NSPCC Scotland response to the statutory inquiry into the historical abuse of children in care in Scotland

26 March 2015

About NSPCC Scotland

NSPCC Scotland is working with others to introduce new child protection services to help some of the most vulnerable and at risk children in the country. We are testing the very best models of child protection from around the world, alongside our universal services such as ChildLine, the ChildLine Schools Service and the NSPCC Helpline. Based on the learning from all our services we seek to achieve cultural, social and political change in Scotland – influencing legislation, policy, practice, attitudes and behaviours so that all children in Scotland have the best protection from cruelty.

NSPCC Scotland Response

Our response is based on research conducted by NSPCC Scotland during 2014 which included:

- Interviews with experts;
- Assembling a time-line of publicly reported instances and inquiries into child abuse in institutional settings in Scotland post- 1970 and analysis of media coverage and reports relating to these;
- Searches of UK and Scottish parliamentary records;
- Investigation of the Human Rights Act and Scottish criminal and civil law in relation to concealment and failure to act in relation to child abuse.

The Inquiry is an opportunity to look at accountability in relation to the specific cases of child abuse brought before it. It also has an important role to play in enabling scrutiny of our wider systems in order to fully protect children now and in the future. We should use the Inquiry to robustly challenge our systems and practice, as called for by Alexis Jay.[1]

A framework of measures has been developed over the years to both prevent abuse and ensure an effective response in the event it occurs. Most were introduced as a direct result of cases of abuse of children in care coming to light during the 1980s and after. These measures constitute a legal and regulatory framework which has improved the

[1] A. Jay (2014) Independent Inquiry into Child Sexual Exploitation in Rotherham (1997 to 2013). http://www.rotherham.gov.uk/downloads/file/1407/independent_inquiry_cse_in_rotherham

accountability of those responsible for safeguarding vulnerable children and are outlined in full in Kendrick's recent review (2014).[2]

- Standards relating to recruitment, selection, training, including vetting & barring.
- Legal duties and criminal sanctions;
- Regulation through standards, monitoring and inspection (which now includes an element of self scrutiny through internal evaluation of integrated children's services).
- Advocacy services and participation of vulnerable children and young people in closed settings
- Record keeping – legislation has been introduced to strengthen this, so that vital evidence about the care and protection of children is accessible.[3]
- Whistle-blowing – protection for those who speak out about wrong doing
- Significant case reviews –scrutiny of practices and procedures when things go wrong.

In the 15 years since the Scottish Parliament was established there have been some significant developments, including:

- The creation of the post of Scottish Children's Commissioner: case for it was raised as part of the Regulation of Care (Scotland) Bill which set up a Scottish Commission (body) for the regulation of social care which Malcolm Chisholm as health minister referred to as being in part about tackling the problem of abuse within institutional care settings.
- The development of Children's Rights Officer posts in local authorities (as advocates for children in care).
- Legislation on the registration of individuals considered unsuitable to work with children and a legal requirement on employers to refer people to the register, to prevent abusers being able to move about unmonitored or to be offered protection by their employer via redeployment.
- Introduction of a requirement for qualification as part of a registration scheme for all social care staff in Scotland.
- The new Children & Young Peoples Act 2014 includes new reporting and information sharing requirements – tightening accountability of all staff to share information with the Named Person, and the accountability of the Named Person themselves – their duties presently being set out in Guidance.

The primary purpose of the Inquiry is to provide answers for those individuals who experienced abuse whilst in care. We also welcome the Inquiry as an opportunity to gather and test evidence about the practical effectiveness of these measures and to identify further areas for action.

We are aware of the thought which has been given to the best model for the Inquiry, taking into account international precedents. The methods by which the Inquiry seeks to achieve its outcomes are important. We believe these are best achieved through a diversity of methods of data collection, of which the 'hearing' format will be one.

