place, or the defences may deteriorate over time through modifications in the way they are used, or due to a reduction in the organisational priority given to maintaining them. These defences can also be damaged due to the ripple effects of attempts to solve other problems (Perrow, 1999), as happened in the English child protection system, where more stringent enforcement of procedures and recording requirements was designed to solve one set of work problems while inadvertently creating new ones. Yet other holes can create 'error provoking conditions' (understaffing, time pressures, inexperience) or long-lasting weaknesses in the defences (unworkable procedures). When it comes to improving safety, latent conditions are easier to identify and remedy than active failures by individuals.

5 Individual errors of reasoning

Psychological research provides valuable understanding of human reasoning processes that can illuminate why errors have occurred in tackling the tasks of suspecting, investigating and responding to grooming and abusive behaviour toward children. The following account shows that when we seek to understand the actions or inaction of those involved in the organisations where an abuser has operated, we should not think of these workers as cold, logical processors of data but as living, feeling human beings whose understanding and actions arise from the interplay of their reasoning capacities and emotions as they respond to the world around them.

The Euro-American world has seen the human ability to think logically as our supreme achievement and, while it is acknowledged that intuitive reasoning and emotions influence how we see the world, they have generally been seen as inferior influences and in some ways positively harmful. For many, the ideal has been to eradicate their contamination and aspire to pure logic. The latest work in psychology and neuropsychology on how we make sense of the world undermines this view. It is now theorised that we have two ways of processing information and hence 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.'*
> (Evans, 2010 p.v)

Most cognitive tasks involve aspects of both our analytic and intuitive reasoning skills and, rather than thinking of them as a dichotomy, it is more accurate to think of a cognitive continuum with different tasks using varying proportions of each type (Hammond, 1996).

Our understanding of the role of emotions has also been revised by recent research. Emotions have typically been viewed as unwanted noise in the system; a source of bias and distraction. The ideal thinker has been seen as devoid of emotion and wholly logical. This is now seen to be a mistake. Emotions can certainly distort our thinking but they cannot be wiped out. They have also been shown to be a valuable source of

evidence, used with caution. Damasio's (2008) studies of people with brain damage found that those whose emotional capacity was damaged became bad at cognitive tasks. He theorised that emotions play the role of '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.

Moreover, intuition and emotion have come to be seen as not just necessary parts of our skills but the main players. As Daniel Kahneman expressed it:

> *'System 2 [our analytic skill] is the supporting character who thinks she is the hero. The defining feature of system 2 is that its operations are effortful and one of its main characteristics is laziness. As a consequence, the thoughts and actions it thinks it has chosen are often guided by system 1.'* [intuition] (Kahneman, 2011)

Intuitive reasoning is much faster than analytic skill and can process numerous items of information by using heuristics – rules of thumb that produce conclusions quickly and with a high degree of accuracy (think how swiftly you can recognise someone).

However, while these same heuristics are good enough in many everyday circumstances, they can lead to '*large and persistent biases with serious implications for decision-making'* (Kahneman, Slovic, & Tversky, 1982 p.464). Those serious implications have been demonstrated in analyses of child death review reports where the biases were found to have contributed to faulty risk assessment and consequently faulty responses to suspicions of abuse, contributing to death or serious harm to a child (Munro, 1999). They can also be detected in the case studies we analysed. The most salient are the confirmation bias, the representativeness heuristic, the availability heuristic and hindsight bias. These are detailed below, with illustrations of how they can help explain evidence in the case studies.

Confirmation bias: Once we have formed an opinion, 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.

The confirmation bias is apparent in Case Study Two in the way that workers in the institution were slow to consider that a respected colleague was in fact grooming or abusing a child. Professor Smallbone, in his report on Case Study Two, provides a

useful list of Lord's behaviour that, with hindsight, we can see as evidence of grooming:

> *'Children received notes with Mr. Lord's personal telephone number, parents noticed unusual degrees of familiarity and favoritism shown by Mr. Lord to their children, Mr. Lord himself let a co-worker know he was seeing children outside the workplace, he left notes with children telling them he thinks they are "awesome" and will miss them, he told Ms. Ockwell that he "loves" a particular boy, he called work to speak to children, he sent text messages to Ms. Ockwell asking for her assistance to organize babysitting, he was observed by Ms. Ockwell with a photograph of a child on his mobile phone, he told another co-worker that he has been 'sacked' from his position at a summer camp in the United States, he picked up children from after school care, and he offered to look after children during school holidays.'* (Paragraph 84)

When presented as a list, this information suggests that, at the least, Mr Lord had unusually intense feelings about his work and there was a need to examine his conduct in more detail. Yet each individual incident was seen in isolation by a busy co-worker who explained it in a way that did not conflict with the positive opinion they held of Lord. Ms D. Ockwell, for instance, knew that Lord babysat some of the children who attended the outside school hours care (OSHC) for free. She did not consider it unusual, but interpreted it in line with her pre-exisiting view of Lord, she '*just thought that he was a nice guy*' (CS2, p. 60). Mrs Beer said that she saw Lord with a child on his lap once but she did not 'think anything bad about it back then' (CS2, p. 63).

