The Safer Safeguarding Group

Response to Government Consultation

"Reporting and acting on child abuse and neglect"

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This response to the Government's consultation on Mandatory Reporting of Child Abuse and Neglect and a Duty to Act is divided into the following sections.

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In Section 5 we have responded to the Consultation Document questionnaire. We were unable to download an editable tabular version of the questionnaire and so have been constrained to reproduce the questions (together with our answers) in plain text format. We found in several places that responding by 'ticking a box' was insufficient to convey an accurate impression of our views. We have therefore both ticked boxes (e.g. 'Strongly Agree' 'Disagree' 'Yes' 'No' etc.) and provided an explanation of why we have answered in a particular way.

1. Executive Summary

- Members of the Safer Safeguarding Group (comprised of professionals from a variety of backgrounds with an interest in promoting safer child protection services through a *human factors* approach) believe that the Government's proposals on Mandatory Reporting and a Duty of Act would make children ***less*** safe.
- Safe organisations are ones in which people feel free to report and discuss their concerns about safety, including their own errors. A responsive safety culture can only thrive as part of a *just reporting culture*, one in which people know that if they draw attention to service failures they will not be disciplined or punished for their errors or omissions, as long as they have acted in good faith.
- The introduction of criminal sanctions for failing to report or to act would in our view impede the much needed development of just reporting cultures in organisations which deliver services to abused and neglected children.
- We believe that the only way of making child protection safer depends on the willingness of front-line employees to identify and address safety concerns. The proposals to introduce criminal offences associated with failures to report child protection concerns or failures to act will make it even more difficult to begin this important journey.
- We do not believe that examples of service failures quoted in the consultation document, such as the Daniel Pelka tragedy or the Jimmy Savile affair or the Rotherham scandal, provide an argument for the introduction of the proposed new powers. On the contrary, we believe that these cases provide evidence of the need to create open, transparent organisations (which did not exist in Coventry or the BBC or Rotherham) in which all employees can draw attention to, and freely discuss, the things that go wrong and work constructively with colleagues to reduce the probability of reoccurrence.
- We found a number of puzzling things in the consultation document, not least the fact that there seemed to be little or no clarity about who would be covered by new duties to report or act. It appeared that the focus would be on frontline workers, which increased our unease that the impact would be to make creating a just reporting culture in child protection even more difficult.
- We conclude that the proposals should not be implemented. They run counter to the creation of a responsive safety culture and would make organisations involved in child protection and, most importantly the children they serve, less safe.

2. Background

2.1 The Safer Safeguarding Group - who we are

The Safer Safeguarding Group was formed in 2014. It comprises professionals from a variety of backgrounds: social work, social care management, medicine, civil aviation, higher education. Those contributing to this response include two former airline pilots who are *human factors* specialists, four people with extensive experience of child protection social work and child protection management, a consultant paediatrician who has been instrumental in raising concerns about unsafe system issues in child protection services and a senior social work academic.

2.2 The problem as we see it

Child protection is a ***safety critical*** activity. When things go wrong they can go very wrong indeed. Ever since the enquiry into the death of Maria Colwell in 1974 policy makers in Britain have wrestled with the issue of how to make child protection services safer. Various approaches have been tried – more procedures, more training, more inter-agency working, more information sharing, new approaches to assessment, new checklists and forms, serious case reviews, organisational redesign. But serious service failures have persisted.

The core of the problem is that we are not learning appropriately from error. There is a culture of anxiety and fear within services. Professionals and organisations practice defensively. There is a general unwillingness to admit to mistakes and to examine objectively how errors occur. Practitioners who have genuine safety concerns are often silenced by coercive organisational cultures. There are people who can see what is going wrong and who could speak out. But they don't.

Formal means of learning from error, such as Serious Case Reviews, are time-consuming, expensive and have become formulaic. Following inquiries, leaders often declare that 'lessons will be learned', but there is resignation and cynicism. Many people try to keep their heads down and hope that the next time a tragedy occurs, it will not be on their watch.

We know from approaches to organisational safety in other safety critical sectors and industries that safe organisations are ones in which service failures and errors are openly acknowledged, discussed, analysed and understood. Unless this happens in children's services there can be little or no progress towards reducing the frequency of serious service failures: children will continue to face risks which they need not face.

2.3 What needs to happen?

We believe that there are *five* things that can be put in hand immediately that would begin the process of building a ***Responsive Safety Culture*** in child protection; of making safeguarding appreciably safer. This is not just a 'shopping list' of proposals that are merely desirable. Doing these things is essential if we are to put an end to repeating the cycle of unnecessary tragedy, stunned disbelief and public outrage.

- **Learn from other safety critical industries.** The kinds of mistakes that happen in child protection are very similar to those that occur in other safety critical fields. In civil aviation it has long been understood that human error is the major single cause of disasters. Since the 1980s civil aviation professionals have developed an impressive portfolio of training and development approaches to help professionals deal constructively with loss of situation awareness and other types of human error. Child protection professionals should seek to understand and adopt these approaches.

- **Develop a just reporting culture.** Practitioners must be given permission and encouraged to talk about errors. Organisations that inhibit discussion of errors are inherently unsafe. A *reporting culture* is one in which committing, discovering or witnessing an error is seen as a learning opportunity: a chance to make the organisation safer. Blame inhibits reporting but we do not advocate a blame free culture. What is required is a *just culture.* That is one in which it is acknowledged that those who make errors while acting in good faith should not be blamed simply because a bad outcome has ensued.

- **Support and respect those who raise safety concerns.** Professionals are often well placed to see the risks, but too often they are silenced. People who raise safety concerns, either about their own work or about organisational failings, must be rewarded for doing so. Whistle blowers should be supported and shown respect. Sadly all too often whistle blowers in health and social care have been overtly bullied or subjected to subtle forms of maltreatment. This must stop.

