ANALYSIS OF PAST INQUIRIES INTO INSTITUTIONAL CHILD SEXUAL ABUSE

PREPARED FOR BRAND TASMANIA AND THE DEPARTMENT OF PREMIER AND CABINET (DPAC)

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Terms and Acronyms

CoI	Commission of Inquiry
DPAC	Department of Premier and Cabinet
Cornwall Public Inquiry	Commission of Inquiry into the Events Surrounding Allegations of Abuse of Young People in Cornwall
IJCI	Independent Jersey Care Inquiry
The Forde Inquiry	Commission of Inquiry into Abuse of Children in Queensland Institutions
ToR	Terms of Reference

Background

The Commission of Inquiry (CoI) into the Tasmanian Government's Responses to Child Sexual Abuse in Institutional Settings referred to past Australian and overseas inquiries into institutional child sexual abuse. Following the release of the CoI report, the Department of Premier and Cabinet (DPAC) sought to better understand the outcomes of past inquiries into institutional child sexual abuse in other jurisdictions. They were especially interested in the recommendations that arose from the inquiries and whether the government accepted and implemented them, particularly those related to broader systemic changes. DPAC aims to use these insights to further inform policy decisions and the implementation of Recommendation 19.1.[1] DPAC worked in partnership with Brand Tasmania and engaged the team at Folket Consultancy to conduct the research.

The approach we used

Three inquiries were selected based on a set of criteria we established in a collaborative workshop.[2] The inquiry cases were:

1. Independent Jersey Care Inquiry (IJCI)
2. Commission of Inquiry into the Events Surrounding Allegations of Abuse of Young People in Cornwall (Cornwall Public Inquiry)
3. Commission of Inquiry into Abuse of Children in Queensland Institutions (The Forde Inquiry)

In collaboration with DPAC and Brand Tasmania, Folket Consultancy workshopped a set of questions to use when analysing the cases:

1. What were the details of the Inquiry (incl. where, when, why, how)?
2. Where applicable, what elements of culture (e.g. connectedness) held issues regarding child sexual abuse in place?
3. What were the recommendations and what is the status of the recommendations?

We conducted a document review, and all material has been referenced for further exploration by DPAC (see, Appendix). To manage the large volume of data and aid the analysis, Folket Consultancy used NVivo, a qualitative analysis software. As part of the analysis, we also applied a system change lens by incorporating the Water of Systems Change conditions of the semi-explicit 'relationships and connections' and 'power dynamics', and the implicit 'mental models' to analysis the inquiry findings and recommendations.[3]

Limitations

Any research project will have limitations, including this project. The main limitation in this research was time and resource constraints. This limited the depth of analysis allowed for each case. Since we were analysing each inquiry separately, it also meant this research does not take into account other

[1] For further information and specificities of Recommendation 19.1, see Commission of Inquiry into Tasmanian Government's Response to Child Sexual Abuse in Institutional Settings (2021), available from https://www.commissionofinquiry.tas.gov.au/report

[2] The criteria developed to select the cases were: (1) Inquiries are concluded and there has been sufficient time lapsed for government response to recommendations, (2) There are cultural and/or other similarities with Tasmania, for example Jersey characterised by connectedness, Cornwall a small community (pop. 50,000-ish), Queensland is a State of Australia, (3) sufficient information available in English, and (4) Inquiries were not dominated by faith-based institutions.

[3] For additional information, see Kania J., Kramer, M., and Senge, P. (2018) The Water of Systems Change, available from https://www.fsg.org/resource/water_of_systems_change/

influences that may have been happening at the same time or the potential ripple effect these factors might have had on shaping policies, practices, and/or broader society. It is also challenging to measure the full extent to which governments accepted and implemented recommendations. While government statements have said to accept or endorse recommendations, more in-depth analysis, including legal and expert advice, would be needed for a definitive conclusion. As a result, the cases are descriptive, not conclusive. Furthermore, each inquiry took place in a different location and context, with different triggers, approaches, government responses, reporting requirements, and available documentation. Whilst they cannot be directly compared, all three cases showed recurring themes of historic and ongoing abuse with the need for significant changes.

