MANDATE NOW REVIEW OF THE KEY RECOMMENDATIONS MADE IN THE FINAL REPORT OF THE INDEPENDENT INQUIRY INTO CHILD SEXUAL ABUSE

IICSA's final report was published 20.10.22

Abstract

IICSA's inquiry has clearly identified the many challenges that impact the protection of children within institutional settings It's recommendations mostly fail to address them

Mandate Now

6.2.23

Reviewed recommendations and page number.

Child sexual abuse	
B.1**: Introduction**	
1. Children are sexually abused every day in England and Wales.	
1.1. According to the Office for National Statistics (ONS), an estimated 3.1 million adults in England and Wales have been sexually abused before the age of 16.	
1.2. One estimate suggests that the number of children abused in a single year is around 500,000.	If there are 12.7m children in UK (see para 2 below) this suggests that the proportion abused *each year* is approx. 4%.
1.3. Other estimates suggest that around 1 in 6 girls and 1 in 20 boys are sexually abused before the age of 16.	A research article dated 31 Jan 2017 : Reports of child sexual abuse of boys and girls: Longitudinal trends over a 20-year period in Victoria, Australia, revealed that almost as many boys as girls are sexually abused. This only came to light more recently as a result adult disclosures of child sexual abuse which in part predated the 2005 introduction mandatory reporting in the State. The article prompts serious questions about the Government relying on the UK 'guesstimates' of child abuse in England and Wales.

1.4. Over 7,000 children were referred to sexual assault referral centres (SARCs) in England during 2020/21, 20 percent more than in the previous year. This equates to nearly 20 referrals each day. Half of these referrals were for children aged 14 to 17, five out of six of whom were female.	If the estimate of paragraph 1.2 is accurate, then only 1.4% of abused children each year are being referred whether as a result of members of staff referring a concern or on the rare occasions when children disclose abuse to a member of staff.
1.5. There has also been a significant rise in online-facilitated child sexual abuse in England and Wales, as well as globally, and in the estimated number of perpetrators who pose a sexual risk to children.	
2. As the Inquiry has noted in its investigation reports, the true scale of offending and the number of children abused are likely to be greater than is presently known. Limitations with current methods of data collection have hampered the Inquiry's ability to conduct a realistic assessment of how many of the 12.7 million children in England and Wales have been sexually abused, or are at risk of sexual abuse, by whom and in what settings. The current data do not distinguish between familial abuse and abuse committed in an institutional context (the latter being the focus of this Inquiry). Little is known about the ethnicity of victims and survivors and perpetrators.	This once again reveals the absence of data which we have repeatedly brought to the attention of IICSA.

3. As set out in the UK government's Tackling Child Sexual Abuse Strategy (2021):	We reviewed this initiative in October 21. The article is available here : Home Office: Tackling Child Sexual Abuse Strategy 2021 | No strategy, few proposals and little money
"Over 83,000 child sexual abuse offences (including obscene publications) were recorded by police in the year ending March 2020, an increase of approximately 267% since 2013.	
Of these, around 58,000 would be considered contact offences, which have increased by 202% in the same period."	Again, if the 500,000/year estimate of paragraph 1.2 is accurate, only 11.6% of contact CSA is even getting recorded.
The Strategy recognised that these figures do not include certain sexual offences committed against 16 and 17-year-olds, such as rape, as well as sexual assault committed against children over the age of 13. As an indication, the Strategy noted that exploratory data published by the ONS in January 2020 suggested, where it was possible to identify that the victim or survivor was a child, that there were approximately 73,200 child sexual abuse offences for the year ending March 2019.	This brings the figure up to 14.6%, or about 1 in 7. This accords quite closely with the estimate in the research published by the Office of the Children's Commissioner for England in 2015.
4. This significant gap in understanding the scale of child sexual abuse impacts detrimentally on the ability of statutory agencies and other institutions to respond comprehensively to the level and nature of the threat to children. Different forms of child sexual abuse require different institutional responses. The Inquiry therefore recommends improved data collection by key statutory agencies.	It also suggests that these agencies would be severely under-resourced to cope with the true scale of CSA if the majority of cases actually came to light at the time.
B.2: **The nature and characteristics of child sexual abuse**	

5. In addition to the accounts recorded in Victims and Survivors' Voices, the Inquiry heard evidence of the sickening, painful and degrading sexual abuse of children. Each of these acts is a crime. Chief Constable Simon Bailey, at that time the National Police Chiefs' Council Lead for Child Protection and Abuse Investigations and now retired, told the Inquiry that the police were encountering:	
"levels of depravity that are – if they could get worse, are getting worse. We are seeing babies being subjects of sexual abuse."	
6. Some victims were forced to repeatedly perform sex acts, including acts of mutual and group masturbation, or were sexually assaulted and raped as forms of humiliation. Sexual abuse was often accompanied by extreme violence and acts of sadistic nature.	
7. As the UK government's April 2019 Online Harms White Paper observed, "The sheer scale of CSEA [child sexual exploitation and abuse] online is horrifying". Some child sexual abuse is live streamed. The sums paid to watch and, in some cases, to direct live streamed sexual abuse of children can often be trivial, facilitating the engagement of would-be offenders in child sexual abuse on a significant scale. One seven-year-old victim in the Philippines was paid US$6 to perform online sexual acts on a webcam for foreigners three times a day. The Inquiry is also aware of a case where a perpetrator paid just 93 pence to watch a girl being sexually abused.	
The impact of sexual abuse	
8. Some children experience acute physical injuries, often, but not exclusively, as a result of penetrative abuse. Sexually transmitted infections and pregnancy are an additional risk to an abused child's health.	

9. Victims and survivors also experience emotional distress, including fear, anger, sadness and self-blame, manifesting itself in panic attacks, flashbacks, anxiety and signs of posttraumatic stress disorder. Some engage in self-harming behaviours, such as cutting, hitting and burning their bodies. Some children were so distressed that they tried to take their own lives. Longer-term physical and mental health problems were also common, impacting upon an individual's quality of life. Depression and anxiety disorders were particularly prevalent. There are often difficulties developmentally (including educational achievement and prospects on the labour market) and in relationships (both familial and later in life). Some victims and survivors adopted coping mechanisms as a way of dealing with the impacts of the abuse, some of which were disruptive or harmful.	**The economic and social cost of contact child sexual abuse -** Published 13 December 2021 | Home Office. There are many reasons to question the 'estimated' cost of child abuse not least the nonexistence of child abuse data reported by IICSA.
Key characteristics	
10. While there is no stereotypical victim of child sexual abuse, there are a number of characteristics that may make some children more vulnerable to sexual abuse. These include age, sex and ethnicity, which are examined further below.	
11. There are also a number of other characteristics that may make some children more vulnerable to sexual abuse.	
11.1. Those who had experienced childhood neglect were nearly five times as likely to have experienced child sexual abuse as those who had not.	

11.2. Surveys also suggest that children who lived in a care home were nearly four times as likely to have experienced child sexual abuse. As at March 2021, there were 80,850 children in care in England and 7,263 children in care in Wales. Children in care are some of the most vulnerable children in society, due to both the experiences and situations that led to them being placed in care and certain factors associated with being in care, such as going missing from care and being placed a long way from home. As set out in the Child Sexual Exploitation by Organised Networks Investigation Report, in England in the year to March 2018, child sexual exploitation was identified in 3,160 assessments for children in care. This equated to 16 percent of all the assessments which identified child sexual exploitation.	The suspicion is that there are wholly inadequate resources of people and funding to properly look after children in care.
11.3. In surveys, disabled participants were twice as likely to describe experiencing child sexual abuse as non-disabled participants. Of those who participated in the Truth Project, a higher proportion of individuals who reported other forms of abuse and neglect were disabled. As noted in the Inquiry's Child Sexual Exploitation by Organised Networks Investigation Report, research indicated that children with disabilities were at an increased risk of being sexually exploited.	Key example of this was Stony Dean in Amersham in Bucks. An unidentified perpetrator at the setting hired another man who shared his interest. The Head and Deputy Head were sanctioned. **Once again, a Local Safeguarding Children's Board failed to investigate the extent to which the safeguarding framework inhibited or facilitated the reporting of concerns of abuse**.
11.4. Research indicates that children who are lonely or socially isolated may be more likely to be targeted, whether online or offline, by perpetrators. In relation to online offending, children who are exploring their sexuality, particularly LGBTQ+ children, may also be more vulnerable to abuse.	The overall story of 11.1 to 11.4 is that abusers often go for easy targets: disability, neglect (including by the state towards those in care) and social isolation. Identify and protect those easy targets and much abuse can be prevented.
Sex	

12. Both girls and boys can be victims of child sexual abuse. The data show that a greater proportion of victims are girls, but there is evidence to suggest that boys may be less likely than girls to report sexual abuse in childhood. In the year ending March 2021, of those children on child protection plans in England under the primary category of sexual abuse, 59 percent were girls and 41 percent were boys. Police recorded crimes for the same period showed that the number of rapes and sexual assault offences of under 13s recorded on girls far exceeded the same offences against boys. The Truth Project data recorded that 70 percent of victims and survivors were females. In relation to reported online-facilitated child sexual abuse, girls are more likely to be the victims.	As already stated in our commentary in 1.3, the pronounced difference between the abuse of boys and girls that is repeatedly used in this and other countries, should be revisited in light of the 20-year longitudinal study undertaken in Victoria. The child abuse crisis could well be far greater than is currently acknowledged.
13. The overwhelming majority of evidence heard by the Inquiry related to male perpetrators of child sexual abuse. Male perpetrators featured in 89 percent of accounts given to the Truth Project and studies examined by the Inquiry's Rapid Evidence Assessment found that perpetrators of online-facilitated child sexual abuse are "mostly men". This accords with official data showing that, where the sex of the alleged perpetrator was recorded, most individuals convicted of child sexual abuse (98 percent) were males.	
14. In its 2021 annual report, the Internet Watch Foundation (IWF) noted that where an offender is visible in child sexual abuse material "they are most often a man". However, over the course of a two-month study in 2021, the IWF analysed the prevalence of female perpetrators in child sexual abuse material seen by the IWF. It encountered images showing a female abuser "on average 13 times per working day. In half of the images and videos (49%) showing a female abuser, she was abusing a boy".594	
Age	
15. Children of all ages are at risk of abuse but younger children are at greater risk, as shown below.	

15.1. For participants in the Truth Project, 79 percent of the victims and survivors were aged 11 or under at the time the abuse began.

Table B.1: ***Truth Project data – age of the victim and survivor when sexual abuse began***

0–3 years old	12%	686
4–7 years old	35%	1,936
8–11 years old	32%	1,745
12–15 years old	18%	1,006
16–17 years old	2%	116
Total		**5,489**

Source: See data compendium to this report

It is worth comparing this table against the much-touted change in the law backed by the NSPCC, extending the definition of "position of trust" to include faith group leaders and sports coaches, making it illegal for them to have sex with children over the age of 16. **This improves the protection to 2% of abused children currently and these referrals to the local authority, of the police in appropriate circumstances, remain entirely discretionary.**
https://learning.nspcc.org.uk/research-resources/briefings/preventing-abuse-positions-of-trust

15.2. This is also reflected in the age ranges of those children in England in the year ending 31 March 2021 who were placed on child protection plans because they were judged to be at significant risk of sexual harm. A child protection plan is a written record for parents, carers and professionals which sets out how the child's welfare will be checked, what changes are needed to reduce the risk to the child and what support will be offered to the family.

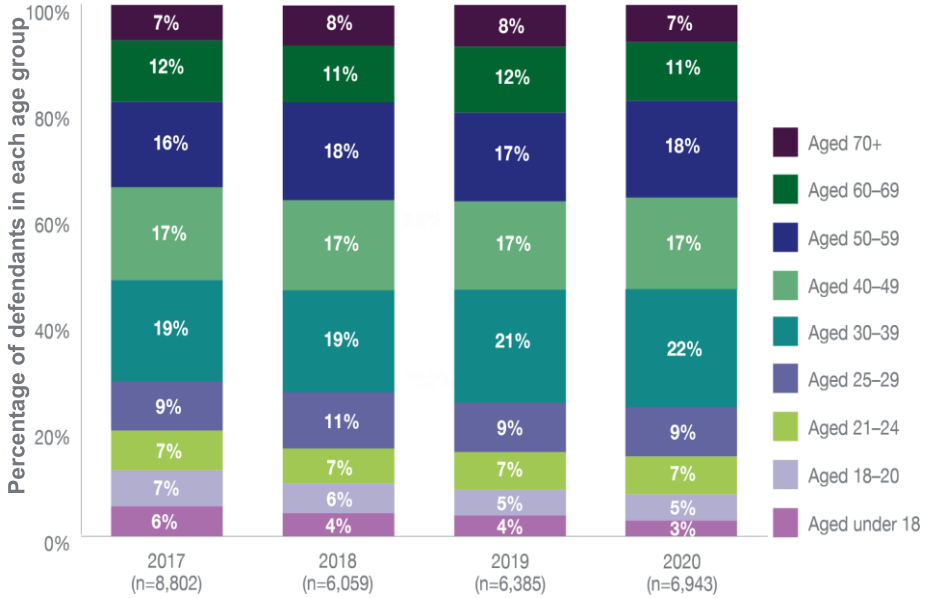
Table B.2: ***Department for Education data – age of children on child protection plans at significant risk of sexual harm, in the year ending 31 March 2021***

0–4 years old	26%	510
5–9 years old	27%	520
10–15 years old	39%	750
16–17 years old	8%	150
Total		**1,930**

Source: See data compendium to this report

16. Online-facilitated abuse involves ever younger victims. Some online sexual abuse forums require the perpetrator to prove that they have access to or can produce newly created child sexual abuse material. One site on the dark web required its subscribers to upload 20 newly created images of child sexual abuse or a two-minute video of infant or toddler abuse, each month.

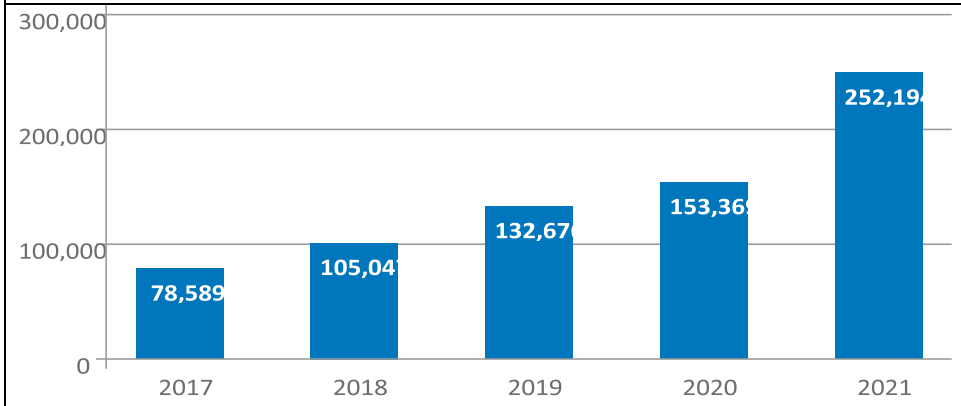
17. In relation to other forms of child sexual abuse, some child sexual abuse offences specifically refer to a 'child under 16' or a 'child under 13' and so it is possible to ascertain the number of police-recorded offences involving children under those ages, as discussed below. However, the data do not provide the age of the victims at the time of the sexual abuse.

18. Statistics recording the age of perpetrators are primarily based on criminal justice agency data which record the age of defendants proceeded against for child sexual abuse offences (Figure B.1). As demonstrated, the number of adult defendants in each age bracket has remained consistently stable. However, the data do not identify the age of the defendant at the time of the commission of the offence, which is a key consideration when analysing trends in cases of both recent and non-recent child sexual abuse. The data also suggest that a relatively low proportion of those defendants were aged under 18.	The last sentence cannot be shown to be true, since the perpetrator age at the time of commission is not recorded, and we know that there is often a long delay before the victim comes forward to report the abuse.
 **Figure B.1:** ***Defendants proceeded against for child sexual abuse offences, by age, 2017–2020, England and Wales*** *Source: Child sexual abuse in 2020/21: Trends in official data, Centre of Expertise on Child Sexual Abuse, p32*	
Ethnicity	

19. Accurate data on the ethnicity of victims and perpetrators play an important part in enhancing understanding of child sexual abuse and the context in which such abuse occurs. The data assist the relevant statutory agencies to target resources appropriately, including, for example, enabling the police to engage with communities where child sexual abuse and child sexual exploitation occur. Victims and survivors may require culturally sensitive support from the statutory authorities.	
20. However, data recording the ethnicity of victims and survivors are not easily available. As set out in the Inquiry's Child Sexual Exploitation by Organised Networks Investigation Report, there were "widespread failures" to record data about the ethnicity of victims in six case study areas, resulting in the police and other agencies being "unable to identify local patterns and trends of child sexual exploitation in respect of ethnicity". The CSA Centre notes that "it is common for children's ethnicity not to be recorded in agency data".	
21. Data relating to the ethnicity of perpetrators are also lacking. In the Inquiry's Child Sexual Exploitation by Organised Networks Investigation Report, the six case study areas also failed to properly record the ethnicity of perpetrators:	
"Many of the high-profile child sexual exploitation prosecutions have involved groups of men from minority ethnic communities. This has led to polarised debate about whether there is any link between ethnicity and child sexual exploitation networks. Poor or non-existent data collection makes it impossible to know whether any particular ethnic group is over-represented as perpetrators of child sexual exploitation by networks."	The danger of this is that in the absence of comprehensive data, anecdotal data can be cherry-picked to suit almost any political purpose, and the lack of data can be claimed to be a cover-up to prevent the supposed "fact" of a particular minority's over-representation coming to light.
22. Analysing any pattern or trends in respect of the ethnicity of victims and survivors or perpetrators is difficult due to the paucity of this data. As considered further below, the government recognises that current methods of data collection are "inadequate" and that:	

"More robust data collection on characteristics, as well as further analysis of this data, is therefore needed to better understand offenders and victims because community, cultural, and other factors are clearly relevant to understanding and tackling offending."	
B.3: **The scale of child sexual abuse**	
23. As the UK government has acknowledged in its Tackling Child Sexual Abuse Strategy (2021):	
"it is difficult to truly understand the scale of offending and how many victims and survivors remain unidentified because of under-reporting, under-identification of victims and survivors by agencies, and a lack of robust survey data."	Under-reporting and under-identification of child abuse are highlighted in the Home Office report. Our critical review of it is here.
For these reasons, the Inquiry agrees that it is difficult to measure accurately the scale of child sexual abuse in England and Wales. The Inquiry is in no doubt, however, that the scale of abuse and exploitation is considerably greater than is currently recorded by the statutory agencies. This was a conclusion in nearly every investigation conducted by the Inquiry.	
Data in relation to physical or contact sexual abuse	
24. One recent estimate – described as "conservative" – has suggested that around 500,000 children are abused in a single year.	
25. There is no consistent approach to the recording of data, including, at its most basic, the use of different reporting periods. Some data refer to the financial year, other data to the calendar year or a different timeframe.	

25.1. In the year ending September 2021, police forces recorded a total of 67,675 sexual offences against children. This figure is based on analysing police recorded crime figures where offences include reference to the victim's age, including some specific child sexual abuse offences where the child is under 13 or under 16 years old. However, this may not record all child sexual abuse offences. For example, there is no specific offence code for sexual assault where the victim is aged over 13 but is under 16 years old.	
25.2. In the year ending December 2020, there were nearly 950 prosecutions for raping a child aged under 13 or under 16 years old, just under 1,000 prosecutions for sexual assaults on a child under 13 years old and more than 1,470 prosecutions for sexual activity with a child under 13 or under 16 years old.	Unfortunately this does not necessarily reflect current trends in abuse as many of these prosecutions will be for non-recent offences.
25.3. Local authority data for England record the primary reason why children are made the subject of a child protection plan. In 2019/20, 2,600 children in England were placed on child protection plans under the primary category of sexual abuse.	
25.4. These figures for children subject to child protection plans are comparatively low when compared with the assessments conducted by children's services which show an increase in identification of child sexual abuse and exploitation as a risk factor. In the year ending March 2020, child sexual abuse was identified as a risk factor in 29,640 assessments and child sexual exploitation in 16,830 assessments.	
26. As a result of the lack of a coherent set of data, it is difficult to gain a comprehensive understanding of the scale of child sexual abuse in circumstances where, as demonstrated by the Inquiry's work, sexual abuse and the estimated number of perpetrators continue to rise.	
Data relating to online-facilitated child sexual abuse	

Child sexual abuse material online	
27. The proliferation in online child sexual abuse material is of significant concern. In the calendar year ending 2020, the IWF processed over 153,000 reports containing child sexual abuse imagery or UK-hosted non-photographic child sexual abuse imagery. The figures rose again in the year ending 2021, with more than 250,000 URLs (Uniform Resource Locators) confirmed to contain images or videos of child sexual abuse.607 A URL is the specific location where a file is saved online. Some URLs can contain thousands of images and videos.	
 **Figure B.2:** ***Number of reports of webpages assessed as containing child sexual abuse images, from 2017 to 2021*** *Source: See data compendium to this report*	
28. The IWF noted year-on-year increases in reports of webpages that were found to contain child sexual abuse imagery between 2017 and 2021. In particular, the number of reports of webpages containing self-generated imagery (a naked or partially naked image of a child taken by that child) increased almost 13-fold from nearly 13,700 in 2017 to over 182,000 in 2021 (Figure B.3).	

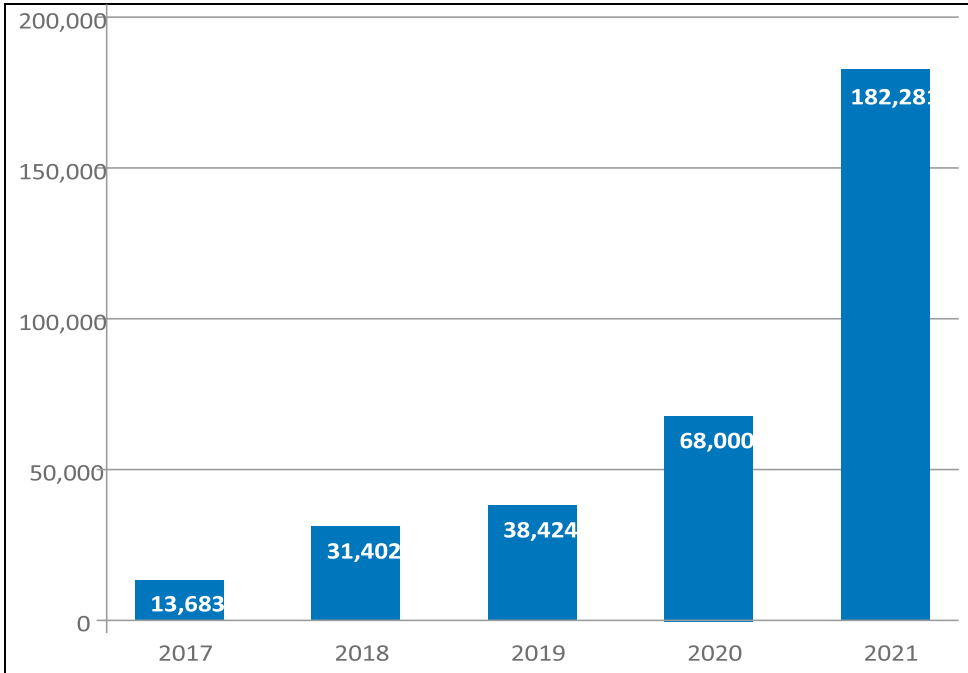


Figure B.3: ***Number of webpages containing self-generated child sexual abuse images, from 2017 to 2021***

Source: See data compendium to this report

29. There were sharp increases in self-generated images depicting 7 to 10-year-olds and in particular 11 to 13-year-olds (Figure B.4, in which 'other' relates to children for whom the specific age range could not be identified). Some self-generated imagery involved perpetrators encouraging children to involve their brother or sister in the abuse.

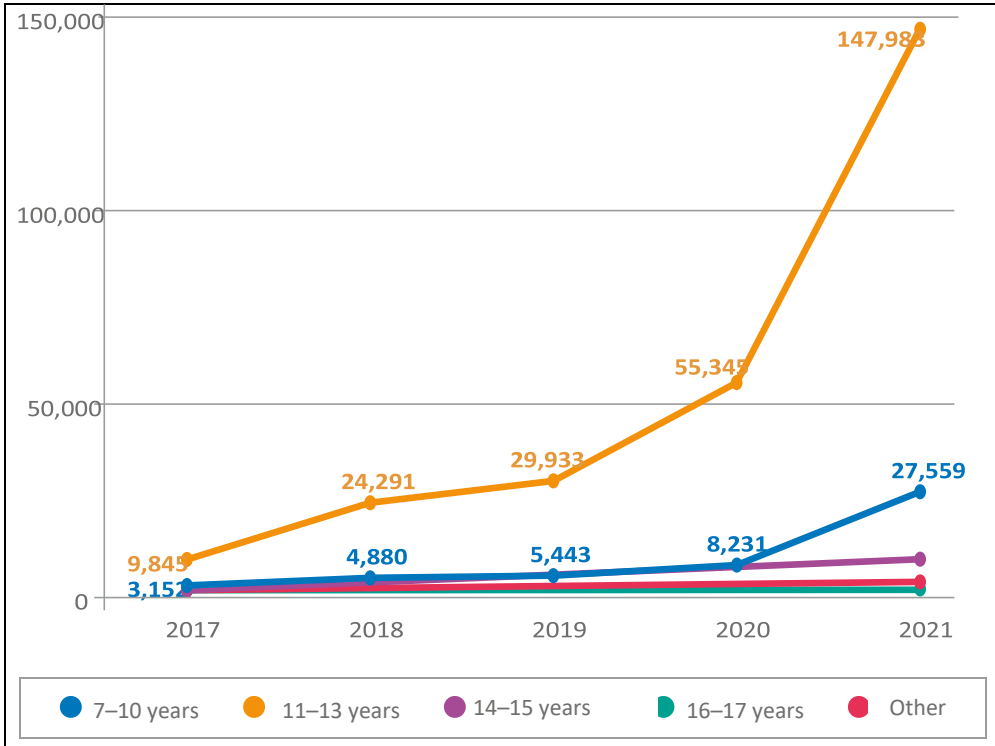


Figure B.4: ***Reports assessed as self-generated child sexual abuse images, from 2017 to 2021, by age of victim***

Source: See data compendium to this report

Data relating to perpetrators

30. It is also difficult to establish the number of perpetrators who sexually abuse children.

31. Official data state that in the year ending December 2020, 4,649 individuals were convicted of child sexual abuse offences (Figure B.5). This figure also shows a decline in the number of prosecutions since 2016 (the criminal justice response is examined in further detail in Part G).