- **Equip practitioners to talk about workplace errors and to analyse and understand how mistakes happen**. *Human Factors* training (HF) is a form of non-technical training that emerged in civil aviation during the late 1970s and 1980s. [1] It has now become mandatory for all US and European airlines. In recent years HF thinking has been found to be transferable to medical contexts such as surgery and anaesthesia. We have found that it can also be used very successfully with child protection professionals. A short basic course of one or two days duration equips someone with sufficient knowledge to begin to practice and share HF thinking at work, using it to help reduce and mitigate workplace error.

- **Gain a broad and accurate picture of the types and frequencies of mistakes and service failings.** We need better systems to create better quality data about the kinds of errors that occur daily in child protection practice. Confidential Near Miss Reporting (sometimes called Critical Incident Reporting) is a simple, cost effective technique for gathering information about the kind of errors that occur daily, not just fatal, or near fatal, incidents. [2] It is widely practiced in transport industries and also in some branches of medicine. We believe that it should be practiced in child protection too. That would allow managers, practitioners and academics the opportunity to study the nature and circumstances of errors that routinely occur; and to analyse them and suggest ways in which they can be reduced or mitigated.

2.4 Why now?

The experience in aviation and other safety critical industries shows that while technological changes can result in steady safety improvements, there are always residual human error issues that will continue to compromise safety, unless specifically addressed. For example, the computerised flight deck in aviation has a number of advantages, but it has also brought with it new varieties of human error, associated with misunderstandings, often complex, about what the computers are do or telling the pilots.

In child protection new ways of working – innovations – will hopefully lead to higher quality and safer services. But innovations also have their risks. While new structures, new service offerings and new accountability arrangements may offer some clear advantages, they also embody dangers associated with novelty and change.

We believe that to take forward significant changes, specific steps need to be taken to create appropriate systems and a suitable environment in which learning from error can easily and effectively take place. In addition, all key personnel need to be equipped with critical skills in understanding the effects of human error in their working environments and in devising ways of avoiding, reducing and mitigating error in their day-to-day work.

Practices and policies which stand in the way of learning in child protection need to be avoided at all costs. We believe that Mandatory Reporting and the Duty to Act are proposals of exactly that type; if implemented they would make learning and improvement more difficult and so make services **less** safe. In the next section we explain why we believe that.

3. Our assessment of the government's proposals

In this section we explain why we believe that the Government proposals on Mandatory Reporting and a Duty of Act would make children ***less*** safe.

We should say at the outset that we wholeheartedly endorse Government's current guidance in *Working Together*, that all professionals and practitioners working with children and their families should always report child protection concerns, when they arise. We are, however, **not** in favour of Mandatory Reporting, if that means making it a *criminal offence* not to report. If practitioners come to believe that they will be punished for failing to report suspicions of child abuse and neglect their practice will become defensive. At worst some will be acting to protect themselves.

We believe that a Duty to Act in cases of suspected child abuse and neglect is already implicit in legislation, especially Section 47 of the Children Act 1989 (relating to the duties of local authorities) and the Section 11 of the Children Act 2004 (relating to the duties of a range of agencies). Guidance (especially *Working Together*) also makes clear the expectation that all practitioners will act to safeguard and protect children who are suffering abuse and neglect.

However, we **do not** believe that the Government needs to legislate to make these implied duties more explicit. They are already widely acknowledged and understood. We ***do not*** believe that backing duties with sanctions, especially criminal sanctions, would have the desired effect of making children and young people safer. If practitioners come to believe that they will be punished for failing to intervene in a case in which, with the benefit of hindsight, it appears that intervention should have taken place, they will practice defensively.

In what follows, we urge great caution on the proposed changes relating to the issues of Mandatory Reporting and the Duty to Act. Our argument is based on an understanding of how to create safer organisations, not on ethical or political considerations.

Safe organisations are ones in which people feel free to report and discuss their concerns about safety, including their own errors. Cultures like this are sometimes called 'reporting cultures'. [3] They are characterised by an absence of fear in talking about human error. Indeed, in such organisations people are congratulated for participating honestly and openly in discussions about mistakes, including their own.

It is easy to see why organisations that have embraced reporting cultures are safer than those that have not. Where people are free to talk openly about making mistakes, it is easy to identify error traps, dangerous 'work-a-rounds', repeated slips and lapses and violations of safe procedures. [4] And it is possible to explore their causes and effects. Measures can be put in place to reduce their future incidence or mitigate their impacts. Rather than operating blind, those responsible for organisational safety and service quality (ideally all employees) are constantly learning about how errors occur and how they can be prevented.

In the last thirty years this type of culture has become progressively established in civil aviation and the nuclear industry; and is now widely recommended by experts in

safety in medicine. Indeed, the Secretary of State for Health has earlier this year made plain his own endorsement of this approach and its appropriateness for the NHS, telling Parliament that:

“Other industries – in particular the airline and nuclear industries – have learned the importance of developing a learning culture and not a blame culture if safety is to be improved. But too often the fear of litigation or professional consequences inhibits the openness and transparency we need if we are to learn from mistakes.” [5]

In an effective reporting culture, individuals, who report that they have committed or witnessed unsafe acts or made significant omissions, are not punished unless these acts and omissions result from gross negligence, wilful violations for personal gain or intentionally destructive behaviour. This is not a ‘no-blame’ culture; but it strives to be a *just* culture. [6] It allows potentially dangerous situations, which might otherwise have been covered up, to come to light. For example, the pilots of a British-registered Airbus A330 airliner freely admitted both falling asleep at the same time during a flight in 2013. Their identities have remained a secret and no action has been taken against them. They have co-operated fully in enquiries to discover safeguards and thinking about how to avoid a reoccurrence [7].

Sadly, there is manifest evidence that the cultures of local authorities and other organisations involved in child protection in Britain are not of this type. All too often the culture is one of punishment and blame. Not infrequently professionals who have committed errors in good faith, but which have resulted in child protection tragedies, have been made subject to disciplinary procedures, including dismissal and being struck off. We believe that the mandatory reporting of suspicions of child abuse and neglect, backed by the threat of criminal sanction and imprisonment, runs directly counter to the creation of a just reporting culture in child protection practice and serves to stoke the fires of blame and punishment that already compromise safety.

