

# Exploring the case for mandatory reporting: a summary of a roundtable hosted by the NSPCC

July 2014

## Acknowledgements

The NSPCC would like to thank Laura Hoyano, Associate Professor in Law and Senior Research Fellow at Wadham College, University of Oxford for her expertise and research and for providing a stimulating presentation to the roundtable presenting the evidence of impact of mandatory reporting around the world.

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## Mandatory Reporting

### Introduction

NSPCC is the country's largest child protection charity and we are driven by the wish to make children as safe as possible. A strong culture of safeguarding across all of society is the most important form of protection, and institutions that provide services to children are a pivotal part of that culture. For many years the NSPCC has worked with institutions to improve child safeguarding and protection to enable institutions to 'build in' this type of culture. A balance between building in good practice and prohibiting or punishing poor practice is important. Too much reliance on institutions to set their own safeguarding culture leads to uneven practice, whilst an over reliance on rules and checks leads to box ticking and a lack of personal responsibility for developing a safe environment.

The NSPCC convened a round-table event on the 12th of June 2014 to consider the measures that may be required to ensure that children are better protected from abuse when they are in the care of institutions. The professionals at the roundtable event explored whether the current child protection requirements on individuals or institutions are adequate and whether there should be an additional duty to report abuse. On the issue of reporting abuse, the discussion explored the benefits, risks and implications of introducing a form of mandatory reporting.

The aim of the roundtable was to provide an opportunity for the key stakeholders to come together to begin to explore this complex issue and these discussions were not in any way conclusive. As such this paper is intended as a starting point for further discussion and refinement. In publishing this paper the NSPCC wants to start a debate of this complex issue. The paper draws on individual views expressed around the table and does not pretend to represent any definitively shared view. The purpose was to understand common ground where it existed so that where possible, participants could work from a common base in formulating their view.

This paper comprises three sections:

- Part A: Briefing Paper – this section was provided to delegates in advance of roundtable on the 12<sup>th</sup> June 2014 to set out the issues that the roundtable would seek to explore.
- Part B: Roundtable Discussion Paper – this section summarises the discussions at the roundtable and sets out where consensus was reached and the issues, concerns and suggestions raised by the delegates.
- Part C: Summary and next steps – this section considers the next steps required in order to progress the discussions about whether an additional duty to report would serve to improve protection of children.

## Part A: Briefing Paper

NSPCC is the country's largest child protection charity and we are driven by the wish to make children as safe as possible. Today's event is to consider the measures that may be required to ensure that children are better protected from abuse when they are in the care of institutions which are entrusted to their care. It has been prompted because a significant number of cases have recently come to light where there has been a failure to protect children, leading to questions about whether current child protection requirements on individuals or institutions are adequate.

For many years the NSPCC has worked with organisations to improve child safeguarding and protection. It is our view that a strong organisational culture of keeping children safe is the most important form of protection and we have worked with organisations to 'build in' this type of culture. We also recognise the need for legislation, regulations and inspections to reinforce a strong safeguarding culture. A balance between 'building in' good practice and 'prohibiting' or punishing poor practice is important; too much reliance on organisations to set their own safeguarding culture leads to uneven practice, whilst an over reliance on rules and checks leads to box ticking and a lack of personal responsibility for developing a safe environment.

Cases, both non-recent and recent, have come to light that cause us to question whether the current balance is right. Inquiries into cases of abuse in settings such as hospitals, schools and child detention facilities in the UK show that, in many incidences, individuals were aware that child abuse may have been happening but failed to take effective action to protect children. Some of these cases have been very recent and so we cannot assume that poor practice is a thing of the past. Concern about protection of children within institutions is not confined to the UK; there are currently two major inquiries into cases of institutional abuse in Ireland and Australia.

### Defining the Problem

Recent cases have exposed weaknesses in the protection of children in settings which are entrusted with their care, resulting in children being abused by adults or peers within those settings, often over a considerable period of time before action is taken. These have included schools, hospitals, residential children's homes, secure accommodation, religious organisations and sports establishments. In some cases people in leadership positions have taken ineffective action, failed to disclose allegations and/or allowed professionals to continue their activities and/or to move on to other institutions unchecked. Recent examples include:

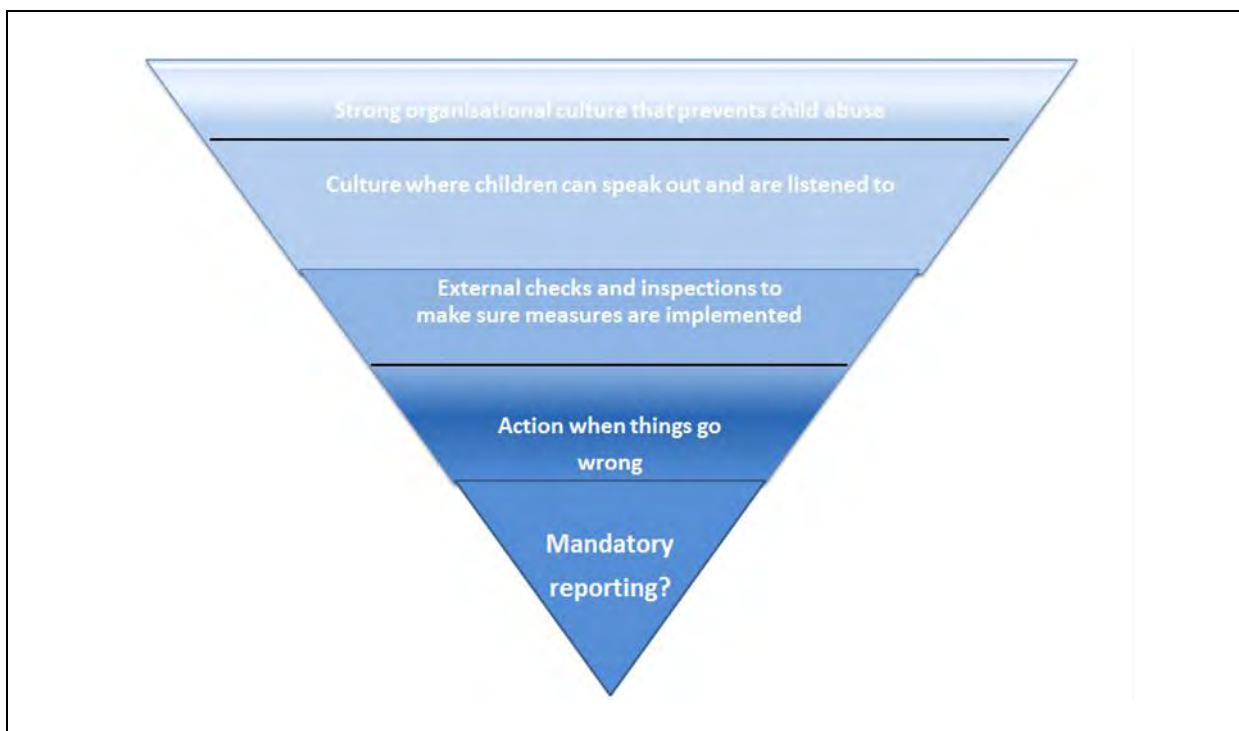
- The Jimmy Savile scandal, where it has now emerged that he committed offences in a broad range of settings. A significant number of offences were committed at institutions including Duncroft School, Broadmoor Hospital and Stoke Mandeville Hospital. Savile's regular visits to these institutions allowed him to identify potential victims whom he went on to abuse.
- Stanbridge Earls School in Romsey (an independent residential special school), where it is alleged pupils were abused by other pupils and incidents of abuse were happening as recently as July 2013. In January 2013, the Special Educational Needs and Disability Tribunal (SEND Tribunal) concluded that Stanbridge Earls had 'inexcusably' failed to protect a vulnerable disabled pupil. This case brought to light other alleged cases which are being investigated. Notably, although the tribunal strongly criticised the head teacher, he remained in post without disciplinary action and was only replaced months after the decision.
- Greater Manchester Police launched 'Operation Kiso' in February 2013 to investigate allegations of sex abuse at Chetham's and the Royal Northern College of Music, both in Manchester. The bulk of the offences are alleged to have taken place in 1970-1990 although incidents are alleged to have happened as late as 2010. The Greater Manchester Police investigation has broadened to investigate incidents at other specialist music schools in the UK.

- In August 2013, a fresh police investigation was launched to consider allegations of abuse at Medomsley Detention Centre in Durham. A total of 143 victims came forward initially. After a BBC programme about abuse at the centre was shown, more than 200 further victims have come forward bringing the total number to approximately 375 victims.
- Members of staff of more than 130 independent schools have been implicated in allegations of child abuse with a significant surge in criminal prosecutions since 2012. There are approximately 300 institutions where inquiries are being made regarding allegations of abuse.

These cases have typically taken place in institutions or settings where there is a clear power imbalance between the victim(s) and the abuser(s) and the victim is relatively isolated from other adults not associated with the institution or setting. Sometimes it appears that those leading the institution may have placed reputational interest above child protection. In many cases it appears that suspicions or evidence about abuse have remained within the institution rather than being referred to external authorities such as the police, social services and regulatory bodies.

### Protecting children – a multi-faceted approach

The NSPCC believe that child safeguarding and protection works best when there is an effective structure that; creates good protective, organisational cultures; supports children speaking out and being heard; has external checks to make sure the right measures are being implemented; and takes action when the system fails to protect children properly, including giving protection to those who report their concerns or take action to make children safe.



### Strong safeguarding culture

Strong safeguarding cultures have an openness between staff, children and parents/carers, ensuring that concerns are raised immediately and effective action is taken. Organisations and institutions with excellent child safeguarding performance have zero tolerance of any forms of bullying, whether between managers and staff, staff and children or between children themselves. They have a low

thresholds for raising concerns and encourage open discussions about any concerns, whether deliberate or accidental.

Such cultures require senior leadership and commitment of all staff. Robust arrangements should be in place for the recruitment of all staff and volunteers. These should include job descriptions and person specifications for all posts. Vetting and barring checks should be carried out in line with legislation but should operate within a wider context of sound recruitment and supervision practices. References should always be taken and followed up where necessary.

Interview methods such as Values Based Interviewing help to identify those individuals with the appropriate orientation to contribute to a strong safeguarding culture. Use of VBI is not only likely to discourage or weed out applicants with inappropriate attitudes towards children and vulnerable adults but improves staff and employer satisfaction ratings and staff retention.

Other key elements for a strong safeguarding culture include effective induction and supervision for both staff and volunteers, ongoing training and staff development that is linked to the specific competencies for their roles, and simple, transparent complaints procedures. All of the above ought to be captured in a clear policy which is well publicised and well understood.

### **Children speak out and are heard**

Safe organisations allow children to speak out and are willing to hear them. It is often difficult for a child to disclose abuse. We know that it can take a child a long time to talk about the sexual abuse they have suffered. Disclosure is rarely a single event and children may try to communicate their suffering in non-verbal ways by acting out.

In terms of a culture which encourages disclosure, this can occur when someone notices the signs and impact of abuse and asks about it. It is a very powerful motivator for young people to disclose if an adult takes notice of their struggles and asks them. Some young people describe how others asked a direct question, whereas other young people said their disclosures were promoted over time through building trust which often took the form of providing a safe place to talk and encourage eventual disclosure.

Organisational arrangements where it is well advertised to children about what routes they have to report abuse, both within and outside the organisation, can also create a culture where children feel safe to speak out and believe they will be listened to.

### **Checks and inspections**

Inspection of child safeguarding and protection is undertaken by many bodies, most notably Ofsted. Other bodies include HMIC and Independent Schools Inspectorate (ISI). There are concerns that schools inspections are not always effective and that Ofsted and ISI have failed to find evidence of abuse, even after they had been given information from concerned parents (e.g. Stanbridge Earls School and Northease School).

In addition to general efficiency inspections, HMIC inspects police forces on specific subjects or themes such as child protection, however, these inspections may be many years apart.

A small number of people are barred each year from 'regulated activities' by the Disclosure and Barring Service because of convictions or other concerns about their suitability to work with children and/or vulnerable adults.

### **Action when things go wrong**

Alongside criminal offences for those who commit abuse against children, civil law, statutory guidance, professional duties and organisational and institutional rules require professionals to take

effective and appropriate action when they suspect that a child may be at risk of, or is suffering abuse or neglect.