Despite these limitations, the cases provide important insights into the role and outcomes of inquiries.

Cases

1. Independent Jersey Care Inquiry (IJCI)

1. Details of the IJCI Inquiry

The Independent Jersey Care Inquiry (IJCI) took place in Jersey, the largest of the Channel Islands and a British Crown Dependency. Jersey is self-governing with its own financial and legal systems and has just over 100,000 residents. The inquiry was triggered by persistent and growing allegations of historical child abuse within Jersey's care system, particularly at the former children's home, Haut de la Garenne. The IJCI was announced on 6 November 2012, and officially adopted on 6 March 2013. It was established to investigate what went wrong in Jersey's care system over many years and to provide answers for those who suffered abuse as children (States of Jersey n.d.).

The timeframe examined ranged from the 2010s back to 1945. The process included 149 days of public and private hearings and consultations across three phases: gathering evidence from former residents and alleged abusers, collecting information on policing and decisions on prosecution, and consulting on the future of childcare services in Jersey. Overall, the IJCI collected evidence from over 200 witnesses with additional evidence provided by over 450 former residents of, and those connected to Jersey's care system.[4] The IJCI also received over 136,000 documents and had more than 100 consultations and meetings with various stakeholders, including childcare experts (Minister of Councils 2017, and Jones 2017, p.1). The IJCI was the most expensive inquiry in Jersey history costing £23million.[5]

2. Where applicable, what elements of culture (e.g. connectedness) held issues regarding child sexual abuse in place?

We see in the inquiry how the cultural context in Jersey, referred to as the "Jersey Way," played a significant role in sustaining issues related to child sexual abuse.

> *At its best, the "Jersey Way" is said to refer to the maintenance of proud and ancient traditions and the preservation of the island's way of life. At its worst, the "Jersey Way" is said to involve the*

[4] These included the police, social workers, victims of abuse, staff working in the care system and convicted offender (Jones, 2017, p.1)

[5] This would equate to over $50 million when converted into Australian Dollars and adjusted for inflation.

protection of powerful interests and resistance to change, even when change is patently needed (Minister of Councils 2017, p.3).

The "Jersey Way" captures the community's commitment to traditional practices and its distinct way of life. It also implies resistance to change and the protection of powerful interests. This in turn has been linked to protecting perpetrators and delaying the process for responsible people to be held accountable.

'The 'Jersey Way' protected the powerful. It was the establishment protecting the guilty and ensuring that those who probably should be held to account will not be held to account (Former Deputy Trevor Pitman in Council of Minister 2017, p.4).

It is evident in the material that the "Jersey Way" was identified as having hindered practice, policy, and legislative changes for children. It also meant that some perpetrators escaped accountability for their actions.

3. What were the recommendations and what is the status of the recommendations?

The Inquiry made eight recommendations to address the 'ten fundamental failings' identified in the Jersey care system. The recommendations centred on explicit conditions of change, such as policy, practices, and resource flows, but also sought to address semi-explicit and implicit conditions. For instance, Recommendation 1 "Establish Commissioner for Children" and 2 "Giving Children and Young People a Voice" can both be seen to have the intent and potential to shift established power dynamics between young people and adults. Furthermore, Recommendation 7 "The "Jersey Way" was solely concerned with connections and relationships and associated power dynamics – expressed as the 'Jersey Way'.

To address the cultural issue known as the "Jersey Way" the IJCI response focused on two key areas. The IJCI suggested a clarification and separation of powers in Jersey's government structures including responding to previous reviews such as Clothier and Carswell. They also highlighted the importance of improving avenues to increase transparency, openness, and means for community involvement to permanently shift the negative elements of the "Jersey Way".

The government accepted all the recommendations and released an initial response in 2017. The response contained 41 actions. Of these actions, six actions related to the "Jersey Way". A review panel was established in 2018 to monitor the government's progress and reports from 2018 and 2019 showed mixed progress. While there have been some positive changes, such as appointing a Children's Commissioner and making legislative updates, challenges remain in areas such as cultural change and addressing the "Jersey Way".[6]

Whilst the cultural changes required are not possible to be implemented over night, it is concerning that clear actions (such as the appointment of a public services ombudsman or addressing complaints systems) do not appear to have been brought forward at pace …. (Care of Children in Jersey Review Panel 2019, p.27).