The name of Daniel Pelka has been adopted by a campaign calling for mandatory reporting or ‘Daniel’s Law’ as they refer to it. The campaign’s website states:

“Four-year-old Daniel Pelka was starved and mistreated in full view of his primary school teachers and teaching assistants, who observed his desperate attempts to forage for food, his severe weight-loss and the numerous bruises on his body, before his death at the hands of his mother and step-father.” [8]

But this account, vitiated by hindsight bias, cruelly misstates the reality. Members of staff at Daniel’s school were not heartless or callous. They were sadly deceived by Daniel’s plausible mother who was able to account for Daniel’s weight loss and aberrant behaviour by the fiction of an eating disorder. [9.] How people were taken in should be something that is explored and understood, but in a climate of fear it is no surprise that professionals are unlikely to be fully open and frank about mistakes that have been made. In circumstances in which professionals in similar circumstances might be sent to prison, the right to avoid self-incrimination is likely to be invoked and the full facts never understood.

There is a wealth of literature from both aviation and medicine that confirms our belief that a responsive safety culture can only thrive as part of a just reporting

culture [10]. A very clear statement of the position we espouse was given by the US Federal Aviation Administration's Randy Babbit announcing in 2009 a new safety culture applicable to understanding error in air traffic control. He said:

"We're moving away from a culture of blame and punishment. It's important to note that controllers remain accountable for their actions, but we're moving toward a new era that focuses on why these events occur and what can be done to prevent them. We need quality information in order to identify problems and learn from incidents before they become accidents. The best sources of that information are our front-line employees. Our success depends on their willingness to identify safety concerns." [11]

We believe that the only way of making child protection safer depends on the willingness of front-line employees to identify and address safety concerns. The proposals to introduce criminal offences associated with failures to report child protection concerns or failures to act will make it even more difficult to begin this important journey.

We believe that there already exists an array of criminal offences (such as Assisting an Offender, Conspiracy to Pervert the Course of Justice, and Misconduct in a Public Office) which can be used to deal with cases of clearly egregious behaviour involving deliberate wrongdoing. The danger of introducing a new offence, applicable only to child protection, would be that it could be used inappropriately to punish people who commit tragic errors, rather than deliberate misdeeds. It would take only one such prosecution to send a chill through the community of professionals and practitioners who work to protect children from abuse and neglect. The effect would be one of deepening the culture of blame and punishment, resulting in greater secrecy and obfuscation when things go wrong and decreased reporting of mistakes which should be analysed and understood, not hidden.

4. Issues arising from the consultation paper

In this section we consider issues arising from the consultation paper under three headings: 'What we agree with', 'Where we take issue' and 'What puzzles us'.

4.1 What we agree with

We were pleased to see that Ministers, writing in the Foreword of the consultation document (page 3), acknowledge that protecting and safeguarding children "… is not a simple or straightforward task" and that "signs of abuse and neglect can be hard to identify and judgements about the best interests of the child are rarely clear-cut". They also acknowledge that failings can "…result from a variety of different factors, from not recognising abuse for what it is to incorrect assessments of risk and from failures to properly share information between agencies to deliberate cover-ups".

These remarks are confirmed in the main body of the document:

"Decisions about what steps to take in response to abuse and neglect are not always

straightforward. A warning sign or indicator of abuse or neglect may be difficult to spot and does not automatically mean that a child is or will be abused or neglected. Practitioners need to use their professional judgment, based on the circumstances of each case and the information available to them, to decide on the best course of action for the child…." (paragraph 5, page 4)

In support of these remarks we observe that in the vast majority of cases where a public enquiry or serious case review has been deemed necessary, the causes have been identified as stemming from *human error* rather than from wilful wrongdoing. Child protection is a very complex activity in which there are any number of factors which conspire to wrong-foot practitioners, not least the deliberate actions of some parents and carers who are adept at misleading and misdirecting even the most experienced professionals. We believe that the correct response to managing human error in complex situations is the creation of *just reporting cultures* in which practitioners and managers are free to explore the things that go wrong without fear that they will face sanction or discipline, unless their actions have exceptionally been wholly and wilfully egregious. It is only in this way that it is possible to learn from error and so improve. Indeed, to inhibit this sort of learning results in organisations that are systematically unsafe.

We also noted the Ministers' observation, in the Foreword, that the issues involved in Mandatory Reporting schemes are "complex" and the evidence for them is "mixed" (page 3). As we have argued above, we believe that the introduction of both Mandatory Reporting or the Duty to Act would make establishing a reporting culture significantly more difficult, so making learning from error much more difficult and so resulting in services which are less safe. Thus proposals discussed in the Consultation Document involve high risks and are based on "mixed evidence". We contend that is not a good basis for policy-making.

We conclude this section by strongly endorsing the Consultation Document's identification of the following risk of both Mandatory Reporting and the Duty to Act. We agree that both would:

"…lead to those bound by the duty feeling less able to discuss cases openly for fear of sanctions, hinder recruitment and lead to experienced, capable staff leaving their positions." (pages 14 and 16)

4.2 Where we take issue

We believe that the Consultation Document fails to relate the proposed changes to actual cases. For example, although the document uses the words 'reckless' and 'deliberate' to indicate the kind of behaviour by practitioners that it is sought to prevent, there is no clear account in the consultation document of an actual case of a practitioner being deliberately reckless. One would think that if a law was necessary to prevent a particular kind of behaviour, there would be no shortage of examples of that behaviour; so this omission is surprising. Certainly if any such law is to be *just* it must clearly define the behaviour which it criminalises, but we see no evidence of such a definition in the Consultation Document which provides no exploration of the problematic boundary between 'work-arounds', slips, lapses and violations, on the one hand, and deliberate recklessness and wrongdoing on the other. Psychologists

[12] who have studied organisational safety are clear that a *just reporting culture* is a precondition for the development of safer practices. And a *just* culture is one in which that problematic boundary is constantly and scrupulously explored. Only where people know that errors made in good faith will not be punished, and know the boundary between error and wilful wrongdoing, can they be encouraged to be open about their mistakes. The fact that the Consultation Document does not do this leads us to believe that anybody endorsing its proposals would be signing a blank cheque.