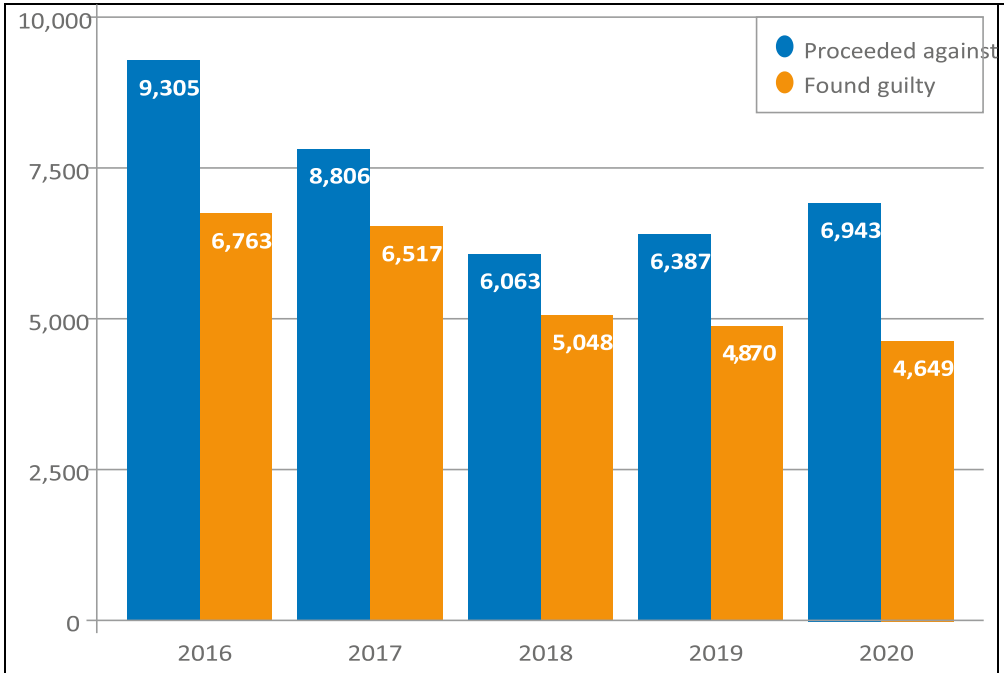


Figure B.5: ***Number of defendants prosecuted and convicted for child sexual abuse offences from 2016 to 2020***

Source: Ministry of Justice, Criminal Justice Statistics Quarterly, year to December 2020

32. This number of convicted individuals is in stark contrast with the National Crime Agency's 2021 estimate that there were between 550,000 and 850,000 individuals in the UK identified by law enforcement as posing varying degrees of sexual risk to children. These figures did not, however, include non-UK offenders or children who sexually abuse other children and were therefore likely to be an underestimate. The gap between these two figures is a matter of concern as it suggests there are far more children being abused or at risk of being abused than are being identified by local authority and local police crime recording data.

33. In the UK in 2019, the Lucy Faithfull Foundation, which provides advice and preventive resources for those with concerns about their own or another's abusive sexual behaviour, was contacted 94,342 times by people seeking help through its website and helpline. Between March–May and September–December 2020, the average number of weekly users of Stop It Now! Get Help (the offender-focussed website maintained by the Lucy Faithfull Foundation) increased by 128 percent. In 2020/21, there was a significant increase in the number of young people contacting the Lucy Faithfull Foundation for advice and support, including 155 calls, chats or emails from under 18-year-olds who had committed a sexual offence online – this was a 177 percent increase compared with 2019/20.	
Global scale	
34. The pattern identified in England and Wales is also consistent with the global trend of rising levels of child sexual abuse. In its Global Threat Assessment 2021, the WeProtect Global Alliance provided a snapshot of the wider scale of the problem.	

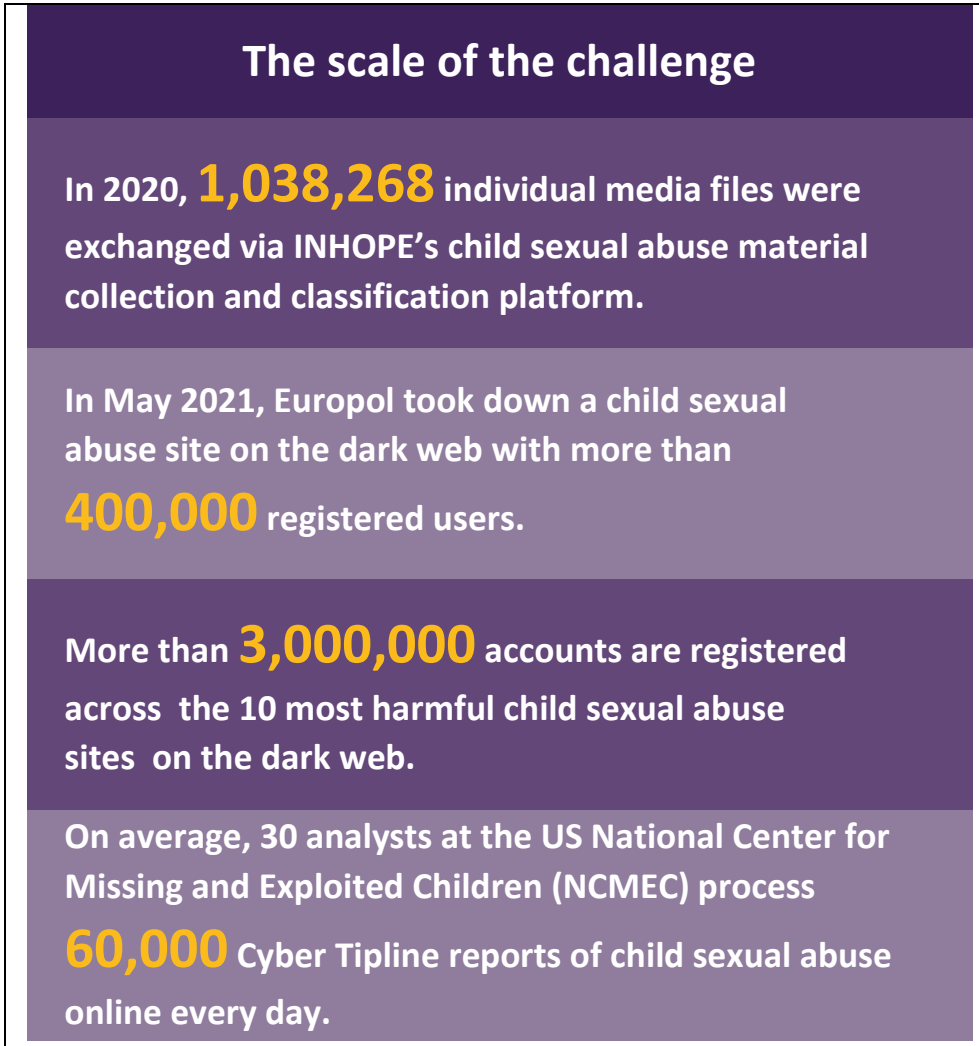


Figure B.6: ***The scale of the challenge***

Source: INQ006749_004

35. The internet and social media platforms have created new and increased opportunities to offend, with no foreseeable end to the growing demand for child sexual abuse imagery and no realistic prospect that perpetrators will stop in their pursuit of sexual gratification at the expense of harm to children. It is a national and global crisis.	
36. It is this horrifying picture that underpins the Inquiry's recommendations in this report and the need for urgent action by both State and non-State institutions. Protecting children from sexual abuse and exploitation, and its often lifelong harmful consequences, is of fundamental importance to future generations.	**The overall conclusion that can be drawn from this is that in statistical terms we know almost nothing about the extent and distribution of child sex abuse and exploitation in England and Wales**. We don't know the numbers of victims, nor their distribution by age, sex, geography or ethnicity. And we don't now the numbers of perpetrators nor their distribution by age, sex, geography or ethnicity. In such circumstances the authorities are to a significant extent working blind in terms of effective resource allocation and most importantly, there is no reliable data from which a coherent and effective strategy can be developed to address child abuse in this country.
B.4: Improving the understanding of the scale of child sexual abuse	
Under-reporting of child sexual abuse	
37. Data recording the number of child sexual abuse offences will inevitably present only a partial picture of the scale of child sexual abuse.	
37.1. Not all children, for example, will be able to understand that what is being done to them amounts to child sexual abuse and some may not be able to tell someone about it.	
37.2. The 2020 Crime Survey for England and Wales estimated that 76 percent of adults who experienced rape or assault by penetration did not tell anyone about their experience at the time. People were even less likely to tell the police – only an estimated 7 percent of victims and survivors informed the police at the time of the offence and only 18 percent told the police at any point.	

37.3. Research has shown that disclosure of abuse is a complex and lifelong process. It often takes place for the first time in adulthood. For example, analysis of data on allegations of child sexual abuse in the Roman Catholic Church between 1970 and 2015 indicate the abuse was alleged to have occurred or begun an average of 26 years previously.	Note that average of 26 years. This suggests that the proportion of children who disclose while still children is extremely small. This is important when we come to the recommendation on Mandatory Reporting of child sexual abuse.
38. Police data from 2004/5 to 2019/20, published in the UK government's Tackling Child Sexual Abuse Strategy (2021), show relatively stable levels of recording of child sexual abuse offences in the mid-2000s. However, the data will not capture all child sexual offences, such as sexual assault, because they are based only on offences where a child is specified in the offence itself.	
39. The data show a sharp increase in recorded offences from 2012 onwards. In its 2021 Tackling Child Sexual Abuse Strategy, the UK government considered that this increase was linked to "an increase in victims' willingness to report" following police investigation Operation Yewtree, which was established in the aftermath of widespread media coverage about child sexual abuse perpetrated by Jimmy Savile.	

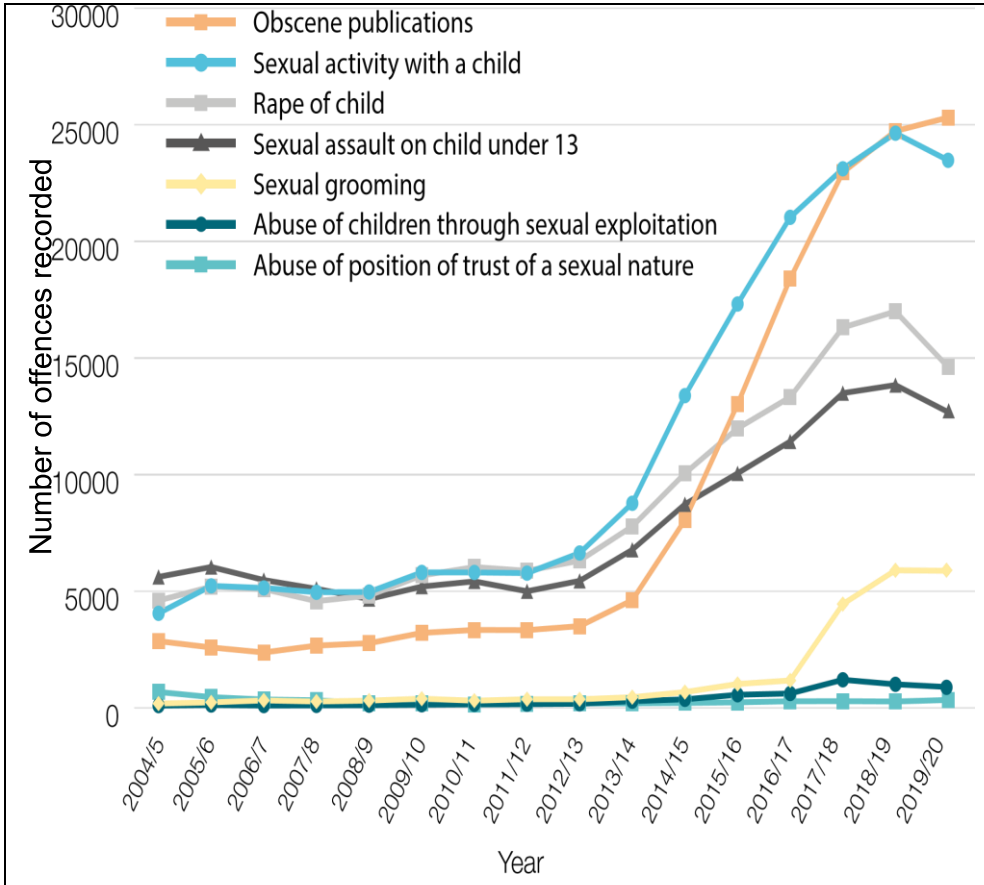


Figure B.7: ***Police recorded child sexual abuse offences in England and Wales, 2004/05 to 2019/20***

Source: INQ006448

40. The numbers in the graph for 2018/19 onwards appear to suggest a more recent fall in offending in relation to some child sexual abuse offences, including sexual assault on a child under 13 and rape. However, nearly a decade on from Operation Yewtree, it is not surprising that the initial explosion in reporting has abated. Nonetheless, as Figure B.7 depicts, tens of thousands of child sexual abuse offences have been recorded during the lifetime of the Inquiry. In particular, there has been a rapid increase in indecent image offences (referred to in the graph as falling within 'obscene publications' offences).	
41. The recent Crime Survey for England and Wales for the year ending December 2021 recognised that:	
"High levels of non-reporting combined with changes in reporting trends can have a significant impact on sexual offences recorded by the police. Prior to the coronavirus (COVID-19) pandemic, the number of police recorded sexual offences was well below the number of victims estimated by the crime survey, with fewer than one in six victims of rape or assault by penetration reporting the crime to the police."	
Limitations with available data	
42. Even where abuse is reported and recorded, the data may not reveal the complete scale of abuse. In respect of understanding patterns and trends in child sexual abuse over time, the Inquiry has not been helped by the inadequacies of the existing data collection systems. Different organisations have developed their own approaches to categorising and recording data. As a result, operational data from different organisations cannot be brought together and consolidated in a way which aids an overall understanding of the problem and the institutional response.	

43. The prevalence survey data and the operational data do not distinguish between child sexual abuse within the family setting and that which is committed by perpetrators outside the family. They also do not distinguish between child sexual abuse committed outside the family in institutional settings as opposed to child sexual exploitation, meaning there are no official estimates of the serious criminal activity taking place in these two key areas.	
44. Local authority data relating to child protection plans present only a partial picture of the scale of child sexual abuse. For the purposes of data collection, children are generally only placed on a plan under one of the four 'primary' categories (sexual abuse, physical abuse, emotional abuse and neglect), although sexual abuse may be a secondary risk. Research by the Office of the Children's Commissioner for England suggests that:	
"among children who had been sexually abused according to police data, more were recorded by children's services under the categories of neglect (32%) or emotional abuse (29%) than under sexual abuse (20%)".	

45. The Inquiry has already identified particular problems with data relating to child sexual exploitation where, as noted in the Child Sexual Exploitation by Organised Networks Investigation Report, no specific criminal offence of child sexual exploitation is recorded and measured. As a result, police forces manually apply a 'flag' to offences which fit the definition of child sexual exploitation. In many parts of the country, child sexual exploitation has been recorded within the broader category of child criminal exploitation. Variations in the way offending is recorded may also contribute to differences in the available statistics. For example, police may record an offence of rape that also involves child sexual exploitation as a rape offence, thereby failing to capture the most serious child sexual exploitation crimes. As a result, in February 2022 in its Child Sexual Exploitation by Organised Networks Investigation Report, the Inquiry recommended that the UK government and the Welsh Government should take steps to ensure that data about child sexual exploitation are being collected and disaggregated in a consistent and accurate way by police forces and local authorities. In June 2022, the UK government provided the Inquiry with its provisional response to this recommendation and stated that its final response to this recommendation would be provided by 1 August 2022. The final response is available on the Inquiry's website.	
46. Public agencies rely on accurate and detailed data to make the best strategic and operational responses for the protection of children. This is not possible if the nature of the abuse and changing patterns are not well understood. For example, the institutional response to familial child sexual abuse is categorically different from the response to sexual abuse committed by a child.	

47. The lack of reliable data which measure the current prevalence of child sexual abuse in England and Wales (and across the UK) impedes the ability of statutory agencies and society more generally to prevent and respond appropriately to such abuse. The ONS assessed the feasibility of a survey measuring the prevalence of child sexual abuse in the UK (that is, the proportion of children in the population who are sexually abused) and, in April 2022, it concluded that there was "no fundamental reason not to conduct a survey" of children aged 11 to 15 years administered in a school environment or equivalent educational establishment, notwithstanding some challenges. Such a survey is likely to provide valuable information for those working to protect children from sexual abuse in the future.	From this paragraph: "***The lack of reliable data which measure the current prevalence of child sexual abuse in England and Wales (and across the UK) impedes the ability of statutory agencies and society more generally to prevent and respond appropriately to such abuse***."
48. The UK government's Tackling Child Sexual Abuse Strategy (2021) recognised that:	
"the quality and extent of data that is collected on offender and victim characteristics, including, but not limited to, age, gender and ethnicity, is inadequate".	
It identified a "need to improve the quality and extent of data collected in relation to the modus operandi of offending". It indicated the Home Office would "engage with criminal justice partners, academics, think tanks, charities and frontline professionals on improving the range of data currently collected, the quality of data collected, and drawing out insights from the data to help protect children by preventing and detecting offending". As at June 2022, no further information has been published, although the government has published – in line with its 2021 End-to-End Rape Review Report on Findings and Actions – "performance scorecards" to monitor progress against key metrics, including timeliness, quality and victim engagement in relation to adult rape offences.	

49. Urgent steps should be taken – led by the UK government and the Welsh Government – to improve the data on child sexual abuse. This should include recording when sexual crimes against children take place outside the family setting, both in prevalence surveys and data collected by the criminal justice agencies and local authorities. These agencies have operational intelligence or risk assessment information about the circumstances in which child sexual abuse has reportedly taken place. That information should be recorded and reported in a way that allows abuse of children outside the family setting to be measured. The Inquiry therefore recommends improvements to the data collected about child sexual abuse and the regular publication of that improved data.	
Recommendation 1: A single core data set	
The Inquiry recommends that the UK government and the Welsh Government improve data collected by children's social care and criminal justice agencies concerning child sexual abuse and child sexual exploitation by the introduction of one single core data set covering both England and Wales.	Given the huge inadequacies in data collection reported above, Mandate Now supports this recommendation wholeheartedly. The recommendation should be implemented without delay.
In order to facilitate this, these agencies should produce consistent and compatible data about child sexual abuse and child sexual exploitation which includes:	
• the characteristics of victims and alleged perpetrators of child sexual abuse, including age, sex and ethnicity;	
• factors that make victims more vulnerable to child sexual abuse or exploitation; and	
• the settings and contexts in which child sexual abuse and child sexual exploitation occur.	

Data concerning child sexual abuse and child sexual exploitation should be compiled and published on a regular basis. This should be capable of being collated nationally as well as at regional or local levels.	
Prioritising the protection of children	
C.1: **Introduction**	
1. The vast majority of adults throughout the UK view the effective protection of children from harm as an essential component of a civilised society. Public opprobrium is rightly directed at not only those who deliberately set out to abuse children but also those who fail to protect children when they should do so. Institutions which bear statutory responsibility are required to ensure as far as possible that the right action is taken if children are at risk of harm. Scrutiny arrangements are in place to maintain good governance and accountability in respect of the institutions themselves and for the professionals and employees, as well as volunteers, who work in an institutional context.	If the protection of children were as universally supported as this paragraph suggests, then organisations responsible for the care and protection of children would not frequently (as they do now) give such protection a much lower priority than other considerations. For instance, the government prioritises the saving of money, and religions organisations and others prioritise the protection of their institutional reputations.
2. While key professionals such as social workers and police officers have particular responsibility for protecting children from harm, all adults who work with, care for or look after children have a responsibility to keep children safe. Child sexual abuse occurs in many contexts and settings. The Inquiry's work revealed physical violence as well as neglect and emotional harm that individually, or in combination, created an environment in which sexual abuse could take place. It is virtually impossible to separate out the various forms of harm as if they occurred in isolation. The Inquiry has considered child protection throughout its investigations, where relevant.	There is a moral responsibility, in some cases a public law responsibility and in the case of female genital mutilation a statutory responsibility to report concerns. But public law is not criminal law and the accountability that arises even from a public law responsibility is often vague and unenforceable.

3. Where institutions had child protection arrangements, in many instances there was often a lack of compliance with existing systems. In order to make the further improvements necessary to protect children better in the future, a well-articulated and relentless focus on child protection is required. The economic and social costs of sexual abuse are significant. A recent study published by the Home Office estimated that, in the year ending March 2019, contact child sexual abuse alone cost society over £10 billion. The challenges are therefore considerable and growing and, as set out in Part J, are likely to last well into the future, particularly as the UK recovers from the devastating consequences of a worldwide pandemic.	The question arises as to whether (and if so how), these child protection arrangements can be made more effective. Where systems exist but are not complied with, what would ensure compliance? If the systems exist, then presumably we have a situation where those responsible for the system know that they *should* be operating the system, they know *how* to operate it, but do not. Merely improving awareness will therefore not make much difference. Robust measures are needed to change behaviour and therefore transform culture.
4. It is therefore important that child protection is given the priority it deserves. It should not be subsumed into other areas of practice within institutions or be permitted to drift into institutional obscurity. To address and respond to the complex challenges of child sexual abuse, the Inquiry recommends the establishment of independent Child Protection Authorities for England and for Wales. Their remit should cover sexual, physical and emotional abuse, as well as neglect of children. To signify the importance attached to child protection, the Inquiry also recommends the establishment of a Minister for Children with cabinet status covering a wide range of responsibilities for children's welfare. It should include child protection, so that children's safety and well-being receive the attention they deserve.	
5. Raising the profile of child protection and ensuring that members of the public are better able to identify concerns about child sexual abuse will also maximise society's ability to protect children from harm. In order to do so, wider cultural and societal changes are required. To encourage discussion about child sexual abuse and to achieve the necessary cultural shift, the Inquiry recommends that there should be a wide-ranging programme to increase public awareness about child sexual abuse and the action to take if suspicions and concerns arise.	Members of the public have less to contribute than professionals in a position of trust and responsibility towards children who have sufficient degree of contact with children to be able to see signs of abuse and who have (or can receive) the training necessary to help recognise those signs. A further necessary measure is to ensure that these people receive the support they need when faced with the prospect of having to report suspicions of abuse. Far too many institutions are unsupportive or even actively hostile to reports of abuse being made.

C.2: **The current system for safeguarding and child protection**	
6. At the outset, it is important to distinguish child protection from safeguarding children. The latter covers a much broader range of activity and extends beyond protection of the individual child to the wider responsibilities across society to ensure that children are safe. Both are important and sometimes overlap.	
6.1. Safeguarding is used to describe measures to protect the health, well-being and rights of people to live free from abuse, harm and neglect, particularly children, young people and vulnerable adults. In social work practice it generally refers to all of the actions, support and services that promote the welfare of children and protect them from harm. At its broadest, it means enabling all children and young people to have the best possible outcomes, for example in terms of their mental and physical health, education and family lives.	
6.2. Child protection is part of the safeguarding process. It focusses on protecting individual children identified as suffering, or at risk of, significant harm. Child protection procedures set out how to respond to concerns about a child and should follow government guidance. Child protection policy and practice guidance anticipate the abuse and harm that individual children might experience	
7. Although the statutory agencies have well-rehearsed responsibilities, other institutions do not. During its work, the Inquiry examined the statutory and regulatory frameworks that apply in respect of religious organisations and settings, educational settings, custodial institutions, children in the care of local authorities, political parties and institutions, and current proposals for regulation of the internet. The Inquiry also considered analyses of similar issues conducted by others, including Clive Sheldon KC's 2021 review of the Football Association and Dame Janet Smith's 2016 review of historic practices at the British Broadcasting Corporation (BBC).	

8. In England, individuals working with children are expected to comply with the key statutory guidance for child protection, Working Together to Safeguard Children. This guidance – updated most recently in 2018 – provides that every individual who works with children has a responsibility for keeping them safe, and every individual who comes into contact with children and families has a role to play in sharing information and identifying concerns. It emphasises the importance of early help to promote the welfare of children. Local agencies must identify, assess and provide help for children and families who would benefit from interventions.	Being "expected to comply with the key statutory guidance" is in practice a very weak mechanism. We are dealing with something even less than an unenforceable public law obligation. "Statutory guidance" in this context is something of a misnomer. The phrase is normally understood to mean guidance on how to fulfil one's legal obligations. But for most of the child protection framework there are no legal obligations, and so in practice all we have is "guidance", it is not "statutory". It is necessary to note the that the extremely low levels of detection described in section B above (as compared to the current estimates of the prevalence of abuse) are what is being achieved with the current arrangements.
9. In Wales, the key guidance is Working Together to Safeguard People and is based on the requirements set out in the Social Services and Well-being (Wales) Act 2014, supported by the Wales Safeguarding Procedures. It is primarily for practitioners working with children, including those working in early years, social care, education, health, the police, youth offending and youth, community and family support services (including the third sector) and foster care and residential care. Taken together, this framework sets out detailed practice guidance and sets expectations about how individuals and organisations should work together to safeguard children.	Much the same applies to the situation in Wales.
10. The legal and policy requirements for child protection and safeguarding are often complex. This complexity can lead to assumptions that every aspect of child protection and safeguarding is covered by existing frameworks. That is not the case.	
Scrutiny and inspection	

11. Scrutiny and inspection arrangements in respect of child protection and safeguarding are important features of the current system. Whether, how and by whom an institution is inspected depends on its activities. A number of organisations play an important role in the oversight of child protection and regulation.	
11.1. In England, education, children's social care and early years are broadly overseen by the Department for Education, which also sponsors the Office for Standards in Education, Children's Services and Skills (Ofsted) in England as well as the Independent Schools Inspectorate. In Wales, Estyn inspects education and training.	During the IICSA hearings Ofsted and ISI have repeatedly been shown to be highly incompetent at conducting safeguarding inspections. This is unsurprising as it is not the purpose for which they were originally established (which primarily was to monitor educational standards in the institutions they inspected).
11.2. The Charity Commission is responsible for registering charities in England and Wales, including many religious and voluntary organisations and settings. Each charity is responsible for ensuring that "the charity has proper systems in place to mitigate the risk of child sexual abuse and deal with it properly if a report is made to them of such abuse". Although serious child protection issues are matters of concern to the Charity Commission, it is not able to act as a routine inspector of child protection systems in respect of the many thousands of registered charities in England and Wales.	Similarly, the Charity Commission was until recently primarily tasked with ensuring that charitable funds were properly spent on charitable causes. The idea is new that the Charity Commission has a role in ensuring that the beneficiaries of charities are protected from child sex abuse. Even now, it has no resources with which conduct routine inspections of the safeguarding arrangements of charities which care for children. Instead it is dependent on people raising concerns so that it can then decide whether to start an investigation. The Commission also observes the 'statutory guidance' that fails to support personnel report concerns to external agencies. In one case study (Ealing Abbey/St Benedict's School), the Charity Commission wrote to the school emphasising the need to maintain the school's reputation, a letter which could easily be (and probably was) interpreted as providing support to the idea that claims regarding child sex abuse should be opposed in principle for the protection of the school's reputation so that its charitable aims could more effectively be pursued.

11.3. In the criminal justice system, child protection and safeguarding practice within the police, youth custody and probation are respectively inspected by His Majesty's Inspectorate of Constabulary and Fire & Rescue Services (HMICFRS), His Majesty's Inspectorate of Prisons and His Majesty's Inspectorate of Probation.	
11.4. The Care Quality Commission (CQC) and the Healthcare Inspectorate regulate children's (and adult) health services in England and in Wales, respectively. Both organisations have wide-ranging responsibilities and powers of inspection. In England, the CQC participates in joint inspections of child protection arrangements with Ofsted, HMICFRS, HM Inspectorate of Probation and, where relevant, HM Inspectorate of Prisons. In Wales, the Healthcare Inspectorate works with Estyn, Care Inspectorate Wales and Audit Wales.	
11.5. The Children's Commissioners for England and in Wales were both established by statute. The aim of the Welsh Children's Commissioner is to "safeguard and promote the rights" of children in Wales. In England, the Children's Commissioner's "primary function is promoting and protecting the rights of children in England". Both Commissioners have wide responsibilities and powers, including ensuring that children's views and interests are taken into account by public bodies.	Based on a reading of Children Act 2004 Part 1 section 2 (https://www.legislation.gov.uk/ukpga/2004/31/part/1), generally speaking the Children's Commissioner has (in theory and subject to resource constraints) wide powers to investigate almost anything to do with children, but has no enforcement powers, either to prosecute failings or to ensure that recommendations for change are adopted by government or non-government bodies. Also, according to the Children Act 2004 Part 1 section 2(5) "The Children's Commissioner may not conduct an investigation of the case of an individual child in the discharge of the primary function."
11.6. There are additional workforce regulators, such as Social Care England, the General Medical Council and the Teaching Regulation Agency. These organisations are responsible for regulating the practice of individual practitioners. In the most serious circumstances, the regulator has a disciplinary function which may prevent a member of a particular profession from practising if their conduct merits such a sanction.	Professional 'guidance' and accountability in relation to a child protection concern is of little value. There is a professional expectation that teachers, nurses, doctors *should* report concerns. Discovering a referral was not made often happens years later when a complaint is filed by the abusee in adulthood. Examples include – Hillside First School, Stoke Mandeville Hospital ('*pretend to be asleep if he comes around*'), Ampleforth, Caldicott, and many more besides.

