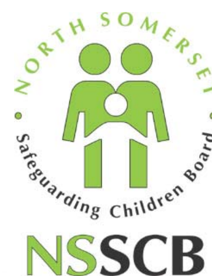
EXECUTIVE SUMMARY



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Children & Young People's Services

1. This is the executive summary of a serious case review commissioned by the North Somerset Safeguarding Children Board following the arrest of a teacher suspected of abusing children in his care.

2. The serious case review was conducted in accordance with the guidance in *Working Together to Safeguard Children 2010*. The purpose of any serious case review is to:

   - Establish whether there are lessons to be learnt from the case about the way in which local professionals and organisations work together to safeguard and promote the welfare of children.
   - Identify clearly what those lessons are, how they will be acted on and what is expected to change as a result.
   - As a consequence, improve interagency working and better safeguard and promote the welfare of children.

Background

3. The sexual abuse of children took place in a first school over a number of years prior to disclosure by a child in December 2010. The perpetrator of the abuse was a male classroom teacher who had taught at the school for 15 years. The abuse came to light when one child made a disclosure to her mother. Following this disclosure a number of photos and videos were found on the teacher's computer and other digital devices. The images appeared to have been taken at school and showed the teacher abusing other children. 5 children were identified in the photos and videos, but not all of these subsequently disclosed abuse when interviewed by the police. All of the children in the images were identified and became subject of the charges in Crown Court. During the investigation a further group of children were also identified. There was a total of 20 pupils who were witnesses to, or possible victims of abuse by the teacher.

4. At a court hearing in May 2011 the teacher pleaded guilty to 36 sexual offences, including 22 counts of sexually assaulting a child under 13 and eight counts of sexual assault by penetration of a child under 13. The teacher also admitted one count of attempted rape, one charge of voyeurism, one charge of causing or inciting a child under 14 to commit sexual activity and two charges of possessing indecent images of children. It was stated in court that, when the police arrested him, they discovered about 30,500 indecent photographs and 720 indecent movies in his possession. Most of these had been downloaded from the internet. It was noted that the youngest victim was aged six. There is no evidence that photos taken at the school were uploaded to the internet. The teacher was summarily dismissed from his teaching post and following a further court appearance in June 2011 was given an indeterminate prison sentence for public protection, having pleaded guilty.

Methodology

5. The serious case review was conducted by an independently chaired panel, which sought to address the following issues:

- How *historical concerns* about the teacher's behaviour, conduct, and performance were dealt with by the school and, if reported, by other agencies?
- What lessons are there for how schools *handle complaints/disciplinary/child protection matters* that are brought to their attention by children/young people and parents; how they are managed and addressed in school, and how they are reported to governors and the local authority?
- What are the lessons for *employment practices* in schools and the *selection of prospective teachers* onto teacher training courses?
- What are the lessons for the *use of technology in schools*?
- What are the lessons for *training* of school staff and governors in child protection matters
- What lessons are there for the leadership of schools in *creating a safe environment and culture for children and young people in school in which childrens' rights to safety and privacy are promoted and protected*?

6. The review was informed by Individual Management Reviews (IMR) provided by the following agencies:

- The first school, to include the work of:
  - Learning and Achievement Branch, Children & Young People's Services (CYPS)
  - Governor Services (CYPS)
  - Schools Human Resources
  - CYPS ICT

- North Somerset Children's Social Care (CYPS)

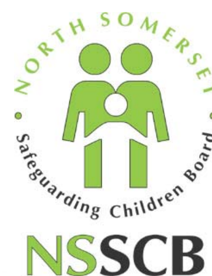
- North Somerset Education Support Services (CYPS):
  - Educational Psychology
  - Special Educational Needs
  - Education Welfare

- Weston Area Health Trust
  - CAMHS
  - School Nursing Service

- NHS North Somerset
  - GPs

- Avon and Somerset Police

- A Health Overview IMR was produced by the Designated Doctor and Designated Nurse for NHS North Somerset



7. The review took into account inspection reports published by Ofsted. Ofsted was asked to comment on their involvement in the school.