Examples of what are called 'high profile cases' are given in paragraph 13 (page 6) of the Consultation Document. Only one of these (the case of Daniel Pelka) is typical of the work undertaken on a daily basis by local authority social workers and other professionals. The report of the Serious Case Review into Daniel's case provides no evidence of wilful or reckless misconduct by any of the practitioners involved in his care, although it clearly concludes that there were serious service failings, the causes of which are ascribed to loss of situation awareness among those concerned and to communication failures between them; to human error, not to egregious or reckless behaviour.

The Serious Case Review report [page 6] states:

"In this case, professionals needed to "think the unthinkable" and to believe and act upon what they saw in front of them, rather than accept parental versions of what was happening at home without robust challenge. Much of the detail which emerged from later witness statements and the criminal trial about the level of abuse which Daniel suffered was completely unknown to the professionals who were in contact with the family at the time." [13]

We submit, in rebuttal of calls for 'Daniel's Law', that there is little evidence in Daniel's case that could be used to justify the prosecution of any professional or practitioner for wilful wrongdoing, by failing to report or to act. Rather there is widespread evidence of human error which could, and should, be addressed by open discussion of how it occurred and how it can be avoided or mitigated in the future. In short we do not believe that Daniel's tragedy provides support for the introduction of Mandatory Reporting, or a Duty to Act. Rather it provides evidence that this is **not** the correct approach.

The other case material alluded to in the Consultation Document concerns sexual exploitation outside the family. The Jimmy Savile affair, although shocking, is a singularly unusual one involving, as it does, such a high profile celebrity. Dame Janet Smith's report [14] into the affair is highly critical of the BBC. She says that some junior BBC employees were afraid to speak out about Savile because of "a macho culture of sexism and sexual harassment" and an "atmosphere of fear" and she found that, as a result, senior managers were not aware of Savile's activities. Clearly this is an example of a toxic organisational culture, in which people towards the bottom of the organisation were afraid to bring wrongdoing to the attention of more senior colleagues. We remain to be convinced that they would have acted differently had a law requiring them to report existed; but in any case that is tangential since the Consultation Document does not propose making employees of the BBC mandatory reporters! It is also worth noting that a police officer involved in the Savile case has said that although he personally believed Savile to be guilty of sexual abuse, when

he brought the matter to the attention of his superiors he was not believed, because Savile was such “an icon”. He was told by a senior colleague that Savile was a high-profile man so “he must be OK”. [15]

Similar themes emerge in considering the scandals in Rotherham and elsewhere concerning child sexual exploitation, which constitute the third example cited in the Consultation Document. Professor Alexis Jay in her report on Rotherham concludes:

“In the early 2000s, a small group of professionals from key agencies met and monitored large numbers of children known to be involved in CSE or at risk but their managers gave little help or support to their efforts. Some at a senior level in the Police and children's social care continued to think the extent of the problem, as described by youth workers, was exaggerated, and seemed intent on reducing the official numbers of children categorised as CSE. At an operational level, staff appeared to be overwhelmed by the numbers involved. There were improvements in the response of management from about 2007 onwards. By 2009, the children's social care service was acutely understaffed and over stretched, struggling to cope with demand.” [16]

We contend that in Rotherham, and indeed elsewhere, there is NO evidence of well-run services occasionally falling down because aberrant employees wilfully, recklessly or neglectfully fail to report abuse. On the contrary, there were serious systematic failings, which extended right to the top of the organisations concerned, which were characterised by a collective delusional self-deception, extending over many years, about the extent and seriousness of the problems. A youth worker, for example, in a place like Rotherham might, in future, be designated a mandatory reporter. But would that mean that s/he would fly in the face of an organisation and a system which seemed hell bent on convincing its workers that they were not dealing with cases of child sexual exploitation? We think not.

Rather than seeing the Savile and Rotherham cases as being arguments for the introduction of Mandatory Reporting or a Duty to Act, we see them as being very good arguments for **not** introducing criminal sanctions. The kinds of organisations that failed to stop Savile and failed to respond to the abuse in Rotherham are exactly the kinds of organisations we believe to be unsafe. They are characterised by fear and the people who work in them, especially at a junior level, are fearful of speaking out and drawing service failings to the attention of others. Such people, if they do dare to speak out, are not listened to or they are scapegoated and silenced. We believe that introducing the possibility of criminal sanctions likely to be directed at frontline workers into this toxic mix would only serve to make such organisations even more opaque; and even more characterised by blame and fear and so very much **less** safe.

4.3 What puzzles us

There were four things in the Consultation Document that we found particularly puzzling and confusing.

Paragraph 43 of the Consultation Document (page 12) says that new statutory measures would require certain practitioners or organisations to report child abuse or

neglect if they knew or had reasonable cause to suspect it was taking place; or to take appropriate action (which could include reporting) in relation to child abuse or neglect if they knew or had reasonable cause to suspect it was taking place.

Our first question about this outline of the proposed law concerns what the word 'child' means in paragraph 43. Does it mean a specific child, who could be named or otherwise identified, or does it mean any child or children in general? Presumably being crystal clear about this issue would be vital if successful prosecutions for failing to report or act were to be made under a new law. It would seem, however, to be insufficient for the law to require the existence of a named or identifiable child, because that would mean that social workers and police officers involved in (say) investigating on-line abuse of children might not be covered by a duty to report or act if specific victims could not be identified, as is often the case with on-line abuse, even if a perpetrator could be identified. But if the definition of 'child abuse' is to be 'the abuse of any child' or 'the abuse of children in general' would this then cover situations in which an adult individual was thought to be dangerous, for example, where s/he revealed to a psychiatrist or psychotherapist that s/he had fantasies about the sexual abuse of children? However, the problem with having a law covering this type of situation is that successful prosecutions of practitioners might be dependent on the testimony of abusers or potential abusers (e.g. either confirming or denying that they had revealed their intentions to their therapist). Such people might, and probably would, have a variety of ulterior and dishonest motives in agreeing to testify.