[2] This reviews developments over the past 25 years in Scotland to protect and safeguard children and young people in residential and foster care.
[3] Public Records (Scotland) Act 2011

To support the aims and objectives of the Inquiry, and to inform its work, we think some parallel lines of inquiry should be pursued through discrete pieces of work, as was the case with the historic abuse inquiry in Northern Ireland.

We outline some proposals for these in Attachment A.

Q1 What do you think should be the outcomes of the Inquiry?
Are there other specific outcomes you think the Inquiry should deliver?
(Comment on the outcomes listed – see table)

Acknowledgement	Accountability
Hear the experiences of individuals who have been subject to abuse	Hear the perspectives of state and non-state providers of residential or other care on meeting their past duty of care
Create a national public record of historical child abuse in institutional or other care	Identify how much risks have been reduced by recent changes to policy, practice and legislation, and decide what further changes are needed to improve safeguards for children in institutional and other care.
Raise public awareness and understanding about abuse and its impact	
Provide an opportunity for public acknowledgement and validation of the experiences of those who have been abused	

We welcome the establishment of the Inquiry on a statutory footing as this is vital for achieving accountability. We would like to see clearer outcomes linked to accountability along the lines proposed below.

Outcomes – Acknowledgement

- We would like a clarification of the outcomes, so that it is understood that by "public acknowledgment" we mean an acknowledgement *in public* from the institutions or organisations with a duty of care at the time the abuse took place (rather than acknowledgement and validation from the public at large).
- This could be achieved by amending the outcome "Provide an opportunity for public acknowledgement and validation of the experiences of those who have been abused", by adding the line, "…by those with a duty of care towards them at the time."

Outcomes – Accountability

The draft outcomes correctly reflect the two key issues: responsibility to prevent abuse from occurring, and responsibility to respond appropriately to uphold the rights of the child when abuse occurs.

We would like to propose two amendments:

First, as they stand the outcomes only mention learning and improvement in relation to the former, i.e. in relation to improving safeguarding practice.

In our view the outcomes should also refer to what further changes are needed to improve the *response* of institutions and agencies, including providing access to justice in practice. This could be achieved by amending the first outcome as follows:
"Hear the perspectives of state and non-state providers of residential or other care on meeting their past duty of care and identify what further changes are needed to improve their response and that of state agencies".

Second, **we propose amending the wording of the second accountability outcome, to remove the language of risk and replace it with reference to practice.**

Rather than "identify how much risks have been reduced by recent changes" we ask whether there have been changes *in practice*. This allow the following types of sub question to be asked:

- is new policy and guidance being implemented at local level and how well?
- Is it understood and acted upon by staff?
- are the new civil and criminal offences introduced to improve child safety being used by police and prosecutors?
- What are the main barriers to best practice?

Setting the terms of reference for the Inquiry.

Timeframe – upper and lower limit

From before what date should 'historical' be defined?
Should there be a date before which the Inquiry will not consider historical abuse?
If so, what should that date be?
Or should any lower limit simply be 'within living memory'?

Our view is that the timeframe must be as wide as possible. We would favour a lower limit of within living memory and an upper limit in keeping with the legal definition of historic that is the offence took place at least one year ago.

We express this view based upon a full understanding of the implications in terms of what the Inquiry is able to accomplish, and to what timescale. In reaching this view we have balanced the timeframe against other aspects of the terms of reference.

The rationale for this view is the need for the Inquiry to balance two different aims: acknowledgement and reparation for survivors and improving care for children today and for the future. The upper and lower limits of the timeframe need to accommodate both of these.

The main driver for the Inquiry has been the long campaign by adult survivors seeking acknowledgement and answers and it is very important that no adult survivor is disbarred from participating on the grounds of age.

At the same time, we need to get to the bottom of systemic failures and secure evidence to test the fitness for purpose of our current systems. There has been a raft of fairly recent legislation and change to improve the safety of children in care; the latest in response to the Shaw Report in 2007. We need evidence about experiences more recently to test these out. For this reason the upper time limit must be later than 2007.