There are many different ways in which evidence can be explained away. A strategy evident in the case studies is rejecting the evidence as untrue or probably untrue: In Case Study One, the growing number of reported incidents of grooming and abuse concerning Larkins seem to have been doubted by the Regional Commissioner of the Scouts because he interpreted them in light of a purported conflict in the local scout team with Larkins, and between the respective families of the person most persistent in reporting concerns about Larkins. His statement for the Royal Commission described having explained that:

> *'Larkins had had a difference of opinion with a member of the Stockton Scout Group and it was generally believed that there was a campaign by the group to "get him out of scouting". The difference of opinion is one that I had had reported to me […] that Larkin's family were an aboriginal family that lived on xxx and were not well liked in the community [and] that there was an ongoing conflict between the Hoitinik and Larkins family.'* (Currie's statement: STAT.0010.001.0001_R. para 74)

A second example is that the perceived lack of evidence contributed, to the limited (and ineffective) actions taken by the Scouts in responses to concerns about Larkins in Case Study One, such as the one cited earlier when a youth worker reported seeing the message: '*Hey, I love you, but you should go home tonight so we don't get caught*'" (transcript day 2, lines 22–-24). The youth worker was told by his line manager: '"*You don't need to report that because it is third-hand information, and you don't know definitely that the text messages came from Steve.*"'

Other strategies for dismissing conflicting evidence that are noted in the literature are that we can avoid seeing it: for example, a manager can deter a junior from reporting further concerns about a colleague by his negative response to the first report. We may forget the evidence: not consciously lying but failing to remember it when it would be relevant.

The complication is that all of these strategies are appropriate at times. We must limit the information we receive to avoid being overloaded. We cannot expect to remember every minute detail of the past. People do indeed lie at times and there is scope for disagreement about the meaning of behaviour. For the individual, the problem lies in knowing when there is sufficient weight of evidence to prompt them to re-think their judgement. For the organisation, it's in finding strategies that will help people, including managers and leaders, to review their judgements more rigorously.

Representativeness heuristic: This entails assessing people or objects based on their similarity to the standard for that category. Most people working in children's services are caring and well motivated in their actions towards children. It's generally assumed that someone who starts work in a children's service will share these characteristics. The default position is to think well of a new colleague. Confirmation bias then helps this default position to persist. This tendency is well illustrated in Case Study Two where Lord was liked by the children and those who worked with him. One mother reported how children would fight over who would be on his team: he '*had a way with children'* (CS2, p. 13). It is probable that this contributed to the way several potentially worrying instances of behaviour were given a benign explanation.

In the same case study, the lax implementation of policies designed to keep children safe contributed to Lord's behaviour looking 'normal' and not arousing suspicion. For instance, he was frequently observed by several people having a child sitting on his lap although the policy clearly stated: '*Children sitting on a staff members laps [sic] is considered inappropriate*'. As a colleague told the Royal Commission, '*at that point,*

everything was so informal – the policies weren't being followed … and people were having kids on their laps and – it just – I didn't think anything out of the ordinary' (CS2, p. 62)

Abusers can neutralise suspicions by reacting to accusations in the typical way an innocent person would. In Case Study One, for example, on two occasions when Ms Henderson heard rumours in the Wrimi Aboriginal community about a past incident involving Larkins 'interfering' with a scout, she confronted him and he 'went off', angrily saying the second time that if he heard it again, he would seek legal advice and take defamation action. He also told two members of the Hunter Aboriginal Children Services (HACS) committee, presumably to highlight the extent of his outrage that the veracity of the rumours was even being considered.

The slowness to think ill of a colleague that is supported by the representativeness heuristic is likely to be a particularly strong factor in the case of sexual abuse because the offence is so repugnant to most people. While minor misconduct such as stealing office stationery can be acknowledged without radically altering your opinion of a person, paedophilia generally arouses very negative feelings in people. Suspecting that a colleague is a person who sexually abuses children will conflict strongly with any positive feelings they may have had for them.

Availability heuristic: Speed in reasoning is achieved by looking at a limited range of information that experience has taught us provides fairly reliable markers. Intuition pays most attention to information that is vivid, concrete, emotion-laden and recent (although first impressions have an enduring impact). Intuition tends to overlook information that is dull, abstract, emotion-free and in the past.

In Case Study Two, this bias can be seen in the greater attention given to current and vivid information about Lord when he applied for a post with the YMCA. His presentation at interview seems to have carried the most weight and the information on his CV was not closely scrutinised. The Royal Commission identified a number of 'red flags' in his CV that should have been investigated, such as the statement that one of his career ambitions was '*to work with kids and help them to experience life, love and friendships in an environment where there are no walls or boundaries'*. As Professor Smallbone informed the Royal Commission, boundaries are among the most critical issues in the childcare sector and this attitude should have been explored.