12. Inspectorates may join together to conduct joint inspections of various sectors.	
In England, joint targeted area inspections bring together several inspectorates, led by Ofsted, to conduct thematic inspections of multi-agency child protection arrangements. In Wales, a similar role is undertaken by the Joint Inspectorate Review of Child Protection Arrangements.	
13. Statutory inspection activity does not always identify poor practice, particularly when conducting inspections that necessarily cover a wide range of topics. Some institutions such as supplementary schools or out of school settings receive little, if any, independent assessment of their child protection practices. There is no power to compel them to have child protection policies and no power for existing inspectorates to inspect the quality of the services provided. For example, the Inquiry's Child Protection in Religious Organisations and Settings Investigation Report noted Ofsted's "serious concerns" about its inability to inspect and evaluate out-of-school settings and unregistered schools. Greater powers for Ofsted, including to take action in relation to unregistered schools, were proposed in new legislation announced by the UK government in May 2022.	Greater powers for Ofsted to inspect additional classes of setting would be of little use given Ofsted's proven incompetence at inspecting for safeguarding in the areas over which is already has authority.
14. There is also a duty to conduct serious case reviews, where appropriate, and identify learning. In England, safeguarding partnerships report to the Child Safeguarding Practice Review Panel, which is responsible for identifying and overseeing serious child safeguarding cases that, in its view, raise issues which are complex or of national importance. In Wales, regional safeguarding boards perform a similar function with support and advice from the National Independent Safeguarding Board, which also reports on the adequacy of safeguarding arrangements and makes representations to Welsh ministers about improvements. Safeguarding partnerships have an important role to play in bringing the statutory agencies together to work on all aspects of safeguarding strategy in local areas.	

15. Inspections, serious case reviews and other regulatory activities are not a substitute for an institution's responsibility for its own quality assurance of its safeguarding and child protection. This could include internal and external audits and reviews of child protection practice.	The primary issue is that there is no legal definition of "an institution's responsibility for … safeguarding and child protection". Unless there is an enforceable legal obligation, all the internal and external audits and reviews will have little or no effect on institutions that are comfortable with the status quo. . Mere bad publicity has been shown to be insufficient to bring about change. To take a recent example, had bad publicity been sufficient to change an organisation's behaviour, the publicity surrounding the succession of failed Ofsted inspections suffered in recent years by Ampleforth College would not have occurred. Instead, the school would have radically improved after the first failed inspection in September 2020 instead of having four further inspections over the following two years, only the last of which demonstrated tangible improvement (presumably because the school had been warned of imminent deregistration in the event of a further failure). But with institutions such as religious organisations which also are not subject to inspection, there is no such registration and therefore no equivalent threat of deregistration and forced closure is available. Sanctions against institutions other than the 'nuclear' option of closure in the case of schools, are non-existent. Safeguarding improvement in the Church of England is glacial not least because the Archbishop of Canterbury is a titular leader of 42 dioceses.
Multi-agency working	
16. As children and families often access a range of services, statutory agencies (particularly local authorities, the police and the healthcare sector) must work together to understand fully a child's circumstances and to coordinate their interventions and support. This multiagency work is coordinated and overseen by safeguarding partnerships in England and safeguarding boards in Wales. Specified statutory agencies must be represented in these arrangements; in Wales this also includes probation services. Other organisations, such as schools and youth services, must be involved in safeguarding arrangements if required by the statutory agencies.	

17. When child protection concerns arise, the relevant local authority has a statutory duty to make enquiries and decide whether to take any action to safeguard or promote the child's welfare. If a child is in immediate danger, the local authority may seek emergency protective orders from the family courts, and the police have the power to remove the child to a place of safety for a limited period of time. Where there is no risk of immediate harm to a child, there is likely to be an assessment of the child's needs and protective steps may be taken. The local authority is required to work with the child's family and professionals to ascertain what steps are in the child's best interests. Early intervention and protection in children's social care must be undertaken in tandem with improved child protection practice so that, if a threshold of significant harm is crossed, the local authority may invite a court to make a care order or a supervision order.	
18. The police are responsible for investigating allegations amounting to criminal offences of child sexual abuse, although joint investigations with local children's services are encouraged, in order to bring a multidisciplinary approach to the investigation process. If there is sufficient evidence and it is in the public interest to proceed, the Crown Prosecution Service will authorise a prosecution.	"*The police are responsible for investigating allegations amounting to criminal offences of child sexual abuse*." This important matter is often forgotten. Criminal matters can be easily compromised by well-meaning personnel going too far with inquiries.
19. The effectiveness of multi-agency working is the critical element of child protection and safeguarding practice. This is the cornerstone of the system and, although there have been changes to organisational structures over the years, the basic concept of good multiagency working has remained a consistent feature. Despite successive policy initiatives to work better together, the statutory agencies have not always collaborated efficiently or effectively. On occasions, this has been marked by an absence of collective leadership by statutory agencies.	The effectiveness of multi-agency working is the critical element of child protection and safeguarding practice *for those cases that actually come to official attention*. Improvements in multi-agency working are always desirable, but as the inquiry has found, both in its statistical analysis of the data collection arrangements described above and its investigations into in individual institutions, a great many cases never come to official attention in the first place because suspicion or knowledge of abuse is not reported by other institutions to the responsible agencies. Therefore to describe multi-agency working as "the critical element of child protection and safeguarding practice" is misleading. It is one critical element among others of equal importance.

C.3: **Reform**	
20. Throughout the Inquiry's public hearings, criticisms were directed at failures of institutions to respond effectively, or at all, to child sexual abuse. Many cases presented in evidence did not involve finely balanced decisions by those in positions of authority but were obvious examples of where action was necessary and often urgent, but was not taken. Institutions frequently valued reputation, including personal and professional reputations, above the interests of children. As a result, whether by design or carelessness, allegations of child sexual abuse were often marginalised.	"Marginalised" a mild word to use for what was discovered during the course of the IICSA hearings. "Ignored or actively suppressed" would have been a better phrase to use. It is important to note that IICSA has in this paragraph stated it has found some of the failures to report were "by design". This is a vital conclusion (if stated in rather a throwaway manner), because the logical consequence is that in such cases change can only come about by enforcement of legal obligations. In the absence of such enforced obligations, institutions will remain free to continue to behave as they do now, even knowing that morally speaking, they should not.
21. As the Inquiry's analysis revealed, the issue of child sexual abuse was concealed from public view for decades. Poor attitudes towards children compromised the ability of institutions to expose and act on allegations of child sexual abuse. There was no real understanding of the scale and depravity of that abuse until national scandals were exposed, such as the posthumous revelations made about Jimmy Savile in 2012 and the conviction in 2015 of Bishop Peter Ball. Even then, some forms of child sexual exploitation remained hidden from view. Many children and young people were groomed through attention and protestations of affection or violence to submit to sexual activity with groups of men. Rather than deal with the perpetrators, the statutory agencies, particularly the police, assigned blame to those who were being abused. They were apparently not worthy of protection.	

22. There were a number of examples of where a particular institution kept allegations of child sexual abuse 'in-house' and did not report the circumstances to the local authority or the police. On occasions, efforts to expose child sexual abuse in internal reports were simply ignored because other priorities dominated the institutional agenda. As an extreme example, political turmoil and corruption within Lambeth Council meant that those who spoke out against child sexual abuse were simply drowned out by the noise of a toxic political debate.	Lambeth Council has been mentioned here, a public body. But many private organisations could equally have been mentioned on the basis of evidence heard by IICSA, including independent schools (such as Chetham's, Purcell), religious organisations (e.g. C of E, Roman Catholic Church, Jehovah's Witnesses). In addition, although abuse in sport was not investigated by IICSA, high-profile cases have come to light of abuse in sport that went unreported at the time.
23. Many people within the institutions examined by the Inquiry knew, or should have known, that serious allegations of child sexual abuse had been made in circumstances where the institution bore some responsibility for the child's welfare. They were responsible for 'battening down the hatches' in the hope and expectation that the so-called 'problem' would go away. Those who complained often met a wall of resistance and antipathy. The Roman Catholic Church and the Church of England demonstrated a persistent reluctance to report complaints of child sexual abuse to external agencies.	The fact is that in doing so, the management of these institutions broke no laws, since there was no legal obligation to report these allegations to anybody.

24. It is more difficult to suppress allegations when the circumstances are shared with other agencies. The exposure sets in motion a series of processes designed to protect the child and investigate what happened. While there is always a risk that an allegation is mishandled, that risk is reduced if each institution complies with the guidance in Working Together and shares information and concerns so that the appropriate action is taken in a timely way. The problem was often not the policies and procedures themselves but failure to share intelligence, and to implement and comply with the child protection arrangements that were in place.	Yes, it is perfectly true that "*risk is reduced if each institution complies with the guidance in Working Together and shares information and concerns so that the appropriate action is taken in a timely way*". But we must recognise that all too often this simply does not happen. There are two underlying causes. The first is that Working Together is "guidance" rather than statute. As a matter of law, agencies and bodies to which it applies must have regard to it when making decisions and should not depart from it without cogent reasons. However, if they fail to do so, the consequence is that the decision could be challenged by way of judicial review. The guidance itself is not actionable or directly enforceable. In practice it can be ignored at will (as the report earlier stated "by design or carelessness"). Noncompliance is often hidden or disguised, and goes undetected through inadequate inspection (where such inspection occurs at all). The second cause is partly a consequence of the first, that Working Together is overly complex in order to try and impress by detail and so obscures the lack of any legal force to most of it.

25. While a number of high-profile prosecutions in the mid-2010s brought child sexual abuse to greater attention, as other priorities have emerged, the focus on child sexual abuse has diminished. In some police forces, child sexual exploitation has been subsumed into child criminal exploitation, creating limitations on the understanding of this type of offending. Statutory agencies have not yet demonstrated a comprehensive ability to understand the scale and nature of child sexual abuse in their areas. For example, some statutory agencies have conflated the concepts of actual harm and risk of harm. This conflation manifests itself in a failure to identify children who have been sexually abused and those who may be at risk of being sexually abused. Making these distinctions effectively enables resources to be targeted where there is an urgent need to remove a child from danger of sexual abuse or introduce a range of protective measures to manage a risk to the child where the harm has not yet occurred. The failure to do so magnifies the risk of further abuse.	
26. The challenges faced by the authorities in dealing with child sexual offences facilitated by the internet is a significant and growing problem. The worldwide trade in indecent images of children is worth vast sums of money. The dark web offers sanctuary to would-be perpetrators who can remain undetectable. Encryption may prevent law enforcement agencies from tracing and ultimately prosecuting perpetrators because they cannot access relevant communications.	

27. Institutions have been responsible for failing to protect children from harm when it was their responsibility to do so. This state of affairs lasted for decades and persists in some quarters today. There is a very real risk that, despite improvements, institutions may revert to poor practice and, worse still, actively downplay child sexual abuse, unless there is longlasting and focussed vigilance. Child protection must be given the profile and continuous attention it deserves. The temptation to exclude the statutory authorities from investigating thoroughly, or for the seriousness of child sexual abuse to be minimised by institutions and authorities, is too great merely to make recommendations that urge them to do better.	We need to consider many institutions where the issues uncovered are "*too great merely to make recommendations that urge them to do better*". We will return to this phrase in comments later in the report.
28. As set out further in this report, the Inquiry recommends the introduction of mandatory reporting for relevant individuals and the establishment of Child Protection Authorities (CPAs) for England and for Wales. These are complementary recommendations intended to tackle failures in the institutional response and to improve and promote effective child protection practice in tandem with enhanced personal responsibility that arises from the implementation of the mandatory reporting recommendation.	Comments on mandatory reporting are provided in detail accompanying Recommendation 13 and its supporting paragraphs. See page 130 of this review
C.4: **Child Protection Authorities for England and for Wales**	

29. In order to meet the rapidly changing environment and the sheer scale of child sexual abuse in England and Wales, the Inquiry recommends legislative reform to create a CPA for each country to provide a much-needed and enhanced focus and consistency of approach to the issue of child protection. The role of the CPAs should be to: • improve practice in child protection by institutions, including statutory agencies; • provide advice to government in relation to policy and reform to improve child protection, including through the publication of regular reports to Parliament and making recommendations; and • inspect institutions as it considers necessary.	
30. The CPAs should be independent, constituted as a non-departmental public body in England and an arm's length body in Wales, dedicated to child protection in relation to sexual and physical abuse, emotional abuse and neglect. As indicated earlier, it is impossible to isolate these harms given they are so interlinked: one of them so often is a warning sign of another. In addition to these functions, the CPAs would take on the substantial role of monitoring the implementation of the recommendations of this Inquiry.	

Recommendation 2: Child Protection Authorities for England and for Wales The Inquiry recommends that the UK government establishes a Child Protection Authority for England and the Welsh Government establishes a Child Protection Authority for Wales. Each Authority's purpose should be to: • improve practice in child protection; • provide advice and make recommendations to government in relation to child protection policy and reform to improve child protection; and • inspect institutions and settings as it considers necessary and proportionate. The Child Protection Authorities in England and in Wales should also monitor the implementation of the Inquiry's recommendations.	There appear to be few additional powers and functions beyond those of the existing Children's Commissioner, as set out in Part 1 section 2 of the Children Act 2004 (text below). It is not clear from the report whether or to what extent the panel has studied the powers and workings of the existing Children's Commissioners. **Primary function: children's rights, views and interests** (1) The Children's Commissioner's primary function is promoting and protecting the rights of children in England. (2) The primary function includes promoting awareness of the views and interests of children in England. (3) In the discharge of the primary function the Children's Commissioner may, in particular— (a) advise persons exercising functions or engaged in activities affecting children on how to act compatibly with the rights of children; (b) encourage such persons to take account of the views and interests of children; (c) advise the Secretary of State on the rights, views and interests of children; (d) consider the potential effect on the rights of children of government policy proposals and government proposals for legislation; (e) bring any matter to the attention of either House of Parliament; (f) investigate the availability and effectiveness of complaints procedures so far as relating to children; (g) investigate the availability and effectiveness of advocacy services for children; (h) investigate any other matter relating to the rights or interests of children; (i) monitor the implementation in England of the United Nations Convention on the Rights of the Child; (j) publish a report on any matter considered or investigated under this section. (4) In the discharge of the primary function, the Children's Commissioner must have particular regard to the rights of children who are within section 8A (children living away from home or receiving social care) and other groups of children who the Commissioner considers to be at particular risk of having their rights infringed. (5) The Children's Commissioner may not conduct an investigation of the case of an individual child in the discharge of the primary function. The main additional functions are to inspect institutions and to monitor the implementation of this report.

The improvement and advice role of the Child Protection Authority	
31. Responsibility for monitoring and implementing institutional child protection lies with several statutory agencies and services, sector-specific inspectorates and government departments. In law enforcement, the National Crime Agency leads on online-facilitated child sexual abuse, but much of the operational work is carried out by the 43 police forces in England and Wales, each of which has objectives set by locally elected police and crime commissioners. At a local level, in accordance with the Children and Social Work Act 2017, local authorities, health providers (clinical commissioning groups in England, and the local health boards and the NHS trusts in Wales) and the police are responsible for child protection policy, procedure and guidance. Local authorities, as the corporate parent for children in care, also have a number of critical responsibilities for those children and for children in need?	In terms of the advice function, there appears to be little here that the Children's Commissioners are not already empowered to do.
32. There are a range of potential responses when child sexual abuse is alleged or identified. Action may be taken against the perpetrator through the criminal justice system, disciplinary or regulatory sanction, local authority investigations and the family courts. Irrespective of criminal proceedings, an assessment of the risk of harm that a suspect might pose is a key part of the institutional response. In responding to a victim of child sexual abuse, the local authority, health services and family courts may become involved. Throughout its work, the Inquiry identified a lack of focus and rigour in the responses of a wide range of settings and institutions.	This issue is not significantly addressed by the recommendation to introduce CPAs as in this respect they appear to have no new powers beyond those of the Children's Commissioners.
33. In order to drive improvement in child protection practices, many institutions require support and advice about appropriate responses where abuse is known or suspected. Although there is much that organisations can do themselves to improve those responses, there are measures that the government should take to assist, encourage and support them in doing so.	This issue is also not significantly addressed by the recommendation to introduce CPAs as in this respect they appear to have no new powers beyond those of the Children's Commissioners.

34. Current structures and practices often subsume child protection into the broader work of safeguarding. It is unhelpful that much of the formal literature and guidance about institutions' responsibilities towards children conflates the two, as this detracts from a distinct focus on child protection. Ensuring good quality child protection across a diverse range of settings requires specialist knowledge, targeted intervention and constant vigilance. This work cannot be incidental to other objectives, and it cannot be sporadic or purely responsive.	"Ensuring good quality child protection across a diverse range of settings requires specialist knowledge … This work cannot be incidental to other objectives" **This is precisely why a specialist safeguarding inspectorate needs to be set up**, to replace Ofsted and other bodies for which safeguarding is "incidental to other objectives". But the recommendation is that the CPAs' inspection function supplements and works alongside the existing inspectorates, rather than replacing them.
35. As a result, the Inquiry considers that the CPAs should have a wide-ranging remit to enhance, extend and improve child protection in institutions and other contexts. Its activities should include: • promoting multi-agency working by statutory agencies; • providing high-quality advice to institutions on new and emerging forms of harm and how best they can be tackled in a multi-agency environment; • supporting local child protection arrangements by developing high-quality resources for practitioners; • providing regular reports of good practice to share at international and local levels; • providing advice to government policy development and proposed legislative reform on child protection; and • publishing reports, including to Parliament about the state of child protection, and the making of any recommendations for improvement.	

36. The CPAs should serve as an authoritative repository of information. This should include information about regulation, guidance and best practice. The CPAs should also signpost other organisations which provide direct support on issues such as workforce regulation and training. For example, an individual who wished to establish an after-school group delivering religious education for young people might contact the CPA and receive advice about appropriate child protection policies. A designated safeguarding lead at a school might wish to seek advice about organisations that offer training.	
37. The routine delivery of authoritative information and advice by an expert body would support improvement and increase consistency in child protection across diverse settings and institutions.	
38. The CPAs will also be uniquely placed to help shape national child protection policy and strategy, and to advise the government. Where, as a result of its work, the CPA considers that there are legislative and regulatory changes that would strengthen institutional child protection, it should make recommendations directly to the Minister for Children or any other relevant minister and to Parliament or Senedd Cymru/Welsh Parliament.	This appears to be a power already held by the Children's Commissioners who to date, have completely ignored the strategically important 'sentinel' reporting role that personnel working in regulated activities have in the lives of children.
The inspection powers of the Child Protection Authority	
39. The primary responsibility for quality control and improvement in child protection lies with the organisation itself. Internal audits and reviews, whether provided by third parties or not, provided an accurate picture of child protection practice in some institutions but criticisms and recommendations were not always heeded. Lambeth Council, for example, produced many reports about child protection, including on child sexual abuse, but important recommendations were never implemented, leading to further reviews and audits which met with a similar fate.	The overall impression given is that the main target of the CPAs' activities is statutory agencies tasked with child protection rather than safeguarding, i.e. investigating reports of abuse, and acting to protect children and prosecute offenders where investigation shows that abuse is happening or children are at serious risk of harm. The only specific body mentioned in this section is Lambeth Council.

40. A principal purpose of external and independent inspection is to verify the quality of these organisations' assessments of their own protection measures. As set out above, the inspection framework is complex. In several respects, it fails to provide an adequate model for the external scrutiny of child protection in institutions. First, it emphasises the wider remit of safeguarding rather than child protection, which requires a more targeted focus. Second, it does not have the necessary powers to inspect the broad range of organisations and settings in which children can be abused. Third, it does not scrutinise sufficiently regularly the multi-agency nature of child protection work.	It is not clear whether this paragraph refers specifically to inspection of child protection by statutory agencies or also to safeguarding by the full range of regulated activities caring for children. The comment below assumes the latter. There is only a benefit "to verify the quality of these organisations' assessments of their own protection measures" if improvements are made to poor practice as a result. To achieve this, it seems that a number of prerequisites exist • That the obligations inspected are simple • That they are legally enforceable, • That the inspectorate has enforcement powers or some other body to whom the inspectorate can refer cases has enforcement/prosecution powers
Inspection and regulation	
41. The different regimes in respect of inspection, regulation and workforce controls are often confused. It is easy to assume that where individuals who work in an institution or setting are 'vetted', this means that an institution is also 'regulated' and that its child protection practices are therefore subject to some form of external scrutiny or inspection. This is not always the case.	
42. Children frequently spend time in less formal settings not subject to inspection. Examples include sports, drama or dance classes, after-school activities and religious education groups. Although individuals may be eligible for criminal background checks at their employer's behest, that is not the same as the organisation being subject to checks of its child protection policies and practices through inspection. Almost every child in the country will spend time in one or more of these less formal settings. For some, it is a daily occurrence.	

43. It would not be desirable or reasonable for the State to inspect every small and informal gathering of children. However, where concerns arise about an organisation or setting, there must be a mechanism for the procedures and policies in place to be scrutinised. Currently, there is not. Child sexual abuse has occurred in settings that were not subject to any inspections at all, making children vulnerable as a result. This is a failure that must be addressed.	In effect, this will mean that there will continue (as now) to be two categories of setting. Those which are regularly but infrequently inspected and those which are not. For settings (such as schools) already inspected by Ofsted or ISI, if the CPAs go in and carry out supplementary inspections, there is likely to be much unnecessary confusion and duplication: duplication where the CPA is applying the same standards and confusion where the CPA tries to apply some different standard from that used by Ofsted. The likely result is turf wars between inspectorates and their sponsoring government departments and complaints from the inspected bodies about unfair and onerous targeting. For other settings, the implication is that an inspection will only be called for when there is already information suggesting serious shortcomings. In other words it will be of a similar nature to emergency inspections commissioned by DfE when a problem is already known or strongly suspected. This unfortunately will have little practical effect for two reasons 1. There is no additional deterrent against bad practice thrown up by inspections that are only ever commissioned when a problem has already come to light by other means 2. In the absence of legal obligations and an enforcement mechanism, a setting can ignore the results of a CPA inspection and carry on as before. A legally enforceable obligation to carry out certain safeguarding functions combined with an ever-present possibility of being inspected against them (even if in practice inspections are rare) would be a much more effective measure
Not sufficiently targeted at child protection	

44. Inspection activity is not routinely targeted at child protection. In the context of schools there are limitations on an inspectorate's ability to judge the adequacy of an institution's approaches to child protection. For example, the Inquiry found instances where education inspectorates considered that an institution met or exceeded expectations of safeguarding only for it subsequently to come to light that children were being sexually abused at school or otherwise experiencing harm because of poor practice. The current system of inspection may lead to false assurances about children's safety. Where reports include positive comments about safeguarding or children's feelings of safety, readers could be left with a false impression that the institution's child protection practices have been rigorously examined. A 'good' or 'outstanding' rating from Ofsted may lead to less oversight.	This is a clear description of shortcomings by Ofsted and ISI and the reasons for such shortcomings: i.e. that "Inspection activity is not routinely targeted at child protection". However IICSA has not made the necessary operational deduction, that inspection for safeguarding and child protection needs to be put into the hands of a specialist body whose sole function is the inspection of these matters. The Commission for Social Care inspection ("CSCI") was unfortunately closed and its function given to Ofsted which then failed to adhere to inspection undertakings given by Ofsted to CSCI prior to handover. Here is an example of a CSCI inspection from 2004.
45. Inspection activity covering a range of topics did not necessarily identify poor child protection practice. General inspections did not have the focus required to undertake detailed analysis. As the Inquiry identified, child abuse – particularly of a sexual nature – is often hidden from view, whether deliberately masked by other activity or through inertia.	See comment above.
Multi-agency focus	

46. Statutory inspectorates are required to concentrate on specific sectors that make up the child protection and safeguarding system, targeting particular areas of interest or concern (for example, child sexual exploitation) and resulting in a narrative report about the work of local partnerships and agencies. Poor cooperation between frontline services has been a long-standing and frequent focus of criticism – for example in serious case reviews – and is an issue that often attracts recommendations for improvement. It is important that these arrangements are subject to external scrutiny, including by the CPAs. Although there are arrangements in England and in Wales for joint thematic assessments of child protection, there is no standing 'joint inspectorate', despite the importance placed on multi-agency working in child protection.	There are two separate issues that seem to be getting mixed up in the various paragraphs of this section: • Inspection of the safeguarding arrangements of schools and other regulated activities caring for children • Inspection of the child protection arrangements of statutory bodies (such as LA children's services) specifically tasked with child protection. There is clearly a need for an effective inspection regime in both cases, but the detailed requirements on the inspectorate and the processes being inspected will differ between them. It would be better to have a separate set of recommendations for the two cases. Mandate Now's knowledge and expertise is limited to the first case (inspection in schools and other regulated activities) and we will make no proposals for the inspection of statutory agencies, save the general point that to be effective, any arrangements will need to be clear, consistent and enforceable. IICSA has already (in the case of Lambeth Council) concluded that the knowledge of the right thing to do is not by itself a guarantee of good practice even for statutory public bodies specifically tasked with child protection.
47. Multi-agency inspections are important but do not take place with the regularity of single-agency inspections and do not receive the profile associated with single-agency inspections. Most schools, for example, will advertise a 'good' Ofsted inspection. However, little is known about the findings of multi-agency inspections of child protection, which do not attract the same profile in the public domain, despite their importance.	From the context, it appears that IICSA here is speaking of joint inspections of groups of statutory bodies tasked with child protection, inspecting *inter alia* the effectiveness of their inter-agency co-operation.
Inspection powers	

48. The Inquiry therefore recommends that an expert inspectorate department is established within the CPAs in England and in Wales. The CPA should have powers to inspect multi-agency arrangements and individual institutions and settings. Expertise from other agencies might be seconded to assist when necessary.	The two separate aspects of inspection are grouped together here again. It suggests that how inspection will be effectively organised has not been properly thought through by IICSA.
49. Multi-agency inspection activity should be limited in the first instance to those areas most in need of independent scrutiny. It is important, however, that the CPAs hold leaders to account for multi-agency child protection practice. As the CPAs become more established, a regular and systematic inspection programme of multi-agency performance should become normal practice.	
50. Institutions and settings which regularly come into contact with children but are not independently inspected should be subject to statutory inspection by a CPA when appropriate. Religious organisations are a good example of a sector where, had there been statutory inspections in the past, failings identified by the Inquiry might have been exposed. The power to inspect such institutions should be used sparingly as the CPAs should be encouraging and supporting good practice. Nevertheless, in circumstances where the public interest demands intervention, the CPAs should have the power to conduct an independent, in-depth inspection, following up on any recommendations it makes with further inspection activity, if necessary.	The phrase "statutory inspection" has little or no meaning unless there are legally enforceable requirements that can be inspected against. The "power to conduct an independent, in-depth inspection" is worthless unless there is the means to ensure that improvements are actually made as a result. But according to paragraph 52 below this will not happen.
51. The CPAs should have the power to inspect institutions and settings that are already inspected by statutory inspectorates. This power would be deployed on the rare occasions when the institution in question has persistently failed to respond effectively to previous inspection reports or the state of child protection was so poor that the public interest and concern demanded further scrutiny by an inspectorate unconnected to a particular sector.	