For example, Working Together 2013, the statutory safeguarding guidance, makes clear that there are both organisational and individual responsibilities to protect children. Also, the recently published Keeping Children Safe in Education 2014 document is clear about the responsibilities of staff in schools and colleges to take action to protect children, including reporting concerns to children's social care departments and following up on that report if no action is forthcoming.

Professional bodies also produce guidance and hold their members to account through disciplinary processes – for example the National College for Teaching and Leadership has barred over 50 teachers as a result of failures in their safeguarding practice in the past 14 months. The GMC also holds disciplinary hearings and can remove doctors from the register that allows them to practise.

However, greater clarity is needed about how such professional sanctions work across the broad range of groups who are charged with protecting children. The consistency with which such sanctions operate is unclear, as is whether some professions are better at acting than others, and the extent to which individuals are contractually or otherwise bound by them.

There has also been employment protection for employees wishing to blow the whistle since 1998. More recently, there have been significant steps to encourage whistleblowing within the health sector, following the Mid Staffs report. However, whistleblowing legislation only provides protection for employees who are victimised or dismissed after having reported malpractice. Consideration should be given to other protections from legal and disciplinary action for those who report their concerns or take action to protect a child.

In other areas of the law, responsibilities are imposed on organisations or institutions through compensation awards in the civil court or through assigning organisational or institutional criminal responsibilities, such as the Corporate Manslaughter Act 2007 and Health and Safety at Work Act 2005. Could similar approaches be helpful in protecting children in regulated settings?

### Questions for discussion

- A. What steps should be taken to strengthen any of these elements?
- B. Are these elements sufficient or should there be an additional requirement to report abuse?

### Mandatory Reporting?

There is a question whether there is a need for an additional protection if all of the elements above fail to adequately protect children. Mandatory reporting has been put forward as a potential solution to such inadequacies which have been exposed by recent child abuse cases. Under mandatory reporting certain groups or professionals would be placed under a legal duty to report suspected cases of child abuse and neglect to proper authorities. These groups are referred to as 'mandated reporters.' Failure to report reasonably held concerns would lead to criminal sanctions<sup>1</sup>. Mandatory reporting systems have been used in a number of countries for many years e.g. USA, Canada and Australia. However, mandatory reporting jurisdictions differ as to who the mandated reporters are and the type of abuse subject to reporting.

There is evidence to suggest that existing mandatory reporting regimes can lead to unintended adverse consequences, such as creating a culture of reporting rather than acting, dissuading children from disclosing incidents for fear of being forced into hostile legal proceedings or overwhelming an

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<sup>1</sup> Whilst a mandatory reporting law need not necessarily be based on criminal provision, we are not aware of any alternative models of mandatory reporting that do not impose criminal sanction for failure to report. Civil law in the UK can currently be used to seek redress for negligent failure to protect children. However, this is an inadequate model because it is slow and expensive and does not always have a child protection focus. It also does not place an individual liability because actions are generally instituted against an organisation and redress, usually in the form of compensation, is paid by insurers.



already stretched child protection system so that attention is diverted from where it is most required (Appendix One).

The debate on mandatory reporting has increasingly focused on organisational and institutional settings, rather than more broadly across services and society. However, some important questions remain. If mandatory reporting is necessary to shift safeguarding culture, which institutions would be covered by such a duty, what kind of abuse should be reported and who should be mandated to report. Given the risk of unintended consequences, it is important to consider the merits and demerits of the possible options.

### Questions for discussion

- a. To which organisations and/or institutions should the proposed duty apply?
- b. To which individuals should the proposed duty attach?
- c. What behaviour should be subject of a duty to report?
- d. Which individuals do we aim to protect under the proposed duty?
- e. Whose behaviour should be subject of a duty to report?
- f. What level of knowledge of abuse would trigger the proposed reporting duty?
- g. Is an external reporting mechanism necessary or desirable? How would such a reporting mechanism operate?

#### 1. *To which organisations and/or institutions should the proposed duty apply?*

- a. There are a number of ways one can define an 'institution', including by 'function' e.g. regulated activities; by 'structure' e.g. 'bricks and mortar' institutions such as schools; or by setting them out in a list or schedule. The duty could attach to a broad range of institutions e.g. any institution/organisation that has the 'care and control of a child' and this could include sports establishments and scout/girl guiding groups. The duty could attach to a smaller group of institutions, such as those providing residential care for children – this would include residential schools, residential care homes, police and other custodial settings and hospitals.
- b. Another option would be to utilise the institutional definitions that currently exist within statute e.g. using the schedules under Section 11 of the Children Act 2004 (Appendix Two) or limit the institutions to which the proposed duty applies to those set out in Schedule 4 (Part 1) of the Safeguarding Vulnerable Groups Act 2006 (Appendix Three). Victoria (Aus) Parliament has just passed a mandatory reporting law and defines the organisations or institutions as *'an organisation that exercises care, supervision or authority over children, whether as part of its primary functions or otherwise'*.
- c. When considering the nature of organisations to be included in a duty, consideration needs to be given to other relevant organisations which may not fall within the definitions above e.g. religious establishments, entertainment organisations such as the BBC. It is also necessary to consider whether wider definitions would create too great a number of institutions and risk creating so many reports that crucial cases were less likely to be spotted than is the case now.

#### 2. *To which individuals should the proposed duty attach?*

- a. The definition of those mandated to report can go from very narrow to very broad. Taken from the narrowest definition to the broadest definition, the proposed duty could attach to chief executives/leadership/designated child protection officer, or it could attach to employees and volunteers; alternatively it could attach to all nominated persons or everyone connected to the institution.

