THE SAFEGUARDING IMPLICATIONS OF EVENTS LEADING TO THE CLOSURE OF STANBRIDGE EARLS SCHOOL

A SERIOUS CASE REVIEW

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1. INTRODUCTION

1.1 Stanbridge Earls, an independent school in Hampshire (the school), closed in September 2013. Its closure followed from concerns expressed forcibly in January of that year by a Special Educational Needs and Disability First Tier Tribunal[1] (SENDIST) and subsequent events. The SENDIST had considered issues of disability discrimination in relation to a former female pupil of the school, Child F. The SENDIST judgment led to a great deal of adverse publicity about the school and the number of pupils attending fell, so that the school became no longer financially viable.

1.2 The report from the SENDIST had raised a range of issues including matters relating to the safeguarding of children at the school, particularly allegations that a child had been subject to sexual assaults by other children while at the school. The SENDIST required that its report be brought to the attention of a number of agencies, including the Department for Education (DfE), Ofsted and Hampshire County Council (HCC). Previous inspections by Ofsted over a number of years had identified no safeguarding concerns, and indeed had largely judged the school "outstanding" in most respects, including safeguarding.

1.3 HCC, on receipt of these reports in January 2013, led a major exercise to investigate the safeguarding concerns raised by the SENDIST report. The Hampshire Constabulary (the police) also played a lead role in that exercise and separately investigated a number of related matters, which indicated that crimes might have been committed. The DfE commissioned a number of emergency inspections by Ofsted. Ofsted also carried out a wide-ranging review of their previous involvement with the school, and their service arrangements more generally.

1.4 These matters were formally notified to the Hampshire Safeguarding Children Board (HSCB) in April 2013. They sparked a chain of enquiries and investigations culminating, for HSCB, in the commissioning of this report.

1.5 This report examines whether the actions taken by local statutory organisations, some national bodies and the HSCB itself were appropriate and in line with statutory guidance. It considers whether responses to allegations were effective, whether there were any failings and what learning there is for the HSCB and its statutory partners in responding to safeguarding concerns, with particular reference to independent schools.

2. THE ACTIONS TAKEN BY THE HAMPSHIRE SAFEGUARDING CHILDREN BOARD

2.1 The current Chair of the HSCB, Ms Maggie Blyth, was appointed in April 2013. Following an initial briefing on Stanbridge Earls she allowed some time

[1] A SENDIST considers appeals against decisions by local authorities regarding provision for children's special educational needs, and also, as was the case here, deals with claims of disability discrimination in schools.

to see whether the police enquiries might be concluded in the near future, but it became clear that this would not be the case.

2.2 HSCB discussed Stanbridge Earls at its first meeting after her appointment in July 2013. The Chair had by then decided that there should be an independent review of the events leading to the school's current circumstances, with particular reference to:

- How allegations of sexual abuse and bullying were dealt with in this school;
- The roles of various agencies in respect of safeguarding concerns arising in an independent school and the agencies' understanding of their roles;
- The way in which professionals worked individually and together to safeguard and promote the welfare of children;
- Whether there should be a Serious Case Review (SCR) in respect of these events.

2.3 At that point no referral for a SCR to the HSCB had been made by any agency because no evidence of significant harm arising from safeguarding concerns had been assessed by any professionals. There was therefore at this stage no dialogue with the new National Panel of SCR Experts, established in April 2013. However, the Chair formally communicated the decision to instigate an independent review to both Ofsted and the DfE.

2.4 That independent review (the Crompton review) was led by a former local authority Chief Executive, Mr Kevin Crompton, who was also at that time the Chair of three Safeguarding Children Boards in other parts of the country. The Crompton review was concluded in February 2014 and accepted by the HSCB in April 2014. The leading recommendations from that report reflect the key matters detailed below about the weaknesses in national structures for safeguarding children attending independent schools. The report also proposed actions to be taken locally to promote the engagement of independent schools in the safeguarding agenda in Hampshire.

2.5 Having considered the Crompton review at its meeting in April 2014 the HSCB concluded that responses during 2013 from the key agencies, HCC and the police, to the safeguarding concerns at the school were satisfactory. A recent Ofsted inspection of HCC and HSCB, in which Stanbridge Earls was a key line of enquiry, had also concluded that HSCB had worked well during 2013/14 to develop new means of seeking assurance about safeguarding policies and practice in independent schools. It also recommended that HSCB might further follow up individual cases.

2.6 However, HSCB accepted some comments from Ofsted in April 2014, principally that the "voice of the children" affected by the events should emerge more clearly from any review. Ofsted had also now specifically suggested that HSCB should conduct a Serious Case Review (SCR).

2.7 The closure of Stanbridge Earls had attracted a great deal of publicity, and the HSCB, through its SCR Committee, had already considered whether the

matters leading to the closure of the school indicated that a SCR was required. It had been agreed that the criteria[2] for conducting an SCR were not met. It was not clear that, despite various serious allegations made, the criterion of having suffered "serious harm" as a result of abuse or neglect was evidenced in respect of any child involved.

2.8 The Chair also held the view that it was necessary to consider the evidence submitted to the Crown Prosecution Service (CPS) regarding any alleged abuse before coming to a final decision on whether it was appropriate to conduct an SCR. It is often not necessary to await information from criminal proceedings before making a decision on an SCR but the situation here was unusual in that so many young people were involved,directly and indirectly, and the criterion of "serious harm" had been judged not necessarily to be met. The CPS could not provide their information until legal processes had been completed and it was envisaged that this would still take several months.

2.9 The HSCB therefore decided in July 2014 to initiate a "second stage" independently led review. The report from the review was to have a clearer narrative and evaluation of the part played by public bodies in these events. It should also consider more closely issues relating to safeguarding in independent educational establishments. The review would seek to draw out the learning points from these events, some of which might have national significance, and it would be published.

2.10 The Terms of Reference for that exercise should also take into account the possibility that its status might change. It should cover the ground that would be expected in an SCR, in anticipation of the decision as to whether there should indeed be an SCR. The HSCB commissioned Kevin Harrington[3] Associates Ltd to lead that process and their work commenced in September 2014.

2.11 In April 2015 the CPS wrote to the Chair of the HSCB setting out the matters which had been under consideration, advising that there were to be no prosecutions on any of those matters and explaining those decisions in detail. The advice from the CPS is explained below in section 4. Having considered that information the HSCB Chair and the Board's SCR Committee judged that the statutory threshold for an SCR was not met: there was no conclusive evidence that any child had been abused, sexually or otherwise, at the school and had suffered "serious harm" directly as a result of that abuse.

2.12 The Chair was mindful however of the discretion afforded by WT 2015, which states that
"If an SCR is not required because the criteria in regulation 5(2) are not met, the LSCB may still decide to commission an SCR or they may choose to commission an alternative form of case review".

[2] The criteria for when an SCR should be carried out stem from the Local Safeguarding Board Regulations 2006. They are then set out and explained further in the government's guidance, Working Together to Safeguard Children (2015), referred to in this report as WT 2015.
[3] See Appendix A

2.13 The Chair took into account the possibility that opportunities to bring important issues to public attention might be enhanced by an SCR. She also noted the views of many families involved, who, for a range of reasons, felt that these events should be more widely publicised and understood. Pragmatically, an increasingly contentious and ill-informed debate between various parties about whether or not there should be an SCR threatened to jeopardise the principal aims of the exercise, to learn lessons and improve practice.

2.14 The Chair therefore judged that it was in the public interest that the work in train should continue and be completed as an SCR. That decision was supported by the HSCB and the SCR was formally initiated on 1st May 2015. By that time much of the work of the review had already been completed.

2.15 The families involved were advised of the change of status and invited to add to the submissions they had already made. Most chose not to do so. Agencies that had already submitted formal contributions to the review were invited to re-consider those contributions in the light of the change in the review's formal status, and again most did not make any new submissions.

2.16 The DfE was now approached and agreed to make a submission to the SCR considering its own role in the events. It was decided that the work carried out to that point did not contain a sufficient emphasis on health provision at the school, having concentrated principally on the actions of police and the local authority, so further reports were commissioned from health services. It also emerged at a late stage that there had been some involvement of the NSPCC in these events and they provided a report.

2.18 The review proceeded through the summer of 2015 and this report was approved at a formal meeting of the HSCB in September 2015.

3. THE REVIEW PROCESS

3.1 The Terms of Reference for this review required that it should prioritise the direct engagement of the families and children affected by the events leading to the closure of the school, and by the closure itself. The involvement of families is described at section 5 of this report.

3.2 The review has considered events during the period from October 2010, when a referral was made to HCC, to the closure of the school in the summer of 2013.

3.3 This report necessarily gives an anonymised account of the key matters relating to individuals. However it is not a review of any individual child or "case". To different extents and in different ways many young people who attended Stanbridge Earls during the period under review, and perhaps previously, have been harmed by aspects of the way in which the school was managed and /or by its subsequent closure.

3.4 The report describes and comments on the involvement of all the agencies which have contributed to the review, before going on to draw out some key emerging themes.

3.5 Very large amounts of information have been provided to this review, considerably more than in other SCRs led by the author of this report. That is perhaps not surprising given that this report considers circumstances and events affecting nearly 200 young people. The information has been provided by all the agencies involved and by many of the families affected by these events. However it has not been necessary or appropriate to relay the detail contained in those reports and accounts in order to draw out the important themes and learning points.

3.6 The rest of this report is therefore structured so as to consist of:

- An outline narrative of the key events leading to the closure of the school and the commissioning of this review;
- A reflection of the contributions made to this review by families of children who attended the school;
- A commentary on the involvement of all the agencies known to have had some involvement in these events;
- A consideration of issues relating to safeguarding in independent schools;
- A consideration of some further matters emerging from these events.

3.7 The conduct of the review has not been determined by any particular theoretical model but it has been carried out in accordance with the underlying principles of the statutory guidance, set out in WT 2015: The review

- *"recognises the complex circumstances in which professionals work together to safeguard children;*
- *seeks to understand precisely who did what and the underlying reasons that led individuals and organisations to act as they did;*
- *seeks to understand practice from the viewpoint of the individuals and organisations involved at the time rather than using hindsight*[4]*;*
- *is transparent about the way data is collected and analysed; and*
- *makes use of relevant research and case evidence to inform the findings".*

3.8 This report has been written in the expectation that it will be published. This means that some confidential material about individual children and professionals is not disclosed.

[4] This review does not rely on hindsight, and tries not to use hindsight in a way that is unfair. It does use hindsight where that promotes a fuller understanding of the events and their causation.

4. THE EVENTS LEADING TO THIS REVIEW – A NARRATIVE CHRONOLOGY

4.1 The context

4.1.1 The school and its background are described by the Independent Schools Inspectorate[5] (ISI), following an inspection in the spring of 2013: *"Stanbridge Earls School is a co-educational day and boarding school for children and adults from the ages of 10 to 20. It specialises in teaching pupils with specific learning difficulties and those with special educational needs or disabilities, some with statements (of Special Educational Needs). Pupils' needs range from those diagnosed as having dyslexia, dyspraxia, dyscalculia, speech and language needs, and autistic spectrum disorder (ASD) to those who for various reasons need a small school environment… The school was founded in 1952 as a charitable trust, and it is administered by a board of governors. It is situated two miles north of Romsey, Hampshire, on a 50 acre rural site. The main school building is a grade 2 listed manor house and it is surrounded by other buildings which were once part of a large estate".*

4.1.2 At this time there were 189 pupils at the school,153 boys and 36 girls. 30 were day pupils, 159 boarded at the school. These arrangements were funded by the children's families, by a local authority or by the Ministry of Defence (because a parent or parents were in the Armed Forces) – or sometimes by a combination of contributions from these parties.

4.1.3 Professionals involved in these events – police officers, teachers, social workers, doctors and nurses – have received, from a small number of families or individuals, a number of allegations of criminality and over a hundred complaints and / or representations to employers and bodies responsible for professional registration. The criminal allegations have been fully explored and none will lead to any further action. Some of the other matters are still under consideration and consequently no specific reference is made to any such matter in this account.

4.2 Events before the SENDIST judgment, June 2010 to December 2012

4.2.1 Child F started attending the school in June 2010 when she was 14 years old. She was a child with particular needs. The extent to which the school recognised those needs was the subject of dispute until the SENDIST found evidence that she was "disabled" and that, from the outset, the school had made a record of the conditions constituting that disability. Soon after her admission to the school it became clear that her level of social and emotional development was significantly below what might be expected in a child of her age.

[5] The ISI is approved by the Secretary of State for the purpose of inspecting schools belonging to the Independent Schools Council (ISC) Associations and reporting on compliance with the Education (Independent School Standards) (England) Regulations 2010.

4.2.2 During the first six months of 2011 there were indications that Child F and others might be engaged in sexual activity at the school. The school's responses to these matters were "ad hoc" – that is, they sought to address the immediate presenting issues in an unplanned way, and without adequate recognition that there might underlying matters to be considered, including deeper concern for Child F's welfare.

4.2.3 In March 2011 Child F approached a member of staff and talked about wanting to kill herself. (It subsequently emerged that this was not the first such occasion but previous instances had not been recorded). The member of staff spoke to the Head Teacher who decided that the child did not have any real suicidal intent and took no further action.

4.2.4 In the same month the mother of another pupil at the school approached the Children's Services Department (CSD) of HCC. She had learned of an incident, five months earlier in October 2010, where her daughter, Child J, then aged 12, was said to have been coerced into removing her clothes by a group of students at the school. CSD advised that this was something the mother should take up directly with the school in the first instance, but that she should come back to them as necessary.

4.2.5 During June 2011 Ofsted inspected the school, reporting positively as indicated above that the school was "outstanding".

4.2.6 Towards the end of that month further evidence emerged, as a result of her receiving medical treatment from the school's GP, suggesting that Child F had been involved in sexual activity. Staff took a view that this sexual activity was both "consensual" and a confidential medical matter. They acceded to a request from Child F, aged 15, that her parents should not be informed. The matter was not reported to other members of staff, the CSD, the police, or to the parents of the other child involved.

4.2.7 In July 2011 Child F told her parents that she had had sexual intercourse at the school. Her parents took her to the family's GP who found an injury which might have been caused by sexual activity.

4.2.8 The mother of Child F raised this with the Headmaster who has reported asking a member of staff to make a safeguarding referral to Hants CSD. Over the next two weeks, the sequence and detail of events is disputed between some of the parties involved, and it is clear that the school's recording of these events was inadequate. However it is also clear that the school was aware of the sexual activity and the mother's concerns some days before any safeguarding referral was made. During that time further information came to light and concerns emerged that the sexual activity had been non-consensual, so that there was effectively an allegation of rape.

4.2.9 By the middle of July the CSD and the police had discussed this under formal child protection procedures. They agreed that there would be a "single agency" police investigation because of the allegation of rape. This police

investigation was to continue over some months and led to other investigations.

4.2.10 Both students returned to the school after the summer holidays. The boy was arrested in September and excluded from school. There is evidence that Child F was bullied by other students following that arrest. That was reported to police by Child F's parents at the time but no action was taken.

4.2.11 There were further incidents involving Child F and other students during September. These included an allegation by Child F against another boy which was subsequently investigated by police. That incident was initially reported to a member of school staff who took some investigative steps before contacting police.

4.2.12 The school initially asked the parents of Child F that she should be removed "for her own protection" before, in October, requiring that she be removed. In the same month representatives of Child F's parents made a complaint to Ofsted, querying the positive findings from the inspection of the school conducted in June of that year.

4.2.13 The family of Child F lived in County Z, some distance from Hampshire. Officers from County Z had become aware of the situation and contacted CSD in October 2011. CSD confirmed their knowledge of previous events and the extent of their involvement. County Z was subsequently to carry out further enquiries as described below.

4.2.14 In October 2011 DfE received, via Ofsted, a range of allegations raising child protection concerns in respect of the school from solicitors acting for the family of Child F. After making enquiries DfE, in December 2011, commissioned an emergency Ofsted welfare inspection which was carried out in January 2012. Because a welfare inspection was already scheduled for the following summer the January inspection did not look at safeguarding procedures generally. Instead DfE asked Ofsted to focus on bullying, the supervision of older pupils and the standard of accommodation for female pupils, issues raised specifically in the complaint from the solicitors. The inspection found that all relevant standards were met. The solicitors were informed of this, and did not ask for any further action.

4.2.15 in February 2012, Ofsted received a safeguarding complaint from the family of Child J in respect of the incident in 2010. This was discussed between DfE and Ofsted and the planned inspection was brought forward from the summer to May 2012. This inspection culminated in an 'outstanding' judgement as before, with all standards met.

4.2.16 The mother of Child J had also made a complaint to police in May 2012 about the same incident. Police visited the school and decided that no further police action was required. The CSD was informed of this.

4.2.17 In June 2012 the parents of Child F made a complaint to police that members of staff at Stanbridge Earls had perverted the course of justice by

removing or destroying records. They alleged that staff had done this to prevent police and CPS reaching the conclusion that there should be criminal prosecutions against pupils alleged to have assaulted their daughter.

