Chapter 5
Child Sexual Abuse in Institutional and Non-institutional Contexts

Abstract This chapter first focuses on major challenges confronting child and youth-serving organisations and high-risk settings. It then discusses the nature, key findings and major recommendations of Australia's Royal Commission Into Institutional Responses to Child Sexual Abuse, a landmark public inquiry into institutional sexual abuse, including a special focus on the Roman Catholic Church. The chapter then focuses on several recent examples of progress in responses to major problems presented by child sexual abuse in institutional and non-institutional settings. Developments from Australia in particular, but also from other countries, will show how new public health law responses, including through civil law, and with various emphases on primary prevention and secondary prevention, can create frameworks for enhanced prevention, identification, and response to cases of child sexual abuse. Some of these responses, such as redress schemes, reportable conduct schemes and child safe standards legislation, have specific application to institutional settings. Other responses, such as the abolition of statutes of limitation for civil claims for injuries caused by sexual abuse, and other kinds of legislative reporting duties, have broader application across society, as they apply to sexual abuse in all settings, whether within institutions, families, private settings, or other community settings. These responses are of broad application regarding prevention of child sexual abuse, early identification of child sexual offending, and ensuring appropriate responses once it is known or suspected. They are particularly relevant when dealing with high risk institutional settings and prolific individual offenders, both of which present especially urgent examples of the need for an appropriate societal approach to child sexual abuse informed by public health and social justice.

Keywords Child sexual abuse generally, and in institutions and organisations · Schools · Churches · Sports, cultural, arts and recreation settings · Prevention approaches · Australia's Royal Commission Into Institutional Responses to Child Sexual Abuse · Key case studies · Catholic Church · Major findings and reform recommendations in 2017 · Key recent progress in reforms to enhance prevention, identification and responses to child sexual Abuse · Legal reforms · Public health reforms · Institutional reforms · Child safe standards for organisations · Education and codes of conduct · Reporting schemes · Redress schemes · Abolition of civil statutes of limitation

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Sexual Abuse in Child and Youth-Serving Organisations

Child and youth-serving organisations (CYSOs) rely on staff and volunteers (both adult and adolescent) to design, supervise and engage in activities and interactions with participating children and youth. The supportive relationships formed between CYSO staff and the children and youth they serve is a key component of their success. However, under the wrong conditions these relationships can place youth at risk of maltreatment, including sexual abuse. Organisations have long recognised the risk of sexual abuse posed by people who are either preferentially attracted to prepubescent or pubescent children (i.e., pedophiles and hebophiles, respectively), or who may offend opportunistically. In addition, other children at the CYSO may inflict sexual abuse on their peers.

Comprehensive data do not exist about prevalence in child and youth-serving organisations (CYSOs), although there is evidence that such victimisation is common. Throughout childhood, approximately 9.6% of children have been found to experience sexual abuse in educational settings (Shakeshaft 2004), 10.0% in sport (Leahy et al. 2002), and an annual incidence of 9.5% has been found in juvenile detention settings (Beck et al. 2010). Accumulated data over extensive time periods have shown conservative estimates of the proportion of Catholic priests who have sexually abused children of 5% in the U.S.A. (Terry et al. 2011) and 7% in Australia (Australian Government Royal Commission Into Institutional Responses to Child Sexual Abuse 2017a).

Features of Youth-Serving Institutions that Create Opportunities for Child Sexual Abuse

In the context of CYSOs, CSA is a challenging context involving vulnerable children, high risk, and multiple industries which are fragmented and geographically widespread, and which have diverse workforces, and varying levels of knowledge of and cultural commitment to CSA prevention (Mathews 2017). Several features of the context of CYSOs create opportunities for CSA, both by adults who work or volunteer of the organisation, and by other children and youths who attend. There are features at the level of the child, the offender, and the organisation.

The child As recognised by Wurtele (2012), one feature is related to the natural vulnerability of children. Adolescent children often have an inherent vulnerability, due to their natural sexual curiosity, needs for intimacy and romantic connections, and still-developing skills of impulse control and self-regulation. In a related sense, pre-pubertal children are generally vulnerable to predation for slightly different reasons. However, these reasons are also related to their emotional needs and vulnerability, their early cognitive development, physical vulnerability, and other components of their personality that contribute to a profound imbalance of power

between the child and the adult offender or the older or more powerful child offender. Some children have heightened vulnerability, particularly those with a history of victimisation, low self-esteem, loneliness, those from single parent homes and or those with low parental supervision, those with disabilities, and those with minority sexuality.

The Offender A second feature is related to the offender. Some individual offenders purposely seek employment in environments where there are vulnerable children to execute a premeditated plan of action, while other adult offenders exploit advantages and opportunities to offend based on environmental characteristics and personal attributes. In both cases, and especially in some types of organisations where the adult occupies a position of substantial power, the offender's status magnifies the opportunity to exploit the relationship of power imbalance. Especially where the offender is a particularly trusted adult, because of the nature of institutional abuse, the trauma is often magnified beyond the level that would have been reached were the abuse inflicted in another context.

The Organisation Third, there are features related to the organisation. Some of these features concern the physical environment, aspects of which can help to facilitate or reduce the perpetration of sexual abuse. These features include structural materials and design: do offices and other rooms have closed doors, windows, and sightlines; are there any surveillance cameras; is there sufficient privacy in bathroom facilities while also providing security. Other aspects relate to the specific organisational context and activities, embracing matters such as:

- the type, size and geographical location of the organisations
- the employee/volunteer composition
- the child clientele
- the general type of activity in which the organisation is engaged and the ways in which this activity is conducted (e.g. whether there are trips away from home; the level and type of supervision provided)
- the degree of control over the child exercised by the adult, for example whether it extends to training, diet, medical treatment, social activity; physical touch; whether there are ongoing relationships; presence of alcohol; rewards systems.

Sporting Organisations For example, sporting organisations may possess several features which create particular kinds of risks. The nature of sports presents multiple factors creating a substantial enterprise risk of CSA. Training often requires direct physical instruction, such as in athletics, swimming, martial arts, gymnastics and ball sports. Travel to competitive events can create further opportunities for offending. Many sports require physical treatment such as massage, and others require specialised attire which may be brief, such as in swimming and gymnastics. Many sports require changing and bathing facilities. Sporting organisations typically are characterised by highly competitive hierarchies in which children compete for status, representative selection, awards and career progression, and this can

increase the closeness and dependency which often normally accompanies the relationship of coach and pupil. Other related aspects further create an atmosphere in which a relationship of dependence and trust and confidence can solidify between child and coach: the intensely competitive nature of sports can produce emotional highs and shared celebrations, while also producing emotional lows and crises.

Cultural, Arts, Recreational and Religious Organisations Other groups – cultural, arts and recreational – may share some of these features. In addition, the literature on CSA in religious contexts suggests that some key themes about CSA in that context may have parallels in some sporting, cultural, arts and recreational groups. Terry and Ackerman (2008) and Smallbone and Wortley (2001) found that substantial proportions of offending are committed in the offender's residence (41% of religious offenders in the Terry and Ackerman study; and 68.9% in the Smallbone and Wortley study of non-religious offenders). Terry and Ackerman (2008) found that a further 17.8% of offending was committed during travel, and similarly, Smallbone and Wortley (2001) found 20% of abuse was committed on an overnight trip.

Organisational Culture However, even more problematically, other CYSOs may possess cultural problems and a lack of intrinsic commitment to the problem of CSA, such that they intentionally cover up CSA, have a priority of protecting the institution's reputation, and may have senior staff who are complicit in CSA (Boyle 2014; Lanning and Dietz 2014). These circumstances may present an insuperable obstacle to self-driven change and sound practice. Such organisations are highly unlikely of their own volition, and without any external oversight, to embed the kinds of measures required, and to educate staff appropriately, to protect staff who make reports, to have leadership take credible responsibility, to create robust codes of conduct, to properly report alleged cases, to appropriately deal with suspected and known offenders, to have transparent decision-making, to resist protective measures to protect the institution's reputation, to instill a culture of ethical behaviour, and to voluntarily allow external oversight of their processes and outcomes.

The problem of poor organisational culture is particularly powerful and challenging for reform efforts. In the context of the Catholic Church, Sipe (2011, p.125) has concluded that "culture trumps reason every time". Smith and Freyd (2014) have concluded that organisations having certain cultural characteristics are more likely to provide an environment within which CSA can both occur, and be inadequately treated. These include the organisation possessing:

(1) strict membership requirements (with a high level of institutional or societal value being placed on membership);
(2) the institution (and or its leaders) having a prestigious position in society;
(3) the institution valuing its prestige, reputation and public image more than the welfare of the children it provides for;
(4) strict hierarchies without viable reporting pathways;
(5) relationships of power imbalance;

(6) relationships of trust and dependency;
(7) prestige or high value to the abused child in remaining in the organisation, despite the experience;
(8) Prestige or high value to the abused child in remaining connected to the abuser, despite the experience;
(9) fear of the consequences that can be visited upon it;
(10) operational lack of an organisational strategy to deal with CSA (including lack of a lexicon around the issue; ignorance of the issue; outright denial of the issue; all characterised by absence of adequate screening; absence of adequate reporting mechanisms and recording systems; absence of staff training/education; absence of policy; overt cover-ups; use of rhetoric and euphemisms to describe allegations; reprisals and adverse consequences for victims and whistle-blowers).

Lanning and Dietz (2014) and Wurtele (2012) also identified many of these organisational features. In addition, Wurtele noted the following:

- Centralised power in strict hierarchies;
- Lack of transparent and shared responsibility for decision-making (leaders make decisions secretly and internally with an emphasis on protection of institutional reputation rather than acting in the child's best interests);
- A sexualised work environment (characterised, for example, by language, dress, behaviour and other sexualised material);
- Lack of a culture of zero tolerance.

Multiple obstacles must be overcome to create and successfully implement CSA prevention and response strategies in all CYSOs. Challenges are presented by individual factors (personal fears; lack of knowledge; unhelpful attitudes; lack of time), and organisational factors (lack of financial resources, time and expertise; size and diffusion; staff turnover; culture (Saul and Audage 2007; Wurtele 2012). These may be viewed as factors of inadvertence (ignorance, incompetence, denial) or intentional wrongdoing (cover-ups, reputational control, financial protection, complicity) (Lanning and Dietz 2014). Accordingly, some CYSOs may not have cultural problems, and may possess intrinsic commitment, but implementation problems will still be posed by lack of scientific expertise, lack of financial resources, lack of time, high staff turnover, volunteers (Wurtele 2012). These organisations may still be reticent to discuss CSA (Wurtele 2012).

The range of measures that can be adopted to create healthier organisational culture has been explored in depth by Palmer (2016). Knowledgeable and ethical leadership in every CYSO is a precondition for effective and morally defensible responses (Mathews 2017). The culture established and exercised in both policy and daily demonstration by an institution's leadership is critical in shaping events, attitudes and behaviour of individuals in the group.

Hallmarks of Child-Safe Organisations

Conceptual advances have been made concerning what kinds of measures may assist in reducing CSA in CYSOs and in identifying and responding to it more appropriately. There is now quite a strong degree of agreement about what kinds of measures should be adopted by CYSOs to minimize risk and ensure appropriate responses. This is evident in approaches and organisational tools proposed by the Centers for Disease Control (Saul and Audage 2007) and by other leading scholars (Wurtele 2012, 2014), which are substantially supported in other approaches and analyses (Parent and Demers 2011; Walsh et al. 2013). These models have subtle differences but all have a common fundamental basis, which emphasise the necessity for seven key prevention dimensions like those articulated in extensive detail by Wurtele (2012, 2014) and further discussed elsewhere (Mathews 2017). These can be briefly detailed here, before examining them in more detail in Parts 1.4.1 and 1.4.2.

First, the CYSO must have a detailed *organisational policy* (including fundamental principles, definitions, objectives, a zero tolerance approach, endorsement by management, and designated contacts). Second, there must be *safe screening and hiring practices*. Third, there must be a robust and detailed *Code of Conduct* (specifying prohibited conduct across a range of situations, and acceptable conduct). Fourth, there must be measures for *implementation and monitoring* (including formal staff supervision, and external auditing). Fifth, actions must be taken to create *safe environments* (at a lower level, requiring further embedding and dissemination of policy and code of conduct, such as by prominent placement in workplaces, websites, and contractual appointments; at a higher level, requiring safe approaches to environmental structures). Sixth, there must be measures embedded to ensure staff appropriately *report and respond to suspected cases, disclosures and allegations* (including processes for making, recording and dealing with such reports, and for ensuring the child's safety). Seventh, there must be sufficiently detailed and sophisticated education and training of personnel about the nature and consequences of CSA, organisational policy, reporting duties, and legal and ethical obligations. Such education is viewed by Wurtele (2012) as the cornerstone of prevention.

It should be noted that involving children in relevant components of the strategy is necessary and desirable (Wurtele 2012). There should be provision of clear, direct instruction to children and youth in the organisation that specific kinds of sexual acts are not only not accepted in the organisation, but are illegal, expose the offender to legal sanctions, and can cause devastating consequences (Wurtele 2012; Lanning and Dietz 2014).

Wurtele's Model Informed by an ecological perspective, Sandy Wurtele has systematically described a detailed multi-layered approach to prevention of child sexual abuse in CYSOs. Wurtele's model and the *CSA Prevention Evaluation Tool for Organizations: Child Protection Policy & Procedures* sets out a matrix of seven key prevention dimensions, with each having multiple subcomponents. Wurtele's model

is consistent with others in this field, but appears the most detailed. This approach includes responses at both the macro level, through national law and policy to implement measures such as: creating specific criminal offences for CSA in institutional contexts; creating common approaches to employee criminal history screening; compulsory employee education about CSA; establishing a national centre which sets standards for institutions, collects and publishes data, and provides leadership and resources to assist in educational and prevention efforts. Her approach also includes responses at the micro level. Components of this approach, such as screening, and the development of a code of conduct, are supported by other experts in this field. This includes insights into offenders (Erooga 2012a; Erooga et al. 2012; Plummer 2013; Smallbone et al. 2013), and insights about effective and ineffective organisations (Erooga 2012b). Both will be discussed further below.

At the organisational level, Wurtele suggests a variety of measures to improve situational contexts and ameliorate risk factors:

- *Securing situational factors* such as features of the physical environment can be addressed to reduce the opportunity for CSA in private spaces;
- *Healthy agency culture* can be developed to ensure a promotion of children's safety through key dimensions of:
  - decision-making processes;
  - organisational openness;
  - healthy relationships between staff members and between staff and students;
  - appropriate language and attire;
  - recruitment processes; and
  - zero tolerance of any form of abuse of children;
- *Risk-management strategies* can include:
  - employee screening (which must include more than simply criminal record checks, extending to properly informed personal interview strategies);
  - child protection policies (which, for example, can include limits on one-on-one interactions between children and adults especially in high-risk environments such as private accommodation, showering and sleeping arrangements on trips);
  - adequate supervisory policies in relation to staff, including regular professional supervision sessions;
  - robust approaches to interaction between staff and students using electronic communications and social media;
  - a code of conduct clearly establishing acceptable and unacceptable behaviour;
  - education about CSA for staff, children's parents, and children;
  - ongoing staff training while in-service, including about sexual boundary violations (physical, emotional, and via diverse kinds of communication).

Wurtele's model is a comprehensive strategic approach to the prevention of institutional child sexual abuse. It is a practical model which is informed by the literature

and an ecological framework, and offers concrete operational guidance on multiple dimensions of law, policy, education and organisational practice.

Wurtele's CSA Prevention Evaluation Tool for Organizations These elements are embodied in Wurtele's *CSA Prevention Evaluation Tool for Organizations: Child Protection Policy & Procedures* sets out a systematic matrix of seven key prevention dimensions (comprising an organisational policy, and six standards), with multiple subcomponents clearly set out for each:

- *The organisational policy* (14 subcomponents),
- Standard 1: *Safe screening and hiring practices* (18 subcomponents),
- Standard 2: *Code of Conduct* (21 subcomponents),
- Standard 3: *Implementation and monitoring* (10 subcomponents),
- Standard 4: *Ensuring Safe Environments* (10 subcomponents),
- Standard 5: *Reporting and responding to concerns, disclosures and allegations* (21 subcomponents),
- Standard 6: *Training and education* (14 subcomponents).

The Organisational Policy Standards (14 Subcomponents) Every sound policy in this context must possess several key components. Some of these, such as definitions of key terms, and the principles which underpin the policy, are universal. The 14 subcomponents of the Organisational Policy Standards are: it contains definitions of key terms; is publicised, displayed, promoted and distributed to all in the organisation; states purpose to protect children from harm in the organisation; states principles underlying the standards e.g. children's right to safety and freedom from abuse; describes zero tolerance for sexual misconduct; policy approved and endorsed by the relevant management or oversight body; policy specifies to whom standards apply; policy developed with relevant stakeholders; policy encourages parents and staff to work together to keep children safe; is reviewed on a regular basis; has process to consult children and parents in the review; identifies personnel with roles and responsibilities in relation to child protection; provides information and contact details about where to seek help, and a designated contact person.

Situations known to present the highest level of risk may be made subject to universal policy approaches. For example, Wurtele has observed that some organizations such as the Boy Scouts of America have a policy requiring separate sleeping and showering accommodations for youth and adults, and limits one-on-one interactions between youth and adults through a "two-deep leadership" policy requiring that at least two adults supervise all scouting activities. Another high-risk situation is when staff members have contact with youth outside the context of the program. A universal policy could limit contact between staff and youth to organization-sanctioned activities and programs (Kenny and Wurtele 2012). Sports coaches could be prohibited from going on trips alone with athletes, and from staying together in hotel rooms. Wurtele also observed that all organisations should develop and implement an appropriate electronic communication policy which sets out acceptable and unacceptable uses of electronic communications with youth, including via social

networking sites. Contextually relevant aspects of policy and implementation may require material specific to the organisation and activity.

Standard 1: Safe Screening and Hiring Practices Working with children checks are often subject to legislative schemes. They are a useful tool and serve the clear function of helping to prevent individuals with a relevant criminal history from gaining employment-related access to children with the intention of offending. However, all such screening schemes have limitations, the most obvious one being that most individuals who have inflicted child sexual abuse and who continue to pose a risk will not have a criminal record, because so few cases are disclosed, and then prosecuted, and then result in a conviction. In addition, such schemes need to be adequately framed and implemented so that agencies within and across jurisdictions have immediate and accurate access to shared data systems.

Standard 2: Code of Conduct Similar to the organisational policy, many aspects of an organisation's Code of Conduct must possess several key components. As recommended by Wurtele, every CYSO should *possess* a Code of Conduct (on Wurtele's model, the CC should have 21 components). Its purpose is to "describe how adults should always maintain professional relationships with youth, both in and outside the agency. It is a straight-forward guide of do's and don'ts to assist staff and volunteers to conduct their work professionally and effectively. It lets everyone know what behaviors are acceptable and unacceptable." The "do's and don'ts" encompass multiple aspects (enumerated as many of the 21 sub-components), including discipline practices, internet use, photography, electronic communications with children, other communication and language, transport, and alcohol and drugs.

Standard 3: Implementation and Monitoring There are several elements in the 10 enumerated subcomponents which clearly relate to internal CYSO implementation and monitoring. Some of these, such as therapeutic supervision and formal supervision, are complex and present substantial challenges (such as professional supervision and mentoring). Modified versions of this may be possible if specific organisations have dedicated child protection leaders, and supervision could be conducted using innovative methods beyond traditional face-to-face debriefings. The other focus of this standard is the task of auditing organisations.

Standard 4: Ensuring Safe Environments There is some overlap with this standard and the Code of Conduct, since many of its 10 enumerated subcomponents relate to the same kinds of "do's and don'ts" which are the subject of that Code. However, this standard is directed towards ensuring these principles are observed in practice, as well as further elaborating on them in the manner of situational crime prevention. These principles draw on situational crime prevention theory, explored below, and accordingly some of them have resource implications (such as the use of windows in doors). However, others require only that established policy measures as detailed in the policy and the Code of Conduct are further embedded, disseminated and

made known throughout the organisation (such as openly displaying and making available the policy and code of conduct to all staff, parents and children).

Standard 5: Reporting and Responding to Concerns, Disclosures and Allegations.[1] In Wurtele's model, there are 21 subcomponents in this dimension. Some of these overlap with aspects of the Code of Conduct dimension, and some overlap with the education and training dimension (e.g., staff being trained about recognising indicators of CSA, and staff, parents and youth being educated about how to report suspected cases). However, a considerable number of these subcomponents relate directly to the development and implementation of processes for receiving, recording and dealing with complaints and allegations. A key question arising here is whether it is preferable, and possible, to develop a single approach to the treatment of such concerns or allegations, detailing what an organisation must do (although in consideration of the different nature of organisations, there could be variations in details, such as which staff member is designated as responsible for doing specific acts such as recording details; and passing on the information to child welfare authorities and or law enforcement; communicating with the staff, parents and children during and following the events; supporting the child; dealing with media; post-resolution processes).

Standard 6: Training and Education Wurtele (2012, p. 2448) has observed that "Education is the cornerstone of preventing CSA and sexual boundary violations by YSO staff members." This dimension has 14 subcomponents, as follows:

- the CYSO has developed and implemented education specifically designed for youth, parents and professionals, staff and volunteers who have significant contact with children;
- all groups are educated about child abuse with in-depth coverage of CSA;
- includes material on professional boundaries (multiple further subcomponents relate to this);
- includes material on ethical conflicts;
- includes material on self-regulation;
- includes material on cognitive distortions and rationalisations;
- includes material on how to recognise and respond to a colleague's inappropriate actions;
- includes material on information about duties to report;
- inclusion of a means of confirming an individual's completion of training;
- training provided before commencement of interaction with children; and
- that education and training be repeated periodically.

Importantly, education and training needs to be implemented comprehensively and appropriately, primarily for staff, but also for children and parents. Wurtele

[1] There are 21 subcomponents of the Reporting and responding dimension: copy on file with author.

urges that children be provided with information about CSA, including material about appropriate and inappropriate interactions online and offline with adults. For further staff development generally, including on sexual boundary education, Wurtele recommended that:

> once selected for positions in YSOs, it is critical that in-service training programs be offered to inform all employees and volunteers about institutional CSA. These trainings can give all adults a heightened awareness of an organization's commitment to youth safety and intolerance of sexual misconduct. Training objectives should include understanding the complex dynamics of child sexual abuse and how youth are harmed by sexual exploitation, recognizing signs that a youth is being sexually abused, responding sensitively to a victim's disclosure, understanding the agency's zero-tolerance policies and consequences, and knowing the agency's reporting policies and state laws. Everyone working with children must be aware of their ethical and legal duty to report any reasonable suspicions of CSA to a designated state agency or to law enforcement.

As noted by Mathews and Collin-Vézina (2016), there are many required elements of staff and volunteer training in relation to child sexual abuse that are universal, such as: the definition of child sexual abuse; its prevalence; its criminality; its serious consequences; who experiences it, and at what ages; who inflicts it; the tendency towards nondisclosure and delayed disclosure; children's truthfulness in disclosure (even if they recant); the indicators of CSA (typical emotional, social and behavioural responses after victimization, including how they may indicate their experience without clear disclosure); and legal and ethical duties to report, and processes for reporting.