- b. A further alternative would be to adopt the approach taken in most jurisdictions where a mandatory reporting law exists, by nominating groups of professionals. On the one hand, this approach could be clear about the range of people covered because they could be limited to those who are members of a professional body. On the other hand, focusing on professionals could create different levels of responsibility to report for the same set of circumstances among people working in the same situation.
- c. There are arguments to support the view that unless this duty is placed on every level of the organisation, the failures to report will continue. A duty limited to those in leadership roles could mean that those lower down the organisational hierarchy may not report because they are unlikely to 'own' the duty because it does not attach to them. They may also seek to protect senior managers from the responsibility to report.
- d. On the other hand, there are arguments to support the view that the proposed duty should attach (perhaps initially) only to the heads of institutions and/or the designated child protection lead, as they have the ultimate decision making capacity and are most likely to be concerned about the reputation of their institution. Limiting the duty to this group would also reduce the number of reports by possibly allowing preliminary investigations to be undertaken before an external body is notified.
- e. It is necessary to point out the correlation between the institutions and the designated individuals within the institutions to whom the duty should attach. For example the duty could apply to a narrow group of persons e.g. head of institution/child protection officer within a wider group of institutions; or alternatively the duty could attach to a narrow group of institutions e.g. residential institutions only, but to all linked staff within the broad group of institutions. Each permutation has potential impact on the likely number of reports and the way in which those reports should be handled – e.g. mandating a smaller group would be likely to result in a smaller number of better defined reports but might miss less well defined, but nevertheless significant, concerns.

### **3. *What behaviour should be subject of a duty to report?***

- a. There are different thresholds that could be employed with regards to the proposed duty, drawing from the thresholds used in civil and criminal law.
- b. For example, the duty could apply to circumstances where it is alleged that there is child abuse of a criminal nature. One of the advantages of purposely limiting the allegations to criminal abuse is that this provides clarity, and avoids circumstances where individuals may be criminalised for not reporting acts that are non-criminal in nature.
- c. Another option would be to utilise the thresholds used in the family law context. For example, the duty to report could be triggered when a professional becomes aware that the child is 'at risk of, or likely to suffer significant harm'. One advantage of this approach would be that it would cover a wider range of behaviours than acts that are criminal in nature. However, one of the disadvantages of this approach is that professionals have not always been able to confidently conclude when a child is at risk of, or is suffering significant harm and there may be instances where individuals are criminalised for not reporting behaviour that falls short of criminal behaviour.
- d. Another option would be to limit the duty to particular types of abuse e.g. sexual abuse. Limiting the scope of abuse would keep the number of reports low. However, one can argue that it is undesirable to support a system that creates different reporting mechanisms (and, therefore, different levels of protection for children) for different types of abuse.

#### **4. *Who should be protected by the duty to report?***

- a. In most existing mandatory reporting models, the duty to report is imposed on groups of professionals in relation to abuse of any child. This approach creates a duty that goes beyond the remit of the professional's occupation. This has the advantage of creating uniformity of duty, regardless of the setting. However, it creates the risk of unfairness because professionals would have unique duties in all circumstances, duties that are greater than the general public who may be in the same situation.
- b. An alternative is to limit the children covered by the duty to those suffering abuse within the organisational or institutional setting. The advantage of this approach is that it limits the duty imposed on the mandated groups to their organisational or institutional context. It also reflects the issues that are raised in most known cases of abuse taking place within an institution and not being dealt with properly, allowing abuse to continue.
- c. The disadvantage would be that there would be different standards of obligation placed on mandated reporters and some abused children may not receive protection. However, existing professional duties and statutory guidance would still apply.

#### **5. *What level of knowledge would trigger the proposed reporting duty?***

- a. The level of knowledge required to trigger the duty to report can be placed on a 'continuum' of certainty. The level of knowledge could range from 'known abuse', through 'beyond reasonable doubt', to 'reasonable suspicion' of abuse; alternatively there could be suspicion on a 'balance of probabilities' that abuse is taking place or simply 'any suspicion' that abuse is taking place within the institutional/organisational setting. The higher the level of 'knowledge', the higher the level of proof required and the greater the obstacles to prosecution. The risk at the higher end of the proof range is that a law is ineffective because so few cases reach the evidential threshold. On the other hand, a higher level of knowledge reduces the possibility of a high number of cases overwhelming investigating and prosecuting bodies. At the other end of the continuum, the lower the level of knowledge, the more cases that are likely to be reported which will call into question the level of quality.
- b. A lower level of suspicion also raises the risk of creating so many reports that crucial cases are less likely to be spotted than is the case now. This could be balanced, to some extent, by limiting the role of the person receiving the report to overseeing or directing the reporting body in carrying out investigations, especially where the report contains low quality or unsubstantiated allegations.

## **6. *Whose behaviour should be subject of a duty to report?***

- a. In organisational or institutional settings the proposed duty could cover the behaviour of various groups of people e.g. staff, volunteers and children (peer-to-peer). Consideration should be given to what extent the proposed duty should or could cover the behaviour of people who are linked to the institution e.g. celebrities.
- b. Any model of mandatory reporting would need to offer greater protections to children, who would otherwise be at risk but for the proposed duty. The debate is currently focused on abuse committed by people purporting to work on behalf of an organisation or institution. This raises the question about whether abuse committed by people outside of the institution should be included in a duty to report – e.g. Daniel Pelka’s school had evidence of abuse committed by his parent/carer.
- c. Once again, it is necessary to consider the link between this question and the others posed in this paper. The greater the scope of coverage, the greater number of reports. The more limited the scope, the greater the potential for abuse not to be reported.

## **7. *Is an external reporting mechanism necessary or desirable? How would such a reporting mechanism operate?***

- a. A possible model of mandatory reporting would be to take safeguarding and child protection beyond the current professional regulatory approach. This could operate by obliging reporting into an external body outside of the institution.
- b. A key aim of this duty would be to ensure that allegations of concern promptly escalate up the chain of reporting and eventually move outside the organisation to avoid an ineffective response within the institution/organisation. In particular, the process of reporting to an external body has the added advantage of enabling external oversight and effective action in order to minimise the risk of further offending whilst an investigation takes place. This could facilitate long term cultural change in the way institutions respond to allegations of this nature.
- c. It is important that the process of reporting does not encourage a culture of shifting of risk and responsibility to deal with child protection issues. There needs to be a process that requires reporting but that does not necessarily shift responsibility for action. For any duty to work there needs to be a regulator with a clear mandate to respond to reports made, and provide an effective enforcement mechanism to monitor and ensure compliance with such a duty.
- d. There also needs to be clarity on the timescales for reporting and the timescale for the regulator to respond to reports. This proposed duty would not be effective in the absence of proper training on the scope of the duty and the practical arrangements arising as a result.