4.2.18 The CPS found that there was insufficient evidence to provide a realistic prospect of conviction against any member of staff for the offence of perverting the course of justice.

4.3 The SENDIST judgment and subsequent events: January to September 2013

4.3.1 The SENDIST issued its findings in January 2013. In sum, the SENDIST found that the school had discriminated against Child F in contravention of a number of the requirements of the Equality Act 2011. The judgment specifically stated that the school did not take all reasonable steps to keep her safe. The judgment was sent to the Secretary of State, in order that the continuing registration of the school be re-considered. The judgment was also to be sent, by the school, to Ofsted, to all local authorities using or potentially using the school, and to the Director of Children's Services (DCS) for HCC. (In fact HCC received an unredacted copy of the judgment from the family of Child F before the school had sent them a copy). The school was required to take a number of actions including issuing an apology to Child F and her parents. There was extensive press coverage of matters discussed in the SENDIST judgment.

4.3.2 These events led to a great deal of activity across many of the agencies involved in this review. The school started to take action in response to the SENDIST findings, and the consequent responses from Ofsted and the DfE. The governing body submitted its own action plan in addition to the action plan submitted by the school. The CSD played the key role locally in responding to the safeguarding implications for pupils at the school. The CSD worked closely with police and other local authorities in a large scale operation, in which some matters requiring investigation as potential criminal offences were identified. Police drew their investigations together into an overarching enquiry, Operation Flamborough.

4.3.3 The DfE liaised with HCC and satisfied themselves that the local authority was leading an appropriate response to the child protection concerns arising from the judgement. The DfE commissioned the "emergency" inspection conducted immediately by Ofsted. From this point the DfE and Ofsted set up a joint working group to improve joint working processes on independent schools generally.

4.3.4 In January Child J's mother again complained to police about the incident involving her daughter in 2010. She also made a further allegation of sexual assault on her daughter. It subsequently emerged as a result of police investigations that another similar matter had been known to school staff but had not been reported to the family, the police or CSD. These matters were all investigated under Operation Flamborough. Child J's mother did not want HCC to be involved in the investigations.

4.3.5 The first feedback from Ofsted at the beginning of February indicated some widespread problems with safeguarding arrangements at the school. It suggested that the DfE intervene directly to secure improvements in the leadership and governance of the school. In fact the DfE had no powers to intervene in that way in the leadership of an independent school. However the DfE did serve a statutory notice requiring an action plan that took account of Ofsted's findings and recommendations. That notice was issued in mid-February and aimed to emphasise to the governing body of the school how serious their position was and what they needed to do about it.

4.3.6 The DfE also referred the school to the Charity Commission, the independent regulator of charities in England and Wales to investigate the role of the trustees. The Charity Commission opened a statutory inquiry in respect of the overall administration, governance and management of the school as a registered charity. Subsequent events are reported below.

4.3.7 Ofsted now also set up the "Stanbridge Earls Inquiry" (the inquiry), a high level investigation of the concerns arising from the apparent contradictions between the findings of the SENDIST and the concerns they had identified in their emergency inspection and, on the other hand, the very positive conclusions of their last three inspections.

4.3.8 In February 2013 Child F's mother contacted HCC making further allegations about sexual activity between her daughter and other pupils at the school. This was discussed between HCC and police and it was again agreed that police would follow up these matters without active HCC involvement. Child F was now no longer resident in Hampshire.

4.3.9 At the end of February DfE officials met the chair of the governing body and some other trustees, in London, at the request of the governing body. DfE reiterated the serious nature of the situation and set out in detail the action planning process the school needed to follow.

4.3.10 In March the school submitted its action plan which was evaluated by Ofsted. Ofsted concluded that although the action plan addressed many of the failings identified in the January inspection, it required further work:
"in some key areas the current action plan lacks sufficient detail and timescales for completion are a cause for concern".

4.3.11 By the end of March the key local agencies had concluded that there were no concerns that needed to be progressed to a child protection enquiry in respect of any child currently attending the school, although wider police enquiries continued. HCC decided that, while the DfE and Ofsted were considering the overall position of the school, they would maintain any current placements there, unless families were unhappy with that. However they would make no new placements, unless directed to do so by a Tribunal. A number of other local authorities were now taking the same line.

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4.3.12 At the end of March DfE officials advised ministers to reject the school's action plan as it remained unsatisfactory and there had been insufficient progress in changing the senior leadership team and governing body. The action plan was duly rejected and the school was advised by the DfE that it was under a serious threat of closure. The DfE urged the trustees to take steps to respond appropriately before the next planned inspection in May.

4.3.13 The Headteacher resigned in April. The Chair of the Governors had also been planning to resign because of family illness. He decided to bring his resignation forward so that a new Chair of Governors could tackle this difficult situation. The new Chair worked with the two Deputy Heads to manage the challenges faced by the school. A team of consultants was appointed to support them. A number of audits and inspections by specialist agencies were commissioned by the school.

4.3.14 In April / May Ofsted again inspected the school and reported on child protection arrangements, leadership and governance. They again concluded that progress had been made in some areas but there were still "*serious weaknesses*". Their report advised that children remained unsafe at the school and recommended that DfE should take urgent action to ensure that the school's leadership was improved, or the school should close.

4.3.15 The ISI carried out an inspection of the school from an educational perspective over 4 days from the end of April, at the same time as the Ofsted inspection. The ISI inspection found considerable variation across different aspects of the school's activities. There was impressive evidence of students' attainment and personal development but the school's governance, leadership and management remained unsatisfactory.

4.3.16 The Office of the Children's Commissioner (OCC)[6] became involved in the spring of 2013 as a result of an approach from the legal representatives of Child F's family.

4.3.17 A new Headteacher was appointed in May. This was an interim appointment, to run till the end of the next academic year. The overall situation was considered by government officials and reported to ministers who decided that the new Headteacher should be given some time to address the situation: Ofsted would inspect again in June.

4.3.18 In May the HCC Local Authority Designated Officer[7] (LADO) became involved in the attempts to support the school. The LADO is a local

[6] The role of the Children's Commissioner was created by the Children Act 2004 and has been strengthened by the Children and Families Act 2014. This Act has changed the primary function of the Commissioner from representing the views and interests of children and young people to promoting and protecting children's rights.

[7] Working Together (2015) refers to local authorities having to designate an officer or team of officers "to be involved in the management and oversight of allegations against people that

government officer responsible for considering cases where it is alleged that a person who works with children may have harmed a child or be unsuitable to work with children. One of the main roles of the LADO is to provide advice to employers dealing with cases where allegations have been made against employees The LADO concluded that no specific concerns were substantiated by his enquiries but recommended that the school should review its policy around the maintenance of proper boundaries between staff and pupils, referring specifically to the use of social media.

4.3.19 In May children from Stanbridge Earls were photographed abseiling naked at an outward bound centre in Scotland. This incident led to a great deal of publicity. The owner of that centre, who was a former pupil at Stanbridge Earls, has subsequently been convicted of sexual offences against children and imprisoned. These offences were committed in the 1980's. They do not involve any of the pupils attending the centre in May 2013, nor any of the children referred to in this report.

4.3.20 Towards the end of May DfE received a judicial review pre-action protocol letter from the parents of Child F. The Treasury Solicitor's department replied in early June. There was subsequent correspondence claiming that the Secretary of State's powers had not been used correctly but the parents of Child F did not pursue the judicial review.

4.3.21 In June 2013 the mother of Child F raised concerns about another girl, Child Y, who was said to have been bullied and physically assaulted at the school. The mother of Child Y was contacted and it was eventually agreed with her that no further action by police or the CSD was necessary, though she remained distressed by the events involving her daughter.

4.3.22 Ofsted conducted a third "emergency" inspection in June. This found some improvements noting that
"Children are now safer within the school than when Ofsted inspected in January and in April 2013".
Nonetheless there were still continuing serious concerns in relation to matters ranging from the leadership of the school to the practical arrangements for police checks on members of staff. The report commented that
"inherent weaknesses remain in how the school promotes the safety and welfare of all pupils".

4.3.23 By this time the possibility of a merger or "takeover" by another independent school was being considered. Ofsted commented that
Many of the structural changes and developments in the last five weeks have been geared towards supporting the proposed takeover of the school. If this takeover were to fall through, or be significantly delayed, then the capacity of the school to maintain progress and continue to make the required changes would need to be assessed".

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work with children". The guidance no longer refers to a "LADO" but the term is still commonly used.

4.3.24 At the beginning of July Stanbridge Earls was told by DfE that it could not continue in its current form and that DfE required an action plan to address this. A further statutory notice was served on the school to enforce this.Then, at the beginning of August the other school withdrew from discussions. The principal concerns for them were the reputational damage already done to Stanbridge Earls and the liabilities which might arise in the event of a takeover, including those arising from actual and potential litigation.

4.3.25 The Ofsted inquiry reported in the summer of 2013. It concluded that the inspections of the school in 2011 – 2012 had been unsatisfactory and that there were
"weaknesses in Ofsted's systems, structures, processes and practices which gave rise to the risk that safeguarding issues might not be fully addressed through the inspection of residential special schools[8]".
The findings of the inquiry contributed to major changes nationally in Ofsted's inspection arrangements. Action under employment procedures was also taken against individual members of Ofsted staff in relation to the inspections of the school.

4.3.26 By mid August the school had 120 registered pupils but needed a further 90 financially backed assurances in order to re-open in September. Negotiations with organisations and groups of parents which might have been interested in taking over the school had been unsuccessful. The school risked insolvency if it attempted to continue until a takeover could be concluded, and company law required it to stop trading. The Board of Trustees announced a decision to close the school and the school was removed from the register of independent schools with effect from 31st August 2013.

4.3.27 School staff, trustees and parents were involved in finding new placements for the children. DfE contacted relevant local authorities about arrangements for pupils who were dispersed to other schools, if their parents had not already withdrawn them from Stanbridge Earls, and asked that those authorities did their best to come to mutually acceptable arrangements for new places. For some pupils there was considerable difficulty in finding new schools.

4.3.28 A second matter concerning Child Y arose in September 2013. The Head Teacher, who was still involved in winding down the business of the school, contacted CSD to pass on concerns that the girl's mother had found indecent images on her daughter's phone, allegedly sent by another ex-pupil. This had already been reported to police by Child Y's mother. It was not necessary or appropriate for CSD to take any action as her mother had dealt with the matter and, in any case, the child had left the school and there were no longer any links with Hampshire.

4.3.29 In December 2013 DfE asked the relevant authorities to supply details of schools in which pupils had been placed. As a result some schools were identified where risk assessments for ex-pupils of Stanbridge Earls could be

[8] Sir Michael Wilshaw's public statement on 31/7/13

checked during inspections. One particular institution had taken a very large number of Stanbridge Earls pupils and the arrangements made for them were a significant factor in regulatory action taken in respect of that school in 2013 and 2014.

4.3.30 In April 2014 the Chief Executive Officer (CEO) of the NSPCC was approached by and met with the parents of Child F, Child J and Child Y. The NSPCC has reported continuing contact with the mother of Child F.

4.3.31 In May 2015 the CPS formally provided details to this Review of their final decision, following consideration under the Victim's Right to Review (VRR) Scheme,[9] that no criminal charges would be brought as a result of any incidents at the school during the period considered in this review. This was a conclusion that had already been reached by CPS Wessex, and had been independently re-considered by the CPS East of England following a complaint from the parents of Child F. The CPS has submitted the information outlined in the next section of this report.

4.4 Information from the Crown Prosecution Service

4.4.1 The reports provided by the CPS to this review give a very detailed account of their work in respect of Stanbridge Earls. The information supplied by the CPS sets out its considerations of both whether there is a realistic prospect of conviction and, separately, whether a prosecution is required in the public interest. These decisions are made in accordance with the Code for Crown Prosecutors.[10] In every instance the decision was that there should be no prosecution.

4.4.2 The CPS had considered matters relating to 5 complainants and 14 alleged offenders. A number of these matters related to incidents alleged to have occurred some years ago. For the purposes of this review the key matters were those affecting Child F and Child J.

4.4.3 There were both weaknesses and inconsistencies in a good proportion of the evidence the CPS evaluated. They are summarised below and in some instances they have important implications for the content of this review. The quotations are all taken directly from the reports provided by the CPS.

4.4.4 On one occasion the actions of a member of staff at Stanbridge Earls, to whom disclosures were made, served even if inadvertently to compromise any subsequent criminal prosecution:
"at this point there was a clear disclosure of non-consensual sexual activity and (the member of staff) should not have continued questioning her. By…continued questioning of her we now have an account that is inconsistent with subsequent accounts that she makes. Even if we did not use this account

[9] The VRR scheme was introduced, initially for consultation, during 2013. The scheme makes it easier for victims to seek a review of a CPS decision not to bring charges or to terminate all proceedings.
[10] Code for Crown Prosecutors (accessible). pdf

as part of the prosecution case it would be disclosable and she would be cross-examined upon it".

4.4.5 There are repeated instances of failures by staff at Stanbridge Earls to keep reliable records, and this hampered the assessment of the evidence by the CPS:
" the school appears to have kept inadequate records and potentially did not deal with this in an acceptable manner at the time. It does not appear that her mother was informed of this incident and there is no reference on the paperwork to whether (the alleged perpetrator) was spoken to and whether he was disciplined in any way".

4.4.6 The consequences of the SENDIST were significant:
"The consideration of the evidence in this case has been exceptionally difficult due to the evidence heard in other Tribunals, some of which conflicts with the evidence given to the police".

4.4.7 The ability of some of the alleged victims to give evidence was an important consideration – Child J was described as
"significantly unwell and unlikely to be fit to be a witness".

4.4.8 The CPS has to consider the potential consequences for a complainant of giving evidence:
"Consideration would have to be given as to whether it would be in the best interests of Child F to put her through the stress and emotional ordeal that giving evidence would entail".

4.4.9 There were weaknesses in the evidence arising, on one occasion, from police having asked "leading questions" when interviewing an alleged victim. On one occasion police did not conduct an identity parade when that might have been appropriate.

4.4.10 Potential medical evidence was considered in respect of one alleged victim on two occasions. However the CPS found no unequivocal medical evidence of harm resulting from sexual activity that could be used to support a prosecution.

4.4.11 The CPS found
"no reliable evidential basis to say that violence was used, or threatened at the time of or immediately before the sexual acts in order for us to utilise the evidential presumptions".

4.4.12 All of the alleged perpetrators had medical conditions or learning difficulties that might affect their cognitive ability and understanding.

4.4.13 There are very complex issues relating to the capacity of both alleged perpetrators and victims. The CPS evaluation notes that
"someone might be capable of exercising choice in one situation but not in another"

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and queries whether it could be proved in respect of a young man with complex vulnerabilities himself that he could comprehend that
" she could consent to some but not all of their sexual acts".

4.4.14 In some situations the ages of the young people allegedly involved were such that
"(she) would be equally as culpable of committing the offence against him".
and, similarly,
"I have considered that this consensual sexual activity between 2 people of a similar physical age, educated a year apart who both had learning difficulties and in those circumstances it would not be in the public interest to prosecute".

4.4.15 In respect of one less serious matter the alleged perpetrator was no longer in the UK, so that it would have been necessary to seek his extradition, which was judged not to be in the public interest.

5. THE CHILDREN AND THEIR FAMILIES

5.1 Background to the input from families to this review

5.1.1 In commissioning this report a significant emphasis was placed on ensuring that it was informed by the views of the families involved. This emphasis was in part a response to the comments of Ofsted on the Crompton review that
"The important views of parents …have been excluded from the review and so do not contribute to its learning. This omission should not be underestimated. We know that the parents have a range of views and have been highly critical of the way in which local and national organisations have worked together to safeguard their children".

5.1.2 In fact, while the majority of parents contributing to this review have indeed been critical, particularly of Ofsted, those criticisms are not about the safeguarding of their children but about the fact that the school was allowed to close.

5.1.3 A second independent reviewer, Ms Jane Whyte[11], was involved in facilitating contributions from parents and children. A series of meetings was arranged between the independent reviewers and:

- The parents of Child F, Child J and Child Y (separately from each other) – that is, the parents who felt that their daughters had been inappropriately treated and harmed at Stanbridge Earls. The parent of Child Y sent apologies on the day of the arranged meeting, but was subsequently able to speak to the Lead Reviewer. By agreement with their parents Child F, Child J and Child Y were not seen because of their continuing vulnerabilities;
- A group of parents, and one young person, who felt that many children had been harmed by the closure of Stanbridge Earls. This group offered to facilitate direct contact with many more young people but the

[11] See Appendix A

reviewers judged that this would not add to what they had already learned, and again would not necessarily be helpful to the children;
- The parent of a child who had been investigated as an alleged perpetrator of a sexual crime at the school. This parent agreed to talk to her son about meeting the reviewers but expressed concerns that this might not be in his best interests, as he has a number of vulnerabilities. The reviewers similarly felt that no action should be taken which might aggravate his situation and he was not interviewed.