8. The overview report on which this executive summary is based was written by Mike Craddock, an independent social care consultant.

9. Families of children at the school as well as teachers have been given the opportunity to contribute their views to this review. In addition a number of teachers and parents who were interviewed by the police gave their permission for copies of their statements to be released to the serious case review. The review also had the benefit of information obtained through disciplinary investigations which were undertaken following the disclosure and the police involvement.

The school

10. The school is a small first school located on the outskirts of a large seaside town. The school had approximately 120 pupils drawn from a cross section of the local population. There was nothing in the abilities or background of the pupils to suggest that they might be vulnerable to abuse. The school is locally managed by a board of governors and the head teacher. The school receives statutory and contracted regulatory and support services from the local authority.

The teacher

11. The teacher joined the school as a mature newly qualified teacher and had worked there for 15 years. There was no evidence that at any other time in his life or in any activity outside work there was any suspicion that the teacher might pose a risk to children.

12. Within a year of his appointment and throughout the time that he worked in the school, a number of teaching and support staff in the school had a variety of concerns about the teacher. Early on it was noticed that the teacher had favourite pupils within his class who were invariably girls, who were often given tasks within the class which were viewed as privileges as well as being given greater personal attention by the teacher. These pupils were allowed to be over familiar with the teacher, who was known to speak and joke with his pupils in a manner which was inappropriately adult. This situation was described by staff to have been common knowledge amongst the school staff.

13. The management report from the school makes reference to at least 30 incidents of inappropriate or unprofessional conduct involving the teacher. These ranged from inappropriate lesson content, through over-familiarity with children to indecent touching. On a number of occasions colleagues advised the teacher of the inappropriateness of his behaviour and pointed to the risk that he could be accused of professional misconduct. However only 11 of the 30 recorded incidents were reported formally within the school. In December 2010 a child disclosed to her mother that the teacher had been indecently touching her in school on an almost daily basis for the past two months. The mother reported this to the police and the teacher was immediately arrested.

The response to concerns

14. Clear guidance had been issued to all schools in the area about the actions to be taken to minimise the risk of harm to children in the school. However the report from the school has established that the guidance was not disseminated within the school and staff there remained unaware of it and their responsibility to adopt the practice standards advocated. In spite of this many of the staff in the school demonstrated that they were aware of the requirements for good practice and acceptable standards of behaviour and made efforts to challenge both the behaviour and performance of the teacher.

15. Overall there was a significant failure to comply with the principles of the guidance designed to promote safer working practice within schools. Combined with the failure to formally report the majority of concerns it must be presumed that staff were both unaware of the guidance and inhibited from following their normal professional instincts and there was a lamentable failure by management to create an environment in which the needs of the child were paramount and good practice was promoted. In spite of there being good continuity in the school management team, all of the incidents reported to management were apparently dealt with in isolation with no consideration being given to the cumulative significance of previous concerns.

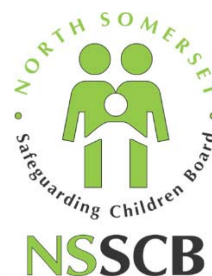
16. Much of the behaviour exhibited by the teacher was typical of grooming activities pursued by adults intent on sexually abusing children. The failure of school managers to take action in response to the concerns raised was compounded by the failure of anyone in the school to recognise that the teacher's behaviour might have constituted grooming for sexual abuse. This raises questions about the impact of the safeguarding training that staff in the school had received. All schools have a designated teacher for child protection who should be accessible to any member of staff to give advice on child protection matters. All schools also have access to the Local Authority Designated Officer (LADO) who can provide specialist advice when there are child protection concerns. No contact was made by the school at any time with the LADO.

The involvement of agencies with the school

17. Few external agencies had any direct involvement with the school. The school received support from professionals in education and support services, which included educational psychology, special educational needs and education welfare. There is no record that any of the children identified as victims or witnesses of the abuse were notified to education support services.

18. Services were also provided to the school by North Somerset Children and Young People's services, through School Improvement Partner visits, Governor Services, Schools Human Resources and ICT. Potential interventions by these services tend to focus on attainment, achievement and people progress. The school was not judged to be in need of additional intervention and consequently input from these services was limited.

