

Richmond

Safeguarding Children Board

**Everybody's Business:
Keeping Children Safe in School**

**A Serious Case Review into Events at
St Paul's School**

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BACKGROUND AND CONTEXT

1 INTRODUCTION

- 1.1 This serious case review was commissioned in April 2017 by Richmond Safeguarding Children Board following five convictions for sexual offences of adults who had previously worked at St Paul's School London. At the time of this decision the Richmond Safeguarding Children Board was also aware that there had been allegations made against 32 ex members of staff and there had been recent involvement by the police, local authority, health professionals and the Safeguarding Children Board with the school. The events leading up to the decision to carry out a serious case review and the rationale for the review are explained in more detail in sections three and four of this report but from the start it was clear that this was a complex set of circumstances that had evolved over time. Although the school had been subject to external inspections, conducted internal reviews including commissioning reviews by independent consultants and worked hard to put in place systems and processes to keep children safe, it was the unanimous view of the serious case review subgroup at Richmond that a wide holistic statutory review of the conduct of agencies involved in allegations of abuse from 1960 onwards would be in the public interest.
- 1.2 Although the impetus for the review had been allegations and convictions relating to sexual abuse, the final terms of reference acknowledged that one type of abuse rarely exists in isolation and the review also explores how pupils can be safeguarded from physical and emotional harm.
- 1.3 The aim of this review is to identify lessons relevant for safeguarding children today, but the starting point has deliberately been to seek to understand the experience of ex-pupils and survivors of abuse at St Paul's who are now adult men. We have wanted to keep their experience as pupils at the heart of the review. Although systems, procedures and guidance may have changed, the fundamental dynamics of abuse have not. We may now be better at recognising physical and emotional harm and understand much more about the modus operandi of sexual offenders: but abuse may still happen and in particular, adults with a sexual interest in children will continue to find ways to offend, with often devastating consequences for those they have harmed. Understanding the relationships and culture within an institution at the time when the abuse happened allows us to reflect on current cultures and safeguarding practices through this lens and develop a deeper awareness of what may prevent abuse reoccurring in the future.
- 1.4 In exploring the experiences of ex-pupils, the report does refer to allegations, complaints and concerns about ex-teachers at the school. The purpose of this review is not to judge whether these allegations were true but to consider what lessons can be learned about safeguarding practice from the way in which they were dealt with. Specifically, where an allegation did not result in any criminal conviction it is not the intention of the report author to imply that this allegation was factually true, since this is not the purpose of this review.

- 1.5 This is a report aimed at improving the safety and wellbeing of *children* and the review panel have debated the extent to which it should include exploration of the way in which adults have been treated by the school, safeguarding and criminal justice systems. The final report does include comment on these matters for two reasons. Firstly, the way people who have been abused as children are treated when they disclose abuse is an important indicator of the culture that drives our response to children and secondly, protecting children in the future will be affected by the extent to which adults are able to talk about their experiences and potentially bring perpetrators to justice.
- 1.6 Although much of the learning may appear to focus on professional and organisational processes, we should not forget that the testimonies of ex-pupils show the potentially devastating, lasting impact of all forms of abuse; with responses ranging from suppressing memories of events, through to difficulties with adult relationships and mental health problems including suicide.
- 1.7 During the review we have spoken to 59 ex-pupils who have shared their perspective of what happened at the school and the impact on them as children and adults. We have also heard about their experience of the school and other agencies when the abuse became public knowledge. We are immensely grateful to this group of people for sharing information which was often painful to recall. They have given us an invaluable insight into changing school cultures, the behaviour of perpetrators and alleged perpetrators, how it felt for them to be a pupil at the school and, for some how it felt to be abused by a member of staff.
- 1.8 Some of the experiences we heard about will be specific to pupils at selective independent schools, although many will also apply to children in all schools and can contribute to our understanding of how we can work together to safeguard children in schools today.
- 1.9 This review has taken place over an extended period due to the amount of information that needed to be processed and the breadth of issues that emerged. It has also been vital to consult properly with significant people with an interest in the review before the final report was agreed and published and to take legal advice as to what information could be included in the final report. It is important to emphasise that the process of the review has generated learning that has been acted upon without waiting for publication and this is explored in relevant sections of this report. There has been ongoing dialogue with the senior management team at St Paul's who have been open to reflecting on where the school can build on the improvements that have already taken place, and have kept the review up to date with new information about their experience of working with the national safeguarding system. This has revealed gaps that affect all schools and has been commented on within this report.

This report

- 1.10 The purpose of a serious case review and publication of the ensuing report is to contribute to professional learning and improvement through understanding what happened, why it happened and what this means for future practice. This is an unusual serious case review due to its depth and breadth and this report attempts to do justice to the wide-ranging information gained from many individuals whilst remaining focused on learning lessons

that are relevant for practice today. The report is derived from a vast amount of written and verbal information and difficult judgements have had to be made about the level of detail that is included. Inevitably some people will feel that it does not do justice to their experiences whilst others may feel the level of non-recent detail is unnecessary if the aim is to focus on future learning.

- 1.11 The final content of the report is the responsibility of the report author and the review chair (the lead reviewers) taking account of legal advice.
- 1.12 The report is set out in the following sections:

	Background and context
1	Introduction to the review and explanation of report structure
2	St Paul's School: history and governance
3	The background events that led to the review
4	The way the review was conducted
	Summary
5	Summary of main findings
	What happened
6	What do we know about the abuse that took place at St Paul's
	Understanding why and what can we learn?
7	Analysis of why the abuse was not recognised at the time
8	Analysis of the way the school responded to specific allegations of abuse
9	Overview of the school's actions to improve safeguarding practice
10	Analysis of the way in which the wider safeguarding system responded when there were specific allegations of abuse
11	Understanding the impact of relationships across the safeguarding system on safeguarding practice
12	Analysis of the role of health professionals in safeguarding children in the school
13	Analysis of the role of regulatory activity in protecting children
14	What can be learned about day to day safe practice in St Paul's
15	Findings and Recommendations - overall analysis of learning and recommendations for system improvement.

Case studies

- 1.13 In order to explore practice issues in detail and to make sure that the evidence base for the findings is clear, the report author compiled detailed case studies for discussion with the review panel outlining events that took place in relation to convicted perpetrators of abuse and others where allegations had been made. The case studies were informed by chronologies from the organisations involved as well as by information gathered from ex-pupils. The specific cases were selected to illustrate various time periods and themes that are explored in the main body of the report. The accuracy of the information within the case studies was checked by panel members.
- 1.14 Following legal advice given to the lead reviewers, it was agreed the detail contained within each individual case study should not be set out as appendices to this report. Some of the information referred to events or alleged events that had not been proven in a court of law and, although some material is in the public domain via press reports, it was agreed that it would not be proportionate and fair to include this in a format which would increase the likelihood of individuals being identified.
- 1.15 The above has resulted in an inability to comment on the detail of specific cases although steps have been taken to include sufficient detail to ensure that learning has not been lost. Ex-pupils may feel that their information has not been valued but this is definitely not the case and the information about specific perpetrators and alleged perpetrators remained important in informing the analysis set out in this report. Ten cases involving four of the six convicted perpetrators and six alleged perpetrators¹ were analysed in detail by the panel and the table below sets out the timeframe that they relate to and the main issues that emerged from the analysis.

1970's-1980's	<p>Cases illustrate:</p> <ul style="list-style-type: none"> • grooming behaviour, "hiding in plain sight" and failure to recognise and respond within the school community; • the interface between school and church; • alcohol use in school and staff/pupil boundaries; • grooming behaviours and responding to rumours, concerns and evidence of inappropriate behaviour particularly where the teacher is popular and charismatic; • managing allegations in school including recording.
1980's	<p>Cases illustrate issues relating to:</p> <ul style="list-style-type: none"> • recognising the meaning of a pupil's behaviour and changes in academic performance; • the conduct of police investigations and supporting alleged victims post trial.
1990's	<p>A case from this period illustrates the importance of tight recruitment processes for freelance staff, school's receiving accurate references, use of alcohol in school, recognising concerning behaviour and a positive response when a previous conviction comes to light.</p>

¹ Alleged perpetrators include those who had been investigated and found not guilty, investigated and no further action was taken and those where there have been allegations that were not substantiated at all.

2000's	<p>Cases illustrate:</p> <ul style="list-style-type: none"> • use of alcohol and boundaries between staff and pupils and managing communications with the school community post-conviction; • the importance of a code of conduct within school; • managing allegations within Children's Social Care and across local authority boundaries; • managing allegations in school and decisions to suspend; • challenges of working with voluntary residential organisations and faith groups; • the positive role of the disclosure and barring service; • recognising emotional abuse and the impact of abuse on pupils; • the proper use of HR processes; • challenges in managing communications where a member of staff is suspended; • the need for effective communication between schools and the teaching regulator; • decision making by the teaching regulator; • positive work with voluntary residential activity organisations; • the importance of a positive relationship between the school and LADO; • managing allegations within the local authority; • thresholds for police enquiries; • giving and receiving employment references.
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Terminology

- 1.16 This report aims to minimise the use of acronyms in order to increase accessibility for a wide range of readers. One acronym that has been used is the LADO who has responsibility for oversight of allegations of abuse in organisations and is referred to in national guidance as the Designated Officer. Although national guidance no longer refers to this role as "the LADO" it is still the term generally used by organisations working with children. In line with the London Child Protection Procedures, it is used in this report in order to distinguish between safeguarding leads in health and education who can also be referred to as 'designated' leads.
- 1.17 Pupils who have attended St Paul's are known as Old Paulines. This report has chosen to refer to "ex-pupils". This is not in any way meant to disrespect the traditions associated with the school but is aimed at making the report accessible to a wider audience.
- 1.18 This report has been anonymised and no pupil, ex-pupil, staff member or other related practitioners have been referred to by name. This also applies to perpetrators and alleged perpetrators of abuse, even though names have appeared on websites and the national press. This decision was taken to comply with the law in relation to those who have not been charged with any offence, to protect the confidentiality of any individuals associated with convicted or alleged perpetrators of abuse and also to help in remaining focused on issues rather than personalities.

- 1.19 Children’s Services is the generic term used in the report to refer to the organisation in Richmond that provides all services to children and, where this specifically refers to social work services, this is referred to as Children’s Social Care. Within Richmond all of these services are delivered on behalf of the local authority by Achieving for Children, a Social Enterprise Company set up on 1st April 2014.

Senior staff at the school

- 1.20 During the period covered by the review there have been five Head Teachers of Colet Court (now St Paul’s Juniors), and seven High Masters of St Paul’s School who have overall responsibility for the management of the whole school. Where relevant, these senior staff are referred to in the report as follows.

High Master			Junior School Head Teacher	
HM1	1960-61		HT1	1964-71
HM2	1962-72		HT2	1972-98
HM3	1973-85		HT3	1999-06
HM4	1986-91		HT4	2007-16
HM5	1992-03		HT5	2016-present
HM6	2004-11			
HM7	2011-present			

2 ST PAUL’S SCHOOL: HISTORY AND GOVERNANCE

- 2.1 St Paul’s School is an independent day and boarding school in West London for boys aged between seven and 18. Boys up to the age of 13 are educated at St Paul’s Juniors (previously known as Colet Court), which has shared the same site as the senior school since 1968. Although both a boarding and a day school, the number of pupils boarding are now very small; with 35 boarding pupils in the senior school in the 2018/19 academic year.
- 2.2 St Paul’s was founded by John Colet Dean of St Paul’s Cathedral in 1509 when it was usual for school governance to be entrusted to the church, but Colet believed that “he yet found the least corruption” in married laymen and chose The Mercers Company (“Mercers”) to run the school. The Mercers are a livery company, founded in the City of London in the fourteenth century and today use their income from property to fund philanthropic activities. They currently have an association with 16 schools, colleges and academies. The Mercers support the schools through their young people and education programme in a variety of ways including funding, building projects, funding research into effective mental health support for children in schools and supporting governing bodies; with a common feature that the school runs itself.

- 2.3 The relationship between St Paul's and The Mercers has always been close and this relationship and associated governance arrangements have evolved over time. These arrangements are highly relevant to the governance of safeguarding and system of redress to survivors of abuse which is explored later in this report. Most of the abuse at St Paul's that is discussed in this report took place prior to 2007 when governance arrangements changed.
- 2.4 Prior to 2007, the two St Paul's Schools were part of the St Paul's School Foundation, a registered charity of which the Mercers' Company was the sole trustee. As trustee the Mercers' Company appointed the majority of the governors who were 'managing trustees' of their respective school with full responsibility for its administration and management. As the school was not a separate, incorporated legal entity, all contracts and commitments were entered into by the governors as individuals and so they were personally liable for the school's operation, to the extent not covered by the assets of the school and the Foundation. By 2007, it was clear that it was no longer prudent or feasible for the two schools to be structured as part of an unincorporated charity or for individual trustees to be liable for the school's activities. In line with many others in the sector The Mercers decided to make St Paul's School and St Paul's Girls School independent charities in their own right. The Mercers maintained an element of oversight through their right to appoint up to 14 out of 16 governors, a veto over the acquisition and disposal of property and the admission of girls. The chair of the governing body must be a Mercer.
- 2.5 It has been clear from talking to ex-pupils that there has been a degree of confusion as to The Mercers' role and the extent to which they are currently involved in the day to day running of the school and responsible for current safeguarding culture and practice. This extends beyond ex-pupils as until very recently (2018) The Mercers Company was named on the Department of Education website as the proprietor of the school whereas this is not the case. Most ex-pupils who spoke to this review also ascribed The Mercers with a proprietorial role.

3 EVENTS LEADING UP TO THE SERIOUS CASE REVIEW

Allegations of Abuse

- 3.1 In 2014, articles in the press, primarily in The Times newspaper, reported on a culture of abuse that had been prevalent at public schools across the UK. The first article² named 130 private schools; St Paul's was not on this list. However, as a result of the publicity, former pupils from St Paul's contacted the Times journalist and there were subsequently a series of articles specifically focused on St Paul's. Allegations were made relating to staff, both living and deceased, and former pupils were either put in contact with the Metropolitan Police by the journalist or made contact directly themselves.
- 3.2 As a result, the Metropolitan Police became aware of allegations made by former pupils in respect of 30 St Paul's teachers who were no longer working at the school. These alleged

² Norfolk, A (2014) *130 private schools in child abuse scandal - Attacks on hundreds of boys at elite establishments. Scandal at 130 schools*. Times, The (London, England) - January 20, 2014.

offences had taken place from the early 1960's onwards with many relating to the 1970's and 1980's. Sixteen of the alleged perpetrators were by then deceased. In the case of the deceased, no further action was taken.

- 3.3 In 2013 another alleged perpetrator was brought to the attention of the police by the school following suspicious images being found on a school's computer. Another allegation was investigated following concerns raised by pupils in the boarding house.
- 3.4 The Metropolitan Police had set up a special inquiry to investigate the allegations of non-recent abuse under the operational title Operation Winthorpe and as a result of this operation and a previous investigation by the local police team five former teachers from St Paul's School were convicted of sex offences involving children. In addition, one teacher stood trial but was found not guilty and another case was withdrawn just prior to trial and a not guilty verdict was recorded.
- 3.5 Not all offences involved pupils at St Paul's School and one perpetrator was found to have had several convictions after leaving St Paul's School; before the allegations about abuse at the school were made. The perpetrators and convictions are set out in Appendix 4 of this report.
- 3.6 As the abuse allegations emerged, two parallel processes developed. Firstly, the school came to the attention of the regulatory authorities. The Department for Education commissioned an emergency inspection by the Independent Schools Inspectorate and the Charity Commission instigated a Statutory (s46) inquiry. Secondly, the Governors commissioned a series of reviews primarily aimed at making sure that the school was compliant with current legislation and guidance and that current pupils were being adequately safeguarded.
- 3.7 An additional review was commissioned by the school and carried out by a QC³. This investigated a specific allegation made by parents of an ex-pupil that complaints in 2005 about one of the convicted perpetrators were not investigated properly by the school. Their son had taken his own life aged 21 having described feeling bad and worthless since suffering emotional abuse at the school. The findings of this review were also reported in the press.⁴ The implications and impact of these inspections and reviews are explored further within this report and a timeline is set out in Appendix 9.
- 3.8 Alongside the reviews and regulatory activity there was an increase in involvement with the school by the Local Authority Designated Officer⁵ (LADO) and the Local Safeguarding Children Board (LSCB). The Richmond Safeguarding Children Board wished to ensure that the school was now complying with its statutory duty in relation to safeguarding children and promoting their welfare and that any lessons that had been learned by the school were understood by the Board and available to other similar schools in their area. This was not always experienced as supportive by the school. The relationship between Safeguarding Children Boards and independent schools has been noted in another

³ A senior barrister

⁴ Norfolk, A. (1015) *St Paul's ignored concerns about 'unstable' teacher*. The Times 15th October 2015.

⁵ The Local Authority Designated Officer is a qualified social worker who has responsibility for oversight and management of allegations against people who work with children.

serious case review⁶ as an area for development and it became clear that further work needed to be done to develop a productive working relationship in this case.

- 3.9 It was in April 2017, after the conclusion of the last of a group of trials involving ex-staff from the school that the decision was made by the Safeguarding Children Board to commission this review. The final trial involved a perpetrator who had abused boys at the school in the 1970's and had received an 18 years prison sentence for serious sexual offences. At that time, the criteria for instigating a serious case review were that abuse or neglect of a child was known or suspected and either a child had died or been seriously harmed and there was cause for concern as to the way in which the authority, their Board partners or other relevant persons had worked together to safeguard the child.⁷ The purpose of the review is to contribute to learning and improvement through reviewing what happened, why it happened and what needs to be in place to prevent a reoccurrence in the future.
- 3.10 The Richmond serious case review sub group reviewed all the information known about the abuse that had taken place at St Paul's School and agreed that there was both evidence of serious harm and concern that all the relevant people and organisations had not worked effectively together to safeguard children at St Paul's over many years. The concerns about interagency working extended through to the more recent period after the abuse had come to light. The subgroup unanimously agreed to recommend to the Chair of the Safeguarding Children Board that a serious case review should be commissioned.
- 3.11 This review is taking place within a national context of increasing awareness of the nature and impact of sexual abuse experienced within institutions in the United Kingdom over many decades. These institutions include schools, children's homes, hospitals, the Catholic Church and the Church of England. As a result of this awareness, in March 2015, the Home Office set up the Independent Inquiry into Child Sexual Abuse (IICSA) as a statutory inquiry to consider the growing evidence of institutional failures to protect children from child sexual abuse, and to make recommendations to ensure the best possible protection for children in future. The events at St Paul's School that have triggered this review therefore need to be understood as part of a national culture that existed over many years which failed to keep children safe. It is hoped that the findings of this review will contribute to the growing knowledge and evidence base about the experience of children, its impact over time and the best way of responding when abuse comes to light.
- 3.12 Before the start of the serious case review the school had self-referred to IICSA and Richmond Safeguarding Children Board also notified IICSA of their intention to carry out the review. IICSA agreed that the serious case review should go ahead and that the final report should be submitted to the national inquiry. All survivors of abuse at St Paul's who had contact with this review were offered details of the IICSA truth project should they wish to share their detailed testimonies.

⁶ Hammersmith & Fulham, Kensington and Chelsea and Westminster LSCB (2016) *Serious Case Review: Southbank International School*.

<https://www.rbkc.gov.uk/pdf/Southbank%20SCR%20REPORT%2012%201%2016.pdf>

⁷ HM Government (2015) *Working Together to Safeguard Children* Page 75.

4 THE REVIEW PROCESS

Background and terms of reference

- 4.1 In line with expected procedures at the time⁸ the Chair of Richmond Safeguarding Children Board appointed lead reviewers who are independent of the Local Safeguarding Children Board and partner agencies. Both lead reviewers worked together throughout the review process with Edi Carmi taking prime responsibility for chairing the review and Jane Wonnacott for writing the final report. Both reviewers have extensive experience of carrying out serious case reviews including those focused on abuse within schools and other institutional settings. Full details of the reviewers' experience is set out in Appendix 1.
- 4.2 The lead reviewers worked with a panel which included representatives of agencies who, either had specific expertise, or whose agencies had been involved with the school in relation to abuse allegations. The members of this panel are set out in Appendix 2.
- 4.3 Care was taken to try to ensure, as far as possible, that no panel member had direct personal involvement with the issues under consideration. This did prove challenging, particularly as a focus of attention was the relationship between the Local Safeguarding Children Board (LSCB) and the school, and members of the LSCB including Designated health professionals were involved with the school during the period under review. The LSCB and the panel were keen to involve St Paul's in the panel process in order to make sure that technical aspects relating to the day to day running of the school were correctly understood, both now and in the past. It was eventually agreed that the best possible option would be for the professional advisor to the LSCB⁹ and Designated health professionals¹⁰ to stand down from the panel and for the school's representative to be a member of the governing body who is not part of the senior leadership team or specifically responsible for safeguarding. The panel are very grateful for the help and input of the governor and the school team who have been instrumental in providing a large amount of factual background information.
- 4.4 The lead reviewers received representation from an abuse survivor who felt strongly that survivors should also be represented on the panel. The lead reviewers had some sympathy with this request but, after discussion, the decision of the Chair of the Safeguarding Board was this was not appropriate as to find one person representing all views would be impossible. The lead reviewers had already planned for all those who contributed to the review, including ex-pupils, to be offered the opportunity to see a draft of the report before it was finalised and comment on the facts, findings and recommendations. It was agreed that this would be the mechanism whereby survivors' views could be represented in the final report.

⁸ HM Government (2015) Working Together to safeguard Children Page 78

⁹ The professional advisor is usually a core member of serious case review panels in Richmond and has responsibility of quality assuring the overall process. They had prior involvement with St Paul's and therefore it was not appropriate for them to be part of the panel in this case.

¹⁰ The term designated doctor or nurse denotes professionals employed by Clinical Commissioning Groups to provide strategic advice and guidance on safeguarding children to the health community and multi-agency partnerships. In this case they had carried out a health assurance visit to St Paul's.

- 4.5 The first task of the panel was to agree the terms of reference for the review and these are attached at Appendix 3. After careful consideration by the panel and chair of the Safeguarding Children Board, the timeframe for the review was agreed as 1960 through to the end of April 2017. This is an extremely long time period, but it was felt necessary in order to understand the experience of those who had been abused at the school, why abuse had happened and to make sure that any lessons relevant for today's practice have been learnt by both the school and the multi-agency system. Although some ex-pupils were known to have been abused and were party to the criminal proceedings, the review team wished to give all ex-pupils who could have been affected in any way by physical, emotional or sexual abuse at the school, and may not have been heard in court, an opportunity to contribute to the review.
- 4.6 The review has therefore aimed to explore both the factors contributing to the non-recent abuse of pupils that led to a conviction in court, situations where there was no conviction, but allegations had been made and situations where pupils at the time had concerns but did not make an allegation. It has also been important to understand the experience of ex-pupils who have views about the factors that contributed to an unsafe culture and the ongoing impact of abuse on survivors right up until the present day.
- 4.7 Some allegations were not investigated by the police due to the death of the alleged perpetrator; others did not reach court for a variety of reasons and in one case a trial resulted in a not guilty verdict by a jury. Responses to allegations of abuse and issues relating to the effectiveness of multi-agency working are a feature throughout the whole timeframe of the review and it has been important to understand the positive aspects of modern practice as well as any areas for learning that remain within the system.
- 4.8 During the review, in July 2018, a teacher who had worked at St Paul's for 16 years was prosecuted, pleaded guilty and convicted of arranging to meet a child to commission a sex offence and inciting a child to commit a sexual act. No pupils at St Paul's are known or suspected to have been abused at any time by this member of staff. Details of the police operation¹¹ and the school's response are included in the review as it provided an illustration of the way such issues are dealt with today. This has shown full compliance by the school with expected procedures and good communication and cooperation by the school with other agencies. The case has also highlighted remaining gaps in the national safeguarding system.

The conduct of the review

- 4.9 The first stage of the review involved gathering paper information in the form of chronologies and other relevant documents. This was not straightforward due to the number of known and alleged perpetrators and known and alleged victims. The first task involved the Metropolitan Police compiling a list of all allegations, convictions and associated victims and for agencies to review information held on their files. Where information was held in relation to specific individuals, permission was sought by the relevant agency for this to be released to the review.

¹¹ This was carried out by Thames Valley Police as the teacher lived in their area.

- 4.10 There was a delay to this stage of the review, partly because of the large quantity of information to be accessed and checked by the different agencies involved and also because St Paul's School rightly needed to consider their position in releasing the data that they held. The school queried whether they could release information to Richmond Local Safeguarding Children Board as the Board is not registered as a data controller. They also took legal advice and contacted the Office of the Information Commissioner. The LSCB had not encountered such a challenge previously when undertaking complex reviews and discussed the reasons for the delay with the Department for Education. It became clear that there was no specific guidance as to whether an LSCB should register as a data controller or the process for sharing sensitive data for the purposes of a serious case review where the LSCB had not registered. This issue took some weeks to resolve before the school were able to release their individual chronologies. This demonstrates difficulties inherent in sharing sensitive personal data between agencies and the importance of a shared understanding of the legal underpinning for any such sharing. Negotiations at this stage became polarised and adversarial and indicative of the breakdown of trust between the school and LSCB. The causes of this breakdown of trust are explored later in this report and these highlight the importance of relationships when working in a challenging and complex environment.
- 4.11 The following organisations submitted chronologies and other associated documentation:
- Achieving for Children – LADO service;
 - Department for Education;
 - Independent Schools Inspectorate;
 - Richmond Safeguarding Children Board;
 - St Paul's School;
 - Teaching Regulation Agency (previously NCTL);
 - The Metropolitan Police;
 - The Charity Commission.
- 4.12 As well as reviewing relevant documentation, the panel considered the best approach to addressing the terms of reference. These included developing an understanding of practice, culture and relationships over time; both within the school and across the multi-agency network. In order to achieve this, it was agreed that key people from all the organisations who had submitted chronologies should be seen plus specific individuals who were considered to have important information to contribute to the review. This included independent experts who had been commissioned by the school to review the school's practices and responses. The list of professionals who contributed to the review is set out in Appendix 6.
- 4.13 National guidance at the time of this review stipulated that a review seeks to understand practice from the viewpoint of the individuals and organisations involved at the time rather than using hindsight¹² In order to understand the experience of children at the school during the time period covered by the review it was agreed that the starting point for the review should be offering survivors and all ex-pupils from the school an opportunity to contribute. A letter was sent via the school system offering this opportunity and by the end

of the review period 59 ex-pupils were seen by the lead reviewers. Attendance at the school ranged from pupils who started in 1953 through to those who left in 2015. Six of the 59 ex-pupils seen were victims of perpetrators who stood trial.

- 4.14 The names of those seen were not disclosed to the wider panel. All discussions were written up and letters sent to the person concerned summarising the discussion and asking for any errors to be corrected. The details of these discussions have informed the findings of his report.
- 4.15 Where any new allegations were made during this process the lead reviewers asked the permission of the ex-pupil before putting them in contact with the Metropolitan Police. In any situation where the ex-pupil did not wish to speak to the police but where there were allegations against a person who could continue to pose a risk to children the name of the alleged perpetrator was passed to the police.
- 4.16 The second group of people who were approached to contribute to the review in order to understand the viewpoint of those involved were current and past staff members and the method for contacting them was agreed with the school. The school explained that they do not hold contact details for all staff who taught at the school during the timeframe for this review but identified 15 ex staff for whom they did have contact details and wrote to them asking whether they were agreeable for their details to be passed to the serious case review. 10 agreed and their details were forwarded to the LSCB. One member of staff specifically did not agree and another four did not respond. Caution should be exercised in viewing this group of participants as representative of the views of all ex staff as they represent those whose contact details were known and agreed to talk to the review. It is also of note that reviewers have been informed by one past member of staff (who was also a parent) that although their details were known by the school, they were not contacted to contribute to the review in the first instance, but did so later.
- 4.17 The school also wrote to current staff who had worked at the school during the 1970's and 80's and asked whether their details could be forwarded to the serious case review. All five staff gave their permission and their details were passed to the LSCB. All other staff were made aware of the serious case review and that they could contact the LSCB directly.
- 4.18 The employment details of school staff spoken to for the review are listed in Appendix 7.
- Three staff members spoken to were female, the other seven were male. Of these 10 staff:
- Two staff were ex-pupils;
 - Four staff had sent their children to the school.

Limitations and constraints

- 4.19 The terms of reference for this review deliberately specified a long time period and covered the wide range of issues that impinge upon the protection of children in a school environment. This is a strength of this review but also a limitation as choices had to be made about information that could be gathered in the time available. The aim was to be proportionate and focus on new information or information that was likely to lead to the most learning.

- 4.20 The review panel considered whether to offer current and past parents an opportunity to speak to the review. One of the previous reviews commissioned by the school (the Badman review) had included parental perspectives and the decision was taken that it would be proportionate to use this information to inform this review rather than conducting a separate parental consultation. The school informed all current parents that the serious case review was taking place and where a parent chose to contact the review, the team were happy to speak to them. One parent gave information to the review coordinator but did not wish to speak to the reviewers, four other parents did ask to speak to the review, and another gave information after a chance encounter in another setting. Additionally, some of the ex-pupils that we spoke to either were previous parents or currently had children at the school. We acknowledge that a large sample of parental perspectives is a gap in this specific review process.
- 4.21 The possible learning from hearing from convicted perpetrators was also considered. The review panel considered carefully whether to offer this group a chance to contribute but the review panel concluded that on balance the extra time and cost involved could not be justified in relation to any learning that may result.

