

IICSA's final report - October 2022

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Introduction

On 20 October 2022, the Independent Inquiry into Child Sexual Abuse (“**IICSA**”) published its final report (“**the Report**”). The Report can be found [here](#), with IICSA’s summary available [here](#).

Background

IICSA was established in 2015 in the aftermath of the Jimmy Savile scandal and widespread revelations of non-recent child sexual abuse (“**CSA**”). IICSA conducted 19 investigations, issuing 107 recommendations.



In addition to the investigations, IICSA liaised with groups of Victims and Survivors via the “Truth Project”; experts on CSA; as well as LGBTQ+ and minority ethnic groups.

Over 6,200 people participated in the Truth Project. The dates of their abuse ranged from pre-1950 to the 2000s. The testimonies of the survivors are both powerful and distressing; illustrated by the four brief examples below.

The Report is intended to look proactively to the future. It draws on the learnings of IICSA’s previous reports and investigations to identify deficiencies and make overarching recommendations. The Report is extensive, so this briefing seeks to give particular focus to

those recommendations most relevant for our clients and contacts working in institutions such as schools, sports clubs, faith organisations and charities.

"Alistair described his childhood as 'idyllic', but **after he was sexually abused he 'never felt like a normal child' again.**"

"Alyssa was **sexually groomed online** from the **age of 10**. She said that the men who sexually abused her... made her feel good: **'I was getting the attention online that I never got elsewhere'.**"

When Danni told her school that a teacher had sexually abused her, **the school told her parents 'you must not tell the police, we will handle it in-house'** Danni said... **'What if he did it to other kids?'**

"Dillan said: **'All I wanted was some help ... maybe people didn't know how to help then ... but these were professional people'.**"

IICSA's findings

To contextualise IICSA's recommendations, we have set out below a summary of some of the key findings and themes of the Report.

Attitudes of society towards CSA

Sadly, but perhaps not unsurprisingly, the Report noted that children had been accused of lying when disclosing CSA. IICSA noted that, even today, instances of CSA were blamed on children's "lifestyle choices". As stated in IICSA:

"Victims of child sexual abuse and exploitation should be treated with empathy and concern. Victim-blaming attitudes and behaviours are incompatible with this. They obscure the seriousness of the crimes committed against them and may support a punitive approach which places responsibility for stopping sexual exploitation with the children. A victim-blaming culture and approach may result in inappropriate or ineffective interventions and support plans that lead children to feel that they are being punished for their own abuse."

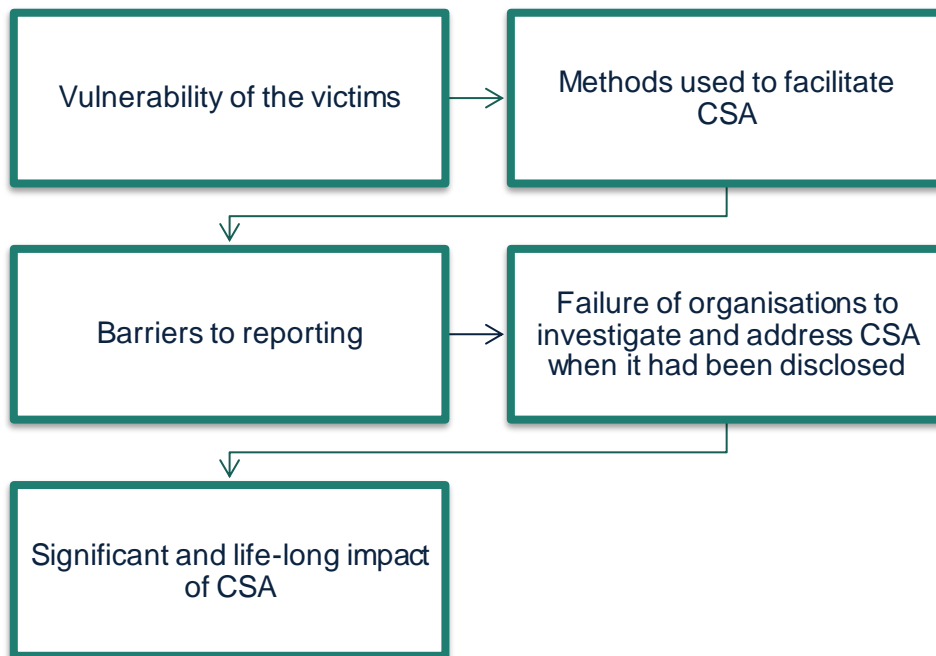
Further information about recognising the child as the victim can be found [here](#).

The trust placed in certain organisations by parents often led to children being disbelieved. Examples were given of parents who could not or would not believe that members of a faith organisation would be perpetrating abuse.

