INDEPENDENT INQUIRY
CHILD SEXUAL ABUSE

Child sexual abuse in contemporary institutional contexts

An analysis of Disclosure and Barring Service discretionary case files

Executive summary

July 2021

Disclaimer

This research report has been prepared at the request of the Inquiry's Chair and Panel. The views expressed are those of the authors alone. The research findings arising from the fieldwork do not constitute formal recommendations by the Inquiry's Chair and Panel and are separate from legal evidence obtained in investigations and hearings.

The report contains direct accounts and quotes from alleged perpetrators, victims and survivors of child sexual abuse and exploitation, witnesses and professionals. Reading the report can have an emotional impact. There are some support organisations that it may be helpful to contact if you have been affected by any of the content in the report: www.iicsa.org.uk/help-and-support-0.

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Introduction

The Independent Inquiry into Child Sexual Abuse ('the Inquiry') was set up as a statutory inquiry in March 2015. The Inquiry has been tasked with considering the extent to which state and non-state institutions in England and Wales have failed in their duty of care to protect children from sexual abuse and exploitation, and to make meaningful recommendations for change to help ensure that children now and in the future are better protected from sexual abuse.

Despite increasing institutional safeguards over recent years, and growing research into child sexual abuse in institutions, there is still a lack of knowledge in relation to child sexual abuse in contemporary institutional contexts. The aim of this study was to better understand the offending behaviours of perpetrators who sexually abused children across a broad range of contemporary institutional contexts in England and Wales ('contemporary' was defined in this study as 2017 onwards). The study also examined the circumstances and situational factors related to how child sexual abuse was perpetrated in a range of institutional contexts, and how institutions and professionals identified, reported and responded to risks of child sexual abuse. The study contributes to the wider evidence base concerned with tackling child sexual abuse and may assist policy makers and practitioners in better understanding institutional grooming, abuse of trust, and safeguarding in institutional contexts, thereby improving prevention of and responses to child sexual abuse.

Two broad research questions were addressed:

1. What is known about perpetrators of child sexual abuse, their offending strategies and the nature of child sexual abuse in a broad range of contemporary institutional contexts?
2. How do institutions and professionals identify, report and respond to risks and allegations of child sexual abuse?

Methodology, sample and ethics

The Disclosure and Barring Service (DBS) is a public body that "*makes considered decisions about whether somebody should be barred from engaging in regulated activity*" (Gov.UK, 2019). Examples of roles which could fall under regulated activity include teaching or providing health and personal care to vulnerable adults or children. This research is the first of its kind,[1] analysing contemporary records (2017–2020) from the Disclosure and Barring Service, involving both male and female individuals added to the Children's Barred List.

A qualitative case file analysis approach was taken, analysing a sample of 43 DBS case files out of the 544 cases in which an individual was added to the DBS Children's Barred List on **discretionary grounds** and on the grounds of sexual harm between September 2017 and June 2020. These 'discretionary referral cases' have been referred to the DBS by institutions (employers, or regulators for example) because there are, or have been, concerns about that individual's behaviour with children or vulnerable adults, which have led to them being removed from or leaving their position. These cases engage the discretionary decision-making powers of the DBS unless the behaviour results in a caution or conviction for a prescribed offence; such cases are reclassified as 'autobar' cases.

1 This study builds on another small-scale study which analysed DBS case files (Darling and Antonopoulos, 2013).

We refer to individuals described in DBS discretionary cases and who have been added to the Children's Barred List as 'alleged perpetrators' when describing events which took place before an individual was referred to the DBS and added to the Children's Barred List, and as 'barred individuals' when describing the sample, or when describing events which took place after an individual was added to the Children's Barred list.

The cases analysed were only those cases relevant to England and Wales jurisdictions and which pertained to the Children's Barred List. These cases involved alleged perpetrators working or volunteering within an institution at the point of referral, and where individuals were under the age of 18 at the time of the reported incidents of child sexual abuse. The sample covered a range of sectors, including education, voluntary and community, sports and leisure, foster care, social care, childcare, faith and healthcare sectors.

Over half of the barred individuals in the sample were between the ages of 19 and 34 years (24 cases) and male (32 cases). The majority of sexually abused children were under the age of 15 (37 cases) and female (51 cases).[2] Some of the cases analysed (16 cases) involved multiple children.

This project received ethical approval from the Inquiry's Research Ethics Committee in December 2019 to carry out case file analysis of DBS's discretionary referral cases and the project was subject to rigorous ethical scrutiny.

Seven key research findings

1. Alleged perpetrators across different types of institutional contexts used similar tactics and methods to sexually groom and sexually abuse children

Sexual grooming strategies were often methodical and gradual, and involved befriending children and their families. Case files illustrated that alleged perpetrators were often charismatic, competent individuals who were well liked and respected by colleagues. Their positive perceptions may have resulted in their offending behaviours being minimised or excused by those around them. We observed that alleged perpetrators:

(a) denied the child sexual abuse occurred at all; or

(b) admitted the contact had occurred but denied it was sexual abuse, using tactics such as victim blaming or describing the sexual abuse as a consensual 'relationship'; or

(c) admitted the sexual abuse but minimised their responsibility, for example by claiming they had made 'mistakes' or 'poor judgements'; or

(d) disputed they held 'positions of trust', indicating that, therefore, safeguarding policies did not apply to them and had not been breached.

