WEST BERKSHIRE SAFEGUARDING CHILDREN BOARD

A SERIOUS CASE REVIEW-
Learning for services arising from sexual offences by individuals connected to a secondary school.

ALEX WALTERS V.3

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1. INTRODUCTION

1.1 This Serious Case Review (SCR) was initiated following the convictions and sentencing of two individuals for sexual offences against children in March/April 2016. Both had both been connected with Kennet School- one as a teacher and one as a youth counsellor who was also a local vicar. The initial focus had been a single agency review of the safer workforce practices of the school and the overall safeguarding culture. However, what became apparent through an initial review of information held by partner agencies requested by the LSCB was that:

a) there were a number of additional individuals in “positions of trust” where there had been criminal/disciplinary proceedings and investigations within the local area of Thatcham who were connected to Kennet school

b) these individuals were also connected and employed by other schools/organisations

c) a review of the responses to allegations /investigations from statutory organisations was likely to provide additional learning

1.2 The matter was referred to the Local Safeguarding Children Board (WBLSCB) in West Berkshire in March 2016, following the convictions and considered by the West of Berkshire joint SCR sub group. The Independent Chair of the WBLSCB decided that the criteria were met and a Serious Case Review (SCR) should be undertaken on 24/3/16.

1.3 There is a legal requirement, as defined in Statutory Guidance, Working Together to Safeguard Children 2015, to undertake a serious case review when abuse or neglect of a child is known or suspected and

- either a child has died; or
- a child has been seriously harmed and there is cause for concern about how organisations or professionals worked together to safeguard the child.

1.4 The purpose of a Serious Case Review, as set out in the statutory guidance, “Working Together 2015”, is to identify improvements, which are needed, and to consolidate good practice in order to prevent serious harm.

1.5. It is not the purpose of any SCR to publically provide a great deal of detail in relation to individuals about whom concerns or allegations have been raised but this process has considered detailed information in relation to at least 11 individuals. It has therefore extracted the key issues and areas of learning from the analysis of each of these reviews and additionally been informed by discussions with members of the public who responded to a public appeal for information.

1.6 Therefore the two primary areas of focus for this SCR are:

Firstly how to create safe working cultures within organisations. This covers areas such as safe recruitment, policies and training for staff, the creation of transparent arrangements for staff and children to raise their concerns with effective management oversight and whistleblowing procedures.

Secondly, how to ensure that statutory agencies and their arrangements for responding to allegations/concerns about adults who are in positions of trust are effective in protecting children from abuse.

1.7 Research undertaken by the NSPCC on feedback from abusers in 2012 identified a range of factors that may have contributed to the development of an environment in which abuse could occur. These are significant issues and identify clear themes around recruitment, organisational messages and organisational culture and the learning from these messages have been considered throughout this SCR.

NSPCC learning

- Recruitment procedures, as described by participants, were often not rigorous.
- Selection processes such as interviews were not particularly challenging; participants who offended more recently described processes focussed primarily on technical knowledge rather than values related to working with children.
- There was evidence that some cases may have had insufficient screening of references; in particular, participants working as temporary staff reported that their employing agencies failed to adequately check historical references.
- All participants who should have been CRB/DBS checked were; in only one case would a participant who abused children have possibly been screened out through this route.
- Participants described organisations, which failed to provide clear indicators of organisational commitment to children's welfare; at the beginning of jobs or volunteering most were no more than basic messages about child protection.
- It appeared that many organisations described by participants were not clear about the importance of rules and regulations; in particular, expectations about relationships between staff and children or young people were rarely spelled out and where they were, were rarely enforced.
- Some organisations were described as being more committed to managing children's behaviour than in their overall welfare.
- Colleagues were described as either being unaware of the abuse participants were perpetrating or aware at some level but not acting on that knowledge. There were examples where it seemed colleagues had some awareness, but showed more concern toward the perpetrator's potential for 'getting in trouble' than for the welfare of the child.
- Location of abuse rarely played a part in facilitating abuse in this study; it appeared that abuse could happen almost anywhere, no matter how many others may have been around or had the potential for walking in on

participants. In a few cases, it is possible that the geographical isolation of participants may have been a factor.

2. ARRANGEMENTS FOR THE SERIOUS CASE REVIEW

2.1 West Berkshire LSCB established an SCR Panel and agreed the representation as set out in Appendix A. The Designated Doctor for Berkshire chaired the Panel and Alex Walters was appointed as the Lead Reviewer. Her CV is set out in Appendix B

2.2 Six Individual Management Reviews (IMRs) were requested from the following organisations/services who were identified through the SCR process as having the most involvement with the individuals identified in Positions of Trust and with the victims. Oxford Diocese undertook 2 IMRs –one for the Diocese and one for the Parish.

- Kennet School, West Berkshire
- West Berkshire Education Service
- West Berkshire LA Local Authority Designated Officer (LADO) function
- Thames Valley Police
- Spurcroft School, West Berkshire
- Oxford Diocese

2.3 In addition, Information and Analysis Reports (IARs) were requested from a further eight organisations/services to establish if there was any broader learning.

These included:

- West Berks Local Authority Children's Social Care
- Reading Local Authority LADO
- Wokingham Local Authority LADO
- Berkshire Healthcare Foundation Trust (BHFT)
- Thatcham Primary School
- John Madejski Academy, Reading
- Methodist church, Thatcham
- Heathfield School,

2.4 This report was written with the knowledge that it will be published, therefore the information in the report is deliberately limited in order to;

a) take reasonable precautions not to disclose any identities of individuals not already in the public domain

b) protect the right to an appropriate degree of confidentiality for the victims and individuals who contacted the LSCB

2.5 The SCR Panel developed comprehensive Terms of Reference (TOR) for this SCR. These are attached at Appendix C. These TOR differentiated the level of information and issues to be addressed by the relevant agencies/organisations in order to be proportionate and focussed in its work.

2.6 Not all the individual management reviews (IMRs) initially fully addressed the terms of reference and some required further work including responding to new information at the request of the Overview Author and the SCR Panel. There continued to be factual discrepancies between IMRs. All the IMR authors of the individual management reviews were independent of direct management, and all conducted interviews with staff involved. At least 49 individuals were interviewed as part of these processes.

2.7 Following consideration of the combined chronology of events and the individual management reviews, the IMR Authors were invited to a full day SCR Panel to discuss their IMRs together and consider the learning identified. Additional meetings were held for some IMR Authors.

2.8 It was decided by the SCR Panel in August 2016 to take the unusual step of undertaking a public appeal for information. This was because the convictions of two of the individuals were already in the public domain following the criminal convictions, and Kennet school had issued a statement confirming the decision to undertake a Serious Case Review. As a result there had been contact from one victim and one other individual and it was felt that a public appeal would afford any individual the opportunity to present information to inform the learning from the SCR process.

2.9 The Public appeal went live on 13/9/16 and covered a 6 week period. A system was established to respond to any contacts and the Overview Author undertook the appeal on video which was issued to the press and posted on the LSCB website. As a result there were a further 4 individuals who made contact and shared information with the Overview Author that was useful to the learning of this review and this is captured in Section 6. This was felt to be an open and transparent process which involved the wider community to contribute to the learning.