5.1.4 It has been stressed to all parties that this SCR does not attempt to investigate or re-investigate allegations about harm done to children while they were at Stanbridge Earls.

5.2 The families who have raised concerns about their children's experiences at Stanbridge Earls

5.2.1 Child J is the child for whom there are the earliest recorded concerns in the period under review. Those concerns arose from the incident in which she is said to have been assaulted, in a sexualised way, by a group of children. Further allegations of sexual assaults were made subsequently and her parents feel that there were other incidents, in a climate of continual bullying.

5.2.2 Child J is a child with complex needs and vulnerabilities and her parents feel that those needs were overlooked by staff, in a culture at the school which was sexist and discriminatory. They also feel that their daughter's needs could never have been met at Stanbridge Earls and that this should have been identified promptly and addressed by the school.

5.2.3 Child J's parents are particularly disappointed by their involvement with HCC. They approached the local authority when they learned of the first alleged assault. They told us that the local authority refused to become involved and would not accept such a referral from a parent. HCC has told us that they had suggested the parents needed to raise this directly with senior staff at the school in the first instance. The parents have a different "take" on the events, and remain upset. They also mentioned learning that part of the school's response at the time was to discuss the events in a school assembly which they understandably consider entirely inappropriate.

5.2.4 HCC have supplied an audio recording of the telephone conversation between Child J's mother and two members of staff who spoke to her. The mother was clearly dissatisfied at the time by the advice she was given. However it was a lengthy conversation and the staff were equally clearly trying to be helpful, making various suggestions as to how the family might liaise with the school, and taking advice from colleagues in the course of the call. It was not a conversation in which the mother was fobbed off.

5.2.5 The parents' anger (at the alleged incident) and frustration (at the fact that reporting it has led to no action) is understandable. The incident as reported was serious, particularly so in the context of the child's vulnerabilities. She has subsequently had contact with Child and Adolescent

Mental Health Services, which her mother feels is linked to her experiences at Stanbridge Earls.

5.2.6 All the matters reported by the parents of Child J have been considered by the CPS and there will be no prosecutions. The first reported incident took place nearly five years ago and the positions of the family and the local authority will not now be reconciled. Setting that dispute aside though, there are the first indications in the school's response of, at best, a differential and clumsy treatment of girls that runs through these events. The parents' account also suggests a lack of alertness to bullying at the school.

5.2.7 Concerns about bullying also arise from the material provided to this review by the CPS. They note that
"The evidence and information considered appears to show that due to her particular personality and disorder that Child J was a young girl who took to heart the cruel teasing that young children will do and that she found it harder to deal with than some and that as a consequence of this she was an easy target for the poor behaviour of the boys".

5.2.8 The mother of Child F was assisted in interview by a legal professional. They gave a detailed account of the concerns arising out of the events directly involving Child F and the broader issues which they feel characterised the problems at the school and led to its closure. They subsequently submitted a written account of these matters and others.

5.2.9 The positions of the parties on key issues are again irreconcilable. The mother of Child F has repeatedly criticised HCC for failing to undertake child protection enquiries under section 47 Children Act 1989, in respect of Child F and other children. HCC have described and provided evidence of their responses to various concerns. On occasions they had Strategy Discussions[12] with police and came to an agreement that police would lead investigations and liaise as necessary. On other occasions HCC carried out enquiries which they judged did not substantiate the concerns that had suggested a potential need for a child protection investigation. Sometimes HCC was not the responsible authority because alleged events took place elsewhere.

5.2.10 The mother of Child F similarly raised continuing concerns about Hampshire Constabulary. The police have confirmed that the concerns all relate to matters which had already been brought to their attention and have been dealt with through complaints procedures or otherwise.

5.2.11 The CPS eventually considered allegations against 4 boys from Stanbridge Earls in relation to Child F. The information from the CPS, outlined in section 4.4 above, explains the reasons for their decisions that there should be no prosecutions.

[12] The statutory guidance at the relevant time was "Working Together to Safeguard Children (2010)" which required that whenever there was reasonable cause to suspect that a child is suffering, or likely to suffer significant harm, there should be a Strategy Discussion involving children's social care services and police.

5.2.12 The mother's written account of her interview for this review also refers to a number of other organisations involved in or affected by these events. That has been followed by extensive copy correspondence between the parents, their representatives and various national and local bodies. In short the parents are concerned that there is evidence of long-standing failure across a range of agencies to protect children at Stanbridge Earls.

5.2.13 The mother has indicated that she intends to raise those issues through the "Goddard inquiry[13]" and that may be appropriate. This SCR aims to focus principally on the issues, arising from the relevant events since 2010, which can lead to practical, readily achievable improvements in safeguarding policy or practice in Hampshire. In that context the most relevant issues raised by the mother of Child F include:

- The role of the HSCB in promoting understanding of safeguarding issues and requirements in independent schools;
- The safeguarding of children educated in the independent sector and the challenges arising from increasing diversification in educational provision;
- Establishing which local authority should be responsible for a child protection investigation;
- The extent to which sexual activity between children is a safeguarding issue.

These issues are considered specifically and throughout this report.

5.2.14 Child Y attended Stanbridge Earls for a relatively short time, the last 10 months that it was open, as a weekly boarder. Her mother feels that she was bullied from the outset and the cumulative effect of this was very distressing for her daughter. She was unable easily to talk about this to anyone at the school, partly because of speech and communication problems. Her mother reports raising concerns repeatedly with a number of members of staff, who, she feels, did not take them seriously.

5.2.15 Child Y's mother reported that her daughter started to self-harm at Stanbridge Earls. Again the mother feels that, although this was known to various members of staff, they did not take it sufficiently seriously. She feels that the trustees should have done more in response to the emerging concerns at the school after the SENDIST. She regrets not removing her daughter once the SENDIST findings became known. She feels she was falsely reassured by the decision of her local authority, which is not HCC, not to remove children but to leave this decision to the discretion of parents.

5.2.16 After the final summer term evidence emerged of a boy at the school sending indecent phone messages to Child Y. This was investigated by police outside Operation Flamborough and did not lead to any further action. The mother has described enduring, damaging consequences for her daughter from these events.

[13] The Home Secretary has initiated a wide-ranging inquiry into the sexual abuse of children headed by Judge Lowell Goddard.

5.2.17 These concerns are of a different order to those raised in respect of Child J and Child F but they add to the emerging picture of a lack of alertness to the needs of girls at the school.

5.3 The families who have raised concerns about the closure of Stanbridge Earls

5.3.1 In the period after the SENDIST judgment and subsequently a number of parents of children at Stanbridge Earls challenged the concerns expressed about the school. Three sets of parents were invited to meet the authors of this report and chose to do so as a group, accompanied by several other parents and a young man who had attended the school.

5.3.2 They were vociferous in their distress at the closure of the school, which they all felt had over many years provided an excellent education to children, both male and female, who had a range of challenges and difficulties. The young person in attendance spoke eloquently about the difference the school had made to his ability to achieve despite difficulties. The mother of another child wrote to the HSCB, following the decision that this exercise should be conducted as an SCR, explaining in detail the positive impact of the school on her child's physical and mental health, and concluding that
"I can say with every confidence that the transfer to Stanbridge Earls School has transformed (my child's) life".

5.3.3 These families also expressed their concern for the harm done to young people – none of whom was represented at this meeting - who had faced allegations of serious crimes for which there was eventually no basis for prosecution.

5.3.4 They felt that most of the agencies involved had let down the majority of children attending Stanbridge Earls. They were particularly critical of Ofsted, highlighting what they see as the agency's readiness to overturn three very positive inspections once the SENDIST judgment brought adverse publicity to the school. One of the parents went to the school during one of the 2013 inspections and told us that the inspectors were reluctant to talk to her though Ofsted contest this. These parents believe that the SENDIST judgment itself exceeded its remit and included unsubstantiated accounts of events. They were very upset by the press coverage of these events, and its impact on their children. They believe that this coverage made the overall situation worse for all concerned.

5.3.5 They were not unrealistic about the school, noting the extent to which it contributed to its own downfall; they felt senior staff and governors should have been more robust and active in challenging the evidenced causes for concern as well as what the parents view as the growing misperceptions and misrepresentations of the school.

5.3.6 Overall they argued strongly that no agency gave adequate consideration to the harmful consequences, personal and educational, of the

closure of the school for the majority of the young people attending. They were able to describe the enduring difficulties this caused for many young people, some of whom were at a particularly sensitive time in their educational careers.

5.4 The family of a child against whom allegations were made

5.4.1 One mother of a child investigated by police came forward. The police investigation took some 18 months before a decision was reached that there would be no charges. She reported that her child received no effective support, except from the school and its staff, throughout this period. She graphically described the harm that this caused to her child and to a number of other aspects of the family's personal circumstances. Her child's emotional well-being has been severely damaged and progress in educational attainment has significantly deteriorated. She too stressed that the effects of these events were hugely aggravated by intrusive press coverage of the events.

5.4.2 The mother was clear that, prior to these matters, attending Stanbridge Earls had been an extremely positive experience for her child, who has a range of disabilities and disadvantages but had made significant progress at the school. She told us that the school and its staff took a very individualised approach to the pupils and this was why they were so successful, a view which she feels would be shared by most of the recent parents and students as well as former students and their families. The school and the parents had formed an enduring "nurturing community" for the young people.

6. THE KEY AGENCIES

6.1 Stanbridge Earls School

6.1.1 At the outset it is right to reiterate that this review does not attempt to re-investigate the specific incidents which eventually led to the closure of Stanbridge Earls. The agencies actively involved in investigations – principally police, the local authority and CPS - have reached their conclusions. This report needs to provide information about what happened but it is important to be clear that this review does not investigate the abuse of individual young people. The review has not been set up to do that and is not equipped to do that.

6.1.2 This report aims to focus on how agencies identified and responded to child protection concerns, the effectiveness of those responses and what can be learned from that. "Responding" includes identifying vulnerabilities and anticipating the possibility of safeguarding issues arising. The agency that had the greatest responsibility for recognising and responding appropriately to such concerns was the school itself.

6.1.3 A large amount of documentary evidence is available. However the very fact that the school, as such, is no longer there meant that we could not talk to some staff and governors. Also, some former members of staff are still

dealing with matters related to professional registration or fitness to practice, and that has affected their ability or willingness to contribute.

6.1.4 One former teacher came forward and spoke of what was described as a campaign of harassment by those whose intention, the teacher felt, was to force the closure of the school. The teacher had faced a large number of complaints to their professional association, all of which had been dismissed after many months of investigation. This teacher and other contributors to the review have produced examples of vituperative material aimed at them from social networking websites. While now recognising that there had been weaknesses in safeguarding arrangements, the teacher felt the extent to which the school had been vilified, and individuals targeted, was unfair and unreasonable.

6.1.5 A member of staff at the point of closure, who had not been at the school in the period when the key events occurred, was keen to contribute to this review. She has a varied educational background with substantial experience in the state sector. She was concerned to communicate some of the positive things she had experienced at the school. She had found it a caring environment that did want to get things right for the pupils. She had also found the governors supportive and caring although she could see how the school may have found it difficult to see emerging problems.

6.1.6 She talked about some of the practical problems at the school, explaining how the residential arrangements were in small houses which required high staffing levels, with significant financial consequences. There were also difficulties in the management structure, with a relatively new leadership team. She felt there was an imbalance of responsibilities between the two deputies, one with a narrower academic role, and one who also had all the "care" responsibilities.

6.1.7 Following the SENDIST local authority officers from HCC had been supportive and helpful on a day to day basis but she felt they and other bodies could have done more to assist the school, which became increasingly isolated. The school came to feel not supported but "*under attack*".

6.1.8 In the period under review the first evidence of the school's lack of alertness to safeguarding issues lies in the events involving Child J in October 2010. The current safeguarding procedures[14] in Hampshire require that *"In cases of sexist (or) sexual.. bullying schools must always consider whether safeguarding processes need to be followed…It is important for schools to consider whether to apply safeguarding procedures both to young people being bullied and to perpetrators. Young people being bullied may need to be protected from the child or young person engaging in bullying behaviour using safeguarding processes".*

6.1.9 The fact that this particularly vulnerable child was distressed as a result of an incident in which she removed items of clothing is accepted by all. The

[14] 4lscb procedures.pdf

incident should certainly have been managed sensitively and a decision to refer to it in a school assembly suggests no such sensitivity. The probability that this would upset and embarrass Child J, and the possibility that it might lead to further victimisation, seem to have been given no thought.

6.1.10 In respect of Child F, the way in which the school approached the SENDIST raises concerns. It was unhelpfully combative while lacking thoroughness and openness. The school produced witness statements, and made submissions, which were found to be inaccurate. The Tribunal repeatedly found evidence that the school had not been straightforward in its evidence. The exasperation of the Tribunal is clear in, for example, its account of the Headteacher saying that he did not accept that a child reporting non - consensual sexual intercourse was necessarily making an allegation of rape.

6.1.11 Looking to the findings of the SENDIST there is little evidence of recognition by the school of the safeguarding needs of Child F. What emerges overall is a failure by the staff and trustees to recognise that the school had safeguarding responsibilities and that these were heightened by:

- The potential vulnerabilities of all the students;
- The particular vulnerabilities of girls in that environment.

6.1.12 The concerns relating to Child F centre first on the suitability of this environment to her educational needs and her wider needs. As a result of the SENDIST it is clear that school staff knew that Child F had had significant difficulties since at least 2007, and knew of a particular diagnosis, among a range of vulnerabilities, at the time that she was accepted for admission to the school.

6.1.13 However the evidence indicates that in her case the school had no real understanding of what that background and diagnosis meant, for her or for them. They failed to make enquiries that would have helped plan for her education and care. The SENDIST found that the school did not have the necessary professional expertise, leadership, management, training, and systems to meet her needs. At the same time, parents of other children at the school who shared the same or a similar diagnosis, have, in their input to this review, challenged these findings, producing evidence of progress and demonstrable achievements by their children.

6.1.14 In any event the Headteacher in post at the time of the key events in this case had very little experience in the education of young people with special needs. He did not make all the enquiries he might have done, and consequently did under-estimate the nature and extent of the support and protection Child F would require. The school's decision to admit Child F was probably inappropriate from the outset and it was certainly not informed by any consideration of the potential safeguarding issues that might arise.

6.1.15 Once evidence of her particular vulnerabilities began to emerge, especially her sexual and emotional vulnerabilities, the continuing responses of school staff were unsatisfactory. In sum:

- There is no evidence of any school staff, including those with designated special responsibilities, demonstrating an adequate awareness of safeguarding issues in relation to Child F – the school had child protection policies but did not follow them and evidence of cause for concern was repeatedly set aside;
- Parents were not always informed of reported serious incidents and allegations;
- Other agencies were not always appropriately contacted – school staff initiated investigations which should have been immediately referred to agencies with statutory responsibilities;
- There was no consistent recognition that sexual activity between young people might raise safeguarding concerns, even in this context of young people with a range of vulnerabilities;
- Some staff displayed, at best, confusion over confidentiality. "Confidentiality" was used inappropriately to excuse failures to act;
- Record-keeping was poor - the school effectively used no reliable systems for keeping formal records of incidents, meetings, communications and advice to staff in respect of dealing with or about Child F, or other young people.

6.1.16 In that context there are examples of individual members of staff being apparently unaware that they were dealing with situations which might have a safeguarding aspect, or indeed criminal implications, and that they might have a responsibility, professional, personal or both, to take action as a consequence.

6.1.17 There was little evidence of alertness to the need to consider informing and involving parents, when it was known that Child F had been involved in sexual activity after the consultation with the school's GP. These matters are not adequately covered in the current procedural guidance in Hampshire and there is a recommendation from this report to address that. That guidance could be based on the London Child Protection Procedures, which set out the issues clearly.
"Decisions to share information with parents require staff to use their professional judgement… Decisions by health, and other professionals not to share information should be informed by Gillick Competency – that the child or young person (s):
- *understands the professional advice;*
- *cannot be persuaded to inform his/her parents;*
- *is likely to have intercourse without contraception;*
- *physical and/or mental health is likely to suffer without advice and support;*
- *best interests require advice and support without parental consent."*

6.1.18 All of those considerations raise concerns in respect of Child F yet, after she was taken to the school's GP, the school staff involved agreed not to speak to her parents. This is probably a more straightforward example of a potential professional dilemma than many similar situations. This girl's

vulnerability was such that her parents clearly needed to be aware of the risks she faced.

6.1.19 Underlying all this there is little evidence of sympathy or compassion for Child F. She was required to leave the school when other students, who had been alleged to have harmed her and faced the possibility of criminal charges as a result, were allowed to remain. The extent to which the Headteacher was out of touch with the "natural justice" implications of this, let alone the safeguarding aspects, was displayed when he told the SENDIST that there was no need to exclude them because they were not vulnerable. In one of its most telling comments the SENDIST judgment remarked that they did not hear any witness from Stanbridge Earls provide evidence that anyone at the school, even at the date of the hearing, actually understood Child F's needs.