Analysis of information and production of the report

- 4.22 All information was collated into a detailed working document which contained case studies which had been written following careful consideration of all the agency information and the discussions with ex-pupils. Each draft of this document was checked for accuracy by panel members and was used to develop the final analysis and findings of this report.
- 4.23 The intention was always to share a final draft of the report with all contributors in order that they could check that their own information had been fairly represented and also contribute further to the final analysis and recommendations. Before this stage of the process:
- A draft of the report was shared with the Metropolitan Police. This was because there were ongoing police inquiries involving ex-staff from the school. This was to make sure that they were aware of the material gathered during this review, assess the relevance of any material and meet their legal obligations regarding Disclosure¹³. The police team confirmed that they were happy for the draft report to be shared with contributors;
 - Advice was sought from a QC regarding the contents of the report.
- 4.24 The analysis was further developed through sharing a draft with those who had contributed and wished to read the report. Contributors were asked to check for factual accuracy and to comment on the findings and recommendations. All comments were carefully considered, and a judgement made by the author as the amendments that were needed. A final draft was then approved by the panel.

¹³ Disclosure is providing the defence with copies or access to all material that is capable of undermining the prosecution case and/or assisting the defence.

SUMMARY OF MAIN FINDINGS

5 SUMMARY

Introduction

- 5.1 This review has considered allegations of abuse at St Paul's School over five decades with a view to understanding what happened, why it happened and what this means for current safeguarding practice both at St Paul's and other schools. Safeguarding children cannot be the responsibility of one organisation and this review has therefore focused not only on events at the school but also on the multi-agency system which is designed to protect children from harm. As a result, the findings and recommendations are relevant for St Paul's, other schools and the safeguarding system as a whole. The review's national findings will be drawn to the attention of the relevant national agencies and the Child Safeguarding Practice Review Panel.
- 5.2 The findings and recommendations focus on:
- Accepting responsibility in order to effect cultural change;
 - Developing positive relationships and partnerships as a prerequisite for effective safeguarding practice;
 - Working with safeguarding in a school environment – balancing various legal requirements;
 - Developing and refining national systems and guidance;
 - Managing complex investigations – the need for strategic oversight;
 - Refining practice systems and processes within the school.
- 5.3 All review recommendations are set out in section 16 of this report.

Background

- 5.4 Within St Paul's, many of the ex-pupils who approached the Serious Case Review described a culture over many years where abuse of all forms was endemic within the school. One ex-pupil has vividly described boys being inhibited from speaking out by an overwhelming culture of power, complicity and coercion. Boys at Colet Court (the junior school) were particularly vociferous in describing to this review a culture where physical violence by staff and between pupils was prevalent and the dominant culture was one of accepting both physical and sexual violence as a "rite of passage".
- 5.5 Allegations or concerns about abuse were not responded to adequately by the school. The evidence presented to this review indicates that this was particularly prevalent between the 1960's and 1990's. The approach was adult rather than child focused, with maintaining the reputation of the organisation and the needs of the alleged perpetrators being prioritised over any consideration of the impact that their behaviour had on pupils.
- 5.6 There are examples of concerns about staff behaviour either not being recognised as presenting a risk to pupils or being responded to by moving the member of staff on without recourse to the proper HR procedures or discussion with statutory agencies. One member

of staff who was moved from a role within the boarding house was convicted several years after retirement of possessing indecent images. Some staff who had concerns were reluctant to think ill of this colleague who was apparently held in high regard by pupils and parents and they also worried about raising concerns without concrete proof. On another occasion records show that there was an apparently deliberate destruction by the (then) High Master of diaries detailing inappropriate behaviour which included spanking of pupils by a teacher. As a result of their destruction, these diaries were not available to a later police investigation of allegations made against this member of staff.

- 5.7 The position of St Paul's as a high achieving, fee paying, competitive entry school inhibited some pupils from speaking out about concerns due to being acutely aware of their parent's pride that they were at the school and in some cases the financial sacrifices that they were making.
- 5.8 Evidence shows that the response of the school began to change in the twenty-first century and from 2013 onwards St Paul's has focused on fulfilling and exceeding statutory requirements in relation to safeguarding practice and developing policies with the welfare of pupils at their heart. The school carried out internal reviews and commissioned six reviews of various aspects of safeguarding practice by external consultants and a QC. These have contributed to the ongoing improvements to the safeguarding system within the school which have included an overhaul of systems, policies and procedures, including the appointment of a safeguarding coordinator, and a focus on achieving cultural change. There has also been a greatly increased involvement by the governing body in the scrutiny of safeguarding practice. It was within this context that this serious case review has taken place.

Lessons for safeguarding - what did the review find?

- 5.9 A major challenge for the school has been to demonstrate unequivocally that it accepts responsibility for past abuse, both in relation to victims of convicted perpetrators and those situations where the perpetrator has died or there has been no conviction. In 2014 the school was unprepared for the impact of publicity surrounding allegations of the history of abuse within the school, the scrutiny by external agencies and did not have sound relationships with the local authority and LSCB to help them through the process. They were perceived by some ex-pupils as slow to apologise to the whole school community and appeared defensive both to external agencies and in early communications to past and present pupils. Although a great deal of attention was being given to policies and procedures there was less evidence to those outside the school that these were underpinned by cultural change. An apology issued to the whole school community after the conclusion of the criminal trials focused on those affected by the actions of the *convicted* perpetrators. Some ex-pupils affected by physical and/or sexual abuse where the alleged perpetrator was not a convicted member of staff felt that the school were not interested in them.
- 5.10 The lack of a wider apology in 2014 was as a result of discussions with the Metropolitan Police who asked the school to pass any allegations directly onto them without engaging with the complainant. It was also the clear understanding of the school that the police had

asked them not to reach out to past pupils until police enquiries had been completed. This understanding guided the school's responses to previous pupils until the trials of former staff were completed in February 2017 when it asked the police for permission to reach out through the independent Barnardo's review.

- 5.11 During the process of this review there has been willingness on the part of the school to engage in dialogue and accept professional challenge, demonstrating positive progress in developing an open culture where effective safeguarding practice can flourish. An area for further development is to consider how survivors of abuse might work positively with the school in order to use their expertise to further improve safeguarding practice.
- 5.12 The multi-agency safeguarding system has not been clear enough in its communication with the school and given a steer as to what could be communicated by the school to the whole school community. Communication would have been improved had the multi-agency strategic management of complex investigations been more effective and this may have helped to an approach to supporting all ex-pupils affected by abuse at the school. The review has confirmed the importance of trusting relationships between schools and safeguarding partners whose role is to both provide support and challenge practice. Attention needs to be paid to these relationships as preparation for a possible future crisis.
- 5.13 The review has acknowledged the tensions facing schools when fulfilling their responsibilities as employers, educational establishments and safeguarding professionals. Balancing these requirements is not easy and there is a danger that in protecting the rights of the employee, pupils will believe that any discussion about abuse is not possible. Ensuring that the safety of pupils is the paramount concern needs to be clearly enshrined in all legislation and guidance relevant to schools and emphasised in communications with staff and pupils.
- 5.14 The national context for safeguarding in education is now vastly different to that during the 1970's and 1980's when the majority of abuse at St Paul's took place. However national systems need to continue to evolve and this review has identified some gaps in the current national safeguarding system that need to be addressed. Specifically:
- The way in which employment references should be followed up when they are vague, insufficient or raise concerns needs clarifying;
 - A code of practice for out of school settings cooperation with investigations needs to be published;
 - The system for referring alleged perpetrators who are found not guilty in court to the Teaching Regulation Agency is not consistent and this need clarifying;
 - The system should be reviewed to make sure that there is no delay in prohibiting convicted perpetrators from teaching where appropriate;
 - A protocol should clarify information sharing arrangements between the Charity Commission and Department for Education.
- 5.15 Specific areas of practice that need to be addressed at a national level are:
- Promoting safeguarding supervision in schools;
 - Clarifying the role of school GPs;
 - Standards of expected practice in relation to school alcohol policies;

- Independent investigation (outside the governing body) of complaints investigations that cannot be resolved by the senior leadership team.

5.16 The review found specific areas of safeguarding practice within the school that could be improved in order to further improve safeguarding practice, although these are not statutory requirements.

- Parents need to feel confident that if they raise any concerns about a teacher this will not reflect badly on their son. Although this is not the intended message given by the school there should be a heightened sensitivity to the worries that parents may have as to how they will be thought of in such circumstances;
- The review recommends that the current expectation that tutors are invited to a pupil's home for a meal is stopped. Even with safeguards this gives the wrong impression regarding boundaries between staff and pupils;
- Good practice in the anonymous reporting of concerns in the junior school should be replicated in the senior school;
- The recording of counselling sessions within the junior school needs review in order to make sure that they are sufficiently detailed and contemporaneous to support effective safeguarding practice.

Conclusion

5.17 This review has brought into stark relief the complexities surrounding keeping children safe in school. Whilst many of the experiences of ex-pupils explored within this review could be described as “non-recent” and expected responses today would be very different, there are lessons for safeguarding that transcend time and place and raise important questions for our current safeguarding practices. A minority of recommendations are specific to St Paul's School and even these may have relevance in other school settings. The majority of recommendations are aimed at firmly establishing a culture where the safety and wellbeing of pupils is paramount and in helping schools to put this into practice in a context where academic success may be perceived as the top priority in state maintained and independent schools alike. The recommendations recognise the importance of a sound legislative, strategic and procedural framework, but most importantly the crucial role played by sound relationships across safeguarding partnerships. These relationships need to be based on trust, clear respectful communication and a willingness to challenge, reflect and learn together.

WHAT HAPPENED

6 ABUSE AT ST PAUL'S: WHAT DO WE KNOW?

The Facts

- 6.1 Sexual abuse allegations were made to the Metropolitan Police against 32 staff who previously worked at St Paul's School from the 1960's through to 2017.¹⁴ 16 of these staff are now deceased. There were over 80 individual complaints against these staff, mostly by ex-pupils from St Paul's School. In compiling this information and reviewing the timeline, the number and range of allegations of all forms of abuse became clear to the review panel.
- 6.2 As a result of these allegations:
- Five former staff were convicted of sexual offences¹⁵;
 - One former staff member stood trial and was found not guilty;
 - One case was withdrawn at court and a not guilty verdict recorded. This was due to no evidence being offered since a key complainant was too ill to continue with the criminal justice process.
- 6.3 Of the alleged perpetrators who are deceased, one was still alive when the first allegation was made against him in 2001 and at that time was a member of the clergy. There was no further action taken by the police in relation to this and there are no records of this allegation held by Lambeth Palace. A second allegation was made by two ex-pupils against a former school chaplain before his death in 2000. This was investigated by the police, but no further action was taken as the alleged perpetrator denied any wrongdoing and the ex-pupils did not wish to take this further with the police.
- 6.4 It is important to re-iterate the point made in the introduction that where this report refers to allegations, complaints or concerns about ex-teachers at the school, the purpose of this review is not to judge whether these allegations were true, but to consider what lessons should be learned in respect of safeguarding from the manner in which they were dealt with. Specifically, where an allegation did not result in any criminal conviction, it is not the intention of the author of this report to imply that the allegation was factually true, since this is not the purpose of the review.

The wider picture

- 6.5 The information given to this review by ex-pupils and former staff, as well as that contained within various press reports and other documents, gives a picture of the abuse, alleged abuse and the context within which abuse took place over four decades. St Paul's is unlikely to be different from many other institutions of its time. We should not judge response of the school in the past by today's standards, but equally we should not forget

¹⁴ See Appendix 5 for a timeline of dates the alleged perpetrators and perpetrators were employed at the school.

¹⁵ For details of these offences please see Appendix 4

that for some ex-pupils, the abuse that took place affected their school life and has continued to haunt them through adulthood.

- 6.6 No institution can claim to prevent all abuse, but we are now acutely aware that being sensitive to the signs of abuse and acting quickly should these occur are the cornerstones of good practice. In addition, understanding and accepting the past helps institutions to ingrain the best safeguarding practice within their culture. The best organisations will be open about past mistakes and will be sensitive to the needs of those who were or may have been abused. This is discussed further in section 8 using our knowledge so far about the depth and breadth of abuse at the school over time.

The 1960's

- 6.7 This covers the period when the school was situated in Victorian buildings in Hammersmith prior to moving to the new site in Barnes in 1968. This has some significance in terms of the impact of environment on opportunities to abuse¹⁶ with descriptions of boys being made to swim naked in the swimming pool in Hammersmith which had no windows. One pupil also describes being caned in a master's study high up in the Hammersmith building reached by its own staircase well out of sight of other staff or pupils. This was far less likely in the new Barnes building which was more open and functional and designed to be less intimidating for the boys.
- 6.8 The accounts of life at both Colet Court and St Paul's during this period contained a substantial element of physical violence including use of corporal punishment which was not banned in UK state schools until 1986 and in independent schools until 1998. (St Paul's School banned its use in 1982 before legally required to do so.) Although one ex-pupil who contributed to this review described the school as a civilised place with no cruelty, the culture was described by others as "brutal", "a hard knocks bullying culture" and "sadistic" with physical punishment being used at times where boys were struggling academically. More than one ex-pupil talked about boys in Colet Court being hit for giving the wrong answers in class.
- 6.9 The culture as described to us was one where parents did not complain, were deferential to the authority of the teacher and were likely to take the school's side and see the boy as being at fault. Comments were made to this review by ex-pupils about keeping a "stiff upper lip" and emotion being seen as a weakness.
- 6.10 Sexual abuse appears to have been known and tolerated by staff and at times the violence also had a sexual element such as removing the pupil's trousers for a private caning. Other teachers were described as voyeurs, with pupils warning each other about who to avoid, for example when taking a shower. A parent has told the review that her son has said that it was sport to comment and joke about teachers who were rumoured to be homosexual. Parents who were more engaged in what happened in school may have been a protective factor with one pupil describing his belief that the interest of his parents

¹⁶ Identifying "target" locations where abuse is more likely is now becoming part of risk reduction strategies. See discussion of situational prevention: Kaufmen et al (2012) in Erooga M (ed). Creating Safer Organisations. Chichester: Wiley-Blackwell.

in what was happening in school kept abusive teachers at bay.

The 1970's and early 1980's

- 6.11 The timeline in Appendix 5 of this report shows the periods of employment of relevant members of staff who were either subsequently convicted or alleged to have committed abuse against pupils. The majority were employed during this period of time.
- 6.12 Descriptions by ex-pupils show a clearer differentiation between Colet Court and St Paul's Senior School and bullying was described as part of the culture "particularly at Colet Court"; although a number of teachers from both schools were named as being particularly violent. One ex-pupil described teachers as having "licence to terrorise". Other descriptions included teachers hitting pupils across the head, banging boys' heads on the desk and beating a boy so badly that he had to be hospitalised.
- 6.13 One ex-pupil felt positively about all aspects of the school during this period and it is notable that he also described parents who were very supportive and would always follow up any issues with school staff. A parent has told this review that in their opinion this was not always possible as in their opinion the school appeared to actively discourage parental involvement. Where parents were not involved, boys seem to have been more easily targeted by abusive teachers.
- 6.14 Generally, those handing out the extreme physical punishments were not those who were believed to have had a sexual interest in boys although there are exceptions where physical and sexual violence went hand in hand. The pattern seems to be that boys were at most risk of sexual abuse from those teachers who cultivated an image of the "good guy" in contrast to those staff who were more hierarchical and disciplinarian in their approach. One convicted perpetrator was described as being perceived at the time as "cool" and would often socialise with the rowing team in the pub.
- 6.15 There are several examples of grooming behaviours during this period, including taking an interest in specific pupils and getting to know their families. One ex-pupil described perceiving one of the members of staff who abused him and was later convicted, as a 'friend' who was kindly and supportive. The pupil played squash with him during evenings and weekends and was flattered by his attention. The abuse only stopped when a lodger living with the family recognised what was happening and told the perpetrator he knew "what he was up to".
- 6.16 During this period there are examples of blurred boundaries with teachers buying pupils alcohol, and others inviting boys to their homes. Ex-pupils described one teacher (also a school chaplain who is now deceased) as opening the door to boys in his dressing gown and one ex-pupil has alleged that he was sexually abused by this member of staff. This staff member was known to have a problem with alcohol, and this became depicted as a cartoon in the school magazine.
- 6.17 Ex-pupils and past staff have told the review of rumours about a female teacher during this period. These rumours related to sexually provocative behaviour, meeting boys in pubs and clubs and inviting boys home.

- 6.18 The issue of boundaries between staff and families today is discussed further in section 14 but comments from staff indicate that, in the past, teachers believed that it was the responsibility of the parents to monitor any contact. Two comments illustrating this view were:

I knew pupils stayed overnight with [alleged perpetrator] but I feel the parents were to blame.

[An alleged perpetrator] was known to have parties in his house for boys in his class and they were told to go in football strip – we thought the parents knew.

- 6.19 One ex-pupil who was abused over an 18-month period described eloquently the phase before the abuse began saying; “once you have been groomed, when the individual strikes it is too late to get away either physically or emotionally”. These teachers were often known to have favourites and one of the convicted perpetrators made no attempt to hide this and was known to take boys for drives in his car. According to several ex-pupils the current favourite of the moment was clear for all to see and on one occasion was even joked about in a public forum. Comments would be made by other pupils and one survivor spoke of feeling anxious, trapped and ostracised by his own peer group for being “teacher’s pet”. Other ex-pupils who were not close to the group surrounding this teacher told the review that they did not notice anything at all, possibly reflecting the size of the school and the separation between peer groups with different interests.
- 6.20 One teacher who was frequently mentioned by those ex-pupils at the school during this period was convicted in 2014 for possessing indecent images of children, having retired from the school over ten years earlier. It is also notable that a retired senior staff member provided a character witness statement for the defence at the trial of this ex staff member and there were very mixed descriptions from ex-pupils, many of whom commented on his popularity and inspirational teaching style, whilst some also noting that it was “common knowledge” that he had an interest in young boys. One ex-pupil told the review that he had heard that this teacher kept a list of boys he fancied, and another pupil described being told by a friend that this teacher had touched him inappropriately in his room at night. There were also several comments made to this review by ex-pupils about this member of staff having favourite pupils for sherry in his study on Sundays and sitting with his arm around pupils. Due to his popularity there was a reluctance to make any formal complaints and one ex-pupil commented to the reviewers “challenging [the member of staff] would have been like calling your dad a paedophile”. Ex-pupils also spoke of a protective culture amongst the staff and a fear that if you spoke out it would be held against you. Another comment from a parent went further, saying that speaking out was impossible if you wanted to remain at the school.
- 6.21 A number of ex-pupils told the review about the ‘common knowledge’ even amongst pupils who had already left the school, that in the early 1980’s a member of staff had videos in his study depicting ‘child pornography’. Those who had been involved in finding these videos wanted the review to know that they had seen the videos and they depicted torture, were very upsetting to look at and their presence in the member of staff’s study was brought to the attention of school staff. Piecing together the series of events from the ex-pupil and staff interviews it seems most likely that although the content may have

contained child abuse images the videos became referred to as ‘pornographic’ and the *detail* of what they contained may not have been relayed to the High Master at the time. (The member of staff who was first told about the images is deceased and this cannot be checked). Another ex-pupil who saw the videos describes not reporting them because he was aware that the member of staff concerned could lose his job. Nothing was recorded in the staff file and the matter was dealt with informally by removing the member of staff from any role in the boarding house. The implications of this episode are discussed further in section seven of this report.

- 6.22 Another theme through this period was the pressure associated with being a pupil in a high achieving school. One ex-pupil described Colet Court as like a “piranha tank” where no one wanted to be seen to be the weakest. Boys who were struggling academically or were not good at sport appear to have had a particularly difficult time. From the perspective of pupils at that time the culture was the complete antithesis of a healthy supportive educational environment. This serves as a reminder for any school of the need to avoid a culture which promotes a focus on achievement at all costs.
- 6.23 The review has also heard from one ex-pupil of sexual and physical abuse by peers during this period. Messages about who could be spoken to were not clear and this, accompanied by the shame and stigma associated with the abuse, meant that this was not an issue that was spoken about or reported to any adult at that time.

The late 1980’s and 1990’s

- 6.24 Descriptions of violent behaviour by staff, and also bullying between pupils, continued through this period; with one description of a pupil in the senior school being led into drug taking by prefects and being physically assaulted in public by his peers. Another description was given of a teacher dragging a pupil around the classroom and throwing him out of the door and another dangling boys out of windows by their ankles. Ex-pupils have told this review that these were not isolated incidents and such behaviour was known about within the staff group although seems not all staff were aware with a member of staff at the time telling the review that they cannot recall these or similar incidents. Many of the incidents described to the review took place at Colet Court with two ex-pupils separately described the culture there as “like Lord of the Flies”.
- 6.25 Ex-pupils told this review of a continuation of blurred boundaries for some pupils in the senior school particularly in relation to staff drinking alcohol with pupils.
- 6.26 One ex-pupil described a positive culture in one of the senior boarding houses where junior boys would talk to senior boys about concerns. The reviewers were told about a teacher’s diary being found by a cleaner and shown to pupils. This contained descriptions of him spanking boys and inappropriate comments such as “nice boxer shorts”. It was positive that this was relayed by junior pupils to a senior boy who passed it onto the house master, but events thereafter were concerning as the member of staff resigned. This is discussed further in paragraphs 8.34-8.37.
- 6.27 The problems for institutions such as St Paul’s operating within a national context of poor standards of practice in relation to staff recruitment can be seen in the appointment of a

part time PE Assistant in 1990, employed through his own company. He was later convicted of indecent assault against a pupil at St Paul's and received six years and eight-month custodial sentence. He had submitted a CV, and his staff file shows that this was after a chance encounter and conversation with the then Head of PE. His CV did not give a full employment history but showed that he had extensive experience as a sports coach in various organisations and in 1978 had been awarded the Queen's Silver Jubilee medal for sport. Another CV on file (apparently a later version) stated that his contract with one of the armed forces had expired and he was awarded a full pension. He was interviewed by the Head of PE and offered work on a freelance basis at the school. This interview was followed up with a meeting with the High Master. He gave four referees (from the armed forces, a London Borough, and two public schools). Two were taken up and both (including the one from the armed forces) were very positive. It was later during police investigations that it became apparent that this member of staff had been convicted of gross indecency against a 15-year-old boy in 1979 and was fined £100. At the time of this conviction, he was serving with one of the armed forces and a submission to this review from the school notes he had been required to leave as a result of this matter.

2000 onwards

- 6.28 Descriptions of Colet Court during this period did not contain accounts of the extreme harsh regime of earlier years but the review was told that parents routinely said that "you survive Colet Court to get to St Paul's"
- 6.29 The recognition of the negative impact of emotional abuse on young people has not always been widely recognised and it was during this period that the events explored in the Laidlaw Review took place¹⁷. This concluded that on balance a member of staff emotionally abused and humiliated one pupil at Colet Court between 2003 and 2005. This pupil experienced mental ill health as an adult and took his own life whilst at university. The member of staff's colleagues at the time have described him as having favourite pupils, a known crush on a former Colet Court pupil, and also to be prone to extreme rages. One staff member who had a son at the school recalls that his son did not want to go into the scholarship class with this teacher as he was known to be a bully and have favourites.
- 6.30 The Laidlaw Review found that when the parents of the pupil made complaints in 2005 and 2006 the school failed to investigate properly, and the Head of Colet Court and the High Master were too easily deceived by the member of staff's popularity with many pupils and parents. The review concluded that neither of the 2005 or the 2006 complaints were followed up, as they ought to have been, with the effect that nothing was done in the years to protect other children that [the member of staff] might have picked on.
- 6.31 In relation to sexual abuse the information given to the review indicates that pupils and parents were becoming more willing to speak out about abuse and the school were becoming aware of their responsibilities to deal with allegations of sexual and physical

¹⁷ This review had been commissioned by the school in 2015 following a complaint by parents that their earlier complaints about a member of staff had not been investigated properly by the school. See Appendix 10 for further details.

abuse but did not always manage this well. The challenges of changing culture within organisations such as St Paul's is explored further in section seven of this report.

- 6.32 At least one teacher during this time was referred to by pupils as a "paedo" although this mainly remained at the level of gossip and jokes between the boys rather than being reported to parents or the school. One parent has however told the review that a member of staff, later convicted for possessing indecent images, called her in for a meeting to express concern that her son had called him "a paedo". This parent feels that this was an example of the member of staff "hiding in plain sight". The parent's immediate reaction in the meeting was to support the teacher in reprimanding her son and she has since reflected on the fear that parents have about their son getting into trouble. Many parents have fought hard to get their son into the school and will be reluctant to complain about anything. This is explored further in section seven below.
- 6.33 From 2000 to date there have been four allegations of sexual abuse relating to staff who were working at St Paul's. The circumstances surrounding the allegations shows a changing environment, both in terms of how the allegations came to light and the response of the school. One allegation was made by pupils, another by a parent and another as a result of standard IT surveillance within the school. The fourth was as a result of external police activity. Although there are indications of many positive developments in the way these were handled the cases also illustrate the challenges associated with changing practice.
- 6.34 In 2013, pupils alleged that a teacher gave boys alcohol and touched pupils inappropriately. It was positive that these pupils had felt able to talk to a senior member of staff about these allegations. The senior staff member attempted to triangulate the information by offering other pupils the opportunity for pupils to speak with him to disclose additional concerns before he made a referral to the LADO. Expected practice at that time (2013)¹⁸¹⁹ would have been for there to have been an earlier discussion with the local authority²⁰ before investigating within the school. When the police and LADO considered the case, they decided not to investigate further. Although internal disciplinary action was taken this was understandably not evident to the whole school community, although pupils who had raised the allegations were made aware of the action taken by the school. Although the school were complying with the reporting restrictions of the Education Act, and explained this to pupils, this was not fully understood with one ex-pupil expressing concern to the reviewers that this episode was "brushed under the carpet" and that the boys received a strong message that it was not to be discussed. The review was also told that other boys in the school heard discussing the episode were threatened with detention, although this is disputed by the school. It is important to acknowledge that this was how the response of the school was perceived by pupils at that time and this could have been interpreted as a message that concerns about abuse should not be discussed. From the school's perspective they were working within the legal framework which sets out their

¹⁸ As in 'Safeguarding children and safer recruitment in education' (December 2006).

¹⁹ HM Government (2010) *Working Together to Safeguard Children* Page 359. Paragraph 14.

²⁰ The school have assured the review that practice today would be different and the LADO would be informed immediately.

responsibilities to both staff and pupils and the episode illustrates the complexities of managing allegations within school and is explored further in section ten of this report.

- 6.35 Also in 2013, a parent complained to the headmaster of Colet Court about inappropriate boundaries by one member of staff towards her son. It was alleged that this member of staff had become too close to their family, was overly tactile with her son and had been seen rubbing her son's thigh. He was not responding to requests to "back off". This resulted in more proactive action by the school than had been the case in previous decades and the head teacher appropriately told the High Master and the matter was referred to Richmond LADO. Further inquiries with school staff revealed that there had been rumours about this member of staff as far back as the 1990's. The end result was that the police took no further action and at a disciplinary hearing the member of staff's actions were found to constitute serious professional misconduct and he was given a final written warning. He retired soon after.
- 6.36 Another allegation was made in 2013, this time as a result of the school ICT officer informing the Designated Safeguarding Lead of Colet Court that during routine checking of file sharing areas, a large file containing legal images of boys had been found in a member of staff's area. Further investigation found that activity had involved attempts to access sites with links to pictures of young boys. The next day (a Thursday), further investigation of activity in previous months, showed evidence of browsing and downloading images of young boys, some were straightforward portrait images and others in suggestive poses, plus Facebook activity.
- 6.37 The head and deputy head of Colet Court informed the High Master and the same day sought advice from an experienced trainer who advised referral to the LADO. The High Master approved this course of action, but this did not happen immediately, and the member of staff's internet activity was monitored over the weekend. The school chronology acknowledges that this was not the right decision: instead the Police/LADO should have been informed immediately and this is clear in the school's current procedures. The LADO was informed on Monday morning and referred to the local police child abuse investigation team. The initial agreement with the LADO was that the member of staff could remain in school with a risk assessment in place so that he would not be alerted to suspicions. He was arrested the next day with bail conditions that he should not attend school or be left alone with anyone under 16 years. The school instigated disciplinary proceeding, the Disclosure and Barring Service were informed, and the member of staff concerned resigned within the month. A note was placed on his file stating that any future reference request will include a statement that he resigned while facing a disciplinary hearing for gross misconduct and include the details of any future criminal proceedings and/or referrals to regulatory agencies.
- 6.38 On this occasion there was a clearer message from the school about the circumstances. Staff were briefed that the member of staff had resigned after it had been found that he had downloaded "inappropriate written material" and a letter was sent to parents to this effect and the next day pupils in his form were told and asked not to spread rumours but to talk to the deputy head if concerned. The review has been asked by a parent to consider whether the phrase "inappropriate written material" is a truthful description of the activities

that included accessing images of young boys. This is a fair point, but the communications would have been influenced by a concern not to jeopardise criminal investigations. This is further evidence of the issues explored in Finding Two and the need for support to schools in managing communications in these circumstances.