We also find it puzzling, were a new law not to require the identification of a particular child, why the Consultation Document does not propose the inclusion of people such as adult psychiatrists, prison officers and adult psychiatric nurses among those required to report or act (see below).

Our second question also focuses on Paragraph 43 and concerns the issue of what definitions of child 'abuse' and 'neglect' it is proposed to apply in any new law. The best readily available definitions of child abuse and neglect are those provided in *Working* Together, though in the most recent edition [17] these are relegated to a glossary. We are not lawyers and we cannot judge the quality of these definitions for legal purposes, but clearly they were not created with that use in mind. It would be wholly wrong to create new criminal offences which involved poorly defined criteria of what does and what does not constitute a criminal offence, so this issue would need to be addressed if a new draft law came before Parliament. At a practical level a new law would require a distinction between people who had had what may be serious concerns about a child's health or welfare, but which they believed fell short of abuse and neglect, and those who failed to act or report when they firmly believed abuse or neglect to be occurring. We suggest that there may be quite a large grey area extending from 'very worried, but not yet suspecting abuse' to 'definitely suspecting abuse but not yet willing to report'. Any law that failed clearly to distinguish between such cases would be unjust. We are puzzled that the Consultation Document does not appear to have addressed these important issues and suggest this shows that a great deal of thinking about any legislative change has yet to take place.

Our third area of puzzlement concerns the term 'reasonable cause', which also occurs in Paragraph 43. Cases of child abuse often involve competing accounts and

conflicting evidence which make it difficult for people on the ground to see what is going on. It is not infrequently the case that medical opinions diverge, with, for example, a consultant orthopaedic surgeon having a different opinion about the cause of a fracture to the consultant paediatrician who had referred the case. One professional might *reasonably* reject the opinion of another, but would that mean that they then lacked reasonable cause to make a referral? It is difficult to know.

At a more practical level we would hope that practitioners would not make referrals based on legalistic considerations ('do I have reasonable cause or not?') but on the basis of how concerned they are about a particular child. It seems that the proposed drafting of a new law might send out the wrong signals about what approach should be taken to referrals.

Our last area of puzzlement concerns the question of who is to be a mandated reporter if new laws come into force. Table 1 (pages 19 and 20 of the Consultation Document) purports to show which organisations and which roles would be covered by the new duties. Although there is a *caveat* in Paragraph 68 (page 19) saying that "… the table provides the main examples only and is not intended to be exhaustive", it seems to us to be 'not exhaustive' in a way which betrays that the serious issue of who will be covered by the new duties has NOT been addressed by those who have prepared the Consultation Document. Such an omission is both puzzling and troubling, because it appears that the Government is considering a new law without first considering to whom it will apply.

Our puzzlement increased, as did our sense of unease, when we noted that the professional roles listed in the third column of Table 1 are mostly frontline workers, not their managers and supervisors. Thinking back to our example of the police officer in the Jimmy Savile case (see above page 12) would it be the case under the proposed new duties that such a person would be prosecuted for not reporting his concerns, while his senior officers, who dismissed his suspicions as unfounded and asserted that Savile must be 'OK', would not be prosecuted? Or, thinking back to our comments on the Rotherham scandal (also page 12), would junior staff in a similar situation be prosecuted for failing to report or act, while senior people responsible for creating a repressive organisational culture, that denied there was a problem, did not face the possibility of sanction?

There are also some other very puzzling omissions from Table 1, which suggest a lack of thought, rather than a desire simply to provide examples. What about Prison Officers and Prison Governors as well as Probation Officers? What about Orthopaedic Surgeons, Radiologists and Psychiatrists as well as Paediatricians? Why is there no mention of Dentists or Maxillo-Facial Surgeons? What has happened to Child Psychologists and Counsellors? Why is Cafcass not mentioned? The list could go on and on, because once one accepts that some people should face sanction for failing to report, there is a powerful argument for including others as well.

In view of numerous reports of abuse by clerics, and failures of senior church figures to act on reports of abuse [18], we find it puzzling that the Consultation Document does not address questions of whether religious institutions, clerics and other church employees should be covered by the proposed duties to report or act.

The truth of the matter is that it is very hard for those who wish to introduce these new duties to draw the line between those who should be covered by them and those who should not. One thought is that if anybody is to be a mandated reporter, then everybody (including members of the public) should be. Another thought is that not being able to draw the line is a powerful argument against introducing the duty in the first place.

5. Our response to the consultation paper questionnaire

Question 1

Child protection training for practitioners should be improved so that they are better qualified and able to provide the right help at the right time to keep children safe.

We **strongly agree**. Indeed, it is hard to disagree with this statement. But different types of practitioners require different types of technical training. For many groups (e.g. teachers, nursery workers, police officers) the need is for training in recognising abuse and neglect. On the other hand, many health professionals require more highly developed diagnostic skills. Some groups (social workers, specialist police officers, paediatricians) need training specifically related to intervention, as well as recognition. The emphasis across the board needs to be on *continuous improvement*. No matter how competent a practitioner, there will always be scope for further growth and improvement. In a *safety critical* environment like child protection, all groups of practitioner, no matter what their professional designation, require *non-technical* training, by which we mean training in how to work more safely by understanding how and why errors and adverse events occur; and how to analyse and understand them so that action can be taken to reduce the likelihood of re-occurrence or mitigate its impact.

More needs to be done within the child protection system to encourage new and innovative systems to better protect children.

We **strongly agree**. In particular, we believe that there needs to be innovation in learning from error. We believe that child protection practitioners need to work in 'learning organisations' which are characterised by 'just reporting cultures'. These are the kinds of organisations in which people are not afraid to admit to error and in which mistakes and service failures are openly discussed. Only in this way can practitioners and managers understand how and why errors occur and how they can be avoided and mitigated. Everybody who works in a *safety critical* organisation needs to have a basic understanding of *human factors*; of how and why we make mistakes at work and how we can learn to work more safely. Organisations in which this does not happen are not safe. There is much that children's services can learn from civil aviation, in which during the last thirty years there has been steady progress towards creating learning organisations based on just reporting cultures and knowledge of human factors.