In our view these two objectives are not necessarily in conflict. Some adult survivors will have reported their experiences for the first time only recently and have testimony about the response received in the recent past.

Types of abuse

We agree that the Inquiry should cover all forms of abuse – physical, sexual and emotional as well as neglect. Recognising the inter-related nature of forms of abuse, we do not see the rationale for limiting the scope to particular types.

However, we recognise the difficulties presented here for the Inquiry, given that physical abuse in school settings was not prohibited in state schools until 1986 and in non-state provision until 1993. 'Severe' physical punishment of children by parents was only outlawed in 2003. We propose that cases of physical abuse could not be heard where these fell within 'accepted norms' of physical chastisement in place within the legislation at the time. Finally we think the Inquiry should include all kinds of perpetrator-victim relationship, including peer to peer abuse as well as abuse of children by adults.

Culture of abuse

By this we mean circumstances where the culture of an organisation or care setting condoned and/or failed to act to deal with abuse or report it.
Do you think it will be helpful for the Inquiry to include these circumstances and that it is about the 'acts of omission' of institutions or care settings where abuse took place?

Yes. It is crucial that the Inquiry looks into acts of omission if it is to achieve the outcomes linked to accountability.

One of the myths about child abuse is that children do not tell. Evidence from Time To Be Heard (2011) and from many previous enquiries and research tells us that children do report, but are typically not listened to, not believed, ignored, or punished for speaking out.[4]

As a result acts of omission, including failure to act, has been a consistent theme in investigations and inquiries into abuse in care settings in Scotland.[5] The complexity of the related factors was highlighted in the 1999 report of the Inquiry into abuse in residential care homes in Edinburgh.[6] A series of measures has been introduced over the years, as a direct result of these findings, in order to improve things.

This must include acts of omissions not only by the organisation with a duty of care, but of criminal justice agencies with a responsibility to investigate and take proceedings.

One of the main lessons from historic inquiries and investigations is that organisational policies and strategies (and indeed legislation) are as strong as the culture that underpins them.

The actions and behaviour of individuals are best understood in the context of the systems, cultures and hierarchies of the organisations in which they work, and of their status or

[4] http://www.nspcc.org.uk/globalassets/documents/research-reports/no-one-noticed-no-one-heard-report.pdf
[5] We examined these from 1970 to the present where information about these was publicly accessible.
[6] http://www.gov.scot/Resource/Doc/1124/0059977.pdf

position within them. The approach developed for the InterAction process is about respecting, protecting, and fulfilling human rights *both in process,* and in *outcome*, i.e. it is about creating the kind of *culture* needed to support and ensure human rights, rather than comply with legal requirements.

We consider it essential that the Inquiry gathers information to help us (a) better understand the issues involved, including organisational culture (b) establish whether the introduction of measures has resulted in better practice.

- We believe the Inquiry should adopt the InterAction approach.
- We believe the Inquiry's work should be informed by a review of what is known about acts of omission and the related circumstances from previous investigations and inquiries into the abuse of children in care settings in Scotland. A proposed piece of work is outlined in see Appendix A.

In considering acts of omission, and seeking to understand these in the context above, there are a number of areas which in our view the Inquiry should focus attention on in collecting and interrogating evidence about historic abuse:

1. We know that very often individuals in positions of authority have placed political, reputational and financial considerations above the protection of children.[7] NSPCC Scotland has sought advice on the civil and criminal law in Scotland regarding acts of omission in relation to child abuse. According to that advice criminal sanctions already exist in Scots law in relation to failure to act and concealment/cover up of child abuse. The issue is that these are not being used in practice. If we are to ensure that these sanctions are meaningful in practice and improve the criminal justice response, then we need to understand why this is the case. Our consultation with experts highlighted awareness and understanding of children's rights, and prevailing attitudes towards vulnerable children and young people, especially young women, as being a part of the issue.

2. To help achieve a better understanding of the issues, we think it is important that the Inquiry scrutinises the handling of reported crime by police and prosecutors, based on the experiences of victims. It must consider acts of omission by the police and Crown Office, as well as institutions responsible for the care of children.