- 6.39 In 2018 a teacher who had been teaching at St Paul's for seventeen years was arrested in the Thames Valley Police area having been tracked by the police having sexualised online communication with a 13-year-old girl. Further details of this case are discussed in section eight as although it demonstrates a prompt and appropriate response by the school once they became aware of the member of staff's identity, and effective liaison with the LADO, there are also lessons to consider in the use of language in written communication. Other lessons primarily relate to the role of social media platforms, communication between police officers and the school and the effectiveness of the Disclosure and Barring System and the regulation of the teaching profession.

UNDERSTANDING WHY AND WHAT CAN WE LEARN?

7 WHY WAS ABUSE NOT RECOGNISED?

- 7.1 This section of the report primarily focuses on general themes relating to the overall culture of the school and how this has in the past supported a system where the sexual, physical and emotional abuse of pupils was not recognised. The section explores the challenges associated with changing a whole school culture that also have relevance today.
- 7.2 Section seven of this report which explores the school's response to specific allegations is also relevant to consideration of why abusive behaviour was not recognised as such and sheds light onto the immediate response to allegations and the way in which these may or may not immediately be considered to fall within the realms of child abuse.

A question of culture?

- 7.3 The abuse of children cannot be prevented by policies and procedures alone but requires a culture that has at its heart a real desire to put the safety of children centre stage, zero tolerance of any form of abuse and an understanding that abuse can be present in any institution at any time.
- 7.4 The culture of an organisation, in the absence of explicitly values based leadership, develops from a myriad of individual and collective attitudes, values and actions that develop over time. This is often referred to as "the way things are done around here" (Deal & Kennedy, 2000).
- 7.5 The appointment of High Master 7 in 2011 came at a time when "the way things were done" in too many child care organisations in the UK was to privilege the needs of adults and the organisation over the needs of children. Similarly, at St Paul's School information given to this review gives a picture of a culture over previous decades where the safety of children was not at the heart of the organisation. Too often, the possibility of abuse was

not acknowledged and, when it was, there was a response which appears to have been focused on maintaining the reputation of the organisation and the needs of staff rather than the needs of pupils and. On at least three occasions in the 1970's and 1980's staff resigned or retired after allegations had been made, or their behaviour had been commented on by pupils, parents or colleagues. On one occasion evidence in the form of a diary detailing punishments was destroyed and information given to the Department for Education and Science that evidence of beatings would be mentioned in future references was not followed through.

- 7.6 Although knowledge about the prevalence of sexual abuse had been available for many years, this discussion had primarily remained within the professional community. By 2012, the revelations about Jimmy Savile made the sexual abuse of children part of the national conversation, along with a recognition of the part that organisational culture can play in allowing abusers to hide in plain sight. Within this context, and faced with allegations of abuse within the school, High Master 7 took steps to change the safeguarding culture at St Paul's to one where the safety of pupils at the school was paramount. The specific steps that were taken to improve safeguarding practice are set out in section nine of this report.
- 7.7 Established cultures cannot be changed overnight, and a picture has emerged of an organisation with a real desire to change and develop excellence in safeguarding but also an organisation with deep rooted beliefs and behaviours which have from time to time, during the period of change, hindered the most effective safeguarding practice. The development of sound practice and, alongside this, deep cultural change, has been a challenge to both the current leadership and the surrounding multi agency partnership. The associated lessons for all parties are explored throughout this report.
- 7.8 From the perspective of those ex-pupils who spoke to this review, it should have been obvious to those in authority from the 1960's to the 1990's that some teachers were either physically, emotionally or sexually abusing boys. As one ex-pupil alleged to this review:
- There was an underlying sense that this was a system where male teachers were involved with boys and this was almost a rite of passage that boys had to navigate their way through. It was something boys had to deal with and it was almost Darwinian in that the weak and frail were preyed upon the most. Behaviours such as being asked by some teachers to do PE in the nude, knowledge that teachers kept journals about their behaviour (including instances of 'spanking') and boys being sodomised in the toilets were a cultural 'given'.*
- 7.9 However, there is a stark mismatch between pupil's assumptions that abuse was "common knowledge" and the perceptions and actions of staff within the school at that time. The reasons for this will vary between individuals and time periods: Whatever the reason, many ex-pupils feel that they were let down by school staff and a system that failed to act to protect them and they wish to understand why this occurred. This understanding is also important in providing a context for checking the effectiveness of current arrangements within St Paul's and in the wider education system.

Assumptions and abuse as “normal” behaviour

- 7.10 The early period covered by this review (1960's -70's) coincided with a time when physical violence in the form of corporal punishment was still legal and the harsh regime described by many ex-pupils would have been prevalent across many similar schools. Staff who had been brought up through the same system may not have been likely to question the validity of this approach. A similar dynamic may have been the case in respect of sexual abuse in the 1960's with it being regarded as almost inevitable. Lack of action to prevent it would have been compounded by a lack of any clear procedures or guidance as to what to do with any concerns.
- 7.11 This explanation does not in any way mitigate the extreme distress caused to the ex-pupils that we spoke to who experienced physical and sexual abuse. It does serve as a reminder of the importance of putting pupils at the heart of the safeguarding system and for institutions to constantly reflect on the degree to which cultural norms and assumptions may be driving harmful behaviours.
- 7.12 Assumptions also came into play in relation to staff believing that parents knew and were happy about close relationships with specific staff and pupils. Assuming that parents were happy for their son to spend time with teachers beyond school-based activities, other staff members ignored the danger associated with lax boundaries and failed to question or challenge the apparently very close relationships that developed.
- 7.13 There is some evidence that the gender of the staff member may have influenced assumptions about “normal behaviour” and this had an impact on both recognition and response. Both ex-pupils and staff described the behaviour of a female member of staff as “sexually provocative” and spoke about her lack of boundaries, inappropriate conversations and socialising with pupils in pubs and clubs. Serious concerns about her behaviour with at least two pupils were raised during discussions for this review and on one occasion it seems that senior staff knew of the possible sexual abuse of a pupil. Information suggests that although this happened during a period when any complaint about a staff member was not treated seriously enough, the gender of the teacher compounded the problem, with little sympathy for the alleged victim who was either seen as being complicit in events or the cause of the problem.

The dynamics of the staff group

- 7.14 Although there is no suggestion that staff *deliberately* failed to report suspected abuse, staff discussions for this review do reveal a reluctance to think badly of a colleague and friend. Many staff had been at St Paul's for a long time (although this situation has now changed), a few had also been pupils at the school and there was a strong sense of loyalty to colleagues which detracted from a child centred approach. This was specifically an issue where there was no clear “evidence” of abuse and the staff member was concerned about making an allegation that could have a negative impact on a colleague's career. Where staff did have concerns, they tended to think about the individual as emotionally troubled rather than dangerous and one ex staff member told this review they lacked the confidence to act. Some staff have now reflected on situations where, with the

benefit of hindsight, they now wish that they had spoken to someone about worrying behaviours and would have welcomed clearer direction at the time.

- 7.15 The member of staff, who was convicted for the possession and distribution of indecent images of children some years after he left the school is an example of a situation where the popularity and charisma of the member of staff meant that concerning behaviours were not challenged or even noticed by other staff members. Ex-pupils wanted the review to know that this member of staff had considerable contact with the school after retirement. They described him showing prospective parents around the school and being active in the former pupil's association although the school have no records of this being the case. He has also been described by ex-pupils as living "in plain sight" for years and being "untouchable". The extreme difficulties that many staff members had in coming to terms with this particular member of staff's conviction and the disquiet expressed by some that he is now no longer able to attend functions at the school is testimony to the difficulty in admitting the possibility that the charming, empathic colleague might also abuse children.
- 7.16 The phrase "thinking the unthinkable" is often used when training staff to recognise abuse. However, in any institution, this will not achieve the desired aim unless there is also a recognition that thoughts are influenced by emotions and staff need space to explore and express conflicting emotions that are influencing their responses and arrive at decisions about any action that should be taken. Safeguarding supervision is one place where this can occur and is embedded in the day to day practice of professions including health and social care but is less well developed in schools. Although the Early Years Foundation stage requires supervision to be in place for staff in nurseries and reception classes²¹ there is no similar expectation for teachers of older children where issues will be no less complex. There are logistical challenges in implementing supervision within a school environment²² but the evidence from this case would suggest that this is an important area for practice development. St Paul's have been proactive in moving beyond statutory requirements by putting in place safeguarding supervision for all pastoral and safeguarding leads and a formal evaluation of impact would be a positive contribution to national learning.
- 7.17 Ex-staff members described a dynamic, particularly in the senior school, where the impact of a large busy staff team was that people tended to be close to only a small group of like-minded colleagues. A narrow focus on their own role and function and cliques within the staffroom resulted in worrying behaviours by others not being noticed by many in the staff team. In addition, the possibility of abuse, particularly sexual abuse, appears not to have been on the radar of many in the staff group from the 1960's through to 2000 and if they were concerned, they lacked confidence to do anything about it. One staff member commented to the review that one of the boys who was weak academically may have been exploited by a staff member: "I was half conscious that something was going on, but I lacked the grip to do something". Subsequently a different ex-pupil made allegations of sexual abuse against this member of staff although this did not lead to a conviction.

²¹ Department for Education (2017) *Statutory Framework for the Early Years Foundation Stage* Page 21

²² See chapter 6 in Sturt, P and Rowe, J (2018) *Using Supervision in Schools*. Brighton: Pavilion

- 7.18 The review is aware of one instance in the early 1980's where a member of staff brought the behaviour of one of the convicted perpetrators to the attention of the High Master following a "joke" in the school magazine about his close relationship with a pupil. This did not result in any action by the High Master. The reason for inaction is not clear and despite several attempts by the review team it has not been possible to make contact with the master who made the complaint and was the one ex-teacher who provided evidence for the prosecution in court.
- 7.19 This lack of awareness amongst staff at that time was compounded by a lack of training, few policies and procedures and no clear message that abuse "could happen here".
- 7.20 Since the advent of the first national safeguarding guidance for schools in 2006²³ training and safeguarding policies have been formalised. When the current High Master was appointed in 2011, he immediately began a process of reviewing and improving policies and procedures; for example, consolidating and improving a school-wide staff code of conduct. Although changes in culture and practice will take longer to embed than a change in procedures, discussions with current and recent staff for this review highlight that there is now a general acknowledgement that the school has become more child orientated and staff now know when, how and to whom to report concerns. Many staff spoke of the relentless focus on safeguarding through training and procedures but one staff member made the observation that an overemphasis on procedures could give a false sense of security and another referred to a feeling that some systems such as neutral reporting felt like "back covering". One ex-pupil and parent who still has strong links with the school felt strongly that the pendulum had swung too far, and procedures were inhibiting the use of common sense. Staff who have been at the school as it has grappled with managing abuse allegations will now be hyper aware of the expectations placed upon them. The challenge will be to ensure a relentless focus on the safety of pupils remains embedded in the culture of the school as the leadership turns over and new staff join the organisation.

Academic excellence

- 7.21 Historically, St Paul's reputation as a centre of academic excellence appears to have contributed to a culture where both parents and boys were reluctant to complain. From discussions with more than one current or recent parents this may still be a pertinent issue that needs further consideration. The way in which complaints processes may either encourage or discourage complaints is considered further in paragraphs 7.26-7.32 below.
- 7.22 Some ex-pupils told the review that they were acutely aware of their parent's pride that they had gained a place at St Paul's and, in some instances, they knew parents were making considerable financial sacrifices to send them there. Within this context some pupils spoke of not feeling able to admit that their experience may be less than perfect.
- 7.23 The review was told by recent past parents that the school is felt to be a powerful institution and where the parents group heard rumours about teachers at the school these would not be brought to the attention of the senior leadership team as they would not wish to be seen to be causing trouble that may reflect badly on their son. This is particularly

²³ Department for Education (2006) *Safeguarding Children and Safer Recruitment in Education*.

pertinent when the school is responsible for university references. Parents who did complain about the behaviour of one of the convicted perpetrators told the review that they were ostracised by other parents for criticising a popular teacher.

- 7.24 In the past, deterioration in schoolwork was not explored as a form of communication or distress. Negative school reports for some pupils abused by convicted perpetrators clearly show uncharacteristic behaviours including deterioration in the quality of their work. These were then seen as the pupil's problem. There was no evidence of any attempt to understand the causes of such changed behaviour or attainment and for the pupils the distress of the abuse was compounded by negative feedback about their academic performance. The associated emotions were hard to handle in such a competitive environment and, in some instances, have had a long-term negative impact on their mental health.
- 7.25 St Paul's have taken steps to improve the wellbeing of pupils. The previous focus on academic excellence and competition at the expense of pupil care in Colet Court has been mitigated by the removal of the requirement (which commenced in 1976) to pass an examination to obtain a place in the senior school. This exam no longer exists, and boys at the junior school are automatically given a place at the senior school unless this is clearly not the right educational pathway for them. However, although such steps are important, St Paul's exists within a national culture where academic success has been the benchmark by which schools and individuals are judged with the attendant risk that this will influence the actions of staff, parents and pupils.

Complaints and allegations

- 7.26 In the early stages of following up a concern it can be difficult to identify when a complaint about the behaviour of a member of staff is in fact an allegation of abuse. This will depend upon evidence, thresholds and professional judgement, and these difficulties were evident when members of staff were accused of giving alcohol to boys and violating boundaries. As discussed elsewhere in this report in paragraphs 8.43-8.46, one such incident was reported to the LADO, but then the LADO, the school and the police had different points of view as to whether this was potential abuse that required external investigation or a complaint that could be handled internally. Since then revised guidance local training for designated safeguarding leads have made the thresholds and expectations much clearer.
- 7.27 Professional judgements are not infallible, but what is crucial is that complaints are taken seriously and investigated properly in order to make sure that it becomes clear when behaviour crosses the boundaries into abuse. The Laidlaw review clearly identified when failures in responses to complaints meant that opportunities to identify abusive behaviour were not taken:

It ought to have been clear to both [x and x] that the complaints were likely to have substance to them. A proper investigation would not only have revealed them to be true but that there was further evidence of inappropriate behaviour by [the staff member].

The heightened sense of awareness necessary to identify abusive behaviour was displayed by neither of the heads....²⁴

- 7.28 The report into safeguarding practice commissioned by the school in 2017 (the Barnardo's report) found that the school had developed good systems whereby concerns about the behaviour of a member of staff could be reported. There remained some challenges in making sure that complaints from individuals outside school, such as parents, were always treated in the appropriate way. The authors of the Barnardo's report told this review of one example where they found that a parent had expressed concern about the behaviour of a member of staff "in the light of historic abuse", this was not immediately treated as a possible safeguarding concern and was thought to be as a result of boys spreading rumours. Once this was brought to the attention of the High Master appropriate action was immediately taken. The Barnardo's report acknowledged that the issue of whether concerns about the behaviour constituted a complaint or allegation is a difficult one for all schools and organisations and commented:

Matters relating to concerns regarding adults' behaviour towards children was consistently well managed and properly dealt with within the school. However, there was some evidence that staff and managers may need some support with considering how best to manage and properly deal with concerns regarding staff conduct or behaviour, which may be inappropriate and does not constitute an immediate safeguarding risk to children, but which may present risks to children if it is repeated and not addressed. It is recommended that senior managers may find benefit in accessing a workshop on the interface between safe working practice and the management of allegations against staff, as this can be a particularly complex area for all schools. The focus should be on improving understanding of how leaders might best manage concerns regarding the behaviour or conduct of staff, allegations against staff and general safeguarding matters respectively. (4.6.2)

- 7.29 This serious case review would concur with Barnardo's regarding the need to make sure that complaints from outside school, including those from parents are always treated appropriately. Although only a small number of parents have directly contributed to this review, they give a consistent message about the courage that is needed to complain and the fear that any complaint may have a negative effect on the treatment of their son. It is therefore incumbent upon the school to understand this and treat all complaints with the same degree of fairness and respect.
- 7.30 The complaints procedure at St Paul's is fully compliant with statutory requirements and similar to other schools. It involves three stages: informal resolution, a formal investigation - usually by the High Master - and finally an opportunity for the complainant to put their case to a panel, two of whom are governors and one who is independent of the school. If it is not resolved at this stage the procedures state that the school can close down the complaint and the complainant can contact the Department for Education School Complaint Unit. At no stage is there a requirement that there will be an individual independent investigation of the complaint by someone external to the school prior to consideration by the panel.

²⁴ Laidlaw Report Paragraph 11

- 7.31 Given the feelings expressed by parents about the perceived power of the school, a procedure which has no external element until the third stage, which involves putting their case to a panel, may feel intimidating and is unlikely to redress any power imbalance. A more balanced approach within statutory guidance would be similar to many Local Authority Children's Services procedures which include independent investigation reports before any panel or final adjudication.
- 7.32 This is relevant to safeguarding since some complaints about the behaviour of staff may indicate possible abusive behaviours, for example where the complaint refers to favouritism, bullying or similar behaviours that may have a negative impact on emotional wellbeing. An analysis of the history of abuse at St Paul's and other similar organisations makes clear that there are risks associated with managing such concerns about staff behaviour within the school system without a strong parental voice and adequate independent scrutiny.

8 THE RESPONSE OF THE SCHOOL TO ALLEGATIONS OF ABUSE

- 8.1 As well as managing specific current cases there is the broader issue of how a school responds to evidence that pupils have been abused in the past. For those who have in any way been affected by abuse, the issue of who is ultimately taking responsibility for past abuse is of crucial importance. This section of the report will start with exploring this issue of responsibility and the school's response to survivors of abuse before moving on to considering practice where specific allegations have been made.
- 8.2 In relation to specific allegations the response of the school falls into three main categories
- The immediate response when an allegation is made;
 - Managing the allegation within the whole school community;
 - Responses following criminal investigations.
- 8.3 The final part of this section will reflect on the way in which the school has focused on learning lessons from past mistakes in order to improve contemporary responses to allegations of abuse.

Past abuse: the issue of responsibility

- 8.4 Although the focus of this serious case review is on lessons for current safeguarding practice, the way in which a school responds to non-recent abuse allegations is a litmus test for current safety as the safest institutions are those who are willing to admit mistakes and continue to be alert to the possibility that abuse could have happened, or could happen in the future. In addition, the response to those who were previously abused at the school is an important marker of the extent to which an institution has internalised and demonstrated a real understanding of child abuse and continuing its impact for the victim/survivor.
- 8.5 The overriding impression is that St Paul's were totally unprepared for what faced them in 2014.

- 8.6 As a registered charity the school did not notify the Charity Commission of the arrest of members of staff in 2013 and 2014. These should have been reported as a serious incident and the school now accepts that they should have done so. Correspondence from the (then) Chair of governors in a personal e-mail to the (then) Chair of the Charity Commission describes surprise that the Commission were going to open a statutory inquiry into the school's current safeguarding practices, questioned the evidentiary premises underpinning the decision to initiate an inquiry and stressed the need for the Charity Commission and the school to combine their efforts to protect the reputation of the charity. The school went on to challenge the way the inquiry was carried out and the impression given was of an institution that did not welcome external scrutiny. The challenges associated with accepting responsibility whilst protecting the reputation of the charity are explored further in Finding One.
- 8.7 For an institution that is used to being one of the best in the country, it appears to the lead reviewers that it has been a challenge for the school to comprehend the scale of humility—and its manifest expression—needed to admit mistakes and manage the emotional aftermath. Although letters to the school community and communications with ex-pupils from 2014 -17 show a determination to be open about the allegations and assure current parents that the school was safe, the content and tone of the communications was perceived by some ex-pupils as aimed at minimising reputational damage and not wanting to accept responsibility and publicly acknowledge the severity of past abuse. The tone of some confidential correspondence from the school to safeguarding partners was also interpreted as defensive and contributed to the concern of the LSCB chair that the school could not listen to advice and guidance when this was offered to them. This is explored in more detail in section 11 of this report.
- 8.8 One example frequently referred to during discussions with ex-pupils was a letter sent by the High Master in 2014 following police investigations into an ex-teacher which resulted in the conviction of an ex-staff member²⁵ for the possession of child abuse images. This letter that was sent out to all ex-pupils following the conviction is an example of a communication that was well intentioned but angered many ex-pupils who knew of rumours and allegations whilst he was at the school. The tone of the letter was understood by many as another example of the school failing to accept responsibility and wishing to distance the school from the conviction of a perpetrator of abuse. They continue to feel that it failed to acknowledge the seriousness of his offences or the possibility that he may have abused pupils at the school.
- 8.9 The letter stated that the conviction related to events that took place long after the staff member's retirement from St Paul's, that he had always been held in high regard by colleagues and pupils, that there was no record of complaints whilst he was at the school and the school had not been contacted by the police during their investigation. The letter expressed surprise and shock at the conviction and stated that the member of staff would no longer be able to enter school premises without clearance from the Disclosure and Barring Service barred list.

²⁵ This conviction was for the possession and distribution of images and did not relate to the abuse of pupils from St Paul's School.

- 8.10 The High Master had not been informed of the rumours about this staff member by any longstanding member of staff and there was nothing in his staff file to suggest that there had been any concerns; (the issue of allegations about “pornographic videos “ found in his study is explained in paragraph 6.20 above). The letter was written in good faith, it drew the attention of all current parents and pupils to the conviction and sought to provide reassurance that current pupils would be protected, but with the benefit of hindsight the High Master recognises that it conveyed the wrong and unintended impression to those ex-pupils who had concerns about the staff member’s previous behaviour when he was teaching at the school. Ex-pupils have told the review that the impression given was that the school wished to distance itself from the conviction of an ex-member of staff who had taught at the school for 37 years and had remained in contact with some staff at the school. That notwithstanding, ultimate responsibility for the lack of sensitivity in response must lie with previous senior staff at the school who failed to record adequately previous allegations about this member of staff’s possession of “pornographic videos” and make adequate inquiries about this at the time.
- 8.11 Linked to the acceptance of responsibility is the issue of how a school apologises to those who may have been affected by non-recent abuse. From the school’s perspective, from 2014 onwards they were having to juggle several often-competing demands and this review acknowledges that there was a lack of consistent advice and support from statutory agencies to help them through this process. This is discussed further in Finding Two, Three and Five of this report.
- 8.12 The role of the governing body is important, and evidence points to governors having to come to terms with the severity of what had happened, their role as trustees of the charity and responsibility to the current school community. The review has heard that in communications with individual survivors and statutory organisations some members of the governing body were perceived to be unduly defensive and gave the impression that minimising reputational damage was their priority. The reviewers have not seen any evidence that this was the *intention* of the governing body or senior leadership as a whole but it does indicate the shift in culture and the unconscious bias that needs to be addressed in order to move towards an organisation that will readily accept responsibility for past mistakes.
- 8.13 The learning for the governors of St Paul’s and other schools is that careful honest thought must be given as to the motivation behind each communication and the extent to which it keeps the wellbeing of current pupils and survivors at its heart. Use of language has been an important issue and it is here that learning lessons from survivors of abuse could be of assistance. For example, one survivor explained that comments which refer to the number of ex-pupils who had a positive experience at the school are insensitive because they might imply that the needs of survivors are of less importance than the experience of the majority.
- 8.14 Once the extent of the non-recent abuse came to light, the school have told this review that they were first and foremost focusing on supporting police inquiries and making sure that any perpetrators were brought to justice. They told the review that they had been instructed by the Metropolitan Police in 2014 not to contact any ex-pupils directly and they

passed any allegations of non-recent abuse directly to the police. They were not aware of the detail of police inquiries including the names of the alleged victims. The school aimed to keep the school community and ex-pupils informed and signposted them to the NSPCC national helpline should they need support. The letters sent from 2014 onwards to parents are also clearly aimed at allaying any concerns of current pupils and parents and assure them that systems were being reviewed and pupils were safe at the school.

- 8.15 A letter sent to the whole school community by the Chair of Governors in February 2017 after the conclusion of the criminal trials contained an apology and stated “we wish to apologise to you and all those in our community who have felt the impact of these cases”. Lead reviewers have been told by some ex-pupils who had alleged abuse by those who had not been convicted this gave the impression that they had been abandoned by the school.
- 8.16 In a submission to this review the school comments that the reason the school did not apologise generically for all past abuse in 2017 was that an institution that apologises generically for past abuse that it still only dimly understands, is making an empty PR gesture. A genuine apology of real contrition, and a sincere acceptance of responsibility can only follow from detailed knowledge of what had happened. The school argues that their plan to commission a wide-ranging review by Barnardo’s and the acceptance of the Barnardo’s proposal which included listening to the voice of victims/survivors and considering unsubstantiated allegations would have given them a sound base from which to apologise and accept responsibility.
- 8.17 Following the decision to undertake this serious case review the school agreed to postpone the start of the Barnardo’s review and amend the terms of reference to avoid duplication across the reviews. The plan had been for the Barnardo’s reviewers to work with the serious case review in carrying out any interviews but the timing and logistics of this proved impossible. The school have told this review that they were concerned that this delay and change of plan would confuse ex-pupils and be interpreted as the school shirking their responsibility. These concerns were expressed in correspondence to the LSCB chair and lead reviewers between May and July 2017.
- 8.18 There are lessons to learn in respect of how to apologise in a manner most likely to be welcomed by victims as genuine. Although the school cite the reason for a more generic apology being a lack of specific knowledge about what had happened, one approach could have been to write a letter and ask the police team to pass this on to any ex-pupils who had made allegations. There had also, by February 2017, been enough information within previous press reports to indicate that there were likely to be more ex-pupils who would describe themselves as victims of non-recent abuse than had been involved in the trials and more alleged perpetrators. In the light of this it would not have been unreasonable for the apology in February 2017 to acknowledge that there may be ex-pupils who were not involved in the trials who may have been affected by non-recent abuse at the school and to apologise to them if that was the case.
- 8.19 The High Master was open to discussion with the lead reviewers about the continued need for an apology and a letter was sent to all ex-pupils in September 2018 and a further letter in February 2019. The review has been informed that not all ex-pupils or parents who were

known to have been affected recall receiving these letters although both letters were published on the website.

- 8.20 The first letter apologised unreservedly for the inappropriate and abusive behaviours of some teachers and gave an open invitation to a meeting with the High Master. The tone of this letter was perceived by a small group of ex pupils as somewhat defensive although the school have informed the review that 89% of those who responded to the school were very positive about its contents. A number of pupils contacted the school and met the High Master and following these discussions, a further letter was sent in February 2019 giving a more personal reflection by the High Master on what had happened and showed a willingness to engage with confronting what had happened and learning from past mistakes.
- 8.21 In summary, it is the opinion of the lead reviewers that St Paul's gave the impression to ex-pupils and some partner organisations that they were reluctant to accept responsibility for non-recent abuse of pupils at the school. They were perceived as being slow to apologise and this was distressing for many ex-pupils who had suffered abuse. This review accepts that this was not the intention of the school and the reality was that this was an un-precedented situation for them to manage, for which they were not prepared. For any school in this situation, planning alongside key safeguarding partners must be key and, in this case, there was insufficient support and constructive challenge and dialogue between the school and the local safeguarding system. Strategic planning needs to consider the needs of all ex-pupils and families from the outset of any investigation and identify sources of support and when and how the school can issue apologies. This is discussed further in Finding Three.

The School's response to survivors

- 8.22 The issues in this section relate specifically to adult survivors of abuse rather than child safeguarding. These issues have been included as they formed part of the evidence given to the review by ex-pupils and from the perspective of some survivors are an indication as to the school's depth of understanding of child abuse including the potential impact of abuse on individuals. This is a legitimate point of view.
- 8.23 The issue of redress is a sensitive area and survivors who spoke to the review had strong opinions about the way it had been handled and the message this gave about the school's capacity to accept responsibility. As identified by submissions to IICSA²⁶ :

.....there is no "one size fits all". There are a variety of outcomes that victims/survivors seek from the civil claims process. These include: acknowledgment of the abuse having taken place; acknowledgment of the harm done; justice; compensation; access to counselling and therapeutic support; an apology; an independent and impartial investigation; truth and accountability; punishment of the abuser; an admission of institutional failure; a commitment to learning lessons; changes to prevent recurrence; vindication; closure; and a "day in court".

²⁶<https://www.iicsa.org.uk/key-documents/916/view/inquiryseminarupdatereport-accountabilityandrepairs.pdf>

- 8.24 The evidence suggests that the High Master of St Paul's approached the task of responding to survivors from a position of compassion and a wish to do the right thing, and to take a flexible approach which circumvented some of the challenges presented by governance and insurance arrangements. However, some survivors did not experience the approach taken as a positive one and, although the review has been told that The Mercers have always been willing to consider requests for redress from any former pupil, the communication from the school did not make this clear. Those ex-pupils where abuse had not been proven in a criminal court told the review they were unaware of this. There are now ex-pupils whose alleged abuser has not been convicted whose claims are being considered.
- 8.25 The system that was devised was complicated by the change in governance in 2007 and an ongoing discussion with insurers about liability and liability in the absence of insurance. This was not always clearly conveyed to survivors resulting in misunderstanding about liability and the approach to handling claims.
- 8.26 The abuse carried out by convicted perpetrators took place before 2007 when there was no separate legal entity in place and all contracts and commitments by the school were entered into by governors as individuals. The majority of governors were Mercers and The Mercers Company was corporate trustee of the St Paul's School Foundation, which after the 2007 restructure retained ownership of school land and their investments. The Charity Commission had in fact warned the school it could not make compensation payments to victims in relation to actions before the school itself existed as a legal entity i.e. pre 2007. The Governors did though apply for special dispensation to use its own money to provide ongoing support to victims and the school and The Mercers worked together to deal with redress for pre 2007 abuse.
- 8.27 It became clear to the school that the two insurers that had covered the school prior to 2007 were likely to take a more protracted approach to victim's claims, and the school have told the review that they asked The Mercers to put insurance on one side and deal immediately with redress themselves. The Mercers and the school collaborated on agreeing the best approach and a lawyer was then instructed by The Mercers to assist the school in setting up a scheme of redress and to have this ready as soon as the criminal trials had finished. Following negotiations all survivors settled.
- 8.28 The school report that for the majority of survivors their engagement with this scheme has been positive and none have had to resort to litigation. In contrast more than one survivor has told this review that they did not feel positive about the process and described it as distressing.
- 8.29 It is beyond the scope of this review to comment on the pros and cons of specific redress schemes for survivors of abuse as this is a complex area with competing viewpoints and experiences but the feelings of some survivors about the process in this case need to be heard and understood. What is clear from discussions that have taken place during this review is that there are immense challenges in developing such schemes and the likelihood is that not all will feel that it in any way compensates them for the abuse they have experienced.