Organisations with child protection responsibilities need to work better together.

Again we **strongly agree**. There is always scope for better working together. Better understanding of situations in which failures in inter-agency co-operation have come about is required. This requires open discussion of how and why failures occur. There is no room for agency protectionism and organisational defensiveness. An open and just reporting culture is required, in which people feel free to talk about errors, together with a basic knowledge of *human factors*.

Practitioners and organisations with child protection responsibilities sometimes recklessly fail to take proper action (including reporting) to stop or prevent child abuse and neglect.

We **disagree** with the sentiment behind this statement. While it is trivially true that it is *possible* for practitioners to act recklessly, there is no systematic evidence to show that this is a pervasive problem. Indeed, in cases like those of Daniel Pelka and Khyra Ishaq, where serious service failures occurred, there is no evidence of *recklessness*. Rather there is evidence that people who were acting in good faith were deceived and wrong-footed by manipulative and devious carers, made poor decisions or failed to communicate them effectively or tried in difficult circumstances to work around cumbersome procedures and in so doing lost their ways. In nearly all the cases of serious services failures, which have been reported in public enquiries or Serious Case Review reports, the evidence points to professionals who make mistakes, not to people who have acted recklessly or otherwise behaved egregiously. Even in cases such as the failure to respond to child sexual exploitation in Rotherham, the evidence points to people's judgements being constrained by low expectations created by coercive organisations and cultures, not to evidence of widespread egregious behaviour by individual practitioners.

Child abuse and neglect is generally under-reported by practitioners involved in children's lives.

We **agree** that there is under-reporting of child abuse and neglect. But there is generally under-reporting of all kinds of crime, and child abuse and neglect is no exception. It is difficult to imagine how practitioners could report all, and only all, cases of child abuse and neglect. On the other hand, practitioners could *over-report* child abuse and neglect, by including cases in which suspicions are not well formed. This would not be helpful because the false positives generated as a result would divert resources from investigating and responding to cases of genuine concern. We believe that better training in recognising the signs of child abuse and neglect, better inter-agency communications and more professional space, in which concerns of abuse and neglect can be carefully considered, are the correct responses to the problem of under-reporting, not criminal sanctions for failing to report.

Question 2

Mandatory reporting will generate more reports of suspected and known cases of child abuse and neglect.

We believe that the correct response here is **Don't Know**. There appears to be mixed evidence of the extent to which mandatory reporting increases the number of reports. In some jurisdictions (e.g. South Australia) systems appear to have been placed under pressure as a result of mandatory reporting [17].

Increased reporting may divert attention from the most serious child abuse and neglect cases.

We **agree** that this is an important risk of mandatory reporting.

***Increased reporting could mean that abuse and neglect would be captured at an early point in a child's life*.**

We **disagree** with the sentiment behind this statement. There is no evidence that mandatory reporting promotes early intervention – indeed we do not know of a study which examines this issue. A much more effective way of achieving early intervention would be to ensure that professionals and other practitioners working with children in the first two or three years of life were much better supported and equipped, including better systems of child health surveillance. If professionals such as Health Visitors carry such large caseloads that they cannot adequately monitor the health and welfare of individual children, it is not surprising that opportunities for early intervention are missed.

Mandatory reporting could have an adverse impact on the child protection system (e.g. impacting recruitment and retention of staff, creating a culture of reporting rather than acting, negatively impacting the serious case review process).

We **strongly agree** with this statement. We believe that mandatory reporting, backed by criminal sanctions, would be a major contributor to the culture of blame which already creates serious problems for developing a responsive safety culture in child protection. If people believe that admitting to a mistake, or being associated with a service failure, could result in being taken to court and punished, they are not surprisingly more reluctant to confess to errors or to talk openly about mistakes and service failings. It is hard to imagine that many people want to risk the possibility of being charged with criminal offences as the result of failings in the way they carry out their jobs. Indeed, it is likely that publicity associated with the punitive way in which some social workers have been treated in child protection tragedies adds to problems in recruiting people to that profession which experiences high levels of vacancy and staff turnover. Research indicates that the average working life for a social worker is under 8 years, compared to 16 years for a nurse, 25 years for a doctor and 28 years for a pharmacist. [19] Undoubtedly the blame culture is an important factor in the causation of this deeply troubling disparity.

Mandatory reporting could dissuade victims from disclosing incidents of abuse and reduce 'safe spaces' for children.

We can only respond that we **do not know** what the likely effect of mandatory reporting on children and young people would be. There seems to be little evidence on the impact on victims. Those of us who have practised child protection, however, know that there are some children and young people who are very fearful of disclosing maltreatment, either because they do not want their carers to be blamed and punished or because they fear reprisals from abusing or neglectful carers following a disclosure of abuse or neglect. The working practices of professionals, and organisational processes and systems, need to be adapted as far as possible to minimise the trepidation that some victims experience at the prospect of disclosure. As the impact of mandatory reporting on this is unknown, there is clearly an unquantified risk that mandatory reporting could make matters worse. This should not be ignored.

Mandatory reporting could lead to greater prevention and awareness of abuse and neglect.

We **disagree.** We are very sceptical about this claim. Any policy change regarding abuse and neglect will create some level of public awareness, which needs to be separated from the specific effects of any particular policy. We believe it is unlikely that mandatory reporting would have a measurable impact on prevention. Indeed, the effect may be to divert resources away from preventative services into more investigations of false positive cases.

***The introduction of a mandatory reporting duty would not in itself mean that appropriate action would be taken to protect children*.**

We **strongly agree** with this statement. We believe that appropriate action is much more likely to be encouraged by appropriate training, both in *technical* skills, such as the recognition and diagnosis of abuse and neglect, and in *non-technical skills* such as learning from error. Practitioners are **not** less likely to make mistakes because they fear retribution for not taking appropriate action. They **are** less likely to make mistakes because they work in a learning environment in which they can improve and develop their practice, resulting in improved situation awareness, clearer communication and enhanced decision-making skills.