Another challenge was in implementing Recommendation 4, "Building a Sustainable Workforce". It was reported the challenges were experienced when attempting to change the culture of current staff and retain and attract talent.

[6] See, Care of Children in Jersey Review Panel, 2019, p.8

The IJCI report highlighted the difficulties that had been faced over many years in recruiting and retaining suitably qualified and skilled staff at all levels within Children's Services (Care of Children in Jersey Review Panel 2018, p.20).

The 2019 report also questioned the timeline set out and how the Government would achieve the plan's objectives. Questions around budget and where funding would come from was also raised (Care of Children in Jersey Review Panel 2019). It also foreshadowed the findings in the 2020 summary review and the lack of progress in changing the 'Jersey Way'.

Whilst there have been some positive developments (appointment of a Children's Commissioner and advocacy support) and proposed developments to provide means of redress (including a Public Services Ombudsman) the Review Panel is concerned that there appears to have been little tangible progress made in addressing the wider implications of the perceived 'Jersey Way' at this time. (Care of Children in Jersey Review Panel, 2019, p.8)

By January 2020, the government released a summary report of its progress, indicating incremental improvements across various areas (Council of Ministers 2020, p.3). Concerns relating to the "Jersey Way" identified that not enough had been done. Positive shifts were noted of increased accountability and improved structures for working between government and non-government entities. However, the attempts to separate powers had failed.

Furthermore, it was found that there were varying understandings of the "Jersey Way" among individuals and within the community which hindered change. This in turn contributed to inaction or resistance to necessary changes. More work was suggested to be done outside of government and with the community to ensure effective reforms were implemented (see, Care of Children in Jersey Review Panel 2019, p.27-28).

Overall, while there has been some progress in implementing the IJCI's recommendations, work remains to be done to re-address victim-survivors and address the underlying cultural issues resulting in child abuse (Jersey Citizen Panel 2022, and Care of Children in Jersey Review Panel, 2019).

2. Commission of Inquiry into the Events Surrounding Allegations of Abuse of Young People in Cornwall (Cornwall Public Inquiry)

1. Details of the Cornwall Public Inquiry

The Cornwall Public Inquiry took place in Cornwall, Ontario, Canada. Located in the eastern part of the country, Cornwall is bilingual with both French and English spoken and has a population of just over 47,000. The inquiry was triggered by persistent rumours and allegations of child abuse within Cornwall and surrounding areas, including accusations of a paedophile ring and a conspiracy to cover up abuse by people in authority (CBC News 2009).

The Cornwall Public Inquiry took place 2006-2009. It was carried out under the Public Inquiries Act and was led by Justice G. Normand Glaude of the Ontario Court of Justice. The inquiry aimed to investigate the allegations of abuse of young people in Cornwall over decades and to assess the response of the justice system and other public institutions.

The inquiry had two phases. The first was a fact-finding phase to investigate the response of the justice system and other public institutions to the allegations and to make recommendations for improvement. The second phase focused on community healing and reconciliation, involving

commissioned research papers, community meetings, educational workshops, and support programs.

The inquiry included 300 days of hearings and collected evidence from more than 170 witnesses and 3,400 exhibits. In addition, around 400 individuals received provincially funded counselling through the inquiry. The inquiry ran over time and at significant cost. The final cost was over CAD$50 million[7] of which 60 percent was associated with legal fees. It was the most expensive inquiry in Ontario's history.[8] At the conclusion of the inquiry, the Ontario Government took action to control the scope and expense of any future inquires to avoid a similar situation.[9]

2. Where applicable, what elements of culture (e.g. connectedness) held issues regarding child sexual abuse in place?

A key feature of the Cornwall Public Inquiry was the rumoured peadophile ring and coverups of child sexual abuse by people in authority. Initiating the rumours was a 1992 case of a man reporting having been a victim of sexual abuse and was then offered payment to withdraw his report. A police officer reported the coverup. More people came forward reporting abuse, spanning over decades with some individuals reporting they had been 'passed from one abuser to another by a ring of pedophiles' (CBC News 2009). We can trace throughout the documents how elements of close connections and unequal power dynamics resulted in a secretive culture, institutional coverups or at least inaction, distrust, non-responsiveness, and silencing of whistleblowers.