- 8.30 In the opinion of the reviewers, whilst a great deal of attention has been paid by the school to developing a system of redress for those who were abused by convicted perpetrators it is less apparent that there was a plan for reaching out to those whose abuser or alleged abuser is dead or not convicted of a crime or where an affected pupil may be deceased. Two civil claims were made against St Paul's in 2014 alleging abuse by members of staff who are now deceased. These claims were passed to insurers and were repudiated on the basis that the alleged abusers were dead, the school had investigated as far as they were able and found no records to support or disprove the claims and the passage of time meant that the school's ability to investigate and defend the claim had been compromised and no further contact had been received from either claimant.
- 8.31 This approach has left some ex-pupils and parents feeling that the school does not care about their experiences and is reluctant to take any responsibility for the harm they may have suffered. The school strongly rebuts these criticisms and insists that it has made every effort to address the needs and concerns of each survivor on an individual basis. As explored elsewhere in this report, from the school's perspective they did not know who had alleged abuse and did not feel able to reach out more widely whilst police investigations were still taking place, having understood from the police that no further contact was appropriate at that time; (see paragraph 8.14 above). A lesson for the future is that a strategic approach which plans for a response to both proven and alleged survivors needs to be in place.

Managing specific allegations in 1970's and 1980's

- 8.32 There can be no doubt that the response to allegations in the 1970's and 1980's fell well short of the standards that would be expected today and it is likely that St Paul's School was not very different from some other similar institutions in the way that concerns about individual staff were dealt with without the involvement of outside agencies. That notwithstanding, there are clear examples of situations where the response was poor even by the standards of the time. A focus on preserving the reputation of the organisation and an approach which privileged the needs of adults over the wellbeing of children meant that abuse was not reported and this failure to act in the best interest of pupils left children at St Paul's and elsewhere at risk from sexual offenders. This is clear from the examples below.
- 8.33 Ex-pupils have told the review about the alleged inappropriate behaviour of an assistant chaplain in the 1970's and 80's and school records confirm that it was known that he invited sixth form pupils to his flat and one parent had complained about this. An ex-pupil has told this review that he believes that the senior chaplain was aware of this inappropriate behaviour as the ex-pupil's father phoned the senior chaplain on one occasion and asked him whether he would like his son to be going around to the flat and he replied that he would not. This pupil alleges that on one occasion he woke up in the member of staff's bed after becoming drunk the previous evening. The assistant chaplain was suspended in 1985 due to concerns about teaching quality and alcohol use (not for inviting pupils to his flat). Following in-patient hospital treatment and confirmation from a doctor that he was fit to work he returned to teaching under clear conditions regarding punctuality, teaching quality and abstinence from alcohol. When concerns about his

drinking became more serious, he was dismissed. Following an appeal, the Governors decided on a negotiated resolution and he took early retirement with an ex gratia payment in lieu of notice. No formal action was taken about concerns regarding his behaviour with pupils other than where it impacted in their academic performance. The lead reviewers checked whether the Church of England had any record relating to this chaplain and none could be found.

- 8.34 The review has also heard from ex-pupils that in the late 1980's cleaners found a diary in a master's room where he detailed spanking boys. There was also a video with unpleasant (but legal) pornography and both items were passed on to pupils. A senior pupil at the time has told the review that he was shown the diary which detailed punishments with notes such as "nice boxer shorts". He described telling the house master and after doing so he does not remember seeing the member of staff again. He "disappeared", and the message was that the school had moved on from this incident. Some other ex-pupils recall being told to keep quiet about what had happened and describe the school as putting a lot of time and effort into finding out which pupil had sold the story to a national newspaper. The official message from the school to the pupils was that the member of staff had resigned for family and personal reasons and his staff file indicates that colleagues were informed he had resigned with immediate effect after he had "beaten" some boys in the school.
- 8.35 When the Department for Education and Science contacted the school about a report of the above incident in the press, the school informed them that if the member of staff had not resigned then he would have faced disciplinary action in connection with a video of corporal punishment and a punishment diary. The Department for Education and Science asked for further information in order that they could consider the member of staff's suitability to teach. The further information supplied included that no evidence of indecency had been found by the school and the Department for Education and Science was assured that events would be mentioned to any future employer. The school also commented that "the problem is compounded in that certain parents supported the beating" and "they asked their sons to be transferred to him as tutor knowing he beat boys". Even though the school had banned corporal punishment before these events took place the culture was still one that minimised the impact of physical abuse and did not prioritise the safety of pupils.
- 8.36 Within a year the school supplied a written reference in support of the member of staff's application for a non-teaching job which did not adhere to the assurance given to the Department of Education and Science. This reference stated that he was a very successful school master and exceedingly conscientious and "I can recommend him in every way in that he has a good mind is very ambitious and a fine organiser". High Master 4 confirmed to the member of staff that a reference had been submitted, that the diary had been destroyed and advised him not to worry and to let him know if there was anything else he could help him with.
- 8.37 Destroying the diary shows an extremely serious lack of judgement on the part of the High Master and is further evidence of a culture which failed to put the safety and welfare of children first. This member of staff was an alleged perpetrator whose court case in 2016 resulted in a not guilty verdict due to lack of evidence. Although it cannot be said with

certainty that the presence of the diary in his school file would have changed this verdict it is possible that it would have assisted the police inquiries.

- 8.38 Also, in the 1980's, a member of staff now convicted of abusing pupils left suddenly after a pupil's mother went to the High Master concerned about her son's wellbeing. This pupil had been a "favourite" of the staff member and was ostracised by his own peer group for being so. There are no concerns recorded in the member of staff's file staff although anecdotal information from ex-pupils and an ex member of staff's police statement provide evidence that there were suspicions about him. A joke about his relationship with one pupil appeared in a public forum and an ex member of staff has now told the police that he was going to bring this to the attention of the High Master but, on his way to do so, saw an undermaster and commented to him that either the boy that wrote the joke should be expelled or "one of us [meaning the member of staff] should be in prison". The undermaster said that he would take it up with the High Master and it was eight weeks later that the member of staff left the school. One of his victims told this review that after he left the school, he saw another current member of staff (later convicted of possessing indecent images) in a social situation and confided in him about his abuse by the perpetrator concerned. There is no evidence that this resulted in any further action. The expectation would have been that this information would have been relayed to the High Master who should have informed the local authority and the police.
- 8.39 A failure to act decisively and appropriately where there were suspicions of sexual abuse not only left pupils at risk of harm but also damaged their emotional and academic development. The issue of ascribing deteriorating academic performance as the pupil's problem rather than considering the reasons behind it has been discussed elsewhere. In another example the unprecedented step was taken of moving a pupil up to the senior school a year early, away from his peer group. The ex-pupil understands that this occurred once other parents complained about him sharing accounts of what had happened between him and a member of staff with his peers. This pupil also alleges that the school were aware of the member of staff's inappropriate behaviour with pupils and this was corroborated by ex-staff members who spoke to this review. However, there is no evidence that concerns were relayed to senior managers at the time. The move was re framed as an "opportunity" to go into the upper school but from the ex-pupil's perspective this was the cause of profound emotional problems for him.
- 8.40 Although these examples of failure to act to protect children may have reflected a wider cultural problem at the time which failed to put children first, this does not negate the extreme suffering experienced by pupils at the school. Even where abuse was brought to the attention of those in authority, they did not inform the statutory agencies and children were left at risk of abuse from people who should have been protecting them. This not only failed pupil's at St Paul's but also put children in the wider community or at other schools at risk.

Managing specific allegations – more recent practice

- 8.41 More recently, under the leadership of the current High Master and Designated Safeguarding Lead there has been a marked improvement in responses to allegations although this has taken time to develop.
- 8.42 When pupils complained about inappropriate behaviour and use of alcohol by a master, there was a willingness to listen to pupils and take allegations seriously. There was initially a lack of judgement by the school in investigating internally by conducting interviews with the pupils before contacting the local authority or police and the school have acknowledged that this was not best practice at that time. Following referral, the police decided to take no further action, although there was a further investigation a year later. This again did not lead to any criminal prosecution.
- 8.43 The broad outline of subsequent events can be traced via meeting minutes but discussions with the LADO and further commentary from the school reveals differing points of view as to the quality of practice and judgements made by both parties. Indeed, these differing points of view are clear from the minutes of the second management of allegations meeting which were challenged by the school and clearly set out areas of dispute. From the LADO's perspective his concern was that the school were defining the member of staff's behaviour as improper rather than abusive and were placing too much emphasis on the fact that the member of staff had expressed contrition and had cooperated with the safety plan. Following a review of all the information in his possession he advised that the member of staff should be suspended, and that he would be making a referral to the Disclosure and Barring Service. The school provided the Disclosure and Barring Service with all relevant information, including the details of the disciplinary procedures and outcomes which by that stage had been concluded and after consideration the decision made was that it was not appropriate to bar the member of staff.
- 8.44 The school did not understand why the LADO appeared to change his mind about the advice he gave, and that they felt referral to the Disclosure and Barring Service should have followed the completion of all investigations and disciplinary procedures to make sure that teacher concerned had the chance to state their case and the Disclosure and Barring Service could make the decision on all the information available.
- 8.45 Although there was nothing to prevent the LADO making his own referral to the Disclosure and Barring Service, this was unusual practice and driven by a concern about the school's original response to the allegations and an appropriate concern that the threshold for understanding behaviour as abusive (rather than improper) was too high. The LADO also felt the police threshold at that time was too high and that the fact the police did not take any action should not prevent safeguarding activity taking place. There is further discussion about the relationship between the school and the LADO in section nine of this report.
- 8.46 A later "lessons learned" meeting with the new head of the LADO service noted that it was unusual for a referral to be sent to DBS without an investigation being undertaken by

Police and/or Children Services but that the LADO can refer when the legal duty is not met and where there are safeguarding concerns.

- 8.47 At the time the statutory guidance was not sufficiently clear regarding timings of referrals to the Disclosure and Barring Service in such cases. The most recent statutory guidance²⁷ has now clarified that a referral should only happen after the completion of all investigations and disciplinary procedures.
- 8.48 This case was then referred to the teaching regulator (NCTL) but the case did not progress to a panel hearing and no further action was deemed necessary.
- 8.49 Around the same time another member of staff (who was later convicted of possessing indecent images) was referred to the local authority when images of boys were found on his computer. The school's chronology identifies that legal images of boys were found on a Wednesday during a routine check of the computers in Colet Court; further investigation found that activity had been taking place with attempts to access sites with links to pictures of young boys. The Headmaster of Colet Court was informed. The next day (Thursday) further activity was found on the computer of the member of staff concerned which included downloading images of boys posing in sexually suggestive ways. The High Master was informed. The designated safeguarding lead at Colet Court consulted with an experienced freelance child protection trainer who advised referral to the LADO. The decision taken within school was to monitor internet activity of the member of staff over the weekend. According to information given to the review by the school, new evidence came to light over the weekend and the LADO was informed on the Monday morning.
- 8.50 It is the view of the lead reviewers that the school could have been swifter in informing the LADO of the images that had been found and should have contacted the LADO rather than a child protection trainer. Even though the images found on the Wednesday were *legal* they were unusual, and as outlined above, it was clear by Thursday that the member of staff was being proactive in attempting to access sexually suggestive images of young boys. There had been previous complaints about this member of staff, and this should also have influenced decision making at this point. The school dispute this analysis and argue that it was only over the weekend that *explicitly* erotic material was accessed and that at the time the guidance to schools regarding expected speed of reporting was not specific. There is agreement between all parties that had these events happened within today's context there would have been a prompt discussion with the LADO.
- 8.51 Both these instances appear to reflect differing views as to what constitutes risky or abusive behaviour and highlights the need to move to a broader understanding of what these involve. Two of the convictions of staff were for the possession of indecent images and various communications, but most notably that from the (then) Chair of Governors questioning the Charity Commission's inquiry report, take issue with these convictions being referred to as child abuse. Even though no pupil at the school may have been harmed the possession of such images should have been understood as falling within the definition of child abuse and involving abuse of other children.

²⁷ New guidance Keeping Children Safe in Education (2019) is now explicit that referrals to the Disclosure and Barring Service should be made "after the resignation, removal or redeployment of the individual".

- 8.52 Managing specific allegations within the school provides many challenges, most particularly at the interface of good safeguarding practice and employment law. Ex-pupils told this review that they believed even more recent allegations in 2013 had been “hushed up” when the reality is that the school had reported three issues to the LADO and the police that year, and all three were investigated. However, teachers in such circumstances possess rights under both employment and criminal law, which have to be observed and prevent any school from sharing details with third parties. This can create the impression to third parties, even those within a school, that issues are not being followed up when in fact they are. Section 141F of the Education Act 2002, inserted under section 13 of the Education Act 2011, introduced an anonymity clause for teachers who are subject of an allegation. It is an offence for anyone to put information regarding an allegation by a pupil against a current teacher into the public domain, where this is likely to lead to the public identifying the teacher, prior to any charge or subsequent court appearance or before the Teaching Regulation Agency publishes information about an investigation. This means that schools face challenges in encouraging a culture of openness whilst at the same time protecting the confidentiality of the accused in an institution where rumours are likely to be rife. It is unhelpful if the message is somehow conveyed to pupils that the school wishes to shut discussion down as this is at odds with good safeguarding practice which would always want to encourage open dialogue about any concerns relating to inappropriate or abusive behaviour.
- 8.53 The most recent conviction of a member of staff in 2018 does provide evidence of an organisation that is learning from past mistakes and has a deeper understanding of how to manage the aftermath for both past and current pupils and their parents. This example is set out in some detail as it refers to recent practice and serves to highlight good practice as well as some the challenges involved, including the use of language, and the need for clarity about communication processes amongst all agencies. It also indicates that the current system in place to prohibit offenders from teaching may not be working efficiently.
- 8.54 This member of staff had been a science teacher at St Paul’s for seventeen years when, in February 2018 he was arrested in the Thames Valley Police area having been tracked by the police having sexualised online communication with someone he believed to be a 13-year-old girl. He had been tracked and known to be both a teacher and a father from November 2017, but his true identity could not be revealed by the social media platform as their policy is only to do so if there is a risk to life.
- 8.55 Regulation of social media platforms is being debated at a national level and this example serves to remind those considering this issue of the way in which perpetrators can hide behind the anonymity that they provide.
- 8.56 Having made arrangements to meet with the “girl” he was detained by the police and immediately wrote to St Paul’s telling them of the arrest under the Sexual Offences Act and offering his resignation, citing a “nervous breakdown” leading to him making “ill-judged decisions”.
- 8.57 The initial contact from Thames Valley Police to the school was unfortunate as the police communications manager contacted a junior member of the marketing department at St Paul’s giving information regarding the arrest. This member of the marketing department

was unaware of, and wholly unprepared for, the situation. Police officers should be reminded that they should only speak to the Designated Safeguarding Lead or Head regarding an allegation/concern/suspicion/arrest of a teacher.

- 8.58 There immediately followed good communication between the school, LADO and the police and the school informed the Disclosure and Barring Service immediately they were aware of the arrest. Expected procedures were followed which resulted in the school holding a disciplinary hearing and recording that the member of staff would have been dismissed had he not already resigned. There was discussion during this process about what point the Teaching Regulation Agency should be informed and advice from the LADO was that this should not happen until point of charge. The school then put them on immediate notice of the case pending further information and kept them regularly updated. Statutory guidance²⁸ advises that this should be considered at the point an allegation is substantiated or at the point of dismissal but is not unequivocal in setting out expectations as it is with a referral to the Disclosure and Barring Service, where there is a legal duty to inform them when a school thinks that an individual has engaged in conduct that has harmed (or is likely to harm) a child. There is further discussion of when to involve the Teaching Regulation Agency in paragraphs 13.19-13.23.
- 8.59 Letters were sent to staff and parents (agreed by the LADO) explaining that the member of staff would not be returning to school after half term due to “mental ill health” and being involved in an investigation that “has nothing to do with the school or his work here”. The aim of the school was to give parents, pupils and the wider school community as much information as was possible within the confines of the law. The teacher had rights to anonymity under law, yet the school had to explain his sudden departure in a manner that was not misleading while providing reassurance against possible suspicions that the issue related to an allegation involving pupils at the school. The school worked closely with the LADO and the police to agree the contents of the letter. On the one hand, including the phrase that the issue had nothing to do with his work in school is technically correct, but is hard to square with a sexual offence and can give the impression of a school wanting to distance itself from the issue. On the other hand, without an explicit assurance that the issues were unrelated to conduct within St Paul’s then the letter would have given rise to parents and members of the community worrying about the possibility that the staff member was suspected of abusing pupils at the school.
- 8.60 The member of staff was charged on 22nd June 2018 with arranging to meet a child for the commission of a sexual offence and inciting a child to commit a sexual act (aged 13). His first appearance at court was set for 24th July 2018.
- 8.61 Throughout this time, the school and LADO were advised by the police officer in charge of the case that Thames Valley police would not be making any statement until the day of the first court appearance on 24th July 2018. This continued to be confirmed as the approach at a strategy meeting on 12th July and the school arranged its own communications to the school community based on this assurance. Then, on 18th July, the school was advised directly by Thames Valley Police Communications Department that their press release would go out the next day. The school queried this and were told by the police officer in

²⁸ DfE (2018) *Keeping Children Safe in Education* Paragraph 234

charge of the case that he had not been aware of the police's obligation to supply a press release so press could attend court if they wished. The police press office did agree to delay the release by 24 hours but from the school's perspective this still gave them only limited time to finalise their own communications to ensure the school community was advised prior to the police press release.

- 8.62 The school submission to this review notes that the member of staff appears to have been told by the police that the timing of their press release was forced by the school's decision to write to their community (when the opposite was true). When the police did issue the press release this erroneously referred to the date of charge as 19th July (rather than 22nd June).
- 8.63 At this point the school were able to write and advise all current and past pupils about the member of staff's pending court appearance and one letter was drafted to current parents and another to past pupils. Again, this shows the difficulties in drafting communication that is sensitive to everyone's needs. More than one survivor of previous abuse at the school took issue with the reference in the letter that was sent to current parents which stated that the member of staff had *informed the school that he was obtaining professional support for mental ill health which had led him to act out of character and to his subsequent arrest*. The intention behind the communication was positive as the school wished to be open and proactive in communicating with their community. However, with hindsight this was not a good choice of words, as to survivors of abuse, or to other members of the community, this phrase is interpreted as diminishing or excusing his actions. This captures the difficulties faced by schools when communicating on such matters as different sections of the community have different expectations and needs for information. Many current pupils, staff and parents sought some explanation from the member of staff for his actions: the school prohibited him from writing to his students and their parents but included this explanation instead. Communicating to the different needs of different sections of the community on matters of sexual abuse is almost impossible for schools to balance. Survivors of abuse could be a useful resource for schools in helping them to understand the impact of abuse over time and how this should underpin current communication strategies.
- 8.64 Following the conviction of this member of staff, although the school had informed both the Disclosure and Barring Service and the Teaching Regulation Agency, his name did not appear on the barred list for seven months after he pleaded guilty and at this point he had not been prohibited from teaching by the Teaching Regulation Agency. This is discussed further in section Thirteen of this report.

9 IMPROVING PRACTICE - THE SCHOOL'S RESPONSE

- 9.1 Once it became clear in 2014 that past safeguarding practice at the school had failed pupils, the governors and senior management team undertook an extensive review of current processes and procedures. A timeline of these reviews integrated with other external inspections is set out in Appendix 9 and details of those reviews commissioned specifically by the school and their response in Appendix 10. The internally commissioned reviews covered all aspects of safeguarding practice including health provision and show

that the school took what had happened seriously and have resulted in a range of improvements; some of which were designed to make sure that the school was totally compliant with statutory guidance and others derived from a wish to move beyond compliance to excellence in safeguarding practice. The evidence seen by the lead reviewers shows the enormous amount of energy and resources that were committed by the school to this process.

- 9.2 This section of the report cannot explain and comment on all the practice developments that have been made but concentrates on those areas where developments address the issues that have been identified through information gathered for this review.
- 9.3 In 2013 a review of boarding policies and practices was conducted, and a number of changes were implemented. Some of these changes reflect specific issues relating to the boarding environment with the need to make sure that there was sufficient oversight by staff outside the boarding house. There were changes to the location of staff accommodation, boarding house staff were to no longer act as pastoral tutors to pupils, increased staffing to increase mutual and increased oversight from senior managers and governors. Although not driven by all the information that is now available from ex-pupils via this serious case review, the changes in 2013 respond to the concerns of ex-pupils who had been boarders in the 1970s and 1980s who told the review of blurred boundaries between staff and pupils and the problem of the location of staff accommodation within the house.
- 9.4 Other responses included an updated code of conduct (which is clearly linked to principles and values which put the safety of children first) and an alcohol policy as well as increased staff training. The focus on expected staff standards of practice within the code of conduct is important as this should give all staff the confidence to challenge colleagues whose behaviour is outside the code. This previous lack of confidence to challenge colleagues has been commented on elsewhere in this report.
- 9.5 In 2014 the school commissioned an unannounced independent safeguarding review by a leading firm of solicitors with expertise in compliance in independent schools. This found the school to be compliant but recommended changes in the formatting of the single central register, amendments to staff information posters and job descriptions. These changes were immediately implemented. The single central register has been seen by the lead reviewers and is now an extremely comprehensive document which covers all aspects of pre-appointment checking.
- 9.6 Also in 2014, the school commissioned Graham Badman to carry out a comprehensive independent review of the safeguarding policies, procedures and culture of the school, and to make recommendations to enable the school to develop and improve practice. The report published in 2015 noted that the school was fully compliant with statutory requirements and made recommendations for the Governing Body to enable the school to move beyond compliance to excellence. The report noted mistrust underpinning the relationship between the school and local authority, mainly due to disagreements with previous LADOs and recommended that four specific concerns from the local authority should be reviewed by the governing body. These were subsequently addressed in the school's action plan. During the review the LSCB chair met with the school and the review

team and was noted to be helpful in offering support and suggestions, asking for a meeting to review progress in due course.

- 9.7 The report by Graham Badman is available from the school ²⁹ and further details of significant actions and recommendations can be found in Appendix 10 of this report. It was as a result of the Badman review that a safeguarding coordinator was appointed, working across both junior and senior schools and the quality of safeguarding audits by the governing body was improved. These now provide effective scrutiny and the governing body is now appropriately involved in overseeing the quality of safeguarding practice within the school.
- 9.8 It was also following the Badman review that changes were made to the operation of the Christian Union within the school. This is significant in relation to this serious case review as the Christian Union was mentioned by several ex-pupils, with some seeing it a force for good whereas others were concerned about the degree of oversight provided, particularly on residential activities. One past parent told the review that she was aware that her son was uncomfortable in the Christian Union in the 1990's but although he mentioned this to his tutor, those running the union were popular so a complaint would seem to be disloyal. Both residential and non-residential activities were run by ex-pupils operating through a registered charity, called the "Pauline Meetings", the school was not directly involved in the administration and running of the organisation and the charity operated within its own safeguarding procedures. It is not clear how transparent this arrangement was to pupils and parents who may have expected that the school were responsible for safety standards.
- 9.9 In 2014, the school revisited the historic arrangements and determined that it would be clearer, safer and better for the school to take over the safeguarding and organisational functions of all of the activities of the Christian Union, to ensure absolute transparency of arrangements and quality assurance of safeguarding procedures. All activities were brought under the school's educational visits policy and procedures, and are led by staff employed by the school, supported by the ex- pupil volunteers. This arrangement means that the school has oversight of all activities and is responsible for the standards of safeguarding practice. Lines of accountability for both parents and pupils are therefore much clearer.
- 9.10 In order to respond to concerns that staff had not always felt able to speak about any worries they may have about the behaviour of a colleague and to give staff an opportunity to inform the safeguarding lead about any actions they may have taken that could be misinterpreted, a process of neutral reporting has been introduced. The school policy notes that *the purpose of neutral reporting is to protect both pupils and the staff working with them and allows a system for a simple record to be kept in case events are later referred to or any patterns emerge*. It is important that this is a neutral act with no detriment or stigma associated with making the report. Discussions with staff members confirmed that the possibility of neutral reporting is well embedded in the minds of staff although the examples given of where this had been used related to notifying about their own behaviour rather than others: for example, finding themselves alone with a pupil after

²⁹ <https://www.stpaulsschool.org.uk/safeguarding-pupil-welfare>

a drama rehearsal. This innovative system which may be of interest to other schools would benefit from a formal evaluation in order that learning about the benefits and areas for improvement in this the system could be disseminated more widely.

- 9.11 The other important area that was highlighted from consideration of past abuse incidents was the need to have in place a culture and systems which supported pupils to report any concerns about the behaviour of others. A review of safeguarding practice at the school carried out by Barnardo's in 2017 sets out a range of methods whereby the school had developed a culture of listening to pupils. It noted: *the pupils consulted stated that they feel well supported and appreciated the many talks given to them about keeping safe. They clearly knew who to talk to or what to do if they felt unsafe and named a range of people they could talk to or methods through which they could report concerns e.g. Heads of Year, Form Tutor, welfare boxes.* One case study examined for this serious case review noted that in 2013 there was evidence that pupils were more open about reporting abuse to the Designated Safeguarding Lead and it is also of interest that they did so after attending a level 1 safeguarding session. Training pupils to understand what safeguarding means would seem in this instance to have had a positive effect.
- 9.12 There is a difference between the junior and senior school in respect of the way they can report concerns about staff or pupil behaviours. In the junior school pupils have access to an online platform called Tootoot which enables them to report any concerns anonymously. Reported concerns usually go direct to the pupils' head of year who will investigate the matter. This system relies on the head of year reporting any concerns that might relate to inappropriate staff conduct to the head teacher who would be in a position to identify serious concerns of patterns of behaviour that need attention.
- 9.13 In the senior school 'Anything to Say' (A2S) is a group of pupils devoted to listening to what other pupils have to say about any matter relating to life at school or outside it and answering any questions pupils might have. Emails received by the service are immediately passed to A2S anonymously and responded to within one day. Only the member of staff in charge will be able to see the sender's e-mail address and submissions remain completely confidential, except where the member of staff in charge thinks that there is considerable, immediate risk to the sender or those around him. In that case, the member of staff in charge may intervene to ensure the safety of the sender and those around him, following the safeguarding and child protection procedures of the school. This system does not have the features of an anonymous reporting system that would enable senior managers to see and respond to patterns of complaints and this is discussed further in Finding Six.
- 9.14 A further investigation commissioned by the school in December 2014 was carried out by Jonathan Laidlaw QC (the Laidlaw report)³⁰. This focused on the way that the school had handled complaints parents had made about the treatment of their son in 2005–07 and again in 2011 and 2013. Their son had taken his own life as a young adult and from the perspective of the parents concerned, the Laidlaw report was only commissioned after considerable pressure from themselves supported by another parent and ex-pupil. The school confirm that representations were made, but the governors concluded

³⁰ Further details of investigation are set out in Appendix 10 of this report.

separately that this parental complaint from the mid-2000s must be independently reviewed once police clearance had been received.

- 9.15 Following consideration of the details of the Laidlaw report, the senior management team decided to adjust the content of the compulsory safeguarding training for all staff to place special emphasis on spotting and reporting possible signs of inappropriate or odd behaviour that might lead to or indicate possible physical, emotional or sexual abuse, and how to report any such concerns. With the agreement of the family an annual lecture series on mental health was inaugurated in the name of their son and there has been an increased emphasis on promoting positive mental health within the school. The report by Barnardo's into the effectiveness of safeguarding practice commented that the mental health and wellbeing of pupils is high on the school's agenda.

10 THE RESPONSE OF THE WIDER SAFEGUARDING SYSTEM TO ABUSE ALLEGATIONS

The Local Authority

- 10.1 The LADO plays a key role where allegations have been made about a member of staff within a school. The national requirement for local authorities to appoint a designated officer (LADO) to manage allegations against adults who work with children was first set out in statutory guidance in 2006³¹ reiterated in 2010³² and further developed in guidance issued in 2013³³.
- 10.2 At the point of first contact with St Paul's in 2013, Richmond Children's Services did not have a dedicated LADO role or team and the officer concerned also had responsibility for chairing child protection conferences. It was within this context that St Paul's experienced the LADO as tardy in producing minutes of meetings and highlighted the need for an adequately resourced LADO service. This is now in place.
- 10.3 Also, in 2013, there was no expectation within Richmond that children's social workers would routinely attend allegations management meetings. This meant that consideration of whether there should be child protection enquiries under section 47³⁴ planning for any such enquiries or support that might be provided by social workers for pupils could not take place at that meeting. Again, this is now routine practice.
- 10.4 The details of the disagreement in 2013-14 between the school and the LADO as to whether a referral should be made to the Disclosure and Barring Service is set out in paragraphs 8.42-8.48 of this report. The sequence of events contributed to a deterioration in the relationship between the LADO and St Paul's. The school experienced late arrival of meeting minutes and when they did arrive felt them to be inaccurate; these issues were

³¹ HM Government (2006) *Working Together to Safeguard Children* Page 152

³² HM Government (2010) *Working Together to Safeguard Children* Page 200

³³ HM Government (2013) *Working Together to Safeguard Children* Page 48

³⁴ Section 47 Children Act 1989 requires the Local Authority to undertake enquiries when they have reasonable cause to suspect that a child (who lives or is found in their area) is suffering or is likely to suffer significant harm.

raised by the school with the LADO's manager. The LADO has told the review that he checked the minutes with the police officers concerned and they were satisfied that they were accurate. Whilst it is not possible to comment on the accuracy of minutes it is clear that the administration of meetings was poor, and this seems to be a result of a LADO service which was structurally unfit for purpose at that time³⁵.