Errors arising from this heuristic are particularly common when an accurate assessment depends on bringing together small items of information known by several different people or over a long period – items that in isolation do not look very worrying but when combined suggest a serious problem. Professor Smallbone's list of suspicious instances in Case Study Two cited earlier (2014, para. 85), provides a good example of how this bias can contribute to the failure to suspect grooming or abusive behaviour.

The power of first impressions in the availability heuristic merits particular attention. That first opinion that we form when meeting someone remains a very vivid and available memory subsequently and, combined with the confirmation bias, can be very enduring. This is visible in Case Study Two in one person's account of her relationship with Mr Lord. She commented on a conversation she had early on in his time with the organisation when he said he had a soft spot for kids and boys. This led her to think '*he has very clear goals and aspirations for his career within the childcare sector*' and, she added, '*that statement then went on to justify a lot of his behaviour in the future*'. Having classified him as a good worker, she interpreted future actions as fitting that description rather than undermining it: '*any time I would see him paying attention to children or going above and beyond in his job role or wanting to stay behind to finish off games, that first statement that he made to me made me believe his intentions were good*'.

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 is particularly apparent in the reaction of the public and media when a child dies or is seriously harmed by maltreatment. Evidence of their danger can seem glaringly obvious when you look back at their recent history, and professionals are often criticised for failing to see this at the time and to take steps to protect the child. When we know that someone has been convicted of child sexual abuse, we may look back and think his colleagues should have been able to see that his friendliness to the children was worrying.

This bias is most apparent in the responses of people looking at the evidence after the perpetrators have been convicted, some of which we have quoted earlier in discussing the ambiguous nature of much grooming behaviour. Those appearing before the hearings provided several examples of how they were now re-interpreting behaviour that had not made them suspicious at the time:

> *'One thing that seems suspicious to me on reflection is how much [Lord] babysat. I now ask myself what sort of 24-year-old wants to spend every weekend babysitting the entire time?'* (Ms Starr, Case Study Two, p. 60)

> *'On reflection, John did sometimes have children on his lap. At the time I didn't think it was suspicious by itself, but I did think that it wasn't a good look, as it made it look to the other children that he had favourites.'* (Ms Dellaca, Case Study Two, p. 62)

When you know that the behaviour was followed by abuse, it is far easier to classify it as evidence of grooming. The claim that the behaviour was *intended* to facilitate later abuse is easier to make when you know that it did in fact do so. However, when you look at people's accounts of the sense they were making of behaviour at the time, you see how much more ambiguous or benign it seemed.

The power of hindsight is increased when reports looking back at people's behaviour list all the signs that we can now see as cause for concern so that their cumulative effect is very convincing. However, for those involved at the time, these instances of behaviour were immersed in a busy working day with many other things going on to catch their attention, some of which might have been more important. Reports can also fail to mention all the evidence that people had about good behaviour by the perpetrator that supported their belief that he was a likeable colleague and so adds a counterweight to any suggestion that he might be a person who sexually abuses children.

5.1 Reducing errors of reasoning

Considerable research has gone into finding ways of helping people detect and avoid biases in their thinking such as those commonly found in child abuse inquiries detailed above. One general conclusion is that this is hard to do. The biases operate at an unconscious level and so cannot be avoided by a simple act of will. For instance, however well you understand the hindsight bias, it is difficult to read a case study without the disturbing information standing out vividly so that it looks obvious the child was being harmed or in danger.

The availability bias can be counteracted by using checklists and frameworks when making decisions since they act as a prompt for remembering the information that tends not to spring to mind intuitively. Gawande and Lloyd (2010) have done extensive work on creating checklists in healthcare, with impressive results in improving safety.

They make the valuable point that a checklist should contain the items that people tend to forget, rather than being a list of everything relevant.

The confirmation bias, however, is particularly challenging. When people try to examine their judgements, their intuition will automatically produce all the evidence that backs them up and overlook counterevidence. There are also so many often reasonable ways of discrediting challenging evidence that it is hard to know when it needs to be taken seriously. There is no straightforward rule to follow but judgement is needed. 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.

Overall, research finds it is difficult for people to police their own thinking. And, as highlighted in the earlier section on the complexities of the task, identifying grooming and abusive behaviour is challenging because it is so often ambiguous. This highlights the importance of the environments created by organisations, which can either make errors of reasoning easier to pick up quickly or more likely to go undetected.

6 Systemic contributions to human error

6.1 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. Woods et al call it 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*' (Woods, 1994, p. 93). 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 (Dekker, 2006).

Applying this concept 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 of 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.