While positive change had been noted in recent years, the Report noted that an estimated 3.1 million adults in England and Wales were reported (as in March 2020) to have experienced sexual abuse before the age of 16.

Common features of CSA in disparate contexts

IICSA investigated a spectrum of different organisations from residential schools, music schools, religious organisations, custodial institutions, children’s homes and charities previously involved in child migration. Despite the different contexts in which CSA occurred, common themes were noted, as outlined below.



We would suggest that a useful action for **all** organisations to do, arising from IICSA, is to consider the ways in which CSA occurred as well as the themes identified and consider these in the context of their own settings to assess whether any of the barriers or structural issues identified by IICSA might still apply today within the setting and therefore pose risks to children. This can be done through safeguarding audits and reviews.

Barriers to disclosure and structural issues

The following image details the six most often cited reasons why participants in the Truth Project did not disclose CSA at the time it occurred.



The Report noted that some organisations did not have adequate safeguarding policies. Occasionally, such policies were more focused on protecting adults from false allegations than protecting children from truthful ones.



In Farrer & Co's Safeguarding Unit, we advise that children and adults are best protected by a strong safeguarding system including having robust safeguarding and related policies in place, which are effectively implemented. These should not be generic and "off-the-shelf" but should be specifically tailored to the organisation. Everyone in the organisation should be aware of the expected standards of behaviour as set out in, for example, their codes of conduct. Policies and procedures should be consistently applied, and where concerns or allegations (including low-level concerns) are raised, they should be responded to promptly and appropriately.

Reverting back to the Report, reputational concerns of organisations and a desire to "[protect] their own" members accused of CSA were found to have trumped child welfare considerations. This meant that allegations of CSA were "marginalised". Perpetrators were quietly moved on from one organisation to another, without appropriate references being made, enabling them to abuse again. This scenario had clearly occurred across a number of sectors.

The Report repeated previous criticism that statutory inspectorates often fail to adequately examine safeguarding arrangements leading to "false assurances about children's safety".



Whilst statutory inspectorates play a very important role in the system of ensuring that institutions are safe and meet required standards, we suggest that senior leaders and boards of governors and trustees play a vital role and are obligated to ensure that the particular setting is safe for everyone. This can be done through the use of audits and lessons learned reviews, which we know many of our clients have found invaluable.

Data, records and access

The Report was critical of methods used to record and catalogue instances of CSA. The Report repeated that the true scale of CSA is likely to be much higher than currently identified.

Specifically, the Report criticised the lack of a coherent dataset. It noted that, without access to accurate data, it is impossible for bodies to manage an effective response to CSA. This also had an impact when victim-survivors were seeking redress. The Report found that, all too often, records were destroyed sometimes in line with data-retention policies. Even where records were retained, gaining access to records was noted to be time-consuming and traumatic for victim-survivors.



From our work on cases, we have observed that occasionally case records appear in a poor state (for example sometimes notes are illegible or the record of the meeting is not a full account or allegations are summarised rather than using the actual allegations verbatim). Some organisations have historically had an over-zealous understanding of the requirements of data protection law, without consideration of the value and necessity of this data for victim-survivors in particular. Organisations working with children should ensure that staff are trained in this area.

Prevalence of online abuse

The Report expressed concern at the “**explosion**” of **online abuse**. This signifies that CSA is not a historic problem, rather it is “**endemic**” in England and Wales.

There was a significant rise in indecent image offences and predators using online services and applications to facilitate grooming. This was noted as a national and international issue, made worse by globalisation.

While the initial increase in online abuse was due to the lockdown measures, the Report was sceptical about it decreasing, even now where those measures have been lifted.



Within an organisation working with children, it should be clear that an individual's online conduct should always adhere to the same expected standards of behaviour as their offline conduct. Concerns or allegations about online behaviour must always be responded to and handled in line with statutory guidance and an organisation's relevant policies and procedures.

In addition, organisations working with children ought to familiarise themselves with good resources that help staff, children, parents and carers identify online risks and help to minimise the potential risk of abuse (see [here](#), for example).

The Recommendations

The Report makes 20 recommendations, nine of which we highlight below (six in detail, and three in summary). In each case, we refer to the recommendation using the number and title as assigned to the recommendations in section K.10 of the report (page 354). We have focused on six particular recommendations, where we have produced the detailed text of the recommendations from the remainder of section K (page 326-353).

In each case, the recommendations are made to the government or other relevant statutory bodies. A full list of all of the recommendations across IICSA’s reports can be read at Annex 3 of the Report.

Recommendation 2: Child Protection Authorities for England and for Wales

“The Inquiry recommends that the UK government establishes a Child Protection Authority for England and the Welsh Government establishes a Child Protection Authority for Wales.