- 10.5 The Department of Education were informed in 2013 of concerns about the school's practice by Ofsted who had been contacted by the LADO who, at the request of the Department for Education shared two sets of strategy meeting minutes. This triggered the emergency inspection in 2014. The school was informed of the referral to the Department for Education but have told this review they were not informed of the reasons or the procedures being followed, and the LADO "declined to explain the process" or to engage in any discussion about it. From the perspective of the school this caused the relationship between the LADO and the school to deteriorate. The lead reviewers have spoken to the LADO believe that he did explain the process however it is clear that full transparency in such situations should always be expected practice."
- 10.6 The issue of when a LADO should refer to the Teaching Regulation Agency (which is now responsible for the regulation of teachers) is discussed in Section Thirteen of this report.

Police investigations

- 10.7 Children will be best protected in the future where the criminal justice system works fairly and efficiently to bring perpetrators to justice. In this case police investigations meant that six perpetrators have now been convicted.
- 10.8 Most of the people who had contact with the police and contributed to this review spoke very positively of their experience. Those who made allegations felt that they were always listened to and the police acted professionally. However, there are a number of specific issues that have come to light that need to be considered as areas where practice may be improved both in relation to specific police practice and the wider criminal justice system.
- 10.9 In 2013, the LADO felt that the local police child abuse investigation team was operating a high threshold, and this had led to no further action at that time in the case of one allegation. A subsequent review of the case in 2014 acknowledged this and a police investigation initiated. It is possible that pupils who made the original allegation would have been more forthcoming had they been interviewed at the time rather than some months later.
- 10.10 One ex-pupil raised the issue of an investigation in 2001 where an alleged perpetrator was also a member of the clergy. He felt that there was a delay in the investigation due to liaison between the police and church authorities and the church may not have responded appropriately to the potential risks. Although the ex-pupil clearly recalls being told that Lambeth Palace had been contacted, there is nothing in the police records about this and the Church of England National Safeguarding Team have confirmed to the review that there are no records of this incident have been found in Church of England files. This begs

³⁵ From 2014 there was a restructuring of the LADO service in order to address these problems.

the question of whether the police did liaise with the church and if they did, whether this was properly considered and recorded. Similarly, there is no record in the church of the member of staff (referred to in paragraph 8.33) who was a member of the clergy leaving his position at the school as a result of alcohol misuse.

- 10.11 One of the cases that reached the stage of criminal court, was recorded as not guilty due to the poor mental health of one of the complainants. This meant that he could not give evidence. Since abuse survivors may well have emotional or mental health difficulties it is important that our system does all it can to support them in giving evidence and although is particularly relevant to adult survivors, it is also important in keeping children safe from perpetrators of abuse. Currently there are schemes to support children, but adults in this position are signposted by the police via a leaflet to voluntary organisations where there may not be specialist help or services may be stretched. A more consistent service needs to be in place if justice is to be achieved.
- 10.12 Although police investigations generally stop when a verdict is reached at court, the management of a not guilty verdict requires sensitivity particularly towards the complainant. The Crown Prosecution Service had authorised a charge against one such teacher. The fact that a charge had been brought meant that the decision had been made that there was sufficient evidence for a realistic prospect of conviction and that prosecution was in the public interest. Following the not guilty verdict by a jury the complainant who lives out of the UK was informed by a telephone call from a police officer and the words he recalls hearing were “you were not believed”. Although these words are likely to have been part of a longer explanation, and, from the police and Crown Prosecution Service perspective, they had felt there was sufficient evidence to present to a court, these words have stayed with the complainant and caused considerable distress. In this case the distance involved made a more personal approach difficult, but it serves as a reminder that thought needs to be given as to how our system can adequately provide support to complainant pre and post-verdict, whether the verdict is guilty or not.
- 10.13 In this case there have been some specific lessons for the police as a result of some criticisms made by the judge. These were not a formal complaint but resulted in an internal investigation by the Metropolitan Police.
- 10.14 One issue raised by the judge was whether an officer introducing themselves as from the “paedophile unit” was appropriate. Although the name of this unit has now changed this was the official name at that time and it is the view of the senior officer who undertook the internal police investigation that the officer was not wrong to use this terminology as it is hard to see how an officer can introduce themselves by anything other than the organisational name of their team. Another concern within this trial was the way in which intimate photographs had been taken and whether it had been necessary for the alleged perpetrator to have been detained by the police overnight. The internal investigation found that these were areas where police practice could have been improved.
- 10.15 The allegation in this case was made by one pupil and relates to two incidents one when he was at Colet Court and another particularly serious incident which was alleged to have taken place at the member of staff’s home when he was in the senior school. The alleged victim told the review he told friends about the first incident and following complaints from

other parents about his sexually precocious behaviour, he was moved up into the senior school a year early without taking the common entrance exam. Staff have told this review that this would have been unheard of at the time, but confirmation that this happened has now been found within the alleged victim's school records. A report within the record comments that this pupil was *'kicked upstairs' from Colet Court six months ahead of his time in an unprecedented way because he had outgrown local rules*. The pupil explained to us that he told police on more than one occasion the causal link between being sexually abused and being moved up a year, but when the police prepared his witness statement the only recorded reason was as his academic ability. There is nothing in the school record to suggest that academic ability was the reason. Police statements are written by the investigating police officer using the verbal information given by the complainant and in this case, the significance of the information about moving up a year early seems to have been missed. It has not been possible to speak to the officer concerned to understand the police view and whether it was considered relevant evidence in the case.

- 10.16 One issue in relation to the police approach is the challenge faced by police in achieving a balanced approach in complex investigations. In 2014 when the investigation took place, the guidance to police officers was that first and foremost they should believe the complainant. This approach, may have been behind some of the concerns of the judge about the investigation but the information gathered from this serious case review (outlined above) would point to a complex picture where some evidence supporting the complainant's account was not given sufficient weight and other aspects of the police investigation such as the manner in which the alleged perpetrator was treated following arrest (for example the procedures that should have been followed when taking intimate photos) were not of a sufficiently high standard. The guidance to police regarding their approach to complainants in sexual abuse cases is now different, with an expectation that investigators will take an approach which respects the complainant's information and is also open to all possible explanations. Achieving this requires effective support and supervision of those in the front line who will be subject to conflicting and emotional responses and need the opportunity to reflect on day to day practice. Current supervisory documentation provides a valuable checklist for the supervisors of child abuse investigations, but it does not include any reference to the need for emotional support, exploring unconscious biases and the emotional responses that may have an impact on officers and their decision making.

The involvement of out of school settings

- 10.17 One issue that has emerged from consideration of the case studies is the link between several of these staff to other activities outside school, such as holiday clubs and other voluntary residential activities. Some staff against whom allegations had been made, worked outside school for such organisations and it is concerning that in 2013 when the LADO contacted a faith based residential holiday organisation where an alleged perpetrator worked he felt that they were "not interested" in hearing about the allegations of grooming activity that had been investigated by the police. On another occasion notes from meetings record there was an appropriate response from an Educational Cruise Company when they were informed of allegations against a member of staff.

10.18 It is to be hoped that action following the Government consultation on a code of practice for safeguarding children in out of school settings³⁶ may address some of the weaknesses in this aspect of safeguarding practice. The link between these settings and the LADO needs to be strengthened with an expectation of information sharing and participation in any inquiries involving staff and volunteers.

Managing Complex Investigations

10.19 Complex abuse is described in the current London Child Protection Procedures³⁷ as:

...abuse involving one or more abusers and a number of related or non-related abused children and may take place in any setting. The adults concerned may be acting in concert to abuse children, sometimes acting in isolation or may be using an institutional framework or position of authority such as a teacher, coach, faith group leader or be in a celebrity position to access and recruit children for abuse.

...The complexity is heightened where, as in historical cases, the alleged victims are no longer living in the setting where the incidents occurred or where the alleged perpetrators are also no longer linked to the setting or employment role. These will all need to be taken into consideration when working with a child or adult victim.

....Where the Strategy Discussion confirms that the investigation will relate to complex and organised abuse, it will appoint a multi-agency Strategic Management Group

...The Strategic Management Group should be chaired by a senior manager from children's social care³⁸.

10.20 Using the above definition, the investigations into allegations of abuse at St Paul's fell into this category. It should be noted that it is only since February 2014 that Children's Social Care is expected to chair strategic management group meetings and before that date the procedures stated that the meeting should be chaired by the police (or rarely by local authority Children's Social Care). Consequently, at the point that the need for a strategic management group was being considered the expectation that Children's Social Care would take the lead and chair the meeting was relatively new.

10.21 In December 2014, following discussions with partner agencies, the Professional Advisor to the LSCB raised the need for a strategic approach via e-mails to the Senior Investigating Officer in Operation Winthorpe. The senior investigating officer agreed to chair the meetings; terms of reference were prepared by the professional advisor to the Local Safeguarding Children Board and are set out in Appendix 8 of this report. One meeting took place in early 2015 with an agreement that the group would meet every two-three months until the end of the last trial.

³⁶ Department for Education (2018) *Out of School Settings a voluntary safeguarding code of practice. Government Consultation*

³⁷ http://www.londoncp.co.uk/chapters/organised_complex.html

³⁸ It should be noted that in 2014 when the abuse first came to light procedures allowed for the meeting to be chaired either by the police or Children's Social Care.

- 10.22 Meetings did take place although continuity and regularity were hampered by changes in senior police personnel and it is unclear how far the group fulfilled all the requirements of the terms of reference. For example, although the terms of reference required identification and liaison with relevant LSCBs and their local agencies, there is no evidence of this happening in respect of the management of an investigation where the arrest took place outside the Metropolitan Police area.
- 10.23 Minutes have been obtained from the LADO meetings in the area where the previous member of staff was working and was arrested which contain worrying information. At the first meeting the Richmond LADO had sent apologies and the investigating police officer gave information about the member of staff's behaviour at the time of arrest and during interview. This described a member of staff who would be totally unsuitable to work with young people. These minutes also contain information from the police statement that when this member of staff was working at St Paul's in the 1980's other pupils from St Paul's would visit the member of staff's house for counselling and that the school encouraged 1:1 time socialising with pupils outside and within their homes.
- 10.24 The second meeting took place at the point that the CPS had decided to charge the member of staff with two offences of gross indecency and three indecent assaults over two incidents. The member of staff remained suspended and their post had been made redundant. At the meeting it was acknowledged that this could lead to them slipping through the net as regards to the Disclosure and Barring Service but health problems were noted and the unlikelihood that they would be seeking employment elsewhere.
- 10.25 Information from the LADO in the area where the teacher resided is clear that there would have been no consideration of referring to NCTL (who were at that time responsible for teaching regulation) unless found guilty. This does not seem to have been a joint decision with the Richmond LADO which would have been appropriate given that the alleged offences were against an ex St Paul's pupil. This case should have prompted a planned approach to communication between the police investigating team and the Richmond LADO and clarity regarding roles and responsibilities for informing other agencies such as those responsible for teaching regulation. It would also have been appropriate for the Richmond LADO to explore with the school the implications of pupil's visiting staff homes and determine whether this could still be current practice. This might have been more likely had Children's Social Care been chairing the meetings. Issues relating to teaching regulation are discussed further in paragraphs 13.19-23 of this report.
- 10.26 Part of the problem in developing a strategic approach to management seems to lay in the split between non-recent allegations of abuse at the school being investigated by the Police via Operation Winthorpe, and those current investigations into staff who were still working at the school. The later investigations were led by the local police Child Abuse Investigation Team. Where the member of staff was still employed by the school, the local LADO (and therefore Children's Social Care) were aware, but they would not have known of the totality of police activity relating to non-recent incidents at the school. The school were certainly not fully aware of all the police investigative activity.
- 10.27 The result of this lack of effective strategic management meant that there was no coordinated approach to working with the school on a communication strategy. One of the

tasks of the strategic management group set out in the London Child Protection Procedures is to.... *ensure that appropriate resources are available to meet the needs of the children and families or adult survivors, including any specific health issues arising from the abuse.* Working with the school to develop an approach which provided information and support to those who had made allegations as well as the whole school community might have prevented some of the disquiet amongst the group of ex-pupils who had been affected.

10.28 What seems to have happened is that the development of the police structure for managing complex investigations had not been sufficiently well aligned with safeguarding procedures. The Police system for the management of complex operations involves a clearly defined structure led by Gold, Silver and Bronze Commanders. Gold groups were first introduced in 2000 and Gold commanders will lead a group focused on overall strategy. Silver commanders will coordinate tactical activities and Bronze commanders control resources and actions at incident level. What is less clear is how this dovetailed with an overall multi -agency approach to the child abuse investigations that were linked to St Paul's School. There was little apparent planning for the involvement of social work advice and expertise which could have focused on ensuring the needs of families and adult survivors was met.

10.29 There is a current need for procedures to provide clarity about the interface of the police command structures via Gold, Silver and Bronze groups and the multi-agency strategic management of complex safeguarding inquiries. Gold groups are mentioned within the London Child Protection Procedures (8.2.5) but their role vis a vis the multi-agency network remains unclear. Children's Social Care are now expected to chair strategic management meetings for complex abuse inquiries which does clarify the importance of an approach that encapsulates maintaining the integrity of criminal investigations alongside the needs of the wider community. This should now be taken further with an integrated approach which is understood by all.

11 ST PAUL'S, THE LSCB AND RELATIONSHIPS WITH OTHER STATUTORY BODIES.

The LSCB

11.1 When the terms of reference for this review were being agreed, the Local Safeguarding Children Board (LSCB) chair suggested that the role of LSCB should form part of the review as although in her view there was a negative atmosphere she wanted to clarify what had happened to bring about such a difficult relationship. St Paul's were also keen that the review should examine the relationship between the school and the Local Safeguarding Children Board (LSCB). The picture that has emerged is a complex one influenced by several factors which are expanded upon below:

- A confusion of roles and responsibilities, with the school expecting more support from the LSCB than was within the LSCB's remit;
- A different perspective between the school and the LSCB regarding the quality of the relationship between them from 2013 onwards: the depth of concerns within the school were not apparent to the chair of the LSCB;

- Clash of cultures and diametrically opposed communication styles;
- Relationships within the LSCB.

Confusion of roles and responsibilities – support to schools

- 11.2 From the school's perspective, by early 2017 trust in the LSCB had been eroded by a series of events which they believed illustrated an unjust and deficit focused approach to work with the school. Also, from the time of the first allegations of non-recent abuse in 2014, the school had expected a more supportive approach from the LSCB and felt that this had not been forthcoming. They cited the support that Southbank International School had received³⁹ following the abuse of their pupils by a member of staff and felt that they had not received this level of help.
- 11.3 The situation at Southbank School⁴⁰ was very different to St Paul's as in that case there was a current joint police investigation and social care s.47 enquiry, not just a single agency police investigation. Consequently, a team of social workers worked alongside police colleagues and as a result there was considerable involvement by the LADO and education safeguarding lead for the local authority. At St Paul's, there were two current investigations in 2013 managed by the local police Child Abuse Investigation Teams alongside Operation Winthorpe which was a police investigation focusing on non-recent abuse by staff who were no longer working at the school.
- 11.4 It must be stressed that it was not the role of the LSCB to provide *operational* support to the school, this role should have sat with children's services. Had there been strategic oversight of the investigations (see section ten of this report), support via the local authority could have been planned and more effectively met the school's needs.
- 11.5 The issue of general support and safeguarding advice to schools is not specific to this case and it has highlighted the need for local safeguarding support for schools to be readily available beyond the statutory LADO requirements and for these arrangements promoted across the education sector. Some local authorities have retained a senior officer with the role of safeguarding lead for education who provides a free service to both independent and maintained schools, and in other areas financial restraints have meant that this role no longer exists. Arrangements within Richmond and Kingston (delivered by Achieving for Children) do *not* include a free service to independent schools but independent schools in the area *are* able to buy advice from an online safeguarding advisor and since September 2016 a social work qualified education safeguarding advisor or an online safeguarding advisor. This service was not widely advertised but is now promoted through the regular designated safeguarding lead networks for independent schools. St Paul's only became aware of and used the service of the online advisor after safeguarding issues emerged in 2014. In addition, in 2016, the LSCB appointed a 14hour per week term time education coordinator to provide free liaison with maintained and independent schools.

³⁹ Hammersmith & Fulham, Kensington and Chelsea and Westminster LSCB (2016) *Serious Case Review: Southbank International School*.

<https://www.rbkc.gov.uk/pdf/Southbank%20SCR%20REPORT%2012%201%2016.pdf>

⁴⁰ The author and chair of this review were also author and chair of the Southbank review: any information set out in this report regarding Southbank School is already in the public domain.

Relationships over time – differing perspectives

- 11.6 From the perspective of the LSCB, they had tried to forge a close and supportive working relationship with the school and believed that they had done so, with the designated safeguarding lead from the school becoming a member of the LSCB representing independent schools and being asked to chair the independent school's forum set up by the LSCB. The school's submission to the review is less positive with a view that there had been an historic failure to provide support to independent schools in the Borough and a belief that there had been insufficient support following Operation Winthorpe. The Board chair was unaware of these issues at the time and there is no indication that they were raised directly with her.

Communication and collaboration

- 11.7 The LSCB's prime role was to work with the school in scrutinising and ensuring good safeguarding practice. The LSCB needed to be assured that the school had learnt lessons from their knowledge of past abuse and that the current safeguarding culture and systems were meeting the needs of pupils. As a part of this process the serious case review sub-group asked the professional advisor to the LSCB to compile a report outlining what was known about both non-recent abuse and current allegations so as to assist them in making any recommendations about next steps including whether the threshold was met for a serious case review. In a spirit of collaboration, the plan was for this to be a shared joint report with the school. This was a reasonable course of action, but the school have told the review that communication with the school from the professional advisor at this point was not clear in respect of the purpose of the report. The LSCB chair has a different recollection and believes that the purpose of the report was discussed with the school. When a draft of the advisor's report was shared with the school they were concerned about several inaccuracies and although discussions took place to try and agree a final draft, the school became increasingly unhappy about the unwillingness of the author to recognise their concerns and make all the changes asked for. From the perspective of the LSCB reasonable amendments were made but it became clear that an agreement could not be reached and in order to reduce conflict with the school the professional advisor and LSCB chair agreed that no report would be presented to the sub-group and the school would be asked to make their own presentation; which they did.
- 11.8 The unintended consequence of this attempted collaborative approach was a breakdown in the relationship between the LSCB and the school. Both parties contributed to this breakdown. Communications from the LSCB at times lacked clarity and were not always prompt but answering correspondence which was usually several pages long about matters that the Board chair believed had been resolved in face to face meetings was a time-consuming process. The LSCB in Richmond was judged by Ofsted to be good in December 2017⁴¹, the chair was very experienced and found this a challenging and unusual situation to manage.

⁴¹ Ofsted (December 2017) *Review of the effectiveness of the Local Safeguarding Children Board*

- 11.9 Correspondence between the school and the LSCB in 2013 and again 2017 is another example of a negative communication pattern. The school raised concerns about the policies on the LSCBs website being out of date. Whilst the tone of communications could be considered as wanting to apportion blame the lack of prompt response from the LSCB to the school was also not helpful. In both instances the lack of constructive dialogue, with each party showing little understanding of the other's point of view is an indication of the deep-rooted distrust between them.
- 11.10 The style of communication between the school and partners is unusual in a multi-agency safeguarding environment. It comes across as combative and more appropriate to intellectual debate than an attempt to understand the others' point of view and reach a mutually satisfactory agreement. Although this may not be the school's intention, it serves to highlight the importance of relationships where open honest dialogue and constructive challenge can take place.
- 11.11 The overarching picture is of a clash of cultures and expectations between the school and specific staff in the LSCB and some misunderstandings about the various roles and responsibilities of the LSCB, the LADO and Children's Social Care. The significant breakdown in the relationship between the LSCB and the school became apparent to the LSCB from the autumn of 2016 onwards when they began to review information in order to determine whether a serious case review should take place. The school agrees that the relationship broke down in the autumn of 2016, but attributes this to the LSCB's lack of transparency about the process it was following and their concern about factual inaccuracies in the LSCB's initial draft report.

Relationships within the LSCB

- 11.12 The management of the quality assurance of the health arrangements is an example of where any tensions *within* the safeguarding partnership can result in lack of effectiveness in challenging external organisations and holding them to account. The LSCB and Health partners did not manage the quality assurance of health arrangements at the school well (discussed in paragraphs 12.14-12.21 below) and some of the difficulties stemmed from, and, resulted in lack of confidence in the professional advisor by health professionals. The full detail of these concerns is not relevant to this review report, but it is of concern that the Designated Doctor has told the review that concerns were raised about the professional advisor's conduct with senior leaders in the local authority and the Chair of the LSCB but this was not resolved to the satisfaction of the Designated Doctor. This lack of constructive dialogue and communication between partners resulted in a poor response to the school undermined a focus on scrutinising and challenging safeguarding practice. Developing more effective communication and trust must be a priority in the newly developing safeguarding partnerships.

Other Statutory Bodies

- 11.13 Although the new High Master in 2011 had begun a process of improving safeguarding arrangements and making sure that they were in line with modern practice, managing the specific allegations in 2013 was the first time that these procedures had been tested. The

overriding impression at this stage is of a situation where a school was not used to external scrutiny and there were no pre-existing relationships that allowed both parties to navigate their way through differing perspectives on what action should be taken.

- 11.14 From the outside St Paul's is perceived as a powerful institution, used to being in charge and in fact some of the ex-pupils who contributed to this review spoke of still being frightened by the power of the school. There are important general lessons here for working together across the independent and public sectors. There may be a perception by independent schools that statutory bodies have a prejudice against them, and by statutory bodies that independent schools are powerful and bastions of privilege. The potential for these biases needs to be acknowledged and time taken to develop and build positive working relationships before a crisis develops. Where relationships break down the means of resolving this needs to be clear rather than positions becoming polarised and a loss of focus on what really matters; good effective safeguarding practice.
- 11.15 As the extent of non-recent abuse became public, St Paul's describe feeling "under siege", managing an inquiry by the Charity Commission, and an emergency inspection by the Independent Schools Inspectorate and interest from the national press. Communications from the school to statutory bodies during this period came across as defensive and adversarial. For example, the Chair of Governors sent a strong letter to the Charity Commission querying whether the threshold for a statutory s46 inquiry had been reached (although the school now accept that it had) and then queried the scope and process of the inquiry itself. The school argued that the Commission's initial letter was unclear about whether this was an investigation into the historic abuse concerns or current arrangements and was unclear about the scope of the inquiry. The school also entered into extensive dialogue with the Department for Education regarding the definition of a "serious failing" which was the phrase the Department had used in their letter to the school dated 7th April 2014. The school asked the Department to define what constituted a serious failing and to confirm if internal threshold or guidance existed for the Department for Education on this point. The school remain concerned that there is no published criteria and this issue is discussed further in paragraph 13.16 of this report.
- 11.16 From a consideration of the information submitted to the review from all relevant agencies, it is easy to see why the impression was of an organisation focused on managing their reputation rather than engaging in a dialogue focused on learning. The school strongly refute this assertion and argue that the Charity Commission and Department for Education were challenged privately and out of the public eye. In their view the grounds for challenge were entirely legitimate but they do now accept that the timing and tone were wrong. It is the issue of tone and quality of communications within a multi-agency environment that is a point of learning for all involved with more consideration given as to how communications will be perceived and understood by those to whom they are directed.

12 THE HEALTH SYSTEM AND SAFEGUARDING IN SCHOOLS

- 12.1 Health practitioners are key members of the safeguarding system and where a school has boarding facilities the role of members of the health team are particularly significant. In the case of St Paul's, this team consists of a matron in the boarding house, school nurses, a

GP and school counsellors. Not all provision is full time with the GP working 5 hours per week and the school counselling service providing 3.5 hours per week at the junior school and up to 17 sessions per week (of 35 mins) at the senior school.

- 12.2 The national context for this team is that individuals are accountable to their own professional bodies. Alongside this the local Clinical Commissioning Group commissions the health safeguarding team which consists of a Designated Doctor, a Designated Nurse and a Named GP: only the Designated Nurse works full time in this role. These designated safeguarding professionals have a responsibility for effective clinical, professional and strategic leadership for child safeguarding within the health economy and this includes assisting and facilitating the development of quality assurance systems. Statutory guidance⁴² also makes it clear that this applies to private healthcare and independent providers of health. The review has heard that during 2015-17 the health safeguarding team in Richmond was experiencing some challenges, primarily relating to confusion around role, responsibilities and lines of accountability and there were difficulties in relationships between team members which resulted in poor communication and planning of responses. This became particularly relevant in relation to a safeguarding assurance visit to the school in September 2016 which is discussed further in paragraphs 12.15-12.21 below.

School nursing

- 12.3 In 2016 the school carried out a comprehensive review of the service with the intention of strengthening the provision, particularly in respect of the school nursing service. This included the creation of a new Head Nurse to ensure proper accountability and line management, and adherence to new safeguarding policies. The review and changes in working conditions resulted in the loss of several experienced school nurses who had been at the school many years. Their views about the way in which the changes were managed by the current senior leadership team is described below but in addition they have helped this review to understand *previous* safeguarding cultures in the school described elsewhere in this report.
- 12.4 It is the view of nurses that the changes to the service following the review were not handled well. They felt that their experience was not valued, and that the culture within the senior leadership team was defensive, intimidating and policy driven. This perspective is disputed by the school although the communication style described by the school nurses is similar to that described by some of the other contributors to this review (see paragraphs 11.7-11.11). The school's perspective is that proper procedures were followed, and all four nurses were offered employment within the new structure, which they declined.
- 12.5 The focus is now on building a team in line with the expectations of a modern school nursing service. There is every reason to believe that this team will provide a positive contribution to the overall safeguarding environment within the school.

⁴² Safeguarding Children and Young People: Roles and Competencies for Healthcare Staff: Intercollegiate Document (2019) Page 84

GP Provision

- 12.6 GP provision at the school is provided by a practitioner whose own GP practice is in a neighbouring Borough. All boarders are registered with the school's GP and provision of a service to those pupils is the priority. In practice, because there are a small number of boarders whose medical needs tend to be limited, most of the GPs time is taken up with other pupils' needs, particularly responding to sports injuries. They also provide consultation to staff if time permits.
- 12.7 The role of the GP in the safeguarding system within the school is constrained by the hours available and the complexity of working in a school where many day pupils come from outside the Borough and even boarders are likely to be also registered with a GP elsewhere. There are additional issues relating to provision of safeguarding advice from the local partnership. GPs would normally seek safeguarding advice from the Named GP in their local area and in this case, it is unclear whether the GP would seek this from the Richmond Named GP or from the area where their own practice resides. It is apparent that the Richmond Named GP had no professional relationship with the GP at the school believing that this was the remit of the named GP in the neighbouring Borough. This was not the understanding of colleagues in Richmond LSCB. The situation was further complicated as the quality assurance role of the Clinical Commissioning Group did not extend to scrutiny of GP provision for boarders at the school.
- 12.8 When the GP at St Paul's sees a day pupil there is no automatic notification to the pupil's home GP. This is a gap in the system and if any drugs are prescribed, this is not in line with General Medical Council guidance⁴³. This gap in communication also prevents the child's registered GP building a comprehensive picture of their medical history. Similarly, the school's GP may not be notified of other outside medical consultations by boarders and this was of concern to the school in the case of medication (methylphenidate) prescribed to a boarder by a private paediatrician for the symptoms of ADHD. This paediatrician has reflected on their prescribing practice and the risks associated in assuming that the parent or guardian accompanying the child will automatically inform the school and ensure safe storage of medication. Where a child is seen privately by a paediatrician the referral may not come from the registered GP (unlike for NHS patients) and this raises a broader issue concerning the degree to which patients seen privately may be disadvantaged in the safeguarding system.
- 12.9 It has also been brought to the attention of the review that there are no national guidelines from the Royal College of GPs regarding the expectations of the GP role in schools.

The Counselling Service

- 12.10 Prior to the 1980's, when much of the abuse discussed in this report took place, there was no counselling service at the school. The school counselling service started in the 1980's but did not feature in our discussions with ex-pupils as a place where they could go to

⁴³ <https://www.gmc-uk.org/ethical-guidance/ethical-guidance-for-doctors/prescribing-and-managing-medicines-and-devices/sharing-information-with-colleagues>

discuss their concerns about the interactions between staff and pupils. In fact several were unaware of the service and comments were made by ex-pupils (one of whom is a recent parent) that “boys do not want to go to someone inside the school” and, “a counsellor employed by the school would be seen as part of the establishment” One of the counsellors currently working in the senior school, has been in post since 1998 and has managed only one allegation against staff. Although the service plays an important role in promoting the mental wellbeing of the pupils, the evidence would suggest that it plays a marginal role in providing a place where pupil’s discuss concerns about inappropriate or abusive behaviour by staff. This is not a criticism of the service but an issue that needs to be understood by those with responsibility for the overall safeguarding strategy within the school.