Situational Crime Prevention The literature on situational crime prevention, and especially as applied to child sexual abuse in CYSOs, is also instructive. Situational crime prevention does not aim to reduce offending through measures related directly to the offender or the victim. Rather, it is a criminological model concerned with actions taken about the "situation" or environment within which crime occurs to reduce the likelihood of offending. As explained by Smallbone et al. (2013), the questions ask: what is the nature of the crime; where does it occur; when it occur; who is involved; and how does it occur? Preventative approaches from the perspective of situational crime prevention aim to alter the environment in which crime occurs to reduce the likelihood of offending, informed by the nature, location, timing and method of the crime (Boyle 2014; Kaufman et al. 2012; Leclerc et al. 2011; Smallbone et al. 2013; Terry and Freilich 2012; Terry 2015; Wurtele 2012).

Smallbone et al. (2013, pp. 166–171) emphasise that regardless of the strength of the offender's motivation, child sexual offending requires a "conducive immediate environment". They propose methods of situational prevention for different contexts, including the institutional context. Key proposals, grouped under conceptualised strategic methods, include:

- "Increasing effort": effective strategies to screen personnel; inclusion of material in formal job descriptions about expected and prohibited behaviour towards children; presence of a specialised risk management position dedicated to prevention

of harm to children; presence of a formal action plan to reduce risk of harm; staff awareness of the plan; regular review of the plan;
- "Increasing risks to offenders": reducing opportunities for adults to be alone with children; physical redesign of the environment through, for example, glass panels; requiring staff to make reports of abuse; enhancing opportunities for disclosure by the child; a requirement of inspections and reviews by an independent authority;
- "Removing excuses/reducing permissibility": ensuring the institution is not a "pathological institution" in which a culture of abuse distorts individual moral judgments, enabling rationalisation of illegal and otherwise prohibited acts, through the use of formal protocols about conduct between staff and children to set clear rules which unequivocally establish acceptable and unacceptable conduct. These should establish acceptable and unacceptable conduct to ensure children are safe, and opportunities for CSA and grooming are minimised (e.g. regarding being alone with children, travel, overnight stays, bathing, communication, and grooming behaviors, and prohibition on taking children to the staff member's home). Punishment of breaches is also essential.

Similarly, Leclerc et al. (2015) proposed a series of key measures, informed by a study of sexual offenders and their insights into effective situational prevention. They recommended:

- In *screening at intake of new recruits*: verifying criminal records; and including questions about the person's motivations for working with children; ensure the interview process includes clear discussion of the organisation's commitment to child protection and expectations of staff conduct, and require signed commitments from the individual to this;
- In *developing policies and regulations about staff conduct to prevent offending*: never leaving a child alone with an adult; prohibiting staff from taking children to the staff member's home; prohibiting adults from showering with children and from showering at the same time; prohibit mobile phone communication between staff member and child; prohibit gift-giving between staff and children; limit contact outside institutional hours; where abuse becomes known, a requirement that the organisation report it immediately to authorities;
- In *environmental design of the institution*: eliminating hidden areas and rooms; using windows to overlook corridors; installing closed circuit cameras at entrances and exits.

Consensus on Measures to Prevent, Identify and Respond to CSA Other insights from the general literature are consistent with Wurtele's model (Kaufman et al. 1998, 2012; Saul and Audage 2007). This is also evident in approaches and organizational tools proposed by the Centers for Disease Control (Saul and Audage 2007) and by other leading scholars (Wurtele 2012, 2014), which are substantially supported in other approaches and analyses (Parent and Demers 2011; Valentine et al. 2016; Walsh et al. 2013). In addition, literature on situational crime prevention of CSA in religious contexts indicates key themes that may have application there

and in other CYSO contexts (Terry and Freilich 2012; Terry and Ackerman 2008). Terry (2015) integrated sociocultural, psychological, situational, and organizational perspectives, and concluded that prevention approaches should focus on situational prevention, as well as education, and oversight and accountability. These models have subtle differences but all have a common fundamental basis, which emphasize the necessity for the key prevention dimensions like those articulated in extensive detail by Wurtele (2012, 2014) as further discussed elsewhere (Mathews 2017).

For convenience, these can be summarised as follows. First, the CYSO must have a detailed organizational policy (including fundamental principles, definitions, objectives, a zero tolerance approach, endorsement by management, and designated contacts). Second, there must be safe screening and hiring practices. Third, there must be a robust and detailed Code of Conduct (specifying prohibited conduct across a range of situations, and acceptable conduct). Fourth, there must be measures for implementation and monitoring (including formal staff supervision, and external auditing). Fifth, actions must be taken to create safe environments (at a lower level, requiring further embedding and dissemination of policy and code of conduct, such as by prominent placement in workplaces, websites, and contractual appointments; at a higher level, requiring safe approaches to environmental structures). Sixth, there must be measures embedded to ensure staff appropriately report and respond to suspected cases, disclosures and allegations (including processes for making, recording and dealing with such reports, and for ensuring the child's safety). Seventh, there must be sufficiently detailed and sophisticated education and training of personnel about the nature and consequences of CSA, organizational policy, reporting duties, and legal and ethical obligations.

Implementation Challenges The challenges are then to achieve coordinated implementation of such responses by CYSOs, government agencies and communities, for responses to be practicable and tailored to the context, and to foster the participation of communities. Lived experience, public health and regulatory theory, and the nature of CSA in CYSOs, all indicate that organizational self-regulation is unviable to meet the social justice imperative in this context. It has been argued elsewhere (Mathews 2017) that a model of direct legislative regulation is required, driven by a posture of responsive regulation, tailored to the context, and with CYSOs being nurtured towards voluntary compliance and informal enforcement but with stronger coercive measures available if necessary to compel compliance and penalize breaches (Dorbeck-Jung et al. 2010; Hutter 2011).

In advancing any centralized program based on direct regulation, it is important to promote the public health tenet that community participation and ownership is vital, and to accept that modifications are permissible where appropriate. Accordingly, this approach should not be simply a "top-down" approach relying only on direct regulation. Rather, guided by public health principles and insights, it requires fostering productive, collaborative partnerships with CYSOs, and strategies involving organizational leadership and individual staff members (Palmer 2016), to help develop intrinsic organizational and individual attitudes to heighten

the likelihood of compliance and sustained cultural change. The benefits of the preferred approach to CYSOs should be emphasized, including savings to CYSOs of money, time, expertise and personnel, and, more importantly, providing assistance in improving organizational capacity to protect the children and youth they serve, professionalizing staff and management, and minimization of organizational liability. As well, it is important to note that, in the spirit of public health as originally conceived and with regulatory theory as applied to high risk environments with diverse industrial participation and varied intrinsic commitment, government has not only a role to play, but an obligation to do so.

In general, then, based on an analysis of public health theory and regulatory theory (Mathews,2017), the features of the context of CSA and CYSOs indicate direct government regulation is required for situations of high risk, high complexity, and uncertain industry or sector commitment to robust policy. The optimal approach to implementing many of the required dimensions of regulation is a unified, centralized approach implemented by a central authority having the power and capacity to develop, communicate, administer and enforce the desired measures. This offers the greatest likelihood of promoting quality of design and best practice, avoiding fragmentation of policy and practice, using resources efficiently, and enhancing child protection. Achieving this requires direct regulation, involving a small number of organizational actors in an organized, centralized and homogenous environment, which can: enable cooperative and coordinated support between major government and nongovernment actors; create consistent, sound, simple procedural structures; and aim to develop genuine organizational and individual commitment to the policy measures and practices through the development of attitudinal factors which underpin an internalized normative duty.

This would generally require a legislative scheme, endorsement by government and major nongovernment organizations, and financial support from the state, all of which are consistent with public health law and public health theory. It would need to be supported and enforceable by an external framework of recognition and enforcement. A single, centralized national regulatory body should have responsibility for as many of the seven key dimensions discussed above as possible. This body could be supported financially and logistically by governments at national and or provincial levels. It should have considerable strength in its regulatory actions, being supported by a legislative scheme, or could at least have power to compel certain acts through organizational accreditation or registration requirements, or made a condition of receiving state financial support. In developing harmonized, common approaches to as many of the relevant aspects of the regulated subject matter as possible, this body could consult with peak organizations while retaining ultimate decision-making power. Mechanisms for providing aspects of the prevention approach could be simple, streamlined, and cost-efficient, such as using online methods for education. Quality assurance and review could be conducted at practicable intervals, conducted by one body or a small number of auditing bodies, themselves overseen by the central agency. At all stages of this approach, provision of support by the government regulator to CYSOs should aim to foster dispositions conducive to a child-centred approach.

As will be seen below in this chapter, the significance of his emerging body of knowledge is that it can be used to inform developments in legislative requirements and policy guidance applied to CYSOs, responding to key dimensions of how best to prevent, identify and respond appropriately to CSA.

Australia's Royal Commission into Institutional Responses to Child Sexual Abuse: Its Nature, Key Findings and Major Recommendations – The Roman Catholic Church

The Australian Royal Commission Into Institutional Responses to Child Sexual Abuse delivered its Final Report in December 2017. While other countries have conducted similar inquiries, due to the nature and scope of Australia's Royal Commission, it can reasonably be judged to be the single most extensive Inquiry of its type ever undertaken. It made 400 recommendations, targeting the most significant problems and shortcomings presented by social and legal systems, and institutional practice and malpractice, related to the prevention, identification, and response of child sexual abuse. The recommendations were made generally to cover all CYSOs, but with further recommendations specific to some CYSOs, including the Roman Catholic Church, which was the institution most frequently involved in cases of CSA brought to its attention. The recommendations encompass direct recommendations for specific legislative reform, policy reform, and practical reform. Separate reports published during its tenure provided recommendations about criminal justice systems, civil justice systems and redress schemes, and criminal history screening. For any society wishing to take steps to improve the prevention and appropriate responses to child sexual abuse in CYSOs, the work of Australia's Royal Commission constitutes an invaluable resource.

Background to Australia's Royal Commission

Australia's Royal Commission Into Institutional Responses to Child Sexual Abuse (the Royal Commission) was initiated on 12 November 2012 by the then Prime Minister of Australia, Julia Gillard, due to growing concern about the prevalence of child sexual abuse within public and private institutional contexts, the inadequacy of preventative and responsive measures undertaken by institutions, and active concealment of such abuse by institutions including most notably the Catholic Church (Australian Government 2013; Australian Government Royal Commission Into Institutional Responses to Child Sexual Abuse 2014). This concern existed despite numerous prior inquiries into institutional CSA, which had less extensive powers, narrower scope, and lacked the support of state and territory governments.

The Letters Patent gave the Royal Commission a broad remit, including to "inquire into institutional responses to allegations and incidents of child sexual abuse and…what institutions and governments should do to better protect children against child sexual abuse and related matters in institutional contexts in the future… [and] to achieve best practice in encouraging the reporting of, and responding to reports or information about, allegations, incidents or risks of child sexual abuse" (Australian Government 2013).

The Royal Commission initially received $285 million in funding for 4 years, and this tenure was extended until December 2017 with further funding of $104 million (Australian Government Royal Commission Into Institutional Responses to Child Sexual Abuse 2014). Six Commissioners were appointed with collective experience across multiple fields, and the Commission employed approximately 250 fulltime staff by April 2014 (Australian Government Royal Commission Into Institutional Responses to Child Sexual Abuse 2014).

Broadly, the Royal Commission engaged in three major fields of work. First, it convened private sessions to listen to survivors, bear witness to their experience, validate their experience, and learn from their accounts. Here, it conducted 8013 private sessions, and referred 2562 matters to police). Second, it conducted 57 public hearings to formally conduct investigations and obtain detailed evidence about institutions and cases of particular interest. This function was supported by extensive powers, including the ability to call witnesses and compel testimony and the production of documents. Some of these lasted for weeks. Third, the Commission engaged in a detailed research and policy program, involving both work conducted by its own staff, and 59 externally commissioned research projects conducted by Australian and international researchers, most of which were published on the Commission's website. This program of research was organized around eight themes (causes; prevention; identification; institutional responses; government responses; treatment and support needs; institutions of interest; ensuring a positive impact).

In addition, the Royal Commission engaged in a comprehensive program of public engagement, to create community awareness of its work and to build trust and confidence in its activity. This included engagement with the broader community including through media and numerous formal speeches, as well as with specific groups such as children, people with disabilities, people in correctional institutions, people experiencing homelessness, and people from culturally and linguistically diverse groups. The Commission developed a comprehensive website which made materials available for public consumption, streamed public hearings live to the public, and archived transcripts of evidence from hearings. Special measures were devised to give survivors facilities to share their experiences and views about desired reforms.

Its major final report was released in December 2017, comprising 17 Volumes, and this will be returned to shortly. Here, it can also be noted that the Commission completed and released an Interim Report (Australian Government Royal Commission Into Institutional Responses to Child Sexual Abuse 2014) and major reports including on Civil Litigation and Redress (Australian Government Royal

Commission Into Institutional Responses to Child Sexual Abuse 2015a) to enable immediate reforms to law, policy and practice.

Key Findings on Demographics

Before proceeding, it is useful to note some key findings about the demographics and reported experiences of those who appeared in private sessions with the Commission (Royal Commission 2017 – Final Report). While not strictly able to be considered a representative sample because of self-selection, this sample is nevertheless a very large sample of self-selected individuals, gathered over several years, who reported experiencing sexual abuse while a child in an organisation providing services to children (broadly defined to include religion, education, sport, culture, arts, recreation, welfare, out-of-home care, foster care, and juvenile detention).

- Average age when first abused: 10.4 years (males 10.8 years; females 9.7 years).
- Sex: 63.6% male; 36.1% female.
- Offender's age: 85.2% reported being abused by an adult perpetrator.
- Offender type: 31.8% reported being abused by a person in religious ministry; 20.4% by a teacher; 13.5% by a residential care worker; 11.3% by a foster carer.
- Frequency: 85.4% said they were abused multiple times.
- Severity/nature: 55.7% reported experiencing penetrative abuse; 71.4% other contact abuse.
- Organisation type: 58.1% reported the CSA occurred in a religious organisation[2]; 32.5% in a government-run institution, and 10.5% in a non-government, non-religious institution.
- Denomination of religious organisation: Of those abused in a religious organisation, 61.4% were in a Catholic institution; 14.8% Anglican.
- Catholic CYSOs: As a proportion of all survivors, 35.7% said they experienced CSA in a Catholic institution.

Case Study Investigations An important part of the Royal Commission's activity was to conduct investigations into specific institutions. These aimed to understand systemic issues, identify ways to learn from institutional errors, and inform recommendations for reform. The case studies had a strong focus on religious institutions, with the Catholic Church prominent, being the subject of 15 case studies including the Church as a whole (Case Study 50) and in specific dioceses including Melbourne (Case Studies 16, 28, 35), Ballarat (Case Study 28), Toowoomba (Case Study 6), Wollongong (Case Study 14), and Maitland-Newcastle (Case Study 43), and Marist Brothers schools (Case Study 13). Other religious institutions were also investigated,

[2] In May 2017, reporting the most recent data, the Chair of the Royal Commission, the Honourable Peter McClellan, stated that Of those who reported abuse in a religious institution, over half (51%) stated the abuser was a person in religious ministry, and almost one quarter (22%) reported the abuser was a teacher (McClellan 2017).

including the Anglican Church (Case Study 42), Jehovah's Witnesses (Case Studies 29, 54), and Yeshiva Colleges (Case Study 22). Educational institutions were prominent, including private boys' schools in Brisbane (Case Study 34), Geelong (Case Study 32), and Sydney (Case Study 23). Numerous other educational and out-of-home care institutions were investigated, as were organizations including scouts (Case Studies 1, 48), sporting clubs (Case Study 39), swimming groups (Case Study 15), YMCA (Case Studies 2, 47), and performing arts (Case Study 37).

Features Contributing to CSA in CYSOs Identified in Hearings and Case Studies A major result of the public hearings undertaken as part of the case studies was that they revealed the features and actions of institutions where CSA occurred, and was concealed and facilitated. These findings are instructive generally, and reveal similar themes to other national inquiries, especially in Ireland (Ryan 2009; Wright 2017). Conceptually, they may be grouped under themes of:

- an organizational culture of concealment, corruption and protection of individual and institutional reputations;
- managers' and staff members' ignorance and inadvertence;
- absence of child protection policy, or lack of compliance with policy;
- lack of staff and student education about CSA;
- lack of effective reporting mechanisms internally and to external agencies;
- allowing known offenders to have continued access to children, enabling further abuse;
- allowing unsupervised private access to children;
- failure to prioritize children's welfare; and
- lack of external oversight.

These findings helped to inform many of the Royal Commission's recommendations for reform.

In the Yeshiva hearing, for example, the Commission identified many of these problems (Australian Government Royal Commission Into Institutional Responses to Child Sexual Abuse 2016). Regarding responses to allegations against three staff at Yeshiva Melbourne, it was found, for example, that within this extremely insular group there was a consistent pattern of total inaction despite repeated allegations by parents and children of CSA by several staff; ignorance amongst Rabbis about what constitutes CSA and the nature of grooming; rhetorical minimization of CSA; punishment and isolation of anyone who spoke out; absence of support for survivors; a lack of adequate policies, processes and practices for responding to complaints for over 20 years; and confusion about whether Jewish law allowed reporting of abuse to police leading to cover-ups.

Similar findings were made in the hearing into the Marist Brothers, which focused on the prolific offending by two known offenders against multiple children periods in multiple locations over extended periods of time (Australian Government Royal Commission Into Institutional Responses to Child Sexual Abuse 2015b). One of these offenders was promoted to Principal even after it was known he had sexually

abused children; he then continued to offend and was transferred to another school, again as Principal, despite the school authority's knowledge of his further offending.

Similar findings have been made in other secular and non-secular educational settings. In Case Study 34, which concerned abuse at two private schools, several similar themes emerged (Australian Government Royal Commission Into Institutional Responses to Child Sexual Abuse 2017b). In relation to the first school (Brisbane Grammar School), it was found that the school counsellor had a locked private room where he sexually abused boys who were seeing him for counselling. He abused multiple students for years at this first school, and then left the school in 1988 and joined the second school investigated in this case study. At the first school, the principal was told in 1981 by a student's father that his son had been abused by the school counsellor. The Commission found that the principal failed to investigate the allegations, failed to report the matter to the police or the school board of trustees, and that during this principal's tenure there was a culture where boys who made allegations of CSA were not believed and their claims were not acted upon (pp. 9, 73); and that there was a culture which did not encourage or facilitate the reporting by students to staff of CSA. It was found that during the period this counsellor was employed (1973–1988), the school had no systems, policies or procedures to deal with allegations of CSA (p. 12), and there was no adequate system of record-keeping of the sessions or of the boys' absences from class, and this precluded prevention of further abuse.

In relation to the second school (St Paul's School), where the counsellor worked from 1989–1997, again with a system of a locked room, it was found that in 1996 the principal dismissed two boys' allegations of CSA by the counsellor, told them they were lying, and threatened to punish them if they continued making the allegations (p. 10). In January 1997, the counsellor was charged by police with offences regarding abuse of another student over a period of 2 years, and the counsellor committed suicide the next day (p. 10). Subsequently, this same principal at the second school was promoted to an executive director position with responsibility to create and implement child protection education policy throughout Brisbane; this appointment was by a Diocesan committee including two members who knew of the principal's prior failure to act, with one of these being the Archbishop of Brisbane (pp. 11, 57–58). The Commission found the principal's inaction meant he failed his most fundamental obligation of keeping the students safe, and that there were no systems, policies or procedures to deal with allegations of CSA.

Frequency of Offending in the Anglican Church and the Catholic Church

The Commission also undertook analyses of claims made with respect to CSA in Catholic Church institutions and Anglican Church institutions respectively (Australian Government Royal Commission Into Institutional Responses to Child

Sexual Abuse 2017c, d). For the Anglican Church, the Commission found there were 1119 complaints of CSA made to all 23 Anglican Church dioceses between 1980 and 2015, involving 1085 individual complainants, with 75% being male and the average age at the time of the first alleged incident being 11.8 years of age; these allegations involved 569 alleged offenders of whom 43% were ordained clergy and 94% were male (Australian Government Royal Commission Into Institutional Responses to Child Sexual Abuse 2017d). These data were limited because not all complaints made to Anglican institutions such as schools were received and recorded by the diocese, and the data did not enable estimates of prevalence of offending by Anglican clergy and non-clergy. Even taking into account the different time periods studied, these data appear to show a higher frequency of complaints than those from an earlier study. This Anglican Church study used data from church files from 20 dioceses between 1990 and 2008, and found there were 191 allegations made by 180 individuals against 135 Anglican clergy and non-clergy, with 58% involving clergy, 76% of complainants being male, and large proportions of alleged abuse occurring in the alleged offender's home, especially those involving clergy (Parkinson et al. 2012). While this study could not calculate the proportion of Anglican clergy to be subject to allegations, the authors estimated it as fewer than 1%. Caveats on this finding would include the general tendency for nondisclosure of CSA in all circumstances (Alaggia, 2005; Collin-Vézina, De La Sablonniere-Griffin, Palmer, & Milne, 2015), and, for CSA in Church contexts, for nondisclosure to the Church in particular.

The Roman Catholic Church: Frequency of Offending Findings ion the frequency of offending in Catholic institutions were particularly notable. The Commission obtained data from 201 Catholic Church authorities to identify the number and features of claims of alleged CSA made to these authorities between January 1, 1980 and February 28, 2015, regarding abuse from 1950–2010 (Australian Government Royal Commission Into Institutional Responses to Child Sexual Abuse 2017c). "Claims" were limited to those subject to a formal application for redress through judicial or non-judicial processes, and those made where redress was not sought but which were substantiated after investigation by the Church or another body, or were otherwise accepted by the Church) (Australian Government Royal Commission Into Institutional Responses to Child Sexual Abuse 2017c). The survey also captured data on the number of clergy and non-clergy employed from 1950 to 2010 to enable estimation of the proportion of offenders.

It was found that: 4445 claimants alleged incidents of CSA, involving 1880 identified offenders and 530 other unspecified offenders; 78% of claimants were male; the average age of claimants at the first alleged incident was 11.4 years (11.6 for males; 10.5 for females); 90% of alleged offenders were male; 37% of alleged offenders were non-ordained religious, 30% priests, and 29% lay people. Allegations involved 1049 institutions. Of all Catholic authorities with priest members, 7.0% of priests were alleged offenders, and some authorities had much higher rates. Of all non-ordained religious who were alleged offenders, some institutes also had substantial proportions of offenders: 22% of non-ordained Christian Brothers were

alleged offenders (n = 483). Given that many incidents of CSA are not disclosed at all, or are not disclosed to authorities (including the offending institution), it is clear that the estimates generated are conservative. These data represent only the fraction of cases that were disclosed, and were made the subject of a formal complaint, and accepted as proven. The results are broadly comparable to those in the United States. The John Jay College of Criminal Justice (2004) estimated 4% of Catholic priests and deacons from 1950 to 2002 were subject to allegations, and subsequent data placed this figure at 5%, involving 15,000 children (Terry et al. 2011; Terry 2015).