52. It is not intended that the CPAs will have powers to regulate an institution by, for example, imposing a sanction for failure to implement improvements, though other bodies with appropriate powers could take action. This would not preclude the CPAs referring an institution to other bodies with appropriate regulatory functions. The public exposure of failings in any report is envisaged to be sufficient to bring about the necessary changes. In line with other statutory inspectorates, the CPAs should have the power to inspect documentation from any relevant institution and to enter premises.	This is a mess. CPAs will not have powers to regulate an institution but can "[refer] *an institution to other bodies with appropriate regulatory functions*". These regulatory functions are unspecified. No proposal is made for harmonising the legal obligations for safeguarding between the institutions subject to the different regulatory bodies. Nor is any proposal made for harmonising the means by which the regulatory bodies will act. Furthermore, there are a wide range of bodies (e.g. religious settings) which lack any kind of external regulatory body. The idea that "*the public exposure of failings in any report is envisaged to be sufficient to bring about the necessary changes*" is embarrassingly naïve and directly at odds with IICSA's own experience. It has doled out lots of bad publicity to a wide range of institutions, and yet the extent to which improvements have been made voluntarily by government and non-government bodies is minimal. A classic example of this is Ampleforth College, the subject of a highly adverse report published by IICSA in August 2018 following widely publicised hearings in November-December 2017. Had "bad publicity" been sufficient to ensure good practice thereafter, then Ampleforth would not have been placed under a DfE warning notice in July 2018 and an Enforcement notice in November 2020, failed an emergency Ofsted inspection in September 2020, nor the subsequent three inspections over the next 12 months. It wasn't until October 2022 when (presumably under direct threat from DfE of deregistration and therefore closure) Ampleforth finally passed an Ofsted inspection of its safeguarding.
53. The annual reports of the CPAs should be laid before Parliament. Other reports will be published and may be laid before Parliament. The CPAs will also make recommendations as appropriate.	
C.5: **A cabinet Minister for Children**	

54. The introduction of the Child Protection Authority should be coupled with the introduction of a cabinet Minister for Children. This post would provide a sharper focus within government on critical issues which affect children and would provide the necessary leadership, profile and influence on matters of child protection.	It also appears that the cabinet position has not been fully thought through. More on this below.
England	
55. In order to maintain the profile of child protection and deal with the challenges of reform, a Minister for Children should be created with cabinet status. The Minister for Children would be required to work across government departments to enable the welfare of children to remain a high priority.	
56. At ministerial level, there are areas of overlap in responsibilities within government between issues of child protection and the protection of vulnerable adults, and the portfolios of ministers are necessarily complex. For example, the Minister for Safeguarding sits in the Home Office with responsibility for the policy area of violence against women and girls. The Children and Families Minister sits in the Department for Education and deals with subjects as diverse as school food and children's social care. Both ministers have wide ranging responsibilities and hold the title of Parliamentary Under Secretary of State, the most junior ministerial position.	

57. A Minister with cabinet responsibility for children would bring the diverse strands of policy development together by giving a voice to the child's perspective. The creation of such a post would signal the priority and importance attached to this role and importantly provide strong, single leadership for child protection at the highest level. Additionally, the Minister for Children would be able to sponsor the CPA and, when necessary, commission inspections from the CPA.	The problem is that the implementation of all this is left as an exercise for the reader. There are no specific proposals as to which functions will be transferred to the Minister for Children. For instance, if coordination of safeguarding inspections is to be managed through the CPAs (reporting to the Minister for Children) how will this be managed when inspections of schools are still being carried out by ISI and Ofsted (which report to DfE, and presumably will continue to do so for the educational standards aspects of their work)? It is all very well to say that a Children's Minister will "provide strong, single leadership for child protection at the highest level" but leadership only exists where there is a willingness for others to follow.
58. The appointment would inevitably mean working across government to improve outcomes for children. It may, of course, be possible to reallocate certain policy areas to facilitate greater cohesion across all aspects of children's welfare. That is a matter for the government. The essential point is that the role of children in society is given a different status than the one that has existed in reality in institutions over many decades. The government should lead the way in signalling the leadership required.	It's all very well to say that how all this is organised "is a matter for the government". That's true of just about everything government does, but it hasn't prevented IICSA from making specific proposals elsewhere. But here, there is no specific proposal for how to make all this work, and there is every reason to believe this is because IICSA has no idea what it wants the Children's Minister to do.
Wales	
59. The Welsh Government comprises 14 ministers, of which nine are cabinet members.	
Safeguarding of both adults and children is the responsibility of the Minister for Health and Social Services, and safeguarding in schools is the responsibility of the Minister for Education and the Welsh Language. There are no formal departmental divisions within the Welsh Government, instead it is divided into four groups: the Office of the First Minister Group, the Health and Social Services Group, the Education and Public Services Group and the Economy, Skills and Natural Resources Group.	

60. The creation of a further cabinet post may be more difficult in Wales, given the number of ministerial arrangements, and so the Inquiry's recommendation is couched slightly differently to provide the Welsh Government with an appropriate degree of flexibility to implement this recommendation. However, the principled consideration that children's welfare should be given greater priority and status with single leadership at high office remains the same.	
Recommendation 3: A cabinet Minister for Children The UK government The Inquiry recommends that the UK government creates a cabinet-level ministerial position for children. The Welsh Government The Inquiry recommends that the Welsh Government ensures that there is cabinet-level ministerial responsibility for children.	While this measure is welcome, much more work should have gone into defining which responsibilities would be moved to the new minister and how the relations with other departments would be addressed.
C.6: **Attitudes to child sexual abuse**	
61. Alongside elevating the status of children in the political sphere, there remains a need to raise public awareness about child sexual abuse. Myths and stereotypes about child sexual abuse are still held by many. Outdated attitudes that perpetuate myths, for example that children lie about being abused, need to be dispelled, and although society's attitudes to child sexual abuse have changed, more work is needed to ensure that members of the public are better informed.	Better public awareness is always welcome, but changing attitudes this way is a slow and haphazard process. Changes in attitude usually follow changes in law – the introduction of mandatory seat-belt wearing and drink driving law are classic examples. Decades of public information films on both subjects had little effect on numbers of fatal road traffic accidents, but the passing of laws for both saw an immediate drop in accidents and the number of fatalities. This extract from article by Professor Furnham (UCL) makes the point well.
Historical attitudes	

62. Sexual abuse of children has long been recognised as morally wrong. It was recognised as legally wrong in 1885, when the age at which individuals could consent to sex was raised from 13 to 16 years old to protect the "virtue" of young girls and punish their "violators". Archaic language was used to describe child sexual abuse and, in the early part of the 20th century, included phrases such as "immoral relations", "indiscreet fondling", "fooling" and "philandering conduct". This language served to minimise abuse and frame it as a contravention of social mores around marriage and relationships.	
63. Between the 1940s and the 1960s, child sexual abuse was not believed to be widespread and was thought only to affect certain groups across society (such as the "lower social classes". Beliefs that there was such a thing as a "seductive child" and that child sexual abuse was "not harmful" persisted into the 1990s.	
64. In the 1960s and 1970s, some malign influences advocated to reposition child sexual abuse within broader societal debate about sexual liberation. The Paedophile Information Exchange (PIE) was one group that sought to garner support for the idea that paedophilia was a legitimate type of sexual attraction. Organisations such as the Albany Trust and the National Council for Civil Liberties (now known as Liberty) and prominent public figures gave support to PIE. PIE was able to gain a platform for its agenda to lower the age of consent, and argued that sexual activity with a four-year-old should be 'allowed' within the family setting, with the age of 10 being applicable in other contexts. In part as a result of the support it received, some of PIE's suggestions appeared to gain traction.	

65. In the 1970s, 1980s and 1990s, the idea that child sexual abuse could be attributed to problems within individuals' families became prominent. In the late 1980s, those involved in political, legal and social-work spheres mooted that some responses to child sexual abuse were "over-zealous", or constituted a "moral panic" or a "witch hunt". Such narratives minimised the scale of the problem. Harmful sexual behaviour between children was described as "sexual malpractice" and those who raised concerns were belittled as being "prissy and middle class". Some placed emphasis on the needs of perpetrators of harmful sexual behaviour as vulnerable and requiring support.	
66. Between the 2000s and the 2010s, understanding about and attitudes towards child sexual abuse became more sensitive and victim-focussed. Some individuals deflected blame from perpetrators and institutions, or rationalised it by proposing that abuse was perpetrated by a small group of perverse individuals who had "something wrong with them" or occurred in particularly corrupt or wayward institutions. Others challenged this perspective and increasingly held institutions to account.	
67. In the 2000s, there was a growing awareness of the problem of child sexual exploitation.	
In October 2013, the then Director of Public Prosecutions revised the Crown Prosecution Service guidance on child sexual exploitation, providing a list of stereotypes about young victims of child sexual exploitation that should no longer undermine a willingness to prosecute. Those included the way that a victim dressed or acted, whether they had used alcohol or drugs, whether they were in a relationship with the alleged offender or whether they screamed, fought or immediately complained about their sexual abuse.	

68. Such developments were held back by a persistent characterisation of exploitation as being the result of children's 'lifestyle choices', or deliberate behaviour aimed at payment or reward. Terms such as 'child prostitution' and 'slags' continued to be used through the 2010s to describe some children, including by statutory agencies. This gave some children and young people the impression that they were not believed to be worthy of protection.	
69. More recently, this has created and perpetuated notions of 'deserving' and 'undeserving' victims of child sexual abuse. This was a wholly inappropriate and unethical way of treating serious criminality against children.	
70. The Inquiry's research found that, from the 1940s onwards, "tendencies to disbelieve allegations of child sexual abuse remained a constant thread". This led to a fear among child victims that they would not be believed or taken seriously when they disclosed their abuse, a fear that persists today. Similarly, discussions about consent and 'lifestyle choices' continue to detract from an understanding of abuse, exploitation and power dynamics.	Following on from the comment to paragraph 61, the best and quickest way to change attitudes is to make a relevant change in the law, specifically a well-designed mandatory reporting law, so that suspicions and disclosures of child sex abuse have to be taken seriously. We will make comments about the precise content of such a law in the comments against recommendation 13. It suffices here to point out the effect of law in changing behaviour and attitudes.
Changing dynamics	
71. In recent years child sexual abuse has been given greater priority on the public agenda. The establishment of this Inquiry in 2015 and its work have given the issue of child sexual abuse greater visibility in society.	
72. In January 2021, the UK government published its Tackling Child Sexual Abuse Strategy and in July 2021 its strategy for Tackling Violence Against Women and Girls. It stated that the government is "determined to build on this awareness and momentum for change".	Again, to repeat our earlier statement – we reviewed the strategy in this article. Home Office: Tackling Child Sexual Abuse Strategy 2021 | No strategy, few proposals and little money

73. The #MeToo campaign has highlighted the growing visibility and confidence of victims, survivors and whistleblowers. In its wake, the movement Everyone's Invited brought the concept of 'rape culture' dramatically into the mainstream media and public consciousness. It provided an opportunity for many victims and survivors of child sexual abuse to share their stories anonymously. By June 2022, it had received more than 50,000 testimonies. It has been an effective platform for the engagement and empowerment of victims of child sexual abuse.	
74. In April 2021, the UK government commissioned Ofsted to conduct a rapid thematic review of sexual abuse between children in schools and colleges. Estyn conducted a similar review in September and October 2021. Both reviews identified the prevalence of sexual harassment and online sexual abuse. Ofsted noted that sexual harassment and online sexual abuse are "much more prevalent than adults realise" and that the prevalence of online sexual abuse was "consistently underestimated" by professionals. Estyn found that approximately half of all pupils reported that they had experienced peer-on-peer sexual harassment, some of which took place during school hours but most of which happened online and outside school.	
75. In response to the reviews, the Department for Education announced that schools and colleges will be encouraged to dedicate an in-service training day to help train staff on how to deal with sexual abuse and harassment among pupils. It stated that a 'whole school' approach should be put in place to address this. Approaches might include classroom discussions on topics such as consent and the sending of explicit images, routine recordkeeping and analysis of incidents of sexual harassment and violence, a culture of zero tolerance for sexual harassment and online sexual abuse, and training for all staff and (where applicable) governors. It made a number of recommendations for schools and colleges, multi-agency partnerships, the government and inspectorates.	This is a tokenistic approach to the problem. A single additional INSET day will have very little effect on schools which aren't taking the problem seriously and will not be needed by the schools which are. It doesn't address at all the issue of awareness in non-school activities involving children.

76. These developments have encouraged a number of victims and survivors to discuss their experiences and disclose their abuse. It is important that the government, the media and the public have started to listen to them. This is a positive step towards improving child protection. However, more can be done to encourage and facilitate the engagement and empowerment of children and young people.	
77. Storylines and literary portrayals involving child sexual abuse also have an important role to play in influencing public attitudes and understanding of such abuse. Children and young people told the Inquiry's engagement team that, although they thought some portrayals of child sexual abuse in drama had been dealt with "in a sensitive and compelling way", the topic needed to include a focus on the long-term impacts of abuse. They expressed the view that when sexual abuse is covered as a topic, it usually concerns abuse of adults and not of children. The Inquiry's Victims and Survivors Forum emphasised that both social and traditional media had an opportunity to make a positive impact by showing victims and survivors as courageous, rather than showing repetitive presentations of shame and injury.	
78. Public attitudes to child sexual abuse may be both influenced by and reflected in the media. It is important that the experiences of victims and survivors are not undermined by the media, and that misleading or simplistic representations do not dominate debate. There have been instances in which the print and broadcast media have played a key role in exposing child sexual abuse and in increasing awareness of particular forms of abuse. In particular, investigative journalism has exposed some of the worst examples of child sexual exploitation. The Office for National Statistics suggested in its 2019 statistical analysis of child sexual abuse in England and Wales that high-profile media coverage of child sexual offences and the police response to reports of non-recent child sexual abuse may have played a part in an increase in police recording of such offences.	This is one of the reasons far more comprehensive data collection is needed. Trends in reported crime are largely meaningless when they can be affected by so many things other than the underlying actual crime rate, especially when (as the available evidence suggests) reported crime is such a tiny fraction of the underlying rate.

Empowering conversation	
79. Discussion about child sexual abuse remains an uncomfortable subject for many. Respondents to the Inquiry's 2020 survey indicated that they would feel more comfortable talking about any other topic than child sexual abuse. Younger people were least likely to feel comfortable talking about abuse. It remains the least preferred subject for discussion, with only 37 percent of people feeling comfortable talking about child sexual abuse. Many of the Truth Project participants have emphasised the importance of bringing discussions about child sexual abuse into the public arena. Children and young people who participated with the Inquiry's Engagement Team also expressed the view that there needed to be a cultural shift at societal level so that talking about child sexual abuse ceases to be a taboo. Participants stated that conversations needed to be frank, without being sensationalist or 'titillating':	
"If they want to make a change, they have to tell it like it is, that's the only way people will start taking notice of it".	
The Victims and Survivors Forum agreed that action should be taken to bring about cultural change, pointing out that people find it hard to talk openly about a subject that they fear.	'Cultural change' is heard repeatedly. The answer for this again is in the introduction of law as precedent shows. (See our link in C.6 para 61 page 55)
80. It is important that adults are able to have discussions with young people about subjects such as sex, sexuality, relationships, grooming and exploitation. Those conversations are part of society's collective duty to ensure young people are well informed and can navigate the risks of abusive and exploitative sexual relationships. Some professionals, such as youth workers, are well equipped to do so and to understand young people's perspectives in a way that can help to identify risks of child sexual abuse. But children and young people should feel able to broach these subjects in the more routine aspects of their lives should they wish to, such as with their teachers, parents and peers. Empowering children and young people to talk about this topic, and opening up discussions between them and a broad range of adults, is therefore essential.	

81. By June 2022, the UK government and the Welsh Government had undertaken a number of campaigns.	
81.1. 'Stop Abuse Together', for which the Cabinet Office has responsibility, is part of the UK government's programme of work under the Tackling Child Sexual Abuse Strategy and provides information to parents, carers and the wider public about child sexual abuse. The campaign ran on the radio, digital audio and social media channels, such as Instagram, Twitter and NextDoor, for three months between January 2022 and March 2022. Its aim was "to educate parents and the general public about child sexual abuse, including its prevalence, the signs to look for, and where to go to find further support".	
81.2. 'Enough', for which the Home Office takes responsibility, is a campaign in England and Wales which is part of the UK government's Tackling Violence Against Women and Girls Strategy. The campaign is proposed to run in stages, dealing initially with the nature of such crimes and aiming to make them less socially acceptable and to increase people's confidence to safely challenge perpetrators. Paid advertising carrying these messages ran throughout March 2022. Subsequent phases of the campaign aim to educate young people about healthy relationships, including consent, and ensure victims can recognise abuse and non-contact sexual offending. These phases are proposed to run through the remainder of 2022 and early 2023.	
81.3. In Wales, the campaign 'This is Sexual Abuse' was launched in February 2020 and is part of a broader programme designed to address domestic violence. It aimed to highlight the different types of sexual abuse (including sexual assault, rape, sexual or derogatory name-calling, child sexual abuse, harassment and female genital mutilation) and to help people to recognise the signs of sexual abuse and to seek help. It is conducted through a number of channels, including paid advertising and a social media campaign. The broader campaign programme, called 'Live Fear Free', is ongoing.	

82. Of these campaigns, only 'Stop Abuse Together' dealt specifically with the issue of child sexual abuse and exploitation. It is unfortunate that it was scheduled to run for such a short period of time and is unlikely to have the sort of profound and prolonged impact that is required to displace the taboo that is still attached to this subject.	There is no information as to any measured effect of these campaigns which indicates that the effect is likely to have been minimal and/or no attempt to measure it has been made.
83. The Inquiry therefore recommends that the governments in England and in Wales initiate specific and long-term programmes to increase public awareness of child sexual abuse.	
Recommendation 4: Public awareness The Inquiry recommends that the UK government and the Welsh Government commission regular programmes of activity to increase public awareness about child sexual abuse and the action to take if child sexual abuse is happening or suspected in England and in Wales. The programmes should: • challenge myths and stereotypes about child sexual abuse; • make maximum use of different approaches including, but not limited to, public information campaigns, the use of positive role models and creative media, such as television drama; and • be supported by continuous evaluation to measure their impact.	Improved public awareness is always welcome, but public information campaigns on a subject most people want to avoid are not likely to have very much effect. It is important that the effect of any campaigns is measured to see whether this is an effective use of public money.
Creating a more protective environment for children	
E.1: Introduction	

1. While no system can guarantee the eradication of child sexual abuse, there are measures that should be taken to help to create a protective environment for children.	
2. This begins with institutions, organisations and settings which work with or come into contact with children. It involves recruiting the right people, vetting applicants to prevent those who have demonstrated their unsuitability to work with children, putting effective child safeguarding policies and procedures in place, and providing appropriate training and monitoring to ensure those policies are understood and implemented.	Criminals don't offend if they think that the chance of being detected and caught are unreasonably high. While many abusers might have deluded themselves into believing that their actions are morally acceptable because they have persuaded themselves that the child welcomes their attentions, most abusers are rational enough to keep their offending secret because they know that society and that abusing a child is a criminal offence.
3. The Inquiry has previously made many recommendations to improve protective measures, both generally and for specific institutions. Its work has also revealed that there is patchy and incomplete regulation of occupations involving work with children in England and in Wales. Professional regulation of occupations which involve working with children can contribute to the protection of children and young people. Two important elements of an effective regime of regulation are continuing professional development or training and the power to address issues of professional misconduct.	Improvement in protective measures are fairly easy to enumerate, but boil down to a small number of key issues. • Keep those known to be a danger to children away from working with children • Ensure that all reasonably grounded suspicions get reported so that they can be independently evaluated • Train staff to understand what constitutes a reasonably grounded suspicion A potential abuser in such an environment is most unlikely to abuse because of the high risk of detection. This is our ideal state – that abuse is not merely promptly detected and stopped, but that it is prevented from occurring in the first place. This is entirely achievable.
4. The Inquiry has also identified limitations on the disclosure and barring checks available for certain roles, as well as a marked disparity in the quality of child protection and safeguarding arrangements across different institutions and different sectors.	Even if DBS worked perfectly, effective DBS checks can only ever be a supplement to the main line of defence, because people on the DBS list have already been found out once, but to get onto the list they need to be found out when there is nothing already known against them. There are major shortcomings in the DBS list which are described later.

5. To enhance the measures currently available in the workforce and in the workplace which aim to prevent abuse occurring, the Inquiry makes four specific recommendations concerning workforce registration and the vetting and barring regime.	
E.2: **Regulation of the workforce**	
6. Certain institutions or settings (the workplace) and those working in them (the workforce) are regulated to ensure adherence to appropriate standards.	
7. The criteria for workplace regulation depend on the type of setting involved and whether it is legally subject to regulation and inspection. Institutions with legal duties to safeguard children in their care – such as schools, nurseries, healthcare settings, children's homes and some other social care services, the police and young offender institutions – are regulated and inspected against standards to ensure the welfare of children.	While workplace regulation might be a good idea, it is subject to issues already described in the context of the various existing inspectorates. Simply that safeguarding and child protection is not the primary purpose of most workplaces (even those which care for children). It follows that the regulations the workforce are subject to are inevitably going to be more about overall fitness to practice than safeguarding, and the primary emphasis of regulatory bodies will inevitably be on the same subject. Therefore, the specific concentration of safeguarding and child protection will not be achieved by these measures, though one can reasonably hope for a bit of improvement at the margins. The description of current professional bodies such as the GMC in the paragraphs below demonstrates this. There is also the question (unaddressed in the final report) of whether a professional standards body, having an interest in maintaining the reputation of its profession, will have much enthusiasm for pursuing suspected cases of child abuses by its members that could bring the profession into disrepute. The inquiry has noted that many other organisations have demonstrated priorities that put such considerations ahead of child safety.

8. However, individuals working in those institutions are not necessarily subject to any form of workforce regulation, that is regulation based on their occupation. For example, children's homes must be registered with and inspected by the Office for Standards in Education, Children's Services and Skills (Ofsted) to ensure compliance with quality standards, but workers providing care for the children residing there are not regulated by an independent regulatory body.	The same workforce is also not required by legislation to report known or suspected child sexual abuse to the Local Authority or the police for independent assessment.
9. As the Inquiry noted in the Interim Report of the Independent Inquiry into Child Sexual Abuse (the Interim Report), regulation of settings responsible for the care of children by an independent regulator complements effective professional regulation of staff – it does not replace it.	
The purpose of workforce regulation	
10. Workforce regulation is intended to ensure that those in a specified occupation are suitably trained and held to appropriate standards of professional conduct. It is usually mandated in the interests of public safety and protection, such as where the occupation involves working with potentially hazardous materials or working with people in particularly vulnerable situations. It can provide public assurance that those who work with children are held to professional standards of competence, ethics and integrity by an independent regulatory body defined in legislation. For example, doctors in the UK are regulated by the General Medical Council, a public body which sets standards, maintains a register of members, assures the quality of professional education and development, and investigates complaints.	
11. The scope of a workforce regulator may be wide-ranging and extend to several occupations within that sector. It may be limited to a specific profession. A number of different regulators may operate to regulate different occupations within one sector. For example, there are eight regulatory bodies which regulate specific occupations in the health sector in England and in Wales.	

12. The powers and functions of a workforce regulator can vary. Some regulators are limited to dealing with allegations of misconduct. Others have some or all of the following roles: • controlling admission to the profession; • maintaining a register and setting requirements for registration such as qualifications and background checks; • prescribing a level of continuing professional education or training, to enhance knowledge and keep up to date with good practice; and • maintaining professional standards by investigating and determining allegations of misconduct.	
13. Where allegations of professional misconduct are made, whether or not this leads to referral to a regulatory body, employers may also use their own disciplinary process. The Inquiry encountered a number of instances where an employer's internal disciplinary measures in response to allegations of misconduct were inadequate, lacking or poorly executed.	
14. Close or regular contact with children does not automatically result in legal regulation of a particular workforce. In the social care sector in England, for example, the only regulated occupation is that of qualified social workers, even though other individuals work closely with children and with vulnerable adults, such as care workers in children's homes and care homes. As set out below, there are several key areas in which greater workforce regulation would improve the protection of children.	
The education workforce	
15. Regulation of the education workforce varies considerably between England and Wales, but neither country has a comprehensive system of regulation.	

16. The regulator in Wales is the Education Workforce Council (EWC), an independent body which drafts and maintains the code of professional conduct for education workers. It also accredits initial teacher training and keeps records of professional learning and development. All teachers and headteachers, teaching assistants and learning support workers who work in the state-funded sector in Wales must be registered with the EWC. Registration is not compulsory for those who work in the independent (fee-paying) education sector, although independent school teachers in Wales may choose to register or be required to do so by some independent schools. The EWC also investigates and determines allegations of professional misconduct or incompetence, and may apply a range of sanctions, including prohibition from teaching. This misconduct jurisdiction extends only to registered workers.	
17. As a result of this critical gap in the registration scheme, the education workforce in the independent sector in Wales is effectively unregulated. The Welsh Government has committed to extending the regulatory regime of the EWC by 2023 so that the workforce in the independent education sector in Wales would also be required to register, although the Inquiry notes that this was originally proposed in 2017. In March 2022, in its Residential Schools Investigation Report, the Inquiry recommended that registration with the EWC be made compulsory for those working in independent schools in Wales.	

18. In England, there is no longer a system of registration for the education workforce. While teachers in state schools must complete teacher training and gain qualified teacher status (QTS), those who teach in state-funded academies or in independent schools are not required to register. The Department for Education sets the standards of professional conduct for all individuals engaged in unsupervised "teaching work" in educational establishments, regardless of QTS status or whether they work in state-funded or private education. Serious breaches – which could merit prohibition from teaching, the only available sanction – are investigated and determined by the Teaching Regulation Agency (TRA). Less serious misconduct as well as issues of competence are dealt with at a local level by schools. As set out in the UK government's April 2022 White Paper, there are 270,000 teaching assistants and 230,000 other support staff in schools. However, the disciplinary regulations do not apply to most teaching assistants and learning support staff because they are "subject to the direction and supervision of a qualified teacher or … head teacher". This is a serious deficiency in the regulatory regime for those working in teaching roles in England.	
19. In February 2022, the Department for Education launched a consultation on broadening the scope of the TRA's misconduct provisions, but this did not include any proposal to widen its remit to include serious misconduct by teaching support staff working under the direction of teachers.798 In its response to the consultation dated April 2022, the UK government confirmed that it would extend the teacher misconduct regime to: • include persons who commit misconduct when not employed as a teacher, but who have previously carried out teaching work; • a wider range of education settings (specifically further education as well as post-16 and online providers); and • make provision for the Secretary of State to consider referrals of serious teacher misconduct regardless of how the matter comes to their attention.	