Multiple investigations by the Ontario Provincial Police were also happening prior and concurrently, including a high-profile operation called Project Truth. From this operation, only one person was convicted out of 115 charges laid against 15 individuals. As we reviewed the documents, it was evident that parts of the community were questioning the roles of institutions and their apparent failure in the investigation process. Comments also raised questions about a culture where authority protected abusers, acting inappropriately, and helped abusers 'avoid serious consequences' (CBC News 2009).

It is also reasonable to believe that there was a lack of appropriate awareness and a culture within institutions that either ignored or did not respond to cases of abuse. The Cornwall Public Inquiry Final report listed the improvement of training for corrections, probation, and parole staff as well as police and crown attorneys as a key and re-occurring recommendation. This suggests a culture within these institutions that would have been marked by a lack of understanding and knowledge of the seriousness and complexity of child abuse. Including how to appropriately respond to allegations and handle such cases. Yet, many recommendations were focused on improving explicit conditions of change such as policy and processes and detailing prescriptive steps for organisations:

> *12. A protocol should be implemented or augmented to ensure that when after-hours meetings with probationers occur, another staff member is present and that the file notes include a reference to the time, location, reason for the after-hours consultation, and a sign-off by the other employee who was in the office (Cornwall Public Inquiry 2009, p.345)*

[7] This would equate to over $80 million in 2024 when converted into Australian Dollars and adjusted for inflation.

[8] For an analysis on the costs and fallout, see CBS News Cornwall Inquiry billed $30M in legal costs. (posted Jun 17), available from https://www.cbc.ca/news/canada/ottawa/cornwall-inquiry-billed-30m-in-legal-costs-1.905840

[9] Government of Ontario (2009) Public Inquiries Act, 2009, S.O. 2009, c. 33, Sched. 6, available from https://www.ontario.ca/laws/statute/09p33

Part of the recommendations that followed the inquiry did focus on addressing cultural stigma, secrecy, and shame associated with sexual abuse. Here we see a public awareness campaign launched on raising awareness on the issue of abuse of children and young people targeting cultural stigma, secrecy and the shame associated with abuse. The second phase of the recommendations also highlighted the need to overcome cultural barriers to victim-survivors speaking out. The culture of secrecy and shame surrounding child abuse leading up to the inquiry had made it difficult for victim-survivors to come forward. The inquiry had a focus on healing and reconciliation on a community level to enable people to give informal testimonies as part of the healing process. This in turn meant the community as a collective listened to victim-survivors, acknowledged the presence of abuse, and addressed the problem.

Hindering the Cornwall Public Inquiry were setbacks of court challenges, the refusal of a key witness to testify, as well as issues with inappropriate treatment of witnesses. While it highlighted cultural factors that contributed to holding issues of child abuse in place, it remains uncertain whether the inquiry managed to restore much trust in institutions or effect broader changes.

3. What were the recommendations and what is the status of the recommendations?

The Cornwall Public Inquiry made over 230 recommendations across its two phases. Phase 1 focused on 160+ recommendations targeting specific institutions such as correctional services, religious institutions, and government departments. These recommendations are granular in detail, prescriptive to specific institutions (n=15), and largely concerned with changing the explicit conditions for systems change such as policy, procedures, and practices.