The Roman Catholic Church: Cultural Problems, Corruption, and Concealment The issues raised by the unique organization that is the Roman Catholic Church would require an entirely separate treatment, and it is beyond the scope of this book to thoroughly examine its nature, history, canon law, governance, and culture. However, it is essential to identify important characteristics of the Catholic Church that are relevant to this context. This institution was the locus of the majority of institutional CSA revealed to the Commission, and has been the subject of multiple industrial scale cover-ups and major inquiries in the USA, Canada, Ireland, Belgium, Germany and the Netherlands (Böhm et al. 2014; Murphy 2009, 2011; Ryan 2009; Terry 2015). After the release of the Cloyne Report (Murphy 2011), the Prime Minister of Ireland, Enda Kenny, famously eviscerated the Roman Catholic Church in an unprecedented attack, declaring that it had brought to light "the dysfunction, disconnection, elitism [and] narcissism that dominate the culture of the Vatican to this day. The rape and torture of children were downplayed or "managed" to uphold, instead, the primacy of the institution, its power, standing and "reputation"…[the Vatican has responded] with the gimlet eye of a canon lawyer. This calculated, withering position being the polar opposite of the radicalism, humility and compassion upon which the Roman Church was founded" (Kenny 2011). Kenny was particularly incensed because the Cloyne Inquiry exposed "an attempt by the Holy See, to frustrate an Inquiry in a sovereign, democratic republic…as little as three years ago".[3]

One cannot ignore this particular institution because it qualitatively different from others, and because its uniquely high risk of child sexual abuse and its concealment make it a special case requiring special attention. In addition, it is the

[3] Kenny was also endorsing the Irish Government's new efforts to protect children, including through its Children First bill. He stated (my emphasis): "Cardinal Josef Ratzinger said: 'Standards of conduct appropriate to civil society or the workings of a democracy cannot be purely and simply applied to the Church.' As the Holy See prepares its considered response to the Cloyne Report, as Taoiseach, I am making it absolutely clear, that when it comes to the protection of the children of this State, *the standards of conduct which the Church deems appropriate to itself, cannot and will not, be applied to the workings of democracy and civil society in this republic.* Not purely, or simply or otherwise. Children…First" … through our legislation, through our Government"s action to put Children First., those who have been abused can take some small comfort in knowing that they belong to a nation, to a democracy where humanity, power, rights, responsibility are enshrined and enacted, always....always.... for their good. Where the law - their law - as citizens of this country, will always supercede canon laws that have neither legitimacy nor place in the affairs of this country."

largest Christian church globally with over 3000 dioceses and archdioceses in scores of countries, and accordingly presents both the highest risk and the risk of greatest magnitude. This extends to nations where the population may be at even greater risk, due to poverty, and less stringent adherence to the rule of law. Brazil, Mexico and the Philippines, for example, have a combined population of 400 million Catholics. The populations in Ireland and Australia (around four million and five million respectively) pale by comparison.

Many scholars have sought to understand the factors contributing to CSA within it, and have criticized the separate and combined devastating effects of a range of its specific features (e.g., Doyle et al. 2006; Frawley-O'Dea 2004; Keenan 2012; Lothstein 2004; Parkinson 2016; Robertson 2010; Robinson 2007; Sipe 2011; Tapsell 2014). These may be understood as a group of five conceptually distinct features which are related to and reinforce one another:

- Culture (an exceptionally strong hierarchical power structure requires complete obedience to Church rules to protect one's personal standing, job security and career prospects, and, for some, vaulting ambition[4]; strong obligations are owed by clerics to superiors and to the Pope; total conformity with organizational attitudes and beliefs is required; dissent is silenced; objectors are marginalized);
- Dominance of internal organizational rules (where canon law and Church doctrine take priority over civil law and criminal law; the authority of national civil and criminal law is not recognized; the organization considers itself not only separate from but superior to civil society, and administers its own discipline even for matters which otherwise would attract sanctions by civil and criminal legal systems; there is internalized fusion of organizational and state-like power);
- Protection of the institution's existence and reputation at all costs (complete secrecy of any impropriety is required at the cost of personal expulsion from the group; the top priority is the avoidance of "scandal", i.e., anything that can damage the reputation of the Church or its priests; protection is provided to individual sexual offenders; whistleblowers are punished and even excommunicated; secret internal administrative and governance mechanisms are used to deal with known and alleged offenders);
- Governance that is authoritarian, and both centralized and fragmented (where authority and rule-making are both entirely at the behest of one individual, yet are also otherwise fragmented and where each bishop is endowed with almost unlimited authority over the management and administration of his diocese, subject to canon law and Papal direction); and
- Sexual distortion and dysfunction (distorted masculinity, psychosexual development and personal sexual functioning is embedded by culture, conditions and rules including celibacy and rationalization of sex with males or boys as not

[4] The analyses of the career of Cardinal George Pell, who at the time of writing has been committed to stand trial in Melbourne, Victoria, for a range of child sexual offences, may provide insights into this and other aspects of Church culture: see Marr (2014) and Milligan (2017). The Royal Commission's case studies also detailed the testimony of Cardinal Pell, which included some admissions about his conduct in responding to complaints.

violating celibacy; a limited homogenous ideal of personhood exists; illicit sex is treated institutionally as sin rather than crime).

Royal Commission Findings on the Catholic Church

All these features were noted by the Royal Commission in 15 case studies into Catholic institutions. These case studies were exceptionally thorough analyses of what happened, and why it happened, in dioceses, archdioceses, and particular settings. Reports of the case studies included findings about what happened (or, if the institution claimed otherwise, was more likely to have happened), which then informed recommendations for reform. The thoroughness of these studies can be appreciated immediately by noting the length of the reports. The Report of *Case Study 28: Catholic Church authorities in Ballarat* alone is 536 pages.[5] It is instructive to note some key findings from this specific case study example of Ballarat, and then to summarise the Commission's findings from all 15 case studies as applied generally to this institution.

A Specific Case Study Example of Catastrophic Failure and Appalling Malfeasance: Case Study 28 (Ballarat) Ballarat has frequently been described as the epicentre of child sexual abuse in Australia. It is known as the location of Church parishes (including St Alipius) and schools where some of the most widespread clergy child sexual abuse occurred over decade. It is known as the location where 140 people had made a claim of child sexual abuse against priests and religious staff during the time period of the Royal Commission's data analysis. It is known as the location where some of the worst prolific offenders – including Gerald Ridsdale (who held 16 appointments over 29 years as a priest), Robert Best, and Edward Dowlan – perpetrated child sexual offending on an industrial scale. It is known as the location where Church leaders for decades harboured known groups of offenders, and individual offenders; and it is known as the location of some of the individual bishops

[5] In Case Study 28 the Royal Commission inquired into "the response of the Congregation of Christian Brothers in the St Patrick's Province of Ballarat and the Catholic Diocese of Ballarat (the Diocese) to complaints and allegations of child sexual abuse by Christian Brothers, clergy and religious." The Christian Brothers operated or provided staff for six primary and secondary schools in Ballarat and Warrnambool. St Alipius Boys' School, a primary school in Ballarat East, and St Patrick's College, a secondary school in Ballarat, were primarily staffed by Christian Brothers and were the principal focus of this study. Part One of the public hearing examined the response of relevant Catholic Church authorities to the impact of child sexual abuse on survivors, their families and the community of Ballarat. It also examined their responses to survivors, their families and the community of Ballarat following the conviction of clergy and religious for acts of child sexual abuse committed at institutions associated with Catholic Church authorities in Ballarat. Part Two examined the knowledge of Catholic Church authorities in and around Ballarat to allegations of child sexual abuse and their response to those allegations. It also examined the response of Victoria Police. Part Three examined the knowledge of and response to allegations of child sexual abuse by Christian Brothers in St Patrick's Province, specifically in institutions within the Diocese: See Case Study 28, Executive Summary, p. 21.

most heavily criticised for its concealment and continued facilitation, including Ronald Mulkearns (Marr 2014; Milligan 2017). It should be taken as a model of what an organisation must not allow itself to do. It must be taken as a model of what a society must not allow an organisation to do.

In Case Study 28, the Commissioners drew conclusions about the nature and adequacy of responses of the Christian Brothers (pp. 192–3), and of the Catholic Diocese of Ballarat (pp. 403–420), to allegations and complaints of child sexual abuse. Regarding the Christian Brothers, for example, it was found that (pp. 192–3):

> The response of those in positions of authority within the Christian Brothers in St Patrick's Province … was grossly inadequate… On some occasions, the response to allegations or reports of Christian Brothers conducting themselves in a sexually inappropriate manner with children was dismissive. Questions were not asked and details not sought, when they should have been. Few investigations were undertaken. For example, in relation to Dowlan, we are satisfied that there was no effective response to any of the many reports or complaints in order to manage the risk to children that Dowlan posed. … Often, the Christian Brother in question was allowed to remain in the position he held where the allegations arose, with continuing access to children. On many occasions, the Brother was moved to a new location after a complaint or allegation was made about his conduct. In some cases, the reason given for the move was to conceal the true reason for it and to protect the reputation of the Christian Brothers and avoid scandal and embarrassment. Whether the Brother remained in place or was moved, few effective restrictions were placed on his movements. The Christian Brothers did not share information about allegations or complaints of child sexual abuse against Christian Brothers when that information should have been shared. It is clear that the systems and procedures in place which permitted each of these to occur were inadequate and unacceptable. We are satisfied that the Christian Brothers, similar to other Catholic orders, have a structure in which ultimate power and responsibility rests with one person: the provincial. A system without checks and balances has the obvious potential for mismanagement or abuse of that power and neglect of that responsibility.

Regarding the Catholic Diocese of Ballarat, it was found that (pp. 403–4):

> This case study exposed a catastrophic failure in the leadership of the Diocese and ultimately in the structure and culture of the Church over decades to effectively respond to the sexual abuse of children by its priests. That failure led to the suffering and often irreparable harm to children, their families and the wider community. That harm could have been avoided if the Church had acted in the interests of children rather than in its own interests.
>
> The response of the Diocese to complaints and concerns about four of its priests was remarkably and disturbingly similar. It is apparent that the avoidance of scandal, the maintenance of the reputation of the Church and loyalty to priests alone determined the response. It was only when there was a possibility that the sexual abuse of children by a priest would become widely known that any ac on was taken. Invariably, that ac on was to remove the priest from the community for a short period and then place him in another, more distant parish. Restrictions were not placed on priests and supervision was not given.
>
> Untrue or misleading reasons for the priest's departure were given to the old parish, and no warning was given to the new parish …
>
> Euphemistic and elliptical language was often used in correspondence and minutes to mask the true nature of the conduct discussed. There was repeated reference to 'pressures', 'strains' and unspecified 'problems'. On occasions, records were deliberately not made or kept or were destroyed. Bishop Mulkearns and other clergy were dismissive of complaints

and complainants. The response to reports was characterised by the encouragement of secrecy, assurances that the matter would be dealt with and a failure to follow up, ask questions or investigate reports. Reports were never made to the police and victims were not supported. This pattern was repeated. The structure of the Diocese was flawed and lacked any accountability. The bishop was autonomous. He alone was the decision-maker about his priests. The structure was hierarchical and did not encourage priests to challenge or otherwise influence the actions that the bishop took. Even if the structure had done so, other priests in the Diocese, including consultors and vicars general, were part of the same culture as the bishop. They too sought to avoid scandal and negative publicity and protect the Church and fellow priests. Such a hierarchical structure of Church authority has the obvious potential for mismanagement and abuse of power.

At p. 404 (my emphasis):

We have found that on many occasions the most likely explanation for the conduct of Bishop Mulkearns and other senior clergy in the Diocese was that they were trying to minimise the risk of scandal and protect the reputation of the Catholic Church. The grave consequence was that the safety and welfare of children were not given the highest priority. *The Church parties acknowledged that the evidence repeatedly exposed a tendency or instinct on the part of those in positions of authority, once they learned of the occurrences or of an accusation of child sexual abuse, to seek to keep the spread of knowledge of such matters to a minimum, with a view to ensuring that the reputation and good name of the Church were not harmed.* They conceded that such an approach is plain in the ways in which Bishop Mulkearns responded to his receipt of information of various kinds about Ridsdale [and others].

At p. 405:

We accept … that only the bishop had the power and authority to take action in respect of a priest against whom an allegation had been made. It was the bishop who had exclusive authority to appoint, remove or transfer a priest in his diocese. Such a hierarchical structure of Church authority has the obvious potential for mismanagement and abuse of power. … However [we have also found that] Bishop Mulkearns discussed allegations about priests with his consultors. … The evidence revealed that the true reason that a priest was being removed from a parish was not disclosed outside the bishop's close advisors. In some cases, parishes were lied to about the reason their priest was being or had been transferred following allegations or complaints of child sexual abuse by that priest. In no case were parishes told the true reason. The Church parties accepted this.

At p. 420:

The evidence in this case study revealed an extraordinary failure within the Diocese to respond adequately to allegations and complaints about the sexual abuse of children by clergy over the course of at least three decades. The response primarily revealed a desire to prevent or minimise the risk of scandal and to protect the reputation of the Catholic Church. It also revealed a tendency by Bishop Mulkearns and other clergy to treat complaints or allegations dismissively and in favour of the priest the subject of the allegation. The response to reports was characterised by the encouragement of secrecy, assurances that the matter would be dealt with and failure to follow up, ask questions or investigate reports.

The offending priest was often removed from the parish where the allegations had arisen and moved to a new location where the allegations were unknown. Untrue or misleading reasons for the priest's departure were given to the old parish, and no warning was given to the new parish. … Either restrictions or conditions were not imposed on the priest in his new parish or there was no effective supervision of his conduct. Often, more allegations against the priest emerged in the new parish.

> The result of these inexcusable failures was that more children were sexually abused by Catholic clergy in the Diocese. There was a catastrophic institutional failure which resulted in many children being sexually abused. We heard about the devastating, often lifelong, consequences in the lives of those children. The welfare of children was not the primary concern of Bishop Mulkearns and other senior members of the Diocese when responding to complaints and allegations of child sexual abuse against their priests. There is no doubt it should have been.

Just one particular example from loved experience of this catastrophic failure was described as follows, regarding Ridsdale and one of his scores of victims, Paul Levey. The Commissioners accepted that "at various times, Bishop Mulkearns, the Bishop of Ballarat, knew or strongly suspected that these priests [including Ridsdale] had sexually abused children in the diocese" and they were satisfied that "by late 1975 Ridsdale had admitted to Bishop Mulkearns that he had offended against children and that Bishop Mulkearns knew that Ridsdale's conduct was known to the police in Bendigo". The Commissioners found that "His concern was overwhelmingly about protecting the reputation of the church and avoiding scandal. There was little evidence that he was concerned to protect children from these priests."

When aged 14, after the breakdown of his parents' marriage, but despite his mother's misgivings, Paul Levey had been invited to live with Ridsdale in the presbytery, and did so for about 6 months. He had previously been sexually abused by Ridsdale, some 2 years earlier, on a camping trip. The Commission accepted his testimony that while living at the presbytery, Paul was sexually abused "all the time, just about every day".

The Commissioners concluded that (p. 66):

> We are satisfied that, by about April 1982, Bishop Mulkearns knew that Mr Levey was living with Ridsdale in the presbytery at Mortlake. He knew that the boy's mother was concerned about the situation and sought his assistance, but he ignored her. By this time, Bishop Mulkearns knew of Ridsdale's admission of offending against boys. It is inconceivable that it would not have occurred to him that Ridsdale should not have had a boy living with him and that the boy was, at least, at risk of sexual abuse by Ridsdale. Bishop Mulkearns' response to Mr Levey living with Ridsdale in the Mortlake presbytery demonstrated a total absence of concern for the welfare of that boy. Bishop Mulkearns deliberately left Mr Levey in danger. The Church parties properly conceded the possibility that Ridsdale was abusing Mr Levey should have occurred to Bishop Mulkearns and, given the knowledge he already had about Ridsdale by this me, he should have insisted that the boy be removed from the presbytery immediately. This was an extraordinary and inexcusable failure by Bishop Mulkearns, and his failure to act subjected Mr Levey to ongoing sexual abuse by Ridsdale. Bishop Mulkearns' conduct was appalling.

Major Findings Applying Generally from the Case Studies into Catholic Church Institutions

Major findings about the problems in Catholic Church institutions can be distilled from the collection of these 15 case studies. These findings are made across the 15 case studies, and were synthesised by the Royal Commission in its *Final*

Report – Preface and Executive Summary (2017a). They cover aspects of: the nature of the Catholic Church's decentralised structure and governance; lack of accountability of bishops and other senior clergy; the exclusion of lay people and women from leadership positions; the nature of Church doctrine and procedures; unswerving obedience to these doctrine and procedures by individuals and leaders; clericalism[6]; abuse of religious and spiritual power and authority; the nature of activities undertaken and unsupervised access to children; inadequate training and formation practices; inadequate training in professional responsibility, ethics, and boundaries; the practice of confession being conducted in private; celibacy not being a direct cause, but being a contributing cause to child sexual abuse, especially when combined with other risk factors.

In sum, key themes recognised as facilitating the systematic infliction, continuance and concealment of child sexual abuse, and systematic failure to respond appropriately, can be grouped conceptually as follows:

- Overarching abuse of enormous power held through religious status and clericalism, both by the abuser, and by leaders in the institution who were knowingly acted inadequately before and after the events
- The theme of inadequate leadership was ever-present. The Royal Commission concluded that "In its response to child sexual abuse, the leadership of the Catholic Church has failed the people of the Catholic Church in Australia, in particular its children. The results of that failure have been catastrophic." (*Final Report – Preface and Executive Summary* 2017a, p. 70).
- Leaders failing to take any effective disciplinary action in relation to the offender, despite knowing the abuse had happened and who had inflicted it
- Leaders transferring offenders, including serial and dangerous offenders, to other parishes, with no penalty, supervision or oversight, and often still allowing the offender to have access to children
- Leaders' actions all being directed towards preserving secrecy and the reputation of the Church
- Leaders failing to take any appropriate action to support the child
- Leaders minimising the sexual conduct and claiming it was not criminal
- Leaders and others failing to report cases of child sexual abuse to police or other domestic authorities, and instead complying with Church doctrine to maintain secrecy
- Leaders treating child sexual abuse as a remediable and forgiveable sin to be dealt with as an internal Church matter, rather than as a crime to be dealt with by domestic legal authorities
- Leaders silencing those who knew about the abuse from disclosing it to authorities
- Abusers grooming not only the child but the child's family, capitalizing on their clericalism and status as representatives of God, gaining unfettered access to

[6] Kenny declared: "Clericalism has rendered some of Ireland"s brightest, most privileged and powerful men, either unwilling or unable to address the horrors cited in the Ryan and Murphy Reports".

children, and manipulating the religious belief held by the child through threats (including of being sent to hell) if they disclosed
- Abusers exploiting the devoutness of children's parents, who would frequently not believe their children, and the religious community itself, which often either disbelieved the child or ostracized the child who disclosed
- Abusers telling the child who disclosed that they did not believe them (whether they did or not), and often punishing the child for disclosing
- Cruel responses to claims made by children or adult survivors for redress through internal Church schemes (including the Melbourne Response, established by George Pell), often exacerbating the initial trauma, and failing all tests of transparency, fairness and humane treatment
- Other exploitation of technical legal loopholes to evade civil liability for the acts of its clergy and non-clergy offenders, even when there was no doubt as to liability (relying on statutes of limitation, and on the church's status as an unincorporated association without normal juridical status, and its reliance on property trusts, meaning there was no juridical entity that could be sued).[7]

[7] Most notoriously regarding this, see Ellis v Pell [2006] NSWSC 109, where Cardinal George Pell was heavily involved in the proceedings and litigation strategy: see the comprehensive account provided in Marr (2014), and Royal Commission transcripts in Case Study 8: Mr. John Ellis, Towards Healing and civil litigation. Here, the plaintiff was John Ellis, who it was accepted experienced sexual abuse between 1974 and 1979 while he was an altar server, by Father Duggan, who was the third defendant. The first defendant was "His Eminence Cardinal George Pell Archbishop of Sydney for and on behalf of the Roman Catholic Church in the Archdiocese of Sydney"; and the second defendant was The Trustees of the Roman Catholic Church for the Archdiocese of Sydney. At this first hearing, Patten AJ granted an extension of time in which to commence civil legal proceedings, also finding that while there would be some prejudice to the defendants' fair trial rights, this did not preclude there being a fair trial. Patten AJ further held that, while it did not need to be determined finally, there was at least "an arguable case that the Trustees, at all relevant times, constituted the entity which the Roman Catholic Church in the Archdiocese of Sydney adopted and put forward as the permanent corporate entity or interface between the spiritual and temporal sides of the Church legally responsible for the Acts and omissions of the Archbishop and his subordinates", meaning that there was an entity that could be sued.

However, this second finding was overturned on appeal by the Church in The Trustees of the Roman Catholic Church v Ellis [2007] NSWCA 117. While the court accepted that statute may modify the situation, the Court accepted the Church's argument that the Trustees could not be liable. The key finding [47] was that the Church was an unincorporated association, and "An unincorporated association that is not a partnership is a group of individuals associated together for some lawful purpose other than profit that may or may not have a rigid constitution or a fixed and finite membership. Procedurally, it cannot (at common law) sue or be sued in its own name because, among other reasons, it does not exist as a juridical entity."

Individuals within an unincorporated association can assume an active or managerial role, and if the activity in which they exercise control creates a contractual or tortious claim, they can be held liable individually as principals; however, this liability remains *personal* and not representative in nature, and liability remains with the members who formed the committee or other controlling body who were in office *at the relevant time* of the tort. The relationship between individual office holders and the "members of the Church as a whole" was not sufficiently strong to establish liability of the broader organisation either in contract, or through vicarious liability in tort (negligence). Further, there was insufficient evidence of a relationship of employment of Father Duggan by Pell or by the Trustees; it was not suggested in evidence that the priest was "engaged or employed by

In Volume 16 of its Final Report, entitled *Religious institutions*, the Royal Commission made a large number of specific recommendations for reform in the Catholic Church (Recommendations 16.6–16.26), which supplement other recommendations applying to CYSOS generally including the Catholic Church. Some of these will be detailed below. In addition, I will also elaborate on some of the difficulties facing the Catholic Church, and will make some specific recommendations to respond to its unique governance arrangements. These recommendations may have particular resonance for the Catholic Church, but they have been conceived to apply generally to provide a more suitable response to heinous cover-ups and malfeasance, and to other particularly high risk situations.

While all these features of the Catholic Church are not shared by all CYSOs which have experienced problems in appropriate prevention and response to CSA, some are clearly present in cases of particularly inadequate institutional practice and coverups. In particular, these include individuals' perceived need to comply with an organizational culture of silence, and not make reports of wrongdoing due to the cost of reprisals; the institution's protection of its reputation at all costs; and authoritarian governance. Such features are instructive when considering what is required, and legitimately necessary, to overcome these forces and become embedded in domestic legal frameworks to better prevent child sexual abuse within high-risk CYSO settings. In their study of the Catholic Church, Terry et al. (2011) recognized that overall culture change was essential, and that such culture change must be led from the highest levels of management. Terry et al. (2011) concluded that mechanisms of transparency and accountability must be installed, and must become ordinary practice in every diocese. However, the problems in achieving this were not specified; and moreover, the specifics of what is involved in "accountability" and "oversight" were not articulated. Who is to be accountable, for what, to whom, and under what circumstances? Who or what bodies, internal or external, are to have oversight of these accountability mechanisms and cultural practices, and how is such oversight to be implemented?