6.1.20 The developmental work with the school, led by the local authority after the SENDIST, also identified some general areas where the school was failing to keep up with basic safeguarding requirements. Recording arrangements were weak, with evidence of staff being unaware of what they might be required to record, a culture of people talking informally rather than making a record and generally too much room for important information to get lost. These concerns could be evidenced in similar educational settings and this is highlighted as one of the learning points from this review. That developmental and support work with the school also included consideration of the school's approach to the health needs of pupils, which is discussed separately below.

6.1.21 A number of parents who remain dismayed at the school's closure expressed great concern about the part played by the trustees of the school in these matters, feeling that they did not respond to the developing situation with adequate commitment and vigour. The parents of Child F have predictably different concerns about the part played by the trustees, commenting that trustees were out of touch with their safeguarding responsibilities.

6.1.22 The trustees have reported to this review that the school was *"fully aware of the importance of all aspects of safeguarding"* and that they themselves were "*fully conversant"* with any issues at the school. Their commitment to the school and its pupils is clear but that contention is difficult to understand in the face of the events leading to this review.

6.1.23 Those events include the "Scottish incident" in May 2013. Given the situation Stanbridge Earls was in at that time, one might have expected a more vigorous response to any safeguarding concerns, especially where those concerns might have a sexualised dimension. This review has not received any information to suggest that these matters were investigated by Stanbridge Earls. At the same time we have learned that another school which had also used that centre had, in response to the press reports, sought reassurances about the welfare of their pupils. That school had not been satisfied by the response from the centre and had stopped using it.

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6.1.24 The Charity Commission[15] itself is clear that
"Trustees have primary responsibility for safeguarding in their charity".
The DfE's guidance[16], developed soon after the events at the centre of this report, reminds trustees that, as is relevant here,
"children need to be protected, but also …trustees have a duty to protect the reputation and assets of the charity. A failure by trustees to protect children may be considered by the Commission as misconduct or mismanagement in the administration of the charity".
That guidance also makes it clear that this responsibility cannot be delegated to senior staff – the trustees themselves are required to ensure that safeguarding arrangements are sound and that safeguarding is promoted.

6.1.25 That government guidance (which was published after the closure of Stanbridge Earls) is in fact very clear and accessible. There is no need to rehearse the detail of its content here but it is recommended that HSCB should consider how best to promote that guidance with agencies in the charitable sector in the light of these events.

6.2 OFSTED

6.2.1 As an independent residential special school the welfare provision at Stanbridge Earls was inspected annually by Ofsted. The educational provision at the school was inspected by the ISI.

6.2.2 As described above Ofsted had conducted a number of inspections over the years prior to the SENDIST, both routine and emergency, and had consistently found the school to be 'outstanding' overall, and to have "outstanding' provision for safeguarding. Then, following the SENDIST, the emergency inspection found that the school was not meeting National Minimum Standards. The subsequent inspections, while recognising some improvements, all reflected serious continuing concerns about the school's ability to improve adequately.

6.2.3 Her Majesty's Chief Inspector, Sir Michael Wilshaw, established an inquiry[17] to review the inspection history of Stanbridge Earls School from January 2011 to January 2013. The review consisted of desk research, compilation of evidence and a detailed chronology, together with interviews with the key people involved where they were still employed by Ofsted. As this was an internal review, the team did not contact external parties, including children and families affected, school staff and trustees and former employees of Ofsted. The inquiry commenced in January and reported in the summer of 2013.

6.2.4 Essentially the inquiry found that all three of the inspections prior to the SENDIST judgement were flawed. These flaws had different causes but

[15] Strategy for dealing with safeguarding vulnerable groups.pdf"
[16] Everyones-Business-Safeguarding-for-Trustees.pdf
[17] Ofsted Inquiry report.pdf

shared a failing to “get underneath” safeguarding concerns, a phrase used repeatedly in the inquiry report.

6.2.5 The inquiry judged that such concerns should have been identified in the inspection conducted in June 2011. The failure to do so was explained by an over-reliance on the positive findings from the previous planned inspection, carried out in 2010, and a failure to take proper account of matters, raised In parental questionnaires, about[18]
“health, privacy, overcrowding and bullying…(while) the inspector did not give sufficient weight to the risk posed by a change of head and the expansion of the school, including the different types of disability amongst the pupils”.

6.2.6 The inspection carried out in January 2012 was a direct response to the complaint from the family of Child F received in October 2011. However the inquiry found that this inspection, carried out in line with an agreement reached with the Department for Education,
“did not look at the key concern of safeguarding as the inspector had been advised that this was being investigated by the Police and the Local Authority Designated Officer in Hampshire and was not to be the focus of her inspection”.
This does seem to be a fundamental failing in an inspection specifically sparked by allegations that children were not safe. Moreover the advice that the LADO was involved was incorrect – no referral had been made to the LADO at this time. The service’s weakness was further evidenced in an absence of
“systematic follow-up or appropriate senior management oversight”.

6.2.7 The inspection in May 2012 followed a safeguarding complaint made by the family of Child J. However this inspection did not review the response from Ofsted to the complaint received in October 2011. Instead it took the view that it was a closed episode which Ofsted had already addressed in the January 2012 inspection. As a result this inspection in May 2012, described as “*poorly conducted*”, was certainly flawed.

6.2.8 As indicated above, Ofsted’s volte-face on Stanbridge Earls is regarded with scorn by those families who feel that their children have been harmed by the closure of the school. They feel that Ofsted had no interest in hearing what they had to say, and they were unimpressed by the notion of conducting the inquiry without talking to a representative range of those affected.

6.2.9 The inquiry led to fundamental and wide-ranging changes to Ofsted’s structure, systems, performance management arrangements and the conduct of relationships with other agencies. Those changes are clearly driven by a commitment to improve the agency’s performance in relation to safeguarding. It may be little consolation to that group of parents dismayed at the closure of the school but one can see from the nature and extent of those changes why Sir Michael Wilshaw was led to conclude that

[18] Quotations in this section of this report are from the findings of the inquiry report.

"We have learnt lessons from Stanbridge Earls that will make our systems, structures, processes and practices more effective."
In the light of that extensive review and the changes it has prompted there are no recommendations to Ofsted from this report.

6.3 Hampshire County Council

6.3.1 HCC, through its CSD, first became involved in these events in respect of Child J. That contact consisted only of a telephone conversation with the child's mother. The contact was in March 2011 and referred to an incident alleged to have happened in October 2010. The local authority judged that the mother should discuss her concerns with the school in the first instance, asked that she do so and come back to them as necessary. The opposing positions held by the local authority and the parents are described in section 5 above.

6.3.2 Child J was only 12 years old at the time of the incident, and that may not have been given adequate weight by the local authority. Children under 13 are not legally capable of consenting to sexual activity and there clearly may have been a sexual component to what had happened, as well as bullying.

6.3.3 Child J's mother had also explained in the telephone conversation that her daughter had epilepsy, and might therefore have been seen as a disabled child. The 4LSCB[19] procedures advise that
"Many factors can make a disabled child more vulnerable to abuse than a non-disabled child of the same age. Safeguarding disabled children demands a greater awareness of their vulnerability, individuality and particular needs".

6.3.4 HCC could have taken a more proactive and enabling approach in these circumstances. They have noted this in their analysis of these events, identifying the following action point:
"when a concerned parent is advised to contact a school to progress a concern the department should also contact the school to ensure that the contact has been made and the outcome is satisfactory".

6.3.5 HCC was then contacted in July 2011 in respect of the first allegation from Child F of non-consensual sexual activity. They and police discussed this under formal child protection arrangements. The agencies agreed that this would be followed up by police as a "single agency" investigation, given that there was an allegation of a serious crime, with police referring back as necessary.

6.3.6 The response to allegations raising child protection concerns should always be founded on discussions between the agencies with protective and investigative responsibilities – principally police and the local authority – with a documented agreement about their respective roles. The judgments on how matters will be pursued rely on a range of considerations but, broadly, one

[19] In Portsmouth, Southampton Hampshire & the Isle of Wight each area not only has its own local LSCB but also works under an umbrella partnership called the 4LSCB.

would expect police to figure more prominently, and the local authority less so, in investigations where there were no concerns that a child had not been adequately protected by or within his / her family. There is no requirement for both agencies to maintain a continuing direct involvement, though they should continue to liaise.

6.3.7 In this instance there was no indication that Child F needed immediately to be protected as she was with her family in County Z, not at school. There was no information to indicate that the alleged perpetrator was an immediate danger to any other young people but, if that were the case, police were the appropriate agency to pursue that in the first instance.

6.3.8 However the issue arises as to what, if any, protective action might have been indicated in respect of the alleged perpetrator. From the point of view of those responsible for the criminal processes, there will be concern about the potential to interfere with evidence around an alleged abuser's thoughts and motivations. However the 4LSCB procedures advise that
"In all cases where the suspected or alleged abuser is a child, Children's Services and the Police will convene a Strategy Discussion/Meeting (usually a meeting) within the timescales set out in respect of all cases.
If the children/young people involved are the responsibility of different local authorities, each must be represented at the Strategy Discussion, which will usually be convened and chaired by the local authority for the area in which the victim lives.
Consideration should be given to the need for separate Strategy Discussion/Meetings in relation to the child/young person who is the person alleged to have perpetrated the abuse and for the child/ren who are the alleged victim(s)".

6.3.9 The procedures go on to say that
"Child Protection Assessments will only be pursued in respect of the child/young person who is the alleged abuser when s/he is personally suffering or at risk of significant harm"
The judgment as to whether the alleged perpetrator is or might be at such risk lies with those involved in the Strategy Discussion / Meeting. Even where it is judged that it is not necessary to carry out a child protection investigation *"a Core Assessment[20] will proceed in accordance with the Framework for the Assessment of Children in Need and Their Families".*

6.3.10 There were no child protection assessments or Core Assessments in respect of any alleged perpetrators, at this time or subsequently. So, the requirement to safeguard alleged perpetrators who were themselves vulnerable was not met. This is a point which has been made by a number of parents, including the parents of Child F, but most tellingly by the parent whose family situation is discussed in section 5.4 above. The issue of safeguarding alleged abusers is complex and there is little national guidance. It will need careful consideration across the agencies and this report

[20] A detailed assessment, usually conducted over a period of weeks, which was a key element in this statutory guidance in place at the relevant time.

recommends that the HSCB should consider this aspect of these events, revise its guidance accordingly and ensure that the guidance is being followed.

6.3.11 HCC next became involved when they learned, in October 2011, that Child F had returned to the school but had subsequently been excluded following sexual activity. They first heard of this from the local authority in which the family lived, Z County Council (ZCC). They gave ZCC information about their discussions with police in July. Again there was no need immediately to take protective action in respect of Child F as she was with her family, having been required to leave the school. However the CSD review of these events has considered the situation of children referred to them who become subject of police investigations but are now living elsewhere. The roles of the different authorities and constabularies can become confused and there is not always effective communication regarding actions and outcomes which are traced back to the original referral. There is consequently a recommendation from this report.

6.3.12 It is reasonable to question whether, at this point, HCC might have become concerned about Stanbridge Earls more generally. The concerns of which HCC were aware were:

- The alleged assault on Child J in November 2010;
- The alleged assault on Child F in July 2011;
- The alleged assaults on Child F reported in October 2011.

6.3.13 There is no reason why the local authority would necessarily make any immediate connection between the incident involving Child J and the incidents involving Child F. If they were from the same family and the same address that would be automatically identified when routine records were made. But the address alone would not automatically connect the two matters.

6.3.14 However following these events, to inform their overall response, the authority's Data Information Team conducted a search of referrals to the CSD involving the post code for Stanbridge Earls School. (This would not have captured information on any of the thirty children attending the school on a daily basis, for whom referrals would reflect their home address, but there were no safeguarding concerns about any of these children). The only significant contacts / referrals from 2010 were those involving Child J and Child F.

6.3.15 No local authority would routinely trawl through its information in this way and this was only done once concerns about this school had arisen. But, having done so, and identified only these two cases, the collated information about Child F and Child J would not have prompted any further action under child protection arrangements in October 2011. In any event, if CSD officers had cause for general concern about safeguarding at the school their first avenue of investigation would be Ofsted inspections which at that time were entirely satisfactory.

6.3.16 In May 2012 HCC was told by police, for information, about the contact from Child J's mother which police had investigated and decided required no further action.

6.3.17 The next time that HCC became involved was in response to the SENDIST judgment. HCC took a lead role in determining and co-ordinating that response. Within a week of receiving the judgment in January 2013 they had convened a meeting of Hampshire agencies and started to liaise with other local authorities with responsibility for children attending the school. They also initiated a programme of visits to the school by the head of the local authority's safeguarding unit, supported by the county's SEN safeguarding lead officer, which was to continue until the summer of that year.

6.3.18 HCC sought to carry out an Initial Assessment[21] on all children at the school, so that all children and their parents would be given the opportunity to discuss with someone independent of the school any concerns they might have relating to safeguarding at Stanbridge Earls. Setting aside the issue of assessing the needs of alleged perpetrators, that was a reasonable starting point. At that time agencies had no information about any child still resident at the school to indicate that an intervention at a "higher" level, a child protection investigation under s47, Children Act 1989, was appropriate or necessary.

6.3.19 Just after this activity commenced there were further allegations that Child F had been sexually assaulted by other students while she had been at Stanbridge Earls. This was again discussed between police and the CSD, and it was again agreed that police would conduct a single agency investigation as part of Operation Flamborough.

6.3.20 That decision was appropriate but HCC has identified a learning point from their review of these events:
"when a strategy decision is taken for an investigation to proceed as a single agency investigation by the police, the process by which any outcomes get fed back in to children's social care needs to be standardised in order that both agencies can be assured that the police are re-referring when necessary".
This is an action point for the CSD and police.

6.3.21 By the middle of March 2013 HCC had contacted 184 children and/or their parents. Some families did not respond. In seventy-nine cases, consent to interview the child was declined by parents. Where school places were entirely funded by families no further action could be taken if those families did not wish to be involved in these arrangements.

6.3.22 Fifty-five children were interviewed by Hampshire County Council Staff. This includes interviews undertaken on behalf of other local authorities. A further twenty-two children were interviewed by the local authority in which their family lived. Some parents preferred to be present while their children

[21] Again, a key part of the Framework for Assessment of Children in Need, the relevant statutory guidance at the time.

were interviewed and some families decided that their children should be seen without their parents.

6.3.23 The majority of children seen did not express any safeguarding concerns. None of the children interviewed who were still attending the school disclosed any information which would meet the threshold for a child protection enquiry. Most of the parents seen spoke very positively about the school.

6.3.24 There was evidence of a small number of children who were said to have engaged in underage sexual activity. One of these children was interviewed by police as part of their investigation. Enquiries in relation to the others did not indicate that any further action was necessary. These included some for whom parental consent to interview was not given. In each of those cases the agencies considered whether there was information such that enquiries should be made under s47, Children Act, 1989 – that is, whether there was reasonable cause to suspect that a child had suffered or was likely to suffer significant harm. They concluded in each case that there was no evidence to support such a course of action.

6.3.25 Twelve children or their parents did raise some sort of concern about the way children had been treated by staff or by other young people. All those matters which suggested that a crime might have been committed, including all those which might indicate sexual abuse, were followed up by police, as discussed in the next section of this report. Where the information received suggested that this threshold had not been met, they were addressed by the Head of the HCC Safeguarding Unit and his team, in the context of their programme of trying to support school staff and governors in dealing with the concerns arising from the SENDIST judgment.

6.3.26 In parallel with these enquiries HCC asked the then Chair of the HSCB, Ms Clare Chamberlain, to review all contacts and referrals from Stanbridge Earls to HCC in the previous five years. She did so and submitted a report at the end of March 2013.

6.3.27 Her report found that there had been nine contacts of any kind. Three had, in some sense, a safeguarding dimension and Ms Chamberlain found that these had been managed appropriately. In relation to the incident involving Child F in July 2011 the report judges that
"This referral was dealt with correctly by referral to the police to undertake a criminal investigation into the allegation. CSD were assured that the child had been protected from the alleged perpetrator. There was no further role for CSD at this point".

6.3.28 Overall the report found that
"The CSD responded appropriately and provided advice and help in line with their statutory responsibilities in relation to the contacts and referrals about children at Stanbridge Earls School".

6.3.29 Following their investigations HCC, and the other local authorities involved (with the exception of ZCC, the home authority for Child F) decided that they did not need to maintain contact with any of the young people at Stanbridge Earls. HCC however decided that they would not support any new placements at the school (unless a Tribunal directed that such a placement be made) until the school was demonstrating adequate progress in line with their action plan, and the positions of the DfE and Ofsted had been confirmed.