3. METHODOLOGY USED TO DRAW UP THIS REPORT

3.1 This SCR Overview report relies on:

- The agency Individual Management Reviews (IMRs) and Information and Analysis Reports (IARs)
- Chronologies provided by all partner agencies
- Minutes and discussions from the SCR Panels

- Discussions with and views of the IMR Authors at SCR Panels and one separate meeting.
- Telephone discussions with previous and current LA senior managers to provide contextual information.
- Telephone discussions between Overview Author and 6 individuals /members of the public who made contact directly- 4 as a result of the LSCB Public Appeal.
- Follow up discussions with individual organisations where appropriate.

3.2 This SCR Overview report consists of:

- A factual context
- Analysis of the IMRs by each agency and overall learning
- Analysis of key messages from IARs and members of the public.
- Closer analysis of key learning issues arising from the review
- Conclusions and Recommendations

3.3 The conduct of this review has not been determined by any particular theoretical model. However, it endeavoured to use an appreciative enquiry approach involving IMR Authors and practitioners in the exploration and learning from the case as well as members of the public. It has been carried out in keeping with the underlying principles of the statutory Guidance, set out in Working Together 2015. These are at Appendix D.

4. SCOPE OF THE SERIOUS CASE REVIEW

4.1 The SCR focused on the following two individuals whose identities are already in the public domain as well as a number of other individuals in positions of trust. The first, Robert Alan Neill was employed as a teacher at Kennet from 1985-2007. Following allegations by his nephews of sexual abuse, a criminal trial was held in 2007 and Robert Neill was found not guilty. He was however dismissed from Kennet School later that year. In 2013 /14, a number of ex pupils then made further allegations and he was convicted of charges of indecent assault and rape and sentenced to 21 years imprisonment in March 2016.

4.2 The second individual, Peter Jarvis was employed as a youth counsellor at Kennet School 2010 -2011 through arrangements with the Church and was the Team Vicar of Thatcham Parish, which included two churches-St Marys and St Barnabas. He was also a Safeguarding Governor at Thatcham Park Primary and delivered assemblies at Spurcroft Primary. He was employed at the John Madjeski Academy, Reading from 2011-2013. Allegations made in 2011 by a young person did not result in criminal prosecution and following suspension, he was re-instated by both Oxford Diocese and the JMA school in Reading. Further allegations were subsequently made in 2013 by ex Kennet school

pupils, which resulted in his conviction of indecent sexual activity and possession of indecent images at a 2nd Trial. He was sentenced to 15 months and 9 months imprisonment in April 16.

4.3 With both these individuals, agencies were asked to look at their information and consider whether there was any single agency or multi-agency learning about how they had recognized and responded to the concerns raised.

4.4 In addition, there were a number of other individuals identified in the Thatcham area through this SCR process who held “positions of trust” where there had been concerns about their behaviour -some of which had also resulted in criminal caution and dismissal from their roles. Agencies were requested to consider the information held within each of their agencies on these individuals and whether there was any single agency or multi-agency learning about their responses to these concerns.

4.5 A number of children and young people were also inevitably identified through this process either as victims, possible victims or children for whom there had been safeguarding concerns, All agencies were therefore requested to consider all of these children in terms of how their agencies had responded and to identify any learning.

5. THE AGENCIES

5.1 Kennet School

Context

5.1.1 Kennet School is a comprehensive school, on the eastern edge of Thatcham. Pupils come from Thatcham itself and from the villages to the north and east, including Bucklebury and Brimpton. Currently there are 1800 pupils on roll, including 360 in the Sixth Form. The school is a popular choice locally and it is oversubscribed. The school follows a determination that each and every pupil should fulfil his or her potential, both academic and personal. There is a House system in place, which is led by a team of pastoral staff, and a tutor group system.
Kennet School opened in 1957 and was reorganised, in 1971, as a co-educational comprehensive school. Kennet School became an Academy in April 2011. It is part of the Kennet School Academies Trust (KSAT). There is a large staff group at the school - teaching staff 150 and non-teaching staff 100. The Head has been in post at Kennet School since 1988. There are strong links with the local community. Many of the staff have educated their own children at the school.
In terms of Governance, there is a small group of Trustees for the Kennet School Academies Trust (KSAT) – they hold overall responsibility for the management of Kennet School and a local primary School – Whitelands Park Primary School. There is a Board of Directors, which oversees the strategic and operational running of the school and there are two Local Governing Bodies, which currently host the Governor Lead with responsibility for safeguarding.

The IMR process and identified learning

5.1.2 The IMR Author has undertaken a lengthy review of the school's policies and procedures and formally interviewed those in key roles. The IMR Author also wrote to all members of staff to invite contact and undertook interviews with around 18 governors and members of staff at all levels in the organisation which was acknowledged by the IMR Author as a comparatively small sample of the workforce but additionally the IMR Author met with a group of children and young people who are pupils. Staff, governors and children were positive about current safeguarding arrangements. The IMR Author also triangulated additional information emerging from the other IMRs and IARs. In addition the IMR Author met with the SCR Overview author to ensure that the IMR provided the maximum opportunity for learning.

5.1.3 The analysis provided by the IMR Author clearly acknowledges that the school staff, governing body and the Head have been deeply affected by the prosecution of the two individuals and were determined that these offences should not be repeated. The IMR Author however recognised that there were occasions when the school had not followed professional guidance or national policy. There were examples of information about individuals, which should have been shared proactively with other agencies in order to protect children which did not occur. However there continue to be differing perceptions between agencies of the detail of some of these. The analysis recognised the progress that had been made, particularly following the appointment of an experienced Deputy Head as Designated Safeguarding Lead (DSL) in 2014 and the commissioning of an external audit by another school DSL in March/April 2016, which set out an action plan of areas requiring further improvement.

5.1.4 Ofsted also undertook an inspection of the school in May 2016, which was published in June 2016. It stated, "The arrangements for safeguarding are highly effective. Staff are regularly trained in child protection and safeguarding. The school makes thorough checks on staff and these are recorded in line with current requirements. Parents and pupils agree that there is a clear culture of safety across the school. This was confirmed during the course of the inspection".

5.1.5 The school and the IMR Author have however not been complacent. In recognition that safeguarding processes, procedures and the organisational culture need to be strengthened and improved to ensure that the safeguarding arrangements within the school are as robust as possible, the IMR Author has made the following recommendations for Kennet school. These are not captured in the existing audit action plan and include a number of additional recommendations following the IMR and the engagement of the SCR Panel and the Overview Author. This has been a robust process and has understandably gone into much greater detail than a time limited inspection process can undertake.

Knowledge, understanding and awareness of the abuse

- The requirements of KCSIE (Keeping Children Safe in Education-DfE) 2016 in relation to staff training – two-yearly and annual update must be met.
- The existing safeguarding and child protection policies are adequate but must be updated and improved in line with statutory guidance and good practice advice.
- For greater clarity, within the policy, the needs of safer recruitment and safe staffing must be within a separate and distinct part of the document. Flowcharts must be introduced – as set out in Working Together 2015 for the identification and referral of child abuse and they must be used in internal training.

Professional curiosity and vigilance

- Safeguarding, particularly in relation to any safeguarding concerns about staff, must be a standing item on senior management team meetings – at least once a month.