19. Observations of the teacher’s teaching were carried out by the School Improvement Partner and local authority advisers as well as by governors, the head teacher and deputy head teacher. The teacher's performance was judged to be in the most part satisfactory. Although



another teacher raised concerns about inappropriate contact with a pupil none of these formal observations of his teaching led to any action being taken about possible inappropriate involvement with any of his pupils.

20. The concerns raised about the teacher should have prompted notifications to the chair of governors and colleagues in the local authority. The school failed to make such notifications and there appears to have been a very poor level of communication in part due to personality traits of key staff.

21. Outside involvement with the school also came from the School Nursing Service, which aims to review health at key stages and support the development of children's personal health. The involvement of this service in the school was limited to routine surveillance of all children in reception and year six, support given to the school with specific issues and advice and support to teaching staff and parents as requested. School nurses did not identify any concerns about possible abuse of children during any of their contacts with the school.

22. The school was inspected by Ofsted on three occasions during the review period. At each of these inspections the school was graded good. The most recent inspection noted the outstanding leadership of the head teacher and that levels of care were outstanding and underpinned by the school's very supportive ethos. The report noted that pupils feel exceptionally safe and secure because they know that staff have their well-being at heart and are always prepared to listen, help and take action. In response to this review Ofsted has stated that they are unable to provide the evidence on which these judgements were based because their records are not retained for more than six months, and have pointed out that these inspections were carried out using a methodology that has subsequently changed.

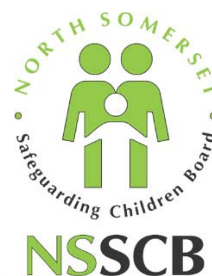
The involvement of external agencies with the children

23. None of the external agencies that were involved with children from the school has been able to detect an unusual or unexpected number of children that have come to the attention of the agency. Some agencies acknowledged that they do not have data management systems that would have enabled them to detect any significant variations during the review period. Both children's social care and education support services conducted comparative studies with similar schools and concluded that there were no unexpected referral rates from the school under review.

24. Nine of the 20 children had at some time received services from the local NHS trust, but in none of these cases was there any possible indication of sexual abuse. 11 of the 20 children are recorded as having contacts with GPs, but again there is no indication of sexual abuse. Six of the children were known to children's social care before the disclosure was made, but there was nothing to link any difficulties to any abuse that might have been experienced at the school.

Conclusions and lessons learned

25. The review report draws conclusions and identifies lessons to be learned in relation to each of the following aspects of the terms of reference:



26. **Historical Concerns** - there is a substantial body of evidence that points to the fact that the concerns about the behaviour, teaching practice and relationships of the teacher were not appropriately dealt with. The following lessons arise from this:

- It is essential for schools to keep accurate records of all incidents and concerns arising in connection with members of staff in order that historical patterns can be detected.

- While it is important to protect staff against malicious allegations, all concerns and complaints need to be treated with respectful uncertainty, and all evidence carefully recorded.

- Child protection training for school staff should aim to raise awareness of grooming behaviour and ensure that external advice is sought in any case causing concern.

27. **Handling of complaints, disciplinary, and child protection matters** - there is evidence that staff were unaware of the procedures to be followed in the case of complaints and child protection concerns. When complaints were made to management they were not appropriately handled and disciplinary procedures were not followed. There was a failure to seek external advice. External scrutiny of the school was ineffective in identifying potential risks to the children. The following lessons have emerged:

- The quality of leadership of the school is of fundamental importance and there needs to be a process to assess and develop school leaders.

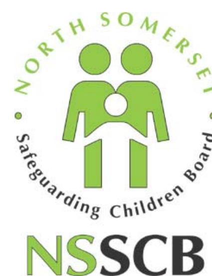
- Judgements about the quality of leadership are dependent on effective external scrutiny, which was lacking in this case and this may have led to a false sense of security in parents and external agencies. Agencies providing external scrutiny must make explicit the limitations of that scrutiny and stress the importance of parents and others acting on concerns that they may have.