A mandatory reporting duty would ensure that those best placed to make judgements about whether abuse or neglect is happening – i.e. social workers – do so.

We **strongly disagree** with this statement. Although social workers have a wealth of relevant child protection knowledge and intervention skills, and although they conduct child-in-need assessments and Section 47 enquiries, coming to a final decision about whether or not a Child Protection Plan is required is a collective multi-agency responsibility. Medical opinion, police investigations and the observations and opinions of key practitioners (e.g. teachers, Early Years workers) all have a crucial part to play. Were the introduction of mandatory reporting to be accompanied by statements of this type, that would be very damaging to the long-standing tradition of multi-agency *working together*. Statements of this type might encourage some practitioners to believe that mandatory reporting absolved them from continued responsibilities for safeguarding and protecting a child as members of a multi-agency, inter-disciplinary team. That kind of 'over-to-them' approach would be uniquely damaging and indeed dangerous.

Question 3

To what extent do you agree that the introduction of a mandatory reporting duty would directly improve outcomes for children?

The correct answer to this question is **Don't Know** because we know of no research which links mandatory reporting to outcomes for children and young people. Indeed, such a study would be challenging, not least because it would involve following up all the children affected by a mandatory reporting regime, including false positives, false

negatives and true negatives; not just true positives. We **disagree** with the assumption behind the question that there is likely to be a simple link between mandatory reporting and outcomes for children, not least because mandatory reporting would have procedural and resource implications for services which might be complex – e.g. resources devoted to mandatory reporting might need to be taken from preventative work or other support services.

Question 4. ***Please outline any risks or benefits regarding the introduction of a mandatory reporting duty that haven't been articulated in the consultation*****.**

Although the consultation paper recognises (in a statement with which we warmly **agree**) that mandatory reporting might "…lead to those bound by the duty feeling less able to discuss cases openly for fear of sanctions, hinder recruitment and lead to experienced, capable staff leaving their positions…" (page 14), it does not fully explore the very serious negative consequences of preventing the development of a *just reporting culture* which we have canvassed at some length above (Section X). Just so there is no possibility of misunderstanding we restate our conclusions on this issue here. It is vital to recognise that safe organisations are ones in which people feel free to report and discuss their concerns about safety, including their own errors. Cultures like this are sometimes called 'reporting cultures'. They are characterised by an absence of fear in talking about human error. Indeed, in such organisations people are congratulated for participating honestly and openly in discussions about mistakes, including their own. Introducing sanctions (especially criminal offences) connected with service failures flies in the face of developing a reporting culture and will result in practitioners being less open about the things that go wrong and the causes of error in their organisations and working practices. That will make organisations and, most importantly the children they serve, **less** safe.

Question 5

A duty to act could strengthen accountability on individuals and organisations in protecting children from abuse and neglect.

We **disagree** with this statement. We do not believe that there is any systematic problem of people or organisations taking child abuse and neglect lightly. On the contrary responsibilities weigh heavily and the vast majority of practitioners are only too well aware that they will be held accountable for a child's safety and welfare. Failures to act are largely a result of misjudgements, errors and systematic failings, not egregious or irresponsible behaviour by individuals. Where on the rare occasions there is egregious behaviour (e.g. abetting child abuse, perverting the course of justice, misconduct in a public office etc.) there are already criminal sanctions which can be invoked.

A duty to act could have an adverse impact on the child protection system (e.g. impacting recruitment and retention of staff, and negatively impacting the serious case review process).

We **strongly agree** with this statement. Not surprisingly people are reluctant to expose themselves to the risk of prosecution for failings in the workplace. Introducing new offences relating to the non-reporting of child abuse concerns, or apparent

failings in a duty to act, would convey a negative message to those working to safeguard and protect children – "get it wrong and we will punish you!". Local authority children's services, in particular, are organisations in which there is already a tradition of blame. There is probably no professional group more familiar with blame than child protection social workers, who, following a tragedy, have not infrequently been named, shamed and even ruined. The climate of fear brought about by politicians and journalists, and sometimes even other professionals, demanding that erring social workers be called to account, has created a wholly dysfunctional environment that frustrates learning and improvement and results in services which are less safe, and of lower quality, than they could otherwise be. We believe that this is an important factor in retention and recruitment, especially of children's social workers. High turnover and vacancy rates in local authority children's services result in unmanageably high caseloads and high levels of stress, which increase the risk of service failures. Adding the threat of prosecution when things go wrong will only serve to make this worse.

A duty to act on child abuse and neglect would be more likely to lead to better outcomes for children than a duty focused solely on the reporting of child abuse and neglect.

We have to respond **don't know** because there is to our knowledge no evidence to support this statement. We **disagree** with the implicit assumption behind this statement that there are simple linkages between the changes proposed in this consultation and outcomes for children, which are long-term and often difficult to measure.

The focus of sanctions for the duty to act on deliberate or reckless failures would ensure that those responsible for the very worst failures in care would be held accountable.

We **agree** that there is always a need to focus sanctions on 'deliberate or reckless failures', not on practice errors and other service shortfalls. The problem is how that is ensured. In the past it has often been front-line workers who have been the focus of disciplinary action when things go wrong. It seems likely that were offences connected with Mandatory Reporting or a Duty to Act introduced the same tradition of 'blaming the usual suspects' would continue.

Q6. To what extent do you agree that the introduction of a duty to act would directly improve outcomes for children?

We know of no evidence to suggest that legislating for a Duty to Act would have any influence on outcomes for children. We believe that any other answer to this question would be speculative.

Q7. Please outline any risks or benefits regarding the introduction of a duty to act that haven't been articulated in the consultation.