2. Most child sexual abuse took place in physical locations away from the institution, or in private and unsupervised spaces where children were isolated by alleged perpetrators

Most child sexual abuse took place in physical locations away from institutional premises. Physical locations where sexual abuse occurred included cars, hotels or the child or adult's home. Where child sexual abuse took place within institutional premises, alleged perpetrators sought out private spaces in which to isolate children and remain undetected, such as bathrooms or disused classrooms. They also targeted children on social media platforms which afforded them constant access to children in unsupervised and unmonitored online spaces.

2 Some cases involved more than one sexually abused child.

3. Sexual grooming and child sexual abuse frequently took place using technology or online and via social media

Technology and social media were frequently used to groom children and perpetrate child sexual abuse. The process of sexual grooming online mirrored the same gradual and systematic sexual grooming tactics that alleged perpetrators applied offline and in person. Instant messaging exchanges allowed them to develop a rapport with children and gain their trust. The nature of the child sexual abuse online sometimes escalated to the use of sexualised language, imagery or the use of live-streaming or video calls to perform sexual acts. Contact with children online or through text messaging offered opportunities to be in frequent – and in some cases almost constant – contact with children.

4. Institutional cultures allowed informal contact and over-familiarity between alleged perpetrators and children, and this enabled individuals to sexually abuse children without raising suspicions

Institutional cultures of over-familiarity and informal relationships between adults and children contributed to child sexual abuse. Informal interactions between adults and children were normalised and were therefore not considered 'unusual' or potentially harmful by institutions and professionals. A range of behaviours associated with informal institutional cultures were observed in the case files, including sharing cars, socialising outside of the institution, going to the pub or fast-food restaurants, and contacting and befriending children via social media or instant messaging. These behaviours and activities often formed part of the culture of institutions, particularly in sports or leisure clubs, societies, and voluntary and community sectors, as well as in schools and residential care homes. In almost all of the cases analysed in this research, alleged perpetrators had developed an informal social relationship with the child. These informal relationships provided opportunities to sexually groom and abuse children without raising suspicions.

5. Alleged perpetrators and institutions framed sexually abusive relationships as consensual and romantic relationships

Sexually abusive relationships between adults and children were conflated with consensual and romantic relationships. This had the effect of normalising and legitimising risk behaviours, and led to institutions not properly assessing risk of harm and handling concerns or allegations where abusive relationships were known to have formed between adults and children under their care. In some cases, children had been groomed to believe they were in consensual relationships with the alleged perpetrators, hindering children's ability to recognise and disclose incidents of child sexual abuse. In some cases, child sexual abuse was concealed due to the wider informal social relationships that commonly occurred.

6. There were numerous missed opportunities to safeguard children because concerns were not escalated, disclosures were not always believed and institutions and staff did not share, record and respond appropriately to low-level concerns

Institutions and professionals responded inappropriately to low-level disclosures. Disclosure pathways were often poorly established which may have made it difficult for children, peers or concerned adults (whether colleagues, parents or family members) to raise concerns. There were examples where information sharing had not occurred across and between institutions. In some cases, the totality of the alleged perpetrator's behaviour was missed and they went on to offend in other institutional contexts. Low-level concerns were often not fully investigated and institutional actions were not always proportionate or timely in addressing the severity of the concerns. Across cases, there were inconsistencies in what constituted harm, how risks of harm were assessed, and where concerns met the threshold of an allegation that should have been formally addressed.

7. Institutions and staff did not consistently apply safeguarding policies and had narrow understandings of safeguarding responsibilities

The frequency and quality of safeguarding training varied significantly between institutions and was not always proportionate to roles that involved contact with children. Several cases referred to institutional social media policies which restricted or prohibited the use of social media to communicate with students, but application and enforcement of and compliance with these policies was often poor. There were contradictions between safeguarding policies, which made certain conduct or behaviour unacceptable, and institutional norms and practices which tolerated the behaviour. Cases where staff did not escalate and disclose concerns exemplified that safeguarding policies were not upheld at all levels by all members of staff, safeguarding 'responsibilities' were not always seen as everybody's business, and institutions may have found it challenging to navigate complex safeguarding processes.

Limitations and what is out of scope for the research

One of the key limitations of this research is that the conclusions drawn from the qualitative sample of 43 case files cannot be deemed representative of particular institutional contexts or 'types' of alleged perpetrators in England and Wales. However, the study presented a unique opportunity to examine aggregate themes of offending behaviours, abuse of trust relationships and failings at the institutional level, in relation to child sexual abuse.

This research did not involve any review of the DBS itself, and none of the research findings in this report are related to the DBS's remit or processes and procedures. The extent of the DBS's involvement was limited to the provision of case files for data analysis only. The research also did not consider other types of DBS cases, such as applications for enhanced disclosure (which is a pre-employment check), or autobar cases (where individuals are automatically barred from working in regulated activity with children or vulnerable adults due to having been cautioned or convicted for a relevant offence).

References

Darling, A. and Antonopoulos, G. (2013). 'Notes on a scandal': Why do females engage in abuse of trust behaviours? *International Journal of Criminology and Sociology*, 2, 525–37.

Gov.UK (2019). Guidance. Barring referrals. [Online]. Available at https://www.gov.uk/guidance/barring-referrals [Accessed 22 April 2021].