As discussed previously in this chapter, the challenges then become not only to work out the content of such education, code of conduct, appropriate responses to

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either named defendant, let alone by all of the members of the Church in the Archdiocese during the relevant years… the evidence showed the trustees "played no role in the appointment or oversight of priests in the Archdiocese in the 1970s". Regarding Archbishop Pell's liability, the Court observed that "liability in tort (even vicarious liability) is personal". Most actions in tort die with the wrongdoer. In this case, Archbishop Pell was not in office during the period of abuse. Argument was made, however, that the Archbishop is a corporation sole, with obligations to settle claims. The Court rejected this, finding there was "no statute or Crown grant constituting the Roman Catholic Archbishop of Sydney a corporation sole".

In New South Wales each diocese has established such a legal entity under the Roman Catholic Church Trust Property Act of 1936. For the Archdiocese of Sydney, its body corporate is The Trustees of the Roman Catholic Church for the Archdiocese of Sydney, who hold legal title to the real property owned by the Archdiocese of Sydney and by all the parishes within the Archdiocese. This land is held for the Church or for the use or benefit or for any purpose of the Church, unless subject to a specific trust. The Trustees of the Roman Catholic Church for the Archdiocese of Sydney is the legal entity used in all matters relating to contracts as required by the norms of canon law.

allegations, situational prevention, and the other strategies noted above. There need to be mechanisms to ensure that the recognised components of a holistic system of prevention, identification and appropriate response are installed, and that the elements of transparency accountability and independent external oversight are built in to the system. In the section of this chapter on progress and responses, methods of pursuing these aims are detailed. We can now consider some of the major recommendations of the Australian Royal Commission Into Institutional Responses to Child Sexual Abuse, which have as their object the development and enforcement of such systems, and which are already catalysing reform of law, policy and practice.

Major Recommendations by the Royal Commission for Reform of Law, Policy and Practice

The Australian Royal Commission Into Institutional Responses to Child Sexual Abuse (the Royal Commission) delivered its Final Report in December 2017 (Royal Commission Into Institutional Responses to Child Sexual Abuse 2017a). This is the single most extensive Inquiry of its type ever undertaken, and its work contributes a historic, international legacy. It made 400 recommendations for legal, policy and practical reforms. Many of these are already beginning to be translated into civil law, criminal law, and policy and practice.

The Final Report in 17 Volumes The Final Report comprised 17 Volumes, devoted to specific issues, and specific contexts. Selected major recommendations include (Recommendation numbers in parentheses)[8]:

Volume 6 (Making institutions child safe): A national strategy to prevent child sexual abuse should be developed, overseen by a federal government office (6.1); that all CYSOs should implement the Child Safe Standards identified by the Royal Commission (6.4), as outlined in 6.5–6.14, requiring child and youth-serving organisations to take measures to improve prevention and response mechanisms; and that education ministers should establish a nationally consistent curriculum for online safety education in schools (6.19);

Volume 7 (Improving institutional responding and reporting):

Improve reporting by:

- Government-issued written guides for mandatory reporters (7.1)
- Provide mandated reporters with access to experts who can provide advice (7.2)

[8] Other Volumes with findings and recommendations not covered here are: Vol 8: Record-keeping and information sharing; Vol 9: advocacy, support and therapeutic treatment services; Vol 10: Children with harmful sexual behaviours; Vol 12: Contemporary out-of-home care; Vol 15: Contemporary detention environments; Vol 17: Beyond the Royal Commission.

- Amend mandatory reporting laws so there is national consistency in reporter groups, and add to existing laws the following groups: out-of-home care workers, youth justice workers, early childhood workers, psychologists and school counsellors, and people in religious ministry (7.3)
- Religious ministers should not be exempted from reporting where knowledge or suspicion is gained in confession (7.4)
- Mandatory reporting legislation should provide comprehensive protection for reporters, including from liability and reprisals (7.5)
- Amend legislation to protect those who make complaints or reports in good faith to any institution about CSA in the institution, or its responses to it (7.6)

Improve responding by:

- Under Child safe standard 6, having clear processes for responding to complaints that are child-centred (7.7)
- Under Child safe standard 1, having a clear Code of Conduct to embed in institutional leadership, governance and culture, clear expectations about acceptable and unacceptable behaviour, reporting requirements, and protections for reporters (7.8).

Improve oversight of institutions' handling of responses by:

- The enactment of nationally consistent "reportable conduct schemes", based on the New South Wales scheme, obliging heads of institutions to notify an external oversight body of any reportable allegation, conduct or conviction involving any of the institution's employees (7.9–7.12)

Volume 13 (Schools) should implement the Child Safe Standards (13.1), with a particular focus on boarding schools (13.3). Similarly, in Volume 14 (Sport, recreation, arts, culture, community and hobby groups), it was stated that these groups should implement the Child Safe Standards (14.1), and that independent State and territory oversight bodies implementing Child Safe Standards should establish free, efficient communications to provide resources to the sports and recreation groups (14.4)

Volume 16 (Religious institutions) applied extensive recommendations to all religious institutions, requiring that they:

- Implement the Child Safe Standards (16.31–16.42)
- Implement comprehensive education and training for candidates for religious ministry, including on policies and codes of conduct (16.43, 16.47), and for all other ministers, leaders and employees (16.50)
- Implement oversight and supervision (16.44–16.45)
- Screen, train and monitor those employed from overseas (16.46)
- Ensure any rite of confession be conducted in an open space within clear line of sight of another adult (16.48)

- Ensure any plausible complaint of child sexual abuse against a person in religious ministry should result in standing down of the person while the complaint is investigated (16.52)
- Ensure permanent removal from ministry of any person found to have inflicted sexual abuse on the balance of probabilities, or convicted of an offence (16.55)
- Ensure dismissal, deposition, or effective removal from ministry of any person convicted of an offence relating to child sexual abuse (16.56)

Special recommendations applied to the Catholic Church, as follows:

- Bishops of each diocese were to ensure parish priests are not the employers of principals and teachers in Catholic schools (16.6)
- The Australian Catholic Bishops Conference should conduct a national review of governance and management structures of dioceses and parishes to improve transparency, accountability, consultation, and participation of lay men and women (16.7)
- Multiple recommendations regarding celibacy changes and management, and screening of candidates (16.18–16.25)
- Request the Holy See to reform numerous aspects of the 1983 Code of Canon Law to (16.9–16.14):
  - Create a new series of canons so that all acts of child sexual abuse are designated as canonical crimes, and not as moral failings or breaches of celibacy
  - That this applies to any person holding a "dignity, office or responsibility" in the Church, whether ordained or not
  - Pornographic image crimes should refer to children aged under 18, not under 14
  - Ensure the "pontifical secret" does not apply to any aspect of allegations or canonical disciplinary processes relating to child sexual abuse (16.10)
  - Remove the "pastoral approach" as a precondition to action in sexual abuse cases
  - Retrospectively remove the time limit for commencement of canonical actions relating to child sexual abuse
  - Remove the "imputability test" so that a diagnosis of paedophilia is not relevant to prosecution and sentencing for child sexual abuse offences
  - Give effect to recommendatons 16.55 and 16.56

Redress, Civil Justice and Criminal Justice In other separate accompanying Reports, the Royal Commission had also made major reform recommendations. These included a range of recommendations in relation to Redress and Civil Litigation about (Recommendation numbers in parentheses):

- Implementing a national redress scheme (1–84)
- Removing the statute of limitations for civil claims for child sexual abuse, with retrospective and prospective effect, meaning that survivors can commence a civil lawsuit at any time after the event (85–88)

- Passing legislation to impose a non-delegable duty on selected institutions even where the act is a deliberate criminal act (89–90)
- Passing legislation to make all institutions legally liable unless it is proven they took reasonable steps to prevent the abuse (reverse onus legislation) (91–93)
- Passing legislation to ensure the Catholic church cannot evade liability due to its lack of juridical status and ensuring its property trust is a proper defendant to sue (94)
- Ensuring that institutions adopt model litigant guidelines when dealing with child sexual abuse claims (96–99)
- Passing special laws to prevent the Catholic Church exploiting a technical legal loophole and evading liability for the acts of its clergy and non-clergy offenders.[9]

Criminal Justice On criminal justice, the Royal Commission also made extensive recommendations on police responses (2–13); prosecution responses (37–43); evidence laws and procedures (44–63); judicial directions and jury management (64–71); sentencing reform (74–78); enhancing appeals capacity and performance (79–82). It also recommended abolition of any remaining statutes of limitations within states on criminal offences involving sexual abuse of children (30–31). It recommended the creation of new offences, including maintaining a sexual relationship (21–24), grooming (25–26), position of authority offences (27–29), failure to report (where an owner, manager, staff member or volunteer of an institution fails to report to police in circumstances where they know, suspect, or should have suspected that an adult associated with the institution was sexually abusing or had sexually abused a child) (33) with no exemption for religious confession (35); failure to protect a child (where an adult knows there is a substantial risk another "adult associated with the institution" will commit a sexual offence against a child under 16, or a child aged 16 or 17 if the "adult associated with the institution" is in a position of authority over the child, and the person has the power or responsibility to reduce or remove the risk and the person negligently fails to reduce or remove the risk (36).[10]

Summary The Royal Commission identified a range of problems in institutional settings, including insufficient education of personnel, inadequate institutional governance and external oversight, failure to report known and suspected cases. Some of the measures proposed to respond to these problems have application to both institutional and non-institutional settings. As the next part of this chapter will show, while many problems have been uncovered by the Royal Commission, its wide-ranging recommendations for reform have already begun to have considerable effect through legislative and policy change.

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[9] See for example Western Australia's Civil Liability Legislation Amendment (Child Sexual Abuse Actions) Act 2018; see also Victoria's Legal Identity of Defendants (Organisational Child Abuse) Bill 2018.

[10] Modelled on Victoria's s 49C.

Progress and Responses

Redress Schemes to Compensate Those Abused in Institutions

Redress Schemes Generally As seen later in this chapter, for multiple reasons including but not limited to the reliance by defendants on statutes of limitation, it can be impossible or extremely difficult for individuals who have experienced child sexual abuse in institutional settings to obtain compensation for their injuries through the civil legal system. Many jurisdictions that have accepted the widespread infliction of child sexual abuse in state and private institutional settings have adopted redress schemes to provide a survivor-centred alternative pathway to justice. Kathleen Daly, one of the world's leading redress scholars, reported recently that by January 2016, 15 jurisdictions had established redress schemes: Australia, Austria, Belgium, Canada, Germany, Iceland, Ireland, the Netherlands, New Zealand, Norway, Scotland, the States of Jersey, Sweden, Switzerland, and the US (Daly 2017). Within nations, redress schemes have frequently been established at state or provincial level, so that by January 2016, there were at least 35 schemes across a range of jurisdictions (Daly 2017). The legislative enactment of a redress scheme was a key recommendation of the Australian Royal Commission Into Institutional Responses to Child Sexual Abuse.

These schemes have been designed with different parameters in the various jurisdictions that have employed them, with significant differences involving claimant eligibility, the process of providing evidence of one's experience and injury, the amount of redress available as a whole, the amount of redress available to each individual claimant depending on their experiences and injuries, and the method of calculation of individuals' redress. However, all these schemes share similar rationales and purposes.

Redress Schemes aim to recognise and respond to the child sexual abuse of each individual in an entire class of individuals across a state or province, or indeed an entire nation, in one holistic scheme. They differ from conventional civil legal proceedings in that they are a less formal administrative process with different rules of procedure and evidence. They are more flexible and speedy, with less formality and cost, and less trauma and confrontation than conventional legal proceedings. Being an administrative process, redress schemes are concerned with establishing participant eligibility, and this does involve an element of demonstrating the experience of abuse in a relevant institution, and usually some evidence of the injuries caused; however, the process involves an informal procedure for establishing such eligibility and a significantly lower evidentiary standard than civil litigation. Especially when designed as a result of the findings of inquiries into historical abuse, a redress scheme may provide the only realistic option for justice when very substantial amounts of time have elapsed since the events, when witnesses and defendants have died, and when institutions may even have ceased to exist. Not all survivors will apply to the scheme, as many survivors do not wish to engage any further with any

institution responsible for their abuse, or with any process that reminds them of their experience. In addition, many survivors have no financial motivation. However, it is clear from the experience of survivors' involvement in these schemes that the level of participation far exceeds what otherwise occurs through the formal legal system.

Redress Schemes have additional features beyond those available in civil legal claims that aim to provide further meaningful amelioration of the impact of institutional child sexual abuse and related non-sexual abuse, and provide justice for survivors. Usually, they include the availability of formal group and individualised apologies, commitments to take steps to prevent re-occurrence of child sexual abuse within their institutions, rehabilitative services including counselling, and public memorials and commemorative activities (Daly 2014; Mathews 2004a). Such additional non-pecuniary features are widely considered essential therapeutic gestures, which are an essential part of a healing response.

A significant difference between redress schemes and civil legal claims is that redress schemes involve payments of "redress" rather than "compensation". This means that financial payments, while recognising the fact of abuse and the injuries and losses caused, and while recognising liability in fact, are not intended to replicate the amount of compensation payable under a formal civil compensation claim through calculation of the full quantum of damages taking into account all available legal heads of damage. As a result, payments of redress are far lower than payments of compensation through the courts. Accordingly, institutions that act ethically in taking responsibility for their acts and omissions, and that contribute financially to such schemes, ultimately benefit financially through a substantially lower pecuniary commitment than would be required through settlement or litigation of formal civil compensation claims. Also significant is that normally, the terms of acceptance of a redress payment require claimants to waive other rights to bring civil proceedings.

Nationally Established Independently Administered Schemes Compared with In-House Schemes In some instances, such as the Irish Scheme, and the anticipated Australian Scheme, Redress Schemes are established through national legislation and administered by a centralised secular authority that is independent from the institutions responsible from the abuse. Such schemes contain clear checks on abuses of power, prevent the likelihood of pressure and coercion, and preclude the provision of inappropriate advice about whether or not to accept the offer, and why. Often, other measures are built in to ensure transparency, accountability, reporting to an oversight body, and review of the scheme.

This is clearly far more appropriate than other in-house administrative schemes that have been established privately, without adequate design, without adequate and consistent measures regarding process and decision-making, without proper external oversight, and implemented by non-independent actors. There is clear evidence that these schemes have facilitated further egregious abuse of power, coerced acceptance of desultory amounts of redress, pressured waiver of rights to sue, forced

confidentiality agreements, and other breaches of administrative justice that have compounded the initial abuse.[11]

The Australian National Redress Scheme

The Australian Parliament has introduced legislation to create a national redress scheme in the wake of the findings and recommendations of the Royal Commission Into Institutional Responses to Child Sexual Abuse. At the time of writing, the Redress Scheme for Institutional Child Sexual Abuse Bill 2017 remains before Parliament, and is yet to receive the commitment of all States, Territories, and relevant organisations. The Royal Commission Into Institutional Responses to Child Sexual Abuse recommended that a national redress scheme be enacted and operational by 1 July 2017.[12] It recommended that the Scheme should have an upper cap of $200,000, with an average redress payment of $65,000. Under the bill, the Scheme's cap is $150,000, substantially below the recommendation, and even further below the average payment in Ireland of over €60,000, where the highest payment exceeded €300,000.[13] The Royal Commission recommended extensive measures for transparency and accountability (Rec 69) and counselling support (Recs 66–68).

As envisaged by the Royal Commission, the Australian scheme contains three elements. First, a monetary payment as tangible recognition of the wrong suffered by a survivor; second, access to counselling and psychological services (estimated at an average of A$5500 per person); and third, if requested, a direct personal response from the responsible institution(s), such as an apology. It is estimated tat the scheme may be open to an estimated 60,000 eligible claimants, with an overall maximum cost of approximately 4 billion.[14] Taking population difference into

[11] See for example Marr (2014) and the discussion of the Melbourne Response, established by Cardinal Pell in the Catholic Archdiocese of Melbourne, with an initial cap of $50,000. This was later slightly increased (first to $55,000, then to $75,000), but this process has been estimated to have saved the Catholic Church hundreds of millions of dollars. Pell's scheme was expedited at a time when the Australian Catholic Bishops' Conference was seeking to create a national scheme, named Towards Healing; this scheme did not cap the redress payment. See also the discussion of this in: Royal Commission Into Institutional Responses to Child Sexual Abuse (2015). Report of Case Study 16: The Melbourne Response; and Royal Commission Into Institutional Responses to Child Sexual Abuse (2015). Redress and Civil Litigation Report, including Part 11.6.

[12] Royal Commission Into Institutional Responses to Child Sexual Abuse (2015). Redress and Civil Litigation Report, Chapters 1–12, especially Chapters 10 and 11.

[13] Residential Institutions Redress Board. (2011). Annual Report of The Residential Institutions Redress Board 2011.

[14] The Royal Commission identified more than 4000 institutions where sexual abuse took place. The Commission estimated that almost 40,000 survivors were sexually abused in institutions run by non-government bodies such as those run by churches and charities, and 20,000 survivors were sexually abused in state and territory government institutions.

account, this is broadly comparable although somewhat less than the Irish scheme outlined below.

Other key aspects of the proposed Australian Scheme are:

- People are eligible to apply to the Scheme if they experienced sexual abuse in an institution while they were a child, before 1 July 2018.
- A lower evidentiary threshold applies, meaning that eligibility for a redress payment is assessed on whether there was "a reasonable likelihood" the person suffered institutional sexual abuse as a child (reflecting Rec 56, Redress and Civil Litigation Report).
- Applicants who have received redress under another scheme or compensation through a settlement or court judgment are still eligible, but prior payments by the institution will be deducted from the amount of redress.
- Only one application can be made per person; if abused in more than one institution, the decision-maker can determine the appropriate share of each institution.
- Applicants can access legal assistance to help determine whether to accept an offer (reflecting Rec 64, Redress and Civil Litigation Report).
- A person who accepts an offer of redress must sign a deed of release, meaning the institution(s) responsible for the abuse will not be subject to other civil liability (Rec 63); but without confidentiality obligations (reflecting Rec 65, Redress and Civil Litigation Report).
- No income tax is levied on payments.
- Reviews of decisions are limited to internal review, and not to merits review or judicial review.
- Criminal liability of offenders is not affected.
- The Scheme is intended to open on 1 July 2018 and operate for 10 years; applications need to be made at least 12 months before the closing date of 30 June 2028.

By the end of May 2018, seven of Australia's eight state and territory governments had formally committed to the scheme.[15] The remaining government (Western Australia) and institutions must opt in and commit resources to discharge their duty. In March 2018, 3 months after the Final Report, former Commissioner Robert Fitzgerald condemned the Catholic Church for still failing to fully accept its responsibility for the abuse, and for inadequate responses to abuse survivors. Part of this criticism related to the Church's failure to commit to participate in the Australian federal government's redress scheme (Schneiders et al. 2018). In addition, the Church had actively misled the Royal Commission by grossly undervaluing its property portfolio; a media investigation found the Church held more than $30 billion in property and assets in Australia (Millar et al. 2018). After continued delays, the Prime Minister of Australia, Malcolm Turnbull, wrote personally to the Catholic Church, and other churches, to urge their immediate commitment to the scheme

[15] On 22 May 2018, the Tasmanian Government committed to join the Scheme. On 28 May 2018, the South Australian and Northern Territory governments also announced they would join the Scheme. Victoria, New South Wales, the Australian Capital Territory and Queensland had previously committed.

(Koziol 2018). The Catholic Church finally committed to the scheme on 30 May 2018. On Thursday 31 May 2018, the Anglican Church, Salvation Army, Scouts Australia and YMCA made a joint announcement committing to join the Scheme. To ensure the scheme does not fail, the Australian Government and state and territory governments should be the funder of last resort in all cases where the institution is unable to reimburse the Commonwealth.

The Irish Scheme The Irish Redress Scheme is arguably the most extensive yet implemented at a national level. It was established under the Residential Institutions Redress Act 2002. Section 5 of the Act sets out the functions of the Residential Institutions Redress Board. The first function was that of public information and transparency: to make all reasonable efforts, through public advertisement, direct correspondence and otherwise, to ensure that persons who were residents of an institution listed in the Act were made aware of the existence of the Board, so they could consider making an application for redress.

The Board's second function in each application is to determine whether the applicant is entitled to an award, and, if so, to make an award in accordance with the Act which is fair and reasonable having regard to the unique circumstances of the applicant.

The procedure followed by the Board for processing applications is prescribed by the Residential Institutions Redress Act 2002, as amended by subsesquent legislation.[16] All Regulations and the legislation were freely available to potential applicants from the Board's office and website. Applications for redress were submitted on a standard application form. The Board issued several accompanying documents to assist applicants and their advisors.[17] These publications provided information to applicants and their legal advisers so they knew what was involved in making an application. They informed the applicants what was involved in the process and what options weere available to them. They explaidn the difference between settlements and hearings and informed applicants what to expect when they arrived at the Board's offices. These were thorough, sensitive approaches to the individuals who wereeligible to make applications. Along with the Board's newsletters they also provided plain English information on costs and expenses, and on procedure at a hearing, and what the applicant could do after receiving an offer. In addition, the Board established a free, confidential and independent financial management service available to all award recipients. In addition, to further inform applicants, advisors and the public of the Board's activities and outcomes, the Board published regular newsletters and statements, and annual reports.

[16] Part 4 of the Commission to Inquire into Child Abuse (Amendment) Act, 2005, The Residential Institutions Redress (Amendment) Act 2011, The Residential Institutions Statutory Fund Act 2012 and by Regulations made by the Minister for Education and Skills in accordance with the Act.

[17] These were: A Guide to the Redress Scheme under the Residential Institutions Redress Act 2002; A Short Guide to the Redress Scheme under the Residential Institutions Redress Act 2002; The Residential Institutions Redress Board Guide to Hearing Procedures.

Number and Amounts of Awards The scheme adopted a method of calculating the amount of redress payable based on the severity of the abuse and injury suffered. The Board commenced making awards in May 2003. Where applications were refused, the reason was generally that the application was outside the Board's terms of reference as laid down in the 2002 Act due to the nature of the institution. Where applications were refused, the reason was generally that the application was outside the Board's terms of reference as laid down in the 2002 Act due to the nature of the institution.

By 31 December 2011, the Board had completed the process in 14,856 cases. This had resulted in 10,873 offers/awards made following settlement talks; 2613 awards made following hearings (12 awards were rejected by the applicant); 430 awards following Review; and 940 applications being withdrawn, refused or resulting in no award. The total awards made to 31st December 2011 amounted to €875.25million. The average value of awards was approximately €62,895, the largest award being €300,500.