Each Authority’s purpose should be to:

- improve practice in child protection;
- provide advice and make recommendations to government in relation to child protection policy and reform to improve child protection; and
- inspect institutions and settings as it considers necessary and proportionate.

The Child Protection Authorities in England and in Wales should also monitor the implementation of the Inquiry’s recommendations.”



We can see that the introduction of these Authorities, together with the creation of a cabinet Minister for Children (per Recommendation 3) could have a significant and positive impact on the visibility of CSA, to maintain the profile of child protection and deal with the challenges of implementing IICSA’s recommendations (to the extent they are adopted).

However, it is not proposed that Child Protection Authorities would have powers to impose sanctions, so in practice they may have limited scope to enforce and improve child protection standards.

Recommendations 9-12: Safer Recruitment and the Disclosure Barring Service

Recommendation 9: Greater use of the Disclosure Barring Service barred list

“The Inquiry recommends that the UK government enables any person engaging an individual to work or volunteer with children on a frequent basis to check whether or not they have been barred by the Disclosure and Barring Service from working with children. These arrangements should also apply where the role is undertaken on a supervised basis.”

Recommendation 10: Improvements to compliance with statutory duties to refer concerns to the Disclosure and Barring Service

“The Inquiry recommends that the UK government takes steps to improve compliance by regulated activity providers with their statutory duty to refer concerns about the suitability of individuals to work with children to the Disclosure and Barring Service, including:

- all relevant regulators and inspectorates include compliance with the statutory duty to refer to the Disclosure and Barring Service in their assessment of safeguarding procedures during inspections;
- the National Police Chiefs’ Council works with relevant regulators and inspectorates to ensure that there are clear arrangements in place to refer breaches of the duty to refer to the police for criminal investigation; and
- an information-sharing protocol is put in place between the Disclosure and Barring Service and relevant regulators and inspectorates.”

Recommendation 11: Extending the disclosure regime to those working with children overseas

“The Inquiry recommends (as originally stated in its Children Outside the United Kingdom Phase 2 Investigation Report, dated January 2020) that the UK government introduces legislation permitting the Disclosure and Barring Service to provide enhanced certificates with barred list checks to citizens and residents of England and Wales applying for:

- work or volunteering with UK-based organisations, where the recruitment decision is taken outside the UK; or
- work or volunteering with organisations based outside the UK, in each case where the work or volunteering would be a regulated activity if in England and Wales.”

Recommendation 12: Pre-screening for illegal images of children

“The Inquiry recommends that the UK government makes it mandatory for all regulated providers of search services and user-to-user services to pre-screen for known child sexual abuse material.”



As noted above, as part of a strong safeguarding system, organisations should have in place robust safeguarding and related policies which are effectively implemented.

We know that a number of our clients have spent considerable time and effort ensuring that best practice is followed in relation to safer recruitment practices. This is essential because of the powerful deterrent effect that this can have.

An organisation that sends out clear and consistent messaging about the prioritisation of safeguarding children from the earliest stages of recruitment will help set a culture of safeguarding and should help minimise the potential risk of those unsuitable to work with children from applying or succeeding in joining the workforce. The principles of safer recruitment include appropriate messaging about safeguarding in job adverts, and a proper system of application and interviews. Gaps in CVs should always be explored, and references should always be taken and followed up.

You can read more about safer recruitment [here](#).

Recommendation 13: Mandatory Reporting

“The Inquiry recommends that the UK government and Welsh Government introduce legislation which places certain individuals – ‘mandated reporters’ – under a statutory duty to report child sexual abuse where they:

- receive a disclosure of child sexual abuse from a child or perpetrator; or
- witness a child being sexually abused; or
- observe recognised indicators of child sexual abuse.

The following persons should be designated ‘mandated reporters’:

- any person working in regulated activity in relation to children (under the Safeguarding and Vulnerable Groups Act 2006, as amended);
- any person working in a position of trust (as defined by the Sexual Offences Act 2003, as amended); and
- police officers.

For the purposes of mandatory reporting, ‘child sexual abuse’ should be interpreted as any act that would be an offence under the Sexual Offences Act 2003 where the alleged victim is a child under the age of 18.

Where the child is aged between 13 and under 16 years old, a report need not be made where the mandated reporter reasonably believes that:

- the relationship between the parties is consensual and not intimidatory, exploitative or coercive; and
- the child has not been harmed and is not at risk of being harmed; and
- there is no material difference in capacity or maturity between the parties engaged in the sexual activity concerned and there is a difference in age of no more than three years.

These exceptions should not, however, apply where the alleged perpetrator is in a position of trust within the meaning of the 2003 Act. Where the child is under the age of 13, a report must always be made.

Reports should be made to either local authority children's social care or the police as soon as is practicable.