- The failure by staff to instigate or pursue complaints, while understandable in terms of management responses to earlier complaints, indicates poor awareness of, and training in child protection.

- As a consequence of this, staff were unaware of how complaints could be pursued externally. Staff and parents must be made aware of channels for pursuing complaints when they are unsatisfied by any internal resolution of a complaint.

- The failure to facilitate expressions of concerns by children may have been significant in this case. All schools should have access to and be encouraged to use skilled external facilitators who, in the event of serious complaints, can help children express their views.

28. **Employment practice in the school and the selection of prospective teachers** - it is clear that appropriate employment practices were not fully adhered to during the recruitment of the teacher. However it must be acknowledged that even if recruitment practices had been closely followed, it is possible that the teacher would still have been appointed. It is therefore important to consider the use of more rigorous recruitment processes, such as value-based interviewing, when recruiting staff to work with children.



29. **The use of technology in schools** - it is apparent that the school policies on the use of computers, mobile phones and cameras, which the school had developed were neither adequate nor appropriately disseminated to staff in the school. However it is also clear that the existence of policies will not necessarily deter a member of staff intent on misusing technology. The key lesson to emerge in respect of the use of technology is that there can be no substitute for a strongly established culture of safeguarding within schools, which gives primacy to ensuring the safety of children and encourages staff to challenge apparent misconduct.

30. **Child protection training for staff and governors** - the review has shown that staff and governors in the school had had access to child protection training, but raises concerns about the effectiveness of this training. The review identifies the potential significance of the role of the designated teacher for child protection, but acknowledges that this did not operate effectively in the school. The lessons arising from this are that it is not sufficient to simply provide child protection training. It is important to monitor the take-up and impact of the training and also to monitor the work of the designated teacher for child protection within the school.

31. **Creating a safe environment and culture for children and young people in the school** - it is clear that the cultural focus of the school was on learning and attainment. The school's development plans demonstrate ambitions to provide an effective learning experience for pupils and an impetus towards continual improvement. Objective data on pupil attainment and evaluation of development plans indicates that in terms of learning the ambitions were being achieved. This focus on learning and attainment was not matched by a culture of safeguarding. The process of reporting and acting on concerns was positively hindered by a management style that discouraged comment and open communication. The clear lesson emerging from this review is that it is not sufficient for a school to have a culture that focuses only on attainment. A school culture needs to recognise that if children are to achieve their potential they must first be assured of a safe environment, in which any risks that they may face will be given full and open consideration by staff at all levels in the organisation.

Recommendations

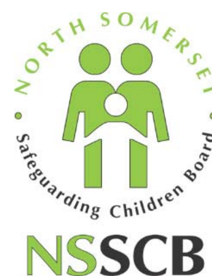
The majority of issues arising from this serious case review are addressed in the recommendations contained within the IMRs which are reproduced below. In addition to these the overview report makes the following recommendations:

Overview Recommendations

1. The North Somerset Safeguarding Children Board (NSSCB) should ensure that this review is distributed to all schools and early years settings together with the Ofsted publication 'Safeguarding in Schools: Best Practice'.

2. The NSSCB should develop an audit based on this Ofsted publication and ask all schools to complete this audit and report to the Board.

3. The NSSCB should review the competencies and role description for the Designated Teacher for Child Protection and take steps to ensure that head teachers, their deputies and school governors are familiar with the role and responsibilities of the post.



4. The NSSCB should seek a review of child protection training for schools and ensure that it addresses the recognition of grooming behaviour, the responsibilities of the DTCP and awareness of external avenues for notifying concerns. The review should include the development of a process for monitoring the engagement of schools in child protection processes.

5. North Somerset Schools Human Resources should recommend the use of Value Based Interviewing (VBI) for recruitment in schools and other childcare settings, and offer training and support for schools wishing to implement VBI.

6. The NSSCB should write to Her Majesty's Chief Inspector (HMCI) at Ofsted to:

- Ensure that HMCI is aware of the inappropriateness of the safeguarding judgements contained in the inspection reports of the school.
- Advise that Ofsted should review the methodology by which such judgements are reached, and the policy on retention of records to support these judgements.
- Suggest that Ofsted should take steps to encourage parents to remain alert and responsive to possible risks to their children in settings in which children are judged by Ofsted to be safe.
- Recommend that inspectors check staff and school managers' understanding of key procedures to include ICT usage, LADO arrangements and safe practice guidance.