Although the consultation paper recognises (in a statement with which we warmly **agree**) that the introduction of a Duty to Act might "…lead to those bound by the duty feeling less able to discuss cases openly for fear of sanctions, hindering

recruitment and leading to experienced, capable staff leaving their positions;…" (page 16), it does not fully explore the very serious negative consequences of preventing the development of a *just reporting culture* which we have canvassed at some length above (Section 3). Just so there is no possibility of misunderstanding we restate our conclusions on this issue here, as we have done above in relation to Mandatory Reporting. It is vital to recognise that safe organisations are ones in which people feel free to report and discuss their concerns about safety, including their own errors. Cultures like this are sometimes called 'reporting cultures'. They are characterised by an absence of fear in talking about human error. Indeed, in such organisations people are congratulated for participating honestly and openly in discussions about mistakes, including their own. Introducing sanctions (especially criminal offences) connected with service failures flies in the face of developing a reporting culture and will result in practitioners being less open about the things that go wrong and the causes of error in their organisations and working practices. That will make organisations and most importantly the children they serve **less** safe.

Q8. Having considered the issues outlined in the consultation and your answers above, which of the following would be most preferable? Please choose one option only.

We strongly endorse the following option:
"Allowing the package of reform measures focused on improving how the whole system responds to child abuse and neglect to be implemented before considering the introduction of additional statutory measures."
We believe that legislation – especially the proposed changes - is **not** required at the present time

Q9. If a new statutory measure is introduced, do you agree with the following elements of the proposed scope?

Because we are strongly of the view that a new statutory measure should **not** be introduced, we are unable to answer this question.

Q10. If there are aspects of the proposed scope that you disagree with, or you would like to provide further information to support your answer to question 9, please do so here:

Because we are strongly of the view that a new statutory measure should **not** be introduced, we are unable to answer this question.

Q11. If you believe new statutory measures should extend to adults, please provide further information, taking into account the existing wilful neglect offence.

Because we are strongly of the view that a new statutory measure should **not** be introduced, we are unable to answer this question. We would oppose similar proposals relating to adults.

Q12. Should the proposed activities outlined in paragraphs 65–68 of the consultation and table 1 be included if a new statutory measure were to be

introduced?

Because we are strongly of the view that a new statutory measure should **not** be introduced, we are unable to answer this question

Q13. Please provide your views, noting if any activities listed should be removed, and if there any other activities that should be included.

Because we are strongly of the view that a new statutory measure should **not** be introduced, we are unable to answer this question

Q14. If a new statutory measure is introduced, where do you think accountability should rest (see paragraphs 69–70 of the consultation)?

Because we are strongly of the view that a new statutory measure should **not** be introduced, we are unable to answer this question fully. We do however believe that accountability is an organisational matter and that heaping more accountability onto individuals will be wholly counter-productive.
lease tick

Q15. If a new statutory measure is introduced, what do you think the type of sanction should be if it is breached (see paragraphs 71–74 of the consultation)?

Because we are strongly of the view that a new statutory measure should **not** be introduced, we are unable to answer this question fully. The least-bad option in our view is for **existing practitioner and organisation specific sanctions only**.

Q16. Please provide further information about the reasons for your answers to the above questions on scope, accountability and sanctions, if you would like to do so.

We have nothing further to add except to reiterate that we are opposed to the introduction of any kinds of sanctions, believing that they will make organisations and practice **less** safe.

Q17. Please detail any additional information that you feel should be taken into account in this consultation.

We hope that the above evidence, arguments and comments demonstrates why the Government should NOT legislate to introduce Mandatory Reporting or a Duty to Act.

Notes

[1] Human factors are sometimes referred to as 'non-technical skills' – see Flin, R., O'Connor, P. and Crichton, M. Safety at the Sharp End: a guide to non-technical skills Farnham, Ashgate, 2008

[2] See for example Barach, P. and Small, S. "Reporting and preventing medical mishaps: lessons from non-medical near miss reporting systems" *British Medical Journa*l. 2000 Mar 18; 320(7237): 759–763.

[3] Reason, J. Managing the risks of organizational accidents Aldershot, Ashgate 1997

[4] Reason, *op. cit.*

[5] Hunt, J "An NHS that learns from mistakes" Oral statement to Parliament, 9th March 2016-10-06 https://www.gov.uk/government/speeches/an-nhs-that-learns-from-mistakes

[6] Dekker, S. Just Culture Farnham, Ashgate, 2007

[7] "Airline pilots asleep in the cockpit during long-haul flight" *Daily Telegraph* 26th September 2013 http://www.telegraph.co.uk/finance/newsbysector/transport/10335427/Airline-pilots-asleep-in-the-cockpit-during-long-haul-flight.html

[8] http://danielslaw.co.uk/

[9] Coventry LSCB Daniel Pelka Serious Case Review, 2nd October 2013

[10] For a discussion of the implications of some of the key research see Reason, J. "Achieving a safe culture: theory and practice" *Work and Stress*, 1998, Vol.12 No.3 pp. 293 – 306

[11] ATCNetwork "New FAA Safety Culture Reflected in Operational Error Reporting" Tuesday, July 21, 2009 12:00 AM http://www.atc-network.com/atc-news/new-faa-safety-culture-reflected-in-operational-error-reporting-

[12] See for example Reason (1997) and Dekker (2007)

[13] Coventry LSCB op. cit.

[14] Dame Janet Smith Review, The Jimmy Savile Investigation Report BBC 2016 http://www.bbc.co.uk/bbctrust/dame_janet_smith

[15] "Jimmy Savile's Broadmoor role came with a bedroom and keys" *The Guardian* 12/10/12 https://www.theguardian.com/media/2012/oct/12/jimmy-savile-broadmoor-volunteer-role?newsfeed=true

[16] Jay, A. Independent Inquiry into Child Sexual Exploitation in Rotherham (1997 – 2013) Rotherham Metropolitan Borough Council 2014 http://www.rotherham.gov.uk/downloads/file/1407/independent_inquiry_cse_in_rotherham

[17] HM Government Working together to safeguard children: A guide to inter-agency working to safeguard and promote the welfare of children March 2015

[18] The Guardian "Damning report reveals Church of England's failure to act on abuse" 15/3/2016 https://www.theguardian.com/world/2016/mar/15/damning-report-reveals-church-of-england-failure-to-act-on-abuse

[19] Curtis L, Moriarty J and Netten A (2010), 'The expected working life of a social worker'. *British Journal of Social Work* 40(5), 1628-1643.