6.3.30 The investigations across the school population, led by the local authority, had been a substantial exercise, and one which required a delicate touch. The initiative had to be pitched at the right level, demonstrating a thorough approach to the concerns raised but also a sensitivity to the feelings of children and families who might feel falsely accused. The well evidenced concerns about the school's approach to safeguarding had to be kept in mind while trying to promote the capacity of the school to improve. Overall the operation was well thought through and delivered successfully.

6.3.31 A further aspect of the involvement of HCC in these matters relates to the LADO. The LADO had never been made aware of any issues at Stanbridge Earls prior to the SENDIST findings but subsequently became involved in the work carried out by the local authority to assist the school. As indicated above the LADO had recommended that the school should review its policy around the maintenance of proper boundaries between staff and pupils, referring specifically to the use of social media.

6.3.32 As a result of concerns expressed by parents of ex-pupils, three specific issues were raised with the school by the LADO, independently of any police investigations. The issues were addressed within the constraints that the families involved did not wish their children to be spoken to by an officer from HCC.

6.3.33 One of the matters, said to have happened some years previously, was an allegation that that a member of staff had repeatedly set off a fire alarm during the night, forcing pupils outside until one confessed to having taken something they should not have taken. This was denied by the school and there was no corroborative evidence.

6.3.34 Secondly it was alleged that a pupil was made to do additional PE and denied water until she was sick. The school provided a copy of a contemporaneous email exchange with the parent which indicated a misreporting and misunderstanding of the issue.

6.3.35 The third matter concerned the school's arrangements where staff on site had families including older children who might not have Criminal Records Bureau checks (now Disclosure and Barring Service checks). This was a general concern which did not refer to any individual or incident. In fact there was a clear policy of CRB checks being required for anyone living on the site of an age where this was relevant. (However the ISI, when inspecting the school in May 2013, did express concern at that time about evidence of individual failures to comply with police check requirements).

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6.4 Hampshire Constabulary

6.4.1 Police first became involved in these events in July 2011 when they were notified by the CSD of a referral from the school that Child F had reported non-consensual sex with another pupil. It was agreed that police would follow up. In September 2011 that pupil was arrested and suspended from the school. Later that month the school reported non-consensual sexual activity between Child F and another male pupil. A second police investigation commenced.

6.4.2 In May 2012 the mother of Child J contacted police and reported the incident which took place in October 2010 and had been originally raised with the CSD in March 2011. Police considered the report and made enquiries at the school. They then decided that they would take no further action. The mother of Child J contacted police again in January 2013, a month after the publication of the SENDIST findings. Her complaint was now incorporated into Operation Flamborough, the overarching investigation led by a single senior investigating officer, to deliver a co-ordinated response to allegations relating to Stanbridge Earls.

6.4.3 A police "Gold Group" of senior officers and staff was formed to steer the operation, meeting regularly, and, in April 2013, a multi-agency "Gold Group" was formed with representation from police, HCC, the DfE, the Office of the Police and Crime Commissioner and the Hampshire Independent Advisory Group[22]. The purpose of this group was to ensure appropriate oversight of actions across all relevant agencies. The group continued to meet until the school closed. Following this, the police Gold Group (including representation from the OPCC and the IAG) continued to meet regularly to manage ongoing issues arising from Operation Flamborough.

6.4.4 Operation Flamborough also dealt with the following matters. Two additional complaints of sexual assault, by another two boys, were made by Child F. Child J also made a new allegation of sexual assault involving one of the boys said to have been involved in the first incident in 2010. Police later discovered that a report had been made to school staff at Stanbridge Earls by Child J regarding a different sexual assault. This had not been passed on to police at the time. (The fact that little documentary evidence was available from the school was a recurring problem for police in their investigations). Operation Flamborough dealt with three children who were identified as possible victims of sexual assault by other pupils, mostly between 2006 and 2008.

6.4.5 In 2007 a pupil at the school, Gareth Stephenson, had been convicted of a sexual offence against another pupil. During Operation Flamborough further allegations of sexual offences committed while at Stanbridge Earls were made against Stephenson. This was initially dealt with as part of Operation

[22] IAGs are volunteer groups which assist police in understanding the way their role and activities are understood by and affect local communities.

Flamborough but investigations revealed a history of similar offending by Stephenson before, during, and after his time at Stanbridge Earls, in both England and Wales, as far back as 2000.

6.4.6 This investigation extended beyond Stanbridge Earls and the CPS found "*no connection*" with the other matters being pursued under Operation Flamborough. These investigations into Stephenson were therefore separated from Operation Flamborough and are not considered in this review. He was subsequently convicted of 11 sexual offences against younger boys, including three at Stanbridge Earls between 2002 and 2006.

6.4.7 Operation Flamborough was notified in June 2013 of the incidents involving pupils from Stanbridge Earls on the rock climbing trip in Scotland. They had no jurisdiction in this matter which was dealt with by Scottish police and prosecutors. However it is right to say that the enquiries conducted by the Scottish agencies found no evidence to suggest that the incident in May 2013 was in any way linked to the "grooming" or sexual exploitation of young people.

6.4.8 In June 2013 Operation Flamborough submitted reports on all their investigations to the CPS. Shortly after that the allegation was made that Child Y had been asked by male students at Stanbridge Earls to exchange naked picture messages. This was dealt with outside Operation Flamborough and led to no further action. As detailed above, no prosecutions arose from the allegations made and investigated under Operation Flamborough.

6.4.9 Hampshire Constabulary has reflected on its involvement in these matters and identified key learning points. The establishment of a comprehensive investigative approach, with a single Senior Investigating Officer, dealing with all the related matters was key to completing a thorough investigation. The "Gold Group" approach, both within the constabulary and across other agencies, was effective in providing strategic leadership and direction and enabling the best use of resources.

6.4.10 The volume and nature of contact with victims and their families was a continuing challenge. That challenge was aggravated by the litigious nature of some of the contact. 72 allegations were made against Hampshire Constabulary, arising from complaints made by various family members and / or their representatives. These allegations have been recorded in accordance with the Police Reform Act 2002, and IPCC guidance. Further complaints were made against other police forces. 9 allegations were upheld after investigation but none related to misconduct by officers. 8 allegations remain as live investigations.

6.4.11 Twitter was used extensively to criticise police for what was said variously to be either inadequate or excessive action. Police report that *"Once it was felt all information and allegations had been captured a more robust and formal line was taken to support officers within the Constabulary who were subject to unacceptable behaviour by a minority of family members".*

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6.4.12 Police then conclude that
"In a similar situation the Constabulary should ensure Chief Officer ownership at an earlier stage to ensure that emerging critical issues have the right level of senior oversight".
That judgment has the benefit of hindsight. It would have been difficult to anticipate that this would have turned out to be such an extensive operation, which, police report, eventually involved over 8 months and across ten counties:

- 6,300 hours of officers' time;
- 1225 documents, amounting to 20,000 pages, received and reviewed;
- 50 files of documents submitted to the CPS.

6.5 Health Services

6.5.1 This report does not disclose any matters relating to the health or medical treatment of any individual. This section of the report does not detail a number of complaints made to various bodies, including those responsible for the professional registration of medical and nursing staff, some of which have not yet been determined. However the events under review have prompted consideration of the overall issue of health provision in educational establishments in the independent sector, particularly boarding schools. The NHS England Wessex Named GP, who was previously the Named GP in Hampshire, has made a significant contribution to this aspect of the review.

6.5.2 A purpose built medical centre on the site of the school provided good facilities to support boarders' health care. Children at Stanbridge Earls may have been registered with a GP local to the school or near their home address. Many of the children were not seen locally when they were unwell as their parents would collect them from school and take them home.

6.5.3 A local GP practice was the main link to direct medical services to Stanbridge Earls and some children were registered there under the General Medical Services (GMS) contract[23] with that GP. They also had a private contract to provide a weekly clinic on site for the children and young people. All children and young people could be seen including those not registered with that GP's practice, the latter being seen as temporary residents. When children and young people were seen in the weekly clinic the school nurse was present as a chaperone and when they came to surgery they were always accompanied.

6.5.4 It is of note that many pupils were being seen elsewhere by specialists, often on a private basis. This could heighten the possibility of failing to identify potential risks and vulnerabilities and share information effectively and highlights the need for an individualised, appropriately documented approach.

[23] The GMS contract is the contract between general practices and NHS England for delivering primary care services to local communities.

6.5.5 The school had three nurses providing medical cover during the day and on-call arrangements outside of the medical centre opening hours. These nurses were employed directly by the school. The arrangements included the school's nurses running asthma clinics and administering immunisations and vaccinations.

6.5.6 There had been no major concerns about health care provision at Stanbridge Earls before the SENDIST. Following the publication of the SENDIST findings a number of matters arose or came to light. The first Ofsted inspections in 2013 identified some positive features. A particularly relevant finding was that

"Health centre staff can clearly articulate their responsibilities when undertaking 'Gillick Competent' assessments[24]*, these always include consultation with other health professionals including the link GP".*

However that inspection found that overall the school did not have formal protocols to support health, care and education staff in working together to meet health needs.

6.5.7 By the May inspection the school had established these protocols but that inspection also found evidence of continuing weaknesses:

"There are…no systems to provide aggregated data from the health centre that would help inform a school development plan. For example, the health centre does not provide data on the number of children who ask for contraceptive advice or raise concerns about peer relationships".

6.5.8 There was also evidence of a deterioration in one important respect

"The nurses working in the health centre no longer have access to clinical supervision and any decisions in relation to "Gillick' competence" are made without reference to a senior clinician".

Nurses can, and regularly do, assess Gillick competency as independent practitioners and do not need to seek clarification / guidance from a senior clinician. However, in this situation, that back-up would have been helpful and was not readily available. After the SENDIST, arrangements were made by the HSCB for a Designated Nurse for Child Protection to talk to nursing staff at the school. It was clear that the practitioners benefited from a discussion about key issues – recording, information-sharing and, in particular, issues around "Gillick competency" and "Fraser consent".

6.5.9 By the Ofsted inspection in June 2013 there was evidence of continuing problems with the administration of medication. That inspection stated that *"The school must issue and implement an appropriate policy for the administration of medication to children. The school must ensure that secondary dispensing*[25] *does not occur and that suitable audit arrangements*

[24] "Gillick competency" and "Fraser guidelines" refer to legal precedent used to help assess whether a child has the maturity to make their own decisions and to understand the implications of those decisions.

[25] Secondary dispensing describes the practice of removing medicines from their original containers and put into other receptacles in advance of administration

are in place to monitor the administration of medication in each boarding house".
Importantly, in the light of previous events, the school still had not made arrangements for appropriate clinical supervision of nursing staff.

6.5.10 These reflect areas for development which are not unique to Hampshire. The Wiltshire Safeguarding Children Board (WSCB) has noted that
"..WSCB has commissioned or contributed to a number of SCR's where privately employed school nurses have featured. Within these SCR's it has become evident that the role and responsibilities of privately employed school nurses has been varied and confused, not least by other agencies who have not necessarily been aware that the school nurse was privately employed or the different roles and responsibilities they have been assigned. Schools have also not always been clear on the registration, qualification and training requirements when they employ school nurses[26]".

6.5.11 There are similar considerations in respect of GPs. Enquiries with the most relevant organisations – the Royal College of General Practitioners (RCGP), the British Medical Association (BMA) and the Medical Defence Union (MDU) – have identified no guidance specifically addressing service arrangements between GPs and independent schools.

6.5.12 In 2006 the Medical Officers of Schools Association (MOSA) - a professional organisation mainly concerned with the provision of medical care in independent schools - drew up guidance to indicate to head teachers what they might reasonably expect from their school health service and from the school medical officer. That guidance describes the responsibilities of a school doctor, principally:

- Medical supervision of the school's health services;
- Advice on occupational and environmental health matters;
- Advice on any individual patient's health, as may be deemed appropriate according to context and to content, having in mind due regard to confidentiality;
- Provision of an annual report for the school's governing body.

The MOSA guidance strongly recommends that this should be a contractual relationship which is regularly reviewed. There were no such contractual arrangements at Stanbridge Earls, and that may not be unusual.

6.5.13 In September 2014 the DfE issued new statutory guidance and non-statutory advice[27] on the roles and responsibilities of GPs in supporting pupils with medical conditions at school. The key issues in the new guidance are that:

- Pupils with medical conditions should be properly supported at school so that they have full access to education, including school trips and physical education;

[26] Minimum expectations for privately employed school nurses -
[27] Statutory guidance on supporting pupils with medical conditions.pdf

- Governing bodies must ensure that arrangements are in place in schools to support pupils at school with medical conditions;
- Governing bodies should ensure that school leaders consult health and social care professionals, pupils and parents to ensure that the needs of children with medical conditions are effectively supported.

However this guidance is specifically directed to maintained schools and academies, not schools in the independent sector.

6.5.14 The DfE has this year revised and reissued National Minimum Standards for both Boarding Schools[28] and Residential Special Schools[29]. In relation to health provision, all residential schools should:

- Promote the health of pupils and have appropriate policies for the care of those who are unwell;
- Provide suitable accommodation to meet the needs of pupils who are unwell;
- Ensure access for pupils to local medical, dental, optometric and other specialist services or provision;
- Have arrangements for the safe storage of medication and ensure that proper records are kept of its administration;
- Ensure that the confidentiality and rights of boarders as patients are appropriately respected. This includes the right of a boarder deemed to be "Gillick Competent" to give or withhold consent for his/her own treatment – an issue which of course did present in the events under review.

6.5.15 In addition, the guidance to residential special schools addresses the use of specific therapeutic techniques, specialist medical or nursing procedures, such as catheterization, and links with specialised health agencies, such as CAMHS. The guidance highlights the need for schools to take account of these issues when considering admissions.

6.5.16 The Royal College of Nursing (RCN) has published a "toolkit[30]" for school nurses which specifically addresses the position of school nurses working in independent educational settings.

6.5.17 While these publications are helpful, they could usefully be complemented by local guidance which more specifically addresses the relationships between health provision and safeguarding in independent sector education. Schools, as employers, have responsibilities for ensuring that there are arrangements for training, mentoring and supervision but health professionals can become isolated in such situations, which could adversely affect their ability to maintain competencies and develop professionally.

6.5.18 The HSCB has relevant sub groups which are well placed to develop guidance and advice on best practice, and competencies of staff working in health settings. This would need to be drawn up in partnership with health

[28] Boarding schools: national minimum standards
[29] Residential special schools NMS.pdf
[30] RCN toolkit forschool nurses.pdf

staff working in independent settings, where there will be particular considerations, for example in respect of contracting and monitoring.

6.5.19 There is then a broad recommendation from this report that the HSCB develop a general strategy for promoting engagement with health professionals working in independent schools, to promote integrated, holistic care in a clear and structured context.

6.6 The Department for Education

6.6.1 The DfE has summarised its part in these events:
"DfE had two roles in relation to Stanbridge Earls School. First, under section 7 of the Children and Young Persons Act 2008, the Secretary of State has a general duty to promote the wellbeing of children in England, although the specific duties to assess and meet the needs of individual children, or take any criminal action, rest with local authorities and the police. Second, as regulator for independent schools, the department's role was to ensure that the school was meeting, or taking steps to meet, the Independent School Standards, which included compliance with Working Together and Keeping Children Safe in Education[31]".

6.6.2 As set out in the narrative above DfE were involved in these events around the turn of the year in 2011 / 2012 and then had no involvement until after the SENDIST. They then were closely involved both in respect of their own responsibilities and as part of the multi-agency response until the school had closed and its pupils had been dispersed.

6.6.3 The report from the DfE notes that this degree of involvement was unusually extensive, in a context where Stanbridge Earls was
"one of a number of highly publicised safeguarding cases, both current and historic, which emerged at independent schools in 2013; these raised broader questions about the strength and clarity of the regulatory regime as well as challenging the department to ensure that its own processes were coherent and efficient".

6.6.4 The key learning points identified by the DfE are:

- The need, when commissioning emergency inspections, to ensure that safeguarding issues are specifically considered for inclusion in the inspection;
- The importance of good communications, principally within the department and with Ofsted, but also with local authorities, police and other parties, in relation to particularly high profile cases;
- Safeguarding children is paramount but there is a need to get the right balance, giving schools (particularly those with good education provision) a chance to improve when there are safeguarding concerns.

[31] "Keeping Children Safe in Education" was first published in 2014, after the events under review. The relevant predecessor guidance was "Safeguarding Children and Safer Recruitment in Education" (December 2006); and "Dealing with allegations of abuse made against teachers and other staff "(2012).

6.6.5 The DfE has described a number of significant actions taken as a result of the events concerning Stanbridge Earls and some other cases. A new standard has been introduced into the regulations for standards in independent schools, to allow the DfE to take regulatory action when leadership and management of a school are failing. In January 2015 the Education and Skills Act was fully commenced and, among other provisions in respect of independent educational establishments in England, this gave new emergency powers to allow the department to apply to a Justice of the Peace to close a school immediately where there are serious safeguarding concerns.