While it is possible to criticise an individual's approach for being lax, seeking to change this attitude requires a group-wide strategy since each individual will have been influenced in adopting this attitude by the behaviour of colleagues. Moreover, it is important to look beyond the local group and consider whether wider organisational factors helped this cultural norm to develop. People respond both to the *overt* organisational messages in formal statements on policies and priorities, and to the *covert* messages often conveyed through actions rather than words. One can 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? No evidence of active implementation is provided in the case study so a firm conclusion cannot be drawn, but failures at senior management level may have contributed to tolerance of the local deviations from policies. If so, the behaviour of senior managers also merits systemic scrutiny to gain a deeper understanding of why they did not prioritise work in reinforcing adherence to policies.

In Case Study One, it appears that the local rationality that had 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. For example, when one of the senior Scouts personnel was asked in the Royal Commission why he did not suspend Larkins when told about Larkins buying lollipops for children at the swimming pool (referred to earlier on p. 7), against a background of other incidents including one of sleeping in a tent with a child, he answered:

> *'… 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.'* (Transcript Day 2: page 138, lines 11–27)

The fact that, on at least two occasions, senior people made ineffective responses to suspicious behaviour and allegations against Larkins, and involved others in their decisions, makes it implausible that each response was based on just one individual's error.

6.2 Organisational culture

The systems approach therefore draws our attention to 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 the literature on systems approaches also highlights that this is not sufficient. The culture within which these factors operate has a major impact on their effectiveness in ensuring the safety of children.

Culture is partly created by explicit strategies and messages from senior managers but is also strongly influenced by the covert messages that run through the organisation and influence individual behaviour. If we think back to the earlier discussion about thresholds for reporting concerns, 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.

Case Study Two illustrates how discouragement can come in subtle ways. Ms Ockwell said she did not feel comfortable raising her objections or concerns about Lord with her manager:

> *'I didn't trust her and I was worried that if I raised an issue with her she wouldn't take it further'.* (Case Study Two, p. 71)

She also failed to use a YMCA 'communication book' where staff could write thoughts, concerns or information to be shared. However, she did not think of using the book to communicate her concerns '*because Lord would have had access to what she wrote in it'*. (p. 72)

Ms Noble said:

> *'I would feel uncomfortable making a complaint [to her manager] because although it is really good that we have lots of friendships with the team, things always seemed to get back to people even if they are not meant to'.* (p. 72)

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

Professor Smallbone also draws attention to the importance of organisational culture and recommends that *'staff should be engaged in a culture of extended guardianship where the responsibility for prevention is seen as an ordinary responsibility of all adults'* (Smallbone, 2014b p.35). This should create an environment conducive to people being alert to suspicious behaviour and ready to share concerns.

In ascertaining how workers assess and compare goals, particular attention must be paid to the 'covert' organisational signals or 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.'* (Woods et al., 2010, p. 128).

In practice, workers often have to make trade-offs between different but interacting or conflicting goals, with safety and cost being frequently in conflict (Brown, 2005; Hollnagel & Woods, 2005; Woods et al., 2010). In Case Study Two, for example, the need to transport children to their different schools economically conflicted with the rule of not having a single child travelling alone with an adult, since the last child to be delivered would be alone with one member of staff.

> *'Organisations reward or punish operational people in daily trade-offs ("We are an ON-TIME operation!"), focusing them on goals other than safety.'* (Dekker, 2002 p.116)

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.

6.3 Effective implementation of policies and procedures

Policies and procedures need to be drafted well, 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.

6.3.1 Reactive vs preventive policies

Historically, the weakness of many policies and procedures was that they were reactive, reflecting a low level of understanding of the problem at the time they were formulated. A key message from Professor Smallbone's reports for the Royal Commission is that organisations should not restrict their activities in responding to incidents of child sexual abuse to after incidents have occurred. 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.

The case studies show that the organisations' preventive policies were limited to some screening of job candidates to weed out any with a known history of abuse. In Case Study Two, policies were concerned primarily with responding to incidents after they had occurred, not with identifying grooming behaviour.

6.3.2 Specifying what behaviour is banned

Earlier discussion in this report on the nature of the problem of abuse mentioned the ambiguity of much grooming and abusive behaviour. This has implications for determining precisely how organisations specify policies. Rules can be drafted to ban some behaviours, such as a single adult sharing a tent with a single child. However, while some policies stipulate rules, they involve some degree of judgement about exactly what is banned and what is acceptable. The word 'appropriate' appears frequently in policy documents. For example, the Sydney (YMCA, 2009)'s Childsafe Code of Conduct (2009) stated:

> *'DO NOT: hold, kiss, cuddle or touch children in an inappropriate and/or culturally insensitive way.'*

Individual workers therefore need to use their own judgement to interpret what exactly it is they are observing.