- 12.11 Today, the school provides a counselling service for boys in both the junior and senior schools. In the senior school there are two part time counsellors offering 17 appointment slots a week and one part time counsellor in the junior school offering six-seven sessions. All are professionally registered Practitioner Psychologists.
- 12.12 In the senior school this is a confidential service and pupils are informed that if confidentiality needs to be broken this would normally be discussed with them, but they may not be informed if doing so prevents a serious act of harm from being carried out. Contemporaneous handwritten notes are kept of each session, are kept securely in the counsellor’s office and form part of the medical record.
- 12.13 The review team were interested to be informed by the counsellor for the junior school that they do not keep notes although the school are adamant that notes are kept and they comply with professional requirements. Further clarification was sought which explained that no handwritten notes are kept or stored on the premises but instead a brief electronic report is sent via the school email to the head of year after the initial assessment and, if applicable, at the end of treatment. This report is minimal with a brief outline of the presenting problem and a treatment plan. This report is stored on the pupil’s welfare notes. This practice would fulfil the requirements of the professional standards for psychologists⁴⁴ which simply require that the practitioner should *keep accurate, comprehensive and comprehensible records in accordance with applicable legislation, protocols and guidelines*; although how far such a record is comprehensive could be debated. The review has been told that this is different from the system in the senior school because of the maturity levels of pupils and different levels of confidentiality; the junior system involved referrals with parental knowledge, but this is not the case with all referrals in the senior school. What is less clear is how effective this system is in documenting the detail of issues that either individually or cumulatively may indicate a safeguarding concern.

Quality Assurance

- 12.14 There is a danger that non-maintained schools may sit outside the day to day systems that are there to develop and monitor the health provision for children in school. In the case of St Paul’s there is no evidence of any interaction between the school and the local health safeguarding system until after the abuse investigations from 2013 onwards.

⁴⁴ <https://www.hcpc-uk.org/standards/standards-of-proficiency/practitioner-psychologists/>

- 12.15 A health assurance visit to the school on 30th September 2016 illustrates the misunderstandings that can occur when interaction occurs at a point of crisis rather than being the norm. It also serves to confirm the importance of healthy working relationships between members of the safeguarding partnership and the negative impact on the partnership's ability to hold organisations to account where such relationships are not in place.
- 12.16 The Designated Nurse had carried out a number of these audits, but it was the first time the Designated Doctor at the time, had done so as it was not usually their role. The Named GP at the time had asked to join the audit team, but it was considered that the audit did not require three safeguarding professionals to visit the school. With hindsight, the presence of the Named GP could have focused their attention on the role of the GP at the school. As a result of the audit the Named GP was asked to make contact with the school but did not do so and passed this task to the neighbouring Borough.
- 12.17 From the perspective of the school they had thought that a visit from the Designated Doctor and Nurse in September 2016 was to follow up on the issues around concerns arising from methylphenidate prescribing by a private paediatrician. These concerns had been notified to the LSCB. In fact, there seem to be conflicting opinions as to the purpose of the visit. Three different opinions have been presented to the review and even now there is still no clear explanation as to who commissioned the audit. The three opinions are:
- The visit was at the request of the LSCB as part of general information gathering to inform a report on the school to be presented to the serious case review subgroup;
 - The visit was part of a usual pattern of health safeguarding assurance visits to schools in the Borough;
 - It was primarily to follow up and discuss prescribing practice following the concerns about methylphenidate prescriptions but, as would be usual practice, the Designated professionals took the opportunity whilst at the school to discuss various aspects of safeguarding practice, write up discussions and present them in the form of an action plan.
- 12.18 In fact, the visit should have sat under the auspices of the Clinical Commissioning Group and, whilst the findings of the audit could be made available to the LSCB, the Designated Doctor and Nurse were not there as officers of the LSCB as was believed by the school. Nothing in communications either between the LSCB and the Designated professionals or the Designated professionals and the school made this purpose clear. The visit is described by all parties as difficult and following the visit, the school were surprised to receive a formal action plan and were unhappy about some of its content and then even more unhappy in delays in receiving any response to their e-mails from the Designated Doctor and Nurse. From the perspective of the health professionals they did not reply as the LSCB asked them not to. This is a further indication of confusion of roles and responsibilities surrounding the audit as it would have been best practice for health practitioners to own their action plan and reply to the school.
- 12.19 The school notified the LSCB that they were considering a formal complaint to the CCG although they decided not to do so in the interest of maintaining a good working

relationship with the LSCB. At this point the factors underlying the problems were, lack of clarity about the purpose of the audit, absence of clear communication from the health professionals, lack of any previous working relationship between Designated professionals and the school and a deteriorating relationship between the school and the LSCB regarding the production of a report for the serious case review sub group (see paragraph 11.7 of this report).

- 12.20 From the perspective of the LSCB, the reaction of the school to the health audit was highly unusual and contributed to the view of the LSCB that this was a school who were defensive and unwilling to engage with statutory agencies.
- 12.21 This experience highlights the need for safeguarding partnerships to direct and foster the development of relationships between relevant individuals and agencies in order to prevent avoidable relationship breakdown which will have a detrimental effect on learning and practice improvement.

13 SAFEGUARDING CHILDREN THROUGH REGULATORY ACTIVITY

- 13.1 As an independent school St Paul's is now subject to statutory inspections designed to provide assurance that the required education and welfare standards are met. As a charity it is also subject to regulation by the Charity Commission, and the Teaching Regulation Agency has responsibility for the regulation of qualified teachers at the school.
- 13.2 Much has changed since most of the known abuse at St Paul's took place, although there are legitimate questions to ask as to how the regulatory requirements enable inspectorates and regulators to identify practices which leave children at risk, including how a school deals with allegations.

Inspections, the Charity Commission and Department for Education

- 13.3 The interaction between St Paul's and the Charity Commission has been commented on in paragraph 8.6 above. From the perspective of the school, in 2014 they were subject to both the statutory inquiry carried out by the Charity Commission alongside an emergency inspection by the Independent Schools Inspectorate and at the time this contributed to a feeling of being "under siege". They have questioned whether this process could have been rationalised. Under the circumstances, the need for scrutiny from two organisations was necessary as each have a different function. The Charity Commission is established by law as the regulator and registrar for charities in England and Wales and their regulatory role focuses on the charity trustees and their conduct. The Charities Act 2011 gives the Commission a statutory function to investigate concerns identified in the administration and running of a charity and in serious cases of abuse the Commission may investigate and open an inquiry. The inquiry looks at a wide range of evidence with the aim of resolving any problems and preventing further abuse. This a different focus from inspections by the Independent Schools Inspectorate who are responsible for inspections of St Paul's School and both were necessary in this case.

- 13.4 The Independent Schools Inspectorate (ISI), a not for profit organisation that is approved by the Secretary of State for Education to carry out inspections of independent schools in membership of the Associations which form the Independent Schools Council. The statutory purpose of inspections is to report to the Department for Education on the extent to which schools are meeting the Independent Schools Standards Regulations (2014). The first set of these dedicated standards was created in 2003 and were therefore not in existence for much of the time period covered by this review. Prior to 2003 Independent Schools were inspected by HM Inspectorate of Schools under the Education (Schools) Act 1992 and prior to that by the Secretary of State under the Education Act 1944. Boarding provision was inspected by various inspectorates until the Independent Schools Inspectorate assumed responsibility in 2012.
- 13.5 Inspections take place approximately every three years and can only be a snapshot of a school's performance at a point in time taking account of information known, and evidence gathered as part of the inspection. The Department for Education as regulator of schools, acts as a central point for gathering information for onwards transmission to other relevant bodies such as local authorities and inspectorates. ISI, however, does also receive information directly from parents, members of the public and from other agencies and any information received directly by ISI is promptly passed to the Department for Education.
- 13.6 Historically, inspectors were heavily reliant on intelligence from the Department for Education and on the school itself disclosing any serious incidents which had occurred or come to light since the previous inspection. Practice has now developed, and ISI also contact LADOs prior to each inspection and an on-line search is completed. Where information has been received from any source, and if appropriate, ISI contacts individual agencies in order to ensure that inspectors are briefed as fully as possible in advance of the inspection. The school is also required to respond specifically to the following question: *'Please indicate any cases where a member of staff or other person connected with the school is subject to investigation, has resigned, or has been dismissed or disciplined because of questionable conduct with children. In each case, briefly mention any referral made Disclosure and Barring Service (DBS) or the Teaching Regulation Agency (TRA) (or their predecessor bodies) since the previous ISI inspection.'*
- 13.7 Part 6 of the Independent Schools Standards Regulations requires the proprietor to ensure that: 'any information reasonably requested in connection with an inspection under section 109 of the 2008 Act which is required for the purposes of the inspection is provided to the body conducting the inspection and that body is given access to the school's admission and attendance registers;'. Where it is found that a school has failed to provide such information, this standard would not be met and regulatory action could be taken by the Department for Education.
- 13.8 Colet Court and St Paul's School passed all independent inspections up until the emergency inspection in 2014 and there is no evidence that either school failed to inform the Independent Schools Inspectorate of any relevant information when inspections took place.
- 13.9 In February 2014, there was an unannounced emergency inspection requested by the Department for Education following concerns raised with them by the Richmond LADO

about the school's handling of two allegations. Prior to the inspection being commissioned, the inspectorate had no knowledge of the allegation relating to a member of staff who had been found with inappropriate (albeit legal) images on their school computer and had been subject of a police investigation. In October 2013, they had heard about the LADO's concerns regarding his difference of opinion with the school regarding the needs for referral to the Disclosure and Barring Service (as outlined in paragraphs 8.41-64 of this report). On receipt of this information from the LADO, the Independent Schools Inspectorate referred the concerns on to the Department for Education. The school remain concerned that although they knew that the LADO had contacted the Department for Education they had not been told of the reasons for the referral or the procedures being followed.

- 13.10 The emergency inspection was commissioned at the end of November 2013 and took place three weeks after the start of the Spring term. This allowed for the right team to be assembled and that there was time to gather pre-inspection information and prepare thoroughly. The focus of this inspection was specifically on safeguarding, whereas the routine inspections carried out previously including the one which occurred a year earlier in March 2013 looked at all applicable standards. In contrast with earlier inspections, the team carrying out the 2014 inspection also had the benefit of contextual information from the Department for Education regarding two recent allegations which enabled them to shape the inspection accordingly. This single focus on safeguarding and the time available enabled the questioning, evidence gathering and analysis to be more focused than for the 2013 inspection.
- 13.11 At the emergency inspection, St Paul's and Colet Court failed the following Education (Independent School Standards) (England) Regulations 2010 ("ISSR") standards and The National Minimum Standards for Boarding Schools January 2013 ("NMS"):
- ISSR 7 (safeguarding arrangements);
 - ISSR 8 & MNS 11 (safeguarding arrangements for boarding schools);
 - ISSR 19 (suitability of staff);
 - ISSR 22 (central register of appointments – now known as the single central register);
 - NMS 14.1 (safer recruitment).
- 13.12 The advice note sent to the Department for Education clarified that ISSR 7 and NMS 11 were not met because the school's child protection policy did not have regard to guidance issues by the Department for Education and ISSR 8 is automatically not met where there is a failure to meet any of the National Minimum Standards. Specifically, at that time:
- the process for reporting concerns was unclear;
 - the policy contradicted itself in relation to the handling of allegations;
 - reporting lines were unclear;
 - the referral process was undermined by various "caveats and thresholds";
 - there was a lack of clarity around staff training and the role of the designated safeguarding person;
 - there was a lack of clarity around working with the LADO and LSCB;

- weaknesses in the implementation of the policy were identified: incomplete safeguarding training records; insufficient proprietorial oversight; uncertainty among staff as to safeguarding lines of communication.

13.13 The Department for Education determined that the inspection had identified “serious failings” and required the school to submit an action plan. There then followed a challenge from the school as to the definition used to determine that the failings were “serious”. From the school’s perspective, the shortcomings mainly related to record keeping and were minor, technical breaches rather than material breaches affecting the safety of pupils. The school have told the review that they remain concerned that the original inspection report did not specify the number or exact nature of shortcomings, so it was not possible for materiality to be assessed from the contents of the report and it is their view that the breaches were technical. The independent reviewers do not accept that this was the case since the advice note giving the details of the issues of concern (see 13.12 above) was sent to the school on 7th April 2014.

13.14 The Department for Education have told this review that they did not accept the school’s argument that the failings should not be defined as serious and wished to move the situation on. A minister from the Department for Education therefore contacted the Mercers to ask for their assistance in resolving matters. From the Mercers’ perspective the purpose of any such meeting was to explain that they had little jurisdiction and the governors were responsible for any response. A final action plan was eventually agreed and approved by the Department for Education and the school passed the follow up monitoring inspection in October 2014.

13.15 This episode raises three issues. One is the issue of ‘materiality’ in inspection judgements. The notion of materiality, derived from the Human Rights Act, has now been introduced into inspection guidance. This permits inspectors to take a holistic view of all the inspection evidence, and to base their judgements on whether a standard has been met in all material respects. This in effect screens out the possibility that a school will fail an inspection on technicalities. However, this would not have changed the judgement in 2014 as the review has been informed that if such failings were identified in a school today, they would be considered to be material and the school would be judged to not meet the applicable standards.

13.16 The second linked issue relates to whether there is a need for objective criteria to define what is deemed to be a serious failing. This remains an issue for the school who argue that criteria should be published by the Department for Education. Having discussed this matter with the Department for Education and the Independent Schools Inspectorate this review does not make a recommendation that criteria are needed. The clear expectation of the inspection standards⁴⁵ is that children will be safe and well educated if all standards are met. In effect these standards are the criteria and if there are material failings (see 13.15 above) then these are serious. The use of the word “serious” by the Department for Education has no real impact beyond the reputation of the school and does not affect the safety and wellbeing of children.

⁴⁵ Currently these are set out in The Education (Independent School Standards) Regulations 2014.

- 13.17 The third issue relates to the continuing need for clarity about the role of The Mercers in the governance of the school. There is no reason to believe that lack of clarity is intentional, but arrangements are complicated and a challenge to understand for anyone outside the system. It is of concern that the governance structure was unclear to the Department for Education and therefore the Independent Schools Inspectorate whose inspectors rely on the registration information published by the Department for Education. Regulatory activity is an important element of the safeguarding system and to be efficient and effective there needs to be a greater degree of clarity about where ultimate responsibility for good practice sits in any organisation.
- 13.18 During this review it became clear that the school, LADO and Charity Commission and knew of an incident in 2018 when a member of staff had been arrested but the inspectorate were not aware of this. Although technically the Independent Schools Inspectorate did not need to be informed until the next inspection, the view of the ISI (and serious case review panel) was that it would be best practice for information sharing to take place as soon as a serious incident comes to light. ISI have raised this issue with the Charity Commission and the Department for Education and the formal information sharing protocol is being reviewed to clarify the information flow between the Charity Commission and the Department for Education when they become aware of a serious incident.

Teaching Regulation Agency and Disclosure and Barring Service

- 13.19 The Teaching Regulation Agency (TRA) has responsibility for the regulation of the teaching profession, including misconduct hearings and the maintenance of the database of qualified teachers. Prior to April 2018 this function was carried out by the National College of Teaching and Leadership (NCTL).
- 13.20 Guidance is clear that employers have a statutory duty to consider referral of cases involving serious professional misconduct to the Teaching Regulation Agency. Where a teacher's employer has dismissed the teacher for misconduct or would have dismissed them had they not resigned first, they must consider whether to refer the case to TRA.⁴⁶ The standard of proof used by the TRA in deciding whether to issue a Prohibition Order is "balance of probabilities" rather than "beyond reasonable doubt" the standard in criminal proceedings.
- 13.21 The prime motive of the ex-pupil who made an allegation against the teacher who worked at St Paul's in the 1980's and was eventually found not guilty was to prevent future work with young people, but because of the verdict no referral was made by the area in which the teacher worked to the regulator (then NCTL). There is a potential gap in the system here with no one organisation or professional seeing it as their responsibility to notify TRA of such a circumstance, although the TRA told this review they would expect to be notified. The reason for notification is that the standard of proof for the TRA is "balance of probabilities" rather than "beyond reasonable doubt" as used in criminal proceedings, and there is a need to assess the information in this light. The experience of the TRA is that in some areas the police do notify, but the Metropolitan Police do not understand this to be

⁴⁶ <https://www.gov.uk/guidance/teacher-misconduct-referring-a-case#referrals-by-employers>

within their remit. The Department for Education told the review that the LADO could undertake such a notification, but the LADO involved in the area where the member of staff was living did not understand this to be their role where there had been a not guilty verdict. The expectations of LADOs and Police in these circumstances needs to be clarified in statutory guidance in order to make sure the proper assessments are made and the potential for future harm to pupils is reduced.

13.22 St Paul's have drawn the attention of the review to a gap in regulatory provision when a member of staff is convicted. In two cases there has been a delay of several months in the member of staff being placed on the barred list following conviction. In relation to the most recent conviction in 2018 an e-mail to the school from the Teaching Regulation Agency informed them that the *TRA's case will therefore be placed into abeyance whilst this matter is being considered by the DBS*. When this point was raised by the school with the Disclosure and Barring Service, they were informed that although this specific case could not be discussed, all correct processes had been followed. If that is the case, there is the possibility that within a delay of several months when the teachers name is neither barred by the DBS nor prohibited from teaching, they could find paid or unpaid work with children. At the very least a system needs to be in place that enables a swift prohibition of a teacher when convicted of an offence against children.

13.23 The TRA confirmed to the school that if the disclosure and barring service put a teacher on the children's barred list then this automatically bars them from working with children for the time they are on the list. This means that the TRA does not carry out a hearing and the teacher is not named on the TRA prohibited teacher list, because the DBS barring decision effectively bans them from teaching children during that period. The TRA confirmed that in such cases the automatic teaching ban is therefore only for the length of time the teacher is on the DBS barred list. The TRA do not look at the case further so do not assess whether in the TRA's view the teacher should be banned from teaching children for longer.

14 DAY TO DAY SAFE PRACTICE

14.1 St Paul's provided the review with a large amount of information setting out their present policies and procedures aimed at complying with national standards and moving beyond these to setting a high standard of safeguarding practice. Much work has been done and other inspections and reviews have complimented the school on their rigorous approach to ensuring that they have a robust safeguarding framework in place, as is expected within UK schools. Progress has been commented on in section nine of this report and as in all organisations there will be areas for further learning and improvement.

14.2 The main focus of this section of the report is on lessons for day to day 'safe' practice emerging from knowledge of past abuse at the school. These lessons are relevant for all schools and in some cases other organisations who provide activities for children and young people.

Recruitment

- 14.3 There has been a great deal of focus in recent years on improving practice in recruiting staff to roles where they are working with vulnerable groups. Guidance for schools⁴⁷ sets out in detail expectations regarding all aspects of staff recruitment and from the evidence seen by this review St Paul's is now fully compliant.
- 14.4 Before the advent of national safeguarding guidance, recruitment practices at St Paul's and other institutions were loose and judged by today's standard unsound. There are examples within the case studies that informed this review of:
- St Paul's receiving references that did not disclose a candidate's previous conviction for a sexual offence against children (see paragraph 6.27);
 - St Paul's allowing an alleged perpetrator to resign and then giving a positive character positive reference; albeit for a job not working with children (see paragraph 8.36).
- 14.5 St Paul's did give a reference in 2016 to another school (agreed with the LADO) noting that a member of staff had supplied pupils with alcohol in an inappropriate context and another allegation had been investigated and found to be unsubstantiated. They were surprised that no contact was received from the other school for further information. This was not in line with expected practice at St Paul's as since September 2016, St Paul's has always obtained verbal verification of all references, even though this is not a statutory requirement.
- 14.6 Schools, like any employer, are under no legal obligation to provide any reference and employers commonly only confirm that the person worked for them and supply relevant dates. However, receiving schools are obliged to 'have regard to' statutory guidance which states that references should always be obtained, they should be scrutinised and should ensure that all specific questions have been answered satisfactorily. Any past disciplinary action or allegations that are disclosed should be considered carefully. Here, the school appointing the member of staff above clearly did not feel that they needed clarification, although St Paul's were surprised not to receive a phone call given the contents of the reference. In these circumstances the outgoing school could refer their concerns to the relevant inspectorate or the Department for Education. While there is no statutory requirement to report such matters to the inspectorate, St Paul's were encouraged to do so following discussion of this case at the serious case review panel, and the school informed the Independent Schools Inspectorate. In order to prevent any room for doubt this review is recommending that all schools should obtain verbal references, alongside written references from the previous employer following the decision to appoint a member of staff. This is discussed further in Finding Four.
- 14.7 One case that caused concern amongst many ex-pupils related to the appointment of a teacher to replace a member of staff who had been arrested in 2013 for the possession of indecent images. The teacher appointed had been a previous pupil and member of staff at St Paul's and had been subject to an allegation of inappropriate conduct (not relating to children) which had received press attention whilst working at another independent school.

⁴⁷ Department for Education (2018) *Keeping Children safe in Education*. Pages: 29-50

One important issue here which is beyond the scope of this review is whether this school should have notified the body regulating teachers at that time since this was behaviour that could bring the profession into disrepute.

- 14.8 In appointing this member of staff, St Paul's carried out all the required employment checks and because neither reference was from his last employment, the head teacher at Colet Court (who was aware of the alleged inappropriate behaviour with an adult) spoke to the previous school and received confirmation that there were no questions about the teacher's suitability to work with children and later put this in writing. The High Master was aware of this decision. The school's submission to this review notes that: *The issue is whether appointing someone against whom there had been an unsubstantiated allegation of a legal indiscretion six years earlier was appropriate or not. In September 2013 this was judged acceptable.*
- 14.9 Although St Paul's did not breach any statutory guidelines in making this appointment, this situation reveals the limitations of an understanding of safeguarding which focuses solely on procedural compliance. It is a failure to act in the spirit of the guidance and to use safeguarding initiative on behalf of other children. The appointment of a teacher where there were public allegations regarding an indiscretion (with an adult), to replace a teacher who had been accused of possessing sexual images of children was extremely poor judgement. Firstly, trust that boundaries will be maintained is an all-important aspect of safeguarding and this teacher had been accused of boundary violation and breach of trust. Secondly, in 2013 it was extremely important to give boys at the school the message that, in the light of the recent arrest of a member of staff the ultimate focus was on keeping them safe and that the staff group could be completely trusted to maintain appropriate boundaries at all times. The allegations about this teacher were common knowledge amongst many pupils and parents and his appointment gave completely the wrong message about the school's attitude to safeguarding. It is however important to note that the school did take action to remove this teacher in 2014 and risked legal action under employment law in asking him to move on.
- 14.10 For some ex-pupils, the above episode illustrates the power of the "old boy network" and past allegiances outweighing all else, with the teacher concerned having been both a pupil and a former teacher at the school. The school refute this and have told the review that this appointment in fact came about because the teacher's subject was *is a highly specialist and scarce subject, these are bright boys and getting a [specialist teacher in this subject] at short notice is very difficult.* There is no evidence that the teacher concerned represented a threat to children, but for some ex-pupils it is indicative of a culture which does not recognise the risks associated with staff teams built on past and current informal networks and fits with the culture that they experienced during their time at the school where the pursuit of academic excellence has overridden all else. The review accepts that the aim of the current senior management team is to put the mental wellbeing of pupils first and there is evidence of innovative thinking and practices associated with this focus. However, the imperative to meet high academic standards whilst focusing on the safety and wellbeing of pupils is a current issue for all schools (not confined to the independent sector) and this example is illustrative of the complexities of this process.

14.11 Although the current High Master has been focused on modernising the school and recruiting and developing a staff team with a much wider range of background experiences than previously, there is no room for complacency. Where a staff group is recruited from a pool of staff who have all been through a similar educational system, it will take time for well-established cultures to change and for unhealthy attitudes and beliefs to be challenged. The governing body will need to be committed to ensuring the current positive approach to ensuring compliance with recruitment standards achieves diversity and a culture where any entrenched attitudes and values are challenged.

Listening to pupils

14.12 Listening to children is a cornerstone of good safeguarding practice yet it is an aspect which can become a trite phrase rather than a phrase with real meaning.

14.13 The education system is by its very nature based on a power imbalance between child and teacher, and there is ample evidence that, in the past, former teachers at St Paul's used this to their advantage while working at the school. Pupils who were abused, for a variety of reasons set out elsewhere in this report, did not speak out about what was happening or have been ignored.

14.14 In recent years, the school have focused on developing a culture where pupils can express any concerns. The internal safeguarding review completed by Barnardos in 2018 commented that:

Pupils have numerous ways to report any concerns they may have and the school has tried to create a culture of 'let's talk' about issues. When pupils start at the school they are given a Prep/Homework diary which contains details of who to go to if they are worried or concerned. Young people have been involved in creating some video clips to help other children around emotional health and wellbeing. Pupil surveys take place annually across both schools and the Governing Body receives and scrutinises these, taking forward any actions agreed to be necessary.

Pupils are buddied up with older boys for support and there are comments/concern boxes available for pupils to use anonymously. Teachers and upper 8th boys respond to anonymous email queries through the 'Anything to Say' mailbox and Tutor groups are also used to encourage discussion among pupils about worries or concerns. There is evidence that when a pupil raises concerns that these are acted upon appropriately....

The pupils consulted stated that they feel well supported and appreciated the many talks given to them about keeping safe. They clearly knew who to talk to or what to do if they felt unsafe and named a range of people they could talk to or methods through which they could report concerns e.g. Heads of Year, Form Tutor, welfare boxes.

14.15 The review understands that the mailbox system is currently for the junior school pupils only and a similar anonymous reporting system could usefully be developed for senior school pupils.

14.16 It is interesting that the concerns raised by pupils about AP8's behaviour in 2013 followed child protection awareness training being given to all prefects and it was one of these

prefects that made the allegation. Empowering young people through knowledge about what behaviour they should expect from those in positions of authority may be an area for further development through the PHSE curriculum.

Relationships with parents: the tutorial system and safeguarding practice

- 14.17 Along with other schools in both the maintained and non-maintained sectors the degree to which St Paul's School has encouraged parental involvement in their son's education has evolved over time. Pupils educated at the school in the 1960's and early 1970's typically spoke about a distance between school and home with parents handing their sons over to the school and having little involvement in their education. If any boys criticised the sometimes harsh or physical punishments the usual parental response was to assume the boy was in the wrong. This would have been in line with a general hierarchical culture within education at the time where the teacher's authority would not be questioned. The message *whatever happens at school stays at school* would have facilitated a splitting between school and home (particularly for boarders) which would have made it unlikely that parents became aware of abuse by teachers.
- 14.18 The challenges which parents experience in complaining about any aspects of their son's life in school have been explored elsewhere in this report.
- 14.19 St Paul's has a well-developed tutorial system which encourages a close relationship between individual boys, tutors and their parents. This tutorial system allocates each senior school pupil to a tutorial group which meets daily and consists of boys from a cross section of all year groups. The boy usually remains with this tutor and the tutorial group for the duration of his time at the school and care is taken in matching boys with tutors. Where the relationship is not working well changes can be made. The role of the tutor is to provide mentorship and support with the pupil's academic and pastoral progress and as part of this to maintain a close working relationship with the boy's parents. It is traditional for parents to invite the boys tutor to the family home for a meal, and staff told the review that this provides the tutor with the opportunity to understand the boy's home environment and make them more approachable to the family. The school website notes that: *the rapport that a boy and his family develop with his tutor lasts throughout his time at St Paul's School and often beyond.*
- 14.20 Staff spoken to for this review were very positive about the system and a recent school pupil survey found that 87% of pupils surveyed agreed with the statement that they could talk to their tutor about things that were worrying them or if they needed advice. Of the remaining 13%, 5% said they would not talk to their tutor with remaining 8% saying they had no view or did not know.
- 14.21 In addition to the positive aspects of the system there are risks associated with the system which need to be acknowledged and steps taken to mitigate them, preserving the many positive aspects.
- 14.22 In the past, relationships developed between several perpetrators or alleged perpetrators and families that crossed the boundaries from what would be expected in a professional relationship including staying with families in the home. In this way families were groomed

alongside the young person and for boys who were being abused their abuser followed them from school into their home. Such risks may also be present in other situations such as a close-knit community where friendships form across teacher /parent boundaries.

- 14.23 The school have thought about issues that were raised by the trial of one of the perpetrators in 2017 and have begun to pilot a co-tutor system which involves more than one tutor working with a tutorial group. This should reduce the likelihood of exclusive or “special” relationships forming which could be exploited by the member of staff.
- 14.24 Many of the 59 ex-pupils spoken to for this review, most of whom had not been abused, questioned why a part of the approach involves tutors being invited to family homes. One parent has also told the review that this can feel uncomfortable, pupils dislike it and the role of tutor could be developed without this expectation. Another ex-pupil believes that the fact that his parents did not invite his tutor home was held against him. There seems to be no good reason why this practice needs to continue. Informal relationships may already exist or develop as they do in any community and in that case will need to be disclosed to the school via the neutral reporting system (see para 9.10). This gives a message that care needs to be taken where boundaries become fluid rather than encouraging formalising the arrangements via the current system.