- The external audit commissioned in April 2016 must be carried out on an annual basis with quarterly reviews of progress reported with evidence to the Head and Governors.

- All discussions, including staff and House meetings, about safeguarding matters in relation to individual pupils must be recorded at the time and added to that child's records.

- All safeguarding concerns about pupils must be recorded in separate and distinct file records.

Timely and accurate recording of incidents and of allegations against staff.

- Without hesitation or delay, any signs of concern suggestive of abusive or inappropriate behaviour must to be recorded in detail, reviewed and senior internal discussion must take place as soon as possible.

- The outcomes of any review and the agreed action must also be recorded. The main responsibility for managing allegations of abuse against staff rests with the Head. However, it is important that this responsibility is shared and exercised with the rest of the senior management team. External discussion with the LADO must also occur within 72 hours.

- Any current or historical allegation that an employee or volunteer has behaved in a way that has harmed, or may have harmed, a child must be taken seriously and dealt with sensitively and promptly. The child's interests are paramount and their views and wishes must be given careful consideration at all times. They must also receive appropriate support. This also applies to former pupils who may contact the school with concerns.

- Concerns and worries must be recorded on a central system accessible to the senior management team and future conduct must be monitored.

Performance reviews must take account of any such concerns about professional behaviours and conduct. The Directors of the KSAT must receive quarterly anonymised information about any concerns raised and the outcomes, which resulted. Any referrals to the LADO must be referred to the Chair of the Directors as soon as possible.

Children, young people and parents need to be actively encouraged to share their worries and concerns

- Key contacts for pupils about safeguarding such as DSL, Tutors and Heads of House must be displayed prominently in the school.
- As per the 2016 KCSIE guidance, safeguarding is covered within the school's curriculum via Personal, Social, Health Education sessions.
- Explicit reference to safeguarding must be included in the school prospectus and on the school's website.
- Promotional information must be available for pupils and parents identifying who they should approach. This must include information about external sources of help such as ChildLine and other relevant local agencies.

All members of staff need to be actively encouraged to share their worries and concerns in relation to safeguarding.

- The learning from this review and other national reviews must be shared.
- Induction and requiring mandatory attendance at safeguarding training must ensure that staff are actively encouraged to share safeguarding concerns.

Safer staff recruitment training

- The school must have standard application forms in place for recruitment to complement or replace the current application by letter process.
- At least one referee must be spoken to directly by a senior member of staff when appointments are being made.
- The senior management team of Kennet School, including the Head must attend, or commission in-house, a one-day safer recruitment workshop to ensure that a shared and consistent approach is in place and that this is known and understood by a wider group of staff.
- All Governors and Directors must attend safeguarding training to ensure they are fully aware of their individual and shared responsibilities.

Governance arrangements and safeguarding

- The roles, responsibilities and training of governors, directors and trustees in relation to safeguarding require review to ensure that they are sufficiently clear and robust.
- The level of safeguarding training undertaken by governors needs to be increased and to occur more frequently.
- The lead governor responsibility for safeguarding needs to be considered in terms of the level of accountability and the level of experience and expertise required. The Governor with lead responsibility for safeguarding requires an enhanced level of safeguarding training.

- The Kennet School Academies Trust members must consider how they will link with and refer to the Regional Schools Commissioner in relation to safeguarding.
- An addendum to the Deputy Head's job description must be added to cover her DSL responsibilities as set out in KCSIE 2016.

Joint working and relationships between the school, the Local Authority and other agencies

- There must be consideration by the Local Authority and the Kennet School Academies Trust about how relationships can be improved and trust restored.
- Kennet School's DSL must be encouraged to be involved in some of the activities of the LSCB.

The Overview Author endorses all these recommendations

5.1.6 Key learning issues identified by the Overview Author

1. The need to consistently and robustly demonstrate the commitment to ensure there is a safe and evidenced transparent culture in the organisation that encourages staff, parents and children to raise their concerns.
2. The review has demonstrated some of the inherent governance issues and tensions around safeguarding for Academy Trusts who no longer receive services from the Local Authority. The Kennet School Academies Trust members must consider how they will link with and refer to the Regional Schools Commissioner and the Education Funding Agency in relation to safeguarding as well as the LA and LSCB.
3. The IMR Author suggests that the current arrangements around the roles, responsibilities and training of governors, directors and trustees in relation to safeguarding require review to ensure that they are sufficiently clear and robust and this is endorsed by the Overview Author.

5.2 West Berkshire Education Service.

Context

West Berkshire's Education Service delivers services as 'Local Education Authority' to schools, pupils, parents and carers. The Service sits within the Council's Communities Directorate. It assesses and plans education provision across the area, delivers and commissions support at both school and pupil level. As well as providing statutory services to all schools, it offers a range of traded services to maintained schools and academies. The latter are defined as 'independent' publicly funded schools, not maintained by West Berkshire Council, but responsible to the Regional Schools' Commissioner.

5.2.1 The IMR process and learning identified

The IMR Author provided a comprehensive analysis and undertook discussions with 5 officers within the council including Human Resources (HR), Education Welfare, Special Educational Needs, School Improvement and Governor services. It reviewed a number of records and documents and guidance and made the following recommendations to the Local Authority, LSCB and partner agencies.

1. All agencies should adopt as policy that disciplinary dismissal hearings relating to safeguarding should always continue to their conclusion even if the member of staff resigns before a decision has been reached.

2.The Service should take steps to improve its record keeping to ensure that, where practicable, full documentation on all cases is available. If capacity permits, annual reviews should be carried out to ensure that all actions have been appropriately concluded.

3.The Service should undertake periodic reviews, at perhaps six monthly intervals, of safeguarding reports made to the LADO in order that trends or patterns might be identified. Where significant, the results should be reported to the LSCB Chair.

4. An audit should be undertaken of the Service's safeguarding policies and procedures to ensure that all activity is covered. Any identified deficiencies should be made good.

The Overview Author endorses all these recommendations

5.2.2 Key Learning issues for the Overview author;

1. All disciplinary proceedings undertaken by **all** partner agencies should be concluded even if the member of staff is on a temporary contract or resigns prior to their conclusion to support ongoing safe recruitment and should be included in agency safeguarding policies and procedures.

5.3 Local Authority Designated Officer function -(management of allegations)

Context

Working Together 2015 states that Local Authorities should have designated a particular officer, or team of officers to be involved in the management and oversight of allegations against people that work with children. Any new appointments to such a role, other than current or former designated officers moving between local authorities, should be qualified social workers. Local Authorities in England should identify designated officers (referred to as the LADO) to be involved in the management and oversight of individual cases of allegations of abuse made against those who work with children as set out in the Allegations against People who Work with Children Procedure.
Their role is to give advice and guidance to employers and voluntary organisations;

liaise with the Police and other agencies, and monitor the progress of cases to ensure that they are dealt with as quickly as possible consistent with a thorough and fair process. In West Berkshire the role of LADO was established in 2008 and has been filled by the same Service Manager (Children and Family Services) since that date.

The IMR process and learning identified

5.3.1 This IMR included discussions with seven practitioners and reviews of the records and key documents in relation to the LADO function. The analysis recognises that recording of the processes and formal advice provided could be strengthened and identifies there is an issue in relation to how the LADO function follows up and has oversight of internal investigation/disciplinary processes undertaken by individual organisations.