6.6.6 DfE reviewed internal processes and formalised new arrangements, to include:

- Circulating a fortnightly list of all serious and high profile independent schools cases where DfE is investigating allegations or pursuing regulatory action;
- Improved liaison between its teams - the serious incident team and the safeguarding in schools team - to ensure that both teams are aware of any allegations or incidents in all schools.

6.6.7 DfE also looked at how the department works with external partners. The department clarified its guidance (both Keeping Children Safe in Education and Working Together) so that it was even clearer that all schools – in all sectors - have a responsibility to work closely with local authorities and to allow access to social workers so that local authorities can discharge their duties effectively under the Children Acts. DfE deposited a list of practical actions with Parliament on 28 March 2014.

6.6.8 DfE agreed new working arrangements with Ofsted on the handling of concerns, commissioning of inspections and follow-up actions at independent schools. A Memorandum of Understanding (MoU) was published by the department and Ofsted in January 2014 that explains responsibilities and how they will be met. Dfe and Ofsted continue to meet on a monthly basis at that level to discuss policy, processes and cases, and to then feed into the main DfE/Ofsted liaison meetings.

6.6.9 Some concerns about the DfE's part in these events were raised by the former Deputy Children's Commissioner (DCC) in her original submissions to this review, discussed in the next section of this report. Those matters have been closely examined through the review process and were not substantiated. The Children's Commissioner has made it clear that there are no such grounds for concern.

6.6.10 Overall, the DfE responded promptly to the matters arising from the SENDIST and demonstrated a close continuing involvement until the closure of the school.

6.7 The Office of the Children's Commissioner

6.7.1 The OCC became involved in these events in the spring of 2013 after being contacted by those who had represented the family of Child F at the SENDIST. The OCC involvement was led by the former DCC until she left her post in May 2015. She had maintained contact with the family of Child F, and was still in touch with them and their representatives when her employment as DCC came to an end.

6.7.2 Before leaving her post the DCC raised a range of concerns about Stanbridge Earls, and the involvement of some agencies contributing to this review, including the DfE, in a written submission to HSCB. Following correspondence between the OCC and those managing this SCR the OCC withdrew the submission that had been made by the DCC. The final report from the OCC to this review does not include any such criticisms of other agencies.

6.7.3 The DCC had further indicated that the OCC would only be prepared to contribute further to this exercise if it were re-designated as a SCR. The Children's Commissioner has clarified that it was not her intention to withhold co-operation with this review unless it were conducted as an SCR, and agreed that this matter should have been confirmed with the HSCB at an earlier stage.

6.7.4 It was important to understand that this had been an extremely adversarial situation, where the conflict between those children and parents who champion the school and those whose children were not adequately protected continues to be bitter. The complexities of that overall situation were not recognised in the original response from the OCC to this review.

6.7.5 The final report submitted by the OCC highlights some broad issues relating to the safeguarding of children in independent schools. They include the need for:

- Additional courses of action short of closure of an independent school which would ensure that failures in safeguarding are addressed;
- Adequate "whistleblowing" arrangements, relevant to the particular circumstances of independent school staff;
- Independent schools to be usefully connected with their relevant LSCB and local authority safeguarding services.

Some of those are already part of the programme of action led by the HSCB in response to these events.

6.7.6 The OCC report also flags up the issue of "institutional abuse" and how that should be approached by child protection agencies. Institutional abuse is a term used to refer to children or vulnerable adults abused, often sexually, in institutional settings by those who care for them. It can also include situations where adults with protective responsibilities fail to notice cause for concern or fail to take appropriate action when they do notice it.

6.7.7 This review has not received from any source any evidence of staff abusing children at Stanbridge Earls. This review has not been presented with any evidence either by the CPS or the police that suggests any wilful neglect by staff of children. There was evidence of staff failing to respond appropriately to cause for concern, in relation to sexual activity between young people. Whether the nature and extent of that failure takes us into the realm of institutional abuse is another matter, and one that should be approached with caution. It is important that such terms are used carefully and with clarity.

6.7.8 The OCC judges that
"there appears to have been a culture which was at least not supportive of good safeguarding practice, and at worst was potentially conducive to the occurrence of abuse and there was a lack of leadership to address this".
It is that issue of "culture" that prompts the concerns of institutional abuse. However, as we have seen, many of the families contributing to this review, as well as staff and governors, would absolutely reject any such implication in respect of Stanbridge Earls.

6.7.9 More broadly the OCC points up a potential lack of clarity:
"Where there are many children potentially at risk in an institutional setting, because of such a climate or culture, there is a need to clarify which organisation has responsibility to investigate".
This may be a matter which the DfE feels appropriate to take into account in considering the findings of this review.

6.8 The Independent Schools Inspectorate

6.8.1 The ISI is the body approved by the Secretary of State for the purpose of inspecting schools belonging to the Independent Schools Council (ISC) Associations and reporting on compliance with the Education (Independent School Standards) (England) Regulations 2010. Because Stanbridge Earls was also a registered residential school, it was also inspected by Ofsted under separate arrangements. The ISI carried out an inspection in the spring of 2013, from an educational perspective, as part of the response across the agencies to the SENDIST findings.

6.8.2 The inspection recognises particular strengths at the school:
"Many of the pupils have experienced considerable social and academic difficulties before they join the school but rapidly develop the confidence and self-esteem needed for successful learning and personal development.…classroom relationships are extremely positive. The pupils' achievements are well supported by a good curriculum, by excellent extra-curricular provision…"

6.8.3 However, the headline finding is telling:
"The quality of provision at Stanbridge Earls varies greatly across different aspects of the school. The achievement and personal development of pupils are good. However, governance, leadership and management are unsatisfactory because they have not secured the welfare, health and safety

of pupils, particularly in relation to child protection and the recruitment of staff".

6.8.4 In respect of safeguarding, the ISI found that policy was not sufficiently well developed and procedures were not rigorously followed. Staff recruitment practices were flawed by weaknesses in administering the arrangements for police and background checks. The school did not have an appropriate overarching plan for supporting and promoting the welfare of pupils with particular disabilities or needs. Overall governance was particularly weak in relation to the need to secure a clear improvement in safeguarding arrangements following the SENDIST judgment.

6.8.5 The ISI made a number of clear recommendations which would have supported the school in developing adequate arrangements to address these issues. The ISI did not then have a continuing part in these events but its report serves to confirm the key weaknesses identified by other agencies, as well as highlighting the school's strengths.

6.8.6 The parents of Child F have specifically challenged the role of the ISI and the general inspection framework, commenting following their meeting with the reviewers that
"The inspection regimes of all independent and non-maintained schools need to be conducted by one body, namely Ofsted (which) needs to divide itself into two parts, one for educational delivery and two for child safeguarding and protection in all aspects of the curriculum whether a day or residential school".

6.9 The Charity Commission

6.9.1 The Charity Commission is responsible for the registration and regulation of charities in England and Wales. Stanbridge Earls was a registered charity. That is not unusual. The advancement of education is a charitable purpose, independent schools are capable of being charities and many are so registered.

6.9.2 The parents of Child F have expressed concern about aspects of this situation which were connected to the school's charitable status, and the obligations arising from that status. Following the failure of the Charity to put in place an acceptable action plan the DfE contacted the Charity Commission. The Commission decided in April 2013 to initiate an inquiry, announcing that
"The purpose of the inquiry will be to examine:

- *the overall administration, governance and management of the Charity by the trustees, including whether the trustees have fulfilled and are capable of fulfilling, their legal duties and responsibilities; in particular their ability to put in place and implement an action plan that is acceptable to the DfE*
- *the consequences to the charity should the trustees fail to put in place an acceptable action plan and the DfE proceed to issue a determination to remove the school from the register of independent schools*

The Commission will consider whether any remedial action to remedy the situation is necessary".

6.9.3 The Commission made it clear that it had a very specific view of what it was, or was not, reviewing:
"The Commission is not responsible for safeguarding matters or dealing with incidents of actual abuse and does not administer the legislation on safeguarding children and vulnerable adults. Matters of actual abuse and the application of safeguarding legislation are dealt with by the Police and/or the Local Education Authority as appropriate. DfE and Ofsted have primary responsibility for matters relating to schools and education".

6.9.4 The inquiry was, as is usual in such situations, to culminate in a published report. In December 2014 there was media coverage of findings from the Charity Commission's inquiry, which were said to be broadly to the effect that trustees made reasonable decisions in managing the school as a charity. The report from this inquiry did appear briefly on the Charity Commission's website, as is normal practice, but was removed.

6.9.5 The parents of Child F provided this review with recent copy correspondence in which they have been informed that the Charity Commission, as a result of representations made by the parents, has agreed to carry out further enquiries. The Charity Commisssion then wrote directly to the HSCB advising that
"further to the publication of the Statement of Results of Inquiry regarding the Charity in Nov/Dec 2014 issues have been raised with the Commission by a member of the public about the content of the report and basis for the findings and conclusions drawn in it. The Commission has opened an assessment case to review the basis of and evidence for those claims to determine whether any adjustments to the report are required or should new information be provided, whether it will be necessary to re-open the inquiry. The report has been temporarily removed from publication whilst these issues are assessed".

6.9.6 However the Charity Commission has also confirmed directly to the HSCB that it has considered the Terms of Reference for this review and, at this point, it
"does not think the Commission has any information to provide… at this stage. The scope of the Commission's investigation was to examine the (i) overall administration, governance and management of the Charity by the Trustees, including whether the Trustees fulfilled and were capable of fulfilling their legal duties and responsibilities; in particular their ability to put in place and implement an Action Plan that was acceptable to the DfE (ii) monitoring the implementation of an Action Plan and the financial situation of the Charity".

6.9.7 The author of this report has liaised directly with the Charity Commission and shared information as necessary, to reach agreement that this SCR could proceed and be concluded while the Commission's reappraisal of its inquiry continued.

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6.10 The NSPCC

6.10.1 The nature and extent of NSPCC involvement in these matters came to light only after the decision that there should be a SCR. The HSCB found out about this by chance. The parents of Child F had raised concerns about that decision and the way it had been reached with someone who has had extensive experience in policy and practice in children's services.

6.10.2 That person gave the parents of Child F some advice in an email which was copied to a number of people including the Chief Executive Officer (CEO) of the NSPCC, and to the administrator of the HSCB, which is how the correspondence came into the orbit of this review. The email contained a number of criticisms aimed at Hampshire agencies and the HSCB. The Director of Children's Services for HCC has raised concerns with the sender of that email about the content of that advice and the way in which it was distributed.

6.10.3 Once this correspondence was passed to the HSCB Independent Chair she wrote to the NSPCC CEO seeking clarification of NSPCC's involvement, and that of the CEO himself. She was advised that the NSPCC, and the CEO personally, had been in direct contact with parents of Child F, Child J and Child Y in April 2014 and subsequently.

6.10.4 The NSPCC was therefore asked to provide a report to inform the SCR and did so. The report advised that
"From the papers that we have we believe that teachers in the school may have failed to take action in relation to sexual abuse. Disclosure and Barring Service (DBS) grounds for barring teachers appear to us not to address failing to take action in relation to sexual abuse and we have fed this as a concern into the recent review of DBS, without reference to SES. We do not have any specific information relating to the Stanbridge Earls teachers and the DBS".

6.10.5 The NSPCC was asked to clarify their comment that
"teachers …may have failed to take action in relation to sexual abuse".
as this may have suggested sexual abuse by adults rather than sexual activity, consensual or otherwise, between young people. They subsequently confirmed that they had seen
"no evidence of direct involvement by adults in the abuse of children at the school".
It was important to clarify this as there had not been any such suggestion in relation to Stanbridge Earls during the period under review.

6.10.6 The NSPCC report also clarified that they had played no direct part in staff training at the school, something previously queried by the legal representatives of Child F's family.

6.10.7 The involvement of the NSPCC and its CEO, in his role as member of the National Panel of Independent Experts on SCRs, is discussed further

below in relation to the relationships between national and local agencies with safeguarding responsibilities.

6.11 County Z

6.11.1 Child F and her family were living at the relevant time in County Z. Z County Council (ZCC) became involved in this situation in 2011 after Child F had been excluded from school and returned to the family home. ZCC was advised of this by Child F's family and contacted HCC for confirmation. Mindful of their responsibilities to other young people from County Z attending the school, officers from ZCC visited Stanbridge Earls, in November 2011. This review has been informed by ZCC that they were satisfied that at that time
"the Headteacher and Deputy Headteacher were clear as to their child protection responsibilities and that they had worked appropriately with other agencies, and had established a safe system within the school community that responded swiftly to any child protection concerns that arose".
ZCC did not contact any other agencies in Hampshire at this time.

6.11.2 ZCC then received "*extensive correspondence*" from the parents of Child F over the summer of 2012. Senior managers in ZCC have reported that they were also becoming aware of the emerging concerns about safeguarding at the school and the disputed accounts of events. Consequently ZCC decided that a senior officer would personally review the overall situation in order to:

- Establish more clearly what had happened to "their" child, Child F, and how her situation had been managed;
- Evaluate the safety and wellbeing of other young people from County Z who attended the school.

6.11.3 Some of the subsequent investigative initiatives were thwarted because by this time an adversarial situation was developing. The Headteacher of the school followed legal advice and declined to co-operate. Hampshire Police also declined a meeting with ZCC. ZCC did have access to specialist professional assessments in respect of Child F . Eventually a limited review was completed by officers from ZCC, informed also by this time by the findings of the SENDIST. ZCC has advised that they were funding the places of two children at Stanbridge Earls and spoke with the families of these pupils after the SENDIST. One family decided that their child, a boy, should leave the school. The other family had a girl at the school and she chose to remain there.

6.11.4 ZCC judged, in October 2012, that they had taken all possible investigative actions to inform their review. The findings of that review have been made available to us. The ZCC review concluded that:

- The school had no adequate understanding of Child F's needs, or their complexity, and the consequent implications for the school;
- The school was not equipped to meet the needs of Child F, or any child with such specific and complex needs, and should have recognised that at the outset;

- The school's understanding and awareness of safeguarding issues and how to address such issues was deficient, showing little alertness to the need for agencies to communicate and work together.

6.11.5 With the exception of the judgment on the school's ability to assist children with similar needs, which would be contested by many of the parents contributing to this review, those findings are in line with the issues emerging in this report.

6.11.6 ZCC played a relatively minor part in these events but it is right to reflect that involvement. It is further evidence, from a well-informed source, of the extent to which the school was not equipped to deal with some issues relating to the safeguarding of young people, in a situation where there was a high probability that such issues would arise.

6.12 Hospital X

6.12.1 The mother of Child J told the reviewers that she had raised concerns about Stanbridge Earls with the consultant managing the care of some of her daughter's medical needs. This doctor has confirmed that Child J's mother had spoken to her about bullying but had not made allegations of sexual abuse. By that time Child J had left Stanbridge Earls and was in contact with CAMHS services. The consultant judged that the parents had taken appropriate action and that Child J's needs were being appropriately addressed. This has been reported back to the mother of Child J.

6.13 The Ministry of Defence

6.13.1 The Ministry of Defence (MoD) was contacted because a high proportion of pupils at the school, including some directly affected by these events, were children with a parent or parents in the Armed Forces. The MoD would usually have been a contributor to the funding arrangements for these children. Children in these circumstances can be particularly vulnerable when, for example, their parent(s) may be out of the UK. The review process did not identify any requirement for the MoD to become further involved, and it was agreed that the MOD did not need to make a formal submission to the Review.

7. KEY ISSUES

7.1 Safeguarding children who attend schools in the independent sector

7.1.1 In October 2008 Sir Roger Singleton, Chair of the former Independent Safeguarding Authority[32], was asked by the then Secretary of State for Children, Schools and Families to
"review the practical application of safeguarding provisions and procedures as they apply to independent schools, non-maintained special schools and

[32] The ISA was a non-departmental public body set up as a result of the Bichard enquiry which followed the Soham murders. It was intended to establish more extensive "vetting and barring" arrangements for all those working with children and other vulnerable people.

boarding schools (so as to)… consider whether best practice is common practice; identify areas for improvement; and make recommendations for changes which would strengthen the current arrangements".
This led to a report, "Keeping our School Safe[33]" (referred to below as the Singleton report), published in March 2009.

7.1.2 The list of those contributing to this review includes a number of familiar organisations – the Charity Commission, the OCC and the ISI, as well as the Association of Chief Police Officers and the Association of Directors of Children's Services.

7.1.3 This was a comprehensive review which goes to some lengths to explain what it describes as the
"bewildering array of regulatory frameworks to which schools are currently subject".
The complexity of the regulatory frameworks remains bewildering, and the report is helpful in unravelling that. The report goes on to make more than thirty recommendations. Some of those recommendations have been implemented while others have been overtaken by events. Some have not been implemented but remain relevant. As part of their submission to this review the ISI helpfully reconsidered the recommendations from the Singleton report against the situation as it stands in late 2015. Some of their comments are reflected in this section of this report.