## **Some Additional Considerations: Confidentiality and Legal Immunity**

### **Child:**

- a. Confidentiality is an important factor for people seeking help. Research suggests that confidentiality is of crucial importance for children and young people and lack of it may make them reluctant to use services when they need help.
- b. A wider definition of mandatory reporting raises concerns that mandatory reporting would impact on reporting behaviour. It is necessary to consider whether the introduction of an alternative mandatory reporting model, based around institutional duty, could result in children being less reluctant to make disclosures.

- c. The issues around confidentiality are affected by the scope of the offence. If, for example, the duty to report was limited to criminal abuse perpetrated by people employed by an institution, the duty to report under a new law would be very similar to existing duties based on guidance and professional rules. A duty to report abuse below the criminal level and/or outside the institutional setting could impact on the willingness of children to disclose and seek help.

**Reporter:**

- a. In other jurisdictions (where professionals at all levels and/or members of the public have a mandatory duty to report) state legislation can protect confidentiality regarding the reporter's identity and the reporter may be endowed with immunity from legal liability arising from reports made.

## Part B: Roundtable discussion paper

NSPCC is the country's largest child protection charity and we are driven by the wish to make children as safe as possible. A strong culture of safeguarding across all of society is the most important form of protection, and institutions that provide services to children are a pivotal part of that culture. For many years the NSPCC has worked with institutions to improve child safeguarding and protection to enable institutions to 'build in' this type of culture. A balance between building in good practice and prohibiting or punishing poor practice is important. Too much reliance on institutions to set their own safeguarding culture leads to uneven practice, whilst an over reliance on rules and checks leads to box ticking and a lack of personal responsibility for developing a safe environment. The NSPCC recognises the need for legislation, regulations and inspections to reinforce a strong safeguarding culture. There is compelling evidence that existing arrangements have not been sufficient to protect children. Furthermore, change is needed as abuse is happening now in some institutions.

The NSPCC convened a round-table event on the 12th of June 2014 to consider the measures that may be required to ensure that children whose care has been entrusted to an institution are better protected.

This discussion has been prompted by a number of significant cases that have recently come to light where there has been a failure to protect children. Inquiries into cases of abuse in settings such as hospitals, schools and child detention facilities in the UK show that, in many incidences, individuals were aware that child abuse may have been happening but failed to take effective action to protect children. The professionals at the roundtable event explored whether the current child protection requirements on individuals or institutions are adequate and whether there should be an additional duty to report abuse. On the issue of reporting abuse, the discussion explored the benefits, risks and implications of introducing a form of strengthened reporting duty.

### Risks of Universal Mandatory Reporting.

There was an introductory discussion, with the benefit of academic expert input from Laura Hoyano, Associate Professor in Law and Senior Research Fellow of Wadham College, University of Oxford, which set out the current models of mandatory reporting that exist in some jurisdictions of the world (notably all US states, some Australian states and all Canadian provinces). The evidence from these jurisdictions indicates that there are significant risks with the 'universal models' which impose a duty to report on groups of professionals and, in some jurisdictions, all members of the public. Furthermore, the available research is not able to conclude whether universal mandatory reporting resulted in professionals reporting concerns that they would not have reported save for the mandatory duty to report. The introductory discussion highlighted the risks, concerns and unintended consequences of universal mandatory reporting and these are summarised in Appendix One of this document. For reference, Laura Hoyano's presentation slides are provided in Appendix Two. The expert's view was not supportive of universal mandatory reporting, in light of findings from research; but was supportive of considering a form of strengthened reporting duty within institutions that have the care and control of children.

The introductory session moved on to explore the expert's view on the potential for a form of mandatory reporting of suspected abuse taking place by those linked to institutions. The expert's view was that the emerging evidence on the dynamics of institutional settings with care and control of children (conflict of loyalties, position of dominance over a child, abuser's association with the institution) require consideration of the role of mandatory reporting in these institutions. Ms Hoyano finds that the emerging evidence suggests that there should be a legal liability for people who fail to report concerns about someone linked to the institution to someone/a body outside the

institution. This duty to report would be underpinned with an external monitor with the right expertise to filter, investigate and lead decision making, including whether the police should be contacted.

MsHoyano clarified the position regarding professionals' concerns about being vulnerable to litigation for reporting. There is case law holding that professionals have protection from civil liability in defamation due to making reports. Although professionals may be liable for professional negligence for making wholly unfounded reports, it is unlikely that the courts would find that the professional breached the standard of care required by the law if there was some basis for suspicion of abuse and would support a professional's judgment which erred on the side of caution in calling in the child protection authorities. In Canada this has been interpreted as extending to immunity from complaints by aggrieved individuals to professional regulatory bodies. Ms Hoyano noted that the undeniable advantage of reporting statutes was the clear statement that good faith reports made under the statutory cloak would attract immunity from any form of liability. There was consensus amongst the delegates that such a clear statement of the law would be helpful to those under a professional or legal obligation to report suspected abuse.

### **Analysis of the current structure of child protection in institutions:**

The discussions around the table reflected that any duty to report would only be one aspect of the wider package needed to enable robust child protection for children in the care of institutions. Discussions reflected that other measures such as professional guidance, inspection regimes and statutory guidance are just as important and should be reinforced where found wanting.

Discussions reflected that pulling together relevant legislation and statutory guidance regarding the reporting of abuse by professionals is complex. The legal status on which primary legislation and statutory guidance is predicated is unclear. There is urgent need for assistance and clarity in consolidating the relevant policies and guidance in this context. For example, delegates discussed the challenge of trying to ascertain whether a head teacher would face legal liability for allowing a person suspected of abuse to remain in the institution and continue to have access to children.

On Disclosure and Barring procedures, delegates reflected that whilst these are necessary and helpful, they may not always become operative at the time intervention is required and come into effect long after incidents have arisen. Delegates reflected that inspection regimes focus on procedural and administrative aspects and could be more effective at considering whether institutions are safe places for children from a safeguarding perspective. It was also noted that compromise agreements resulting in a staff member voluntarily leaving or being moved to a different post could, and have, resulted in a failure to disclose under the current legislation and has placed children at risk.

### **How could a mandatory duty to report work in the UK?**

The delegates recognised that a mandatory reporting duty should only augment the current existing arrangements; it is not an alternative to the existing arrangements and it cannot replace these arrangements. However, the delegates acknowledged that cases such as Savile, and more recently abuse at Chetham's School of Music and the Royal Northern College of Music, suggest that more may be needed over and above guidance, training and a change of culture.