A final 1 year extension to 31 December 2012 resulted in the Board having completed the process in 15,396 cases, with 11,197 offers following settlement talks; 2725 awards following hearings; 456 awards following Review; 16 applicants rejecting their awards; and 1018 applications being withdrawn, refused or resulting in no award. Overall, the average value of awards was €62,860, with the largest award being €300,500. Almost half the awards were in the range of €50,000 – €100,000. Table 5.1 provides a breakdown of the redress payments.

Child Safe Standards Legislation for CYSOs

In 2015, the Australian state of Victoria created a legislative scheme to implement a set of Child Safe Standards in a range of CYSOs. This scheme was embedded in the Child Wellbeing and Safety Act 2005, and established by Ministerial declaration on 31 December 2015 (Victoria Government Gazette G52). The standards were created as part of the state's response to the *Betrayal of Trust Inquiry* (Victorian Family and Community Development Committee, 2013), and are directed to all types of child

Table 5.1 Awards of redress under Ireland's Redress Scheme, 2003–2012

Redress Bands	Total Weightings for Severity of Abuse and Injury/Effects of Abuse	Award Payable by way of Redress	Number	Percentage (%)
V	70 or more	€200,000 – €300,000	43	0.30
IV	55–69	€150,000 – €200,000	261	1.82
III	40–54	€100,000 – €150,000	1954	13.59
II	25–39	€50,000 – €100,000	7018	48.81
I	Less than 25	Up to €50,000	5102	35.48
Total			**14,378**	**100.00**

maltreatment within CYSOs, going beyond CSA. The seven standards require CYSOs to: embed an organizational culture of child safety; create a child safe policy; create a code of conduct; screen, supervise and train staff; have processes for reporting and responding; have strategies to identify and reduce risk; and promote child participation.

The Child Safe Standards promoted by the Royal Commission (Rec. 6.4–6.11) are substantially embedded in legislation in several states, requiring organisations to adopt comprehensive measures to prevent, identify, and respond appropriately to child sexual abuse. The purposes are to:

- promote the safety of all children in these institutional settings;
- prevent child abuse; and
- ensure allegations of abuse are properly responded to.

In Victoria, for example, the Child Wellbeing and Safety Act Part 6, s 17 and the Ministerial Order, sets the following standards, which apply to CYSOs (education, early childhood education and care, out of home care, health, religious, cultural, sporting and recreation services, other welfare services)

- Standard 1: Strategies to embed an organisational culture of child safety, including through effective leadership arrangements
- Standard 2: A child safe policy or statement of commitment to child safety
- Standard 3: A code of conduct that establishes clear expectations for appropriate behaviour with children
- Standard 4: Screening, supervision, training and other HR practices that reduce the risk of child abuse by new and existing personnel
- Standard 5: Processes for responding to and reporting suspected child abuse
- Standard 6: Strategies to identify and reduce or remove risks of child abuse
- Standard 7: Strategies to promote the participation and empowerment of children.

The Child Wellbeing and Safety Act 2005 Part 6 makes oversight and enforcement of the Victorian child safe standards the responsibility of the Commission for Children and Young People. The Commission can take action to investigate whether an entity is complying with the standards – for example, by inspecting an institution or requesting information. The Commission can then take the necessary steps to achieve compliance, such as by issuing a notice to comply or by seeking court orders. Funding authorities as well as sector regulators have a role in oversight and compliance, and the Commission has functions to educate and advise other regulators and funders about the child safe standards. The Commission's annual report should include information about compliance with the child safe standards.

These standards came into effect for the first phase of institutions in 2016, with full implementation from 2017. The standards are mandatory for a broad range of institutions working with children. The Commission for Children and Young People helps institutions comply with the standards. In some sectors, existing regulatory arrangements have been expanded to include monitoring of and compliance with

the standards. For example, in Victorian schools, the standards have been incorporated into school registration requirements.

The Commission for Children and Young People has an essential role in this field and much depends on how well it discharges its role. The Commission must:

- educate and provide advice to CYSO authorities to promote compliance within CYSOs
- educate and advise CYSOs
- oversee and enforce compliance by CYSOs (e.g., inspections, audits, notices to comply, penalties for non-compliance)
- promote continuous improvement in CYSOs.

Victoria's legislative scheme therefore includes enforcement and oversight measures, but remains a model of co-regulation model rather than direct regulation. This is because, while other materials provide further abstract detail about what the standards should achieve and how they could be implemented, the scheme requires CYSOs to create their own substantive approaches to each requirement, rather than having all or some of the requirements centrally prescribed and administered. As a result, the scheme may face challenges in ensuring consistent quality of design, fragmentation within and across CYSOs, duplication of cost, and difficulties in implementation.

Several other jurisdictions in Australia have since made changes in this area, but these have taken different forms. For example, at the time of writing, in New South Wales, in September 2017, the Children's Guardian published non-prescriptive "Principles for Child-Safe Organisations" which were informed by the findings of the Royal Commission into Institutional Responses to Child Sexual Abuse. In Western Australia, the Commission for Children and Young People developed the "Child Safe Organisations WA: Guidelines" in April 2016, informed by the Interim Report (2014) of the Royal Commission into Institutional Responses to Child Sexual Abuse. South Australia had a weaker legislative scheme.

As discussed in Mathews (2017), different models of regulation and implementation of complex systemic responses in diverse CYSO settings all present challenges. Models of pure organisational self-regulation with no direct or indirect influence by the state have been shown by the weight of history to be unsustainable. Co-regulation, as exemplified by the current Victorian model, offers some benefits, but also contains risks. Direct regulation, where there is greater direction by the state about not only what standards exist, but what their precise nature must be, may offer superior quality, cost-efficiency, and efficacy, but faces challenges of responding to situational differences and attracting CYSO commitment and buy-in.

Yet, some dimensions of the Child Safe Standards may perhaps more readily be the subject of direct regulation, with others more suited to co-regulation (Mathews 2017). For example, legislative reporting duties apply state-wide, meaning CYSO policies about reporting could readily be designed robustly, with expert input, and made applicable state-wide to virtually all CYSOs. Similarly, the core elements of a code of conduct could be promulgated to ensure prohibitions on high-risk contexts are clear and universal, and situations of the highest risk are avoided, while allowing

for modifications to suit the nature of the CYSO's activities and the local context. Common approaches to these matters could arguably be developed through a process of consultation and consensus-building with community partners. A centralized approach to some important components would enable enormous savings of cost and time, ensure higher scientific quality, and would relieve organizations of the requirement to generate their own approaches to matters that can be designed by a central, specialized authority. Finally, education programs in CSA involve common principles (definition of CSA; its prevalence; its criminality; its serious consequences; who experiences it, and at what ages; who inflicts it; the tendency towards nondisclosure; children's truthfulness in disclosure; the indicators of CSA: boundary violations; children's typical emotional, social and behavioural responses after victimization). A high quality training program could be designed through a robust process of expert development, and delivered economically online. CSA education programs directed towards professionals serving children and youth have shown positive effects on knowledge, attitudinal dispositions, preventative behavior and reporting (Letourneau et al. 2016; Rheingold et al. 2015). In their best form, some aspects of education are arguably connected with cultural development through genuine change to individuals' empathic concern, especially amongst CYSO leaders, and these aspects of education may be the most challenging to achieve given their complexity (Mathews and Collin-Vézina 2016). However, such efforts are required if society and its key institutions are to meet the social justice concern of public health, and to garner effective participation from relevant communities and their leaders.

As with any policy response, whether a jurisdiction adopts a model of direct regulation, co-regulation, or self-regulation by CYSOs in the prevention and response to CSA, limitations may become apparent, and a robust public health approach should identify these by monitoring outcomes, with refinements made through a commitment to ongoing review and improvement (Mercy et al. 1993). With any direct regulation or co-regulation, challenges include the attraction of genuine commitment to change and oversight, especially amongst organizational leaders. Reassuring stakeholders about the precise nature, extent and practicability of any new policy measure, and of how it strengthens their organization, is an important part of recruiting and retaining participation by CYSOs and the development of authentic commitment. A multi-dimensional model of child safety in CYSOs, especially within those presenting higher risk to children because of the nature of their activities, can be generated as a cooperative and supportive exercise to reduce the likelihood of CSA in CYSOs, enhance its identification, and end active concealment of known cases. Ultimately, such an approach may help to develop and embed new social norms and cultural shifts which promote the fundamental aim of reducing suffering and enhancing social justice.

These kinds of organisational approaches can be one part of a broader social response to child sexual abuse. Other dimensions of legal systems are aimed at ensuring appropriate reports are made of known and suspected allegations, both within and beyond organisational settings. This focus on reporting overlaps with one of the elements of the Child Safe Standards outlined above, but as we will now

see, a jurisdiction's legal duties to report known and suspected cases of child sexual abuse can take different forms. Common to all these reporting duties is the objective of interrupting cases of child sexual abuse at an early stage, which can have other potential benefits; this responds to the child's most urgent need, which is for the abuse to stop. However, further significance lies in how these different reporting duties apply to different settings, both individual and organisational, in the consequences for individuals and their employers when the duties are breached, and in how these duties could perhaps be better implemented and or modified to encourage better outcomes, especially in cases of the most egregious malfeasance.

Duties to Report Child Sexual Abuse: A Common Law Duty; Occupational Policy-Based Duties; Reporting Duties in Criminal Law; Legislative Reportable Conduct Schemes; Legislative Mandatory Reporting Laws

Legal systems have created different kinds of duties to report known cases of child sexual abuse, and suspected cases of child sexual abuse. These duties have several common rationales. Especially when they are in criminal law, these duties are imposed to recognise that citizens have a duty to assist police and the state in the detection of serious crimes, and a similar duty not to engage in acts or omissions to impede detection of the offender. As well, they overcome the human tendency towards official corruption, especially in instances of child sexual abuse within organisations. When imposed in civil laws, such as in mandatory reporting legislation, and reportable conduct schemes, they are imposed primarily to avoid the phenomenon of gaze aversion, the strong tendency for people to look the other way and avoid acting even when confronted with clear evidence of serious wrongdoing. In both cases, when applied to child sexual abuse offences, these duties to report also recognise that the phenomenon occurs in secret, is likely to remain hidden, and the child is unable or unlikely to seek assistance. In all these cases, the essence of the duty to report is based on ethical principles requiring the taking of action to prevent harm to a vulnerable child who cannot protect herself or himself.

Impediments to disclosure by the child are well-known in all contexts of sexual abuse, including organisational contexts, and have been discussed earlier in this book. Some of these impediments are derived from the child's attributes (e.g., not knowing that what is being done to them is wrong); others relate to the offender (e.g., where threats are made to the child). However, there may be particularly powerful barriers to disclosure that are presented by the organisational context. Connected to this, in toxic organisational environments there may be powerful cultural factors which also discourage reporting by employees or volunteers who suspect or even know of child sexual abuse. These situations have been uncovered in multiple jurisdictions and in numerous organisational contexts. Because reporting of unethical conduct by employees require strong ethical leadership and trust in the

organisation's leaders, as well as a culture of ethical behaviour at the employee level, efforts to prevent and neutralise such cultural postures likely require systematic multi-stage interventions, sustained over time.

For these reasons, numerous public inquiries have repeatedly endorsed the use of mandatory reporting laws for child sexual abuse (Mathews 2013). Recently, for example, the Protecting Victoria's Vulnerable Children Inquiry investigated systemic problems in Victoria's child protection and services system (Cummins et al. 2012) recommended the expansion of mandatory reporting duties to further professional groups (p. 349) and amendment of the Crimes Act 1958 to require the reporting by any religious minister, office-holder, employee, member or volunteer of a religious or spiritual organisation providing services to children of a reasonable suspicion of physical or sexual abuse of a child committed by an individual in a religious or spiritual organisation (p. 355). In addition, Australia's Royal Commission (2017) recommended the harmonisation of all Australian state and territory mandatory reporting laws so that a common minimum range of professional groups are designated as mandated reporters across the country (Rec. 7.3).

It is instructive to provide some further detail about these formal legislative reporting duties. Before doing do, we can briefly note other legal and policy-based reporting duties that may coexist with these legal duties, but take different forms and are accompanied by different systemic structures and enforcement measures.

Duties Based in the Common Law In many common law jurisdictions, there will be a duty to take action based in the common law of negligence (Mathews et al. 2009b). Here, depending on the circumstances, an individual (and especially one who has a professionally-based duty to take care of the child, such as a teacher) will have a duty to take reasonable steps to prevent further harm to a child where the person knows or ought to have known, or even has a reasonable suspicion, that a child in their care has been sexually abused. If this duty to act – which can be practicably fulfilled by reporting the suspicion to the relevant department of child protection – is breached by not taking any action, and if the child then suffers further harm through further abuse for example, then the teacher will be deemed to have breached their duty of care to the child. Through the principle of vicarious liability, the teacher's employer would be liable for the teacher's negligence, as occurred, for example, in AB v Victoria (Unreported, Supreme Court of Victoria, Gillard J, 15 June 2000), and as has occurred in medical settings in Canada in Brown v University of Alberta Hospital (1997) 145 DLR 4th 63, and in the USA in Landeros v Flood (1976) 551 P 2d 389.

This common law duty can co-exist with other legislative reporting duties in a jurisdiction which has legislative reporting duties, providing multiple different causes of action, having different ultimate purposes. However, its presence also means that in a common law jurisdiction that does not have a legislative reporting duty (in criminal law, mandatory reporting laws, or both), there can still be a similar substantive legal duty to report. This was discussed by Mathews et al. (2009b) in further detail in the context of medical practitioners in the UK. In the UK, there is no legislative mandatory reporting duty to report child sexual abuse, nor is there

such a duty sourced in criminal law. However, in JD v East Berkshire Community Health NHS Trust & Ors [2005] UKHL 23, the House of Lords held that where a paediatrician suspects child abuse:

1. the paediatrician owes a legal duty of care to the child;
2. there is no competing duty owed to the child's parents, so if a report of suspected abuse is unproven the parents cannot sue for negligence;
3. the proper protection for a parent is that the paediatrician's investigations be conducted in good faith.

This meant that doctors had a common law duty of care towards the child, which took priority over any duty owed to the child's parent. In cases where a doctor suspects child sexual abuse, that duty should be discharged by taking appropriate steps to protect the child from further abuse, which could involve making a report to the relevant government child protect agency. Similar common law principles have been set down in Australia by the High Court in Sullivan v Moody (2001) 207 CLR 562. In 2007, confusion over the situation in England led the Department for Children, Schools and Families and the Department of Health to jointly release a statement of advice supporting paediatricians in England and Wales and clarifying the legal position if parents were to complain. An accompanying letter recognised concerns about parents' complaints but urged that this "should not deter anyone from reporting suspected cases of child abuse provided they have acted in good faith".

Duties Based in Occupational Policy Similarly, a distinct policy-based reporting duty may exist for individuals in a particular occupation. Teachers, doctors, nurses and police, for example, will commonly have professional duties and protocols set out, which will include duties in relation to known and suspected cases of child sexual abuse they encounter in the course of their work. A failure to comply with these occupational policy duties may create liability under industrial policy, such as professional disciplinary measures, as well as other forms of legal liability (Mathews et al. 2008a).

The relevance of both these kinds of duties is that they may exist even in jurisdictions where the more formal reporting duties outlined below are entirely absent, or are not as extensive. Accordingly, for example, even if a jurisdiction has no legislative mandatory reporting law, and no criminal law duty to report child sexual abuse, there may be other duties that require the same kind of action to be taken.

Reporting Duties in Criminal Law

Reporting duties in criminal law can have a unique impact due to their special character and consequences. Legislation can impose a special kind of reporting duty in criminal law, effectively requiring all adults who have knowledge or belief that child sexual abuse has been committed to report this to the police. In Australia, these

duties exist in New South Wales (implicitly through the Crimes Act 1900 s 316), and Victoria, expressly through the Crimes Act 1958 s 327.

Victoria By way of example, in Victoria the Crimes Act 1958 s 327 expressly makes it an offence to fail to disclose a sexual offence committed against a child under the age of 16 years. Section 327(2) requires an adult "who has information that leads the person to form a reasonable belief that a sexual offence has been committed in Victoria against a child under the age of 16 years by another person of or over the age of 18 years" to disclose the information to a police officer as soon as it is practicable to do so, unless they have a reasonable excuse. The provision contains several exceptions, and provides protections from liability for those who make disclosures. The maximum penalty is 3 years imprisonment. This provision was inserted in 2014, in response to the Betrayal of Trust Inquiry's recommendation.[18]

New Additional Reporting Duties: Failure by a Person in Authority to Protect a Child from a Sexual Offence Victoria also has enacted a new additional reporting duty applied specifically to those in management roles in organizations, requiring them to report to police a known risk to a child of sexual abuse by someone in the organization (Crimes Act 1958 (Vic) s 49O).[19] The new duty in s 49O is extremely significant and aims to prevent and punish gross malfeasance in failing to respond appropriately to protect a child in cases of known risk.

A paraphrasing of key parts of s 49O shows its intent and effect (my italics):

Failure by a person in authority to protect a child from a sexual offence
(1) A person (A) commits an offence if—
(a) A occupies a position within, or in relation to, a relevant organisation; and (b) there is a substantial risk that a relevant child will become the victim of a sexual offence committed by another person who is—(i) 18 years of age or more; and (ii) a person associated with the relevant organisation; and
(c) A knows that the risk exists; and
(d) A, by reason of A's position, has the power or responsibility to reduce or remove that risk; and.
(e) A negligently fails to reduce or remove that risk. …
(3) a person negligently fails to reduce or remove a risk if that failure involves *a great falling short of the standard of care that a reasonable person would exercise in the circumstances*. …
(4) For the avoidance of doubt, in a prosecution for an offence against subsection (1), it is not necessary to prove that a sexual offence has been committed.

A Grooming Offence At the same time as this provision was enacted, Victoria also created a new criminal offence of grooming, making it unlawful for an adult to communicate with a child aged under 16 with the intention that the communication

[18] Inserted by the Crimes Amendment (Protection of Children) Act 2014.

[19] In s 49O(7), a *relevant organisation* means— (a) an organisation that exercises care, supervision or authority over children, whether as its primary function or otherwise, and includes but is not limited to— (i) a church; and (ii) a religious body; and (iii) a school; and 11 other types of child and youth serving organisations.

facilitate the child engaging or being involved in the commission of a sexual offence (Crimes Act 1958 s 49M). Victoria's reforms to these criminal law reporting duties were a response to recommendations of its Betrayal of Trust Inquiry (Victorian Family and Community Development Committee, 2013), which found religious organisations had made grossly inadequate responses to cases of child sexual abuse.

New South Wales The current New South Wales benchmark provision (s 316) makes it an offence to conceal a serious indictable offence. Section 316 requires a person who "knows or believes" a serious indictable offence has been committed and "has information which might be of material assistance" in securing the apprehension, prosecution or conviction of the offender must "bring that information to the attention of a member of the Police Force or other appropriate authority". The maximum penalty is 2 years imprisonment. This does not expressly apply to sexual offences against children under 16, but has this consequential effect through the operation of associated definitions and provisions.

New Additional Reporting Duties New South Wales is now in the process of enacting new additional reporting duties similar to those in Victoria, regarding failure by a person in authority to protect a child from a sexual offence, failure by any adult to report a sexual offence involving a child aged under 16, and a grooming offence.[20] These new duties respond to recommendations made by the Royal Commission, as outlined above. The New South Wales Government announced in 2018 that it is making extensive reforms to implement more than 50 recommendations of the Royal Commission, including the these new offences.[21]

Prosecutions The benchmark provisions in New South Wales (s 316) and Victoria (s 327) can be used to prosecute cases where the failure to comply with the duty happened long ago, because in Australia there is no statute of limitations on criminal prosecutions for offences of this nature (Mathews 2003). It is apposite to note that because of the high standard of proof in criminal prosecutions, the difficulties of proving states of mind, and the reluctance of many to bring criminal complaints in such cases, it is rare for a prosecution to be commenced. Nevertheless, especially in cases where clear evidence is present, and egregious misconduct through omissions is apparent these provisions are an important acknowledgment of citizens' duties in society in circumstances of known serious criminal offending. A finding of guilt is possible, provided there is sufficient evidence to meet the normal criminal standard

[20] New South Wales Government, Press Release, 3 April 2018, Holding child sex abusers to account.

[21] Other developments include: legislating a maximum life sentence for a strengthened offence of persistent child sexual abuse; requiring courts sentencing historic child sexual assault offences to apply current sentencing standards and the present understanding about the lifelong effects of sexual abuse on children; requiring courts not to take into account an offender's good character when sentencing for historic offences where their reputation facilitated the offending; and introducing a new offence of grooming an adult to access a child and strengthening the grooming offence to include providing a child with gifts or money.

of proof that that the offence is proven beyond reasonable doubt. Because of this precise kind of criminal law duty and offence, the New South Wales provision was able to be used in a ground-breaking case in 2018 to convict the most senior Catholic clergy member worldwide ever prosecuted for this offence.

The Prosecution of Archbishop Wilson In May 2018, Philip Wilson, the archbishop of Adelaide, was found guilty of concealing his knowledge of child sexual abuse committed by a priest named James Fletcher against two altar boys in the 1970s (Khan 2018). Fletcher had earlier been found guilty of nine counts of child sexual abuse and died in prison in 2006. Wilson now awaits sentence. Wilson claimed he could not remember either boy telling him they were abused, and his counsel argued there was no evidence to prove the archbishop was told about the abuse, believed it was true, or remembered being told about it. However, the Court believed the testimony of Peter Creigh, one of the altar boys. Mr. Creigh testified that he had trusted that Wilson, who at the time was an assistant priest, would take appropriate action after he told him that Fletcher had abused him repeatedly in 1971 when he was 10. He testified that Wilson had a "look of horror" on his face when he heard this, but took no action and did not tell police. The other former altar boy said he went to confession in 1976 when he was aged 11, and told Wilson that Fletcher had abused him. He testified that Wilson refused to believe him because Fletcher "was a good bloke", and ordered the boy out of the confessional with a demand to say 10 Hail Mary prayers as an act of contrition.

Archbishop Wilson exhausted every legal avenue before the case came to trial. He made several attempts to have the case dismissed on technical grounds, and all failed. On 12 February 2015, in the Local Court, Stone LCM refused an application to quash or permanently stay a court attendance notice, in which it was alleged that in 2004–2006 the Archbishop committed an offence under s 316(1) of the Crimes Act 1900 (NSW) (concealing a serious indictable offence) in connection with a sexual assault of a 10 year old boy by another priest in 1971. Then, in Wilson v Department of Public Prosecutions (NSW) [2016] NSWSC 1458, Archbishop Wilson sought leave to appeal this decision by Stone LCM. Schmidt J granted leave to appeal the decision, but dismissed the appeal. This decision by Schmidt J was also then appealed, to the New South Wales Court of Appeal (Wilson v Director of Public Prosecutions (NSW) [2017] NSWCA 128). The issue before the Court was whether at the time Wilson was alleged to have withheld information relevant to Father Fletcher's alleged offence, s 81 (indecent assault on male) was a "serious indictable offence" within the meaning of the Crimes Act s 4. The Court of Appeal dismissed the appeal.