It should be a criminal offence for mandated reporters to fail to report child sexual abuse where they:

- are in receipt of a disclosure of child sexual abuse from a child or perpetrator; or
- witness a child being sexually abused."



For many organisations, this creates a legal obligation to underpin statutory guidance on reporting – schools, for example, should already be disclosing such allegations, in accordance with KCSIE.

The recommendation is limited to disclosures made by the child or perpetrator, so mandated reporters would not be legally obliged to disclose allegations brought to them by third parties. So, if a child were to disclose that their sister is being harmed by an adult (and the abuse isn't witnessed, and no CSA abuse indicators are observed by the mandated reporter), there would be no legal obligation to disclose. We would advise individuals to report such allegations, in any event.

This recommendation notably does not include any exemptions for faith-based organisations, eg where disclosures are made in the context of a confession.

As set out in the recommendation above, the proposal for mandatory reporting also creates an exemption where a child, aged 13-16, is believed to be in a consensual relationship, not at a risk of harm, and where there is no material difference in capacity or maturity between the individuals involved in the relationship. That may be a difficult assessment for a mandated reporter to make, depending on the circumstances.

The exemption appears to be aimed at child-on-child relationships, where such relationships are considered to be consensual and not abusive. Notably, IICSA did not consider child-on-child abuse in detail as part of its case studies, so there is little commentary on the context of this decision or on child-on-child abuse more generally.

It remains to be seen if this recommendation will be adopted by the government, either in this form, or at all.

Other noteworthy recommendations



Recommendation 15: The removal of the three-year limitation period for personal injury claims brought by victims and survivors of child sexual abuse

- ◆ The Report recommends that the three year limitation period for personal injury claims be removed for claims brought by victim-survivors of CSA in respect of their abuse (save in respect of claims that have already been dismissed by a court or settled), with the burden being placed on the defendant(s) to show that a fair trial is not possible (eg as a result of the time that has passed.)
- ◆ The Report recommends that these changes should only apply to claims brought by victim-survivors (and not on behalf of their estates, where such individuals have died).



Recommendation 17: A code of practice on access to records about child sexual abuse

- ◆ The Report makes recommendations to the Information Commissioner's Office ("ICO"), including the introduction of a code of practice on retention of and access to records known to relate to CSA.
- ◆ The Report recommends that any data relating to CSA should be kept for 75 years, with appropriate review periods. The ICO should be directed to produce guidance for CSA record-keeping and for handling related DSARs appropriately, promptly and sensitively.



Recommendation 19: A tiered redress scheme

- ◆ The Report recommends that the UK government establishes a single redress scheme in England and Wales, taking into account devolved responsibilities.
- ◆ The Report stated that the government "should seek contributions to the scheme from the institutions affected" (see page 16 of the Report). If this is to be incorporated into the redress scheme, it is unclear if / how this might be enforced, and how it would operate alongside existing methods for victim-survivors to redress (eg through bringing legal claims).



Whilst IICSA has not made any specific recommendations regarding low-level concerns, we advise all organisations which work with children to encourage the sharing of low-level concerns and implement a low-level concerns policy (further guidance on which can be found in our [Developing and implementing a low-level concerns policy: a guide for organisations which work with children](#), a link to which is contained in KCSIE 2022).

Of course, organisations should ensure all staff have received relevant and up-to-date training on the indicators of CSA, child-on-child abuse, child sexual exploitation and online abuse.

What should organisations do now

In addition to the suggestions made above, we recommend that organisations:



Consider the recommendations in the Report

A full list of the recommendations is set out at page 354 (section K.10) of the Report. The recommendations are made to the government, rather than to individual organisations; however, they highlight failings in relation to CSA, which may be relevant to a number of different sectors.

Organisations should consider these carefully, and identify those relevant to them, and consider if any action is needed in light of those recommendations.



Audit records and policies

Given the issues with data recording and identifying CSA, as highlighted by IICSA, organisations should examine their records. Are there robust procedures in place for ensuring that disclosures are properly recorded for example?

It is for data controllers to determine their own retention periods, according to the purpose for which the data is kept. Whilst IICSA's recommendation for a 75 year retention period (for CSA data) is not yet reflected in current ICO Guidance, it would be a legitimate factor for organisations to consider when setting their retention periods for CSA data. In any event, many safeguarding organisations will have already been keeping safeguarding records (including CSA data) for lifetime or indefinite periods, according to the early recommendations of IICSA.

Organisations may wish to consider commissioning an independent safeguarding review, to test their practices and procedures to ensure that the systems in place reflect best practice and the law.



Staff-wide training

When considering safeguarding training for staff, organisations should keep in mind the findings and recommendations of IICSA (particularly the indicators of CSA as reported by IICSA), and consider any areas where further specific training may be helpful. The case studies from IICSA and the voices of the survivors (powerful in their own right) can be used in internal case studies.