The following recommendations are reproduced from the IMRs:

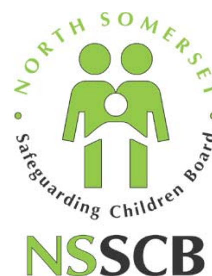
The School

7. NSSCB should, as part of the dissemination of learning from this review, draw the attention of all school Governing Bodies to the desirability of all areas where staff and pupils may come into contact being open to casual observation by other school staff and visitors. They should be urged to review their school premises in this regard and address any shortfalls.

8. NSSCB should reissue and reiterate the requirements contained in the Chair's letter of November 2009 to partner agencies. Its implementation and impact on practice should be subject of audit activity commissioned by the NSSCB.

9. North Somerset Council (NSC) should, in conjunction with the NSSCB, ensure that awareness of the standards outlined in national guidance on Safer Working Practice for Adults who work with Children and Young People is incorporated into school PSHE curricula locally. The Chair of the NSSCB should write to the Secretary of State for Education to promote adoption of this practice nationally.

10. The head teacher and governors of the school should ensure that appropriate e-safety policies are in place, a comprehensive e-safety education programme for everyone in the school is implemented and that these arrangements are subject of regular, initially every six months, review by the Governing Body.



11. NSC should include within the School Improvement service provided a rolling programme for the review of individual school e-safety policies and their implementation. Any deficiencies in these arrangements should be reported to both the head teacher and Chair of Governors of the school.

12. NSC should make available to school managers and Governing Bodies a model of arrangements for robust and auditable appraisal and review of staff performance. The arrangements should include facilities for explicit recording of evidence supporting the appraisal, including any concerns regarding the performance of a staff member. These arrangements should extend to the appraisal and review of head teacher performance by the Governing Body. Consideration should be given to including a 360 degree feedback element in annual performance reviews. The effectiveness of performance management arrangements should be included in school self evaluation frameworks and moderated through the School Improvement system.

13. NSC should ensure that training provided for the DTCP position emphasises the personal responsibility of those holding the role to take ownership of concerns for the safety of a child and to liaise with other relevant agencies, and the LADO. Candidates completing the training should be required to make a positive commitment in this respect before being accredited to undertake the role.

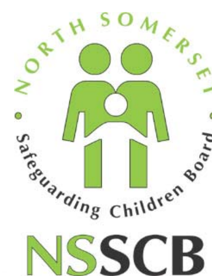
14. NSC should review the curriculum for the delivery of safeguarding training in schools and ensure that it addresses safe professional practice and individual staff responsibilities to ensure that concerns for the safety of a child are effectively addressed, including appropriate communication with children and the use of escalation and whistle-blowing procedures; together with record keeping requirements. Contracted arrangements for delivery of the training within schools should be offered to school Governing Bodies by NSC.

15. NSC should review the content of the training provided on safe recruitment and satisfy themselves that it properly equips both professional staff and school governors to effectively and confidently discharge their responsibilities within the recruitment process. It would be advisable to engage school governors in this review process.

16. NSC should review their provision of induction training for new school governors and ensure that it properly equips them to undertake the role and includes opportunities for benchmarking against practice in other schools/Governing Bodies. Arrangements for governors to observe meetings of other Governing Bodies and share experience across schools as part of their continued development should be encouraged.

17. NSC CYPS, Learning and Achievement Branch should put in place robust systems to check whether areas of concern raised with schools have been addressed within agreed timescales.

18. NSSCB should, as part of the dissemination of learning from this review, draw the attention of all school Governing Bodies to the need for them to rigorously and intrusively ensure that school policies and practice to safeguard and promote the welfare of children are effective. Guidance on ways in which this may be achieved, including ensuring that escalation procedures for parents and children are well publicised, should be provided.