Finally on this point, two other related kinds of criminal law offences can be noted. First, in Queensland, it is an offence to "compound" an indictable offence committed by another person. The Criminal Code s 133 states that a person commits an offence if he "asks for, receives, or obtains, or agrees or attempts to receive or obtain, any property or benefit of any kind for himself, herself or any other person, upon any agreement or understanding that the person will compound or conceal an

indictable offence, or will abstain from, discontinue, or delay, a prosecution for an indictable offence, or will withhold any evidence thereof." This offence has a broad scope, due to its references to simply "receiving" any "benefit of any kind" on any "understanding" that he will conceal an offence or withhold evidence about it.

Second, a standard group of criminal offences in common law jurisdictions provide for accessorial liability. These offences create liability in three categories beyond those who actually commit the relevant act. First, any person who aids the principal offender will also be deemed liable for the offence (e.g., Criminal Code (Qld) s 7(1)(c)). Notably, while aiding is usually constituted by positive acts, it can also be constituted in some jurisdictions by a mere calculated presence which is meant to encourage the principal offender (R v Beck [1990] Qd R 30). Second, those who solicit or procure the offence, but who themselves do not actually commit it, will also be deemed liable for it (e.g., Criminal Code (Qld) s 7(1)(d)). Third, those who are "accessories after the fact" in assisting the primary offender to evade liability, will also be deemed liable (e.g., Criminal Code (Qld) s 10). All these categories of liability extend the reach of the criminal law to ensure those who bear sufficient responsibility and culpability for criminal offending are not permitted to evade liability.

Significance in Organisations Including the Catholic Church The significance of these kinds of criminal offences are particularly notable in the context of any organisation that issues a policy directive to its employees or members not to report known cases and suspected cases to the police. This is even more clearly egregious in cases of known abuse; and it is even more heinous in cases of severe, prolific offending. Plainly, the Roman Catholic Church is the most prominent organisation that issues such a directive. As explained by Robertson (2010) and Tapsell (2014), the Catholic Church's official policy in this regard is sourced in its "canon law" provisions and associated procedural rules prescribed in the 1962 *Crimen Sollicitationis*. Canon law is, to say the least, confusing, and was described by the eminent human rights jurist Geoffrey Robertson (2010, p. 44) as a "mish-mash of divine law (dogmatic moral truths); ecclesiastical law (internal church rules, for example about priestly celibacy) and civil law." However, the core principles of this organisation's policy in this context are sufficiently clear, and their strict observance by clergy is required and enforced by threat of discipline and expulsion, and more immediately and effectively, more subtle methods of career destruction. Most significantly, the relevant principles are that (Robertson 2010; Tapsell 2014):

- The first and paramount obligation is to maintain secrecy regarding any allegation, so as to avoid scandal in the community and damage to the reputation of the Church;
- This obligation of secrecy applies to the accuser, the accused, and all involved in the process, and is enforced by the severest of penalties including excommunication;
- Any proceeding in relation to an allegation must be kept secret;

- The overarching purpose of any proceeding that does occur under Crimen is to maintain secrecy around the entire process and its outcome
- Any proceeding is intended to be restricted to a private internal forum – conducted by priests and presided over by a bishop – therefore lacking impartiality and independence, and further using a mechanism lacking all due process;
- The decision process has the paramount priority of preservation of the clergy member's standing – and thereby that of the Church – and use of the least intrusive punishment possible;
- There is no or virtually no concern regarding the immediate child victim, other past or present child victims of the offender, or other future potential victims of the offender.

In addition, despite several misleading claims to the contrary in recent years, the Catholic Church has not changed its law or ordered its clergy to report cases to domestic authorities (Marr 2014; Robertson 2010). Informal statements, such as Pope Benedict's in 2010, saying "Civil law concerning reporting of crimes to the appropriate authorities should always be followed", have not superseded canon law or Crimen procedure, and were in any case misleading because so few jurisdictions actually have such a clear domestic reporting requirement, and those that do tend to be in countries with a relatively low Catholic population.

In sum, these principles in canon law do not in fact supersede domestic law, but are used by the Catholic Church to dictate what clergy must do to preserve their careers. The Catholic Church's extensive history of concealing even the most heinous prolific offenders, and the intentional concealment of their offending by transferring them between parishes and even countries, demonstrates the extreme level of compliance with these occupational requirements. The record of Church authorities knowingly permitting and facilitating the continued offending by compulsive, dangerous and violent sexual predators is extensive and egregious. It is difficult to conceive of more wrongful action than the conscious aiding of continued offending by those in senior positions in an organisation that holds itself out as a moral beacon. While many clergy have implored their local bishops to take proper action, and many others have resigned in disgust at such clearly unethical conduct, it is clear that there is a system of concealment throughout the structure of the organisation, perpetrated and facilitated and continued by those in extremely senior positions, and with silencing also permeating lower levels. The occupational rules, threat of career destruction, exile and even laicization, combines with self-interest to perpetuate this toxic cover-up.

Criminal Law Responses: The Need for Appropriate Criminal Responses for Leaders of Organisations; Sentencing of Dangerous Offenders Because of this, I recommend a special class of new criminal offences to properly recognise the depravity of this conduct, to provide more appropriate criminal punishment, to enable more meaningful criminal prosecution, and which may help to catalyse change. This approach has a legitimate conceptual basis in other branches of law; for example, breaches of important duties by company directors constitute more serious offences, with more severe punishments, to recognise their gravity, to

acknowledge their effect or potential effect on a wider population, and to encourage compliance. The new offences could be framed as several related offences covering:

- Active concealment by an office-bearer in an organisation of a known child sexual offence by a member of the organisation.
- Transfer by an office-bearer in an organisation of a known child sexual offender to another organisational unit.
- Failure by an office-bearer in an organisation to report known child sexual offences committed by a member of the organisation.
- Offences, and their penalties, could have a sliding scale, to accommodate situations where the concealed offending or the transferred offender involved more egregious child sexual offending.

Multiple instances of offending could constitute a circumstance of aggravation warranting even stronger penalties. The penalties could include long terms of imprisonment, as well as large financial penalties to express the egregiousness of the offence and the damage done or risked by the offending. The offences could also apply to both the principal offender, and to those who aided in the offence. Appropriate definitions of key terms could be added as necessary. For example, the concept of "knowledge" could embrace actual knowledge, constructive knowledge, and reasonable suspicion. The definition of "office-bearer" could clearly and non-exhaustively list all those covered. The concept of "child sexual offence" could be extensively detailed. In addition, notes in the legislation could provide non-exhaustive examples of what conduct will be covered by the offence.

Reportable Conduct Schemes

In Australia, the essence of some of these concepts are reflected in new legislative "reportable conduct schemes", although they are not comprehensively embedded. These schemes aim to ensure that where child sexual abuse occurs in CYSOs, the organisation takes appropriate steps to investigate, and reports the matter to an independent external oversight agency. This agency has powers to initiate its own investigation of particular matters that are brought to its attention, and other powers of audit and oversight.

A reportable conduct scheme has existed in New South Wales since 1998. Influenced by findings of the Victorian Betrayal of Trust Inquiry, and the Royal Commission, schemes have recently been enacted in 2015 in Victoria in the Child Wellbeing and Safety Act 2005 Part 5A, and in 2016 in the Australian Capital Territory in its Ombudsman Act 1989. These schemes aim to overcome malfeasance and conflicts of interest where agencies investigate CSA allegations against their own staff, and instead seek to create a culture of integrity, transparency, and accountability to external independent oversight. Heads of specified agencies are compelled

to notify an external independent agency of allegations involving their employees.[22]

This external independent agency, which, in Australia, depending on the jurisdiction, is the Ombudsman, or an oversight body such as a Commission for Children and Young People, is empowered to monitor investigations, and may in some circumstances conduct its own investigation. Movements towards transparency and accountability are evident in these schemes, but they require effective compliance by organisations, and robust oversight by the external agency. The task of encouraging compliance confronts many organisations and regulators in this and other contexts (Mathews 2017). The nature of organisations themselves can encourage or inhibit compliance (Palmer 2016; Yeung 2004). The task of monitoring and auditing CYSOs requires independence, expertise and resources, and must be supported by the availability and use of appropriate sanctions. Combined, the measures in this approach are consistent with insights from theory, and may in practice help to overcome many of the organizational, cultural, attitudinal and behavioural factors which have facilitated the infliction of CSA in CYSOs.

Other Australian jurisdictions are now in the process of implementing similar schemes, while some have expressed reservations. In 2016, at its 42nd meeting, the Council of Australian Governments (a committee of all eight state and territory governments) agreed, in-principle, to harmonise reportable conduct schemes in a form similar to the model in operation in New South Wales. At the time of writing, Queensland and Western Australia have taken steps to implement a reportable conduct scheme. The Northern Territory appears to have expressed in principle approval while expressing reservations about its cost. Tasmania appears to have expressed concern about the cost of implementation. South Australia has not indicated express support, and has indicated its current area of priority is in more fundamental reform of its overall child protection system.

[22] See for example the New South Wales scheme, set out in the Ombudsman Act 1974 Part 3A. Under s 25C, the head of a designated government or non-government agency is required to notify the Ombudsman of: (a) any reportable allegation, or reportable conviction, against an employee of the agency of which the head of the agency becomes aware; (b) whether or not the agency proposes to take any disciplinary or other action in relation to the employee and the reasons why it intends to take or not to take any such action; (c) any written submissions made to the head of the agency concerning any such allegation or conviction that the employee concerned wished to have considered in determining what (if any) disciplinary or other action should be taken in relation to the employee. Under s 25F, results of an investigation and the action taken or proposed to be taken must also be reported to the Ombudsman. The key investigative power possessed by the Ombudsman is in s 25G. This empowers the Ombudsman to conduct an investigation concerning any reportable allegation, or reportable conviction, against an employee of a designated government or non-government agency of which the Ombudsman has been notified under this Part or otherwise becomes aware. In addition, the Ombudsman may conduct an investigation concerning any inappropriate handling of or response to any such reportable allegation or reportable conviction, whether on the Ombudsman's own initiative or in response to a complaint.

Mandatory Reporting Laws

A separate category of reporting duty is present in what are commonly called "mandatory reporting laws". To avoid confusion, I will here refer to these as "legislative mandatory reporting laws" to reflect their origin, and to distinguish these duties from other common law duties, non-legislative occupational duties, criminal law reporting duties and other reporting duties discussed above, As shown by an extensive program of research (discussed below), these legislative reporting duties are theoretically warranted due to the hidden nature of child sexual abuse, are legally justifiable given their consistency with other legal duties, are ethically congruent with both bioethical principles and dignity and public health, are empirically successful given the findings of multiple studies about their outcomes, and are practically useful in assisting and protecting practitioners who bear the duty and in assisting the children they serve. However, because these duties are complex, differ in presence and nature across jurisdictions, and are situated and expressed in complex technical legislation, these duties are frequently misunderstood in theory and practice. This, and their significance in practice, means some discussion is warranted to explain their nature, their particular application in the context of sexual abuse, and their role within child protection systems.

Nature of Mandatory Reporting Laws

The prevalence and harmfulness of CSA, together with its hidden nature, presents a challenge for all societies from the perspectives of individual child safety, public health, social justice and crime prevention. One response adopted by many jurisdictions in an effort to identify cases that would otherwise remain hidden and liable to continue, has been to recruit as sentinels other adults who deal with children in their professional capacity and who are well-placed to detect signs of CSA or to receive disclosures. This strategy has been deployed most systematically through the use of legislative mandatory reporting laws, situated within child protection legislation, following the model of the original laws of this type which were created after identification of the Battered-child Syndrome by Kempe et al. (1962). Having this similar genesis, the laws are also intended to overcome the phenomenon of "gaze aversion", where those who know of or suspect serious child abuse choose to avert their attention and do nothing, leaving the child exposed and at risk, instead of reporting it to police, child protective services or other social welfare agencies.

These laws have been enacted in dozens of nations worldwide (Mathews 2014), including every single state, territory and province in the USA, Canada and Australia (Mathews and Kenny 2008; Mathews et al. 2009a). Most recently, they have been enacted in Ireland, with relevant provisions of the Children First Act (Part 3, ss 14–19) commencing on 11 December 2017. Within a country, the laws may differ across states and territories, so that depending on the jurisdiction, these reporting

duties may or may not extend to individuals in particular occupations (Mathews and Kenny 2008). There may also be differences in penalties and procedures, and in other technical aspects of the law.

However, the laws have common elements. Typically, the laws require designated professionals who deal with children in the course of their work (such as teachers, police, doctors and nurses) to report known and suspected cases of CSA by any person to government child protection agencies, or sometimes to police. Those who make reports are given protections from liability (in civil courts, criminal courts, and in administrative proceedings) provided the report is made in good faith. As well, reporters' anonymity is protected from disclosure. These laws will also provide that those who are not designated by the law as a mandated reporter are still empowered by these laws to make a report, and will receive the same protections as those conferred on mandated reporters.

The department for child protection which receives the report will then determine if the report contains sufficient information to require that the agency commence an investigation, or whether the report does not contain such information and can be screened out, or added to an existing file. An investigation can involve as little as telephone inquiries, but can sometimes extend to consultation with the child, the child's parents, and other involved professional. The agency will often has such as the child's teacher. The agency will often have dedicated specialised multidisciplinary teams to discharge this role. The child protection agency will involve and work with the police department in appropriate cases to discharge their respective functions. The child protection agency's statutory role is to protect the child, especially from familial maltreatment, and to take action to protect the child, provide health and rehabilitation services, and assistance to the family as needed. The primary beneficiary is the child and the child's family. Police are concerned with the investigation of criminal offending and enforcing the law on behalf of the State, and do not provide health or other rehabilitative services to the child or the family. Due to its nature, reports of suspected CSA will often involve an unknown offender, but in some cases may involve a known familial offender, or a known extra-familial offender.[23]

[23] It is axiomatic that modern child protection investigation teams must use all possible measures to avoid unnecessary distress and intrusion both during and after investigations. There is not a body of compelling and representative evidence about whether and to what extent investigations cause unavoidable trauma for children, parents and others, including for different types of maltreatment. The quantitative study in Iowa by Fryer et al. (1990) of 176 families with parents reported for abuse or neglect found that 74% of respondents rated their overall experience of the quality and impact of CPS service as either excellent or good, with satisfaction levels the same for both substantiated and unsubstantiated outcomes. Detailed analyses by Finkelhor et al. (1990) and Drake and Jonson-Reid (2007) have concluded there is no compelling empirical evidence that investigating unsubstantiated reports causes undue distress. Drake and Jonson-Reid (2007) found that a range of studies yielded a proportion of two thirds to three quarters of CPS clients being satisfied with the investigation process and services received, and concluded that "From the client's perspective, the common and much-repeated assertion that CPS is viewed negatively and is harmful to most families is simply wrong" (p. 357). It is also arguable that the need to protect children from such fundamental violations outweighs mere distress and intrusion (Finkelhor et al. 1990).

These legal reporting duties are intended to be only one part of a systematic approach to child protection, involving the education of mandated reporters and the resourcing of child welfare and law enforcement agencies including their response teams, to increase the identification of cases of CSA which otherwise would remain hidden. The overarching goal is clearly not to prevent the initial CSA, as this could only be the task of systematic primary prevention; accordingly, eradication of CSA is not the measure of policy success. Rather, the goal of a mandatory reporting system is to increase identification of cases of CSA and the facilitation of provision to children in need of assistance, thereby preventing further abuse of the child and possibly of other children, enabling health and safety responses for the child, and criminal justice responses to detect perpetrators.

Reasonable Expectations The creation of a legislative mandatory duty to report, together with professional education about the duty and the context of child sexual abuse, can be expected to better enable reports of appropriate cases and overcome reluctance and lack of awareness that otherwise suppress reporting activity. However, child sexual abuse occurs in secret and is not readily identified even by mandated professionals, and unreasonable expectations should not be formed about the capacity of reporters to suspect a case of CSA. Many behavioural indicators of CSA are consistent with innocent explanations or other childhood adversities. Most CSA leaves no physical evidence (Anderst et al. 2009; Heger et al. 2002), so even doctors who can physically examine a child may legitimately not detect indicators. Therefore, even where reporting laws exist, expectations must be tempered about the degree to which reports will be made, and the extent to which reports will turn

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Yet, small qualitative studies of the experience of mothers have identified both positive and negative experiences with CPS investigations and other systemic interactions, which indicate that at the very least, ongoing efforts are required to develop the required professional attributes and monitor investigators' practice. Plummer and Eastin (2007) conducted focus groups (n = 19) and a survey (n = 40) with mothers who themselves suspected their child had been sexually abused, and whose suspicions had been confirmed by a CPS process or other professional decision. While some mothers reported that CPS workers, police, therapists and attorneys were "very helpful", other responses indicated delays, unprofessional comments, and disrespectful treatment. In Norway, Softestad and Toverud (2012) interviewed 19 parents. Most welcomed professional involvement, but also reported problems with delay, variable professional competence, and in some cases severe emotional strain, especially in cases where the parent was suspected. There is a clear need for rigorous research, including mixed methods research going beyond small qualitative studies, into the experience of children, parents and families regarding investigation, to identify the nature and extent of adverse consequences, their causes, and how they can be ameliorated. This would be particularly useful for different kinds of maltreatment. The experiences and challenges of investigations for CSA may be less common as most investigated CSA reports will not focus on parental behaviour, whereas virtually all other maltreatment reports (neglect, physical abuse, psychological abuse) will relate to the parent's acts or omissions. Finally, some have argued that the cost of investigation and its impact on other areas of the child protection system is also an important consideration. Yet, Drake and Jonson-Reid (2007, 2015) have argued that the actual cost of investigating cases in the USA is an extremely small proportion of the child protection budget, "most likely below 10% of total costs, and possibly below 5%" (2015, p. 41). Others have concluded that in Australia mandatory reporting is not producing excessive rates of reports and investigations in relation to identified cases (Segal 2015).

out to involve CSA or other significant harm. Nevertheless, the laws do have as their primary goal the enhanced reporting of known and suspected cases where the abuse has already occurred.

Substantiation v Investigation of Child Sexual Abuse Reports A brief observation is warranted on official outcomes of cases reported to government agencies. Many cases that are reported to child protection systems do not result in a finding of being "substantiated", either because they are not investigated, or because they are investigated but cannot meet the agency requirements to meet substantiation (e.g., through lack of evidence of harm despite abuse, or through lack of evidence of abuse despite harm): (Cross and Casanueva 2009; Drake and Jonson-Reid 2007; Drake and Pandey 1996; Fallon et al. 2011; Kohl et al. 2009; Mathews 2012). However, a body of research in the USA into the outcomes of reports of all forms of abuse and neglect has consistently concluded that unsubstantiated reports do not differ markedly from substantiated reports in the child's behavioural and developmental outcomes and service need (Drake and Pandey 1996; Hussey et al. 2005; Kohl et al. 2009). Many reports of abuse and neglect that are investigated but unsubstantiated do involve abuse and provide opportunities for early intervention (Drake and Jonson-Reid 2007; Drake et al. 2003; Kohl et al. 2009). Numerically, more unsubstantiated reports result in provision of services than those that are substantiated (Drake and Jonson-Reid 2007). This research into reports of all forms of abuse and neglect taken as a whole, and their outcomes, has resulted in conclusions that the substantiation outcome is "a distinction without a difference" (Hussey et al. 2005), that it is "time to leave substantiation behind" (Kohl et al. 2009), and that "substantiation is a flawed measure of child maltreatment…policy and practice related to substantiation are due for a fresh appraisal" (Cross and Casanueva 2009).[24]

[24] These findings are likely related to the factors affecting agency capacity to substantiate a report, including: evidentiary thresholds for reaching a finding of substantiated; availability of evidence of harm even where there is sufficient evidence of abuse; availability of evidence of abuse even where there is sufficient evidence of harm. As well, reports may not be comprehensively investigated due to internal agency factors such as availability of personnel and resources, and multiple reports about the same child being recorded as one investigation. A limitation of this body of research is that, while some studies expressly include a proportion of CSA reports in their designs and others did not exclude CSA report outcomes from their findings (Cross and Casanueva 2009; Drake et al. 2003; Kohl et al. 2009), the strength of the application of these general findings to the subset of CSA reports is not entirely clear. It is plausible that these findings could apply to the subset of CSA reports, given that a report of suspected CSA is frequently based on the reporter observing the child's adverse health symptomatology, behaviour, and social context, with the child's symptomatology and hence health and welfare need as the basis of the report being unaltered even where the report is unsubstantiated. Nevertheless, further research into this question is necessary to clarify the situation. What seems clear is that there is not firm ground for concluding that when exploring trends in reporting and report outcomes, the sole measure of the "soundness" of a report of suspected CSA is whether it is substantiated. Outcomes such as actual service provision to the child, and perceived need for service provision even if this is unable to be provided, are among those that are also relevant.

Accordingly, it is not legitimate to solely rely on numbers and rates of "substantiated reports" as a proxy measure of a "valid" or worthwhile report of child sexual abuse.

A Program of Research on Legislative Mandatory Reporting Laws for Child Sexual Abuse

Researchers in Australia have conducted a program of research to consider trends in numbers of reports of child sexual abuse, the sources of these reports (stratifying by different mandated and non-mandated reporter group), and outcomes of those reports. These studies, both individually and taken as a whole, have shown the generally positive effects of these legislative mandatory reporting duties as applied to child sexual abuse.

1. A 10 year national study of trends in reports of child sexual abuse, comparing different states, and reporter groups (Mathews et al. 2015)
2. A 7 year study in the state of Western Australia comparing trends in numbers and outcomes of reports of child sexual abuse before and after the introduction of a mandatory reporting law (Mathews et al. 2016).
3. A 20 year study of reports of child sexual abuse in the state of Victoria, comparing trends in numbers and outcomes of reports for girls and boys (Mathews et al. 2017)
4. Comparison between similar jurisdictions, only one of which has a mandatory reporting law (Mathews 2014).

A 10 Year National Study of Trends in Reports of Child Sexual Abuse, Comparing Different States, and Reporter Groups Mathews et al. (2015) conducted a national study in Australia using government administrative data to examine reporting practices for all types of child abuse and neglect, by all mandated and non-mandated reporter groups, in each state and territory over a 10 year period. Most relevant to this book is the data on reporting of child sexual abuse. Analysis of these data examined: the total number and proportion of reports of CSA compared to other forms of maltreatment; the proportion of mandated reports of CSA to non-mandated reports of CSA; report outcomes; and variance over time.

It was found that:

- Across the nation, reports of CSA were approximately 10% of the total number of reports, by all reporter groups combined, of all types of child abuse and neglect (physical, sexual and emotional abuse, neglect, and exposure to domestic violence).
- Non-mandated reporters (e.g., family, neighbours, friends, non-professionals) make almost half of all CSA reports, and mandated reporters make slightly more than half.