It made two recommendations for the Local Authority:

- There is an analysis of the capacity and scope of support on offer from the Children and Family Services Leadership Team into the rigour of any agency's internal investigation into an allegation made by a child in West Berkshire. This test of rigour should give particular attention to;

  - The independence or perceived independence of the investigator(s)
  - The thoroughness of the investigation
  -Any conflict with other professional bodies in respect to the outcome of the Investigation

- There is an analysis of the capacity and scope of support on offer from the Children and Family Services Leadership Team into; when there is found to be a lack of safeguarding procedures in an organisation, or, those procedures are not fit for purpose, a 'critical friend' (such as the LADO) is allocated to support, develop and test their new procedures and policies.

5.3.2 Following further discussion at the SCR Panels, the following additional recommendations were discussed and included.

- Where issues are formally raised with employers these are put in writing requesting confirmation of actions that the employer will take.
- If the employer chooses not to follow advice then this matter is formally raised through the LSCB and should form part of wider system learning to consider what if any other action is required.
- There needs to be a separate stand alone module for LADO to record all actions and decisions so that vital intelligence is not lost and it can be cross referenced when internal checks are completed.
- The process of escalation where employers fail to follow the advice of LADO need to be strengthened and recorded in the Pan Berkshire procedures.

The Overview Author endorses all these recommendations.

5.3.3 Key Learning issues identified by the Overview Author

1. The remit of the LADO function and multi-agency strategy functions in relation to their role in ongoing oversight and responsibility for the outcomes of individual organisations internal investigations and disciplinary processes needs to be agreed.

2.The need to robustly record discussions and clarify expected outcomes of actions.

3. The need to ensure sufficient capacity to undertake strategic cross cutting reviews of LADO activity involved with individual organisations to recognise any potential issues/trends or patterns.

5.4 Thames Valley Police (TVP)

Context

Thames Valley Police is the territorial police force responsible for policing the Thames Valley area covering the counties of Berkshire, Buckinghamshire and Oxfordshire. It is one of the largest territorial police forces in England covering 2,200 square miles and a population of 2,180,200 people.

The Individual Management Review (IMR) process and identified learning

5.4.1 The IMR Author provided a comprehensive and detailed analysis of TVP's involvement with all of the individuals identified through this SCR Process. The IMR process itself involved discussions with 12 individual practitioners and 4 with specific expert knowledge plus a comprehensive review of numerous procedures and guidance documents.

The analysis identified that overall practice had been effective and despite the inherent difficulties in such investigations, TVP and the Crown Prosecution Service had successfully cautioned/convicted a number of the key individuals subject to this review. They however recognized that there were three areas where it was felt ongoing attention was required and opportunities to improve practice.

a) Prosecuting cases of child sexual abuse:
This review has highlighted the difficulties prosecutors face when dealing with child sexual abuse cases. These have become more evident in recent years not least because of the high profile child sexual exploitation cases and those against well known public figures. Cases such as these have prompted the Director of Public Prosecutions to produce revised guidance. This guidance asks prosecutors to abandon any myths or prejudices borne out of personal experience and to apply a merits-based approach. It is hoped that in time this approach will rid the Criminal Justice System of many of the myths and stereotypes around child sexual abuse by challenging them at court.

This review has addressed this learning by recommending

- Thames Valley Police to satisfy itself that their investigators and decision makers are considering the DPP's 'Guidelines on Prosecuting Cases of Child Sexual Abuse' 2013 when making case disposal decisions.

b) This review has further highlighted the effects of positional grooming and the importance of professionals understanding that institutional abuse is a real risk and that 'pillars of the community' can also be child sexual offenders.

- Thames Valley Police to circulate the CEOP 2013 Thematic Assessment entitled 'The Foundations of Abuse: A thematic assessment of the risk of child sexual abuse by adults in institutions' to all investigators and ensure its findings are embedded in training.

c) Indecent images of children: (IIOC)

TVP recognised there had been delay in some of their responses. Today, the number of unique IIOC in circulation on the internet runs into millions, with police forces reporting seizures of up to 2.5 million images in single collections alone. The number of individual children depicted in these images is likely to be in the tens of thousands.As is seen in a number of the investigations in this review, the offenders were also found to be in possession of IIOC. For each of these, the IIOC aspect of the investigation led to lengthy delays with offenders remaining on police bail for many months.

TVP explained that there are a number of initiatives in place now to improve current backlogs and progress the timeliness of the service. Yet with improved Front line triage tools such as SPEKTOR and the CAID (Child Abuse Identification Database) coming into use to speed up the grading of IIOC cases and utilising SFR (Streamlining Forensic Reporting) for faster reporting to the courts to achieve early guilty pleas, TVP are confident the time taken to resolve these cases will reduce. TVP are not alone with this issue and forces are affected nationwide. This review is confident that the issue is being appropriately addressed, escalated and monitored by way of the Force Risk Register. Therefore, this review will not be making any recommendations in this area.

Following discussion with the SCR Panel, TVP agreed an additional recommendation to address the continued need to raise awareness and audit the impact of awareness raising on practitioners.

- Thames Valley Police to ensure that the ongoing audit of effectiveness of the "SaVE" training includes an assessment of safeguarding knowledge in non-specialist departments.

The Overview Author endorses all these recommendations.

5.4.2 The key learning issues identified by the Overview author

1. The criminal justice approach in cases of allegations of historical sexual abuse needs to continue to build on national learning , research and updated guidance.

2. The need to always refer /discuss all cases received by TVP with the LADO.

3. The need to ensure all police practitioners are appropriately trained around issues of safeguarding and particularly by those in positions of power/ trust/highly respected within their communities.

4. The need to ensure that in all cases involving child victims, all aspects of the criminal justice system need to be especially sensitive to the impact on those children of the abuse and their ability to engage in the court process.

5. The need to recognise the impact of delays around TVP undertaking reviews of indecent images on partner agencies ability to conclude disciplinary proceedings.

5.5 Spurcroft School

Context

Spurcroft Primary School is an expanding, larger than average community primary school located in the town of Thatcham. It is fully inclusive and provides places for children aged 3-11. Most children then move on to The Kennet School (secondary) in Year 7.

The IMR Process and identified learning

5.5.1 The IMR Author has undertaken a comprehensive IMR with a detailed and thorough review of the issues and a clear analysis of current practice around safeguarding recruitment, the learning and areas for improvement. The process involved discussions with 14 individuals and a review of all significant guidance and procedures.

The recommendations are as follows:

- Written records should be maintained relating to conversations relating to any concerns raised during the recruitment of school staff. This includes conversations with referees and with applicants about discrepancies identified on employment application forms.
- Consideration should be given to adapting the WBC application form to require references from two previous schools if one of the references relates to a period of employment outside of education for teaching staff.

- The procedure for obtaining DBS checks for governors should be set out in writing, if this has not already been done so and the procedure to obtain references for parent governors should be put in place.

- A school recruitment policy should be developed bringing all the procedures together in one place.

- The school needs to ensure that the new procedures introduced though the government guidance 'Disqualification by Association' are sufficiently robust.

- The Safeguarding Governor should attend the WBC Governance Network Group and ensure the Governing Board is familiar with the Safeguarding Toolkit when it is launched in September 2016.