20. The timescale for legislation implementing these changes is currently unclear but they do not address the issues identified above. In particular, they do not address the Inquiry's recommendation in its Residential Schools Investigation Report, dated March 2022, that all teaching assistants, learning support staff and cover supervisors in England should be brought within the misconduct jurisdiction of the TRA.	
21. As at June 2022, responses are awaited from both the Department for Education and the Welsh Government regarding a number of recommendations concerning schools. This includes a recommendation to introduce legislation to change the definition of full-time education to bring currently unregistered schools within the scope of registration if they are the principal place of education for the children who attend. Registration means that the school must be inspected to ensure adherence to safeguarding standards and that those who teach in registered schools are regulated by the TRA or EWC.	
Care roles in children's homes	
22. In its investigations concerning the sexual abuse of children looked after by local authorities, the Inquiry concluded that there had been sexual abuse of children in residential care by staff. There were failures by staff to identify and act upon clear signs that children were being sexually abused and exploited by adults or other children, and failures to respond appropriately to allegations of abuse.805	
23. From the late 1970s to the early 1990s, children's residential care in England (whether provided directly by local authorities or by voluntary or private organisations) was often poorly resourced and managed, with residential care staff who were predominantly unqualified and received little, if any, training. There have been a number of issues, including the "professional and social isolation" of residential care workers as well as a lack of development resulting in "outdated, insensitive or harmful practices".	

24. In Wales, over a similar time period (1974 to 1990), the Waterhouse Inquiry into sexual and physical abuse of children in children's homes in Clwyd and Gwynedd found similar issues with inadequate management and training of care staff. The 2000 report Lost in Care recommended that staff receive training to spot signs of abuse, senior staff should be trained social workers and post-qualification training in childcare should be made available to residential care staff.	
25. Since 2010, managers of children's homes in England have been required to register with Ofsted and since 2015 have been required to obtain appropriate qualifications and undertake continuing professional development. While Ofsted will assess the fitness of a person to manage a children's home, it is not a workforce regulator. It has the power to de-register a children's home which fails to meet standards, but does not have any disciplinary function by which to regulate registered managers and hold them to professional standards of competence and conduct. Other workers in children's homes and other social care settings are not regulated in any way. There is no system of registration for the approximately 35,000 workers "mainly or solely providing care for children" (that is, in a care role) in England. In Wales (as well as in Scotland and Northern Ireland), children's social care workers must register with a regulatory body.811 Social Care Wales sets requirements for and ensures sufficient provision of training, qualifications and continuing professional development, and also has disciplinary powers for dealing with misconduct, including de-registration.	

26. In April 2018, the Inquiry's Interim Report recommended that the Department for Education introduce arrangements for the registration of staff working in care roles in residential care settings, with an independent body to maintain standards of training, conduct and continuing professional development and having the power to enforce such standards through fitness to practise procedures. In July 2021, the UK government agreed in principle that professional regulation of staff in children's homes in England could provide an effective additional means of protecting children and stated that it would keep the recommendation under review.	
27. This response is inadequate. Workforce regulation is necessary in order to better protect children in residential settings, including secure children's homes. In May 2022, the Independent Review of Children's Social Care, led by Josh MacAlister, published its final report and recommendations. The review includes a recommendation requiring professional registration of the residential childcare workforce alongside professional standards, starting with the managers of children's homes. The UK government has not yet committed to implement this recommendation, but is due to respond in full to the review later in 2022.	
28. The Inquiry therefore reiterates its recommendation that all staff working in care roles in children's residential care settings, including secure children's homes, are subject to registration with an independent regulatory body.	

Recommendation 7: Registration of care staff in children's homes The Inquiry recommends (as originally stated in its Interim Report, dated April 2018) that the UK government introduces arrangements for the registration of staff working in care roles in children's homes, including secure children's homes. Registration should be with an independent body charged with setting and maintaining standards of training, conduct and continuing professional development, and with the power to enforce these through fitness to practise procedures.	Mandate Now does not hold a strong view on this measure. It appears to us that the staff registration scheme as described, is targeted primarily at "standards of training, conduct and continuing professional development" rather than at the quality of safeguarding, and should therefore be assessed according to whether it will be effective in what will obviously be its prime function. Any safeguarding improvement is likely to be marginal and incidental without the introduction of well-designed mandatory reporting of child sexual abuse.
Staff in custodial institutions	
29. As highlighted in Part D, children in custodial institutions are "very vulnerable children in a very dangerous place". In England and in Wales, children in custody are detained in one of three types of institutions – young offender institutions (YOIs), secure training centres (STCs, currently only operating in England) or secure children's homes (SCHs). The Inquiry's work has shown that the number of reported incidents of sexual abuse of children in custody is much higher than was previously understood. Staff were alleged to have been the perpetrators in almost half of all reported incidents, with this rising to over 60 percent of incidents reported by children in YOIs and STCs.	Precisely the same issue applies to the registration of staff is other institutions and we do not propose to duplicate our comments.
30. In March 2019, the Inquiry's Sexual Abuse of Children in Custodial Institutions: 2009–2017 Investigation Report highlighted concerns that the workforce in custodial institutions is unregulated and that staff lacked specialist training, skills and qualifications. Staff working in care roles (that is, mainly or solely providing care for children) in SCHs are legally required to have a qualification in residential childcare. By contrast, even though working with children in custody is a highly skilled and demanding job, there was no requirement for staff providing care to children on a day-to-day basis in STCs or YOIs (such as prison officers) to have any childcare qualifications.	

31. There was particular concern in YOIs, where staff are drawn from the Prison Service and therefore may not have a specific motivation to work with children, or experience of doing so. Prison officers who are untrained and inexperienced in working with children may lack both child safeguarding awareness and an understanding of the particular vulnerabilities of detained children.	
32. The Youth Custody Service (YCS), responsible for the operational running of sites across the youth secure estate, told the Inquiry that there was a "drive to professionalis(e) the workforce in YOIs, STCs and SCHs". The Inquiry recommended that the YCS takes steps to ensure that its training provides staff with an appropriate understanding of safeguarding in the context of the secure estate, and that this training should be regularly reviewed and updated. Following the publication of the Inquiry's Sexual Abuse of Children in Custodial Institutions: 2009–2017 Investigation Report, a review by the YCS in October 2019 noted that "Currently no YCS site appears to be delivering training to a standard that meets the needs of the population in which it serves".825	
33. Her Majesty's Prison and Probation Service introduced a requirement in March 2022 that all staff working with children in the secure estate must undertake specialist training to gain qualifications for working with young people and children. This is a welcome development. Continuing professional development and training must be firmly embedded into the role of custodial care officers.	
34. The YCS October 2019 review proposed that the YCS should develop a code of conduct for all adults working in the youth custody sector, and that guidance and supervision should include professional conduct. It is unacceptable that there are still no sector-wide standards for those working with such a vulnerable cohort of children.	

35. The introduction of minimum qualifications for staff working with children in the secure estate falls far short of professionalising the workforce through registration with an independent body.	
36. The Inquiry's 2018 Interim Report recommendation regarding the registration of staff working in care roles in residential care settings applied equally to staff working with children in SCHs. In February 2019, in its Sexual Abuse of Children in Custodial Institutions Investigation Report, the Inquiry recommended that the Ministry of Justice introduce arrangements for the professional registration of staff in YOIs and STCs in roles responsible for the care of children in these settings. In November 2021, the Ministry of Justice stated that it had reviewed evidence collected through a targeted consultation on professional registration and was considering the issue. In May 2022, more than three years after the Inquiry's recommendations regarding the children's secure estate were published, the Inquiry was informed that the Ministry of Justice was considering the review and would subsequently publish a response to this recommendation. No timescale has been provided.	
37. A requirement for all staff with responsibility for the care of children in the secure estate to register with a regulatory body would improve the quality of care and the protection of highly vulnerable children. The Inquiry reiterates its recommendation that the government introduces arrangements for the professional registration of staff in roles responsible for the care of children in young offender institutions and secure training centres.	

Recommendation 8: Registration of staff in care roles in young offender institutions and secure training centres The Inquiry recommends (as originally stated in its Sexual Abuse of Children in Custodial Institutions: 2009–2017 Investigation Report, dated February 2019) that the UK government introduces arrangements for the professional registration of staff in roles responsible for the care of children in young offender institutions and secure training centres.	The same comment applies as for Recommendation 7.
E.3: **Recruitment, vetting and barring**	
38. Another central aspect of keeping children safe is the use of safer recruitment procedures for those who come into contact with children, whether through paid or voluntary work. This should involve application processes which focus on safeguarding, interviews that probe an applicant's values, attitudes and approaches to safeguarding, as well as rigorous examination of references and employment history, together with criminal record checks.	It is worth noting that that use of DBS is part of "safer recruitment procedures", not "safe recruitment procedures". This is because it must be recognised that every abuser abuses for the first time, and at that point is not on the DBS list. Safeguarding arrangements must therefore be capable of detecting abusers not on the DBS list. That said, the inquiry has reported several shortcomings in DBS arrangements which should be addressed and our observations on the DBS were expressed to IICSA in a submission and feature later in this review.
39. Throughout its investigations, the Inquiry encountered examples of poor recruitment practice, including failures to obtain the appropriate record checks, in schools, local authorities and religious organisations. At times, people classed as volunteers were allowed open access to children without any vetting, as a result of which children were exposed to unnecessary risk.	

40. In February 2022, the Home Office announced that it had commissioned an independent review of the disclosure and barring regime to provide assurance on its effectiveness, to identify key issues of concern about the current regime, and to assess and advise on risks and opportunities. The review, which is expected to include recommendations for improvement, is due to be completed by summer 2022. While this review may lead to significant and wide-ranging changes to the existing regime of disclosure and barring, the Inquiry has identified important deficiencies relating to the current system.	
The Disclosure and Barring Service scheme	
41. The Disclosure and Barring Service (DBS) enables organisations in the public, private and voluntary sectors to make safer employment decisions by identifying candidates who may be unsuitable for certain work, especially that which involves children or vulnerable adults. It does so by: • providing access to criminal records information through its disclosure service; • maintaining lists of individuals barred from working in regulated activity with children or vulnerable adults; and • making independent barring decisions about people who have harmed or are considered to pose a risk of harm to a child or vulnerable person within the workplace.	
42. When engaging a person to work with children, the institution or setting is responsible for complying with safer recruitment measures.	
43. Some settings may be required by specific statutory guidance to obtain DBS checks. For example, Keeping Children Safe in Education 2021 places an obligation on schools to obtain the appropriate level of DBS check before making an offer of employment for any role. There is, however, no legal obligation to do so for many employers.	

44. Applying for the appropriate level of DBS check – a disclosure certificate – is an essential part of safer recruitment because it contains details of an individual's criminal record. It will include convictions and cautions which may be spent or unspent under the Rehabilitation of Offenders Act 1974 and subject to the DBS filtering rules which remove certain older convictions and cautions, albeit not those concerning specified offences (which include violent and sexual offences, and offences against children). It can therefore provide an employer with important information about an individual's criminal background and their suitability to work with children.	
45. The disclosure regime is framed in terms of eligibility for a particular level of check. It is not generally compulsory for employers to obtain a DBS check on a prospective employee. The DBS issues four types of certificate, the extent of the check for each depending upon the role to be undertaken.	

Type of check	Certificate contains	Roles eligible	Who can obtain a certificate	Number issued in 2020/21
Basic certificate	Details of convictions and cautions that are unspent under the Rehabilitation of Offenders Act 1974	Any role (basic checks can be obtained at any time, not only for a job application)	The individual named on the certificate	2.2 million
Standard certificate	Details of unspent and spent convictions, cautions, formal police reprimands and warnings	Certain roles specified in legislation (such as solicitors, barristers, accountants and actuaries) which involve a degree of public trust	Employer (including agencies) registered with the DBS, with the individual's consent	343,000
Enhanced certificate	The same information as standard certificates but also information that the senior officer of the local police force reasonably believes is relevant and ought to be disclosed	Roles working with children and vulnerable adults, and other positions involving a high degree of trust	Employer (including agencies) registered with the DBS, with the individual's consent	168,000

Type of check	Certificate contains	Roles eligible	Who can obtain a certificate	Number issued in 2020/21
Enhanced certificate with barred list check	Barred list checks are only available with an enhanced certificate, and are not available as a standalone check	Regulated activity only	Regulated activity provider (employer, including agencies), registered with the DBS, with the individual's consent	3 million

Source: DBS000024_006

46. The DBS also offers an update service to enable employers to check for any changes to an individual's DBS certificate as frequently as they wish, but many employers do not avail themselves of this opportunity. If this service were widely advertised to employers, it might improve uptake.

Increasing access to the barred list

47. The DBS has the power to bar any person it considers to pose a risk of harm to children from undertaking 'regulated activity' with children in England, Wales and Northern Ireland. This is the term used by the DBS to describe work which a barred person is prohibited from undertaking. In 2020/21, 73,675 individuals were on the children's barred list.

48. It is an offence for a barred person to seek work in regulated activity, or for an employer to knowingly employ a barred person in regulated activity. Regulated activity does not mean, however, that the activity itself is regulated by any supervisory body, or that the worker engaged in such activity is regulated by a professional regulatory body. Many of those engaged in regulated activity with children are working in occupations that are not subject to workforce regulation, and in settings that are not regulated by any statutory regulatory authority.	
49. Regulated activity has a complex definition, set out in the Safeguarding Vulnerable Groups Act 2006. It includes the following activities, provided they are done frequently or for more than three days in a 30-day period or between 2:00am and 6:00am:	
• teaching, training or instruction, care or supervision of children (unless the worker or volunteer is supervised on a day-to-day basis by someone in regulated activity);	
• moderating a web service wholly or mainly for children;	
• providing guidance or advice, other than legal advice, wholly or mainly to children; and	
• driving a vehicle for children.	
It also encompasses those who work (other than under a contract for temporary or occasional work) for the same specific frequency in roles where they have the opportunity to come into contact with children in specified establishments, such as educational establishments (including nurseries), detention facilities for children and secure accommodation, children's homes, children's centres, and childcare premises.	

50. Some activities (such as the provision of personal care or healthcare, and registering to be a foster carer or childcare provider) are also deemed to be regulated activity, regardless of where they take place or how frequently they are performed. For example, certain statutory functions such as the inspection of childminding provision, schools, education and training, religious education and the review of local authority children's services are also regulated activities where they give the person the opportunity to have contact with children.	
51. There are three ways in which an individual may come to be barred by the DBS from engaging in regulated activity with children or vulnerable adults:	
• A criminal conviction or caution for a relevant offence results in automatic inclusion on the barred list (an autobar), either with or without the right of the convicted person to make representations to the DBS. For example, rape of a child under 13 is an autobar offence without representations, whereas the offence of sexual activity with a child under 16 but over 13 is an autobar with representations.	
• A referral by an employer, or by a member of the public, who has information which indicates the individual may pose a risk of harm to children.	
• As a result of an application for disclosure, where an individual applies for an enhanced certificate with a barred list check and the DBS considers whether their criminal history indicates they should be included on the barred list.	
52. Irrespective of the way in which an individual comes to its attention, the DBS must determine whether to bar the person from engaging in regulated activity with children. The person is either barred or not – there are no grades or levels of barring. There is also no interim barring order while the decision-making process is taking place. When the DBS includes an individual on the barred list, it will notify the individual of its decision.	

53. Roles which are within the statutory definition of regulated activity with children are eligible for an enhanced certificate with a barred list check. A barred list check can only be obtained by an employer in conjunction with an enhanced certificate – it is not available as a standalone check. If an individual applies for a role working with children which does not fall within the definition of regulated activity, only an enhanced certificate (without a barred list check) is available.	
54. The Inquiry heard that, increasingly, very little police intelligence is included on enhanced certificates. As it is the addition of this information which distinguishes the enhanced from a standard certificate, this diminishes considerably the value of enhanced certificates.	
55. There are circumstances in which a barred list check would clearly be desirable in order to protect children but such a check is not undertaken.	Some of the fault stems from the ill-considered amendments during the 2012 amendments to the Safeguarding Vulnerable Groups Act 2006. We touched on these in this article: Alternative Perspective to NSPCC – closing 'Loopholes in Sport' VictoriaLIVE 26.1.17, which included relevant debate contributions from Baronesses Heyhoe-Flint (decd) and Grey-Thompson. The nub of the issue is that a determined perpetrator can now easily work with children by taking a role that, post the 2012 amendments, falls below the threshold that demands a DBS check.
55.1. It is the responsibility of the employer to determine whether a role falls within the definition of regulated activity and to apply for the appropriate level of check. The statutory definition of regulated activity is complex and often difficult for employers to understand. The Inquiry understands that the majority of queries received by the DBS from employers concern uncertainty about whether a role amounts to regulated activity. Although there is guidance around the definition of regulated activity, many of the examples draw on schools and other statutory settings with a full-time working environment, making it difficult to apply to other organisations (such as religious settings and charities) where there is a greater dependence on part-time and volunteer workers as well as different roles than are envisaged in the guidelines.	The definition of 'Regulated Activity' is unclear which explains why we list the roles to which our draft legislation for mandatory reporting of child sexual abuse must apply. A facsimile of our proposals is in this live Private Members Bill at the time of writing.

55.2. In 2012, the definition of regulated activity was narrowed to exclude roles which are subject to "day to day supervision" by another person who is engaging in regulated activity. As a result, a role may involve a degree of close contact with children but may not fall within the statutory definition of regulated activity (such as volunteers supervised to a greater or lesser degree by a member of staff). The legislation states that a person does not engage in regulated activity if they are subject to "such day to day supervision as is reasonable in all the circumstances for the purpose of protecting any children concerned". Guidance states that the appropriate level of supervision is a matter for the employing organisation to decide. This compounds the difficulty organisations face when trying to understand which roles are regulated activity.	Please see our comments in the preceding paragraphs.
55.3. There is also a limitation on who has access to the children's barred list. Enhanced certificates together with barred list checks can only be requested by an organisation which is registered by the DBS as a regulated activity provider. Self-employed people – such as a private tutor providing academic or music tuition – can only obtain a basic certificate for themselves and cannot obtain a barred list check, regardless of the work they undertake. Neither can the individual engaging the services of the self-employed person obtain an enhanced certificate with a barred list check. As a result, those who engage self-employed people to work with children are denied access to important information regarding an individual's risk of harm to children. In its 2021 Tackling Child Sexual Abuse Strategy, the UK government noted the need for:	
"a cross-Government feasibility study looking at ways to create eligibility for criminal record checks for those who are self-employed, so that all those working with children and vulnerable people are subject to the same standard of Disclosure and Barring Service checks".854	

56. Where the DBS has determined that an individual poses a risk of harm to children such that they should be barred from regulated activity, this information ought to be available to any organisation or individual considering whether to engage the person in any paid or unpaid role working with children, whether supervised or not. The current disclosure regime permits those who have been assessed as so dangerous that they have been barred from regulated activity to nevertheless come into contact with children in roles that do not meet the definition of regulated activity. This places children at risk.	
57. The Inquiry considers that all employers of adults who work with children (whether paid or voluntary) should be able to check whether applicants have been included on the children's barred list, in order to ensure that children are kept safe from those who pose a risk of harm.	
Recommendation 9: Greater use of the barred list The Inquiry recommends that the UK government enables any person engaging an individual to work or volunteer with children on a frequent basis to check whether or not they have been barred by the Disclosure and Barring Service from working with children. These arrangements should also apply where the role is undertaken on a supervised basis.	Mandate Now supports this recommendation.
Improving notifications to the Disclosure and Barring Service	
58. There is a legal duty on employers to notify the DBS (known as making a referral) when they have dismissed or removed an individual from undertaking regulated activity or when an individual has resigned from such a role, where there is concern that the individual may pose a risk of harm to children.	The inquiry received evidence (for instance in the hearings into Ealing Abbey/St Benedict's School) that even when failure to notify the DBS (which is against the law) is detected, the institution is required to do nothing more than make a retrospective notification. While DBS notification is mandatory in theory, there appears to be no current enforcement mechanism and no prosecutions have been brought.

59. The DBS indicated to the Inquiry in October 2019 that it did not receive the number of referrals it would expect from employers, but it has no means to discover when an institution fails to make a referral in circumstances where notification is legally required. Some inspectorates require organisations to demonstrate they comply with their statutory duties of making DBS referrals as part of their inspection framework. For example, Ofsted includes this in the inspection framework for schools and for early years settings, but not in the inspection framework for children's homes. The Care Inspectorate Wales, which inspects regulated non-school settings for children up to the age of 12 in Wales, does not mention DBS referrals in its inspection framework.	Given the lack of enforcement, it is hardly surprising that DBS is experiencing under-reporting. This is an important point relevant when we come to recommendation 13 on Mandatory reporting. Please see the second link in our comments in paragraph 58 which provides a link to our letter to the Chair of the Inquiry about the DBS shortcomings. The inspectorates inspecting against referrals and reporting upon them in their school reports, to the extent it is possible without breaching confidentiality, continues to fail parents, children, local authorities and the settings themselves. This has been the subject of detailed and exhaustive work by a barrister who works closely with Mandate Now. Here is his submission to IICSA (INQ006384) via Slater Gordon during the Residential Schools strand. Having read it one cannot help but reach the conclusion that the inspectorates, with the approval of successive Governments, have determinedly not inspected against these extremely important referrals. The only conclusion one can reach is that both Government and the inspectorates prefer to keep the public unsighted from safeguarding concerns and therefore stop potential new parents and local authorities from asking challenging questions.
60. While supervisory authorities (workforce and workplace regulators and inspectorates) have the power to refer individuals to the DBS to consider for inclusion on the barred list, they do not have a legal duty to refer or to share information with the DBS unless in response to a specific request. The DBS has developed information-sharing protocols with some workforce regulators such as the TRA and the General Medical Council, which means that these bodies cross-refer any cases with a safeguarding element. However, the DBS told the Inquiry that not all inspectorates or regulators routinely share information with the DBS about resignations and dismissals in circumstances where child protection or safeguarding concerns have been raised.	The porosity of the DBS service and the failure to apply the mandatory reporting obligation renders the DBS unreliable and therefore unsafe.

61. In its Interim Report, the Inquiry recommended that the Safeguarding Vulnerable Groups Act 2006 be amended to place keepers of relevant registers under a duty to refer information about practitioners who had been removed from the register to the DBS. It also recommended that upon receiving the referral, the DBS should be under a duty to automatically bar the practitioner from working with children (subject to the opportunity to make representations). In July 2019, the UK government responded that the Home Office had asked the DBS to continue its "close engagement" with professional bodies and regulators to ensure effective information-sharing takes place. It also stated that the DBS had not identified any emerging issues, despite the evidence received by the Inquiry in October 2019.	The status quo was thereby maintained by Government.
62. The Inquiry remains concerned that individuals who have ceased working in a setting with children and who have acted in a manner which indicates they may pose a risk of harm to children are not always referred to the DBS. This could permit such individuals to move on to a different setting where they continue to work with children, without the DBS considering the potential risk of harm which they pose. As there have been no prosecutions to date for failures to refer, lax employers have little incentive to comply with their legal duties.	See the link in Para 58 which precisely addresses this point to the Chair IICSA.
63. Action is needed to improve regulated activity providers' compliance with their statutory duty to refer concerns about the suitability of individuals to work with children to the DBS. Regulators and inspectorates with responsibility for children's settings should share information with the DBS to ensure that the DBS is suitably informed regarding adults who may pose a risk of harm to children.	See the link in Para 58 which precisely addresses this point to the Chair IICSA.
64. The Inquiry therefore recommends a number of steps to increase compliance with the statutory duty to refer concerns to the DBS.	

Recommendation 10: Improving compliance with the statutory duty to notify the Disclosure and Barring Service The Inquiry recommends that the UK government takes steps to improve compliance by regulated activity providers with their statutory duty to refer concerns about the suitability of individuals to work with children to the Disclosure and Barring Service, including: • all relevant regulators and inspectorates include compliance with the statutory duty to refer to the Disclosure and Barring Service in their assessment of safeguarding procedures during inspections; • the National Police Chiefs' Council works with relevant regulators and inspectorates to ensure that there are clear arrangements in place to refer breaches of the duty to refer to the police for criminal investigation; and • an information-sharing protocol is put in place between the Disclosure and Barring Service and relevant regulators and inspectorates.	Mandate Now unreservedly supports improvements in inspection and enforcement to improve compliance with obligations to make DBS referrals mandatory. We are concerned about the specific form of the recommendation, in that the responsibility for enforcement and particularly for investigating and mounting prosecutions remains somewhat diffuse. We are concerned that where there is no single body responsible for investigation and prosecution. Unfortunately, IICSA has not made clear that the inspectorates must report upon their inspections of referrals in school reports.
Disclosure for those outside the UK	
65. A DBS check may not provide a complete picture of an individual's criminal record if the individual has a criminal record outside the UK. DBS checks on citizens or residents of England and Wales also cannot be accessed by employers based overseas, such as British International Schools, unless the employment decision is being taken in England or Wales. The non-statutory International Child Protection Certificate (ICPC), introduced by the National Crime Agency which some overseas organisations choose to utilise, does not include access to the DBS children's barred list.	
66. These territorial limitations on the DBS disclosure regime facilitate predatory offenders from England and Wales to exploit the system by obtaining employment working with children overseas.866	

67. In its Children Outside the United Kingdom Investigation Report, the Inquiry recommended that the geographical reach of the DBS be extended to enable overseas employers to obtain DBS checks on UK nationals and residents of England and Wales whose role would be within the definition of regulated activity. In response, the Home Office stated that the information provided on an ICPC was broadly similar to that on an enhanced certificate and that the ICPC was simpler and easier for foreign employers to obtain.	
68. The absence of barred list information on the ICPC creates a significant risk to the safety of children in the UK and abroad. The Inquiry therefore reiterates its recommendation that the disclosure and barring regime should be extended to those working with children overseas.	
Recommendation 11: Extending disclosure regime to those working with children overseas The Inquiry recommends (as originally stated in its Children Outside the United Kingdom Phase 2 Investigation Report, dated January 2020) that the UK government introduces legislation permitting the Disclosure and Barring Service to provide enhanced certificates with barred list checks to citizens and residents of England and Wales applying for: • work or volunteering with UK-based organisations, where the recruitment decision is taken outside the UK; or • work or volunteering with organisations based outside the UK, in each case where the work or volunteering would be a regulated activity if in England and Wales.	This is not particularly within Mandate Now's area of knowledge and expertise, but it seems a modest and sensible reform worthy of support.
E.4: Safeguarding and child protection policies	

69. Statutory guidance in England and in Wales makes clear that everyone who works with children has a responsibility for keeping them safe. To achieve this, all organisations which work with children or whose members may come into contact with children should adhere to basic child protection standards and have suitable safeguarding policies and procedures in place. This will assist in protecting children from individuals in these settings who may seek to establish relationships of trust and authority with children in order to create opportunities for abuse.	Note the use for the word "***should***". There is no legal requirement to "adhere to basic child protection standards and have suitable safeguarding policies and procedures in place". For uninspected "regulated activities" there is no requirement and no enforcement mechanism. This includes sports clubs, youth clubs, religious settings – all major activities. Inspected settings such as schools do have some enforcement mechanisms available. State schools, being government-owned, are subject to the power of government that way. Independent schools are also inspected and can in extreme circumstances be deregistered. However, the recent experience of Ampleforth College shows firstly how poor the inspection for safeguarding is, and secondly that the government (having no intermediate sanction) is extremely hesitant about deregistering a school and thereby forcing its closure.
70. Those who work with children, whether in the statutory, voluntary or private sectors, are in a position to identify signs of abuse or to receive disclosures or allegations of abuse from children. Policies and procedures should therefore set out the response to concerns about a child or allegations of abuse, including clear information about reporting and recording in order that allegations can be passed on to the police or children's social services for investigation.	There's that word "***should***" again. If policies and procedures don't do what they "***should***" in many cases there is nothing anyone can do about it.
71. While there is a requirement for institutions in certain sectors to set policies, others are under no legal obligation to do so, despite children visiting their facilities, attending their events or otherwise being involved in the organisation. For example, a child might go to school during the day, play football with a club in the afternoon, attend a prayer group in the evening and then spend time at night on a social media platform. Of the four settings or organisations providing these activities, only the school has a legal obligation to have child protection and safeguarding policies and procedures in place.	Even the school is not required to have procedures complying with "Working Together". All that is required is that its procedures "***have regard***" for what Working Together says. Legal precedent has concluded that '***have regard***' means: '**take the … guidance into account and if they decide to depart from it, they must have and give "clear reasons" for doing so** …'. This gives leaders of institutions latitude which for a safety-critical function such as safeguarding is highly unsatisfactory. Failure to follow 'guidance' is one of the key reasons that prompted the Home Office to commission the statutory inquiry.