Training can obviously make some contribution to helping workers make judgements about what is and is not appropriate. Failure to provide such training is well illustrated in Case Study Two where many staff members had no, or hazy, knowledge of what the policies were and how to implement them. They did not understand why taking photos on mobile devices was banned. Few knew of the whistleblowing service, Ethics Point, effectively removing one of the systems that could contribute to promoting

child safety. Even when one worker asked for training, it was not provided, suggesting that it had low priority in the organisation. The lack of knowledge, combined with a lax attitude to compliance, created a major weakness in the safety of the organisation.

Training is necessary but not sufficient for creating safety. It must be remembered that most workers are not abusive and any one worker is unlikely to come across a person who sexually abuses children at all, let alone frequently, during their working life. Consequently, the importance of understanding the problem of child sexual abuse is not being continually reinforced by observing instances of abuse. When this is combined with the degree of judgement needed, and hence fallibility in applying policies and following procedures, the journey from observing something suspicious to being clear enough to report it can be complicated. We suggest that access to some kind of advisory service would be useful both for those thinking of raising concerns via a formal internal reporting system and for those running that system. This would offer a form 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.

Many already have access to such an advisory service within their organisation. However, there are reasons for being concerned about expecting all advice to be available in-house. First, many organisations are too small to have a specialist of the type needed. Second, internal discussions will be affected by existing relationships within the organisation. The expert's judgement may be distorted by their opinions of both the reporter and the suspect. Third, on rare occasions, the expert may be an abuser and therefore anxious to cover up abuse. Such a scenario was recently revealed in England where a senior paediatrician at Stoke Mandeville Hospital was convicted of sexual abuse during the same period in which entertainer Jimmy Saville was visiting the hospital and abusing patients. Finally, the more closed an institution, the easier it is for abuse to be concealed, and providing an external resource will limit the institution's autonomy.

Children already benefit from a similar service in Kids Helpline, a confidential telephone and online counselling service through which they can take the first steps to report abuse or behaviour that is causing them concern. Kids Helpline helps children to think through how and where to ask for help.

6.3.3. Applying policies and procedures

It is commonly assumed in many domains that following procedures equals safety. In domains involving the care of children, it would follow that if people followed the rules, then grooming and sexual abuse would be prevented. However, research into accidents, has highlighted that there are times when the context of an incident means that the worker would do better to deviate from the procedures. '*Applying procedures is not simple rule-following ... Applying procedures is a substantive cognitive ability*' (Dekker, 2002 p. 121).

Complicating matters is the fact that procedures are often drafted to deal with a specific issue without considering the ripple effects that following the procedure might have on other parts of the system. Situations can occur where multiple procedures must be applied at once, and they may contradict each other, as happened in Case Study One. One issue the Royal Commission focused on was why Larkins had not been subject to any assessment when he took on the direct care of a child, known as 'AD', becoming his foster carer. Finding 25 highlights that the law at the time did not require Larkins to be assessed for his suitability as a foster carer. This is because Larkins was, by virtue of being HACS' principal officer, also an authorised carer – as he told the HACS Management Committee at the time by way of reassurance. HACS procedures did require an assessment but the lack of a legal requirement was allowed to take precedence. The Royal Commission found that HACS should have followed its own procedures.

This case study also provides an example of a situation when it would have been better for workers to deviate from procedures. When Larkins applied for a Working with Children Check (WWCC), he was deemed to be 'medium risk'. The person who carried out the check followed procedures in referring Larkins' risk assessment to the employer. But in this case, the employer was Larkins himself, who then put a falsified WWCC assessment on his human resources file. A better understanding of the aim of the procedures might have led to the realisation that deviating from procedures was sensible in this case and that others besides Larkins needed to be informed of the assessment.

It is useful to point out that when it comes to applying procedures, workers of any kind are often in a double bind in terms of whether they stick to them or adapt them. With the benefit of hindsight, they may be blamed for not making what was

subsequently seen to be the right choice. Dekker writes that applying procedures can be a delicate balance between:

> *'Adapting procedures in the face of either unanticipated complexity or a vulnerability to making other errors. But people may not be entirely successful at adapting the procedures, at least not all of the time. They will then be blamed for not following the procedures; for improvising …*
>
> *Sticking to procedures rigidly, and discovering that adapting them would perhaps have been better. People will then be blamed for not being flexible in the face of a need to do so.'* (Dekker, 2002, p. 122)

It is easy to miss the complexity beneath the successful application and adaptation of procedures. This can lead to unproductive countermeasures; either exhorting people to follow procedures or sending signals that they should use more discretion. This then influences their decision making in difficult situations so that they give less thoughtful consideration to the specifics of the context itself. It is on these grounds that organisations with a high level of reliability in terms of their safe functioning, have moved from a punitive approach to non-compliance with procedures to treating non-compliance as an opportunity to learn about the realities of the work environment. Dekker explains:

> *'High reliability organisations do not try to constantly close the gap between procedures and practice by exhorting people to stick to the rules. Instead, they 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.'* (Dekker, 2002, p. 123)

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.