- The findings of the recent and future safeguarding audits should be reported to the Governing Board.

- The following outstanding actions from the safeguarding audit undertaken in December 2015 should be completed:

- A shortcut to the Berkshire Local Safeguarding Children's Board (LSCB) Child Protection Procedures has not yet been included on all staff laptops.
- Due to the low responses from parents to questionnaires on safeguarding, ways of encouraging parents to get actively involved in school developments and ask about prevention development plans are still to be developed
- The school's policy on the use of reasonable force to control or restrain pupils is due to be reviewed by December 2016

The Overview Author endorses all these recommendations

5.5.2 The key learning issues identified by the Overview author

1. The need for the commitment to and continual monitoring and endorsement of safe recruitment practices and the need for comprehensive recording.

2. Active encouragement of parental engagement in safeguarding developments within schools.

5.6. The Diocese of Oxford and Parish Council IMRs.

Context

The Diocese of Oxford is one of 42 dioceses that make up the Church of England; 41 are in England and the other covers Europe. The Church of England is divided into two provinces (Canterbury and York), and the Diocese of Oxford comes within the province of Canterbury. The diocese is made up of four Archdeaconries (Oxford, Buckingham, Berkshire, and Dorchester) under which 626 parishes operate to support the running of 815 churches. Each Diocese appoints at least one Safeguarding Advisor whose role is to provide

advice and support to the diocese and its parishes on safeguarding matters. All dioceses within the Church of England have a structure of boards and councils that are responsible for different aspects of the Church's work.

The 'Parish' is often described as representing the heart of the Church of England, and is looked after by an ordained Priest with incumbent status, whose title may be 'vicar', rector, team vicar, priest in charge, or team rector. The running of the Parish is the joint responsibility of the incumbent priest and the Parochial Church Council (PCC). A parochial church council (PCC) is the executive committee of a Church of England parish and consists of clergy and churchwardens of the parish, together with representatives of the laity.

Legally the council is responsible for the financial affairs of the church parish and the maintenance of its assets, such as churches and church halls, and promoting the mission of the church.

The Parish of Thatcham comes under the archdeaconry of Berkshire. There are two churches within the parish; St. Mary's church and St. Barnabas Church (which meets at Thatcham Park School).

The IMR process and identified learning

5.6.1 The IMR Author provided a comprehensive analysis of the involvement of ODC with the individuals and the Parish of Thatcham and identified key areas of learning. The process involved interviews with 7 individuals and the reading of numerous documents, procedures and guidance. The IMR recognises areas where procedures could be strengthened and improved in terms of the recognition of and the recording of concerns and increased vigilance around safe recruitment practices.

5.6.2 At the request of the SCR Panel, the IMR Author provided a useful summary of the context of safeguarding in the Church and undertook further reflection on the learning opportunities.

"A key driver in recognizing the need for improving safeguarding practice in the Church has been recognition for a need to change. This has been driven in part from a number of high profile cases concerning representatives of the Church of England who have either been found to have abused children or failed to take appropriate action. It is also based on the realization that, if the Church is to thrive, it must be (and be seen to be) a safe place, where children and vulnerable adults are safe and not at risk of abuse or exploitation because of their vulnerability. This has required the Church to be much more open about how it approaches and responds to incidents of abuse by clergy. Historically, a number of past cases have shown that there has been a tendency to deal with these issues in secret, without involving outside agencies. This culture of 'Forgive and Forget' is steadily disappearing in the Church but there is always a risk that it might be present in pockets of the Church still, and it is likely to take some time still before it disappears completely.

It should also be borne in mind that the culture of the Church of England in the way in which it responds to safeguarding concerns is evolving; the culture that exists today is very different from the culture that existed in the past because

the expectations of society and level of public accountability are now much greater. A good example of this cultural change can be seen in the levels of adherence to DBS checks. Whereas 10 years ago, clergy might well have routinely challenged the necessity for routine CRB / DBS checks, they are now widely accepted as necessary and a valuable part of a wider safer recruitment policy."

Recommendations for the Diocese of Oxford:

- Ensure the proper recording of all safeguarding concerns regarding clergy through effective implementation of the existing policies - on the recording of safeguarding issues and the model policy on recording safeguarding encounters (May 2015)
- Ensure that all incoming Clergy's blue (staff) files are read by the Bishop's Chaplin in order to identify any safeguarding issues
- Consider how employment contracts for church staff involved in direct work with children / young people can be strengthened regarding reinforcing the church policy that abusing the role to engage in sexual and personal relationships with young people they are working with is against church policy.
- Consider implementing the 'Keep it Safe' framework (in youth work environments)
- Explore how the ministerial annual review process can be strengthened with respect to good safeguarding practice and behaviours.
- Strengthen further the diocese's whistleblowing policy by including reference to how the policy applies to Bishops and the Designated Safeguarding Adviser (DSA)
- The diocese to ensure that any concerns raised about a church youth worker must be retained on their personnel file and included in any reference requests
- It is recommended that the diocese explore ways in which all safeguarding issues identified within the diocese can go onto an electronic database, which would allow a further opportunity for links to be made and important information not to be lost.
- With respect to concerns about a member of the church that fall below the threshold for whistleblowing – consider i) identifying someone within the church (e.g. Diocese Safeguarding Advisor or Diocesan Secretary) whose role will be to provide independent advice on whether to formally report / record this information and ii) incorporate this into the Diocese's whistleblowing policy, iii) consider how the model policy on recording pastoral encounters should be strengthened and applied with respect to clergy, in order to ensure that accurate records of all concerns are recorded on clergy's blue (staff) files.

  Recommendations for the Parish of Thatcham

- To ensure the proper recording of **all** safeguarding concerns regarding clergy through effective implementation of the existing policies - on the recording of safeguarding issues (May 2015) and the model policy on recording safeguarding encounters (May 2015)
- Consider implementing the 'Keep it Safe' framework for activities involving children and young people (presented at appendix 2)
- The Parish is also asked to note the recommendations made to the Diocese of Oxford.

The Overview Author endorses all these recommendations.

5.6.3 The key learning issues identified by the Overview Author

1. How to provide, support and monitor safe cultures in organisations particularly those with an inherent public profile and perception of credibility
2. How to encourage and empower professional curiosity across the whole organisation.
3. How to record and ensure the appropriate response to the cumulative impact of low level concerns around individuals.
4. How to ensure internal disciplinary processes are informed by all evidence including the views of multi-agency strategy discussions
5. How to ensure that activities undertaken by the Church ie youth work adheres to the same safeguarding policies and procedures and recognises the inherent risks in more informal settings.
6. To ensure that there is no potential conflict of interest in relation to the independence of the LSCB Chair and the provision of direct operational advice as the LSCB Chair at the time was employed as the Safeguarding lead at ODC.
7. One additional significant issue was identified through these IMR processes, which resulted from the discovery that there are certain roles not covered in primary legislation. In the Sexual Offences Act 2003, clergy youth workers and other youth workers operating outside statutory agencies are excluded from the provisions where there are concerns about behaviour in "Positions of Trust".