- Mandated reports of CSA therefore accounted for approximately 5%–6% of all reports of all types of child abuse and neglect combined (physical, sexual and emotional abuse, neglect, and exposure to domestic violence).[25]
- In each state and territory, trends in numbers of reports of CSA varied across reporter groups. Police were the mandated group who make the most CSA reports (13%–29%), followed by teachers (13%–23%) and health personnel (doctors & nurses: 4%–15%).
- In each state and territory, trends in numbers of CSA reports varied slightly over time, but far less so than for other maltreatment types. Numbers of reports of CSA are relatively stable over time.
- Nationally, on the data provided,[26] there were 37,056 investigated reports[27] of CSA that resulted from reports from the four key mandated groups.
- Nationally, on the data provided, there were 40,698 substantiated reports of CSA over the decade (20,741 from the four major mandated groups, and 19,957 from other reporters; mandated reports therefore accounted for >50% of substantiated reports of CSA.
- When missing data was added, there was a national total for the decade of 64,717 substantiated reports of CSA from all sources, involving a slightly lower number of children; in total, this amounted to approximately one in 75 children, or 1.3% of children).

A 7 Year Study in the State of Western Australia Comparing Trends in Numbers and Outcomes of Reports of Child Sexual Abuse Before and After the Introduction of a Mandatory Reporting Law Another way to analyze the effect of a mandatory reporting law is to explore what happens to the number of CSA reports made, and their outcomes, after a jurisdiction introduces a mandatory reporting law for the first time. Mathews et al. (2016) reported the results of the first detailed exploration over a substantial period of time of the effect of introducing a mandatory reporting duty for CSA.

Western Australia did not have mandatory reporting laws for CSA or any other form of abuse or neglect until 1 January 2009, when the Children and Community Services Amendment (Reporting Sexual Abuse of Children) Act 2008 inserted new provisions into the Children and Community Services Act 2004. These new manda-

[25] For the purposes of the study, the researchers collated data on reports by the four major mandated reporter groups – police, teachers, doctors and nurses and grouped these as mandated reports. These four groups account for the overwhelming majority of all reports of CSA. The estimate is conservative in that for illustrative purposes, it counted as "mandated reports" reports by police even if the state legislation did not expressly designate police as mandated reporters (e.g., Queensland), or if the mandated reporting duty only commenced at some point in time during the ten year period (e.g., Western Australia, where the duty commenced on 1 January 2009).

[26] One small state provided data for 9 years; and one large state provided data for 3 years. Data on substantiated cases could be located for the 7 years in the large state from other sources, resulting in a further 24,019 CSA substantiations.

[27] Some jurisdictions have different approaches to counting reports and making decisions about whether or how to investigate, so that proportions of investigated reports varied.

tory reporting provisions applied only to child sexual abuse. Section 124B(1) set out the reporting duty, which required reports of a "belief on reasonable grounds" of past or presently occurring sexual abuse of a child aged under 18 years of age. The duty did not extend to belief about the likelihood of future CSA, such as grooming or other clear risk. The occupational groups required to report were doctors, nurses, midwives, police officers, and teachers. Such beliefs about the existence of CSA were required to be reported without any consideration of the extent or significance of the abuse or of the harm which may have been caused or which may be likely to be caused. Unusually, the term 'child sexual abuse' was defined, albeit non-exhaustively in s 5, as "sexual behaviour in circumstances where (a) the child is the subject of bribery, coercion, a threat, exploitation or violence; or (b) the child has less power than another person involved in the behaviour; or (c) there is a significant disparity in the developmental function or maturity of the child and another person involved in the behaviour". The term "sexual behaviour" was not defined. The penalty for failure to report was $6000 (s 124B(1)). Reports were required to be made to the Chief Executive Officer (CEO) of the Department, a person approved by the CEO, or a member of a class of persons approved by the CEO: s 124B(2), who then was required to give a copy of the report to the police: s 124D. In practice, reports are made to a Departmental telephone hotline and contact. Reports were required to contain specific details about the case: s 124C. The report could be written or oral but if oral, the reporter was required to make a written report as soon as practicable, with a penalty of $3000: s 124C. For all reports made in good faith, the reporter was given immunity from civil, criminal and administrative legal proceedings: s129. The reporter's identity was kept confidential (s 124F), with specified exemptions to permit the administration of justice.[28]

Three research questions were examined in this study (Mathews et al. 2016). First, we identified the change in numbers of reports of CSA after introduction of the mandatory reporting law for mandated reporters as a combined group, and for distinct groups of mandated reporters (and the rate of reports per 100,000 children). Second, we identified the change in numbers of investigated reports of CSA after introduction of the mandatory reporting law by mandated reporters as a combined group, and by distinct groups of mandated reporters (and the proportion of reports that were investigated). Third, we identified the change in numbers of substantiated reports of CSA after introduction of the mandatory reporting law by mandated

[28] The introduction of the duty did not constitute a single new factor in a pure social experiment. First, a policy-based reporting duty had existed for these professionals for many years, although there was evidence that it had been widely unrecognized (Mathews et al. 2009c). Second, a research study had been conducted with teachers in 2006–2008, which heightened awareness of CSA and spurred new teacher training efforts (Mathews et al. 2009c). Third, the issue of CSA had attracted media attention because of government inquiries into child abuse (Ford 2007) and debate over several years about the introduction of a reporting law (Mathews et al. 2009a). Fourth, some of the professions to be mandated had received further instruction about the duty prior to its commencement. Therefore, it could be expected that the public as a whole, and those in the mandated professions in particular, had a recent and heightened level of sensitization to CSA over the period before the introduction of the duty.

reporters as a combined group, and by distinct groups of mandated reporters (and the proportion of investigated reports that were substantiated).

We analyzed data about numbers and outcomes of reports by mandated reporters, for periods before the law (2006–2008) and after the law (2009–2012). Results indicate that the number of *reports* by mandated reporters of suspected child sexual abuse increased by a factor of 3.7, from an annual mean of 662 in the 3 year pre-law period to 2448 in the 4 year post-law period. The increase in the first two post-law years was contextually and statistically significant. Report numbers stabilized in 2010–2012, at one report per 210 children. The number of *investigated reports* increased threefold, from an annual mean of 451 in the pre-law period to 1363 in the post-law period. Significant decline in the proportion of mandated reports that were investigated in the first two post-law years suggested the new level of reporting and investigative need exceeded what was anticipated. However, a subsequent significant increase restored the pre-law proportion, suggesting systemic adaptive capacity. The number of *substantiated investigations* doubled, from an annual mean of 160 in the pre-law period to 327 in the post-law period, indicating that conservatively, twice as many sexually abused children were being identified.

These findings are consistent with other considerations of these trends by government inquiries. The Victorian Law Reform Commission (1988) found that doctors in Victoria (then without mandatory reporting) reported five to nine times fewer cases of CSA than their counterparts in jurisdictions having mandatory reporting. During debates in the Victorian Parliament (1993, p. 1384) it was observed that in a 12-month period, the State of Victoria (then without mandatory reporting) received almost five times fewer reports of CSA than the State of New South Wales, which had mandatory reporting. Even more starkly, one can note the position in Queensland, where in the 12 month period to 30 June 1981, only 13 complaints of 'incest' were reported and investigated; the year before that, there were eight reports, and the year before that, there were 14 (MacMillan and Jefferies 1981). Similar extremely low rates of reports of CSA have been noted in jurisdictions before the introduction of mandatory reporting laws (Mathews 2014).

A 20 Year Study of Reports of Child Sexual Abuse in the State of Victoria, Comparing Trends in Numbers and Outcomes of Reports for Girls and Boys Mathews et al. (2017) conducted a 20-year longitudinal time-trend analysis of government data to identify reporting trends and report outcomes for CSA in Victoria, Australia from 1993 to 2012. The study examined several key questions: trends in reports of suspected CSA, and their outcomes, for girls and boys over time; trends in reports and report outcomes stratified by different reporter group; and the effect of a mandatory reporting duty on reports of CSA over a 20 year period (Victoria introduced mandatory reporting in 1993).

The study made several significant findings:

- Results indicated a new sensitisation to CSA, especially for boys, although this trend was not stable over the 20 year period. A marked change occurred in the last 5 years, likely influenced by major social factors (including awareness raised

through government inquiries), and political and agency-related factors (including investment).

- Comparison revealed that from 1993 to 2012, the rate/100,000 of reports of boys increased 2.6-fold, whereas rate/100,000 of reports of girls increased 1.5-fold.
- Comparing sexes, with regards to the rate of reporting, in 1993, the sex ratio of girls to boys was 2:1, while by 2012 this ratio changed to 1.14:1 (almost parity).
- Numerically, reflecting contextual significance, for boys, there were 1356 reports in 1993 (1127 from non-mandated reporters and 229 from mandated reporters), and 3942 in 2012 (1657 from non-mandated reporters and 2285 from mandated reporters).
- Numerically, reflecting contextual significance, for girls, there were 2620 reports in 1993 (2119 from non-mandated reporters and 501 from mandated reporters), and 4280 in 2012 (1864 from non-mandated reporters and 2416 from mandated reporters).
- Reports by police and other mandated reporters accounted for the majority of the increase in reports over the 20-year period.
- Positive report outcomes (i.e. substantiations, findings of harm, and referral to services) increased twelve-fold for boys, and nearly five-fold for girls, indicating the increased levels of reports were based on actual clinical need.
- There were four trends over the 20 year period: an initial increase for 2 years after introduction of mandatory reporting; a period of stability for around 12 years; a decline for around 2 years likely connected to a change in agency practice only; and a dramatic increase in the last 4–5 years, likely influenced by major social factors (including awareness raised through government inquiries), and political and agency-related factors including investment in the agency.

Comparison Between Similar Jurisdictions, Only One of Which Has a Mandatory Reporting Law Mathews (2014) compared the experience of the Australian state of Victoria, and Ireland, two jurisdictions which are demographically and culturally similar and which had a virtually identical child population. The significant difference between the two jurisdictions was that only Victoria had a mandatory reporting law for child sexual abuse.

Analysis examined government data on the number, source and outcomes of reports of child sexual abuse from a single year. It was found that, as compared with Ireland (having no mandatory reporting), Victoria, which had mandatory reporting:

- received two times the number of reports of CSA (with 53% of these made by mandated reporters);
- identified 4.73 times the number of sexually abused children; and
- confirmed cases of CSA identified as a result of reports by mandated reporters were 2.5 times the entire amount identified by all reporters in Ireland.

A Final Note on Legislative Mandatory Reporting Laws for Child Sexual Abuse

In sum, there is a strong body of evidence indicating legislative mandatory reporting laws for child sexual abuse are sound in theory, required in practice, and empirically successful in identifying substantially more cases of sexual abuse than would otherwise occur. These reporting laws have also been supported in scholarly literature, especially for sexual abuse (Drake and Jonson-Reid 2015; Finkelhor 2005; Mathews and Bross 2008; Mathews 2012, 2015). In Australia, government inquiries have supported mandatory reporting of CSA as a necessary component of social policy, even after scrutinizing the validity of child protection systems and attempting to control expenditure (Carmody 2013; Cummins et al. 2012; Layton 2003; Wood 2008). Quantitative studies have shown that a mandatory reporting duty has been supported in diverse nations and professions, including by physicians in countries ranging from New Zealand (Rodriguez 2016), Singapore (Fung and Chow 1998), Taiwan (Lee et al. 2007); nurses in Australia (Mathews et al. 2008b) and Taiwan (Feng and Levine (2005), and psychologists in Canada (Beck and Ogloff 1995). A large qualitative study in Nepal also found strong support by health practitioners for a mandatory reporting duty (UNICEF Nepal, 2006).

While some have opposed mandatory reporting laws in general as applied to all child maltreatment (Hansen and Ainsworth 2013; Melton 2005), these claims have been strongly challenged (Drake and Jonson-Reid 2007; Mathews and Bross 2008), and moreover, no opponent has explicitly made such a claim in relation to mandatory reporting of CSA. There are at least three reasons for this. First, CSA is qualitatively very different from other instances of other types of maltreatment (Mathews 2014). Second, the well-established gap between the real and disclosed incidence of CSA nullifies any claim that case-finding is not a challenge. Third, reports of CSA to government agencies account for a very small proportion of all reports of child maltreatment, repelling any claim that CSA reports intolerably overwhelm child protection systems or divert resources from other priorities. Mandated reports of CSA across Australia over a 10 year period accounted for just 6% of all reports of child maltreatment from all reporter groups (Mathews et al. 2015), and USA annual data are similar (U.S. Department of Health and Human Services, 2009). A cautionary note may be made about social context. So, for example, in some extreme socioeconomic settings, such as a state that is war-torn, riven with social strife, or lacking in any semblance of a child protection system because of even more urgent priorities of subsistence, there may be no functional child protection agency to respond to reports; clearly, other kinds of response may be warranted. However, any society must be alert to the hidden phenomenon of child sexual abuse and is responsible for taking practicable steps to respond to it.

Other Civil Law Responses: Removing Unjust Barriers by Reforming Statutes of Limitation

Background: The Nature and Rationales for Statutes of Limitation

Statutes of limitation give plaintiffs in civil actions a designated time period in which the action should be commenced. These time limitation periods are animated by two broad policy considerations. As explained in Chap. 4, these policy reasons have been articulated by the highest courts in the USA, Canada and Australia. The primary justification is to secure a fair trial for the defendant by ensuring that defendants can draw on fresh and available evidence. The second consideration is the public interest in the prompt settlement of disputes, which is connected with the need to administer an efficient court system, and the general principles that defendants' lives should not be encumbered by the threat of claims about long-past events, and that plaintiffs should not slumber on their rights.

Adaptable Rules of Procedure, Not Conferring Substantive Rights on Defendants Expiry of a limitation period does not automatically terminate an entitlement to bring a claim. A defendant must consciously choose to elect to rely on the expiry of time to block the plaintiff's claim from proceeding. This was established by the High Court of Australia in *Commonwealth v Verwayen*,[29] where it was also held that time limits are simply procedural rules which do not automatically bar actions. Similarly, the Supreme Court of the United States has held that limitation laws are an adaptable policy statement rather than an intractable bright line barrier to litigation, and are simply rules of procedure, not substantive rights.[30]

Legislatures have further demonstrated that these laws are not an intractable bright line barrier to the bringing of a claim. For specified types of claims and injuries, some legislatures have removed limitation periods, based on an acknowledgment that these claims' special nature and context justifies different treatment allowing an action to be brought at any time. So, for example, time limits have been removed in Canada for multiple claims, including debt recovery,[31] and Australian state legislatures have removed time limits for claims for injuries from latent dust-related diseases.[32]

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[29] (1990) 170 CLR 394.

[30] *Chase Securities Corporation v Donaldson* 325 US 304 (1945).

[31] See for example Limitations Act, 2002, SO 2002, c 24, s 16.

[32] See for example the Limitation of Actions Act 1974 (Qld) s 11(2), and the Dust Diseases Tribunal Act 1989 (NSW) s 12A.

A Summary of the Reforms Recommended by, and Enacted Since, the Australian Royal Commission

Are conventional statutes of limitation a theoretically, ethically and practically legitimate approach by a legal system to civil claims for child sexual abuse? In Chapter 14 of its 2015 Civil Litigation and Redress Report, the Royal Commission considered whether Australian civil statutes of limitation were appropriate for civil claims for personal injuries arising out of child sexual abuse. There were several main features of the legislative context and practical operative background at the time that were particularly relevant. First, for civil claims for damages arising out of child sexual abuse, most Australian states and territories provided a standard limitation period that applied to any personal injury claim; this translated to 3 years post-majority, which then equates to age 21. There were some exceptions to this in several states that had provided for longer time periods in cases where the abuser was a parent or a close associate of the child's parent (Mathews 2003, 2004b).

Second, while it was technically possible to seek an extension of time due to recent discovery of a decisive material fact – such as the nature or extent of the injury, or the connection of the injury with the abuse suffered – and while some plaintiffs had been granted such an extension,[33] this process was costly, lengthy, and frequently vigorously defended by powerful defendants, including Churches and governments.[34] In addition, Australian courts had often rejected such an application to extend time, based on alternative grounds of either failing to take reasonable steps to ascertain the relevant facts, or due to a residual discretion available to the court, and how that discretion had been applied (Mathews 2003, 2004b; Sarmas 2008).[35]

Further, in many claims, the defendant is a government or one of its agencies, such as a department of education. This is significant because when governments are involved in litigation as defendants, there is a public policy principle that they should conduct themselves as a "model litigant". The model litigant principle requires governments not to rely on legal technicalities to deny a plaintiff who has a sound claim supported by compelling evidence. The model litigant principle has

[33] See for example in Australia the cases of *GGG v YYY* [2011] VSC 429; *NF v State of Queensland* [2005] QCA 110; *State of Queensland v RAF* [2010] QCA 332.

[34] In Australia, examples include *A, DC v Prince Alfred College Inc* [2015] SASC 12; *Carter v Corporation of the Sisters of Mercy of the Diocese of Rockhampton* [2001] QCA 335; *Ellis v Pell* [2006] NSWSC 109; *Hopkins v State of Queensland*[2004] QDC 021 (Unreported, McGill J, 24 February 2004); *HWC v The Corporation of the Synod of the Diocese of Brisbane* [2009] QCA 168; *NF v State of Queensland* [2005] QCA 110; *Salvation Army v Rundle* [2008] NSWCA 347; *Tusyn v State of Tasmania* [2010] TASSC 55; *VMT v Corporation of the Synod of the Diocese of Brisbane* [2007] QSC 219. Scholars have criticised defendants' exploitation of the time bar in cases of clear liability, and the complexity of extension provisions and judicial interpretation of them, in the USA, Canada, Australia, the UK, and New Zealand.

[35] Reflecting the experience of other jurisdictions including the UK (Godden 2010), New Zealand (Manning 2000) and the USA (Hamilton 2012).

long been recognised in the USA,[36] Canada,[37] and Australia,[38] and is reflected in policy statements by governments (Royal Commission into Institutional Responses to Child Sexual Abuse 2015a). It requires the State and its agencies when acting as a defendant to act fairly, to settle legitimate claims without recourse to litigation, to resist reliance on superior financial resources and access to legal advice to defeat plaintiffs, and not to plead legal technicalities when liability is not in dispute. It does not technically apply to religious institutions, although based on their professed nature, it would be a reasonable assumption that such institutions should not behave in litigation in a way that offends the principle.

Radical Reform: A Seismic Shift The Commission determined that conventional approaches were clearly not justifiable in child sexual abuse claims. It recommended radical legislative reform to civil statutes of limitation, making four recommendations. It recommended (Ch 14, Recns 85–88):

- Legislative reform in every state and territory, to remove all time limitation periods for civil claims arising out of child sexual abuse in institutional settings
- Removal with both prospective and retrospective effect
- Retention of court powers to stay proceedings where there was such overwhelming prejudice to a defendant's right to a fair trial
- That these reforms occur immediately.

These were ground-breaking recommendations, and they have resulted in a seismic shift in the legal landscape in Australia. I will shortly set out the legal changes made since these recommendations. First, it is important to note that the Royal Commission accepted several rationales for these reforms. These rationales are underpinned by an appreciation of the nature and purpose of statutes of limitation, and an understanding of their possible exploitation. However, even more significantly, the rationales are animated by an ethical and scientific understanding of the nature of child sexual abuse and its characteristics. Once it is understood that there is a profound power imbalance in all cases of child sexual abuse, which is exacerbated in institutional claims, one can immediately begin to appreciate that there is a fundamental injustice in applying conventional time limitation periods meant for standard personal injury claims to this qualitatively different class of case. These differences arise from the nature of the plaintiff (being a child), the nature of the acts (being secret, hidden, and shameful), the power dynamic (often involving fear, and threats), and the nature of the injuries (frequently including PTSD, which by its very nature precludes revisiting the acts, disclosing the acts, and the activities necessary to bring a legal claim, and often, the difficulty in connecting injuries with the acts, this preventing the plaintiff from knowing the nature and extent and timing of their injuries. Significantly, the Royal Commission found that for those who did actually disclose their abuse in an institutional setting, the average time to disclosure was

[36] *Berger v United States* 295 US 78 (1935).

[37] *Skogman v The Queen* [1984] 2 SCR 93.

[38] *Melbourne Steamship Co Ltd v Moorehead* (1912) 15 CLR 333.

22 years (Australian Government Royal Commission into Institutional Responses to Child Sexual Abuse 2015a, p. 6). This clearly took many of these survivors well outside the standard period in Australia of 3 years post-majority. A brief summary of these bodies of knowledge is instructive.

Non-disclosure and Delayed Disclosure Delayed disclosure is crucial in this context, and must be considered when analysing the nature and justifiability of civil statutes of limitation. Some survivors of child sexual abuse are able to disclose, and can do so proximate to the events. However, due to its nature and context, many survivors will not ever disclose, or will only do so years or decades after the events (Smith et al. 2000). A review of studies found that 60–70% of adult survivors of child sexual abuse said they did not disclose their abuse during childhood (London et al. 2007). Non-disclosure and delayed disclosure is influenced by factors at individual, offender-related, and societal levels (Collin-Vézina et al. 2015; Fontes and Plummer 2010). Individually, the child may be pre-verbal, induced to believe the acts are normal, or have disclosure inhibited by threats, shame, internalised blame, and lack of a trusted confidante. Disclosure is further stifled by the offender's superior psychological, cognitive, age-based, emotional, social, and physical status as parent, caregiver, family member, trusted acquaintance, institutional authority, or older youth. Societal and cultural forces also impede disclosure through the taboo of sexuality, and stigma contaminating survivors (Fontes and Plummer 2010). As discussed earlier in this book, sexual abuse of children in institutional contexts can produce particularly powerful silencing effects due to the nature of individual and organisational authority, and abuse of spiritual authority.

Post–Traumatic Stress Disorder and Avoidance Alongside these behavioural and contextual factors influencing non-disclosure and hence neutralising the survivor's ability to being a legal claim, further significant factors preserving silence and disengagement from the legal system are the nature of the psychological injuries typically caused. As well as secrecy, shame and delayed disclosure, and the disinclination many survivors may feel to take formal legal proceedings against a known and powerful offender, the general avoidance symptom intrinsic to the commonly experienced injury of PTSD produces a second massive impediment to compliance with time limits.

PTSD is particularly relevant because it neutralises a person's ability to bring a civil lawsuit. As recognised by the *Diagnostic and Statistical Manual 5*, PTSD is a trauma- or stress-related disorder, triggered by exposure to actual or threatened death, serious injury or sexual violation (American Psychiatric Association 2013). PTSD impairs social interactions and the individual's functional capacity in myriad aspects of life. In particular, its avoidance symptom means the survivor will persistently avoid all stimuli related to their experience: thoughts, memories, conversations, activities, people and places. The negative cognitions and mood symptom induces self-blame, and the arousal symptom causes self-destructive behaviour. The symptoms of PTSD therefore inherently prevent engagement with the legal system. When compelled to avoid trauma-related stimuli, a survivor with PTSD will find it

impossible or extremely difficult to engage cognitive functions and perform acts required to commence a civil suit. Many survivors will be unable to instruct counsel; revisit and talk about the events; obtain medical evidence of the nature and extent of psychological injury and its connection with the events; recall, see or interact with people, places and phenomena associated with the events; and testify in court and withstand cross-examination. The capacity of survivors with these injuries to engage legal systems is therefore compromised on multiple dimensions. These consequences of PTSD in the context of child sexual abuse survivors and their incapacity to bring a claim have been repeatedly seen in the reported cases in the USA, Canada, and Australia.[39]

It is clear that in the civil legal context, many survivors of child sexual abuse are unable to ever bring a lawsuit to claim financial compensation for injuries and economic loss, and to hold individual and institutional offenders accountable. Even for those who can bring such a claim at some stage in their lives, in most jurisdictions the civil statute of limitation gives only a short time after attaining legal adulthood to commence a claim, meaning many survivors are unable to begin proceedings in sufficient time to seek compensation. This confluence of acts, injuries, abuse of power, and legal technicality can often deny survivors of sexual abuse the capacity to access the justice system, which is a bedrock principle of societies upholding the rule of law.