   Where individuals have been victims of child abuse, the State must ensure the victim's right to an effective remedy is upheld. This right demands access to justice in practice, not only in law, for everyone whose human rights are violated.

   One of the issues reported to us is that the practices of criminal justice agencies in relation to these crimes have not always been transparent or accountable. These issues have increasingly dominated child protection discourse in the wake of Savile and high profile cases of child sexual exploitation in England. Evidence from a review of historic child sexual abuse cases in England suggests that as many as 70% of cases may need re-opened, due to flaws in the initial investigation, including focussing on the criminal or 'immoral' behaviour of victims.[8]

[7] By financial considerations we mean the impact of admissions of liability in terms of organisational insurance policies.

[8] Paul Peachey, The Independent, Wed 5 Feb 2014. http://www.independent.co.uk/news/uk/crime/70-of-shelved-child-abuse-inquiries-could-be-reopened-following-complaints-by-victims-9110066.html#

In Scotland some high profile cases, including the allegations made by Susie Henderson, and the Willie McCrae case, have served to highlight apparent acts of omission. The experts we consulted regarded the lack of transparency and accountability in the justice system as a barrier to understanding the full extent of historic child abuse in Scotland.

In a recent appearance before the Justice Committee, Police Scotland and the Crown Office described current efforts to address this including through an individual Victim Strategy in all High Court cases involving serious sexual offending and the creation of an independent scrutiny panel, where 'critical friends' from external agencies review randomly selected cases. [9] We commend this initiative. The Inquiry provides an additional opportunity for learning. By investigating victims' experiences of seeking justice the Inquiry can play a valuable role in terms of improved transparency and accountability in the delivery of public services and achieving reparation for victims of abuse.

3. The Inquiry must look at whistle blowing and the treatment of whistle blowers. Tie-ing in with the implementation of human rights based cultures, we need to address the organisational systems and cultures within which professionals work and provide care for vulnerable groups. Our consultees stressed that the same imbalance in power within organisations between adults and vulnerable children also applies between managers and staff.

Previous reports including the Edinburgh Inquiry (1999) and Shaw Review (2007) have identified protection for whistleblowers as a vital part of our systems of accountability that requires to be strengthened. The Edinburgh Inquiry specifically identified the creation of a supportive culture for whistleblowers as an important *preventative* measure against abuse. It seems important to note that professionals in Scotland who have blown the whistle tend not to come from practice but from journalism and academia.

In the light of the Savile abuse, an independent review into whistle blowing and the creation of an open and honest reporting culture within the NHS in England has just been undertaken.[10] To our knowledge there have been no similar exercises conducted in Scotland to date.

We believe the Inquiry should make a call for evidence from individuals with personal experience of whistleblowing in cases of child abuse.

Given the context described above we also believe the Inquiry must have the power to take evidence from serving professionals in a way that guarantees them anonymity. Unless it can offer protection we think it unlikely that the Inquiry will be able to reach a full understanding of practice.

[9] http://www.scottish.parliament.uk/parliamentarybusiness/28862.aspx?r=9583&mode=pdf)
[10] http://freedomtospeakup.org.uk/

Types of care settings

What specific care settings should be included in this Inquiry?
Should it focus on the principle that it should include settings where the 'state' has had a role and specific duty in acting to safeguard children and where it would have had a role if using current definitions of a 'looked after child'?

In historical terms the protection of children from abuse in law is fairly recent. Child abuse still occurs today across society, in all spheres of life, and is not confined to particular settings. There is a strong case for the Inquiry adopting a wider definition of 'children in care', to include all forms of provision for caring for children outside of their own family homes. In other words, not only 'looked after' children in residential and foster care, but all closed settings for looking after children and young people, in which they are rendered particularly vulnerable, including:

- Residential provision for children with special needs
- Hospital provision for children with acute medical and mental health needs;
- Detention centres and other youth justice provision (formerly 'borstal' type institutions);

The merits of this are that it would enable many more survivors to come forward and to have their experiences acknowledged, and from a range of other settings, which have received less attention to date. Abuse has come to light in these wider settings in England, and we cannot be complacent about things being different in Scotland.