72. A number of the Inquiry's investigation reports considered the safeguarding frameworks of particular institutions and sectors and made recommendations for specific improvements. The overarching principle, however, is that policies and procedures should be designed to optimise children's safety and well-being, to recognise signs of abuse, to identify concerns such as inappropriate conduct of adults towards children, to respond to disclosures and to take appropriate action. They should enable adults who come into contact with children to understand their role and responsibilities. While policies or procedures cannot themselves prevent abuse, they play an important role in reducing the risk of it occurring.	There's that word "***should***" again.
Statutory obligations	
73. The Inquiry encountered instances of institutions whose policies were incomplete or out of date. Some schools had policies which were not updated to reflect the latest guidance, or which did not include procedures for handling allegations of child sexual abuse by members of staff. In custodial institutions for children, child protection policies were out of date and lacked clarity regarding procedures for reporting and responding to allegations against staff. In some children's homes there was a lack of policies, procedures and training for staff.	

74. The Children Act 2004 places named statutory bodies in England and in Wales under a duty to ensure that their functions are discharged "having regard to the need to safeguard and promote the welfare of children". These statutory bodies include local authorities, NHS organisations, the police, prisons and young offender institutions, the probation service and youth offending teams. They must follow statutory guidance, published by the Department for Education (Working Together to Safeguard Children in England and Working Together to Safeguard People in Wales).	This statutory obligation is considered part of "public law". There is no criminal sanction if the individuals running the bodies fail to comply with the obligation. Nor is the obligation actionable in a civil claim for damages, though a breach of this obligation may be used in support of a civil claim, such as a claim in negligence. Nonetheless, it is a broad statement of principle to which regard must be had, rather than a hard-edged obligation. Essentially, what this obligation means is that the relevant bodies must carry out their functions having regard to the need to safeguard and promote the welfare of children, and a failure to do so when formulating a policy or making a decision may mean that the policy or decision can be challenged in an application for judicial review. However, the weight to be given to this need, so long as it is taken into account, is one for the decision-maker and *"the courts have emphasised the importance of not imposing too high a burden"* (see *R (on the application of Pharmaceutical Services Negotiating Committee) v Secretary of State for Health* [2018] EWCA Civ 1925 at [84]). The remedy for failure to obey public law is different and described here https://publiclawproject.org.uk/what-is-public-law/ In brief, where a public body acts unlawfully, there are a number of ways that those affected can challenge that behaviour or decision. These include: • Complaining using public bodies' complaints procedures or Ombudsmen • Exercising rights of appeal to a tribunal (if such rights exist in relation to the particular decision to be challenged, such as in welfare benefits cases) • Asking a public body to review its decision • Through judicial review It is notable that there are significant hurdles to bringing a public law case to judicial review, and that none of these mechanisms provide for a penalty to be

	levied on the body breaking the law, save for the possibility of some award of damages – the remedy is usually merely an order to start behaving lawfully. Public law principles and remedies generally only apply to public bodies, which of course the “named statutory bodies” are. It is also incorrect to state that these bodies “must follow statutory guidance”. S.11(4) of the Children Act 2004 (and s.28(5) for Wales) obliges the relevant bodies to “have regard” to the guidance. As a matter of public law, they should not depart from it without cogent reasons but, again, this is a public law matter. The guidance is not actionable or directly enforceable – though, again, a failure to follow the guidance may be used in support of a civil claim. Otherwise, so long as a relevant body has taken the guidance into account, its actions and decisions will be lawful. Again, there is no liability directly imposed for failing to follow the guidance.

75. Under the Education Act 2002, schools and educational establishments have a similar duty to "safeguard and promote the welfare of children". They must comply with the relevant statutory guidance, including Working Together guidance as well as Keeping Children Safe in Education (KCSIE) in England and Keeping Learners Safe in Wales.	This is incorrect in a number of ways. Firstly, whilst it is correct to say that this duty is "similar" to the duty discussed in paragraph 74, strictly speaking the duty in s.175 of the Education Act 2002 is not to "safeguard and promote the welfare of children", but to exercise functions "*with a view* to safeguarding and promoting the welfare of children" (emphasis added). Moreover, this obligation is again a "public law" obligation. The obligations of section 175 of the Act apply to a local authority, the governing body of a maintained school, the governing body of an institution within the further education sector, the proprietor of a 16 to 19 Academy, and to the Secretary of State. As above, there is no criminal or civil liability, albeit a breach of the obligation might be used in support of a civil claim. Again, the law does not (as the report incorrectly states) require these bodies to "comply with the relevant statutory guidance". 175(4) merely requires the bodies listed to, *"in considering what arrangements are required to be made by them under that subsection, have regard to any guidance given from time to time (in relation to England) by the Secretary of State or (in relation to Wales) by the National Assembly for Wales".* The legal meaning of the phrase "have regard" is not straightforward. Where statutory guidance is relevant to a decision, it should be followed unless there are cogent reasons not to. This is some way short of "must comply with". Independent schools and educational establishments are outside the scope of section 175 and its obligations. Independent schools instead are covered by part 10 of the Act, comprising sections 156AA to 174. It includes section 157, which states that "regulations shall prescribe standards about the following matters" with a list following which includes an item "the welfare, health and safety of pupils at independent schools". These regulations can be established and varied by statutory instrument, see section 210(1). The relevant statutory instrument is The Education (Independent School Standards) Regulations 2014

	(https://www.legislation.gov.uk/uksi/2014/3283) as currently amended. The key section is paragraph 7, which reads as follows "7. The standard in this paragraph is met if the proprietor ensures that— (a) arrangements are made to safeguard and promote the welfare of pupils at the school; and (b) such arrangements have regard to any guidance issued by the Secretary of State." There's that phrase "have regard" again. So independent schools only have to "have regard" for guidance, and not necessarily comply with it in order to meet the relevant standard for safeguarding. Moreover, independent schools are not generally amenable to judicial review (*Proprietor of Ashdown House School v JKL* [2019] UKUT 259 (AAC) at [194]) and so there is a question over what action if any could be taken over an independent school's failure to have regard to the statutory guidance. Similar provisions apply to further education institutions (study after secondary education that is not part of higher education). Section 175(3B)(a) of the Education Act states that the Secretary of State may not "enter into an agreement with the proprietor of an institution in England for the provision of further education, unless the agreement requires the proprietor to comply with the safeguarding duties". The "safeguarding duties" are in the same form: to "have regard to any guidance given from time to time by the Secretary of State".

76. Working Together to Safeguard Children and Working Together to Safeguard People place a legal obligation on statutory agencies and organisations in England and in Wales to have appropriate child safeguarding policies in place. This includes procedures for responding to allegations against people who work with children. The legal requirement also applies to private or voluntary organisations if they are providing services on behalf of statutory agencies.	Given the analysis above, this is an incorrect description of the legal situation. The guidance does not and cannot itself impose a legal obligation. The legal obligation, imposed by statute, is to have regard to the guidance. The guidance cannot extend any legal requirement to "private or voluntary organisations if they are providing services on behalf of statutory agencies", because it is not the direct source of any legal requirement. This paragraph may be referring to a local authorities duty to promote cooperation between persons and bodies who work with children with a view to improving their wellbeing and protecting them from harm (s.10(1) of the Children Act 2004). Alternatively, it might refer to the "general duty" of local authorities to safeguard and promote the welfare of children who are in need through their services and through "the provision by others (including in particular voluntary organisations) of services". Otherwise, it is unclear where this supposed obligation on private or voluntary organisations providing services on behalf of statutory agencies comes from. It may simply be the case that, in delegating services to a private or voluntary organisation, a statutory agency is carrying out its functions and so should itself have regard to the guidance. It Is notable that, in any case, the report does not state that the legal requirement applies to private or voluntary organisations *not* providing services on behalf of statutory agencies.
Other organisations and settings	
77. Many organisations in the private or voluntary sectors provide a wide range of activities for children – including sports, dance and drama, orchestras and musical tuition, religious teaching, and groups such as Scouts. A number of victims and survivors have detailed appalling sexual abuse at the hands of coaches and tutors providing such activities.	

78. Working Together to Safeguard Children states that, in England, voluntary, charity, social enterprise, faith-based organisations and private sector organisations that work with or around children "should" have policies in place to safeguard and protect children from harm. In Wales, The Wales Safeguarding Procedures are intended to guide safeguarding practice for all those employed in the statutory, third (voluntary) and private sector in health, social care, education, the police, justice and other services. However, voluntary or private organisations in England and in Wales are not legally required to follow this statutory guidance, unless they are providing services on behalf of a statutory agency.	There's that word "***should***" again. It's an unenforceable expectation, wholly inappropriate to such a safety-critical matter.
79. Many voluntary sector and faith-based organisations in England and in Wales are also charities. Under the Charities Act 2011, trustees must take reasonable steps to protect people who come into contact with the charity from harm. The Charity Commission has published guidance called Safeguarding and Protecting People for Charities and Trustees. This guidance is seen as a "starting point", rather than a legal obligation, although the expectation of the Charity Commission is that charities will follow it. Charities are not required to report safeguarding incidents to the Charity Commission unless they amount to a serious incident which results in significant harm to people who come into contact with the charity through its work, or to the charity's reputation. Allegations of child sexual abuse are considered to fall within the definition of a serious incident, which requires the matter to be reported to the Charity Commission. Those that are registered with Ofsted would also be required to make a report to Ofsted.	The Charities Act 2011, does not have any provision about taking "reasonable steps" to "protect" people from "harm" who come into contact with the charity. This obligation is, in fact, simply the common law duty of care. The provision described concerning "serious incidents" also does not seem to exist within the Act, although the requirement to report and procedure for reporting a serious incident is referenced in "Safeguarding and Protecting People for Charities and Trustees". It may be that there are additional regulations covering all this implemented by means of Statutory Instrument. But it appears not to be in the primary legislation of the Charities Act 2011. We are currently unaware of any legal provision that requires charitable organisations "registered with Ofsted" to make a report to Ofsted of a 'serious incident'. Legal requirements are stated with great confidence but without any obvious legal justification by means of reference to a statute or regulation.

80. Organisations which have high levels of confidence in the moral calibre of their members or leaders may find it difficult to contemplate that they may pose a risk to children. This was particularly the case with religious groups. The Inquiry's Child Protection in Religious Organisations and Settings Investigation Report found numerous examples of smaller religious organisations that had no safeguarding or child protection policies in place.	
81. A number of recommendations have been made by the Inquiry to improve preventive measures in religious settings. This included, in May 2019, that the Anglican Church should disclose internal reviews or enquiries about individual safeguarding incidents to the national review body and the Church in Wales should adopt updated procedural guidance in relation to record-keeping. In November 2020, the Inquiry recommended that the Roman Catholic Church should publish its framework for dealing with cases of non-compliance with safeguarding policies and procedures. Both the Anglican and the Roman Catholic churches, as well as the Muslim Council of Great Britain, have introduced guidance, policies and procedures in response to these recommendations. It remains to be seen whether these are implemented in a manner which better protects children.	The disbelief mentioned in paragraph 80 above and the reputation protection mention in section C.3 paragraph 20 are an extremely powerful combination of motivations. Even if the churches work to implement the IICSA recommendations, it is only to be expected that (absent continuing outside pressure) there will be a regression to the behaviours of the past, since they were formed from continuing pressures in that direction over time. **The last sentence here indicates that the panel are aware of this and sceptical to some degree as to the effectiveness of their recommendation.**
82. Similarly, in the Inquiry's investigation into allegations of child sexual abuse linked to Westminster, institutional responses to allegations of child sexual abuse involving the late Lord Janner of Braunstone QC, and also Cambridge House, Knowl View and Rochdale, members of political parties were alleged or known to have gained access to vulnerable children in care through their role in local or national politics. Current practice should now prevent this. Although lacking in the past, most political parties now have specific safeguarding policies in place. However, the Inquiry heard evidence in March 2019 that there remained significant gaps, including political parties that had no such policies, and considerable variation in approach among the policies and procedures currently in place, with some having important deficiencies.	The word 'should' makes yet another appearance.

Content of policies and procedures	
83. It is critical that safeguarding and child protection policies should be clear and easy to follow and implement. They should set out how the organisation will: • protect children from harm; • ensure child protection concerns can be raised; and • respond appropriately to allegations or incidents, including reporting to the relevant authorities. They should also be subject to regular review to monitor their implementation and effectiveness at least every two years, although some settings, such as schools and the secure estate, are legally obliged to review their safeguarding policies annually.	
84. Some institutions lacked a clear understanding of the purpose and content of child protection and safeguarding policies and procedures. Even those institutions which are legally required to have such policies have admitted to having "blind spots" and inadequacies in relation to the scope of those policies. The Church of England, for example, acknowledged that some of its policies were inadequate and has since taken steps to improve them. Other religious organisations had policies and procedures that were rudimentary or incomplete, referred to obsolete statutory guidance or were heavily rooted in religious and theological texts and lacked practical information. Some paid 'lip service' to safeguarding by introducing policies and procedures without checking that these were effective, fully understood and followed. On occasion, the Inquiry encountered policies which appeared to be designed primarily to protect staff from false allegations rather than to protect children from harm and to respond appropriately to concerns.	

85. Working Together to Safeguard Children currently lacks sufficient detail regarding the content of safeguarding and child protection policies and procedures. While the guidance applies to a diverse range of institutions and needs to allow flexibility for those institutions to tailor their safeguarding arrangements to their own requirements, clearer guidance on the appropriate content of policy and procedures is needed.	This is a valid concern. within many safeguarding policies of schools and other bodies. It is depressing how many of them simply quote chunks of Working Together. What you end up with is a document that is not in fact a policy, but instead is a description of what the policy ought to contain. The guidance ought to contain a model policy (or possibly a range of model policies, one for each different type of setting) the vast majority of which can be adopted whole by the setting. This happened in Northern Ireland when in 2005 existing law was used to introduce mandatory reporting of child sexual abuse for teachers via (Section 5(1) of the Criminal Law Act (1967) which provides a criminal offence of failing to disclose an arrestable offence to the police. This includes some offences against children. Safeguarding policies became prescriptive and were supplemented by each school to suit their particular operation. It was a first class document and enabled the school inspectorate to undertake its work effectively and quickly.
86. There are, however, a number of sources of useful information. The UK government has recently published additional guidance on safeguarding to assist organisations in the voluntary sector, in furtherance of its Tackling Child Sexual Abuse Strategy. Government agencies have also partnered with voluntary bodies to provide this advice. For example, the work of the NSPCC Child Protection in Sport Unit – a partnership between the NSPCC, Sport England, Sport Northern Ireland and Sports Wales – seeks to promote safety for children in sport. Guidance on safeguarding children in the third sector is available from the NSPCC, as well as from many other training, advisory and consultancy organisations. The policies of other institutions may also provide a starting point for a new policy. For example, the Scouts Association has designed a 'Young people first' yellow card, designed to fold up and be carried in a pocket or bag for ease of reference. This sets out, briefly and clearly, the code of behaviour for all adults in the Scouts to follow, including what to do if there are concerns that a young person is at risk of harm.	The problem with these additional sources of information is that they are of distinctly variable quality and there is no means by which a layman can distinguish the good from the bad. The NSPCC told us, and an audience of 'professionals', there is a law to report child sexual abuse. The CPSU endorsed Football Association Grassroots Safeguarding Policy that was legally incorrect. Disinformation is rife not least because there is no independent accreditation scheme for individual trainers or companies that provide safeguarding training. If safeguarding and child protection is to function effectively, clarity and simplicity needs to be introduced to assist personnel responsible for the care of children. It's precisely what this subject has never had because there is a government desire that teachers, sports organisations, healthcare personnel and other Regulated Activities should refer safeguarding matters as a last resort. This is known at the 'referral threshold' which can vary from month to month in defence of an overrun system.

87. Variation between organisations is inevitable, given that the types of settings and institutions working with children vary widely. It would not be realistic or helpful to propose one single set of safeguarding and child protection policies for all institutions to apply, but this is a matter on which the Child Protection Authorities recommended by the Inquiry could assist institutions further in due course.	This is not the great challenge this paragraph suggests. Broadly speaking there are two overall groupings of organisations we need to be concerned with. First there are regulated activities (schools, youth clubs etc) which need safeguarding arrangements but whose primary purpose is something else. Then there are the statutory bodies whose purpose is child protection and investigating cases of suspected abuse. The safeguarding requirements applicable to the first group are common to all and relatively easy to summarize: safer recruitment, awareness of signs of abuse, proper record-keeping, and **unambiguous reporting procedures** to ensure that concerns are promptly referred to the statutory bodies for independent assessment or investigation. Overseas mandatory reporting jurisdictions manage this with ease. Because of their different duties within the statutory framework, there will be more variation in what the model policies should include for the statutory bodies, but some significant degree of standardisation should still be possible.
Implementation	
88. Organisations may have appropriate policies and procedures in place but struggle to implement them in their everyday practice. Regular refresher training is key to effective implementation of safeguarding and child protection policies. It helps to ensure that everyone within the institution is familiar with policies and procedures and knows how to respond to and report allegations or concerns about a child.	To repeat, the quality of training varies widely because there is no accreditation system for safeguarding trainers. Anyone can set themselves up in this area and teach the most incredible nonsense.
89. However, some witnesses were frank about the gap between policy-setting and implementation within their organisation. For example, the leader of one religious community commented that “honestly, hand on heart, it is probably put in an office file and kept in the office there to refer to”.	This in essence is a repetition of the point described in paragraph 81. A paper policy is by itself insufficient to change behaviour. To overcome the temptation towards unquestioning belief in the moral fibre of an organisation’s people and towards the need for reputation management, a continuing pressure is needed to ensure that safeguarding policies (and in particular the reporting element of them) are not only written down but also effectively implemented.

90. As noted in the Inquiry's research regarding child sexual abuse in contemporary institutional contexts, staff often did not consistently apply safeguarding policies and had narrow understandings of safeguarding responsibilities. On occasion, allegations were not appropriately reported due to a lack of knowledge or understanding of individuals' responsibilities under existing procedures. There were also failures to implement procedures when disclosures of sexual abuse were made by children.	The same point again.
91. The Inquiry's investigations identified a number of failures by organisations and individuals within them to adhere to policies and procedures. Examples included failures to: • follow vetting procedures in relation to staff members; • make relevant policies or procedures known to staff; • recognise clear signs of abuse or inappropriate staff conduct; and • investigate allegations of sexual abuse by staff or report them appropriately.	The same point again.
92. The safeguarding policies and procedures of institutions providing statutory services (such as schools, children's homes and young offender institutions) are inspected and evaluated by the relevant regulators or inspectorates to assess compliance with current regulations and guidance. Whether or not an organisation is in the statutory sector and subject to mandatory inspection, auditing or reviewing safeguarding policies and procedures to ensure that they are effective, well understood and properly implemented is the responsibility of the organisation itself. The Inquiry saw examples of institutions which undertook no internal review and relied solely on external inspections for quality assurance of their safeguarding arrangements, as well as institutions which conducted internal reviews of safeguarding but permitted no external scrutiny or independent review.	Here is another example of template policies issued by Government as described in para 85 on page 100. In NI which has prescriptive policies the inspectorate undertakes 'dipstick' tests to ensure policy is embedded wherever potential weakness might cause a concern. A unique policy for each institution removes the possibility of the inspectorate doing this or indeed thoroughly inspecting at all.

93. Policies and codes of conduct will not be effective unless they can be translated into changed behaviour and compliance monitored. Leaders retain overall responsibility for safeguarding and child protection within their institutions and must ensure that they have sufficient knowledge and awareness to exercise effective oversight. It is not acceptable, as the Inquiry saw in one school, to say that safeguarding and child protection was not within the headteacher's remit but primarily the responsibility of a designated staff member. All staff and volunteers must recognise the importance of safeguarding, know and follow policies and procedures, and understand their role within those procedures. It is important that leaders at all levels understand the context in which policies will be implemented, and have the competence and determination to convey the organisation's ethics and values to staff, so that safeguarding is seen as part of the culture of the institution.	The same point again
94. In the Inquiry's hearings about effective leadership in child protection, leaders were asked how they ensure that policies and guidance are being implemented and understood by those delivering child protection on the front line. Witnesses spoke about the "implementation gap", explaining that legislation and guidance can just "clutter the landscape" for workforces and complicate things. Ensuring that attention is paid to the conditions and support that workforces require to enable legislation and guidance to be put into effective practice was considered to be of equal importance to training the workforce. Both are essential for effective implementation of safeguarding arrangements.	The problem here is that the good leaders don't need legislation to do the right thing and to bring their staff along with them. Such leaders will be irritated by the presence of legislation that limits their flexibility in getting on with the job. But for a subject as important as safeguarding, we cannot rely on the availability of exceptional leaders always doing the right thing unprompted, simply because IICSA has found that such a state of affairs is far from universal. We need to ensure that organisations without good leaders in this area also implement effective policies and procedures. And because effective safeguarding and child protection is an inter-agency task, it also requires a degree of standardisation of procedures so that each body knows what is to be expected of others.
Identifying and reporting child sexual abuse	
F.1: **Introduction**	

1. Child sexual abuse may come to the attention of institutions in different ways and at different times: • some victims disclose what has happened to them, either as a child or as an adult; • some children show signs of abuse or engage in behaviour which properly trained individuals can identify; • some perpetrators use certain behaviours, particularly grooming techniques, which can be indicators of abuse; and • internet companies and law enforcement agencies increasingly use technology to identify abuse taking place online.	Leaving aside online abuse, we need to consider the relative preponderance of each of these indications. Section B.3 paragraph 37.3 mentions that the average delay before a victim discloses abuse is 26 years. The proportion of victims who disclose while still children is small. A system that relies primarily on child disclosure is therefore inadequate. Disclosure by the victim when an adult is useful, but a great deal of damage may have been done to other victims in the meantime. For a case to come to light by this means is **an indication of a fundamental failure of the safeguarding system to detect the perpetrator at the time**. Far more common are noticing grooming techniques and noticing behavioural or other signs of abuse in possible victims. It is prompt reporting of these that needs to be foundation of an effective safeguarding system.

2. The ability of adults to identify children who are being abused or are at risk of abuse is therefore a fundamental feature of the institutional response and an integral precursor to the reporting process. The Inquiry encountered numerous examples of failures to identify child sexual abuse. Failure to report abuse to the police or social services was an abdication of the responsibility to protect children.	It needs to be understood that this abdication of responsibility is not an entirely irrational response to the situation. Even where an organisation is not overtly hostile to reporting concerns (because of unquestioning belief in the moral fibre of an organisation's people and/or the need for reputation management), the initial evidence (usually in the form of behavioural or other signs of abuse, or indications of grooming behaviour) is often vague and equivocal, and is susceptible to innocent explanations. It is very easy for someone to ask themselves "What if I'm wrong?" Concerned about the possibility of wrecking someone's career by making an unfounded allegation, or themselves been accused of making a malicious allegation, they then persuade themselves that the innocent explanation is the right one and therefore that there is nothing to report. If someone is unfortunate enough to be in an organisation hostile to outside reporting, then they risk their career in reporting – whistle-blowers are all too often sacked for the sin of doing the right thing. **Some strong encouragement towards reporting is needed in order to overcome these hurdles.**

3. A new law is therefore required to place certain individuals who work with children under a statutory duty to report child sexual abuse to the police or social services. In conjunction with recommendations to prioritise the response to sexual abuse, new reporting obligations will dispel any reluctance felt by some in receipt of disclosures from victims and survivors to inform the statutory authorities. This in turn may ensure the statutory authorities are better informed and victims and survivors better supported.	The conclusion reached in this paragraph is entirely correct. No other plausible mechanism for overcoming the barriers to reporting has suggested itself. A well-designed mandatory reporting law will have two major psychological effects. First, through the force of law it makes it absolutely clear what behaviour is expected of people. And second, it removes reporters from the position of being whistleblowers, and into the category of people simply fulfilling their statutory duty. Thirdly, it makes a referral a neutral act because the law demands it. Organisations that have until now been hostile to reporting abuse will also have to change their behaviour as the balance of power would be fundamentally changed between the organisation and a potential reporter. If the leadership of an organisation tries to discourage someone from making a report, the reporter will now have two separate things to report – the initial incident and the potentially criminal act of trying to ensure the report is not passed on.
F.2: Identifying child sexual abuse	
4. Many children who are sexually abused do not disclose what has happened to them for years, sometimes decades. Nine percent of participants reporting abuse to the Truth Project were doing so for the first time. The oldest person who disclosed sexual abuse to the Inquiry for the first time was 87 years old. Some children never disclose that they have been sexually abused.	This paragraph demonstrates that a mandatory reporting system that depends on child disclosure or admission by the perpetrator, or the abuse being witnessed is insufficient.

5. The reasons for not reporting abuse can be complex, deeply personal and contribute to the harm caused by the abuse itself. In particular, the fear of being disbelieved was repeatedly given as a reason for not telling someone about abuse. The Inquiry also heard how feelings of guilt, shame and embarrassment prevented disclosure. Other reasons were fear of the perpetrator and of the consequences of reporting abuse, concern for their families and even for the perpetrator, or simply not having anyone to tell. As set out in the Child Protection in Religious Organisations and Settings Investigation Report, religious and cultural factors have resulted in some victims and complainants facing additional barriers to reporting their abuse. The stigma of talking about sex and healthy relationships in some communities also creates obstacles to discussing and disclosing child sexual abuse.	The point is further reinforced here. As an aside, while initiatives such as the NSPCC's TalkPants campaign will encourage some children to come forward, not too much should be expected of them because of the effect of the psychological manipulation by the abuser in keeping the child silent. The effects are clearly described in this paragraph.
6. The introduction of mandatory reporting, as described below, is intended directly to address victims and survivors' concerns that they will not be believed if they report abuse.	It has to be emphasised that disclosure by a child is rare, and it should not be expected that a mandatory reporting law will have much effect on rates of child disclosure. The research carried out in other jurisdictions (notably that of Professor Mathews in Australia) offers no indication that the introduction of mandatory reporting has an effect on the number of disclosures by children. Mathews' evidence indicates that the effect of the introduction of MR of child sexual abuse occurs on the number of reports made by mandated reporters, predominantly on the basis of "recognised indicators of abuse", and that the increase in reports has not been at the cost of a decrease in quality – the substantiation rate remained the same.
Recognising indicators of child sexual abuse	
7. Child sexual abuse almost invariably happens in private. The chance of the abuse being witnessed is therefore likely to be rare, as are obvious physical injuries resulting from the abuse. As set out in Victims and Survivors Voices, only 8 percent of Truth Project accounts reported that sexual abuse resulted directly in physical injury.	We agree that abuse being witnessed is also rare.