A Summary of Australian Reforms

Significantly, while the recommendations made by the Royal Commission were of necessity limited to its statutory remit of institutional sexual abuse, broader legislative reforms since made by Australian states and territories indicate that the rationale for reform applies to all cases of child sexual abuse, regardless of setting.

While Victoria had already enacted reforms based on its state inquiry, the Royal Commission's recommendations were decisive in influencing other Australian jurisdictions to implement change.[40] New South Wales then enacted almost identical

[39] See for example the case authorities detailed below, in notes 10–11.

[40] Victoria was the first state to enact reform, with a bill introduced on 23 February 2015, which commenced on 1 July 2015. The bill had three components. First, it removed the limitation period for personal injury claims arising from child sexual abuse, physical abuse, and psychological abuse arising from those acts. Second, it applied this with both retroactive and prospective effect. Third, to protect defendants' fair trial rights and prevent abuse of process, it preserved courts' powers to stay proceedings. These reforms were influenced by a government inquiry into the mishandling of abuse allegations in religious and other non-government institutions. The *Betrayal of Trust - Inquiry into the Handling of Child Abuse by Religious and other Non-Government Organisations* (Victorian Government Family and Community Development Committee, 2013) exposed widespread child sexual abuse in these organisations, and unjustifiable reliance by defendants on the expiry of limitation periods to block survivors from accessing civil courts. The inquiry recommended abolition of the time limit for civil claims in child abuse cases, finding "There is no public policy justification for applying limitation periods to civil cases relating to criminal child abuse" (Volume 2, Finding 26.7, p. 542–3).

legislation through its Limitation Amendment (Child Abuse) Bill 2016, which commenced on 17 March 2016. In addition, the legislation expressly stated that prior causes of action may be brought even if a court had previously barred a claim because of lapsed time. This express provision constitutes a limited incursion into *res judicata* – that previously settled claims cannot be re-litigated – but otherwise preserves that doctrine so that previously finalised matters cannot be re-litigated.[41]

Other states and territories gradually enacted reforms, as shown in Table 5.2. Reforms apply to both institutional and non-institutional CSA, and generally also to physical abuse, and to psychological injury arising from sexual abuse or physical abuse. In all instances, legislative provisions expressly preserve courts' powers to protect defendant's rights to a fair trial (e.g., by staying proceedings in the event of insuperable prejudice).[42] The Australian Capital Territory and Queensland applied its reforms to child sexual abuse, but not to physical abuse. Only one State, South Australia, is yet to introduce a government bill, despite the introduction of two private members' bills.

Significantly, some states have taken further steps to secure justice for plaintiffs. Queensland enacted an additional unique provision favouring plaintiffs, enabling revival of actions previously settled by deed in cases where the court accepts "it is just and reasonable to do so". This special exception to *res judicata* recognises that claims in this context may have been settled in circumstances where the plaintiff was under duress and felt compelled to accept a small offer of recompense in return for the defendant not defeating the claim outright by relying on expiry of time. The Northern Territory and Western Australia have enacted similar provisions, applying to both previously barred causes of action, and to previously settled causes of action.[43] In addition, Western Australia has enacted special provisions in its new

[41] It is not expressly applied to matters that have been settled, although there is conflicting information about this. The second reading speech indicates not; but the definition of "judgment" in Sched 5 Pt 3 s 8(2) as "a judgment given extends to a judgment entered and also to an agreement entered into before and in connection with any such judgment" indicates it may.

[42] Court retains its power to summarily dismiss, or permanently stay proceedings, where lapse of time creates overwhelming burden to defendant's fair trial rights, through the court's inherent, implied, statutory or other common law jurisdiction, or under a rule of court, practice note or practice direction – see, e.g., NSW s 6A(6); Vic s 27R).

[43] In the Northern Territory, the provisions effectively allow the bringing of a new claim if a previous judgment was given on the basis of expiry of time. "Judgment" includes an agreement entered into, providing further protection and capacity for plaintiffs. Under s 54(5), if an action is brought, the court may, if it considers it is just and reasonable to do so: (a) set aside any [previous] judgment; (b) take into account any amounts paid or payable by way of damages under such a judgment'; and(c) take into account costs paid or payable in connection with any such judgment.

In Western Australia, the Civil Liability Legislation Amendment (Child Sexual Abuse Actions) Bill 2017 was introduced into Parliament 22 November 2017, and was passed on 19 April 2018; the provisions amending the Limitation Act 2005 have not yet been proclaimed. The key provisions are s 6A, and Part 7 (ss 89–92). Section 91(1) allows an action on a "previously barred cause of action" to be commenced where the action was statute barred; or an action had been commenced but discontinued or not finalized; or a judgment was given, or an action was dismissed, on the ground that the action was statute barred. Under s 91(3), the court may, if it is satisfied that it is just and reasonable to do so, set aside the previous judgment. Under s 91(4), if an action on a previously

Table 5.2 Australian statutes of limitation of civil claims for child sexual abuse

State / Territory – legislation – commencement of reforms	Effect: removal and retrospective effect	Types of abuse	Court powers preserved	Approach to previously barred / settled claims
Australian Capital Territory Limitation Act 1985 (ACT) ss 21C, 30 May 2017	No limitation period; applied retrospectively and prospectively.	SA only	S 21C(3)	n.a
New South Wales Limitation Act 1969 (NSW) s 6A, Sched 5 ss 8-10 17 March 2016	No limitation period; applied retrospectively and prospectively	SA, serious PA, and connected psychological abuse	S 6A(6)	Allows an action on a "previously barred cause of action" to be commenced where a judgment has been previously given on the ground that the action was statute barred (Sched 5).
Northern Territory Limitation Act 1981 (NT) ss 5A, 53-55 15 June 2017	No limitation period; applied retrospectively and prospectively.	SA, serious PA, and connected psychological abuse	S 5A(5)	Allows an action on a "pre-existing judgment" where given on the ground a limitation period had expired (s 54(1)). Under s 53(2) "Judgment" includes "an agreement entered into in relation to settlement of a matter of damages for personal injury".
Queensland Limitation of Actions Act 1974 (Qld) ss 11A, 48 1 March 2017	No limitation period; applied retrospectively and prospectively.	SA only	S 11A(5)	Section 48(2)-(5) allows an action on a previously barred right of action. Section 48(5A)-(5C) allows an action on a previously settled right of action
South Australia Limitation of Actions Act 1936 (SA) ss 36, 45	3 years from majority i.e. must commence by age 21	n.a	n.a	n.a
Tasmania Limitation Act 1974 (Tas) ss 5B, 38 Passed and assent 20 Dec 2017; commences when proclaimed	No limitation period; applied retrospectively and prospectively	SA, serious PA, and connected psychological abuse	S 5B(3)	Does not allow bringing of previously barred claims Does not allow bringing of previously settled claims

(continued)

Table 5.2 (continued)

State / Territory – legislation – commencement of reforms	Effect: removal and retrospective effect	Types of abuse	Court powers preserved	Approach to previously barred / settled claims
Victoria Limitation of Actions Act 1958 (Vic) ss 1, 4, 27O, 27P 1 July 2015	No limitation period; applied retrospectively and prospectively	SA, PA, and connected psychological abuse	S 27R	Does not explicitly allow bringing of a claim previously the subject of judgment Does not allow re-opening of previously settled claims or claims that have been subject to final judgment
Western Australia Limitation Act 2005 (WA) ss 6A(2), 89-92 am by *Civil Liability Legislation Amendment (Child Sexual Abuse Actions) Act 2018* Passed and assent 19 April 2018; commences on proclamation	No limitation period; applied retrospectively and prospectively	SA only S 6A(1) "child sexual abuse" means an act that is sexual abuse"	S 6A(5)	Section 91(1) allows an action on a "previously barred cause of action". Section 92 allows an action to be brought on a "previously settled cause of action".

Part 2A of the Civil Liability Act 2002 ss 15A-15 L,[44] to enable a plaintiff to identify a "proper defendant". These provisions are directed at ensuring organisations like the Catholic Church may effectively be held liable despite their nominal lack of juridical status.[45] The provisions create exceptions to normal corporations laws,

barred cause of action is commenced, the Court may, if it is satisfied that it is just and reasonable to do so, take into account any amount paid under a previous judgment.

Similar provisions apply to "previously settled" causes of action. Section 92 allows an action to be brought on a "previously settled cause of action". Under s 92(2) the plaintiff must apply for leave to commence the action. Under s 92(3), the Court may, if satisfied it is just and reasonable to do so, grant leave to commence the action, and set aside the settlement agreement and any judgment giving effect to the settlement. Under s 92(4), if the action is commenced, the agreement relating to the settlement is void to the extent to which it relates to the CSA the subject of the cause of action. Under s 92(6), the Court may, if satisfied it is just and reasonable to do so, take into account any amount paid under an agreement, to the extent to which it related to the child sexual abuse the subject of the cause of action.

[44] As amended by the Civil Liability Legislation Amendment (Child Sexual Abuse Actions) Act 2018 (WA), passed on 19 April 2018; the relevant provisions have not yet been proclaimed.

[45] Section 15B(1)–(3) effectively provides that if the office holder at the time of the CSA is no longer in office, an action can be brought against the current office holder of an unincorporated association, and the current office holder is liable for the former office holder's liability. Further, s 15C provides that the holder of the office may satisfy the liability out of assets held by or for the office of the institution, including assets of a trust, whether or not a charitable trust.

allowing an action to be brought against the current office holder of an unincorporated association, and authorising the office holder to use assets held by the institution (including trust assets) to satisfy a judgment debt. In Victoria, similar legislation was passed on 24 May 2018,[46] and New South Wales has also enacted this legislation.

Canada In Canada, eleven of the thirteen provinces and territories have also removed limitation periods for child sexual abuse civil claims (Table 5.3). All removals apply retroactively as well as prospectively, and enable suits to be brought against both individual and institutional tortfeasors. Quebec has not removed the

Table 5.3 Civil limitation periods for claims based on child sexual abuse: Canada

Province/territory	Legislative provisions	Effect
Alberta	Limitations Act, RSA 2000, c L-12, ss 3(1), 5.1(2)	No time limit
British Columbia	Limitation Act, SBC 2012, c 13, s 3(1)(i)	No time limit
Manitoba	The Limitation of Actions Act, CCSM c L 150, s 2.1(2)(a)	No time limit
New Brunswick	Limitation of Actions Act, SNB 2009, c L-8.5, s 14.1	No time limit
Newfoundland and Labrador	Limitations Act, SNL 1995, c L-16.1, s 8(2)	No time limit
Northwest Territories	Limitation of Actions Act, RSNWT 1988, c L-8, s 2.1(2)	No time limit
Nova Scotia	Limitation of Actions Act, RSNS 2014, c 35, section 11	No time limit
Nunavut	Limitation of Actions Act, RSNWT (Nu) 1988, c L-8, s 2.1(2)	No time limit
Ontario	Limitations Act, 2002, SO 2002, c 24, s 16(1)(h.1)	No time limit
Prince Edward Island	Statute of Limitations, RSPEI 1988, c S-7, ss 2(1)(d), 5	Must commence action within 2 years of majority
Quebec	Civil Code of Quebec, LRQ, c C-1991, s 2926.1	Must commence action within 30 years from the date the victim becomes aware the injury suffered is attributable to the sexual act
Saskatchewan	The Limitation Act, SS 2004, c L-16.1, s 16(1)(a)	No time limit

[46] Legal Identity of Defendants (Organisational Child Abuse) Bill 2018 (Vic).

limitation period entirely, but has created a special limitation period of 30 years after knowledge the injury was caused by the sexual assault. Only Prince Edward Island retains traditional time limits, generally requiring actions within 2 years of majority.

Canadian jurisdictions were the first to enact reforms, doing so in the 1990s led by British Columbia in 1992, hence predating the American and Australian movements (Roach 2001). This landmark shift in access to justice may have been seen as a natural consequence after the Supreme Court of Canada's insistence in *City of Kamloops v Nielson*[47] that reasonable discoverability had to be accommodated alongside the standard limitation period. As well, further judicial incursions into traditional limitation principles had promoted plaintiffs' rights to proceed in all types of civil claims. This was epitomised in *Novak v Bond*,[48] and in *M(K) v M(H)*,[49] where the plaintiff claimed compensation for injuries caused by incest. Reforms were driven by recognition of the qualitative differences in child sexual abuse cases, which were judged to invalidate traditional policy reasons for limitation periods (Roach 2001). Despite their breadth – with these reforms also applying to claims of adult sexual assault – the reforms in Canada do not appear to have created an intolerable burden for court systems, or gross injustice for defendants (British Columbia Ministry of Justice, 2013).[50]

[47] (1984) 10 DLR (4th) 641.

[48] (1999) 172 DLR (4th) 385.

[49] (1992) 3 SCR 6.

[50] The lack of such an impact can be explained by two main factors. First, while an initial increase in lawsuits is to be expected, especially where a revival window or retroactive removal of the time period is part of the reform, even those claims that are commenced are likely to be settled out of court without reaching the trial stage. Accordingly, the burden on the court system is diluted. Second, for a range of reasons, most survivors of child sexual abuse will not wish to institute legal proceedings. Many survivors will not experience personal injuries of an extent sufficient to warrant a legal claim. Even for those who do, a substantial proportion of potential claims will never be brought because civil suits are futile where the defendant is deceased, unable to be located, or impecunious. Many survivors will lack the agency and capacity to bring proceedings; many will be unable to pursue a claim due to existing trauma, fear of re-traumatisation, distrust of the legal system, inability to navigate the system, or lack of funds. As well, many survivors' primary desire is not financial compensation, but an assurance that steps be taken to diminish the likelihood of sexual abuse in future, especially in institutional contexts (Law Commission of Canada, 2000). Further, for cases of sexual abuse in institutional contexts, many jurisdictions have created informal methods of providing redress or ex gratia payments. These have proven to be accessible to survivors, and preclude pursuit of civil remedies (Australian Government Royal Commission into Institutional Responses to Child Sexual Abuse 2015a).

Note also that scholarly analysis has concluded that claims about "false memories" not supported by strong evidence (Bulkley and Horwitz 1994). Based on an analysis of the literature, including the review of 25 studies by Scheflin and Brown (1996), Freyd (1998, p. 103) concluded "there is no research to date documenting a "false memory syndrome"" and that "there is a large and growing body of evidence documenting the occurrence of essentially accurate recovered memories" (p. 107). Studies have indicated that, as a natural defence mechanism, individuals are more likely to forget details of abuse or to have periods of forgetting when they are abused by parents or caregivers (Freyd et al. 2001; Williams 1995). Freyd (1998) also concluded that in terms of persis-

USA No state in the USA has enacted reforms quite as extensive as those in Canada and Australia. However, some states have enacted substantial reforms short of prospective and retrospective abolition. Delaware and Minnesota have removed limitation periods prospectively (for events occurring after commencement of the amending law); and have created a revival window to provide a limited period of time in which previously lapsed claims can be brought, without any limit on the age of the plaintiff. Similarly, Connecticut has removed the limitation period prospectively for designated serious sexual assaults, and has enacted a revival window for plaintiffs aged under 48, giving a period of 30 years after turning 18 (i.e., age 48). In Massachusetts, reforms took effect on 26 June 2016, giving until age 53 for prospective suits against any defendant, with partial retroactive effect for individual offenders but not institutional wrongdoers (Coalition to Reform Sex Abuse Laws, 2016). Some states have enacted a longer than normal period of time for prospective claims but with no revival period for lapsed claims. Illinois, for example, gives 20 years after turning 18, and Oregon gives until age 40. Other states – Iowa, Maryland, New York, North Dakota, Pennsylvania, Texas, and Utah, and the District of Columbia – have bills pending which make similar amendments, indicating growing momentum for reform. In Illinois, pressure is building to remove the time bar entirely (Schaper 2016). Reform efforts have met substantial institutional opposition in many states including Massachusetts, New York, and Pennsylvania (De Jesus 2016; Hamilton 2012; Holpuch 2016). Advocates continue to lobby for reform, often supported by revelations of abuse in institutions or by powerful individuals who have evaded accountability through expiry of time. Despite these reforms, most states in the USA retain their traditional model and usually give no more than 6 years to bring a civil claim (National District Attorney Association, 2013).

Other Nations It is likely that other nations and jurisdictions will gradually follow the example set by Canada and Australia. In 2017, the Canadian province of Alberta enacted reforms, leaving only Quebec and Prince Edward Island yet to make reforms in that country. Also in 2017, Scotland removed its limitation periods for child sexual abuse cases, with the Limitation (Childhood Abuse) (Scotland) Act 2017 amending the Prescription and Limitation (Scotland) Act 1973. Interestingly, the Scottish reforms apply not only to sexual abuse, but to physical abuse, emotional abuse, and neglect (s 17A).

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tence of memory – namely, whether a memory can be recalled at different points in time – recovered memories of CSA are neither more nor less likely to be inaccurate than continuously accessible memories of sexual abuse. Accordingly, delayed disclosure may sometimes be caused by lack of memory (whether through suppression or blocking), which is subsequently reliably retrieved. Further research into the neuroscience of suppression of memory has confirmed the normality and mechanism of "motivated forgetting" (Anderson and Green 2001; Anderson and Hanslmayr 2014; Benoit and Anderson 2012). Overall, the evidence indicates there is not compelling evidence of "false memories" to cast doubt on the viability of reforms to civil statutes of limitation.

Implications of Reforms to Time Limitation Periods in Civil Sexual Abuse Claims

Fairness for Defendants Fairness for defendants must remain embedded in the civil litigation system to protect its status as a hallmark of rule of law societies. Even where removal of the time limitation period is retroactive, there is a clear argument that this fairness is achieved through multiple measures. First, the doctrine of *res judicata*, a cornerstone of Western common law, means that previously finalised claims cannot be re-litigated (Currie 1978). Arguably, from a policy perspective this rule is not satisfied where a plaintiff's agreement to settle was induced by the defendant's threat to rely on expiry of time. Second, the judiciary possesses strong residual controls on civil lawsuits. Most notably, courts have inherent powers to dismiss or permanently stay civil proceedings where lapse of time creates clear insuperable prejudice to a defendant's fair trial rights. So, where a claim is based on events from so long ago there is no possibility of the defendant being able to defend their case, a plaintiff's claim will not be allowed to proceed. Third, courts retain their normal role and specialised power to determine whether sufficient evidence exists to support a claim. This applies regarding the factual basis of a claim, liability, causation, and quantum of damages. Accordingly, even with time periods removed, many potential plaintiffs will still face substantial challenges in compiling an evidentiary case – with compelling evidence beyond mere memory, including reliable medical evidence – sufficient to establish liability. This is one reason why even with removal of the time limitation, especially when retroactive, most potential claims will not be made through the civil justice system. Finally, reform to the statute of limitations does not guarantee a plaintiff of success; it merely provides an opportunity to have access to the justice system and commence proceedings. There is no substantial evidence to date that such reforms have caused undue prejudice to defendants' rights, either in this context, or in other contexts where limitation periods have been removed.

Fairness for Plaintiffs In a liberal democratic society governed by the rule of law, it is axiomatic that individuals must not be impeded from exercising legal rights (Bingham 2007). Access to courts should be unimpeded and protected as a basic right, adjudicative procedures should be fair, and the law must protect fundamental human rights (Bingham 2007). There is a general case supporting limitation periods for conventional personal injuries suits. In general, a civil claim should be brought in a relatively short period of time where the suit involves a plaintiff injured as an adult, with clear and immediate injuries clearly related to the event, with witnesses and where the gathering of evidence is uncomplicated and non-traumatic, where the plaintiff's capacity to proceed is not intrinsically compromised by injury, where disclosure is not compromised, where there is no power imbalance affecting capacity to commence proceedings, and where failure to proceed promptly may reflect culpable "sleeping on one's rights".

Yet, child sexual abuse cases are qualitatively different from generic civil disputes on all these grounds. The policy reasons for limitation periods are overcome in this different context, which was not publicly recognised or considered when standard limitation periods were devised. The distinction applies to cases involving child sexual abuse occurring in both institutional settings and non-institutional settings. It applies with greater strength when the person inflicting the abuse, and or the institution concealing it, occupies a position of psychological, emotional, economic or institutional power over the victim.

Challenges Remain for Plaintiffs These reforms in Canada and Australia are remarkable breakthroughs in jurisprudence, overturning historical impediments to access to justice. They provide those who wish to commence civil proceedings with much greater capacity to do so. However, major challenges remain. First, the patchwork quilt of legal approaches within a federated country is unsatisfactory. Individuals should all have the same level of access to justice regarding the same types of claims, and the highest level of access to justice. Accordingly, the clearly superior positions adopted by some Australian jurisdictions should serve as a model of reform for the other states and territories, and the laws should be harmonised.[51] The progressive approach to previously settled and barred claims should be adopted by all jurisdictions. The approach to identifying a proper defendant must also be adopted nationally; there is little point removing one barrier to justice if another remains, even if it applies to one particular kind of defendant. Further challenges also remain. There are reports that some powerful defendants are still using technicalities to deny, dispute and delay justice to survivors. This is simply unconscionable institutional conduct, knowingly causing further trauma, and the leaders of these institutions have an ethical responsibility to ensure that it ends.

Above all this, though, remains the fact that it is still extremely difficult for survivors of child sexual abuse to commence a civil claim, even with an appropriately reformed approach to statutes of limitation. The civil litigation system presents an inherent deterrent effect due to its adversarial nature, technical formalities, economic costs, length of time involved, and the traumatic consequences that can flow from involvement in formal proceedings. Many defendants have relatively low levels of agency, may seek relatively low awards of damages perceived as not worth the difficulty and cost of formal civil proceedings, and, especially in the case of individual non-institutional offenders many defendants who inflicted the abuse are

[51] Healing requires survivors to be able to articulate their suffering, be heard, and taken seriously (Herman 1997). Yet, the presence and use of the time limit silences the survivor once more. Judith Lewis Herman has noted the indifference of bystanders can be particularly traumatic, exceeding even the initial abuse (1997, p. 100–101). For survivors, legislatures which do not enact reform can make them a special class of bystander, exacerbating trauma. Rosanne Sliney, whose testimony influenced reform in Massachusetts, crystallised this when she said: "I felt like the state of Massachusetts was like my family...They all were ignoring the fact that I"m suffering. ... No one protected me...and now my state wasn't protecting me." (De Jesus 2016). In contrast, a legislature enacting reform to allow claims recognises and validates the experience of CSA survivors, even for those who do not make a claim.

impecunious and cannot satisfy any judgment debt. These characteristics of the context raise the broader question of whether this qualitatively different class of case merits a specialised tribunal with modified rules and processes, and expert staff. Such tribunals have been created for other contexts in civil and criminal law, and this should be seriously considered if we are to make future progress in this domain.

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