Phase 2 made over 60 recommendations[10] under several categories, including the implementation of a province-wide public awareness campaign and funding for community healing and reconciliation, a five-year plan for sustainable change, education, professional training, policy and legislative change, programs and services, counselling support, and witness support. A series of research papers were also produced during Phase 2 on the topics of historical policy and institutional responses, apologies, sentencing trends, and healing and reconciliation with an emphasis on approaches to healing and recovery from abuse for male victims.[11]

The acceptance and the status of the recommendations from the Cornwall Public Inquiry is mixed. During the inquiry process and since the release of the final report, several initiatives and changes have been implemented to address the institutional issues raised by the inquiry.[12] Despite these changes, it is challenging to determine the precise status of the recommendations spanning so many institutions, and within specific documentation now archived and no longer accessible.[13] Further, the government stated on release of the inquiry report that they had already implemented many of the changes recommended:

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[10] For Recommendations in full, see Cornwall Public Inquiry (2009) Cornwall Inquiry, Volume 4, p.392-401, available from https://wayback.archiveit.org/16312/20211208101159/http://www.attorneygeneral.jus.gov.on.ca/inquiries/cornwall/en/report/v4_en_pdf/E_Vol4_full_version.pdf

[11] Cornwall Public Inquiry website (2009) Report of the Cornwall Public Inquiry – Research Papers, available from https://wayback.archiveit.org/16312/20211208124340/https://www.attorneygeneral.jus.gov.on.ca/inquiries/cornwall/en/report/research_papers/index.html

[12] Attorney General (2009a)

[13] For example, the Legislative Assembly of Ontario has Hansard and parliament records back to 2018, see https://www.ola.org/en/offices-divisions-branches/library-research/data-resources, as well the Cornwall Public Inquiry Report, ToR and all other associated documents were archived

Over the past two decades, and since the launch of the inquiry in 2005, the government has moved forward with improvements in a number of areas covered by the report. (Attorney General 2009b).

In July 2010, a further statement from the Attorney General (2010) was:

We have been working to address the recommendations in order to help the parties, the people of Cornwall and all Ontarians chart a new path forward. In many cases, changes were already underway well before the report was completed.

In terms of seeking cultural change, the inquiry sought broader changes by advocating for a public awareness campaign to address the social stigma, secrecy and shame surrounding sexual abuse. It also highlighted the need for a more proactive treatment approach for sex offenders and potential offenders to prevent future abuse. There was also a focus on assisting male survivors of abuse which included a funding commitment to establish a network of services including individual counselling, group counselling, and other support (CTV News 2010).

The apologies which had been a recommendation for multiple institutions may have been of some benefits to shift perceptions and assisting survivors. Apologies came from a range of institutions, including the Attorney General, as well as from the Bishop Paul-Andre Durocher of Alexandria-Cornwall (Gyapong 2009). The Apologies Act was also passed during the Cornwall Public Inquiry:

… The Act allows people and organizations to apologize without fear of the apology being used against them. Being able to offer a sincere apology without legal consequences can help healing, help resolve disputes, and reduce the number of lengthy, costly lawsuits.

Another positive contribution by the Cornwall Public Inquiry and other Canadian inquiries was the increased public awareness of sexual abuse and its impacts in Canada (McDonald and Tijerino 2013). However, overall Kennedy (2018, p.325) described the Cornwall Public Inquiry as an 'ineffective public inquiry' as:

The Inquiry was extensively delayed, partially because of five judicial reviews. Failing to find an alleged pedophile ring and making tepid findings regarding institutions' alleged failures to respond to allegations of child abuse, it appears as though the Inquiry had little if any public policy impact, though it may have helped some sexual abuse survivors in their healing processes.

3. Commission of Inquiry into Abuse of Children in Queensland Institutions (The Forde Inquiry)

1. Details of The Forde Inquiry

The Commission of Inquiry into Abuse of Children in Queensland Institutions is known as 'The Forde Inquiry' after the Commissioner Leneen Forde who chaired the Commission. The Minister for Families, Youth, and Community Care in Queensland, Australia established The Forde Inquiry in August 1998. The purpose of the inquiry was to examine whether there had been any abuse, mistreatment, or neglect of children in Queensland institutions. The inquiry followed years of political turmoil and controversies including accusations of paedophiles in positions of power, paedophile networks, investigations, and coverups. Additionally, there were important reports released around that time, including "Bringing Them Home - the Report of the National Inquiry into the Separation of Aboriginal and Torres Strait Islander Children from Their Families", and the UK Inquiry into the welfare of former British child migrants (see, Queensland Government 1999, p.1-2 and Wanna 1999).