6.4 The challenges of balancing risks

A focus on reducing the risk of harm from abuse leads to the creation of a child protection policy. But an organisation also has to pay attention to the risks that may be created by this policy itself. These risks may fall on children themselves, the alleged perpetrators, workers who report concerns about the behaviour of a colleague or the overall functioning of the organisation.

In relation to children, it is challenging to devise rules that prohibit dangerous behaviour but allow nurturing and constructive adult–child relationships. As Professor Smallbone points out:

> *'Severe rules prohibiting any physical contact or appropriate care behaviours should be avoided so as not to deprive children of healthy physical and emotional closeness with adults and peers.'* (Case Study Two, para 36)

For alleged perpetrators, widespread fear of false accusations can make people, especially men, reluctant to work with children. In England, there is a shortage of male teachers in primary schools. It is speculated that this is in part because of this fear and the potential damage to ones reputation when innocent.

Those who report concerns can face severe reprisals for drawing attention to an unwanted problem. Studies of whistleblowing reveal that this is a well-founded concern.

> *'Retaliation comes in many forms including ad hominem attacks, increased monitoring of work performance, demotion or denial of promotion, social ostracism, referral to a mental health professional, being fired, counter accusations, and professional blacklisting.'* (Cassematis & Wortley, 2013 p.622)

Finally, for children's organisations, implementing a child protection policy besides possibly affecting recruitment, as mentioned earlier, will have resource implications. Training in implementing policies and managing the implementation consumes money and time. It's expensive to create safe buildings with no spaces where adults' interactions with children are out of sight. Ensuring that no child travels alone on a bus with an adult is costly. For small organisations in particular, there may come a point where the cost of the child protection policy makes it impossible to continue to run the service.

While a child protection policy remains essential, for an organisation to manage this combination of risks, some decisions about thresholds have to be made. These may cover the range of behaviours that are forbidden and the level of concern at which someone should make a report about a colleague. A low threshold will lead to the banning of many types of behaviour (including behaviour that can be very beneficial for children) and to a large number of 'false positive' (concerns that turn out to be unfounded). A high threshold will allow behaviour that can be used by perpetrators

as opportunities for grooming and a large number of 'false negatives' (failure to report concerns which hindsight shows were evidence of grooming or abuse).

The organisations in the case studies were operating with high thresholds for reporting, so workers were slow to identify and stop both grooming and abusive behaviour. This is apparent in workers' behaviour rather than in an explicit policy.

6.5 Drift into failure – the challenge of maintaining a safe organisation

A final issue that is prominent in safety management literature is the difficulty of maintaining a high level of organisational performance. Establishing good policies, providing good training and creating a constructive organisational culture does not mean the job is done and senior managers can relax. In thinking about organisational safeguards and defences against failure, the systems literature draws our attention to the complex and dynamic nature of both organisations and failure. Returning to the 'Swiss cheese' analogy,

> *'The layers of defence are not static or constant, and are not independent of each other either. They can interact, support or erode one another. The Swiss cheese analogy is useful to think about the complexity of failure, and, conversely, about the effort it takes to make and keep a system safe.'* (Dekker 2002, p. 119, emphasis added)

The dynamic nature of many systems means that continual vigilance is needed for them to function with high reliability. It is an ongoing task. Sydney Dekker coined the phrase '*drift into failure'* to capture one of the biggest challenges to maintaining a safe organisation. Generally, departures from the expected standard or required processes become routine over time – they become the new norm. These departures are often driven by competing priorities and goals, which lead people to '*borrow from safety*' (Dekker 2002, p. 116), such as by cutting corners to free up time for other tasks. Crucially, over time, when no disaster results, confidence grows that the adaptation is a sensible change and it gets further embedded. 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. Practices that were once in line with the cultural norm in efforts to achieve competing goals, with hindsight look like negligence when compared to official procedures.

This drift into failure is apparent in Case Study Two where policies listing unacceptable behaviour were allowed to lapse and workers came to see babysitting and other proscribed behaviours as normal and unconcerning.

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.

7 Conclusion

> *'Learning from institutional sexual abuse cases indicates that there is something about institutions, as environments for child sexual abuse, which appears to aggravate the vulnerability of potential victims and amplifies the power over them that abusers can exercise. This means that institutions are high risk environments for children, young people and indeed other vulnerable people. Such a high risk, coupled with the vulnerability of potential victims, requires a higher investment in mitigation.'* (CEOP, 2013)

We all share the ambition of creating 'safe organisations', where children are protected from harm while being able to enjoy the service provided. The case studies are examples of failure but the analyses of how the abuse was not prevented or identified reveals the challenges inherent in these tasks.

This study has identified a number of challenges to creating and maintaining a safe organisation in which staff members are quick to suspect grooming or abusive behaviour and can trigger a process that investigates the concerns and takes appropriate action so that children are protected from harm.