Alcohol in school

- 14.25 Not all pupils remember that alcohol use by pupils was tolerated at the school, but the chronologies and accounts of pupils are clear that alcohol played a part in much of the abuse that took place.
- 14.26 It is clear that in the past there was a high level of tolerance where staff were known to have an alcohol problem, and this is sometimes described as a source of amusement to the boys. Other ex-pupils have spoken of staff going to the pub at lunchtime and returning inebriated. Allegations about the use of alcohol by staff were as recent as 2013 and there are examples within the cases analysed for this review which illustrate the dangers associated with the fraternisation and blurred boundaries that can result.
- 14.27 In relation to pupils, the modern school has a policy which allows for alcohol to be served (but not sold) to boys aged 16-18 with parental permission at society/club dinners and on school trips (in line with legislation of the host country). This is likely not to be dissimilar from other schools in both state and independent sector. An initial trawl of local authority procedures in relation to staff use of alcohol only found one (Surrey) where there is a zero-tolerance approach to staff and alcohol and the St Paul’s code of conduct does allow for staff to drink alcohol within the boundaries of the code.
- 14.28 There is emerging scientific evidence about the impact of alcohol on children and the current advice from the chief medical officer is that no child should drink alcohol under the age of 15 and between age 15-17 this should always be in a supervised environment. The guidance goes on to say that: *Parents and young people should be aware that drinking, even at age 15 or older, can be hazardous to health and that not drinking is the healthiest option for young people.*

- 14.29 Although the policy at St Paul's is in line with the law and the guidance, there is the additional issue of the part that alcohol plays in blurring boundaries and increasing vulnerability. This was a factor in the abuse of children at the school and the view has been expressed strongly by one victim (where alcohol was a factor in his non-recent abuse) that alcohol should not be allowed at all.
- 14.30 In addition, the review was informed that one of the reasons that the Teaching Regulation Agency dropped the case against one teacher from St Paul's was that the school had a policy that permitted use of alcohol at meals and this would be used by his defence.
- 14.31 Alcohol use is embedded within English culture and there is an argument that young people should be taught to use alcohol sensibly. It is arguable whether this should take place within an education environment. Taking account of these factors and the increasing medical evidence, schools may wish to consider banning the use of alcohol by pupils and staff on school premises (as they would tobacco) and extending this ban for school events off site, for example residential visits.
- 14.32 At a national level, given the strong message from the Department of Health, the Department of Education should review all the evidence and give a clear steer to schools as to the expected standards of practice.

15 FINDINGS & RECOMMENDATIONS

Finding 1:

Accepting responsibility for past abuse must be a foundation for moving forward and developing an effective safeguarding culture.

- 15.1 St Paul's School is a registered charity and the governors of the school are the charities trustees. Trustees must act in the best interests of their charity⁴⁸ and report any serious incident that may harm its reputation. Acting in the best interest of the charity and a focus on reputation runs the risk that trustees will seek to minimise public exposure of abuse allegations rather than understanding that the reputation of organisations will be enhanced by admitting mistakes and accepting responsibility. It is through openness and honesty about what went wrong that safeguarding will be improved in the future. This link between promoting the reputation of the charity through reflecting on mistakes and engaging willingly with investigations and inquiries could be enhanced in the Charity Commissions guidance for trustees.
- 15.2 There are many and varied views as to what "taking responsibility" for what happened in the past means and how best to do it. For some people who have been affected by the abuse, an apology and compensation are enough, for others, resignations of some senior managers or governors is a demonstration that responsibility for the past has been accepted. For others the most important aspect of accepting responsibility is to ensure safeguarding practice within the school is as strong as possible and to put right what went wrong in the past. Conversations with survivors of abuse at St Pauls have identified that

⁴⁸ <https://www.gov.uk/government/publications/the-essential-trustee-what-you-need-to-know-cc3/the-essential-trustee-what-you-need-to-know-what-you-need-to-do#s6>

an important aspect is a clear statement from the school that they accept responsibility for the past abuse of pupils.

- 15.3 This review has found that, within this context of competing views, finding the right approach has been a challenge for St Paul's School. The intention of the current senior management team and governing body has been to do the right thing through being open and transparent with the school community and apologising to those affected at the end of the criminal trials. It is the opinion of the independent reviewers is that the school has not always been sufficiently sensitive in their use of language (verbal and written) and have at times inadvertently given the impression that the needs and feelings of survivors and other affected ex-pupils are not important.
- 15.4 The review has found no evidence that the current senior management team or governing body have attempted to cover up what happened in the past, but it has found that they have not issued a clear statement that accepts responsibility for the abuse experience by past pupils although they thought they had done so. They were also slow to offer a general apology to *all* pupils who had made allegations of abuse at the school. The first information about the extent of allegations of non-recent abuse was in 2014 yet the apology that included all past pupils was not sent until September 2018. The apology in the Old Pauline Magazine on 2017 focused on those affected by the criminal trails and was not sufficiently clear that it was directed at any pupils who had been affected by abuse at the school at any time. This has been an area of discussion and learning through the review period and the High Master has now sent two letters to the school community which were intended to explicitly express sorrow and regret at what has happened and clearly apologise to those who have been affected.
- 15.5 There are several factors contributing to the delay in issuing a general apology and this has been explored in paragraphs 8.18-8.21 above. Significantly, this was a new situation for the school for which they were not prepared, and they relied on guidance from statutory agencies. The police informed the school that they could not contact ex-pupils and the school would not have details of individuals who had made allegations. Although the school were making plans as to how to respond, planning an appropriate response was also hindered by a breakdown in trust between St Paul's School and the multi-agency partnership and gaps in the overall strategic planning for this complex inquiry. This is explored further in Finding Three.
- 15.6 The review has found evidence that a culture existed in the past where abuse was not identified and dealt with properly. Although some of the responses by past senior leaders were not dissimilar from those in other organisations⁴⁹, this does not excuse behaviour which fell short of expected standards and the knowledge that was available within the professional community at the time.⁵⁰
- 15.7 Finding the best way to accept responsibility and move on to embed cultural change within St Paul's and other schools who have a similar experience the school could be greatly

⁴⁹ See for example reports in respect of Jimmy Saville and evidence submitted to the independent Inquiry into Child Sexual abuse in respect of the Church of England.

⁵⁰ For example, in 1993 the report into abuse at Castle Hill School had been published, exploring the dynamics of sexual abuse in a residential school and called for more stringent checks for school staff.

helped by using the expertise of ex-pupils and survivors of abuse where they are willing to do so. Using their experiences to frame current practice and responses is a positive way to helping the current community to engage with the pain of past experiences, learn from them and move beyond the danger of a simple compliance with procedures to a real understanding of reason for practice change. The school and the LSCB chair jointly agreed that they should begin this process by having a staff member attend every day of the trials and they used this information to review practice. They also intended to contact ex-pupils through the internal review carried out by Barnardo's but this did not happen in order not to duplicate the work of this serious case review. Now all statutory processes are complete, engaging positively with ex-pupils as part of the process of embedding and maintaining cultural change will be an important aspect of future practice.

Recommendation 1a

St Paul's School should issue a clear unambiguous statement that they accept full responsibility for the past abuse experienced by pupils at the school.

Recommendation 1b

The Department for Education should support all schools where there have been non-recent abuse allegations to engage with survivors of abuse in order to use their experience to reflect on their response to non-recent abuse and consider learning for the future.

Recommendation 1c

St Paul's School should engage directly with survivors of abuse at Board level and consider co-opting a survivor of abuse to the Board of Governors.

Recommendation 1d

The Charity Commission should make explicit their expectations regarding best practice at times of crisis and specifically that protecting the reputation of the charity includes openness and honesty about any poor practice.

Recommendation 1e

The Department for Education should require schools (state maintained and independent) to have a communication strategy in place for situations where there have been allegations of abuse against a member of staff. This strategy should draw in advice and support from statutory agencies and take account of current Statutory guidance regarding confidentiality and also take full account of learning from survivors of abuse in such situations.

Finding 2:

Schools face difficulties in balancing a response to allegations of abuse that takes account of employment law, education legislation and good safeguarding practice. This can result in an unintended message to pupils that concerns about abuse should be kept secret.

15.8 This review has found that school's response to allegations of abuse involves balancing the requirements of employment law, education legislation and best safeguarding practice. Best safeguarding practice, based on positive relationships with children, involves

developing an open, honest culture where the possibility of abuse is always on the table and there can be a swift response to preventing staff who may pose a risk from having contact with children. Pupils and staff need to feel able to explore worries about the behaviour of colleagues, and there needs to be a system whereby accumulating concerns can be shared.

- 15.9 This needs to take place within a legislative context which promotes fairness in the treatment of staff against whom allegations are made, protecting their right to anonymity whilst investigations take place and preserving their employment rights.
- 15.10 This complex system was not always understood by everyone involved and most worryingly it can be interpreted by pupils as an imperative to keep quiet and not talk about the possibility that abuse could take place within the school.
- 15.11 Schools may also receive apparently conflicting advice from lawyers specialising in specific aspects of the law and safeguarding professionals.
- 15.12 At the very least, the inherent tensions within the system need to be more clearly spelt out in safeguarding guidance and this translated into information given to the school community. One positive move forward suggested to the review team would be for the Education Act to develop the same approach as the Children Act to establishing a paramountcy principle regarding the safety and welfare of pupils. The school has queried what would happen in the case of malicious/unfounded allegations but it the view of the review panel and lead reviewers that where *any* allegation occurs the starting point should be pupil safety and welfare.

Recommendation 2a

The Department for Education should ensure that national guidance to schools on safeguarding practice is clear about best practice in managing the tension between employment law, education legislation and safeguarding practice. Schools should ensure that the whole school community understand its impact on managing allegations and that it should not have a negative impact on pupil's coming forward to express concerns about the behaviour of a member of staff by making the needs of the child their paramount concern.

Recommendation 2b

The Department for Education should consider embedding the principle that the child's welfare is paramount into education legislation in order to assist schools in making decisions when there appear to be competing alternatives.

Finding 3:

Safeguarding partnerships must make the quality of relationships within and between individuals and agencies a top priority in order to provide a high support/high challenge environment which will promote effective safeguarding practice.

- 15.13 In relation to the non-recent abuse at St Paul's School there was no evident relationship between the school and the statutory agencies prior to 2013. As a result, when there were

issues of concern the school did not consult with outside bodies and managed situations where there were any concerns about staff behaviour internally. This would not have been different to many other similar institutions at the time.

- 15.14 The lack of any historical relationship meant that in 2013 when the school did have cause to liaise with the LADO there was no foundation on which to build, and when each challenged the other his escalated quickly into unhelpful defensiveness. There were problems on both sides, with the school not following expected practice in 2013⁵¹ ⁵² by interviewing pupils who had made an allegation before referring to the LADO and the LADO service not always communicating effectively with the school. For example, there was no dedicated minute taker resulting in late minutes and although the LADO told the school that they were referring concerns about the school to the Department for Education they did not provide full written details of the rationale for this action. The situation in both respects has now changed as there is now evidence that the school always promptly refer to the LADO and the LADO service in Richmond is now organised to provide an efficient service.
- 15.15 The lead reviewers have discussed the sequence of events in 2013 with both the LADO and the school and reviewed written information from both parties. As a result, they have formed the view that the school had good reason to question aspects of the LADO service but equally the LADOs advice to the school was appropriately focused on making sure that all relevant steps were taken to ensure the safety of the pupils. Of concern is the way in which the relationship between the school and the LADO so quickly deteriorated. Rather than attempting to understand each other's point of view and resolve professional differences the debate became polarised and defensive on both sides.
- 15.16 This tendency for the senior leaders at the school to become defensive when challenged was an issue raised by a range of individuals and organisations who contributed to this review. This is explored elsewhere in this report: (see for example 11.8 and 12.4)
- 15.17 This lack of trust between the school and the local authority in 2013 did not provide a good foundation when, following the abuse allegations in 2014, the LSCB aimed to work with the school to understand what lessons had been learned and the effectiveness of the current safeguarding arrangements at the school. From the perspective of the school, the LADO and the LSCB were one entity and concerns about the LADOs advice in 2013 affected their perceptions of the Board's role from 2014 onwards. Scrutinising learning and current practice was an appropriate role for the Board but an additional complicating factor was that relationships and communication *within* the LSCB and its constituent agencies was causing misunderstandings, and this prevented a coherent and planned approach to working with St Paul's.
- 15.18 There was a similar deterioration in relationships as had been experienced in 2013 with legitimate concerns from the school about the accuracy of a report prepared by the professional advisor for the serious case review subgroup. This report had been requested by the group in order to facilitate decision making as to whether a serious case review

⁵¹ As in 'Safeguarding children and safer recruitment in education' (December 2006).

⁵² HM Government (2010) *Working Together to Safeguard Children* Page 359. Paragraph 14.

should take place. Relationships should not have deteriorated in the way that they did, and it is the view of the lead reviewers that the LSCB did not always address all the concerns of the school speedily through clear communication and this was frustrating for the school. In addition, the school did not always appreciate that they were (and are) perceived be a powerful institution and can be unaware of the impact of their own communication style on those who are used to a less combative approach to challenge.

15.19 These problems in relationships developed in the absence of a positive relationship with local authority children's services which could have provided support to the school alongside the challenge from the LADO and LSCB and helped the school in the development of their safeguarding practices.

15.20 Support by the local authority's education safeguarding team to schools outside the local authorities control varies from local authority to local authority with some providing a totally free service and other's working with service level agreements and charging structures. There is no national requirement and it is down to individual schools to understand the local provision and access this accordingly. This case demonstrates the importance of good relationships with the local authority and consistent support to all schools who are dealing with complex safeguarding matters. This should not be confused with the very specific role that the LADO fulfils in providing oversight of allegations of abuse in organisations.

15.21 Reviewing all of the above, a key finding of this review is that relationships matter. Multi-agency partnerships need to be fully functioning with strong, positive relationships between members if they are to effectively challenge each other and external institutions.

Recommendation 3a

National safeguarding guidance should be clear that the foundation of safeguarding partnerships is the golden thread of relationships between agencies and this must be the lens through which safeguarding is planned and executed.

Recommendation 3b

There should be a national requirement for local authorities to provide a system of quality assured local safeguarding advice and support for *all* schools which is beyond the LADO role. All schools should be expected as part of the inspection process to demonstrate that they are aware of local resources and that they are sourcing appropriate advice and support service.

Finding 4:

There remain gaps in the national safeguarding system in relation to the recruitment and regulation of teachers, the Disclosure and Barring Service and the way in which information is shared across national organisations.

15.22 Whilst policies and procedures cannot on their own keep children safe, they provide an important framework for practice. The review has found that although the recruitment system is much improved, employment law dictates that unsubstantiated concerns about a teacher's behaviour within the school should not be included within a reference. It is up to

the receiving school to decide whether any information within the reference should be followed up verbally or in writing. It is common in other organisations with responsibilities for children to always follow up a reference, usually with a telephone conversation, when the decision had been made to offer a position and this is part of established safe recruitment training. St Paul's have included this non-statutory requirement as part of their safer recruitment procedures and extending this as a requirement for all schools is a subject of a recommendation from this review.

- 15.23 It was of concern that during one investigation into allegations made by a pupil that the member of staff concerned worked as a volunteer in a residential activity organisation and this organisation did not wish to engage in dialogue with the LADO. It is also of interest that more than one teacher against whom allegations were made worked in outside school activity settings. This highlights the importance of the government's current work on developing a code of conduct for such organisations.
- 15.24 Another area of concern was the finding that the Teaching Regulation Agency had not received any notification in respect of the teacher where there had been a not guilty verdict. Notification should have been made by the LADO and/or school in the area where the arrest took place either at the point of arrest or when a verdict was reached. From the Teaching Regulation Agency perspective in some areas the role of notifying them following a not guilty verdict falls to the police although this is not the case in the Metropolitan Police area, The standard of proof for the Teaching Regulation Agency is (balance of probabilities" rather than " beyond reasonable doubt") and there should have been a thorough investigation as to whether this teacher should have been prohibited from teaching.
- 15.25 One further gap in the system that St Paul's helpfully brought to the attention of the review is the time that it can take to prohibit a teacher from teaching following being found guilty of child abuse offences. In two cases this took several months to place them on both the barred list via the Disclosure and Barring Service and the prohibited list by the Teaching Regulation Agency. This potentially allows the person concerned to work with children in the meantime and the system needs to be streamlined to speed up the process.
- 15.26 It became clear during this review that the Independent School's Inspectorate was not aware of the investigations regarding a recent perpetrator although the Charity Commission had automatically been informed as this was a serious incident. Further discussions between the Independent Schools Inspectorate, the Department for Education and the Charity Commission highlighted the need for an information sharing protocol between the three agencies in order to make sure that all relevant information can consistently be collated and taken account of.

Recommendation 4a

The Department for Education should strengthen the safer recruitment guidance to ensure a fair and consistent process is in place in all schools for the verification of references which satisfies first the need to protect children and then the requirements of employment law.

Recommendation 4b

The proposals by the Department for Education for a code of practice for out of school settings should become expected practice and include the need to cooperate fully with the LADO when a member of staff has been identified elsewhere as possibly posing a risk to children

Recommendation 4c

The Department for Education in collaboration with other state departments should clarify who has responsibility for notifying the Teaching Regulation Agency when there is a not guilty verdict in a trial involving a teacher.

Recommendation 4d

The Department for Education should lead an immediate review of the system to eradicate the time lag between an offender's conviction and appearance on the Disclosure and Barring Scheme barring list, in order to remove the possibility that an offender could obtain voluntary work with children. In addition, the Teaching Regulation Agency must be notified of a conviction immediately so that an interim prohibition order can be issued, which would flag concerns to all prospective employers within the education system.

Recommendation 4e

The Charity Commission and Department for Education should consolidate their current discussions regarding information sharing and developed a protocol to guide action in the future.

Finding 5:

The procedures in London for police and the multi-agency partnership do not provide sufficient clarity as a foundation for managing complex investigations in these circumstances.

15.27 This review has found that police investigations generally worked well and these investigations resulted in six convictions of former staff from St Paul's School. In one case there are some areas where the individual investigation could have been improved and this has been subject of an internal review by the police. From consideration of this case the issue of support and supervision of officers with responsibility for investigations became apparent. Investigating child abuse may be stressful and all professionals need to manage a range of feelings and emotions and consider how these may be affecting their practice. Traditionally investigating police officers have a great deal of autonomy and there is minimal time for the type of reflection and supervision that is common in other professions. This should be an area for practice improvement.

15.28 Although most survivors were positive about the criminal process, albeit acknowledging that it was very stressful, the review has found that where there is a not guilty verdict there is room for a more coherent support plan. Further discussion about support for complainants has revealed a gap in provision. Although some forces have resources to appoint a specially trained officer to keep regular contact with complainants this is not the case within the Metropolitan Police and complainants are signposted to other services such as victim support. For complainants without strong family support this may not be

enough, particularly in situations where they may not have wished to tell family and friends about their complaint. This is of significance for child safeguarding as children are likely to be best protected where they are consistently well supported regardless of age and the recommendation from this review is that there should be a national system of advocacy and support for complainants- both children and adults.

- 15.29 The review has also found that there is a need for greater clarity in the multi-agency management of complex inquiries and that communication between partner agencies and the school does not always work well. This is particularly so where there are inquiries into non recent abuse alongside those focusing on current allegations. The split in the system for investigation within the police means that there is an even greater need for an overarching system of communication between all concerned in order to support the school in managing the multi-layered inquiries and communicate appropriately with the school community.
- 15.30 The system of Gold Silver and Bronze group within the police are designed to manage the investigation of complex criminal inquiries and there is a lack of clarity about how these should dovetail with complex inquiries involving safeguarding children where Children's Social Care are required to take the lead through chairing the strategic management meeting.
- 15.31 The most recent conviction of a member of staff who, in 2018 pleaded guilty to arranging to meet a child to commission a sexual offence and inciting a child to commit a sexual act had highlighted the need for absolute clarity and good communication between police and schools regarding when names will be released to the press in order that the school can plan an appropriate communication strategy. This did not work well in the case of P6 with inaccurate information being given to the school. This case has also confirmed that social media platforms could do more to assist police in their inquiries when there is strong evidence that a user of the platform is grooming another and also has current access to children and young people.

Recommendation 5a

The Home Office should establish a system of advocacy and support for complainants (children and adults) in child sexual abuse cases both pre and post-trial in order to ensure consistency between areas.

Recommendation 5b

The Metropolitan Police should establish a system for the supervision and support of officers carrying out child abuse investigations in order to quality assure the investigation process and provide the emotional support required to minimise the likelihood of any bias within the investigation process itself.

Recommendation 5c

The Department for Education and Home Office should review guidance and practice relating to complex abuse investigations in order to make sure that:

- Where there are current police inquiries relating to an institution alongside specified operations focusing on non-recent abuse one strategic management group has oversight of the whole picture and can plan to meet the needs of survivors, current children and the organisation as a whole;
- There is clarity about the link between police command structures via Gold, Silver and Bronze groups and the multi-agency management of complex inquiries.

Recommendation 5d

Home Office guidance should clarify the process of informing interested parties when names of alleged or convicted perpetrators are released to the public and press statements made. All police officers should be aware of the policy and be able to advise others with accurate information.

Recommendation 5e

The Department for Digital Culture Media and Sport should require social media platforms to release information to the police where they have reason to suspect that a suspect has continuing access to children during an investigation into child abuse.

Finding 6:

This review has found a number of areas where practice could develop further, some areas are specific to St Paul's and others have wider applicability.

- 15.32 St Paul's School has responded to the allegations of non-recent abuse with a tenacious approach to reviewing internal systems and improving practice and the current High Master estimates he has spent around 20% of his entire working hours on safeguarding issues since 2014. The school has had its safeguarding provision and procedures reviewed on nine occasions since 2014 and has told the review that has confidence that its current systems and processes are amongst the best in the country.'
- 15.33 Many significant practice improvements have been made but as in any system there will always be more to do. This review has set out a summary of the main areas where St Paul's have responded to internal reviews and national developments by improving their safeguarding systems.
- 15.34 The Badman review in 2015 made recommendations for school governors which have resulted in a governing body focused on monitoring evaluating and improving safeguarding practice. The review by Barnardos in 2017 commented that the annual internal audit carried out by the lead governor for safeguarding *exceeds expectations and is evidence of the school's commitment to ongoing learning, to raising awareness of its safeguarding responsibilities and to ensuring accountability from those working directly with children through to the governors.*
- 15.35 The High Master and members of the senior management team have also made safeguarding a priority and have provided this review with much evidence of the intensive work that has been done by the school, particularly in relation to the mental health of

pupils, staff recruitment and the monitoring of safeguarding practice by the school's safeguarding team and safeguarding committee.

15.36 Developing safeguarding practice is a process of continuous learning for all involved and additional learning has continued with the school as this review has progressed. The following recommendations have developed from discussions with the school and serious case review panel, some of which have applicability beyond St Paul's.

15.37 The following recommendations link to specific aspects of practice discussed in this report and for further detail please see the relevant paragraph.

Recommendation 6a (*paragraphs 14.25-14.32*)

At a national level, given the strong message from the Department of Health, The Department of Education should work with the Department of Health to review the evidence in respect of the impact of alcohol on young people and links with child abuse and give a strong steer to schools as to the expected standards of practice for staff and pupils in day and boarding environments.

Recommendation 6b (*paragraph 12.8*)

The role of GPs within school should be clarified through the development of guidance by the Royal Collage of General Practitioners

Recommendation 6c (*paragraph 7.16*)

The Department for Education should require schools to develop a system of safeguarding supervision for staff which provides an opportunity for reflection on any concerns about the safety of pupils.

Recommendation 6d (*paragraphs 7.29*)

St Paul's School should review communication with its parents in order to strengthen the message that parents are welcome at the school and any concerns or complaints about the wellbeing of their son in school are welcome and will be treated sensitively.

Recommendation 6e (*paragraphs 7.29-30*)

The Department for Education should revise national complaints guidance for schools to ensure that complaints that cannot be resolved informally (stage 1) or by formal internal investigation (stage 2) should always include an independent investigation at the next stage prior to any panel hearing.

Recommendation 6f (*paragraphs 14.19-14.24*)

St Paul's School should stop promoting any expectation that parents invite tutors to the family home for a social visit. Any visits to the home should be formalised and recorded.

Recommendation 6g (*paragraphs 9.13 and 14.15*)

St Paul's School should review their process for anonymous reporting of pupils concerns in the senior school and make sure that it replicates the good practice in the junior school.

Recommendation 6h (*paragraph 12.13*)

St Paul's School should require the counselling service in the junior school to keep contemporaneous notes in line with expectations in the senior school.

Recommendation 6i (*paragraph 14.20*)

St Paul's School should understand any barriers that might be in place preventing pupils from talking openly to their tutors and take steps to overcome them.

Implementing Learning and Monitoring Change: Recommendation for the Local Safeguarding Partnership.**Recommendation 7**

The serious case review panel are aware that what has been recommended may be seen as challenging for both St Paul's School and the Departments of State. Moreover, there is no mechanism for local partnerships to hold Departments of State to account. A panel member has knowledge of the Independent Jersey Care Inquiry and the powerful motivator for change of the recommended review by the same panel two years after publication. For that reason, and given the complexity of our findings, we recommend that a similar short review of progress in about two years would be advisable in this case to consider the progress of the recommendations locally and nationally. The partnership board should consider how best this should be undertaken.

16 SUMMARY OF RECOMMENDATIONS

Recommendation 1a

St Paul's School should issue a clear unambiguous statement that they accept full responsibility for the past abuse experienced by pupils at the school.

Recommendation 1b

St Paul's School should continue to engage with survivors of abuse at the school in order to use their experience to reflect on their response to non-recent abuse and consider learning for the future.

Recommendation 1c

St Paul's School should engage directly with survivors of abuse at Board level and consider co-opting a survivor of abuse to the Board of Governors.

Recommendation 1d

The Charity Commission should make explicit their expectations regarding best practice at times of crisis and specifically that protecting the reputation of the charity includes openness and honesty about any poor practice.

Recommendation 1e

The Department for Education should require schools (state maintained and independent) to have a communication strategy in place for situations where there have been allegations of abuse against a member of staff. This strategy should draw in advice and support from statutory agencies and take account of current Statutory guidance regarding confidentiality and also take full account of learning from survivors of abuse in such situations.

Recommendation 2a

The Department for Education should ensure that national guidance to schools on safeguarding practice is clear about best practice in managing the tension between employment law, education legislation and safeguarding practice. Schools should ensure that the whole school community understand its impact on managing allegations and that it should not have a negative impact on pupil's coming forward to express concerns about the behaviour of a member of staff by making the needs of the child their paramount concern.

Recommendation 2b

The Department for Education should consider embedding the principle that the child's welfare is paramount into education legislation in order to assist schools in making decisions when there appear to be competing alternatives.

Recommendation 3a

National safeguarding guidance should be clear that the foundation of safeguarding partnerships is the golden thread of relationships between agencies and this must be the lens through which safeguarding is planned and executed.

Recommendation 3b

There should be a national requirement for local authorities to provide a system of quality assured local safeguarding advice and support for all schools which is beyond the LADO role. All schools should be expected as part of the inspection process to demonstrate that they are aware of local resources and that they are sourcing an appropriate advice and support service.

Recommendation 4a

The Department for Education should strengthen the safer recruitment guidance to ensure a fair and consistent process is in place in all schools for the verification of references which satisfies first the need to protect children and then the requirements of employment law.

Recommendation 4b

The proposals by the Department for Education for a code of practice for out of school settings should become expected practice and include the need to cooperate fully with the LADO when a member of staff has been identified elsewhere as possibly posing a risk to children.

Recommendation 4c

The Department for Education in collaboration with other State departments should clarify who has responsibility for notifying the Teaching Regulation Agency when there is a not guilty verdict in a trial involving a teacher.

Recommendation 4d

The Department for Education should lead a review of the system for prohibiting teachers from teaching following being found guilty of a child abuse offence, in order to make sure that there is no delay. This should include the TRA investigating and making their own decision regarding length of prohibition from teaching to assess whether it should be for a longer period than the person is on the barred list.

Recommendation 4e

The Charity Commission and Department for Education should consolidate their current discussions regarding information sharing and developed a protocol to guide action in the future.

Recommendation 5a

The Home Office should establish a system of advocacy and support for complainants (children and adults) in child sexual abuse cases both pre and post-trial in order to ensure consistency between areas.

Recommendation 5b

The Metropolitan Police should establish a system for the supervision and support of officers carrying out child abuse investigations in order to quality assure the investigation process and provide the emotional support required to minimise the likelihood of any bias within the investigation process itself.

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17 APPENDIX 1: DETAILS OF LEAD REVIEWERS

Edi Carmi (review chair)

Edi Carmi, qualified as a social worker in 1978 and after a career as a practitioner and manager in both statutory and voluntary sectors, has worked independently for 19 years. During that time she has focused primarily on the safeguarding of children, undertaking serious case reviews as well as writing policy and procedure. She was the lead author of the first pan London child protection procedures, as well as the procedures throughout the South East. Since 2009 she has been working with the Social Care Institute for Excellence (SCIE) in the development and implementation of the Learning Together methodology for learning from practice and more recently leading the national audit of diocesan safeguarding for the Church of England and author of the 3 published overview reports.