The inquiry focused on two areas. The first was to investigate past instances of abuse based on oral and written evidence. The second was to review current systems, including legislation, policy, and practice. The inquiry aimed to identify systemic factors contributing to child abuse or neglect and recommend changes to current policies, legislation, and practices.

The Forde Inquiry examined 159 institutions between 1911 and 1999. It gathered evidence from more than 100 current and former residents and staff in private hearings and received written submissions from over 150 people. Professionals and academics also gave evidence through written statements and public hearings. The inquiry also reviewed a large amount of documentary evidence, including over 250,000 files and records from the Department of Families, Youth, and Community Care), policies, and other documents.

2. **Where applicable, what elements of culture (e.g. connectedness) held issues regarding child sexual abuse in place?**

In the context of The Forde Inquiry, we were able to identify several cultural elements that enabled child sexual abuse to take place and persist. Firstly, the inquiry identified evidence of historical abuse in Queensland institutions indicating a culture where abuse could go undetected, ignored, and even hidden. Reports of abuse were dismissed or concealed to protect the reputation of the institution, making it less likely for instances of abuse to be uncovered and addressed. We can also see the presence of power imbalance with the inquiry highlighting issues within institutions where adults with authority exploited their positions of power over vulnerable children. This power dynamic also contributed to silencing children, making it more challenging for them to seek help or report abuse.

The recommendations that came out of the report also focused on increasing transparency and monitoring of institutions. It is reasonable to assume that the lack of transparency in turn had contributed to abuse going unchecked. The inquiry also revealed that some abuse had been normalised within the institutions, making it harder for the abuse to be recognised or reported by both victims and bystanders.

We also see in the material how the institutions such as juvenile detention centres, were said to have worked in isolation and without community involvement or oversight. This in turn meant that young people were kept separated from their broader community and had limited access to external support systems. For young people in detention, the separation also meant they did not have an ongoing social connection with the community they were from. This isolation made it less likely for young people to have a trusted adult they could confide in to report abuse.

The inquiry also noted a lack of appropriate education and training for staff, suggesting that a culture of inadequate knowledge and understanding of child abuse may have contributed to the issue. Lastly, there appeared to be cultural stigma and shame around discussing abuse, which made it difficult for victims to report their experiences and discouraged survivors from coming forward.

3. **What were the recommendations and what is the status of the recommendations?**

The Forde Inquiry made 42 recommendations in total. A strong focus was on reducing the detention rate of young people and improving the treatment of those already in the justice system, particularly for Indigenous youth. When examined through a system change lens, most of the recommendations fall within the remit of explicit conditions of change. Most recommendations focused on improving policies, practices, procedures, resource allocations, and facilities to protect children and prevent abuse and neglect in Queensland institutions. There were some recommendations that sought to shift semi-explicit conditions, especially in power dynamics. These recommendations aimed to

increase transparency, improve record management and monitoring, and provide apologies and support to those affected by past injustices.

Some recommendations aimed to shift power dynamics by increasing transparency and oversight, while also creating more opportunities for young people. For instance, the recommendations suggested strengthening the authority of the Children's Commissioner (Recommendations 25-27) and 'Official Visitors' (e.g. Community Visitors Scheme) of community members to provide young people with community connection and increase transparency in institutions (Recommendations 28-33). Recommendation 9 also proposed that the Department of Families explore ways to involve the community more in juvenile detention centres. This would help keep young people connected to their communities and give them more power and better ways to report issues and find someone to trust.

The majority of recommendations were directed to specific institutions, with the most recommendations made to the Department of Families, Youth and Community Care. Only one recommendation was directed to the 'whole of government' urging for a concerted effort to 'reduce the gross over-representation of indigenous children in juvenile detention centres' (Forde 1999 p.189).