The delegates' discussions highlighted and refined the issues that the roundtable was seeking to solve. The issues identified focused on the perceived conflict of interest that arises following an allegation of abuse; specifically the perceived conflict of interest between reputational damage to the institution and protection of the child. The delegates identified additional features of institutions which exacerbate the risks including the abuser's association with the organisation, institutional position of dominance and isolation over a child, attempts to conceal and/or cover up allegations and inaction or inadequate action following disclosure of abuse.



The next section summarises the discussions of the group in response to the questions posed in the briefing paper.

### Questions for discussion

1. To which organisations and/or institutions should the proposed duty apply?
2. To which individuals should the proposed duty attach?
3. What behaviour should be subject of a duty to report?
4. Which individuals do we aim to protect under the proposed duty?
5. Whose behaviour should be subject of a duty to report?
6. What level of knowledge of abuse would trigger the proposed reporting duty?
7. Is an external reporting mechanism necessary or desirable? How would such a reporting mechanism operate?

### Discussion

#### **1. To which organisations and/or institutions should the proposed duty apply?**

Delegates identified that the nature of institutions can cause professionals within to ‘close ranks’ and take a defensive approach when allegations of abuse are made that may be damaging to the institution. The discussion highlighted that institutions can be ‘closed’ in the psychological sense, in that they respond to damaging allegations with denial and/or defensive behaviour. In this sense, even institutions subject to external inspection such as schools and health care facilities can be considered ‘closed’. Fear of authority and hierarchical structures were identified as other features which can hamper information sharing in institutions.

The delegates discussed the definition of institutions in other jurisdictions. For example, in Victoria, Australia the definition of institutions for the purpose of their legislation is ‘...an organisation that exercises care, supervision or authority over children, whether as part of its primary functions or otherwise’. Using that example, delegates questioned whether there was any institution which would not be covered i.e. they perceived the definition in this piece of legislation to be wide. Concerns were expressed about the risk of overwhelming the system if a mandatory reporting system is introduced using a similar definition, given the large number of institutions that hold care and control of children (e.g. churches, schools, beavers/cubs/scouts, sports clubs etc.).

In response, it was suggested that the discussion around the narrowing or broadening of the defined institutions should not be resource-driven. Another view was that it might be easier to focus on the behaviour that we are seeking to prevent including concealing abuse and/or inaction following disclosures of abuse by individuals linked to institutions.

*The general view was that it would be difficult to narrow the range of institutions. .*

#### **2. To which individuals should the proposed duty attach?**

The definition of those mandated to report ranges from the very wide (universal mandatory reporting where the duty attaches to professional groups or all members of the public) to the narrow (where the duty would attach to certain role-holders within particular organisations). In the former example, the duty could attach to specific groups of professionals e.g. health and education professionals only. This discussion also flagged up organisations where staff do not necessarily have professional obligations to report e.g. youth clubs etc. In the latter category, it could attach to certain levels of professionals e.g. institutional heads and leaders such as chief executive officers



and/or child safeguarding officers. The roundtable discussion did not explore in any depth the option of duties attaching to certain levels of professionals e.g. heads of institutions and/or chief safeguarding officers.

The first option discussed was the universal model of mandatory reporting. In this option, the duty to report, at its widest, attaches to everyone in every context i.e. all professionals and/or all members of the public. This model of mandatory reporting was discounted as an option in light of the significant number of disadvantages and unintended consequences highlighted by the research evidence.

The roundtable raised the potential for a defence that averted liability, provided that the institution had in place proper organisational policies and guidelines, but more importantly that the mandated reporter had complied with these policies and guidelines. This would have the advantage of ensuring institutions had effective and compliant safeguarding policies. The roundtable recognised that many organisations to which a wide duty might apply may lack policies and procedures which are sufficient for this purpose. The potential advantages and pitfalls of such a defence were not fully discussed at this session.

The role of criminal corporate liability was raised. How criminal corporate liability may influence the culture, ethos and response of institutions merits further investigation.

The issue of to whom the duty would attach has a significant bearing on the different mandatory reporting options. The discussions appeared to favour a broader group of people being mandated, with optimism about the potential for a statutory defence to filter out the cases where there has been compliance with policy and guidance.

*There were options on which individuals the proposed duty should attach that were suggested and discussed at the roundtable but no consensus was reached.*

### **3. What behaviour should be the subject of a duty to report? or What behaviours would be covered by a duty to report?**

The delegates agreed that the abusive behaviour subject to the duty to report should be all kinds of abuse, including physical, sexual, psychological, emotional abuse, and neglect (including abuse in online settings). A delegate considered whether neglect would fit within the scope of such a duty. Discussions were had about examples of neglect within institutions e.g. staff neglecting patients in a children's hospital. The view that the duty to report should only apply to sexual abuse (e.g. Victoria, Australia) did not receive support from the delegates.

*Overall, the delegates could not see any justification for different reporting requirements depending on the type of abuse and they agreed that all kinds of suspected abusive behaviour should be subject to the duty to report.*

### **4. Who should be protected by the duty to report?**

The general thrust of discussions was that the proposed duty should focus on children under the care and/or control of the institution who are at risk of abuse by those within the institution or those linked to the institution. The duty would still apply where abuse occurred outside the physical premises of the institution provided that its functions enable the suspected abuser to have access to children. This approach would limit the duty to the institution. A delegate raised the issue of online spaces which blur institutional boundaries and this needs to be factored into the thinking in this area.

*There was broad consensus that the proposed duty should focus on children under the care and/or control of the institution who are at risk of abuse by those within the institution or those linked to the institution.*

## **5. What level of knowledge would trigger the proposed reporting duty?**

The discussions recognised that the level of knowledge required to trigger the duty to report can be placed on a 'continuum' of certainty.