The first difficulty lies in the nature of the problem itself – especially with regard to the ambiguity of much abusive and grooming behaviour – where behaviours that should trigger concern cannot simply be listed. Policies can certainly help to explain the type of behaviour to look out for but the use of words like 'appropriate' and 'inappropriate' indicate the need to make judgements about the meaning of what is being observed.

Such judgements are fallible. The section of this report on errors of reasoning detailed how people's reasoning processes can lead to errors so that they fail to interpret what they see as suspicious behaviour. Research shows that it is hard to police one's own intuitive reasoning and most strategies to reduce bias involve other people helping you to critically review your explanation and consider alternative explanations.

The need for help in reaching more accurate judgements and detecting abusive or grooming behaviour more quickly brings in the central role that organisational systems play in creating a safe place for children. Opportunities to reflect on one's reasoning are valuable if conducted in a supportive, non-blaming atmosphere. For this reason, all staff, including the senior people to whom others report their concerns, would benefit from supervision to ward against common errors of human reasoning.

> *'Studies have demonstrated that one of the most effective safeguards within organisations or professional settings is to provide frequent, open and supportive supervision of staff.'* (CEOP, 2013)

Our analysis of how organisational factors have influenced individuals' behaviour showed that these should, in part, be explained by features of the work environment, some aspects of which may help to produce the right behaviour and other aspects of which may encourage the wrong behaviour. While individuals must hold some responsibility for their actions, the case studies show how many organisational factors contributed to what, in hindsight, was poor practice in protecting children.

Good training and policies are necessary elements but their contribution to safety requires that they be implemented accurately. They need to be seen as important in the organisational culture, with senior managers demonstrating this by monitoring whetherthat people understand and use them. Failure to do this is evident in Case Study Two.

Organisations also influence the level of concern that will cause a worker to report suspicions. In this, they are not faced with a simple choice between 'safe' and 'dangerous', but a requirement to balance risks. Efforts to ensure the safety of children can have negative as well as positive effects. For example, a threshold that is low for reporting concerns may lead to many false alarms, potentially harming the reputations of innocent people and deterring people from working with children. A high threshold for reporting will mean that workers miss or will be slow to detect some instances of abuse.

The wider society also influences organisational and individual behaviour. The Royal Commission will itself have a strong influence on future behaviour, demonstrating how society considers child sexual abuse as a very serious matter. The Royal Commission's existence will alter the equation in terms of calculating reputational risk. In Case Study One, the desire to protect the organisation's reputation was deemed to lead to a failure to act effectively in stopping abuse. The reputational risk in being found to have concealed instances of abuse is now much higher and should make cover-ups less appealing.

The current social concern about institutional sexual abuse is beneficial in many respects but it does carry the danger of creating an atmosphere of public vilification for past mistakes that leads to defensive practices in organisations. For instance, organisations may retreat to the safety of fixed rules governing behaviour, such as banning *all* physical contact between an adult and a child, thereby removing any need for individual judgement. This protects adults from false accusations of grooming or abuse but at the cost of depriving children of appropriate and nurturing human contact. Even if the policies themselves avoid naïve rules, workers may interpret principles as rules because they are scared of getting into trouble if their judgements turn out to be wrong. To counter this, a 'fair' culture is needed where workers are confident that they will receive a just hearing and only be punished if they acted carelessly or with malice.

Organisations that achieve a very good safety level – known as High Reliability Organisations (Weick, 1987) – provide useful examples of what organisations can do to make themselves safer places for children. They share a fundamental belief that mistakes will happen and their goal is to spot them quickly. They encourage an open culture where people can discuss difficult judgements and report mistakes so that the organisation can learn from them.

Safety can also be improved by organisations recognising the central importance of the frequent, open and supportive supervision of staff members, to help them maintain vigilance and to counteract the difficulties people face in making sense of ambiguous information about colleagues. A shared acknowledgement of how difficult it can be to detect and respond effectively to abuse contributes to a culture that keeps the issue high on the agenda.

The Royal Commission case studies analysed in this report identify the failure of people to see or act effectively upon suspicions of grooming and abuse in institutional

settings and, with hindsight, these failures seem incredible. In this study, we set out to find out whether applying a different lens could help to better explain such failures. We have illustrated how applying current understanding of human reasoning and a systems approach to error investigation can help make people's decisions and actions more understandable. There are common ways in which people fail to accurately interpret the world around them and common organisational factors that contribute to the failure of people to see or act upon suspicions of grooming and abuse. These provide additional insights into failures to protect children from sexual abuse in institutions. Providing better explanations of why people acted as they did in error, holds promise for providing the kind of support that will help people to better protect children in the future. Crucially, a safe organisation requires the combination of several factors that will jointly contribute to facilitating and encouraging the protective behaviour that is needed.

References

Bennett, N., & O'Donohue, W. (2014). The Construct of Grooming in Child Sexual Abuse: Conceptual and Measurement Issues. *Journal of child sexual abuse*(just-accepted).