Forty-one of 42 recommendations were accepted. The government rejected the recommendation of establishing a working group to develop alternatives to building a new juvenile detention centre. The government also did not fully support Recommendation 23, which proposed creating a short-term residential facility for comprehensive assessments when children first enter care. Instead, they opted for a statewide assessment service rather than a centre-based approach. A 'Forde Implementation Monitoring Committee' was appointed to oversee and report on the annual progress of implementing the recommendations. The Queensland Government invested a significant amount of funding, around $78.2 million, to carry out the recommendations across three budgets (Queensland Government 2001, p.5). However, there was debate whether this amount was sufficient compared to what was recommended.[14]

We can see how the progress on implementing the recommendations was mixed. Determining the full implementation of the recommendations is challenging, but some progress was made. The government made strides, such as establishing the Forde Foundation, passing new child protection legislation, increasing funding, and making progress in youth justice. The government also took steps to decrease the overrepresentation of Indigenous children in youth detention centres by introducing preventive and responsive practices and programs.

Since The Forde Inquiry there have been further inquiries such as the 2012 Queensland Child Protection Commission of Inquiry and the 2018 Truth, Healing and Reconciliation Taskforce (the Taskforce).[15] The Taskforce allowed those who experienced institutional child sexual abuse, as well as support services and organisations, to share their perspectives and give advice to the Queensland Government. This advice focused on implementing reforms from the (Commonwealth) Royal Commission into Institutional Responses to Child Sexual Abuse.

[14] For different accounts of the amount spent see, Bligh (2000), Copeland (2002) and Spencer (2001).

[15] The Taskforce was not established as a result of the Forde Inquiry (1999). However, there are resources, including annual progress reports, and other outputs of interest. More information available here https://www.dcssds.qld.gov.au/about-us/reviews-inquiries/queensland-government-response-royal-commission-institutional-responses-child-sexual-abuse/truth-healing-reconciliation-taskforce#about-taskforce-1

Conclusion

The cases highlighted various triggers for inquiries and different approaches taken, but they all concluded that historical abuse indeed occurred and persisted. Each case attracted significant media and political attention before and during the inquiries, which gradually declined once the final reports and recommendations were issued.

After the inquiries, as attention shifted elsewhere, it became challenging to track the extent to which recommendations were implemented and their effectiveness. Yet, we see how each inquiry uncovered systemic failures within institutional settings such as a lack of action or general knowledge about best practice response.

We also see across all the three cases how the presence of power imbalances hindered effective responses to the abuse, or as noted in some cases, allowed the abuse to continue. The power imbalances between children and adults, victims and abusers, and a lack of trusted adults meant young people often found themselves either not believed, or simply not having a person to trust and report the abuse to.

Connections and relationships worked to exclude certain people and protect others, at the cost of vulnerable children. These dynamics contribute to a lingering sense of distrust in authority and institutions, negatively affecting the cultural change sought by the inquiries. The “Jersey Way” is the most prominent cultural element which was identified with its own recommendation and need for change. Although, without a unifying understanding of what the expression meant within individuals and larger community, most of the attempts to change the “Jersey Way” culture were limited.

In the lists of recommendations provided by the inquiries, it is clear that most recommendations focused on explicit conditions of systems change such as policies, resource allocation, or processes. Those recommendations trying to tackle cultural change were less in numbers and the outcomes from these either missing or less clear in terms of success. While progress had been made in some areas, challenges persisted in effecting broader cultural change.

In our document review, we came across several reports that provide insights into this topic. For example, Parenting Research Centre (2015) identified a list of factors either contributing or preventing the success of implementing recommendations.

The Parenting Research Centre found that the following factors contributed to Recommendations being implemented:

- Establishing processes and structures to facilitate implementation
- Strong leadership and stakeholder engagement
- An accountability framework and monitoring process (see, Parenting Research Centre 2015, p. xv-xvi and p.78-159).

Whilst the major barriers or inhibitors identified were:

- Practical constraints, e.g. limited budget, resources, and time
- Organisational culture, e.g. resistance to change
- Structural constraints, e.g. cross-jurisdictional differences and working with other entities
- Narrow or prescriptive recommendations (see, Parenting Research Centre 2015, p.xvi and p.78-151).

In our review of the three cases, we see a similar list of barriers appear where the recommendations failed to succeed. For more information on this report along with a list of further research worth exploring, see Appendix.

Appendix: References and additional resources

Below lists all the resources for the cases and additional resources of interest. Included have been resources relating to Inquiries in-general.

Two papers stood out in our research. We have summarised these below.