7.1.4 Following the change of government in 2010 the new administration decided that the proposals to be implemented by the ISA should be re-considered and scaled down. The ISA itself was merged with the Criminal Records Bureau into the Disclosure and Barring Service.

7.1.5 Nonetheless the overall messages from the Singleton report remain relevant and, in one area, they anticipate key findings from this review:
"The expectation that independent schools should participate in local safeguarding arrangements overseen by the LSCB may require some LSCBs to take initiatives to understand the distinctive needs of independent, non - maintained special schools and boarding schools, recognising their particular circumstances and respecting their unique contribution whilst being willing to share safeguarding knowledge and experience".

7.1.6 The government has now produced new, simplified guidance in its document "Keeping Children Safe in Education[34]", published in March 2015, which clarifies some issues, such as the responsibilities placed on independent sector schools to refer to and work with local safeguarding agencies. The guidance is clear that
"Everyone who comes into contact with children and their families has a role to play in safeguarding children. School and college staff are particularly important as they are in a position to identify concerns early and provide help for children, to prevent concerns from escalating."

[33] Singleton review.pdf
[34] Keeping children safe in education

and
" "school" means all schools whether maintained, non-maintained or independent schools, including academies and free schools, alternative provision academies and pupil referral units."

7.1.7 Most importantly, for HSCB, the guidance requires that
"Governing bodies and proprietors of all schools and colleges should ensure that their safeguarding arrangements take into account the procedures and practice of the local authority as part of the inter-agency safeguarding procedures set up by the Local Safeguarding Children Board (LSCB). Section 10 of the Children Act 2004 requires a local authority to make arrangements to promote co-operation between itself and its relevant partners and other organisations who are engaged in activities relating to children. Under section 14B of the Children Act 2004 the LSCB can require a school or college to supply information in order to perform its functions; this must be complied with."

7.1.8 However the HSCB, in its work since the events at Stanbridge Earls and in its contribution to this report, has identified a number of issues which remain unclear or problematic. We are aware of a complex Serious Case Review being carried out elsewhere in which this issue may again figure prominently.

7.1.9 Independent schools are expected (see "Keeping Children Safe in Education") to take into account procedures and practices of the local authority as part of the inter-agency safeguarding procedures set up by the LSCB. However there is no specific duty or responsibility to tell their local authority which pupils are attending their school. Nor is there any duty to inform a pupil's 'home address' local authority that they are educating the child, (despite that home authority's duty to assure itself that a child is receiving an appropriate education).

7.1.10 Independent schools must refer safeguarding issues about individual children to local authorities / police. However there are no powers vested in local authorities or Safeguarding Boards that would enable them to quality assure whether this is happening appropriately or not.

7.1.11 There are further potential weaknesses in respect of specific staff groups – for example, there is no way, without the co-operation of schools in this specific respect, of knowing whether all 'school nurses' are appropriately qualified, registered and supervised, and up to date with their professional development, particularly in relation to safeguarding issues.

7.1.12 Overall, there are already arrangements for the regulation of independent schools, a responsibility which sits with the Secretary of State who will ask the approved inspection bodies, generally Ofsted and the ISI, to carry out inspections. It would be inappropriate and unhelpful for the local authority or other local agencies, including the Safeguarding Board, to become involved in activity which would replicate or duplicate the work of those inspection bodies.

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7.1.13 In Hampshire since July 2013 the local authority and the HSCB have decided to move forward in these circumstances by way of an “offer”, seeking to promote a more open dialogue and a closer relationship with independent schools. The intention is to help these schools understand and comply with safeguarding requirements and expectations. Elements of this offer have included:

- Sharing model safeguarding policies and audit processes;
- Seminars and other events;
- Input on the role of the LADO;
- Information on referral processes;
- Training opportunities;
- Representation on the LSCB education sub-group.:

7.1.14 At the same time the local authority and the HSCB aim to draw together appropriate information in respect of individual pupils (specifically to address issues of children potentially missing from education) and information that would enable them to start to compile a meaningful database of DfE registered independent schools in Hampshire.

7.1.15 As a result a comprehensive list of DfE registered independent schools in Hampshire was established during 2013/14. Independent schools have also been asked to complete a structured report on their safeguarding practice, mirroring requests already made to maintained and academy schools in Hampshire.

7.1.16 Completed reports were received from 37 independent schools, believed to be a 57% return. This should be seen as a positive result given that this was the first time an attempt had been made to engage these schools in this way and that the return rate for Hampshire’s maintained and academy schools from the comparable exercise in 2013 were 74% and 50% respectively.

7.1.17 In June 2014 the HSCB held its first “independent schools event”, attended by 31 representatives from 25 different establishments, of various shapes and sizes. 17 schools apologised as they were unable to attend on that specific day (which was close to the end of the school year). Taking a positive view, this could be taken to show 75%, of providers of independent education as willing to engage. The Chair of HSCB and the most senior officers from the local authority’s CSD were able to attend.

7.1.18 Schools attending were:

- Given broad information on the structure and function of the Safeguarding Board;
- Reminded in outline of their duties under ‘Keeping Children Safe in Education’ and ‘Working Together 2013’;
- Told about training they could source from HSCB / HCC;
- Given information on the role of the LADO in relation to allegations made against those within the children’s workforce.

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7.1.19 Key outcomes were decisions to:

- Seek a representative from the independent sector to join the LSCB;
- Set up and facilitate local 'cluster groups' where a sector focus on safeguarding could be maintained;
- Send out further information and improved contact arrangements;
- Involve the independent sector directly in designing the next safeguarding report/self-audit;
- Facilitate another county-wide event for the sector in 2015.

7.1.20 In June 2015 HSCB held a subsequent event for independent schools across the county which was attended by 57 representatives from 33 different schools, all varying in sizes and student groups. Discussions were had with the Chair of HSCB and senior officers from HCC on a range of general and thematic issues. Feedback from this forum was positive and it is likely that further events will be held later in this financial year.

7.1.21 HSCB now considers that most local independent education providers are welcoming opportunities to engage with the "safeguarding children agenda". At the same time it is right to recognise that there has been no response or engagement from a number of schools. HSCB has decided to identify these establishments in its collation of outcomes from the "section 175 audit[35]".

7.1.22 One of the recommendations from the Singleton review was that local authorities making placements in schools outside their area might

- *"take a closer interest in the way in which the receiving school participates in local safeguarding arrangements overseen by the LSCB in whose area it is located, for example by asking before making a placement and at regular reviews for evidence of the school's engagement*
- *contribute to school inspection evidence by offering their perspective on the safeguarding performance of the school"*

This is a further area of practice which could be developed jointly by HSCB and HCC.

7.1.23 The HSCB itself, in its formal contribution to this review, made the following key points. Firstly it is essential to understand the statutory basis of relationships between education providers, local service providers and commissioners, inspection and regulatory bodies and these organisations' individual roles. Those relationships need to be seen in the context of the range of general responsibilities for both education providers and the HSCB, which are broad, and the scope of the HSCB's powers which are limited.

[35] Section 175 of the Education Act 2002 requires school governing bodies, local education authorities and further education institutions to make arrangements to safeguard and promote the welfare of children. Such arrangements will have to have regard to any guidance issued by the Secretary of State. Similar requirements are in place for proprietors of Independent Schools under Section 157 of the Education Act 2002.

7.1.24 Any notion of a homogenous 'Independent Schools Sector', in Hampshire or anywhere else, is flawed. The differences in culture, structure and resourcing between schools falling under this umbrella heading are significant and need to be recognised. A small, privately run preparatory school, an establishment owned by a national company providing local authorities with places to purchase to meet the needs of teenagers with severe learning disabilities and a major public school may all be 'independent' but may have little else in common. Offers from the HSCB and responses to approaches from all schools will need to be tailored accordingly, whether they are maintained, academies, independent, free schools or faith schools.

7.1.25 It will remain difficult to carry out this work without a regular collation and analysis of relevant data to underpin understanding of issues and enable targeting of responses. Despite the initiatives described above there is no clearly mandated framework for the management or collation of such data.

7.1.26 Finally there is no mechanism to ensure local authorities know of children living in their area by virtue of attendance at an independent school, whether that placement is made by the family or the state (for example in independent schools for children with special educational needs).

7.1.27 The HSCB, through its Independent Chair, has indicated that it will continue to make representations on this last matter, as well as on the issue of the imbalance between duties and powers in respect of non-maintained schools. The HSCB will report any school that fails to complete its s175/157 return in its Annual Report for 2015/16.

7.1.28 The Singleton review in 2009 had recommended that independent schools be required to report on their safeguarding arrangements in their annual returns to government. The government department should then *"make the report available to the relevant inspectorate, alongside other information collected as part of the annual return. There would also be value in the school sharing it with the relevant LSCB and where applicable with placing local authorities. This would provide the LSCB with useful data on which to develop its forthcoming advisory and training plans and it would give a placing local authority confidence that safeguarding issues were being appropriately addressed".*
Despite the improvements we have noted, this has not been introduced as a requirement.

7.1.29 The headline recommendation of the Singleton review in 2009 was that the government should undertake a
"comprehensive re-appraisal of the entire regulatory framework as it applies to the categories of school within scope of this review, aimed at reducing overlap, eliminating inconsistency, updating requirements and filling gaps, to achieve the further benefits of reducing the regulatory burden and improving the quality of safeguarding within schools".

7.1.30 The ISI had strongly supported this recommendation and, in contributing to this review, noted that, after some early progress, there had

been a loss of momentum. Consequently, the ISI comments, it remains the case that
"There are many areas of overlap and inconsistency, particularly between regulation and statutory guidance…".
The DfE is asked to consider this in the principal recommendation from this review.

7.2 The safeguarding implications of sexual activity between young people

7.2.1 The intervention of child protection agencies in situations involving sexual activity between children can require difficult professional judgments. Some situations are statutorily clear – for example, a child under the age of 13 cannot consent to sexual activity. But it will not necessarily be appropriate to initiate safeguarding procedures where sexual activity involving children and young people below the age of legal consent (16 years) comes to notice. In our society generally the age at which children become sexually active has steadily dropped. It is important to distinguish between consensual sexual activity between children of a similar age (where at least one is below the age of consent), and sexual activity involving a power imbalance, or some form of coercion or exploitation. It may also be difficult to be sure that what has or has been alleged to have taken place definitely does have a sexual component.

7.2.2 As usual, important decisions should be made on a case by case basis, on the basis of an assessment of the children's best interests. Referral under safeguarding arrangements may be necessary, guided by an assessment of the extent to which a child is suffering, or is likely to suffer, significant harm. Key specific considerations will include:

- The age, maturity and understanding of the children;
- Their social and family circumstance;
- Any evidence in the behaviour or presentation of the children that might suggest they have been harmed;
- Any evidence of pressure to engage in sexual activity;
- Any indication of sexual exploitation.

7.2.3 There are also contextual factors. Gender, sexuality, race and levels of sexual knowledge can all be used to exert power. A sexual predator may sometimes be a woman or girl and the victim a boy. At Stanbridge Earls the fact that all the children were, to some extent, away from their families, will have been significant.

7.2.4 Stanbridge Earls was first and foremost a private school. Parents could choose to send their children there and the children at Stanbridge Earls were not necessarily disabled. However the children involved in the events leading to this review were all vulnerable. Child F was disabled, as the SENDIST found, and others involved may by the same measures have been "disabled". Disabled children are likely to be particularly vulnerable to coercion and there is inevitably an increased risk that a sexual relationship may not be consensual. It may be appropriate for the HSCB to target this area in its developmental work with independent sector schools.

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7.2.5 There was an additional aspect of vulnerability to consider, specific to Stanbridge Earls.The girls attending were heavily outnumbered by the boys at the school – 153 boys and 36 girls when the ISI inspected in the summer of 2013 after the SENDIST. That inspection reported that
"In discussion, girls, who represent a small minority of the pupils educated at the school, were clear that they do not feel disadvantaged in any way".

7.2.6 However the former HSCB Chair, Ms Clare Chamberlain, had picked up the potential difficulties in these arrangements when she reviewed the situation in January 2013. She remarked that
"Depending on the distribution across year groups this suggests that there may be as few as three or four girls in a year group of up to 20. Such a balance makes the girls more vulnerable to potential exploitation or bullying".
In such circumstances staff should be alert to the possibility of inappropriate or sexist cultures or activity developing. No such sensitivity is evidenced in the information supplied to this review in respect of Stanbridge Earls.

7.3 Establishing the locality responsible for a child protection investigation

7.3.1 There are inherent complexities in addressing child protection concerns in respect of children who are not living "at home", and this issue has been raised by some parents in their input to this review. However the requirements across localities and the statutory basis for those arrangements are clear.

7.3.2 Taking the family's address as the "home" authority and the school's address as the "host" authority:

- Any continuing case responsibility for a child lies with the home authority;
- Where concerns arise in relation a child being abused / neglected within the host locality, the host agencies will lead the enquiry;
- Any emergency action should be taken by the host authority unless agreement is reached for the home authority to do so, as they might if for example they were neighbouring authorities;
- Where concerns relate to the child's home circumstances, the home agencies should lead the enquiry, advising and informing the host authority;
- Where concerns arise in relation to parenting (e.g. where parents are visiting a child in school), the home agencies should lead the enquiry, involving the host authority;
- Where matters are dealt with by the host authority, responsibility for the child will duly revert to the home authority.

In all these situations, as is always the case, the welfare of the child will be the paramount consideration and negotiations about responsibility must not cause delay.

7.3.3 In fact there is generally no evidence that these arrangements were not followed here. The exception is in relation to the situation of alleged perpetrators of criminal or abusive actions. As discussed above the needs of

these young people were not assessed. That would be the responsibility of the home authority (which in at least one case was also the host authority).

7.4 Mandatory reporting of child protection concerns

7.4.1 Mandatory reporting of child protection concerns refers in general to the introduction of a legal requirement on professionals to report such concerns, with sanctions under criminal law if they fail to do so. It has been seen as particularly relevant to children living in "institutions", such as boarding schools. It is addressed here because it has been raised with us and vigorously promoted by the parents of Child F and their representatives with reference to Stanbridge Earls.

7.4.2 Discussions about this initiative have demonstrated a wide range of opinions. The effectiveness of criminalising professionals, who are dealing with difficult issues and decide not to make a referral, has been challenged. There have been predictions that this initiative would herald such a significant increase in referrals that the statutory services would struggle to cope, and the consequent concern that worrying cases might not get the fullest attention. The former College of Social Work noted that there is no clear evidence that mandatory reporting would be effective, but that it could deflect attention from some of the more easily identifiable weaknesses in current arrangements, such as training, and keeping pace with the different forms of abuse coming to attention, including child sexual exploitation.

7.4.3 Nonetheless there is probably growing support for the introduction of some form of mandatory reporting. The position of the NSPCC[36] on mandatory reporting has discernibly changed over time, shifting from an explicit opposition to a view that some new form of legal requirement with sanctions is necessary. The CEO of the NSPCC has also said[37] that *"In addition, we are particularly concerned about closed institutions, where contacts with adults beyond the institution itself are strictly limited. Here we are interested in examining the case for stronger corporate duties to protect children and more serious consequences in the event of failure to do so."* The NSPCC has noted in its submission to this review that the arrangements made by the Disclosure and Barring Service currently do not include provision in respect of teachers who fail to take action in response to concerns about sexual abuse.

7.4.4 The NSPCC continues to oppose a "blanket" obligation to report concerns, having looked at countries where this has been done and noted evidence of the system becoming overloaded. The NSPCC has also pointed out the weaknesses in a system which is process driven, rather than being fundamentally based on the identified needs of the child. Their most recent published position proposes the introduction of:

- A new criminal offence of concealing or ignoring known child abuse;

[36] NSPCC policy-briefing-strengthening-duties-professionals-report-child-abuse.pdf
[37] This quote is taken from publicised comments on the review led by the CEO into historical abuse.

- A restricted form of mandatory reporting for concerns or suspicions about abuse conducted by those within an institution.

7.4.5 That “middle road” has been challenged, particularly by the proponents of mandatory reporting, on the basis that it would create a muddled, unenforceable situation, less satisfactory than the current arrangements. However, as the NSPCC has pointed out, there are also dangers that a more sweeping requirement would be similarly unenforceable.

7.4.6 The NSPCC suggests that, while supporting the introduction of a restricted form of a duty to report, there should be further consideration of
“the definition of the institutions to which the proposed duty should apply;
the individuals which the proposed duty should apply to;
the behaviour that should be subject to a duty to report or the threshold for reporting;
what level of knowledge of abuse would trigger the proposed reporting duty;
whether an external reporting mechanism is necessary or desirable and how would such a reporting mechanism operate;
whether increased governance obligations on board members, trustees or governors would support a duty to report.”

7.4.7 From this review there is a further complexity in respect of the actions which should be the subject of a duty to report. The public debate has largely focussed on the reporting of abuse allegedly perpetrated by adults. This review essentially arises from incidents which did not involve adults. The professional judgments arising from such circumstances would often be even more difficult to get right.