Delegates discussed a level of knowledge from '...making a conscious and wilful decision not to report where there was an absolute knowledge of risk...' to failing to report a 'known pattern of abuse.' Reference was made to thresholds in civil law and examples were given e.g. 'balance of probabilities' or 'reasonable suspicion' or 'suspicion on reasonable grounds'. Another example that was referred to is the current definition in the Victoria legislation i.e. 'reasonable belief', but the drawback to that formulation would be that the mandated reporter would have to believe that the allegation was true before being affixed with the duty. The delegates discussed the challenges where professionals 'feel' that something is wrong and/or where it is the child's behaviour rather than what the child verbally discloses that suggests abuse has taken place.

*The discussions on the level of knowledge that would trigger the reporting duty were varied. No consensus was reached. Further detailed exploration is required to refine the level of knowledge required to trigger the proposed duty to report. This refinement is necessary as it has a direct impact on the number and quality of referrals and reports made.*

## **6. Whose behaviour should be subject of a duty to report?**

The delegates' discussions were focused on individuals linked to institutions that have care and/or control of children including professionals, staff, volunteers and independent contractors linked to that institution e.g. music and swimming instructors. There was consensus that the proposed duty should exclude parents/carers as the conflict of interest is not at play in these situations and professionals should follow existing policies and procedures. The individual's behaviour that would be subject to a duty to report was described as follows: "...it is about an adult reporting on another adult..." or professionals reporting on other adults who are individuals linked to institutions "...the focus [of the discussions] has been on reporting on a colleague..." A delegate identified that the problem with limiting it to 'a colleague' was that this definition would exclude people like Jimmy Savile. It was said that the proposed mandatory reporting offence should aim to address the issues that have arisen in cases that have recently come to light including cases that involve suspicion of concealment.

It was suggested that the people whose behaviour should be subject to a duty to report should be individuals carrying out functions as a result of their links to an institution with care and control of children. A delegate pointed out that individuals should be subject to a duty to report, even where incidents occur off the premises of an institution (e.g. school trip etc), in light of the fact that it is the institution that has enabled access to the child.

A delegate raised the issue of peer-to-peer abuse and highlighted the fact that this can occur where the culture of the institution allows it to happen and there is a lack of professional challenge.

*The broad consensus was that the duty should focus on individuals linked to institutions that have care and/or control of children including professionals, staff, volunteers, and independent contractors. The discussion clarified that the reporting of abuse of a child, committed by persons not linked to the institution e.g. parents/carers, was outside the scope of the discussion (unless they are undertaking functions or activities on behalf of the institution).*

## **7. Is an external reporting mechanism necessary or desirable? How would such a reporting mechanism operate?**

There was limited time to discuss this question. However the delegates' discussions throughout the round table identified the conflict of interest within institutions (especially 'closed' institutions) and

the crucial role that could be played by an external monitoring body in triaging and/or investigating referrals made from within organisations with care and control of children.

*Although there was limited time to discuss this question, the broad view was that there was support for further consideration of whether an external monitor with the right expertise to filter, investigate, lead decision making could provide an enforcement mechanism.*

## Part C: Summary and Next Steps.

Understandably within the scope of four hours discussion at the roundtable the delegates were not able to reach conclusive positions on the framework for a proposed duty. However, the focus of the discussions provided helpful insights into the issues from different stakeholder perspectives which prompt the need for further analysis.

The round table refined the problem that the proposed duty would aim to address:

- the conflict of interest between reputational damage and protection of the child.
- That the context should be limited to institutions that have care and/or control of children
- That there are additional features of institutions that exacerbate the risks i.e. the abuser's association with the organisation, institutional position of dominance and isolation over a child, attempts to conceal and/or cover up allegations and inaction or inadequate action following disclosure of abuse.
- that any proposed duty should be limited in scope and targeted to avoid the risks and unintended consequences of the universal mandatory reporting model. At present, internationally, there does not appear to be any jurisdiction that has a narrowly defined mandatory reporting system in place.

The delegates were able to reach broad consensus on the following questions that were discussed:

- The institutions to which the proposed duty should apply - The general view was that it would be difficult to narrow the range of institutions but more discussion is needed.
- The behaviour that should be subject to the duty to report - Overall, the delegates could not see any justification for different reporting requirements depending on the type of abuse and they agreed that all kinds of suspected abusive behaviour should be subject to the duty to report.
- Who should be protected by the duty to report - There was broad consensus that the proposed duty should focus on children under the care and/or control of the institution who are at risk of abuse by those within the institution or those linked to the institution.
- Whose behaviour should be subject to a duty to report - The broad consensus was that the duty should focus on individuals linked to institutions that have care and/or control of children including professionals, staff, volunteers, and independent contractors. The discussion clarified that the reporting of abuse of a child, committed by persons not linked to the institution e.g. parents/carers, was outside the scope of the discussion (unless they are undertaking functions or activities on behalf of the institution).

Consensus was not reached or there was not time for detailed discussions on the following issues:

- The level of knowledge that would trigger the reporting duty.
- The individuals to whom the proposed duty should attach.
- The external reporting mechanism.

Delegates at the roundtable raised additional issues and possible options which merit further exploration including:

- There is a need for clarity on whether the issue that we seek to address is the alleged cover up of abuse within institutions or the failure to report concerns
- Whether or not criminal corporate liability would positively influence the culture, ethos and response of an institution?

- The option of a statutory defence.
- Whether the duty to report applies irrespective of whether the source of the risk is an adult or a child (e.g. in the situation of peer to peer abuse)

There is need for further exploration and discussion of the matters considered and raised at the roundtable between the government and relevant stakeholders, particularly given that a duty to report would only be one aspect of a wider package of child protection for children in the care of institutions.

The group agreed that they could see a role for a form of strengthened reporting duty, as outlined above, to help protect children, but more work is needed to ensure that a model achieves that whilst minimising unintended consequences.