She has considerable experience on learning from reviews where there are multiple victims, involving both non recent and recent abuse; this has included reviews into cases of child sexual exploitation, child on child abuse, the early deaths of 13 care leavers in Somerset and the abuse of children within adopted families. She has a particular interest in institutional abuse and was the author of a report for the Diocese of Chichester, subsequently known and published in 2014 as the 'Carmi' report, into the abuse of choristers. She was also a joint lead reviewer, with Jane Wonnacott, on the serious case review into Southbank International School London.

Jane Wonnacott (report author)

Jane qualified as a social worker in 1979 and has an MSc in social work practice, the Advanced Award in Social Work and an MPhil as a result of researching the impact of supervision on child protection practice. She has significant experience in the field of safeguarding at a local and national level. Since 1994 Jane has completed in excess of 150 serious case reviews, many of national significance. She has a particular interest in safeguarding practice within organisations and was the lead reviewer for two reviews into abuse in nurseries and the serious case review into Southbank International School London. She has contributed to the literature exploring effective safeguarding education settings. Jane is a member of the national Child Safeguarding Practice Review Panel pool of reviewers.

As Director of In-Trac Training and Consultancy, Jane has been instrumental in developing a wide range of safeguarding training and oversaw In-Trac's contribution to the development of the "Achieving Permanence" training materials for the Department of Education. She has a long-standing interest in supervision and developed a national supervision training programme for social workers with the late Tony Morrison. She has recently worked with colleagues to apply this model in school settings.

18 APPENDIX 2: PANEL MEMBERS

- Associate Director School Standards and Performance, Achieving for Children;
- Deputy Head of Investigations Team, Charity Commission;
- Detective Sergeant, Specialist Crime Review Group, Metropolitan Police Service;
- Deputy Chair of Governors, St Paul's School;
- Director of Children's Social Care, Achieving for Children;
- Designated Doctor for Safeguarding Children, Wandsworth Clinical Commissioning Group;
- Consultant Psychiatrist, CAMHS;
- Chief Inspector, Independent Schools Inspectorate;
- Head of Law, Social Care and Education, South London Legal Partnership.

19 APPENDIX 3: TERMS OF REFERENCE

Decision to hold the Review

This Learning and Improvement Case Review has been instigated by Richmond LSCB (Local Safeguarding Children Board) under the auspices of Working Together 2015.

The LSCB Chair, decided on 26.04.17 that a Serious Case Review should be held in respect of St Paul's School, Barnes following concerns about multi-agency working in situations of non-recent child abuse from 1960-2013. St Paul's School includes both the Senior and Junior Schools (formerly known as Colet Court). Notification to the Department for Education was made on 09.05.17, to IICSA (Independent Inquiry into Child Sexual Abuse) on 09.05.17 and to the National SCR Panel on 04.05.17.

It was deemed that the case review was necessary because it is now known that at times during the period in question:

- Children have been harmed and there are concerns how the organisations or professionals worked together to safeguard the children;
- Children are known to have been subjected to particularly serious sexual abuse in the period 1974 - 1992;
- Another child is known to have suffered emotional abuse from September 2003 - June 2005
- Agencies had a significant history of involvement with the School since 2013. (Working Together 2015)

Methodology:

This review will use a methodology for the serious case review, which focuses on learning about the safeguarding systems in the period under review within the school and the multi-agency environment. This aims to learn how to improve the ways professionals in all agencies can better safeguard children within SPS and other children's educational establishments.

The review will have two lead reviewers. Edi Carmi will be the independent Chair: she is an experienced SCR review report writer and Chair. The other reviewer will be Jane Wonnacott, an independent experienced reviewer, who will be the prime author of the report. Both have a social care background of expertise.

The Serious Case Review will be overseen by a Panel, which will support the work of the lead reviewers, agree the review process, help facilitate the co-operation of their own agency and agree the final report.

The lead reviewers will determine the exact nature of the evidence required and how this should be collated. This determination will include information from the:

- Metropolitan Police;
- London Borough of Richmond Children's and Adult Services;
- Richmond LSCB;

- St Paul's School, including the School Health Team and School Counsellor;
- Any relevant evidence from health services including GPs - Wandsworth and Richmond CCGs (Clinical Commissioning Groups) and community health services, including mental health services as required;
- National College of Teaching and Learning (NCTL);
- Independent Schools' Inspectorate (ISI);
- Charity Commission.

In line with national guidance which expects that professionals, families and survivors should be fully involved in serious case reviews, the review panel will determine what opportunities to offer staff, pupils and former pupils (including survivors), parents and professionals to contribute to the review directly. This will include consideration of how the review learns about cultural change and how best to communicate the findings of the review.

Key issues and questions this case raises:

The purpose of this Serious Case Review is to establish understanding of the multi -agency management of allegations of abuse in SPS and to identify learning for multi-agency working with independent schools and other relevant educational establishments.

The review has been timed to begin after the trials for Met Police Operation Winthorpe ended in February 2017 and when information was released into the public domain.

The reviewers will consider in respect of all agencies involved:

- What happened at St Paul's School? This relates the what is known about the abuse children suffered in the period under review, and what opportunities were there to investigate possible abuse of pupils, including the events already identified through the police investigation;
- Professional responses: Who did what and the underlying reasons that led to individuals and organisations acting as they did?;
- What improvements have been made and how they have been sustained?
- What further improvements need to be made?

Lines of enquiry

So as to build on learning from the Southbank International School Serious Case Review (January 2016), published by Hammersmith & Fulham, Kensington and Chelsea and Westminster LSCB the SCR Review Panel have highlighted the following lines of enquiry:

- How to effect changes in an institution to improve the safeguarding of children;
- How can we develop national learning around the interface between independent schools and the multi-agency safeguarding systems;
- What can we learn about the involvement of the whole integrated school network in keeping children safe, including school nursing, school counsellor and school GP?
- How do internal school health systems relate to the wider multi-agency safeguarding systems?

Time period of review

Enquiries and chronologies will cover the period from 1960 to 19.04.17. This latter date marks the point when it was recommended by the SCR sub-group of the LSCB to initiate a serious case review. The decision to cover this extended period is to be able to look at both historical, non-recent and current practice, so as to cover:

- The periods when perpetrators and alleged perpetrators were working at the schools;
- The period when the more recent perpetrator worked at the school and also the concerns highlighted in the Laidlaw review;
- Current practice (it is usual and expected in serious case reviews to contrast and compare current safeguarding practice / culture to that existing when the abuse occurred).

Panel members

Senior managers from involved agencies constitute the SCR Panel:

- Edi Carmi – Lead Reviewer: Independent Chair;
- Jane Wonnacott – Lead Reviewer: author of report;
- Governor, St Paul's School;
- Director of Children's Services Children's Social Care (Achieving for Children);
- Named Nurse SWLStG (South West London and St George's);
- Associate Director for School Standards and Performance, Education Services, AfC;
- LSCB legal adviser;
- Designated Doctor, Wandsworth CCG;
- Metropolitan Police Review Team;
- Chief Inspector Independent Schools' Inspectorate;
- Deputy Head of Investigations Team, Charity Commission.

The LSCB manages and provides administration for the review process.

Information from agencies

Each agency will be asked to provide information to the SCR as follows:

Preliminary information:

In order to facilitate what information is required and where this can be obtained we are firstly asking the police to provide the names of each ex member of staff from SPS who has been convicted or suspected of abusing children. This includes suspected abuse of children who were not pupils at the school. Also for the police to provide all pupils or ex-pupils of SPS known or suspected to be a victim of abuse from any ex members of staff at SPS . There is no information of this nature in relation to current members of staff, but should this emerge the SCR needs to be notified.

Agencies (see section 2) are asked to identify what sources of information may provide relevant information about each person on the police list. Consideration needs to be given to where there

may be concerns reported e.g. the individual child and adult files and records of complaints, concerns and disciplinary investigations.

Agency Chronology

Each agency is required to provide a chronology of the information on files about any concerns or complaints in relation to the welfare of children linked to the behaviour of staff named on the police list, and the professional responses that resulted. To accomplish this the files of the ex-teachers on the police list are to be accessed, along with the files of those ex-pupils who are mentioned in the police list. The latter should include checking for relevant information on all the child's files, including any GP, School Nursing and School Counsellor records. It is important to include the rationale at the time for decisions made and actions taken or not taken. The time period to be covered is 1960-19.04.17

For SPS and SPJ, we are requesting, in addition to the information on named individuals, a review of the following records for any allegations (and responses) that indicate concerns that a member of staff has behaved in a way that has harmed a child, or may have harmed a child, possibly committed a criminal offence against a child or behaved towards a child in a way that indicates he or she could pose a risk of harm to children:

- the Welfare/Safeguarding Concern files,
- the SPS/SPJ Formal Complaints files,
- SPS/SPJ Informal Concerns files,
- Bullying files.

Relevant information relating to individuals should be provided without disclosing the individual's name (using a code instead e.g. child A, teacher X). The purpose of this information is to assist an understanding of safeguarding culture over time. If the name of a pupil and/or member of staff comes up repeatedly or is the subject of serious concerns, the relevant individual's files should be checked for more detail of the management of the concerns / complaints.

Other agencies are asked (at least initially) to collect information relating to the individuals identified by the police (children and convicted or suspected perpetrators). Additionally, please include all contacts with the school itself around safeguarding. Should SPS and police identify further individuals of interest (either as victims or suspected perpetrators), the SCR Panel may ask for further information.

All agencies should use the chronology template provided by the LSCB, as the individual agency chronologies will be merged so as to provide a single multi-agency chronology.

Agency report

No management reviews are requested as part of this SCR. Instead, each agency is asked to provide a very brief comment on practice of their agency over the years, and thoughts in relation to the issues and lines of enquiry listed in sections 3 and 4 of these terms of reference.

Additionally, each agency is asked to identify any staff who should participate in the review by way of an individual or group meeting.

Involvement of staff

The review will consider the collated chronology and develop its learning through individual practitioner and group interviews. The group sessions will be particularly helpful to consider cultural change.

Involvement of victims /survivors, pupils and families

Victims / survivors and/or their families will be offered opportunities for individual meetings with the lead reviewer and another panel member.

Research evidence

Appropriate research will also be used to inform the review.

Review report

The Review report will identify how the learning will be acted upon by agencies and within which timescales, in order to improve safeguarding practice in the borough, other local authority areas involved. It is also anticipated that the review will provide learning for independent institutions in general and possibly for other children's educational establishments.

Parallel reviews

SPS have commissioned Barnardo's to undertake an independent review of safeguarding culture within the school. This will be provided to the SCR. It is not intended that Barnardo's approach any victims/survivors for interview and Barnardo's will collaborate with the SCR lead reviewers, including a planning meeting, to ensure in so far as possible that no-one is subject to repeated meetings (unless that is their wish).

There is a current Met Police Sapphire investigation taking place involving an ex- teacher from St Paul's School. No current or past pupil from SPS is involved in this investigation. This and any subsequent investigations will be reported into the SCR Panel by the Met Police representative, DS Rendell, but will not be taken into the scope of the review.

There has been a Police senior management review into one of the recent investigations, which led to Court acquittal.

A timeline is found at Appendix 1.

Management of SCR

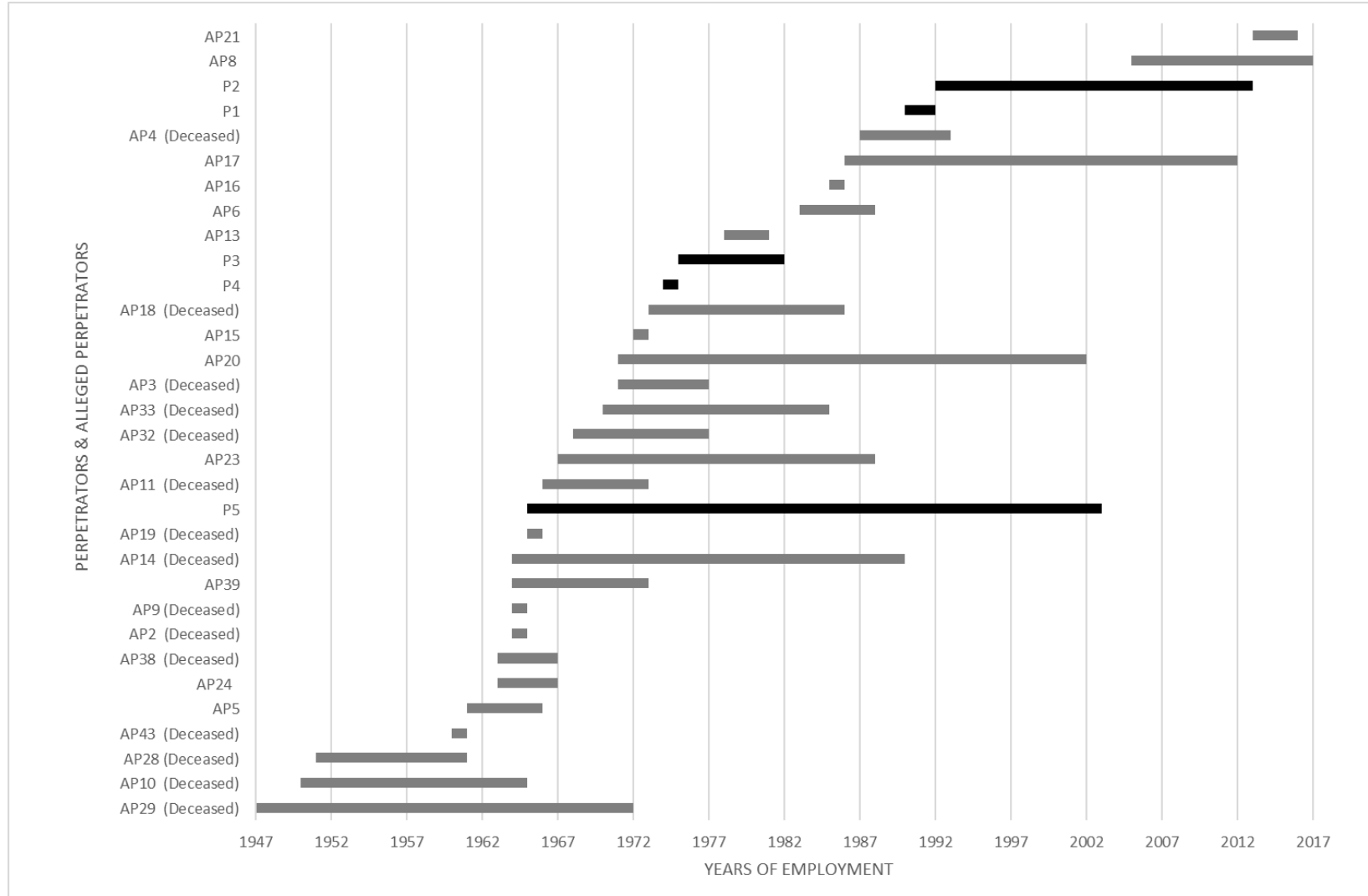
Elisabeth Major, LSCB Professional Adviser will be the link person for the review and will coordinate this review with Sarah Bennett, LSCB Coordinator.

These terms of reference have been agreed by the LSCB Chair, Deborah Lightfoot on 5th July 2017, following discussion at the first panel on 29th June and the SCR Subgroup on 5th July 2017. The terms of reference should not be changed by any independent agency or by the overview writer. Where changes or amendments are required as a result of emerging issues, this should be agreed by the SCR Review Panel and by the LSCB Chair.

20 APPENDIX 4: CONVICTED PERPETRATORS

Perpetrator	Date of Conviction	Offences and Sentence	Period of Employment at St Paul's School
P1	1979	Convicted of gross indecency against a 15-year-old boy. He was fined £100. At the time of this conviction, P1 was serving with the Royal Navy and was required to leave.	1990-92
	July 2016	Convicted of indecently assaulting a pupil at St Paul's School in 1992. He received a six years and 8 months custodial sentence.	1990-1992
P4	April 1987	Convicted of gross indecency with a child and fined £350.	1973-75
	May 1991	Convicted of gross indecency with a child and fined £100 and bound over for 12 months.	
	August 2001	Convicted of four counts of indecent assault and sentenced to four years imprisonment and required to register on the Sex Offenders Register for life. He was released from custody in March 2004.	
	May 2010	Convicted of Making Indecent images of Children. He received a two-year Conditional Discharge and was made subject of a Sexual Offences Prevention Order for life.	
	November 2011	Convicted of breaching his notification requirements and sentenced to an 18-month Community Order and a Supervision Requirement. A travel ban was imposed, preventing him from travelling outside of the UK until November 2016.	
	September 2016	Convicted of non-recent indecent assault on a St Paul's pupil and possession of indecent images of children and sentenced to 14 years and 9 months imprisonment.	
P5	February 2014	Convicted of possession, making and distribution of indecent images of children and sentenced to two years imprisonment suspended for two years, Supervision Order. Sex Offenders Notice for ten years.	1965-2003
P2	June 2015	13 offences of possession of indecent images of children. He was sentenced to three years imprisonment suspended for 24 months, 2-year supervision order, sex offenders notice for 7 years, Sexual harm prevention order for 7 years and disqualified from working with children.	1992-2013
P3	February 2017	Sentenced to 18 years imprisonment for 24 counts of non-recent indecent assault and 1 count of gross indecency.	1972-81

21 APPENDIX 5: TIMELINE OF PERPETRATORS AND ALLEGED PERPETRATORS EMPLOYMENT



AP44 started in 2000 but end date unknown
 AP7 start date unknown but employment ended in 1975
 AP41 (Deceased) employment dates unknown

Perpetrator
 Alleged Perpetrator

22 APPENDIX 6: PROFESSIONAL DISCUSSIONS FOR SERIOUS CASE REVIEW

<p>Charity Commission: Head of Schools and Education, regulatory compliance Head of Investigations and Enforcement Senior Investigator</p>
<p>Department for Education: Team Leader Deputy Director for Independent Education Division</p>
<p>Feltham CAIT: Detective Constable Detective Superintendent</p>
<p>Independent Schools Inspectorate: Chief Inspector Duty Team member Legal, Regulatory and Policy team Duty Team member</p>
<p>LADOs: Current LADOs and former LADO</p>
<p>LSCB: Professional Adviser LSCB Chair</p>
<p>Health: Designated Doctor for Safeguarding Children Designated Nurse Private Consultant Paediatrician</p>
<p>Insurance Company: UK Legacy Technical Manager</p>
<p>Mercers Company: Clerk to the Mercers Principal Staff Officer Legal Representative</p>
<p>Met Police: Sergeant, Met Police Review Team Detective Constable, Operation Winthorpe Retired DI (was SIO), Operation Winthorpe Detective Superintendent</p>
<p>School Counsellors: Dr, SPS counsellor Dr, SPS juniors counsellor</p>
<p>School Health: Chief Operating Officer School doctor Head Nurse SPS Nurse St Paul's Juniors Nurse, Former School Nurse SPS Former School Nurse SPS Former School Nurse Colet Court Former School Nurse Colet Court</p>
<p>School Leadership and safeguarding professionals: High Master, (x 2 meetings) Safeguarding Governor Chair of Governors Deputy Chair of Governors</p>

Human Resources Director Designated Safeguarding Lead (x 2 meetings) Safeguarding Coordinator
TRA (Formerly NCTL): Team Leader Head of Operations Head of Teacher Misconduct Unit
Report Authors of Commissioned Reports: Jonathan Laidlaw QC Co-authors “the Badman report” Barnardo's Report authors:

23 APPENDIX 7: STAFF DISCUSSIONS FOR SERIOUS CASE REVIEW

Ex Staff	Dates at School	Senior or Junior?
1.	1966-97	Senior
2.	1978-2007	Both
3.	1991-1999	Both
4.	1968-2002	Junior
5.	1976-2016	Senior
6.	1981-2009	Senior
7.	1965-2001	Senior
8.	1974-2006	Both
9.	1970-2004	Both
10.	1967-2002	Senior
Current staff		
1.	1986-present	Junior
2.	1983 -present	Senior
3.	1978-present	Senior

24 APPENDIX 8: TERMS OF REFERENCE FOR STRATEGIC MANAGEMENT GROUP

Strategic Management Group

An investigation of organised and complex abuse, as these Operations constitute, is carried out under the auspices of the LSCB. Recognising the strategic complexity of these operations, Richmond LSCB has requested the formation of a Strategic Management Group (SMG) to coordinate and oversee these Operations and report to the LSCB. This follows LSCB Procedure Organised and Complex Abuse Investigations [enclosed] and builds on Working Together 2013, the London Child Protection Procedures 2014. The SMG will remain in existence at least until the Court or CPS has made a decision regarding the alleged perpetrators.

The SMG ensures a coordinated response to concerns of complex and organised abuse. It acts as a steering group to ensure:

- Identification and liaison with relevant LSCBs and their local agencies;
- An information sharing protocol;
- The scale of the investigation, and staff required;
- The tasks of the joint investigative group and its interface with the SMG, via a named coordinator;
- Development of a risk management protocol;
- Agreement regarding the management of potential compensation for victims;
- Sufficient support, safety and debriefing of staff involved in the investigation;
- Preparation of [vulnerable] witnesses for criminal proceedings;
- Secure records management;
- Briefing of key senior leaders, including the LSCB Chairs and a media strategy;
- The welfare of children and vulnerable adults involved;
- The timely commitment of resources to the investigation;
- Involvement of independent / third sector agencies;
- The quality, progress and integrity of the investigation;
- The appropriate timing of the termination of the investigation;
- A debrief meeting with the joint investigation group to identify lessons learnt;
- Regular reports in writing to the LSCB SCR Subgroup;
- The recommendation to the LSCB regarding a review of the case.

The SMG must agree a schedule of dates for future meetings.

25 APPENDIX 9: OVERVIEW OF INTERNAL AND EXTERNAL REVIEWS AND INSPECTIONS OF ST PAUL'S SCHOOL

ISI Inspection	October 2001
ISI Inspection	November 2007
ISI Inspection	March 2013
ISI Emergency Inspection	February 2014
Independent Compliance Inspections (VWV)	April 2014
Badman Review Commissioned	June 2014
Charity Commission Statutory Inquiry opened	June 2014
Laidlaw Review commenced	January 2015
Independent Compliance Inspections (VWV)	August 2014
ISI Progress Monitoring Visit	October 2014
Badman Review findings published	March 2015
Laidlaw Review findings published	July 2015
Charity Commission statutory inquiry findings published	August 2015
Independent Boarding Review	October 2015
Independent review of in-house provision of routine medical services	January 2016
ISI Inspection – Boarding & Compliance	March 2016
ISI Inspection – Educational Quality and Compliance	March 2017
Barnardos review completed	December 2017

26 APPENDIX 10: SUMMARY OF INTERNAL REVIEWS AND THE SCHOOL'S RESPONSE.

Internal Case Review

- 26.1 In 2013 following a serious incident a review of boarding [policies and practices led to a number of changes. The changes were effected immediately and included:
- A reduced workload of the House Master and increased boarding staff team to ensure mutual supervision;
 - Changes to accommodation of staff to further reduce risk;
 - Boarding House staff no longer act as pastoral tutors to boarders – providing boarders with a pastoral tutor who is not a member of the house staff helps to ensure any concerns can be raised away from the house;
 - Level 2 and 3 Child Protection training, as appropriate for all staff;
 - Updated Staff Code of Conduct and Alcohol Policy;
 - Increased oversight of the boarding house by Senior Managers and Governors;
 - Increased induction training for staff regarding safeguarding and Staff Code of Conduct.

Independent Compliance Review

- 26.2 In 2014, the Governing Body responded to the publication of news stories about historic abuse allegations, and the introduction of KCSIE⁵³ in April 2014, by commissioning an unannounced independent safeguarding review by a leading firm of solicitors with expertise in compliance in independent schools. This found that the school was compliant with statutory requirements and suggested several improvements which were immediately implemented. These included changes in the formatting of the single central register, amendments to staff information posters and job descriptions.

The Badman Review

- 26.3 In June 2014 the Governing Body commissioned Graham Badman, who had no previous contact with the school, to carry out a comprehensive independent review of the safeguarding policies, procedures and culture of the school, and to make recommendations to enable the school to develop and improve practice, in order to move beyond basic standards of compliance.
- 26.4 The Badman Review confirmed that the school was “fully compliant with statutory requirements and regulations pertaining to child protection.” Its recommendations were therefore designed to enable the school to move from compliance to becoming a centre of excellent practice and focused on strengthening the role of the Governing Body. As a result of the recommendations of the review an action plan

⁵³ Department for Education: *Keeping Children safe in Education*

was implemented in 2015 and 2016 and was monitored frequently by the Governing Body. Significant actions were:

- changing the name of the preparatory school to St Paul's Juniors to create a single school identity; creating a single admissions office with unified marketing and communication; and a review and alignment of school policy, management and staffing and curriculum;
- The development of an annual Governor safeguarding review;
- The creation and appointment to the new role of a Safeguarding Coordinator who is Deputy Designated Safeguarding Lead at both schools, providing a link across the schools and ensuring consistent standards of practice. The Safeguarding Coordinator also reports to the weekly pastoral management meeting at the senior school, the weekly safeguarding management meeting at the junior school and provides supervision meetings for the school nurses, undermasters and boarding housemaster. This role also undertakes training of staff on safeguarding issues; and is available to all staff to discuss any safeguarding issue;
- The establishment of a new Governors' Safeguarding Committee with a specific remit to bring together the governance and oversight of safeguarding policy and practice across the whole school.

The Laidlaw Review

26.5 In January 2015 the school commissioned Laidlaw QC to investigate a complaint by parents about the way that the school had handled complaints they had made about the treatment of their son in 2005 – 07 and again in 2011 and 2013. The request from the parents for the investigation had been prompted by the arrest of a member of staff at Colet Court for the possession of indecent images of children. Although the Laidlaw report was commissioned by the school, a full copy was given to the parents who were happy for this to be given to this serious case review and have spoken openly to the reviewers knowing that the final serious case review report will be a public document. In addition, the contents of the Laidlaw report were shared by the parents with a journalist and reported in detail in The Times newspaper⁵⁴.

26.6 The Laidlaw review found that the investigations by a previous head teacher at Colet Court and a previous High Master at St Paul's School were not in accordance with regulations. Laidlaw did not make any recommendations for improvement to the school, on the grounds that he was 'quite certain' that the complaint would have been treated differently in 2015. His basis for this judgement was the evidence of confidential and anonymous staff interviews; the substantial changes in the national safeguarding framework between 2005 and 2015; the evidence from the Badman Review of compliance with that framework; and evidence of cultural change within the school.

26.7 Following consideration of the details of the report the senior management team:

⁵⁴ Andrew Norfolk The Times 10th October 2015

- Adjusted the content of the compulsory safeguarding training for all staff to place special emphasis on spotting and reporting possible signs of inappropriate or odd behaviour that might lead to or indicate possible physical, emotional or sexual abuse, and how to report any such concerns;
- Initiated an annual lecture series on mental health;
- Created a new role of Head of Mental Health and Wellbeing (Head of MH&W) as a member of the school's senior leadership team;
- Set up a 'Mental Health and Wellbeing Working Group', which reviewed the school's PSICHE provision to provide an enhanced curriculum to include life skills, critical thinking, safeguarding and wellbeing education, as well as the traditional PSICHE components (which have included education on anti-bullying and online eSafety);
- Commissioned Youth Mental Health First Aid Training for the pastoral staff;
- Improved monitoring of mental wellbeing.

External Report on Boarding

26.8 The school's executive commissioned an experienced independent inspector (Sally Rosser) to review boarding provision at the school. The conclusions were positive but as result refinements were made to practices and procedures focused mainly on the storage and recording of medication.

Review of Medical Provision, including an independent report from SAPHNA⁵⁵

26.9 A comprehensive review of medical provision was led by the school's Chief Operating Officer and in order to ensure appropriate specialist input, a separate visit and report was commissioned from SAPHNA who provided an independent report. SAPHNA concluded that practice was safe and students' needs were at the heart of nursing care but the nursing role was under-developed and opportunities, particularly in relation to nurse-led health interventions, were likely to be missed.

26.10 The overall review concluded that medical provision 'is broadly appropriate' and recommended a restructure of roles and reporting lines; recording systems and the creation of an overarching medical strategy. These recommendations were accepted and implemented.

Review of lessons from an external serious case review

26.11 St Paul's School reviewed its own practices and procedures in the light of the published recommendations of the South Bank serious case review. The main changes included:

- Changes to the educational trips policy to make sure staff did not attend without a DBS check;
- Reviewing interview questions and panels to make sure no sole interviewing took place;

⁵⁵ School and Public Health Nurses Association

- Creation of a bespoke system for overseas checks;
- Review of educational visits policy;
- Review of in house training to ensure that the content includes the modus operandi of sex offenders and to ensure sufficient attention is given in training in respect of recognition, reporting and responses to abuse of young people by persons in a position of trust;
- Introduction of online Neutral Notification system so that staff can record possible concerns;
- Improving pupil's awareness of availability of staff members to turn to for advice.

Barnardo's review

26.12 Before the start of this serious case review St Paul's School had begun discussions with Barnardo's Consultancy regarding an independent evaluation of current safeguarding practice and progress since the Badman review. The four key areas addressed by the review were:

- The effectiveness of the overall safeguarding system and the various safeguarding arrangements already in place;
- The safeguarding aspects of activities offered to boys across both junior and senior schools including boarders;
- The targeted activity carried out to safeguard vulnerable groups of children;
- The identification and prompt response to child protection concerns.

26.13 The review took place concurrently with this serious case review, reported in 2018 and its findings have been used to underpin the analysis in this report.

26.14 The review confirmed the school's progress in developing sound safeguarding practice and made 33 specific recommendations for further improvement which were developed into an action plan.