The overriding concern is for the Inquiry to be productive in achieving its aims and objectives.

Balancing all considerations, we believe the rightful focus for the Inquiry is on 'looked after' children in residential and foster care.

We believe this is important given the origins of the Inquiry.

A statutory inquiry into abuse of looked after children will build upon an existing base of investigation and evidence/knowledge of the issues. An Inquiry on a statutory basis will ensure that questions are answered and agencies called to account to an extent not achieved before. This will allow a depth, as well a breadth.

While there have been many instances of abuse coming to light in residential care, inquiries have taken place in some places – Fife, Edinburgh, Dumfries & Galloway – but not in others.

To achieve meaningful outcomes and get to the bottom of the issues, it makes sense to have a concentrated focus on a specific population. **For these reasons we think the Inquiry should confine itself to these settings.**

Timescale for reporting – when would it be reasonable to expect the Inquiry to be able to report once it has been set up?

We believe the timescale for the Inquiry will be dependent on the scale of its remit.

Definition of a child – while the legal definition of a child has changed over the years, for the purpose of the Inquiry, should this be defined as anyone aged 18 years or under at the time of the abuse?

Yes, we support the proposed definition.

Where the abuse happened – will be limited to abuse that happened in Scotland or where those with responsibility for arrangements for safeguarding were based in Scotland
Is this reasonable and does it reassure survivors that their experiences, wherever they happened in the UK, would be taken into account?

We agree this is reasonable. Where there is any suggestion of a link with organised abuse occurring elsewhere in the UK we would expect this to be referred to the Inquiry being conducted by the Home Office in England.

What should we look for in a Chair or Panel? We are asked to comment on and to supplement a list of personal attributes
Views are also invited on issues arising from the InterAction process including:
Commemoration
A Survivor Support Fund
Current difficulties with the 'time bar' for civil proceedings
We have no comment on this.

APPENDIX A

Proposals for lines of inquiry to be pursued:

1. **A desk review to identify, for the timeframe of the Inquiry:**

- any large scale police investigations carried out into allegations of abuse in Scottish institutions, across all police force areas.
- Significant Case Reviews conducted involving abuse in organisational or institutional settings, including foster care.
- Inquiries established by Scottish local authorities into allegations of serious abuse within educational or care settings.
- Relevant material relevant held within the archives of the Scottish Office Social Work Services Group, which provided Direct Grant support to residential institutions for CYP.
- Allegations of serious abuse in health settings (for example, closed psychiatric wards)
- Allegations of serious abuse in criminal justice settings (e.g. YOIs).

As this is linked to a statutory Inquiry we would expect all relevant agencies to cooperate in providing access to archival material.

2. **An audit of the recommendations from previous inquiries**

A systematic review of the conclusions and recommendations from all previous internal investigations, independent inquiries and reviews into the abuse of children in care, which occurred within the proposed timeframe of the Inquiry, in order to identify:

- Common or Systemic themes and issues identifying those pertaining to accountability.
- the cultural factors identified as contributing to acts of omission.
- whether these recommendations have been actioned and the extent of the implementation in terms of evidence from practice.

Access should be secured to all previously unpublished internal inquiries into child abuse and an evidence review conducted of reports of investigations and inquiries into abuse in institutional settings in Scotland identifying the cultural factors identified as contributing to acts of omission.

3. **An independent audit** of historic child abuse cases handled by Police Scotland and the Crown Office and Procurator Fiscal Service, using the sampling methodology of the 2003 Audit and Review of Child Protection in Scotland.

4. **Listening to children and young people's experiences of foster and residential care today.** The experiences of children and young people under 18 years of age should be part of the Inquiry and a piece of participative work should be undertaken to a specification that meets the requirements of the Inquiry.

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