6. KEY LEARNING FROM THE INFORMATION AND ANALYSIS REPORTS

6.1 The SCR received 8 Information and Analysis reports (brief factual reports) and they each made a limited number of recommendations for their own agencies. There were clearly areas of safeguarding practice, which required improvement, and the recommendations identified will all help to improve safeguarding practice around workforce awareness and compliance with safe recruitment as well as how agencies respond to concerns/allegations.

6.2 Recommendations related to the need to improve safer recruitment practices i.e. requiring references from previous schools, requiring verbal telephone calls with referees and ensuring references are provided by the Head. There was recognition of the additional support and safeguarding

training required by school governors. There was also recognition that internal disciplinary processes need to be concluded even if staff are no longer in post.

6.3 Learning was also identified in the response by adult services to historical child sexual abuse allegations made by adults. Improvement was identified and the need for increased training and discussion with safeguarding leads. There was also learning around the need to ensure escalation by statutory services where responses from organisations are not provided or of insufficient quality.

6.4 There was learning related to the LADO function and the need to ensure this was clearly understood and included in audit activity and that there should always be personal contact with the victim and family and joint visits wherever possible with other statutory partners involved in investigations.

6.5 The Overview Author and SCR Panel have endorsed all IAR agencies recommendations. The key strategic areas of learning have been taken from these reviews and incorporated into Section 8, which sets out the key learning issues.

7. KEY LEARNING FROM THE DISCUSSIONS WITH MEMBERS OF THE PUBLIC

7.1. The Overview Author had detailed telephone discussions with a number of adults who contacted the LSCB in response to a public appeal for information. The unusual step to issue a public appeal was taken as the LSCB had been directly contacted by two individuals who were aware that there was an SCR being undertaken and wanted an opportunity to share their information. It was therefore felt appropriate by the SCR Panel to offer this opportunity to anyone in the general public who might have relevant information they wanted to share. This opportunity was taken up by a further four individuals and the SCR would want to recognise the courage of all of these individuals to make contact and share their experiences and their learning. There was considerable learning for this SCR gained from this process.

Key messages for the SCR:

- An adult who had been a victim wanted to propose that if there were allegations about someone in a position of trust within a family context, the investigation must include the children who may have contact with the individual in that role and include public appeals.
- Adults who had been children at school during this period shared their desire for there to have been access to an adult within schools who was not a member of staff but clearly identifiable as someone who had a role in safeguarding and was felt to be approachable
- Adults who had been children at school during this period suggested that sometimes their behaviour ie absconding and being challenging should be investigated further to consider any other possible causes.
- One adult victim praised the support received from TVP and the CPS

- Adults who were working professionally with some of the victims felt that these children were frequently not believed and discredited because of their behaviour by other professionals- they were seen as “troublesome rather than troubled adolescents”
- It was felt by one professional that the criminal justice system did not ensure one of the cases was sufficiently robust and the victims were not treated fairly as a result, which had a profound impact on the victims who had found the process distressing. More support and understanding is needed for child victims to recognise the impact of their abuse on their ability to provide clear and detailed evidence.
- There was a view expressed by one individual that the culture within one organisation had and continues to have a profound impact on staff feeling comfortable to raise any concerns. The view was maintained that not all organisations involved in this review had achieved transparency and provided that level of confidence to staff. This is clearly of concern and reinforces the need for all organisations to work openly on these issues and embrace constructive feedback.

7.1.2 All of these key learning messages were welcomed and have been incorporated into the conclusions and recommendations made by the Overview Author.

8. ANALYSIS -KEY ISSUES IDENTIFIED THROUGH THE OVERALL SCR PROCESS AND LEARNING

8.1 Safe cultures in all organisations-

- **Escalation and challenge**. There is evidence from most of the agencies in this SCR that issues around either individuals or processes were not always escalated either within organisations or between organisations. Safe cultures rely on transparent clear procedures and active encouragement by senior managers for practitioners to raise and escalate their concerns within their organisations through whistle blowing and between organisations. The potential impact of powerful leaders on cultures should be negated by all of these transparent processes.
- **Safe recruitment practices**. This is a fundamental expectation that recruitment processes are robust irrespective of the nature of the role (public credibility) and the status ie temporary or in the private or voluntary sector. All organisations need to give this high priority and adopt the best practice.
- **Safeguarding training**. This was evidenced by a number of agencies as lacking in terms of frequency, not always including the right roles and insufficient monitoring of engagement. It was not routinely undertaken by some roles particularly within schools ie school governors.

- **Dealing with low level concerns around staff behaviour**. There was evidence in this SCR of numerous occasions when low level concerns about individuals were not recorded or acted upon, discussed or escalated. This frequently resulted in the full understanding of concerns/previous behaviours not being available to strategy discussions and not informing the assessment of risk.
- **Impact of perceived seniority or status of the role on safe cultures**. This issue was apparent within a number of agencies where the role of the individual in organisations felt to be "pillars of the community" meant that there was a reluctance to raise concerns or a feeling that if that was done, it would not be heard or responded to. *The CEOP 2013 Thematic Assessment highlights the following point: 'Positional grooming' revolves around the inherent trust elicited by institutional settings. There is a degree of transference between the level of respect attributed to an organisation and to those representing it. By virtue of holding a position within a respected institution, an offender carries some of that respect – and the trust subsumed in it –vicariously. The myth that a 'pillar of the community' cannot be an abuser needs to be tackled"*

8.2 Role of the Local authority Designated Officer (LADO)

- **Recording-** There is a need to ensure there is sufficient capacity to undertake clear recording of concerns and of challenges made by partner agencies during strategy discussions.
- **Follow up and oversight**. There is a need to be clear that the current arrangements allow LADOs sufficient capacity to pro-actively follow up the outcomes of individual agencies discussions to ensure that they have been undertaken with rigour and to the appropriate standard and to escalate if that isn't achieved.
- **Escalation**. As with all organisations, LADO needs to be empowered and supported in raising challenges and escalation with organisations and this needs to be reviewed and endorsed in procedures.
- **Interface between LADO and individual organisations HR processes** Co-ordination function- this needs to be recognised and given sufficient capacity to ensure that individual agencies internal disciplinary procedures are aligned and robust.

8.3 Quality of individual's disciplinary investigation processes.

- What should be the Quality Assurance process adopted to ensure that an individual organisation's disciplinary investigation is of a the required standard and robust? If this sits with the LADO function this will need to be endorsed by all organisations. This should be included in the S.11 self-assessment as a specific question.

8.4 Governance arrangements within Academies

- The interrelationship between the layers of governance within Academy schools needs to be explicit and should ensure that there is sufficient independence from the Head/Senior Leadership Team.

8.5 The Interface between Academies and the LA function in relation to safeguarding and the Role of Regional Schools Commissioner (RSC) and Education Funding Agency

- This SCR has identified some significant learning at both a local and national level about the way the governance arrangements for safeguarding are not clear or aligned. The Local Authority no longer has the support function with Academies unless services are bought from the Local Authority as one of a range of possible provides. These services include school improvement and safeguarding expertise. The Local Authority however does retain its overall responsibility for the safeguarding of all children in the area through its DCS and Lead Member role as set out in the Children Act 2004.
- The SCR process has highlighted the opportunity to consider the role of the Education Funding Agency and the RSC in relation to safeguarding children in Academies. It is unclear how these bodies can be aware of concerns within Academies ie criminal prosecutions and dismissals of staff and undertake the detailed scrutiny required of individual Academies safeguarding arrangements. In the light of the learning from this SCR, there needs to be a recommendation to DfE and the Education Funding Agency and Regional Schools Commissioners proposing a national review of the appropriateness and effectiveness of current safeguarding requirements in relation to the overarching governance and accountability for Academies.