Blom-Cooper, L. (1996). Some Reflections on Public Inquiries. In J. Peay (Ed.), *Inquiries after Homicide*. London: Duckworth.

Boeing Product Safety Organization. (1993). Statistical summary of commercial jet aircraft accidents: Worldwide operations, 1959-1992. Seattle. WA: Boeing Commercial Airplanes.

Broadhurst, K., Wastell, D., White, S., Hall, C., Peckover, S., Thompson, K., . . . Davey, D. (2009). Performing 'initial assessment': identifying the latent conditions for error at the front-door of local authority children's services. *British Journal of Social Work*, 1-19.

Brown, J. P. (2005). *Ethical dilemmas in health care. Safety ethics: cases from aviation, health care and occupational and environmental health.* . Aldershot: Ashgate.

Cassematis, P. G., & Wortley, R. (2013). Prediction of whistleblowing or non-reporting observation: The role of personal and situational factors. *Journal of business ethics, 117*(3), 615-634.

CEOP. (2013). *Thematic Assessment: The Foundations of Abuse:*
A thematic assessment of the risk of child sexual abuse by adults in institutions. Retrieved from London:

Cooper, J., & Kitz, R. (1984). An analysis of major errors and equipment failures in anesthesia management: conditions for prevention and detection. *Anasthesiology, 60*, 42-43.

Damasio, A. (2008). *Descartes' error: Emotion, reason and the human brain*: Random House.

Dekker, S. (2002). *The Field Guide to Human Error Investigations*. Aldershot: Ashgate.

Dekker, S. (2006). *Ten Questions about Human Error*. London: Lawrence Erlbaum Associates.

Evans, J. (2010). *Thinking Twice: Two Minds in One Brain*. Oxford: Oxford University Press.

Finkelhor, D. (1994). The international epidemiology of child sexual abuse. *Child Abuse & Neglect, 18*(5), 409-417.

Fish, S., Munro, E., & Bairstow, S. (2008). Learning Together to Safeguard Children. London: SCIE.

Gawande, A., & Lloyd, J. B. (2010). *The checklist manifesto: how to get things right* (Vol. 200): Metropolitan Books New York.

Hammond, K. (1996). *Human Judgement and Social Policy*. Oxford: Oxford University Press.

Haugaard, J. J. (2000). The challenge of defining child sexual abuse. *American Psychologist, 55*(9), 1036. Retrieved from http://psycnet.apa.org/journals/amp/55/9/1036/

Hollnagel, E., & Woods, D. (2005). *Joint Cognitive Systems: Foundations of Cognitive Systems Engineering*. Poca Raton: Taylor & Francis.

Institute of, M. (1999). *To Err is Human: Building a Safer Health System*. Washington, DC: National Academic Press.
Kahneman, D. (2011). *Thinking fast and slow*. London: Allen Lane, The Penguin Press.
Kahneman, D., Slovic, P., & Tversky, A. (1982). *Judgement under Uncertainty: Heuristics and Biases*. Cambridge: Cambridge University Press.
Munro, E. (1999). Common errors of reasoning in child protection work. *Child Abuse & Neglect, 23*(8), 745-758.
Munro, E. (2005). Improving practice: child protection as a systems problem. *Children and Youth Service Review, 27*(4), 375-391.
Munro, E. (2011). Munro Review of Child Protection, Final Report: A child-centred system. London: Department for Education.
Perrow, C. (1999). *Normal Accidents: Living with High-Risk Technologies*. Princeton, New Jersey: Princeton University Press.
Reason, J., & Hobbs, A. (2003). *Managing Maintenance Error*. Aldershot: Aldgate.
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:
Weick, K. (1987). Organizational Culture as a Source of High Reliability. *California Management Review, XXIX*(2), 112-127.
Wolfe, V. V., & Birt, J.-A. (1997). Child sexual abuse. In E. Mash & L. Terdal (Eds.), *Assessment of childhood disorders* (Vol. 3rd edition). New York: Guildford Press.
Woods, D. (1994). Behind Human Error: Human Factors Research to Improve Patient Safety. Washington, DC: Public Policy Office.
Woods, D., & Hollnagel, E. (2006). *Joint Cognitive Systems: Patterns in Cognitive Systems Engineering*. Boca Raton: Taylor & Francis.
Woods, D., Johannesen, L., Cook, L., & Sarter, N. (2010). *Behind Human Error: Cognitive Systems, Computers and Hindsight* (2nd Editio ed.). Wright-Patterson Air Force Base, Ohio: CSERIAC.
Wright, D., Mackenzie, S., Buchan, I., Cairns, C., & Price, L. (1991). Critical incidents in the intensive therapy uni. *Lancet, 388*, 676-678.
YMCA. (2009). *Childsafe Code of Conduct*. Retrieved from www.unsw-**ymca**.org.**au**/.