INTRODUCTION

'Learning from institutional sexual abuse cases indicates that there is something about institutions, as environments for child sexual abuse, which appears to aggravate the vulnerability of potential victims and amplifies the power over them that abusers can exercise. This means that institutions are high risk environments for children, young people and indeed other vulnerable people. Such a high risk, coupled with the vulnerability of potential victims, requires a higher investment in mitigation.' (CEOP, 2013 in Munro & Fish, 2015, p35)

Munro and Fish share the ambition of creating 'safe environments' where children are protected from harm while being able to enjoy the services provided.

Focusing on two case studies available from the Royal Commission into Institutional Responses to Child Sexual Abuse, Munro and Fish turned their attention to seeking a deeper understanding of why errors occur. They explain that solutions to failures are built on understanding the factors that contribute to human error such as: the nature of the problem; errors in human reasoning; and organisational factors that influence who well children are protected.

Applying this approach to their study, Munro and Fish offer some speculative findings on individual and organisational factors that contributed to the failure to protect children in a timely and effective way.

KEY LEARNINGS

The study identifies a number of challenges to creating and maintaining a safe organisation that is quick to recognise grooming or abuse behavior and triggers a process that investigates concerns and takes appropriate action to protect children from harm as outlined below.

The nature of the problem

The challenges posed by the problem of child sexual abuse are (1) that perpetrators seek to conceal their activities; (2) children and young people who are abused can be unable or slow to ask for help; and (3) many of the behavioural indicators of abuse and 'grooming' are ambiguous' as it involves actions by the perpetrator to increase their chances of abusing a child undetected. As such, judgment or interpretation is required to decide if they are cause for concern (Munro & Fish, 2015, p5).

RESEARCH OVERVIEW

TITLE

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

Published September 2015

AUTHORS

Professor Eileen Munro and Dr Sheila Fish for the Royal Commission into Institutional Responses to Child Abuse.

KEY FOCUS

This report suggests that a new approach that seeks a deeper understanding of why errors occur would be more effective in encouraging safe practices.

KEY OBJECTIVES

The study identifies a number of challenges to creating and maintaining a safe organisation where staff members are quick to recognise grooming or abuse behavior and triggers a process that investigates concerns and can take appropriate action so that children are protected from harm.

DOWNLOAD REPORT AT

http://www.childabuseroyalcommission.gov.au/getattachment/3d61d8c9-452e-4dc7-b32f-d6a23ff93e1b/Hear-no-evil,-see-no-evil

Errors of human reasoning

Munro and Fish (2015, p6) identified in their study that workers' judgements are vulnerable to cognitive biases and that it is especially hard for a person to eradicate their own biases. As such, their study highlights that organisations have a major part to play in creating the conditions in which errors of reasoning can be quickly picked up and corrected as explained below.

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

Organisational factors

The case studies examined in Munro's and Fish's report explore many of the organisational factors that influence individual behavior in regards to how well children are protected such as: the recruitment process, training in recognising and responding to indications of abuse, and formal policies about what people should do both to prevent and react to abuse (Munro and Fish, 2015, p. 26):.

Munro and Fish further explain that while individuals must hold some responsibility for their actions, the case studies showed how many organisational factors contributed to what in hindsight was poor practice in protecting children including:

Local rationality: The report noted that local rationalities are not unique to the individual but as created within the work group and this leds to a shared understanding of the meaning of their actions as seen below:

'…it is apparent that the local rationality that had developed in the YMCA service included assumptions about the unimportance of strictly following procedures, which allowed the perpetrator to groom and abuse children without appearing strikingly different from colleagues' (Munro and Fish, 2015, p25).

Organisational culture: The report highlights that the type of messages an organisation sends to its staff (both overt and covert) are key factors in determining whether the organization will be child-safe friendly. In particular, Munro and Fish (2015, p.28) emphasises the importance of staff being engaged in a 'culture of extended guardianship' so that the detection and prevention of grooming or abuse is seen as an ordinary responsibility of all staff. This can also significantly affect with rigour with which policies and procedures are implemented.

Balancing risks: Munro and Fish (2015, p.36) report that it is challenging to devise policies and actions that prohibit dangerous behavior but allow nurturing and constructive adult child relationships. This implies that there is a requirement for organisations to balance risk as efforts to ensure the safety of children can have negative as well as positive effects. For example, organisations with make it compulsory to report low levels of concerns can lead to false alarms, potentially harming the reputation of individuals and the organisation.

Drift into failure: Their study quotes the phase 'drift into failure' as one of the biggest challenges to maintaining a safe organisations as the "dynamic nature of many systems means that continual vigilance is needed for them to function with high reliability" (Munro and Fish, 2015, p.34)

CONCLUSION

Finally, Munro and Fish (2015, p.7) share that organisations that achieve a very good safety level – known as High Reliability Organisations (Weick, 1987) – provide useful examples of what organisations can do to make themselves safer places for children. They share a fundamental belief that mistakes will happen and their goal is to spot them quickly.. Organisations seeking to be safe places for children must encourage frequent, open and supportive supervision of staff to help counteract the difficulties people face in making sense of ambiguous information about colleagues. A shared acknowledgement of how difficult it can be to detect and respond effectively to abuse contributes to a culture that keeps the issue high on the agenda.