1. Parenting Research Centre (2015) Implementation of recommendations arising from previous inquiries of relevance to the Royal Commission into Institutional Responses to Child Sexual Abuse: Final Report, Commissioned by the Royal Commission into Institutional Responses to Child Sexual Abuse

Commissioned by the Royal Commission into Institutional Responses to Child Sexual Abuse, the Parenting Research Centre's (2015) report assessed the implementation of 288 recommendations from past inquiries. The Parent Research Centre's (2015) findings revealed that 48 percent of these recommendations had been fully implemented, with 16 percent partially implemented and 21 percent not implemented. Approximately 39 percent of the recommendations not implemented were in progress or under consideration, while 14 percent lacked sufficient information for determination.

Furthermore, The Parenting Research Centre (2015, p. xv-xvi and p.78-159) found that the following factors contributed to Recommendations being implemented were establishing processes and structures to facilitate implementation, strong leadership and stakeholder engagement and an accountability framework and monitoring process.

The major barriers or inhibitors to Recommendations being implemented identified were practical constraints such as limited budget, resources, and time, organisational culture such as resistance to change, structural constraints, such as cross-jurisdictional differences and working with other entities and narrow or prescriptive recommendations (see, Parenting Research Centre 2015, p.xvi and p.78-151). Furthermore, Parenting Research Centre (2015, p.157) noted within the barriers to implementation of broader recommendations focused on prevention and longer-term change:

Political resistance to long-term/preventative/early intervention strategies: A wide view emerged in this project that governments were more inclined to implement recommendations that could achieve results in the short term. There is greater difficulty in securing political will to implement strategies – irrespective of their effectiveness – that are geared to prevention and had longer-term outcomes.

The report methodology involved a multi-method design to assess the implementation of 288 recommendations selected by the Royal Commission. These recommendations were from 67 previous Inquiries related to child sexual abuse. Data was collected and analysed from government documents, surveys and interviews with key stakeholders involved in the implementation of recommendations and legislation verification.

2. Wright, K. (2017) Remaking collective knowledge: An analysis of the complex and multiple effects of inquiries into historical institutional child abuse, *Child Abuse and Neglect*, vol.74, p.10-22, available from http://dx.doi.org/10.1016/j.chiabu.2017.08.028

Wright (2017, p.19) who found when evaluating the success of inquiries is complex, as:

Success is typically measured by the implementation of recommendations and concomitant legislative and policy reform. However, these processes are often protracted, sometimes taking many

years, and tracking the enactment of legal measures, regulatory change, new guidelines, and reform in policy and practice presents considerable methodological challenges. Moreover, the assessment process itself typically depends on the willingness of governments to initiate and resource or is subject to the priorities of researchers and funding bodies. To further complicate this issue, while implementation of an inquiry's recommendations is clearly a key outcome, this measure alone does not fully capture an inquiry's manifold effects.

As for those more 'manifold effects' and broader societal outcomes, Wright (2017) cites benefits of inquiries serving a educative and knowledge productive purpose via enabling the unspeakable to be spoken, raising public awareness, bringing institutions and individuals to account, bearing witness and giving voice to those silenced, marginalised and/or disbelieved. Inquiries can have negatives of constraining the focus on a specific timeframe and type of abuse such as sexual, violence or excluding other forms of abuse, such as interfamilial abuse. In all, Wright (2017, p.20) concludes with a positive tone of the wider effects of inquiries, stating:

The impact of these wider effects is not easily quantified. Yet they serve vitally important purposes in fostering societal and cultural change, which is necessary both for the acknowledgement of past abuse and to help prevent and better respond to abuse that occurs in the future.

Inquiry resources of interest

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ABOUT FOLKET CONSULTANCY

Hej! "Folket" is Swedish and means "The People", think 'folks' in English. We're a boutique consultancy based in lutruwita/Tasmania. Founded by Linda Karlsson, Folket Consultancy is a collective of experienced consultants. Our team of folks all love to work on collaborative projects that create impact in our communities.

Between us, we offer expertise in evaluation, research, facilitation of workshops and community consultation, co-design and program development, community and stakeholder engagement, as well as strategic communication.

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