8. It is essential that institutions and organisations – and those working in them such as carers, social workers, doctors and teachers – receive regularly updated training on identifying potential indicators of sexual abuse as well as current and emerging threats of abuse. It is not the responsibility of the child to come forward. It is for the institution and the adults working within it to ensure that they are able to identify child sexual abuse when it is possible to do so.	This is a correct description of what needs to happen – for adults to be trained to recognise potential indicators of abuse, and promptly to report when indicators are seen. It cannot be emphasised strongly enough that "potential indicators of sexual abuse" are not a proof that abuse is occurring, they are instead "reasonable grounds for suspicion" which are deserving of referral/investigation in order to ascertain whether the child is in need of intervention. **This, and the preceding paragraph, indicate that referral of known and suspected child sexual abuse is a key component of functioning safeguarding.**
9. There are various potential indicators of abuse, which often overlap.	
9.1. Statutory guidance, both in England and in Wales, provides some assistance so that individuals who work with children are able to identify the indicators of child sexual abuse. For example, the All Wales Practice Guides note that those who work with children need to be vigilant to the physical, emotional and behavioural indicators of child sexual exploitation. These could include the possession of money, clothing or technological items, including expensive mobile phones, where there is no reasonable explanation for having them.	Paragraphs 9-17 describe the many varieties of potential indicator that exist, which currently often either go unrecognised, or if recognised often go unreported.
9.2. The NHS website also provides non-exhaustive lists of indicators of child sexual abuse and of child sexual exploitation.	

Some of the following signs may be indicators of sexual abuse: • Children who display knowledge or interest in sexual acts inappropriate to their age; • Children who use sexual language or have sexual knowledge that you wouldn't expect them to have; • Children who ask others to behave sexually or play sexual games; and • Children with physical sexual health problems, including soreness in the genital and anal areas, sexually transmitted infections or underage pregnancy. Some of the following signs may be indicators of sexual exploitation: • Children who appear with unexplained gifts or new possessions; • Children who associate with other young people involved in exploitation; • Children who have older boyfriends or girlfriends; • Children who suffer from sexually transmitted infections or become pregnant; • Children who suffer from changes in emotional well-being; • Children who misuse drugs and alcohol; • Children who go missing for periods of time or regularly come home late; and • Children who regularly miss school or education or don't take part in education.	
9.3. Practical guidance can also be found in various toolkits, such as the template created by the Centre of Expertise on Child Sexual Abuse, which are available to help professionals identify behaviours indicating that a child is being sexually abused. There is also a range of guidance available for the medical profession and for the police.	

9.4. In the case of young children, signs of distress, or behavioural signals such as selfharm, physical injury or personality and demeanour changes, or sexualised behaviour in a prepubertal child, may indicate child sexual abuse. Other children may disclose partially, attempting to convey that something is not right by, for example, writing notes or drawing pictures that indicate their abuse. As the Inquiry noted in its Children in the Care of Lambeth Council Investigation Report, small communication signs or changes in behaviour indicating sexual abuse can be both harder to identify in children with complex needs and more easily dismissed, particularly when the child is cared for by multiple carers.	
10. It is also incumbent on adults to think more broadly about behavioural indicators of child sexual abuse. For example, in a recent survey by the Centre of Expertise on Child Sexual Abuse frontline survey respondents said that:	
"they commonly considered whether child sexual abuse might be taking place when responding to situations involving human trafficking, children going missing from home, female genital mutilation, county lines and child neglect – but were far less likely to do so when responding to drink driving/road traffic offences, serious acquisitive crime and antisocial behaviour, despite research showing links between child sexual abuse and these other types of offence".	
11. The Inquiry's research report on child sexual abuse in ethnic minority communities noted that "Cultural stereotypes and racism can lead to failures on the part of institutions and professionals to identify and respond appropriately to child sexual abuse". One male focus group participant stated:	
"I did a lot of bad things; I was playing up, and I think it should have been picked up on that something's wrong … But I think if a child of colour or black kid or Asian kid maybe plays up and, you know, does things and gets violent or whatever, it's sometimes seen as typical."	

12. In its Child Sexual Exploitation by Organised Networks Investigation Report, the Inquiry identified "widespread failures" to record the ethnicity of perpetrators and victims of child sexual exploitation. As a consequence, statutory agencies may not target resources appropriately – including techniques aimed at detection and prevention – enabling the police, for example, to engage with communities where these crimes occur to take preventive action. Opportunities to identify those children most at risk of being sexually exploited may be lost.	
13. Factors potentially indicative of child sexual abuse are equally applicable to child sexual exploitation (and vice versa). There are, however, additional features of child sexual exploitation that mean that exploitation can be identified in a number of further ways. For example, a child may request contraception or testing and treatment for a sexually transmitted disease from a GP surgery, contraceptive and sexual health service, hospital or clinic. Changes in the child's daily behaviour, such as deterioration in school work, or children who come into school in an exhausted state or show a lack of engagement, may suggest that further enquiries are required.	
14. In particular, a child going missing regularly may be an indicator of sexual abuse. In a number of the Inquiry's investigations, victims and complainants stated that they would abscond from the institution in order to escape abuse, only to be returned by the police.	

15. Statutory guidance in England provides that when a child is found, a return home interview (RHI) should be offered to the child (although there is no requirement that the child participates in it). This should be conducted within 72 hours of the child returning to their home or care setting. RHIs are not a statutory requirement in Wales but there is an expectation on the part of the Welsh Government that an interview will be offered after a child has three episodes of going missing. As set out in the Inquiry's Child Sexual Exploitation by Organised Networks Investigation Report, RHIs were inadequate in most of the six case study areas examined.	
16. While not every incident of running away will be because a child is fleeing sexual abuse, regularly going missing and unexplained absences, whether from home or school, or staying out overnight should act as a trigger for adults to ascertain why a child is behaving in this way. In some cases, a child may not be running from abuse but towards it, making it all the more important that the right questions are asked. The information sought should include where the child has been, who they were with and what they were doing.	
17. Identifying signs of child sexual abuse and exploitation is not the sole preserve of professionals in contact with children. There are positive initiatives that reinforce the need for all adults to be alert to indicators of abuse. For example, in 2014 South Yorkshire Police launched Operation Makesafe, which was designed to train hotel staff to recognise the signs of child sexual exploitation. The initiative was extended to fast food restaurants, taxi companies and transport hubs and rolled out across a number of police force areas to educate workers in these sectors about how to identify and report concerns about child sexual exploitation. In January 2021, as a result of a concern about the impact of lockdowns and the need to stay indoors during the COVID-19 pandemic, Sussex Police offered free training to postal workers, delivery drivers and tradesmen to help them recognise the signs of abuse and to understand how to report concerns to the relevant authorities.	

Indicators of abuse related to the perpetrator	
18. In addition to being alive to the signs of sexual abuse being demonstrated by children, there are ways in which perpetrators of child sexual abuse can be identified.	Paragraphs 18-20 similarly describe often neglected indications of grooming behaviour.
19. Research suggests that, despite beliefs to the contrary, there is no typical child abuser. Whether male or female, there are similarities in the way perpetrators behave, particularly in the methods used to groom children. For example, research on female and male perpetrators from educational institutions indicated that sexual abuse occurred at a higher rate outside the school, such as at the cinema or in the perpetrator's home or car, rather than inside the school. The giving of compliments and special attention, along with gifts, alcohol, drugs and cigarettes, were features of the grooming techniques to sexually abuse and exploit children. As set out in the Residential Schools Investigation Report, a serious case review referred to at least 30 incidents of "inappropriate or unprofessional conduct" by a teacher at one school which "should have been viewed as suspicious". Only 11 of the 30 recorded incidents were reported to the school. In particular, there were concerns that the teacher had female-only favourites and was over-familiar and "frequently observed" to be in "inappropriately close physical contact" with some pupils. The review noted that "This behaviour is characteristic of grooming for sexual abuse and it is a further failure that it wasn't recognised as such".	
20. Ensuring that institutions, and individuals working in them, understand warning signs and indicators of potential child sexual abuse exhibited by a perpetrator is an important preventive measure. This should be addressed by the policies and procedures of an institution, and through the provision of appropriate training. It may be aided further by the Inquiry's recommendation for a public awareness campaign.	
F.4: Reporting child sexual abuse	

Institutional reporting	
47. The Inquiry's investigations have demonstrated that systemic change is needed to ensure allegations of child sexual abuse are reported. The Inquiry heard of many instances in which children who were being sexually abused made disclosures or presented information to someone within an institution, but no action was taken to inform the relevant authorities.	Paragraphs 47-51 describe instances of abuse being suspected or recognised, but not reported. Broadly speaking, the failure to report was primarily either due to incompetence (as described in paragraph 50) or protection of reputation (as described in paragraphs 48 & 49). Any effective mandatory reporting law must be able to address both causes of non-reporting.
47.1. In several cases, no steps were taken by senior leaders of institutions to report sexual abuse to the police and perpetrators continued to have unrestricted access to children.	
47.2. There were personal records of children in care and employment records of those who looked after them that contained references to behaviour amounting to sexual abuse of the child that were recorded but not reported or investigated.	
47.3. There were cases of known perpetrators who were allowed to resign, retire or transfer to similar institutions elsewhere, rather than taking appropriate action.	
47.4. In the educational field, there were instances where teachers were dismissed for sexual offending but referrals were not made for their inclusion on lists of those unsuitable to teach (despite such mechanisms having been in place since the 1920s). In some of those cases, other children were sexually abused who should have been protected by prompt and proper reporting by the adults whose job it was to keep them safe.	

48. A prominent reason that individuals and institutions failed to report child sexual abuse to statutory authorities was a desire to protect an individual or institution from reputational damage. Protection of reputation was particularly prevalent within religious, educational and political institutions, and concerns to avoid embarrassment trumped concerns about risks to children. Leaders were sometimes more focussed on controlling what information about allegations of abuse became public rather than on ensuring authorities were properly notified so that allegations were investigated.981 When concerns arose that were politically or professionally inconvenient for an individual to report, they sometimes did not do so.	
49. Similar considerations applied where institutions comprised individuals with a shared moral code, or in institutions with cultures or leaders that emphasised deference within their ranks through strict hierarchies or moral and spiritual authority. Not reporting an allegation of child sexual abuse out of a misguided sense of wanting to 'protect their own', a shared sense of defensiveness or a fear that making a report would bring their community into disrepute also featured in the evidence received by the Inquiry.	
50. In other instances, factors such as confusing or nebulous procedures for handling reports of child sexual abuse led to reports not being made. In some cases, individuals decided not to make a report because they were applying a subjective filter of credibility or 'seriousness' to an allegation. Sometimes adults simply did not believe the allegation they heard, possibly because it was difficult for them to "think the unthinkable" about the alleged perpetrator, who may be a respected colleague or friend. Prejudiced perceptions about child complainants also featured in reasons for non-reporting of complaints.	

51. Victims and survivors, some senior religious leaders and some organisations argued strongly in favour of mandatory reporting, particularly in the Inquiry's investigations into child sexual abuse occurring in religious settings and organisations and in educational establishments. As noted in Victims and Survivors' Voices, a survey by the Inquiry's Victims and Survivors Forum found that 88.6 percent of respondents said that they would like to see mandatory reporting of child sexual abuse introduced in England and in Wales.	
Current requirements to report child sexual abuse	
52. Many of the individuals who failed to report abuse to the police or social services in these and other examples that the Inquiry examined may have failed to meet their professional or moral obligations, but they did not break any laws in doing so. The legal requirements to report abuse differ between England and Wales. Neither system is an adequate model for ensuring that reports of child sexual abuse are made to the agencies that should receive them.	
The legal position in Wales	

53. In 2016, the Welsh Government enacted a duty for specified public bodies to report children at risk of harm. Under section 130 of the Social Services and Well-being (Wales) Act 2014, specified public bodies must inform the local authority if they have "reasonable cause to suspect" that a child within the local authority's area is "at risk of abuse, neglect or other kinds of harm". This duty applies to those defined as relevant partners in the Act. This includes local authorities, the police, providers of probation services, local health boards, NHS trusts and youth offending teams. There are no criminal sanctions for individuals who fail to comply with the duty to report a child at risk in Wales.	This form of "mandatory reporting" is a public law duty on institutions, not a criminal law obligation on individuals. As described earlier, enforcement and accountability of public law obligations is extremely patchy and problematic. Here is IICSA's assessment of the Act. The important points (i) the law applies to institutions at 'organisational' level (ii) **and not to individual professionals working within the organisation.** (iii) **t**here is no sanction for failing to report. It is therefore mandatory reporting in name only ('MINO'). Mr Albert Heaney (Chief Social Care Officer for Wales) attended IICSA MR seminar 2 on 30th April 2019 and commented on the impact of the Welsh Government version of alleged MR. He said it made no difference to the number of referrals. The Act has seemingly delivered no increase in referrals of child sexual abuse that arrives with well-designed mandatory reporting of known and suspected child sexual abuse.
54. Statutory guidance Working Together to Safeguard People: Volume 5 states that where a member of the public or a practitioner has reasonable cause to suspect that a child is at risk, a "report must be made as soon as possible to the local authority". The emergency services should be contacted in the case of immediate concerns about a child's safety or a criminal offence against a child. In addition, the Wales Safeguarding Procedures state that "a report must be made" by anyone working with children, including in unpaid positions, who has a concern that a child is experiencing, or is at risk of, abuse, neglect or other harm.994 This applies broadly to individuals working with children, including in schools and healthcare settings, the police, children's social care services, youth offending teams, sports clubs and voluntary organisations. It emphasises the importance of individuals reporting concerns about a child's welfare.	That "must" in the sentence: "*report must be made as soon as possible to the local authority*". is without legal foundation. There is no sanction for failure to do so.

55. The Working Together to Safeguard People: Code of Safeguarding Practice sets out the Welsh Government's expectation that all those offering activities or services to children in Wales will ensure that safeguarding arrangements are in place. This includes that organisations should have a safeguarding policy which contains information about how to report safeguarding concerns to the local authority or the police if necessary.	That word 'should' again.
56. The Welsh model leaves a number of gaps in terms of who is required to report, including all staff in independent schools and those involved with voluntary and religious organisations. There is also no sanction in the legislation for failure to report a child at risk. Any failure of a professional to report concerns is dealt with through agencies' own internal disciplinary processes and referral to professional regulators. Further, whereas section 130 of the Social Services and Well-being (Wales) Act 2014 refers in the main to a list of organisations, the accompanying guidance set out in the All Wales Procedures implies a duty on individuals (referring to 'practitioners'). It is unclear whether independent professionals, who might not be associated with the organisations listed, are covered by the obligation. This has the potential to lead to confusion. The Inquiry was informed that, by November 2020, the introduction of the referral-reporting duty in Wales had not led to "a substantive change in practice".	The gaps mentioned here are an inevitable consequence of it being framed as a public law obligation. See para 53 page 117 The fact that there is no individual obligation, and no effective sanction means that the introduction of the requirement in this form in Wales has had little or no effect on the individuals who we want more reports from.
The legal position in England	

57. In England, there is no statutory obligation requiring individuals or institutions to report child sexual abuse.	As described in earlier comments, arguably there is an institutional requirement, by virtue of the public law obligation in section 175 of the Education Act 2002 to "have regard" to guidance such as Working Together. But as the report states in paragraph 52 above, this is not "an adequate model for ensuring that reports of child sexual abuse are made to the agencies that should receive them", and the inquiry has found that it is ineffective in practice. But it is entirely correct to say that there is no statutory obligation applying to individuals. This jurisdiction is out of step with most jurisdictions in the rest of the world in not having mandatory reporting of child sexual abuse.
58. Working Together to Safeguard Children states that anyone who has concerns about a child's welfare "should make a referral to local authority children's social care". This referral should be made immediately if there is a concern that the child is experiencing significant harm or is likely to do so. This statutory guidance does not impose a legislative requirement on those working with children to report child sexual abuse. It only creates an expectation that individuals will comply with the guidance unless "exceptional" circumstances arise.	Paragraphs 58-65 set out the government's "expectations" about reporting, but it is clear from the evidence before the inquiry that these expectations are frequently not met.
59. The government also sets out expectations for other organisations working with children in England to make safeguarding arrangements. Section 11 of the Children Act 2004 places a duty on a range of organisations and individuals to ensure that "their functions are discharged having regard to the need to safeguard and promote the welfare of children". This duty applies to, for example, local authorities, NHS organisations, the police, probation services, transport police, youth offending teams, and governors or directors of custodial institutions. Statutory guidance sets out the arrangements that these organisations should have in place to fulfil this duty, including the need for clear procedures to ensure that staff know how to respond to and escalate concerns about a child's welfare.	

60. Working Together to Safeguard Children also sets out expectations for safeguarding arrangements in organisations not subject to the section 11 Children Act 2004 duty. This includes that voluntary, faith-based, charitable and private sector organisations, sports clubs and social enterprises should ensure that those working with children, whether paid or volunteer, are "aware of their responsibilities for safeguarding and protecting children from harm".1004 This should include knowing how to respond to child protection concerns and how to make a referral to local authority children's social care or the police if necessary.	
Common approaches	
61. Both jurisdictions issue specific statutory guidance for schools which set out the arrangements that schools should have in place to ensure child protection concerns are reported.	
62. The effect of this guidance is that institutions that work with children in England and in Wales are expected to have clear policies and procedures in place to ensure that staff report concerns about child sexual abuse. Individuals working within those institutions who fail to do so may be subject to internal disciplinary proceedings. Those expectations, however, are not the same as legal obligations.	

63. In addition to statutory guidance, some individuals are required to report concerns under standards or codes of conduct set by their professional regulatory body. This includes healthcare professionals, social workers, social care workers in Wales, the police and teachers. In the main, that requirement is part of professionals' obligations to ensure the safety and well-being of the members of the public with whom they work and to raise concerns about colleagues. A professional's fitness to practise may be brought into question if they fail to adhere to such standards. If a professional is found to be unfit to practise, they can be removed from the professional register and prevented from practising. The effect of this is that specific requirements to report children experiencing, or at risk of, abuse, neglect or other harm are generally set out in accompanying guidance.	
64. In both jurisdictions, existing reporting frameworks within particular institutions or sectors can be unduly complicated and professionals are sometimes unclear about their own reporting responsibilities.	
65. Although there are presently a range of non-statutory measures that aim to encourage individuals and institutions to report child sexual abuse, there is a marked absence of a cohesive set of laws and procedures in England and in Wales that require individuals working with children to report child sexual abuse. Children have suffered as a result.	
F.5: The case for mandatory reporting	
66. Commonly referred to as 'mandatory reporting', numerous countries have introduced legislation which places specified persons, or members of the public, under a statutory obligation to report child abuse or neglect to a designated agency. This includes the majority of countries in Europe and some parts of the US, Canada and Australia.	**IICSA manages to not even get this correct. All American States have some form of mandatory reporting.** For clarity – all of Canada and Australia have mandatory reporting. Also 86% of European jurisdictions at the last count. Paragraphs 66-68 give a fairly accurate summary of the variety of mandatory reporting laws in place elsewhere.

67. Although the detail and nature of mandatory reporting laws varies between jurisdictions, there are a number of common features.	
67.1. Most mandatory reporting laws identify designated mandated reporters, creating a group of people to whom the law applies. These individuals are generally those who come into contact with children in the course of their work or have managerial responsibility for others who work with children and are therefore assumed to be in a position to identify the signs of abuse.	
67.2. Mandatory reporting laws also vary in what they require people to report. Some jurisdictions list categories of child abuse, such as physical abuse, sexual abuse, psychological abuse and neglect. It is also common for reporting laws to cover various forms of child abuse, including physical abuse, neglect and sexual abuse.	
67.3. There is also variation in the level of awareness of the alleged abuse mandated reporters need to have before they are required to report.	"Belief" and "suspicion on reasonable grounds" are common among jurisdictions with well-designed mandatory reporting of child sexual abuse.
67.4. All mandatory reporting laws specify the agency to whom the report must be made. This may be the police or, more commonly, social services or child protection services. In some jurisdictions, there is a dedicated agency whose remit is to receive reports (and sometimes also to monitor and produce statistics on the number of reports received) in addition to assessing and acting upon them as required.	
67.5. Most, but not all, mandatory reporting laws also provide for a sanction for failure to report. Such sanctions may be criminal in nature, attracting a fine or custodial sentence.	

68. The combination of these features gives a particular regime of mandatory reporting its character and scope, and the interrelationship between them is important. For example, it tends to be that criminal sanctions apply for the non-reporting of abuse that is known, rather than suspected, or applies to a narrow group of individuals who might be expected to have a heightened level of awareness or duty to children.	
Debates about mandatory reporting	
69. In recent years there has been significant debate about whether mandatory reporting should be introduced in England and in Wales.	
70. Several organisations representing victims and survivors have called for its introduction. In 2014, Baroness Walmsley tabled an amendment to the Serious Crimes Bill which set out a legal duty for those working in regulated activity (see Part E) involving children or vulnerable adults to report suspected or known abuse. The amendment attracted both support and criticism.	Support for the proposed law was so great during the debate that the Government promised a consultation to avoid a vote. The details are here including a transcript of the debate highlighted for ease of reference.
71. In July 2016, the government launched a public consultation on reporting and acting on child abuse and neglect. In its response (March 2018), the government concluded that the case for mandatory reporting had "not currently been made" and stated that it would not seek to introduce a mandatory reporting duty.	The form of mandatory reporting duty proposed in the July 2016 consultation was seriously (and we suspect deliberately) flawed to the extent that even Mandate Now could not support mandatory reporting in the form proposed in the consultation document. Mandate Now Review of: Summary of consultation responses and Government action
72. The Inquiry has considered the government's consultation response. However, the broad body of evidence examined by the Inquiry has led to the Inquiry reaching different conclusions on some of the government's key concerns about mandatory reporting.	
Referral figures	

73. The introduction of mandatory reporting in other jurisdictions has led to an increase in the number of referrals made about child abuse to authorities and in the number of children subsequently identified as being in need of protection from sexual abuse. This gives rise to concerns about potentially unmanageable increases in the number of referrals made to children's social care services.	It is necessary to state in more detail what these "concerns" are. There are two possibilities. One is that the system is swamped with trivial and unsubstantiated reports, the other is that the system received a large number of valid reports, more than childen's services on their present level of resource can safely deal with. The Australian evidence offers no indication of swamping by trivial reports. If the concern is a large increase in *substantiated* reports this should not be regarded as a concern, it is the object of mandatory reporting law. Paragraphs 73-79 make the case for mandatory reporting in terms of the evidence of a major increase in the number of children protected as a result of these reports being made. Please also bear in mind Mandate Now proposes mandated reporting of known and suspected child *sexual* abuse only. This difference is very important and evidentially supported.
73.1. In 1993, the Australian State of Victoria introduced mandatory reporting for incidents of suspected child sexual abuse and physical abuse. At the time of enactment, doctors, nurses and the police were subject to the duty, and in 1994 it was broadened to include teachers. Analysis of subsequent trends in reporting of child sexual abuse found that between 1993 and 2012 there was a six-fold increase in the rate of children identified as in need of protection.	

73.2. In 2009, the State of Western Australia introduced legislation giving doctors, nurses, midwives, teachers, the police and boarding supervisors a statutory duty to report any reasonable belief of child sexual abuse. Analysis of reporting trends in the three years prior and the four years following enactment found that, on average, following the introduction of mandatory reporting the number of children identified as in need of protection from sexual abuse doubled. This means that the law enabled children's services to provide help to more of those children who needed it.	This paragraph does not inform us that this was the last State to introduce MR largely as a result of political ideology against the MR law. The design of the legislation had to be changed because of the onerous reporting on police officers that prompted a huge rise in referrals from this group. Following redesign numbers returned to the norms expected. Following the recommendations from the Royal Commission into child abuse, WA has recently further strengthened its mandatory reporting laws. Australia is closer to having MR uniformity in all States.
74. Similar long-term improvements have been observed in Canada in the identification of children who were in need of protection and received support, as a result of mandatory reporting. One study examined the contact that individuals who were sexually abused as children had with child protection services both before and after the introduction of mandatory reporting. The study found that those born after mandatory reporting was enacted in their province (1965 onwards) were three times more likely to have had contact with child protection services than those born before or in the same year as the legislation's enactment.	
75. Research also indicates that the number of children identified as in need of protection from sexual abuse is higher in jurisdictions where mandatory reporting exists than in jurisdictions which do not have mandatory reporting. Over a 20-year period, the number of substantiated reports of child sexual abuse in Victoria, Australia, was 4.73 times as high as in the Republic of Ireland, a comparable jurisdiction which did not have mandatory reporting at the time.	

76. Conversely, some have argued that there is no need for the introduction of this law as rates of referrals for child abuse and neglect in England and in Wales are "comparable or already higher" than in jurisdictions which have mandatory reporting. During the Inquiry's seminar on mandatory reporting, Stuart Gallimore (then President of the Association of Directors of Children's Services) observed that "there is no evidence in modern times … of professionals routinely failing to report concerns about child sexual abuse".	Unfortunately, the inquiry may not be comparing like with like. Stating referrals from two jurisdictions is not necessarily comparison from which any deductions can be made. One has to compare like with like – what is mandated and by whom in the jurisdiction being compared with referrals in E + W? If neglect, physical abuse, emotional abuse, sexual abuse included? What proportion comes from mandated reporters in the MR jurisdiction compared to public? We are given no information. There is no value in this paragraph.
77. However, throughout its investigations, the Inquiry repeatedly found that allegations and indicators of child sexual abuse were under-reported by adults who ought to have reported them. Child sexual abuse is not sufficiently well reported at present. Reliance on bare statistics about rates of referrals risks a complacency about child sexual abuse. In 2021, the Inquiry asked the Department for Education and the Welsh Government for information on the number of referrals for child sexual abuse made to local authorities. Neither government could provide this information, because it was not collected.	This paragraph has nothing to do with para 76 despite the report trying to link the two. **To demonstrate the extent to which Government is asleep at the wheel on child sexual abuse the inquiry says :** *"The Inquiry asked the Department for Education and the Welsh Government for information on the number of referrals for child sexual abuse made to local authorities. Neither government could provide this information, because it was not collected."* With such a head in the sand approach to data gathering learning is almost impossible. Furthermore any argument from Government in support of retaining the status quo of 'discretionary reporting' of child sexual abuse by regulated activities cannot be supported by evidence.
78. The proportion of referrals to children's services which result in them identifying factors of child sexual abuse or child sexual exploitation in particular – as opposed to rates of referral of child abuse or neglect in general – is relatively small.	

78.1. In 2021, child sexual abuse was identified as a factor in 6 percent of assessments and child sexual exploitation as a factor in 3.4 percent. By comparison, the proportion of assessments for which emotional abuse was identified as a factor was 21.6 percent, neglect was identified in 17.2 percent of assessments and physical abuse was identified in 11.9 percent of assessments.	These figures immediately reveal the inherent dysfunctionality stemming from the design of the statutory framework absent of MR. In 1987 MR of CSA was extended to teaching in New South Wales. Here is data for the three months before MR was introduced and three months following. An article by Lamond mined the data to reveal the following which contrasts with the limited data in IICSA's paragraph. Stemming from results of five empirical studies into MR in Australia (10-year national study) Reports of child sexual abuse are consistently ~ 10% of all reports of child maltreatment and only half are by MR groups. See paragraph 5 of this graphic presented at IICSA MR seminar #2 by Professor Mathews. These are substantiated referrals cases rather than assessments.
78.2. Existing referrals for child sexual abuse are therefore likely to represent a small proportion of all referrals, and a proportion much smaller than the proportion of referrals represented by other types of abuse and neglect.	
78.3. A potentially higher rate of referrals is therefore not the same thing as a high rate of referrals about child sexual abuse or exploitation.	Absolutely correct and political anti MR safeguarding rhetoric simply does not recognise this important point.
79. Mandatory reporting laws have the capacity to improve significantly statutory services' ability to target help and support to child victims of sexual abuse. The international evidence supports the view that England and Wales ought to introduce mandatory reporting laws to enable the police and local authorities to better identify children in need of protection. Striking the balance in mandatory reporting	
80. The requirement to make a formal report of child sexual abuse has led to concerns about a potential loss of privacy or confidentiality that a child may request when making a disclosure.	The harm done to a child through loss of privacy or confidentiality would appear to be trivial compared to the harm resulting from continued abuse. If the interests of the child are paramount, then formal reporting of a disclosure is obviously in line with promoting those interests.