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## APPENDIX ONE: SUMMARY OF RISKS, CONCERNS AND UNINTENDED CONSEQUENCES OF UNIVERSAL MANDATORY REPORTING

The introductory discussion highlighted the risks, concerns and unintended consequences of universal mandatory reporting, as summarised below:

- Evidence suggests that the universal model can create a significant increase in the number of reports to statutory agencies. This leads to diversion of resources from provision of support and services, into assessment and investigation. Linked to this is the risk that children who are being abused or at risk of being abused are less likely to be identified and helped than they were before.
- Universal mandatory reporting does not guarantee effective child protection and creates a false sense of security. It has resulted in child protection work forces placing greater focus on investigation at the expense of safeguarding. There are high percentages of unsubstantiated reports in countries such as the USA and parts of Australia (approximately 78%). High levels of unsubstantiated reporting does not necessarily mean that the reports were wrong; abuse may have taken place.
- Prosecutions for non-reporting are low and in some countries there have been no prosecutions e.g. Canada. Despite universal mandatory reporting laws there are significant instances of abuse within settings in the USA, Canada and Australia with inquiries ongoing at present.
- Universal mandatory reporting may deter victims from seeking help for example from sexual health clinics due to concerns about confidentiality and/or being catapulted into the criminal justice system without their consent or proper preparation. Universal mandatory reporting may also deter families from revealing abuse in order to seek help.
- There is evidence that children value the opportunity to disclose abuse and want to remain party to the decision to officially report the abuse. Removing their right to involvement in the decision making process, for older children, could have perverse consequences.

*Mandatory  
reporting:  
A grand gesture --  
But with perverse  
consequences?*

**Laura Hoyano  
Wadham College, Oxford  
NSPCC 12 June 2014**

## (1) The 'Pontius Pilate' effect

- After a report has been made, those surrounding the child, including neighbours, teachers, and health professionals, relax their vigilance
- (Erroneous) assumption that the 'experts' (police, social services) will protect the child once they are notified [(eg *X v Beds CC* (HL 1995)]
- MR laws = merely a reporting system, not intervention!
- Overwhelmed social services raise the barriers to investigation eg Victoria (Aus) 1992-93: 92% of notifications investigated
- → 1993 MR introduced → 1999-2000: only 40% investigated
- Health professionals spend more training time on how to protect themselves from criminal liability for failure to report than on how to detect, protect and treat children at risk (US Institute of Medicine, 2002)



## (2) Child Protection Providers become Investigators not Safeguarders

- Welfare concerns are treated as allegations of wrongdoing from the outset, without assessment of need for support services
- A tidal surge of allegations:

US: MR in all states & territories [Federal Child Abuse Prevention and Treatment Act (1974)]

- 2010: ca. 3.3 million reports to child protection agencies

*US Govt, Administration on Children and Families, 2003:*

- 1/8 of reports are screened out without investigation
- 2/3 of investigated reports are never substantiated
- substantial proportion of validated reports do not result in any services for the child
- “an enormously successful calamitous system” [Melton (2005)] which has caused “chronic and critical multiple organ failure” within the child protection system [US Advisory Board on Child Abuse and Neglect, 1990]

## (2) Investigators not Safeguarders

### Australia

#### **New South Wales:**

- >10% of children in entire population referred by age 5 – >190,000 referrals p.a. [NSW Department of Community Services (2005)]
- **78.7%** of notifications **unsubstantiated** (1999-2000: Ainscough, 2002)

**Queensland:** “an unsustainable increase in reports” from mandated reporters [Queensland Child Protection Commission of Enquiry, 2013, p. 22]

- Only 4,359 of 114,503 reports substantiated on investigation (2011-12)
- **Fewer than ¼ of reports met the threshold for notification** (“reasonable suspicion that child in need of protection”)
- **78% of investigated reports concluded that the child’s safety was not at risk so no follow-up action** (Queensland Child Protection Commission of Enquiry, 2013: “... The over-reporting of children to Child Safety Services is inefficient, not to mention damaging to those families who are being unnecessarily reported.”)

#### **Western Australia:**

- NO MR laws
- **Same period as NSW: only 55.8% of notifications were unsubstantiated**
- Mandatory reporting rejected by the Government as counter-productive in 2002 (research study by Harries & Clare, 2002)

### **(3) Victims are deterred from seeking help from mandatory reporters**

- E.g. sexual health clinics, sexual assault crisis centres, child helplines, health professionals, schools, counsellors, community workers
- Children may want intervention, protection and/or treatment, not criminal prosecution – the abuser deprives them of autonomy and choice, and the law should not do the same by making their secrets public against their wishes (obviously subject to any concerns about other children at risk).
- Children are catapulted into the criminal justice system without proper preparation whereas adult victims are given the time they wish.
- investigations are foiled where children cannot be persuaded to cooperate
- SO: mandatory reporting regimes can harm (1) the child's well-being and recovery and (2) evidence-gathering for eventual prosecution [Hoyano & Keenan *Child Abuse Law and Policy across Boundaries*]

## **(4) Families and offenders are deterred from seeking help**

- US: implementation of MR resulted in a dramatic decline in offenders' revelations of child sexual abuse (Berlin, Mallon & Dean, 1991)
- Loss of confidentiality: health and social care professionals perceived as prosecutors not therapeutic supporters
- Stigmatisation, not assistance
- Disruption in any treatment already underway
- Disruption to the family
- Compare Low Countries: new assurances of confidentiality increased families' self-referral for help (Marneff 1997)

## Paucity of prosecutions against non-reporters

- Extremely few criminal prosecutions in all jurisdictions with mandatory reporting
- US & Canada: MR laws primarily used in support of civil negligence actions to set up the duty to act
- Problem of choosing **whom** to prosecute, especially in jurisdictions with universal reporting laws
- Has not prevented cover-ups of institutional abuse, e.g. in clerical and residential school/care settings in **all** jurisdictions with MR laws

# Conclusions

- “overwhelming evidence that mandatory reporting systems are in chaos worldwide” (Harries & Clare research report commissioned by Western Australia Child Protection Council, 2002)
- Criminalising the public for failing to act is not the answer
- Professionals are already accountable:
  - to children (but not parents) in tort law [*JD v East Berks*]
  - to children and parents in human rights law [ECHR Art 8] and
  - to their professional disciplinary bodies.
- **NO empirical evidence linking mandatory reporting with reduction of either child maltreatment or child deaths** [Ainsworth (2002), Harries & Clare (2002), NSPCC (2007, 2012)]
- considerable empirical evidence that MR is counter-productive, consuming scarce resources on futile investigations and diverting police from major investigations such as child trafficking, and social workers from providing child protection services

## One clear benefit of MR statutes

- Statutory confirmation that good faith reports of concerns about a child's welfare to the police or social services are **immune from criminal or civil liability**
- In some jurisdictions provision has been held to prevent complaints to professional regulatory bodies for having reported suspect abuse to the authorities

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