19. NSC should review the training provided to governors and Chairs of Governing Bodies to ensure that it highlights the potential difficulties which may be associated with the head teacher's role, particularly in smaller schools, as the central link between the Governing Body and the school and equips them to recognise and address circumstances where this may be an issue.

Education Support Services

20. Physical Environment.

Classrooms should have non covered internal windows.
Designated changing areas for members of staff separate from areas where children are allowed.

21. Management Role.

Unplanned visits to classrooms during school day on regular basis including at break times.
Head teachers/deputy head teachers to be linked with a critical friend from another school to discuss decision making
New managers to be mentored for first 2 years.

22. Governors

Compulsory governor training re safeguarding and child protection.
Annual separate governor meeting with school advisor.

23. Reporting allegations about members of staff.

Compulsory reporting system for DTCP into LADO indicating nature of allegation and action taken.

24. Safe places to talk.

All schools to have a named safe person for children to talk to about any concerns (not their teacher or head teacher).

25. ICT

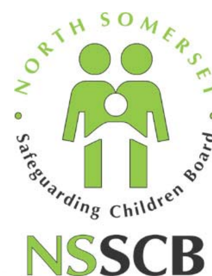
Policy for safe use of ICT by staff and pupils in each school eg images processed in school, times when videoing appropriate and legitimate, ways of monitoring individual use of ICT.

General Practitioners

26. Ongoing updates per Laming Report, 3 yearly to ensure up-to-date knowledge of all practitioners.

Health Overview

27. Referrals.



There is no doubt that a single set of health records per patient from birth to death would facilitate information sharing (recommendation from the Laming Report 2003) However this is an NHS national issue and one that cannot be resolved locally. Therefore we would recommend that in the absence of this all agencies, including school nurses, always copy referrals to GPs who hold the responsibility as 'gate keepers' for collating information about all of their patients.

28. Training

a) Significant patterns of presentations to health professionals were not a feature in these cases however it is possible in cases of institutional abuse that this might happen therefore teaching materials need to reflect this issue in addition to individual presentations. Also that individual practitioners may hold seemingly small and irrelevant pieces of information whose significance is only appreciated when information is shared.

b) As the Continence Service is now managed by Adult Services it is vital that the staff engaged with children are trained correctly to Level 3 and that managers appreciate the importance of this.

29. Equality and Diversity

Ethnicity and Disability information pre 2008 needs to be updated in all GP records.

NHS Community Services

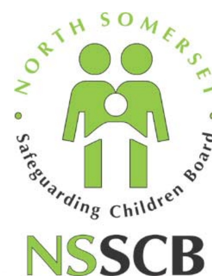
30. Systems and processes for referrals made / received by school health nurse service should be reviewed to identify and implement strategies that would strengthen methods of collation, retrieval and audit. This could then be used to identify any emerging patterns and allow comparison of referral trends across matched year groups. This work should be undertaken by the lead for School Health Nursing / Named Nurse for Safeguarding Children.

31. Communication pathways between the Enuresis Service (provided by the Bladder and Bowel Service) and the School Health Service should be reviewed and strengthened to ensure that all practitioners are aware of all relevant information relating to children that are referred and reviewed by the Bladder and Bowel Service. This work should be undertaken by School Health Nurse Lead / Bladder and Bowel Service Manager

32. Practitioners/team leads and child protection staff should receive multi-agency training regarding sexual abuse with respect to its perpetration in institutional settings. This should aim to raise awareness and provide the necessary knowledge, skills and confidence for staff to recognise the pertinent signs and symptoms of such abuse and the actions to take to address this.

This training should be delivered in a multi-agency setting via the safeguarding board.

Weston Area Health Trust (WAHT)



33. The issue of providing training about institutional abuse should be raised at the NSSCB training sub-group. This should be raised by the Trust Safeguarding Lead at the next sub-group meeting.

34. The importance of including ethnicity and disability status in children's notes should be discussed at single agency training. This should be addressed by the Trust Safeguarding Lead and be added to training immediately. The practical implementation for each department at WAHT will be discussed at the next Trust child protection committee meeting.

35. Learning from this serious case review to be added to single agency training by Safeguarding Lead when results published.