81. Children and young people told the Inquiry that mandatory reporting could discourage children from disclosing sexual abuse for fear of the potential consequences for them, for their families and potentially for their abuser. The National Society for the Prevention of Cruelty to Children has separately observed that children might be deterred from accessing support in respect of mental health or sexual or reproductive health if professionals were required to report abuse that they became aware of through such treatment.	When considering this issue, it is necessary to look at the evidence rather than theorise about the effects on victims. Disclosure is already rare, and evidence from abroad indicates that mandatory reporting has little effect on disclosure rates either way. What mandatory reporting does is increase the number of substantiated reports and as a result increase the number of children protected. (source – Mathews presentation to IICSA 29.4.19, but please note this is MR of known and **suspected** child sexual abuse by personnel working in our equivalent of Regulated Activities)
82. Some victims and complainants told the Inquiry that when they sought help they wanted the abuse to stop, without wanting there to be any legal consequences. Children and young people have commented that, once a report is made, they may feel a loss of control over this aspect of their lives. They may not be able to decide for themselves whether to engage with the criminal justice system, particularly where the abuser is a peer who they do not necessarily want to see investigated by police and prosecuted in a criminal court. The distress that children and their families might feel at the prospect of a formal investigation into allegations must not be underestimated.	Again, the objective is that the abuse is stopped. It can't be stopped without some kind of intervention. It is notable that the report doesn't indicate that significant numbers of victims regret the fact that their disclosure brought their abuse to an end. Furthermore, there are very clear terminologies relating to peer on peer behaviour. These are set out in para 3, page 5 of this a 'MODEL LAW FOR MANDATORY REPORTING OF CHILD SEXUAL ABUSE IN ENGLAND AND WALES' submission by Prof Ben Mathews.
83. It is also possible mandatory reporting could deter families from seeking help and that families are more likely to self-refer where they believe their disclosure will be handled confidentially. Parents may be worried about the consequences of disclosing a concern about sexual abuse in their household if they believe it would lead to the criminal investigation of a family member. Social, familial and economic factors might also influence parents' decision-making.	A well-designed mandatory reporting law would not impose an obligation on family members. If a family member raises a concern to the police or children's services, the police already have a statutory duty to investigate, and this is almost certainly already realised by the family member making the disclosure. **It appears that the inquiry, in an attempt to offer balance, has repeated in its report unevidenced assertions by opponents of mandatory reporting. Where is the data to support the claim?**

84. The countervailing consideration is the significant public interest in reporting, investigating and prosecuting perpetrators of child sexual abuse, and protecting other children from harm. If abuse is not reported in this way, perpetrators may continue to abuse. Child sexual abuse is a crime that is known to be under-reported. The prevention of abuse in the future is of the utmost importance.	
85. In the delicate balance between the need to provide an individual child with confidential advice and support (whether medical, psychological, legal or social) and ensuring child sexual abuse is prevented, it is essential to recognise that there are some circumstances where privacy ought to be protected and some where prevention is paramount. One important example is in the context of consensual, non-abusive relationships between young people. In other jurisdictions, mandatory reporting laws provide for exemptions to the duty to report where the child concerned is in a sexual relationship with a person who is near in age to them and where that relationship lacks features of exploitation or coercion. The Inquiry considers that it is desirable that such a measure is included in a new mandatory reporting law.	To repeat, this was included in a model law submission to IICSA by Prof Ben Mathews.
F.6: Mandatory reporting for England and for Wales	
86. Mandatory reporting is a powerful weapon against child sexual abuse, but caution must be exercised to ensure that the legislation works for the people it is intended to protect. Having considered a range of views during its investigations and the various possible approaches to a scheme, the Inquiry has concluded that mandatory reporting is required so that those who work with children in certain roles report child sexual abuse to the police or social services.	This is also the Mandate Now view

Recommendation 13: Mandatory reporting The Inquiry recommends that the UK government and Welsh Government introduce legislation which places certain individuals – 'mandated reporters' – under a statutory duty to report child sexual abuse where they: • receive a disclosure of child sexual abuse from a child or perpetrator; or • witness a child being sexually abused; or • observe recognised indicators of child sexual abuse. The following persons should be designated 'mandated reporters': • any person working in regulated activity in relation to children (under the Safeguarding and Vulnerable Groups Act 2006, as amended); • any person working in a position of trust (as defined by the Sexual Offences Act 2003, as amended); and • police officers. For the purposes of mandatory reporting, 'child sexual abuse' should be interpreted as any act that would be an offence under the Sexual Offences Act 2003 where the alleged victim is a child under the age of 18. Where the child is aged between 13 and under 16 years old, a report need not be made where the mandated reporter reasonably believes that: • the relationship between the parties is consensual and not intimidatory, exploitative or coercive; and • the child has not been harmed and is not at risk of being harmed; and • there is no material difference in capacity or maturity between the parties engaged in the sexual activity concerned, and there is a difference in age of no more than three years.	The description in the first three bullets stating the circumstances that must be mandatorily reported accords with the Mandate Now position. We have serious reservations about the next three bullets, describing who the mandatory reporting law should apply to. It is important that people without appropriate responsibilities and training are not caught up in the obligation. So "any person working in regulated activity in relation to children" might for instance include staff preparing school meals since they work in a school (which is a regulated activity). **The wording should be refined to ensure that only those responsible for the personal care of children within a regulated activity are included into the obligation.** We have some concerns about ensuring that the mandatory duty applies to suspected child-on-child abuse as well as to adult-on-child abuse, the wording of the exception for consensual relations between children over the age of 13 may need to be refined to ensure that the reporting duty applies in cases of doubt. The destination of mandatory reports should be LA children's services rather than the police and preferably to one point of contact i.e. the LADO whose role will need to be redefined to accommodate this extended brief. This does not rule out an additional report to the police if the reporter considers it necessary. The last part is flawed. Defining the criminal offence for non-disclosure by excluding: "observe recognised indicators of child sexual abuse" from the initial three bullets ignores empirical evidence and precedent from multiple jurisdictions in the rest of the world. **Suspected abuse, on reasonable grounds, is by far the most common form of referral from institutional settings in mandatory reporting jurisdictions. These are the very type of reports which are most needed to support good personnel and to ensure referrals are properly made. It is increases of referrals of this kind which is the basis of the success of mandatory reporting in Australia and elsewhere.** The inquiry has already established conclusively that witnessed abuse and child disclosure are both rare relative to other indicators of abuse. The inquiry has not

These exceptions should not, however, apply where the alleged perpetrator is in a position of trust within the meaning of the 2003 Act. Where the child is under the age of 13, a report must always be made. Reports should be made to either local authority children's social care or the police as soon as is practicable. It should be a criminal offence for mandated reporters to fail to report child sexual abuse where they: • are in receipt of a disclosure of child sexual abuse from a child or perpetrator; or • witness a child being sexually abused.	provided examples of voluntary disclosure by a perpetrator, so it can reasonably be supposed that this is also rare. So having gone to the trouble of clearly establishing the need for a mandatory reporting law covering both disclosures and other indicators, the inquiry has failed to follow that reasoning in its crafting of the recommendation. Why might it have done this? **At IICSA MR seminar #2 in April 2019 Professor Mathews was asked by counsel about a particularly weak model of MR and in essence asked whether that was better than nothing. Here is the exchange.** With its recommendation, IICSA has consciously recommended a public policy for the introduction of mandatory reporting of child sexual abuse that it knows from evidence presented at MR seminar #2 is far weaker than others that are operating in multiple jurisdictions . In our opinion, grounded on evidence, it will make no discernible improvement to safeguarding children.
What should be reported	

87. Mandatory reporting laws are designed to facilitate the prompt and efficient reporting of child sexual abuse and to remove subjective filters of self-interest, fear, seriousness or credibility. They are not designed to encourage people to undertake their own investigations where they suspect abuse, or to conduct their own assessment about whether or not they believe an allegation to be true or false. Nor are they designed to interfere with the private enjoyment of sexual relationships between young people that are safe and consensual. The law must clearly define the level of 'knowledge' a person is required to have and the 'abuse' that triggers a report.	The "*subjective filters of self-interest, fear, seriousness or credibility*" are greatest when the evidence is equivocal, i.e. when the evidence is in the form of "recognised indicators of child sexual abuse" rather than witnessed abuse or disclosure by perpetrator or victim. It is in precisely this circumstance that reporters most need the support of a well-designed **mandatory reporting of known and suspected child sexual abuse** to help overcome the obstacles to reporting.
Level of knowledge	
88. A mandatory reporting duty must define what individuals need to know before a report is required to be made. Some mandatory reporting laws relate to 'known' abuse, whereas others refer to 'alleged' or 'suspected' abuse. In the Republic of Ireland, for example, the Children First Act 2015 requires reports from a mandated person who "knows, believes or has reasonable grounds to suspect … that a child – (a) has been harmed, (b) is being harmed, or (c) is at risk of being harmed".	We agree that "reasonable grounds for suspicion" is the appropriate threshold for reporting. It is a form of words that has been used before in UK law, for instance in section 330 of the Proceeds of Crime Act 2002 dealing with mandatory reporting of suspicions of money laundering. **However, this is not included in IICSA's mandate to which any sanction for failing to report is attached.**
89. A law requiring an individual to 'know' that a child has been sexually abused implies that the reporter would have to be satisfied of the truth of the allegation. In some cases this is uncomplicated; 'knowledge' might be based on the fact that a reporter has witnessed the abuse, has seen evidence of it (by, for example, having seen incriminating messages or images) or has heard a confession by the perpetrator.	
90. However, 'knowledge' might be taken to imply a subjective test, which can lead to prejudice and bias, and may encourage individuals to conduct some level of investigation into an allegation themselves. All that should be required is that the individual knows – or ought to know – that the information they are presented with amounts to an allegation of sexual abuse.	Where is the evidence to support the investigation claim? If such evidence exists in jurisdictions where mandatory reporting of child sexual abuse is operating i.e. the majority of countries in the rest of the world, we expect the inquiry would have cited it.

91. A person should be required to report when they either receive a disclosure of child sexual abuse from a child or perpetrator, or witness a child being sexually abused. A failure to report in those circumstances should be a criminal offence, as discussed below.	

92. In many circumstances an individual working with children may recognise indicators of child sexual abuse that give rise to a reasonable suspicion that the child has experienced, or is experiencing, sexual abuse. It was evident throughout the Inquiry's investigations, and supported by accounts provided in the Truth Project, that in a number of cases clear signs of child sexual abuse were missed or not acted upon. These included, for example, sexualised or sexually harmful behaviour, physical signs of abuse or consequences of sexual abuse such as pregnancy or sexually transmitted diseases. There should also be an obligation to report abuse based on well-recognised indicators of child sexual abuse. Those indicators should be set out in detailed guidance that can be updated and amended as needed. However, the Inquiry acknowledges that identifying indicators of abuse is more complicated than witnessing or receiving a disclosure of child sexual abuse and so a failure in respect of this aspect of the duty should not attract a criminal sanction.	The report says that "there should also be an obligation to report abuse based on well-recognised indicators of child sexual abuse" but later in the same paragraph says that ***"this aspect of the duty should not attract a criminal sanction"***. Without a criminal sanction, there is no legal obligation on an individual. It is not mandatory without the criminal sanction as the Republic of Ireland has discovered and where there is significant pressure being applied to strengthen it's version of the law. An increase in referrals is desired in order to protect more children. The key to this is overcoming the barriers imposed by fear and uncertainty. Establishing a mandatory duty to report on the basis of '*recognised indicators'* provides precisely this support – it makes it absolutely clear what is expected. It is to be expected that prosecutions under the law will be relatively rare, since the vast majority of those working with children will be law abiding and will also want to do what is right for the children in their care. They need support against their own doubts and fears (and in a minority of cases, support against an institution hostile to reporting out). In exactly the same way, the intention of the law mandating the wearing of seatbelts was to get the vast majority of road users to wear seatbelts as a matter of course. It succeeded in that aim and death and injury from road traffic accident fell dramatically and immediately. Prosecutions for non-wearing are rare. The law supported law-abiding road users to overcome social pressures against seatbelt-wearing. There has been much public debate about how a mandatory reporting law would "criminalise teachers". But it would no more do that than mandatory seatbelt wearing criminalises drivers. There is a further point. In addition to promptly detecting child sex abuse in order to protect children, an objective should also be to deter potential abusers from offending in the first place. A climate of vigilance where it is known that indications of abuse or grooming behaviour will be promptly reported is a

	powerful deterrent. Abusers are usually very skilful in persuading their victims not to disclose, and so abusers will believe they have little to fear from a mandatory reporting law that is limited only to disclosed and witnessed abuse.
Nature of abuse	
93. For the purposes of mandatory reporting as recommended by the Inquiry, a mandated reporter should report any act that would amount to an offence under the Sexual Offences Act 2003 (the 2003 Act, or any subsequent relevant legislation) where the alleged victim is aged under 18.	
94. However, in some limited circumstances where the victim is aged between 13 and under the age of 16 a different approach may sometimes be necessary.	
95. In England and in Wales, the legal age of consent is 16. The 2003 Act therefore criminalises a wide range of sexual abuse committed on children under the age of 16 including rape, penetrative and non-penetrative sexual assaults, sexual activity with a child, and grooming offences. In law, children under the age of 13 cannot consent to any sexual activity and so the 2003 Act also includes separate offences for children aged under 13.	
96. It is not always the case that all sexual activity involving children under the age of consent is prosecuted. While there is no suggestion that acts of this nature be decriminalised, Crown Prosecution Service guidance states that consensual sexual activity between teenagers should not be prosecuted unless there are aggravating features such as an element of abuse or exploitation. Just as it is not in the public interest to prosecute children and young people in a consensual relationship, it is not in the public interest to criminalise mandated reporters for failure to report consensual teenage sexual activity that would not ordinarily be prosecuted.	

97. An exception to the mandatory reporting regime is therefore essential. Without it, for example, a teenager (in a relationship with someone close in age) who seeks advice on contraception or sexual health may worry that a formal report will be made to the police or social services and that there may be an investigation into the circumstances of their relationship. This is likely to deter young people in non-abusive relationships from seeking advice.	
98. Internationally, many mandatory reporting laws carry exemptions for particular forms of sexual relationships between children and young people. For example, in the Republic of Ireland there is an exemption in respect of sexual activity involving a child "who is aged 15 years or more but less than 17 years" where the other party is no more than two years older and there are no issues regarding capacity to consent or a relationship of power over the younger party. In Canada, there is a 'close in age' exception to the statutory age of consent which means that a child aged 14 or 15 can consent to sexual activity with another person who is less than five years older, and a child aged 12 or 13 can consent to sexual activity with another person who is less than two years older, providing there is no position of trust and the activity is not exploitative.	

99. The Inquiry therefore recommends that where the sexual activity relates to a child: • under the age of 13, a report must always be made; • between 13 and under 16 years old, a mandated person should not be required to make a report when he or she knows or reasonably believes that all of the following to be true: • the relationship between the parties is consensual and not intimidatory, exploitative or coercive; and • the child has not been harmed and is not at risk of being harmed; and • there is no material difference in capacity or maturity between the parties engaged in the sexual activity concerned, and there is a difference in age of no more than three years.	
100. There are also specific child sexual abuse offences designed to protect 16 and 17-yearolds from sexual relationships which would not be criminal but for the perpetrator's position of trust in relation to the child. In short, while the child ostensibly consents to the activity, the law considers that consent is not relevant because of their particular relationship with the abuser. Individuals within the scope of a position of trust offence include those who look after children under the age of 18 in local authority accommodation, in care homes, hospitals and educational institutions as well as those who regularly coach or teach in a sport or a religion. Evidence heard by the Inquiry into the scale of abuse in these settings makes it essential that these cases come within the mandatory reporting regime. Accordingly, irrespective of the age of the child, where the alleged perpetrator is in a position of trust as defined by the 2003 Act, a report must be made.	We agree with this point.
Who should be required to report	

101. In international models of mandatory reporting, the individuals subject to a duty to report are most commonly those employed in education, health, the police and social care. In the Republic of Ireland, mandated professionals include those working in health and social care, organised sports, religion, teaching and law enforcement, and managers of language schools, domestic violence shelters and accommodation for asylum seekers and those who are homeless. Across Canada, mandated professionals include those who work in healthcare, education or childcare, religious officials, lawyers, government employees and police officers. Several jurisdictions have a relatively lengthy list of mandated reporters that includes people employed in or associated with non-public bodies.	"*Several jurisdictions have a relatively lengthy list of mandated reporters that includes people employed.*" There are many such jurisdictions on all four continents.
102. Typically, mandatory reporting duties apply to individuals. In a minority of jurisdictions, such as Australia's Northern Territory, mandatory reporting applies to all (adult) citizens. In Ontario, Canada, both the public and professionals are mandated to report, but the sanction for failure to do so (a fine of up to the equivalent of £3,000) only applies to professionals.	There are also 19 States in the USA that have all individuals as mandated reporters and of more types of child abuse than sexual abuse. .
103. The category of individuals who are to be required to report must be carefully identified. Individuals engaged in regulated activity (as set out in Part E) are among the individuals who are most likely to become aware of an allegation of sexual abuse from a child, or to observe indicators of child sexual abuse from a child's behaviour or physical presentation. They should therefore be subject to a law of mandatory reporting.	We agree with this, provided that it is clear that merely having employment within an institution that is a regulated activity (such as a school) does not trigger the mandatory duty (with a criminal offence attached) if the nature of the individual's work has nothing to do with the personal care of children i.e. catering staff, ground staff and similar.

104. There are other professions to which a responsibility to report should also apply. The Sexual Offences Act 2003 (the 2003 Act) contains 'abuse of position of trust' offences, criminalising sexual abuse committed by adults who occupy a position of trust as defined in the 2003 Act. Currently, those in 'positions of trust' are persons who 'look after' (are regularly involved in caring for, training or supervising, or have unsupervised contact with) children who are: • detained in an institution; or • resident in a home provided by a local authority or voluntary organisation; or • accommodated in a hospital, care home, children's home or community home; or • receiving education at an educational establishment.	
105. Positions of trust in the 2003 Act also include adults who look after a child on an individual basis or have regular unsupervised contact with children because of a specified statutory or court-appointed duty, such as guardians or carers, and includes foster carers. This has recently been amended to extend the definition of positions of trust to include coaching, teaching, training, supervising or instructing in a sport or a religion, where this is done on a regular basis.	

106. There are several groups of individuals whose work may bring them into contact with children but who do not fall within the definition of positions of trust or regulated activity. Some of those may, because of the nature of their role, become aware of reports of child sexual abuse of the sort that ought to be subject to mandatory reporting. In particular, police officers in the course of their work might receive a disclosure or become aware of evidence of child sexual abuse whilst investigating an allegation of a non-sexual crime. A failure to formally report such disclosure should be covered by mandatory reporting laws.	
107. In the absence of a statutory category that extends to all the groups of people who ought to be subject to a duty of mandatory reporting, the Inquiry recommends that mandatory reporting should apply to all individuals who fall into the existing statutory categories of regulated activity and positions of trust, and to police officers. It will be for the government to consider whether present statutory categorisations of individuals who work with children require review.	The better alternative is the one taken in the Private Members Bill tabled by Baroness Tanni Grey-Thompson to clearly enumerate the categories, and allow the list to be modified by statutory instrument should the need arise. The definition of 'RegulatedActivity' in the Safeguarding Vulnerable Groups Act 2006 unclear.
108. Institutions should make arrangements so that there are not multiple reports of the same incident. For example, where an organisation has procedures for reporting child protection concerns (such as an appointed designated safeguarding lead), reports could be escalated through those procedures and a report made on behalf of the organisation. Individuals should also be assured – by both their organisation and the mandatory reporting scheme – that they will be afforded protection from repercussions when making a report in good faith in line with the duty to report.	Reporting must be made directly to the Local Authority Designated Officer or the police by the employee (Regulated Activity) when the reporter considers it appropriate. Long communication chains weaken the likelihood of referrals being made and it is the mandated reporter who is legally responsible for the report being made. Professor Mathews was asked 'who reports' during MR Seminar 2 in April 2019. Here is his reply. Baroness Grey-Thompson's Private Members Bill explicitly includes protection from detriment for those making a mandatory report in good faith. This is an element not directly included in Recommendation 13 but which should be included in any mandatory reporting law.

109. Some core participants and witnesses argued that a mandatory reporting law ought to provide exemptions for some faith-based settings or personnel and, in particular, in the context of sacramental confession. As the Inquiry has already noted, the respect of a range of religions or beliefs is recognised as a hallmark of a liberal democracy. Nonetheless, neither the freedom of religion or belief nor the rights of parents with regard to the education of their children can ever justify the ill-treatment of children or prevent governmental authorities from taking measures necessary to protect children from harm. The Inquiry therefore considers that mandatory reporting as set out in this report should be an absolute obligation; it should not be subject to exceptions based on relationships of confidentiality, religious or otherwise.	Full agreement on this. Evidence IICSA on 13/3/18 by Revd Canon and Worshipful Dr Rupert Bursell QC - former Chancellor of Diocese of Durham made clear that in the case of money laundering (Proceeds of Crime Act 2002) and two sections of the Terrorism Act state that no confidence such as the seal of the confessional money laundering is an excuse for failing to report.
To whom reports should be made	
110. All mandatory reporting laws specify the agency to whom the report must be made, typically the police, social services or a dedicated agency. For example, in the Republic of Ireland, the Child and Family Agency receives reports. The Child and Family Agency also provides literature and online training to assist mandated professionals in their reporting duty, as well as designated points of contact in each jurisdiction to provide advice and clarification.	

111. In England and in Wales, existing practice (pursuant to statutory guidance) is that child safeguarding concerns should be reported to local authorities. If a child is in immediate danger, a report should be made to the police immediately. A mandatory reporting law should therefore provide that reports should be made to local authority children's social care or the police, to allow mandated reporters to direct their report to the most suitable agency depending on the circumstances. In the majority of circumstances, this will be local authority children's social care services, who can take action as appropriate to protect the child, including involving other agencies such as the police. An individual social worker or police officer in receipt of information that would trigger the duty to report must make a report to the appropriate department defined by their institution.	In our view the statutory duty should be to report to LA children's services within a defined period of time and specifically in the first instance to the LADO as the single point of contact. The LADO's role will require enhancing. This proposal has the benefit of clarity and simplicity. There is a further benefit for comprehensive data gathering to commence at this point. Our proposal, which was recommended to IICSA in one of our submissions, does not prevent statutory guidance from indicating that in urgent and serious cases a report should also be made immediately to the police.
112. To ensure the effectiveness of any mandatory reporting duty, the government must ensure that agencies receiving reports are sufficiently resourced to be able to respond to any increase in reports about child sexual abuse that mandatory reporting laws generate. The UK government and the Welsh Government should collect and publish data on the operation of the mandatory reporting scheme.	Complete agreement on this point.
Sanctions for failure to report	
113. Most, but not all, mandatory reporting laws also stipulate a sanction for failure to report. Some sanctions are criminal in nature (such as a fine or custodial sentence).	

114. Criminal sanctions for failures to report vary in severity. For example, mandated reporters who fail to report child sexual abuse in line with their statutory duty in Western Australia face a $6,000 fine. By contrast, Article 434-3 of the French Penal Code stipulates that a failure to report allegations of sexual abuse to the relevant authorities carries a three-year prison sentence and a €45,000 fine, or five years' imprisonment and a €75,000 fine where the offence concerns a child aged under 15. Some jurisdictions have introduced mandatory reporting without a criminal penalty, such as the Republic of Ireland, and in New South Wales the criminal penalty for mandated reporters who fail to report was removed in 2010.	The removal of a criminal offence by NSW is 2010 was raised by the inquiry with Prof Mathews in MR Seminar #2 in April 2019. NSW had MR in place as early as 1987. After 23 years the criminal offence was removed. Here is the exchange during the seminar. Mathews concerns about not having a penalty at the outset of new law are very clear.
115. In England and Wales, criminal sanctions exist for failure to report safeguarding concerns to the appropriate authority. For example, regulated activity providers must make a referral to the Disclosure and Barring Service where a person working in regulated activity has resigned or been dismissed, or moved to a different role, due to concerns that they may pose a risk of harm to children or vulnerable adults. Failure to comply with this duty is a criminal offence, punishable with a fine.	Here is our letter to Professor Jay sent in advance of Dr Suzanne Smith (Director of Safeguarding DBS) giving evidence in the Residential Schools strand). Using our letter this exchange occurred which revealed that no one has been prosecuted for failing to return a notification despite the identified examples of law breaking in our letter. The law mandating referrals to the DBS in prescribed circumstances is law in name only and the result of which is makes the DBS an unreliable cornerstone of safeguarding. Once again poor schools safeguarding inspections by the education inspectorates is in part to blame for not inspecting or reporting against these key documents.
116. Where an individual to whom mandatory reporting laws apply has witnessed or received a disclosure of child sexual abuse, it should be a criminal offence to fail to report that to the relevant local authority or police force. Such a failure would amount to a deliberate decision not to pass on information about child sexual abuse to those authorities empowered to protect children from harm and to prevent future abuse by investigating and prosecuting it when it occurs. For those who work with children or are in a position of trust to fail to facilitate that is inexcusable, and the sanction for such an omission should be commensurate.	The Mandate Now view is that the penalty must be sufficient to make it clear that the individual legal duty exists and so encourage desired behaviour in law-abiding citizens. But an excessive penalty is likely to prompt people to report "just in case" when the threshold is still somewhat below "reasonable grounds for suspicion". In our view a fine is a proportionate sanction. This error was made in Western Australia with the belated introduction on MR in 2009. Amendments to its design were made and referrals adjusted to an expected level.

117. Where a mandated reporter recognises indicators of child sexual abuse (but has not directly witnessed abuse or received a disclosure of abuse from an alleged perpetrator or victim), it would not be appropriate to enforce the duty to report with criminal sanctions. Reports of this nature must be encouraged, and organisations must provide their staff with necessary and regular training to support recognition of indicators of child sexual abuse.	**See comment on paragraph 92.** Simply put this ignored empirical evidence.
118. The introduction of this statutory duty is not intended to discourage an individual from reporting concerns about child sexual abuse which do not fall within the specific ambit of the mandatory reporting regime.	
119. The current absence of mandatory reporting laws in England and in Wales marks these jurisdictions as outliers among internationally comparable jurisdictions. As regards reporting obligations, the current provisions are confusing, unfocussed and ineffective. The Inquiry's recommendation for mandatory reporting resonates with that found in many other jurisdictions and will represent a fundamental change to the way institutions identify and report child sexual abuse.	If the scope of the mandatory duty is limited to witnessed and disclosed abuse, the law here will be unlike that in any internationally comparable jurisdictions. England and Wales will remain mandatory reporting outliers. It will have little or no effect simply because disclosure and witnessing of abuse is exceedingly rare as compared to the availability of other indicators of abuse.
The justice system response to child sexual abuse	
G.1: Introduction	
1. The criminal and civil justice systems play an important role in the way the State responds to child sexual abuse.	The criminal and civil justice systems have not been the primary focus of Mandate Now's knowledge and activities, therefore comments on this section will be few. We do not like to make comments except in areas of expertise. Our emphasis has been on ensuring as far as possible that cases of child sex abuse come to the attention of the authorities, and mandatory reporting has been the method we have concluded is the key component of this.

2. Investigating and prosecuting those who commit criminal offences involving the sexual abuse of children is rightly a matter of significant public interest. Inadequate responses of the police, Crown Prosecution Service and courts featured in a number of the Inquiry's investigations and was a matter frequently raised by Truth Project participants when giving their accounts.	It is wholly right that the inquiry has also looked at the police and criminal justice system and also the civil justice system, and we are aware of a number of improvements needed in these are outside our Terms of Reference. .