8.6. The Role of governors in safeguarding

- This SCR has recognised that Governors are a key element of safeguarding governance in schools and are there to hold the Head, Designated Safeguarding Leads and staff to account. Assurance of the quality of the training support and access to external expertise available and how is this monitored is required. There should be consideration that Governors complete their own S.11 or undertake an external audit process.

8.7 Clarity when there are roles with overlapping responsibilities-school/church/youth work

- This SCR has demonstrated that there was insufficient clarity about the responsibility for and oversight of individuals who were effectively undertaking a number of different roles in the community-some of which were operating from the same location. There needs to be clear contractual arrangements in place for all those employed or working in a voluntary capacity with children and young people and the same safe recruitment practices adopted.

8.8 Professional Curiosity by all organisations

- In addition to the need for staff to be encouraged and empowered to escalate their concerns, staff, volunteers and practitioners need to be encouraged to continually demonstrate professional curiosity in every situation to ensure that they ask and pursue questions, voice their concerns and to "think the unthinkable"

8.9 Challenge to professional myths about allegations against adults

- This is particularly seen in the education system and there were a number of examples in the evidence provided to this review that children are perceived to make malicious allegations against staff and were discredited and judgements made about their credibility. All staff should be encouraged to ensure that they look deeper into the underlying reasons for a child's behaviours.

8.10 Current restrictions in Sexual Offences legislation.

- The Sexual Offences Act 2003 does not include Youth Workers employed by anyone other than the Local Authority as meeting the criteria for a "Position of Trust". This means that the clergy or non- statutory voluntary workers are not included as being in "a position of trust" under section 16 of the Sexual Offences Act 2003. Positions of trust are defined within section 21 and 22 e.g. looking after persons in educational establishments, residential settings, or where duties involve regular unsupervised contact of children in the community. This SCR has learnt that this restriction has allowed an individual to not be prosecuted when he had clearly abused his position of trust.

8.11. **Significance of Independence**

- To consider any potential conflict of interest for an Independent LSCB Chair when they may have an operational safeguarding role in one of the LSCB partner organisations.

9. CONCLUSIONS AND LESSONS LEARNED

9.1 This Serious Case Review recognises that there were a number of missed opportunities to prevent the abuse of children. The analysis and conclusion reinforce many of the messages about abuse in institutions, which have previously been identified through other SCRs and national research. What is indisputable is the importance of safe organisational cultures, which adopt all the required features and are vigilant in their ongoing monitoring and scrutiny, and which can and do protect children.

9.2 The culture of listening to, consulting with and giving children a voice is crucial to developing safe cultures within organisations. This requires opportunities for children to disclose, an environment where it is easier for children to overcome barriers preventing this and when they do, for adults to actively listen, really hear and take protective action, which keeps children at the centre of their thinking and safeguarding practice.

9.3 This SCR has also highlighted questions around the response to allegations from statutory partners and those with key statutory responsibilities and how they provide oversight and quality assurance of institutions/organisations and has highlighted the following areas:

- The role and powers under current legislation of the LADO in the follow up and challenge to individual organisations HR processes
- The role of the LSCB in requesting and scrutinising S.11 assessments from all partner organisations- Voluntary, Community and Faith sector

9.4 This SCR has also highlighted the need for clear and transparent governance arrangements of safeguarding, particularly in Academies. This relates to both the school level where there may be differing layers of governance within their structures and a potential lack of clarity and the responsibility for the oversight for safeguarding and the relationship and accountability between the Local Authority, the Regional Schools Commissioner and the Education Funding Agency.

10. RECOMMENDATIONS FROM THIS SERIOUS CASE REVIEW

10.1 In addition to the large number of individual agency recommendations previously set out in this report, the Overview Author makes the following additional recommendations informed by the analysis of the key issues and areas of learning.

It is proposed West Berkshire LSCB undertake:

Safer organisational practice for all organisations

- Re-launch a programme of awareness and training on safer recruitment processes and safe organisational cultures and audit to ensure these messages are embedded. (8.1)
- Review the S.175/S.11 audit tool and process by schools and all partner organisations to request further areas of scrutiny and require evidence of compliance including outcomes of disciplinary processes (8.1 and 8.3)

- Continue to review the pan Berkshire Escalation Policy to ensure evidence of challenge in all organisations is explicitly encouraged and undertake an audit of dissemination by partner organisations. (8.1)

- Undertake an audit across partner organisations to ensure that all staff whistleblowing procedures are in place and audit their use and outcomes. (8.1)

- Consider how to raise awareness amongst all practitioners of the need for vigilance and professional curiosity (8.1 and 8.8)

- To recommend to all LSCB partner agencies that their individual disciplinary procedures are undertaken to their conclusion irrespective of the employment status of the individual and whether or not the individual has left employment in the interim. (8.3)

Faith Sector

- To undertake further engagement and pro-active inclusion of the wider Faith sector in the work of the LSCB in order to raise awareness and understanding of the expectations of safe cultures including proportionate S.11 processes.
- To ensure that activities undertaken by the Church /other voluntary bodies particularly in youth work adheres to the same safeguarding policies and procedures and is alert to the inherent risks in more informal settings (8.7)
- To request that the Diocese of Oxford work with the LSCB to share their learning around safeguarding with the wider faith sector and across LSCBs.

Educational settings

- To ensure that all school Governors and particularly those with safeguarding lead responsibilities are actively engaging in safeguarding training and understand clearly the expectations of their roles and responsibilities, particularly in the context of S.11 self assessment which should include regular reviews on recruitment practice. (8.6)
- To request that the schools involved in this SCR act as Champions for effective safeguarding cultures and work with the LSCB and the LA to share their learning with the whole school community
- To request that all schools consider how they can provide children with access to a trusted independent person in the school environment which is publicised pro-actively .

Local Authority

- To request the Local Authority review the statutory remit of the LADO function including the schools LADO and the oversight/challenge of disciplinary decisions undertaken by individual organisations. (8.2)

- Once the review of the LADO function is undertaken, to request the Local Authority consider the capacity of the LADO function and the strategic oversight suggested. (8.2)
- To request the Local Authority reinstates and facilitates the Designated Leads Forum for safeguarding leads in schools to promote effective safeguarding practice.

Criminal Justice Agencies

- The LSCB to request all agencies involved in the criminal justice system ensure that the impact of the proceedings for child victims are central and that their welfare is of paramount importance (8.10)
- The LSCB to ensure statutory partners investigations of historical sexual abuse overtly consider any other potential victims of the alledged perpetrator and use public appeals wherever possible.
- The LSCB through its CSE sub group monitor the impact of delays in the review of indecent images of children on partner agencies ability to conclude disciplinary proceedings.