7.4.8 In any event this is a public policy initiative that will only be determined nationally. While the events under review may give rise to discussions that could inform action to be taken in the future there are no recommendations to the Board in relation to mandatory reporting.

7.5 The involvement of national agencies in local safeguarding arrangements

7.5.1 As described above the nature and extent of the involvement of the NSPCC and its CEO became clear towards the end of this review. When the HSCB Chair was made aware of this she wrote to the NSPCC CEO seeking clarification of NSPCC’s involvement, and that of the CEO himself.

7.5.2 The CEO is also a member of the National Panel of Independent Experts on Serious Case Reviews. When his involvement came to light he told the HSCB Chair that he had in fact declared a conflict of interests at that panel. He had stepped aside when the panel had discussed the possibility of there being a SCR in respect of events at Stanbridge Earls.

7.5.3 The HSCB had not previously been advised of this. There had been correspondence during 2014 between the Panel and the HSCB Chair regarding her decision to defer a decision on the commissioning of an SCR

but there had not been any formal notification of that decision to stand aside. The HSCB Chair had attended a meeting in December 2014 with the National Panel and was told by the CEO that he had met with some parents from the school in his capacity as the CEO of NSPCC but the full extent of his personal involvement and that of the NSPCC with some families was not made clear.

7.5.4 The NSPCC, in their response to this review, have said that
"We do not think we have sufficient information in relation to local agencies' responses to safeguarding concerns at the school,which is why we have been supportive of the families' wish for a transparent review process".
But, having talked to the families during 2014, the NSPCC did not approach local agencies to request such information, or seek to elicit any information about the review processes which had already been completed.

7.5.5 The former DCC emailed the HSCB Chair in April 2014 about Stanbridge Earls and asked whether there was to be an SCR, but did not then make contact with any Hampshire agency about this until this review process started in September 2014. However, in their submission to this SCR the OCC has reported
"The work of this office during 2014, in conjunction with the NSPCC and others, was to press for an inquiry in some form into the indications of longstanding risk and allegations of abuse to children at the school".
In that connection, the OCC went on to say that
"Discussions were held with the DfE, who also consulted… the NSPCC. (The CEO of the NSPCC) also wrote to (a senior civil servant) in April 2014 concerning the importance of an Inquiry and offering support".
None of these communications or concerns were made known to the HSCB until the OCC's final report to this review was received in August 2015.

7.5.6 Local agencies did not know until this report was being written that representations had been made by representatives of the family of Child F to the DfE in 2011, and that this had led to the Ofsted inspection in January 2012.

7.5.7 It is not suggested that local agencies were deliberately kept unaware of the nature and extent of the involvement of national agencies. But there is a balance to be struck in respect of the roles and responsibilities of agencies nationally and locally. It is the right, and indeed the responsibility, of some national agencies to listen to individual children and families, and to exert their influence to assure themselves that local child protection processes are appropriately in train. It could be applauded that national figures make themselves directly available to some "ordinary" families.

7.5.8 At the same time, when taking a position, particularly one that is supportive or advocative, those parties need to remain aware that there will often be important material, factual and analytical, that they have not seen. Services "on the ground" can also rightly expect to be aware of the nature and extent of the involvement of organisations with a national (or international) role and reputation. Front line child protection enquiries are sensitive and difficult to manage. That complexity can only be compounded if front line

services are not made aware of the involvement of agencies they are entitled to regard in some respects as partners.

7.5.9 In fact, in the course of the work for this review, it emerged that the OCC had in March 2015 received reports of specific child protection concerns that had not been passed on to local agencies for investigation. That information was contained in a welter of copy correspondence about a wide range of issues and it was assumed by the OCC that the relevant statutory agencies had been made aware of the information.

7.5.10 Enquiries by HCC and police have now confirmed that these specific concerns had in fact already been identified and required no further action. However it is an absolutely fundamental tenet in child protection work that one does not rely on other interested parties to ensure that appropriate referrals are made and followed up. A local authority social worker, or a police officer, who received information of that nature but did nothing because they believed someone else had already made a referral, would be rightly criticised. That criticism holds true throughout our safeguarding arrangements. National agencies must exercise the same diligence that would be expected at a local level.

7.5.11 Neither the OCC nor the NSPCC, although they had real and continuing concerns about what had happened at Stanbridge Earls, formally referred any matters to the HSCB before this review was initiated. That is of particular concern because a local Safeguarding Board has relevant responsibilities, to challenge local practice and satisfy itself that children are safe. The HSCB Chair has advised that she would certainly have sought to involve both the NSPCC and OCC in this exercise at an earlier stage had she been aware of the extent of their involvement and their apparent concerns about safeguarding practice in Hampshire.

7.5.12 These matters are all the more important because these events have been so contentious and there are so many families and other parties who believe that children have been seriously harmed by the closure of Stanbridge Earls. The Children's Commissioner has stressed that her Office's intention was to address safeguarding concerns, not press for the closure of the school. However the school has closed, the education of children has been disrupted and the families of those children feel particularly let down when they see high profile agencies and individuals who, they believe, are interested only in "one side of the story".

7.5.13 Child protection work is notoriously bedevilled by the failure of agencies and professionals to talk to each other. Agencies can also be "played off" against each other. The operational work of local agencies may be hampered when national agencies, legitimately pursuing their own interests and responsibilities, do not keep local agencies appropriately informed.

7.5.14 In fact there is a potential correspondence with the matters discussed in section 7.4 of this report, the debate about the mandatory reporting of child

protection concerns. The NSPCC supports this, as described above, but they did not contact statutory agencies in Hampshire upon receiving reports from parents who were concerned that their children had been abused at Stanbridge Earls.

7.5.15 There are issues of accountability and governance here which should be considered by all the relevant agencies when considering what may be learned from these events.

8. CONCLUSIONS AND LESSONS LEARNED

8.1 The consequences of the events at Stanbridge Earls during 2010 and 2011 have already been more far-reaching than could reasonably have been predicted, and the story has not yet run its course. However it is important to stress that this review did not set out to investigate all the individual concerns raised and allegations made by a range of parties who remain disaffected for a range of reasons. It seeks to identify key learning points that will promote the ability of the HSCB to safeguard children and scrutinise child protection arrangements in Hampshire.

8.2 The crux of these complex events is that some vulnerable girls were not adequately protected. The school that should have been preventing that maltreatment, and promoting those girls' best interests, failed to do those things sufficiently thoroughly. Girls were a small minority of the young people attending Stanbridge Earls. Not all of those girls were unhappy or mistreated but the school staff and trustees generally were not sufficiently alert to the needs of vulnerable girls, when that was an apparent area of risk.

8.3 It is clear from the positive reports of families and former staff that many children, including girls, did benefit greatly from going to this school. Concerns that there was an unusual degree of inappropriate or harmful behaviour between pupils have not been clearly substantiated. However the evidence in respect of the girls who are specifically referred to in this report is convincing. There was an insufficient challenge to some established patterns of conduct in the culture of the school, conduct which had the potential to cause harm and did so.

8.4 The school, as an organisation, was not sufficiently alert to its safeguarding responsibilities. The safeguarding responsibilities and duties of any school are demanding but they are much more complex in a school which is looking after children with a range of special needs, most of whom are living away from their family home.

8.5 This review has found evidence of very basic errors by the school, which include:

- An overall lack of alertness to safeguarding issues and incidents with safeguarding implications;
- A failure to keep parents properly informed, perhaps arising from a failure to grasp the seriousness of matters;

- A corresponding failure to make and keep other agencies aware of cause for concern;
- A failure to recognise that sexual activity between children might raise safeguarding concerns, or concerns that crimes may have been committed;
- Confusion about confidentiality, a consideration which was used inappropriately to excuse failures to take essential action;
- Weaknesses in basic administration - the school had inadequate systems for keeping formal records of incidents, meetings, communications and advice to staff on the safeguarding issues leading to this review.

8.6 It is telling that, even as events unfolded after the SENDIST, and the school strove to meet the challenges of OFSTED's reinvigorated inspections, no specialist safeguarding expertise was brought on board. Talented people with a range of specialist knowledge and experience were introduced in an advisory capacity. Some had some safeguarding experience but they did not include, for example, a former Director of Children's Services or someone with a background in safeguarding inspections.

8.7 The response of the local authority after the SENDIST was extensive and thorough. This review finds no fault in how it conducted its safeguarding assessments and the judgements that professionals made. It concluded that none of the children assessed had any safeguarding needs that would require a s47 inquiry and this was appropriate.

8.8 The response of the police was equally thorough and co-ordinated at a senior level once the full extent of investigations was understood. For police in particular this became a major operation. The CPS has provided detailed explanations of their evaluations of the matters referred to them by police and their decisions that no criminal charges should be brought. Those decisions have been subject to a very high level of scrutiny through our legal structures and systems.

8.9 However this review has identified lessons in respect of the co-ordination of actions by the local authority and police when investigating safeguarding concerns. Specifically, there are recommendations from this report about:

- The actions to be taken when a single agency police investigation comes to its conclusion;
- The actions to be taken when a single agency police investigation is agreed and the child/ren who are subjects of that investigation move away from the local authority area where concerns first arose;
- The need to balance investigative and safeguarding requirements when an alleged perpetrator is a vulnerable child.

8.10 There were weaknesses in the way in which the school was equipped to meet the health needs of pupils. Some of these problems were tackled but others persisted and in one important respect, access for nurses to clinical supervision, the situation deteriorated in the months after the SENDIST. That is of particular concern because of the likelihood that school nurses in

independent establishments could become professionally isolated. There were also no formal arrangements for managing the relationship between the school and the General Practitioner who provided health services. The HSCB could usefully work with independent schools, building on national guidance, to improve the safeguarding of children using the health provision at such schools.

8.11 For HSCB the key matters emerging from these events relate to the overarching issue of safeguarding in schools outside the state sector. This report has noted that the government's new guidance, Keeping Children Safe in Education (March 2015) has been helpful. The report has also detailed a number of local initiatives taken by the Board to promote co-operative working with the independent sector. However the review has also highlighted continuing contradictions and weaknesses in current requirements and arrangements.

8.12 A local authority has a "target duty" to safeguard the welfare of children living and / or being educated in its area. However, independent schools are not under any requirement to tell their local authority which pupils are attending their school. Nor is there any requirement that they should inform the local authority for a pupil's 'home address' that they are educating the child, despite that home authority's duty to assure itself that the child is receiving an appropriate education.

8.13 There are no powers vested in local authorities or Safeguarding Boards that enable them to evaluate whether independent schools are sufficiently alert to child protection concerns and are making referrals appropriately, other than the s175/157 self assessments that each school is required to carry out. LSCBs, without the co-operation of schools through these audits, cannot know whether staff are appropriately qualified, registered, equipped and supported to deal with those safeguarding responsibilities.

8.14 Overall, there is a duty on an LSCB to assure itself that schools comply with safeguarding requirements but there are no powers to monitor or ensure compliance by independent schools. At the same time it would be inappropriate for the local authority or the Safeguarding Board to replicate or duplicate the work of the authorised inspection bodies. The local initiatives will helpfully continue but these matters have national implications and that is reflected in the recommendations from this report.

8.15 Sexual activity between young people will be a difficult issue to manage for all schools, but especially so for schools dealing with special needs and residential schools. Schools need openly to recognise that challenge and ensure that staff and governors / trustees are appropriately equipped and supported in dealing with it.

8.16 At Stanbridge Earls there was an additional complexity in the extent to which boys outnumbered girls. The potential consequences of that were not adequately recognised or addressed. Some of the bullying identified in this review had connections with the position of girls in the school, even where the

perpetrators may have included girls. It is a situation which could recur elsewhere and demands a proactive approach, where girls are protected while their independence is promoted.

8.17 As part of the developing relationship between the HSCB and independent sector schools with residential provision, it will be helpful to issue guidance which clarifies the responsibilities of safeguarding agencies in school and home locations.

8.18 These events have associations with and implications for the debate on mandatory reporting of child protection concerns.

8.19 National agencies as well as local agencies have responsibilities towards individual children and families. It reflects positively on national agencies that their most senior officers may still be directly involved with families raising safeguarding concerns. But those agencies need to remain alert to the need to keep local agencies, and especially the Local Safeguarding Board, appropriately informed of any concerns they may have, and any action they are taking.

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9. RECOMMENDATIONS TO THE HAMPSHIRE SAFEGUARDING CHILDREN BOARD

1. The Board should refer this report to the Department for Education with reference to the broader issues identified in respect of safeguarding children educated in schools in the independent sector. In particular the Department for Education should be asked to consider the extent to which an LSCB can reasonably satisfy itself that schools comply with safeguarding requirements when there may be insufficient powers to monitor or ensure compliance in independent schools.

2. The Board should use its arrangements for working in partnership with independent sector schools in Hampshire to disseminate the findings from this report, highlighting:

- The particular responsibilities of trustees to ensure that safeguarding is assured and promoted;
- The need to ensure that all staff, but especially those with specific safeguarding responsibilities, are adequately trained and supported to deal with safeguarding issues;
- The need to ensure that staff providing school health services are appropriately qualified, trained and supported in dealing with safeguarding issues;
- The potential safeguarding implications for all young people with special needs, and consequent vulnerabilities, who are involved in sexual activity;
- The vulnerabilities of girls, particularly girls with special needs, in residential educational provision;
- The need to ensure that parents are always promptly and appropriately made aware of safeguarding concerns;
- The importance of prompt and accurate recording of safeguarding concerns;
- The complementary responsibilities of child protection services in home and school localities, when children are in residential education.

3. The Board should develop mechanisms for engaging with and supporting professionals providing health services in independent schools, in line with national best practice for safeguarding children.

4. The Board should require commissioners of health services to demonstrate compliance in discharging their safeguarding duties against local best practice guidelines, with specific reference to health services in independent schools.

5. The Board should review and amend as necessary its multi-agency child protection procedures, with specific reference to:

i. feedback between the agencies when it has been agreed that either police or the local authority should carry out a "single agency" investigation.

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ii. concluding or continuing involvement in situations where, after initial discussions between the agencies, a case is referred to another police force or local authority
iii. how the two agencies work together in situations where a vulnerable young person is the subject of police investigations as a possible perpetrator of a criminal offence.
iv. decisions by professionals about informing parents when they become aware of a child, who may be vulnerable, becoming involved in sexual activity

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APPENDIX A THE INDEPENDENT REVIEWERS

Kevin Harrington

Kevin Harrington trained in social work and social administration at the London School of Economics. He worked in local government for 25 years in a range of social care and general management positions. Since 2003 he has worked as an independent consultant to health and social care agencies in the public, private and voluntary sectors. He has worked on some 50 Serious Case Reviews in respect of children and vulnerable adults. He has a particular interest in the requirement to write SCRs for publication and has been engaged by the Department for Education to re-draft high profile Serious Case Review reports so that they can be more effectively published.

Mr Harrington has been involved in professional regulatory work for the General Medical Council and for the Nursing and Midwifery Council, and has undertaken investigations commissioned by the Local Government Ombudsman. He has served as a magistrate in the criminal courts in East London for 15 years.

Jane Whyte

Jane Whyte trained in social work at Middlesex University in 1995 and completed her post-qualifying training at Royal Holloway, University of London. She has been employed in a range of settings in both the public and independent sector, including managing the Safeguarding Board of a local authority in London.

Ms Whyte is an experienced complaints investigator and Children's Independent Reviewing Officer, responsible for quality assuring child protection assessments, planning and interventions. Her particular interest is the involvement of children, their parents and family members in child protection processes and she is a sessional advisor for the Family Rights Group.

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APPENDIX B TERMS OF REFERENCE

TERMS OF REFERENCE

THE REVIEW PROCESS

This review will be led by Kevin Harrington Associates Ltd. Kevin Harrington has substantial experience as an independent reviewer of safeguarding issues. He will report to an Executive Board of senior officers from the key agencies involved.

The review process should seek to ensure that the “voice of the child”, and of the parent, is heard and reflected. The review should also be informed by the substantial body of documentation that has already emerged from these events, and through interviews with officers of the relevant agencies. The review should attempt to draw together the views of key staff from Stanbridge Earls who, as a result of the closure of the establishment, may not be readily available.

THE FINAL REPORT

The final report will consider the overall response of the school and relevant agencies to child protection concerns at the school, and any broader relevant issues of public policy. The period under review will be from the summer of 2010 until the closure of the school.

It will consist of:

- An outline narrative of the events leading to the closure of Stanbridge Earls and the commissioning of this review;
- A reflection of the comments made by young people and their parents who contributed to the review;
- An analysis of the response of the school itself and of the key statutory agencies – principally Hampshire County Council. Hampshire Constabulary and Ofsted – to the events leading to this review;
- An analysis of the role of any other relevant public bodies in these events;
- An analysis on the part played by the HSCB throughout these events.
- A consideration of any issues relating to safeguarding specific to independent schools;
- A consideration of any further significant issues emerging from these events.

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