DfE

- The LSCB Chair to write to DfE to highlight the apparent omissions in the Sexual Offences 2003 legislation on individuals in positions of trust. (8.11)

- The LSCB Chair to write to DfE to recommend that the DfE, the Education Funding Agency and Regional Schools Commissioners consider the learning from this SCR and undertake a national review of the effectiveness of current requirements in relation to the governance and accountability for safeguarding within Academies (8.4,8.5,)

General

- To consider the most effective way to provide support and challenge to those organisations involved with this SCR who have clear improvements to make to their safeguarding arrangements identified in the SCR process.
- To follow up and monitor the responses to specific issues of concern identified by the SCR Panel with individual agencies/organisations.
- Undertake a wide dissemination of the learning from this SCR as it is of relevance to all LSCB partner organisations.

Appendix A: Composition of SCR Panel

Chair WB SCR Group Panel
Designated Doctor Child Protection, Berkshire West Clinical Commissioning Groups (CCG)
West Berkshire
Corporate Director, Communities WBC
Head of Children and Families Services, WBC
Head of Prevention and Building Community Resilience,WBC
Berkshire Joint Legal Team
Team Principal, Joint Legal Team, Reading Borough Council

Clinical Commissioning Group Berkshire Federation
Named Professional Safeguarding Children for Primary Care, BW CCG
Berkshire Healthcare NHS Foundation Trust
Safeguarding Children Team Lead, BHFT
Reading Borough Council Representative
Interim Service Manager for Reviewing and Quality Assurance, Reading Borough Council
Wokingham Borough Council Representative
Head of Social work and Intervention, Wokingham Borough Council
Thames Valley Police (TVP)
Detective Chief Inspector 4064 Protecting Vulnerable People Investigations, PVP, TVP
Oxford Dioceses
Independent chair of Oxford Dioceses safeguarding panel,
Representative of Regional Schools Commissioner
Head Teacher, The Avenue School Special Needs Academy

In attendance

Alex Walters, Independent Overview Author

Appendix B: Details of the independent Overview author of this SCR report.

Alex Walters is a qualified social worker with 34 years experience in children's services and currently works independently as a consultant for improvement work across children's services. Alex has been a Children's Services Adviser for the DfE and was part of the Children's Improvement Board team working with LAs in need of improvement for their safeguarding and adoption performance. Before these national roles she had a range of management roles in local authorities, including 6 years as Assistant Director, Children's Social Care. She has been the Independent Chair of Surrey LSCB 2011-15, Bracknell Forest LSCB since 2011 and Swindon LSCB since 2015. She is the joint Vice-Chair of the Association of Independent LSCB Chairs and has published 15 SCRs, chaired 8 and authored 1 previous SCR.

Appendix C: Terms of Reference for this Serious Case Review

1 Key Line of enquiry (for specific response by Kennet School)

To review the effectiveness of current and historic safer workforce policies and procedures for Kennet School.
This includes reviewing the effectiveness and sufficiency of:

- Safer recruitment processes including the interview and selection process;
- Use of annual appraisal and supervision processes;
- Quality of records relating to professional practice
- Quality of response to concerns shared by staff/children or their families
- The appropriateness and timeliness of referrals to partner agencies for

advice and support with safeguarding issues or concerns about suitability/allegations.
To review the effectiveness of senior leadership and governing body oversight of concerns about: or allegations against staff or volunteers operating within Kennet School. or professionals or volunteers regularly operating within the school community]; including reviewing the level of understanding and confidence of these individuals to report safeguarding concerns.
To review the mechanisms for students and parent/carers reporting concerns, including opportunities for anonymous whistle blowing.
To identify good practice arising from Kennet School.

2 Key Lines of enquiry All contributing agencies

Thatcham Park School, Spurcroft school, John Madejski Academy and the ODC are asked to consider the following lines of enquiry;

To review the effectiveness of current and historic safer workforce policies and procedures within the organization or setting.
This includes reviewing the effectiveness and sufficiency of:

- Safer recruitment processes including the interview and selection process;
- Use of annual appraisal and supervision processes;
- Quality of records relating to professional practice
- Quality of response to concerns shared by staff/children or their families
- The appropriateness and timeliness of referrals to partner agencies for advice and support with safeguarding issues or concerns about suitability/allegations.
  To review the effectiveness of senior leadership and governing body oversight of concerns about: or allegations against staff or volunteers operating within the setting or organisation.

3. Local Authority Designated Officers (LADOs), Berkshire West Clinical Commissioning Groups, **Thames Valley Police, Oxford Diocese, Education**

To determine if any concerns were raised or indications of inappropriate behaviour or abuse of harm were held by the organisation; with specific reference to the identified victims of these offences.
To review the effectiveness of information exchange about concerns about suitability, allegations or any other relevant safeguarding concerns pertinent to the learning in this SCR.
To review the effectiveness of information exchange between West Berkshire, Reading and Wokingham LADOs.
To review the quality of responses from West Berkshire, Reading and Wokingham LADOs to incidents.
To review the responses of the relevant Local Authority Education Authority to safeguarding concerns, about individuals or schools, linked or related to school communities within the scope of this Serious Case Review.
To review the response and actions departments to referrals or concerns about individuals or schools (within the context of the Berkshire Child Protection Procedures), linked or related to school communities within the scope of this Serious Case Review.

To determine if any concerns were raised or indications of inappropriate or abuse of harm were held by school nursing, sexual health services, or mental health services or acute providers with specific reference to the identified victims of these offences.
To review the quality of supervision and guidance to Oxford Diocese and staff and volunteers working with children and young people.
To identify single and inter agency good practice.

Appendix D: Principles Underpinning this Serious Case Review

The conduct of this review has not been determined by any particular theoretical model. It has been carried out in keeping with the underlying principles, set out in the statutory Guidance, Working Together to Safeguard Children 2015:

- There should be a culture of continuous learning and improvement across the organisations that work together to safeguard and promote the welfare of children, identifying opportunities to draw on what works and promote good practice;
- The approach taken to reviews should be proportionate according to the scale and level of complexity of the issues being examined;
- Reviews of serious cases should be led by individuals who are independent of the case under review and of the organisations whose actions are being reviewed;
- Professionals should be involved fully in reviews and invited to contribute their perspectives without fear of being blamed for actions they took in good faith;
- Families, including surviving children, should be invited to contribute to reviews. They should understand how they are going to be involved and their expectations should be managed appropriately and sensitively. This is important for ensuring that the child is at the centre of the process;
- Final reports of SCRs must be published, including the LSCB's response to the review findings, in order to achieve transparency. The impact of SCRs and other reviews on improving services to children and families and on reducing the incidence of deaths or serious harm to children must also be described in LSCB annual reports and will inform inspections;
- The review will recognise the complexity of safeguarding children and seek to understand not only what happened but why individuals and organisations acted as they did;

Appendix E: References

This report has been generally informed by the following publications

- Working Together to Safeguard Children (Department for Education 2015)

- In the Child's Time: professional responses to neglect (Ofsted 2014)
- CEOP "The Foundations of Abuse: A thematic assessment of the risk of child sexual abuse by adults in institutions" -2013
- NSPCC-research on abusers 2012
- Triennial Analysis of Serious Case Reviews 2011-14 (Sidebotham et al 2016)
- North Somerset LSCB –The sexual abuse of pupils in a First School SCR 2012
- Keeping Children Safe in Education, 2016