Kevin Harrington Associates Limited

CHILD G

A SERIOUS CASE REVIEW

Kevin Harrington JP, BA, MSc, CQSW

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1. INTRODUCTION

1.1 During 2012 a girl, Child G[1], became involved in a sexual relationship with a teacher at her school, Mr K. Anticipating that this relationship would come to light, they left the country together. After just over a week they were detained by police. Child G returned to her family and Mr K was brought back to this country in custody. Child G was fourteen years old when the relationship began and fifteen when they left the country. Mr K was subsequently imprisoned as a result of criminal charges arising from these events.

1.2 These matters came to the attention of the Local Safeguarding Children Board (LSCB) in East Sussex, where the girl lived. The Independent Chair of the Board, Ms Cathie Pattison, decided in January 2013 to initiate this Serious Case Review (SCR).

1.3 The purposes of SCRs are set out in "Working Together[2]". They are to

- *establish what lessons are to be learned from the case about the way in which local professionals and organisations work individually and together to safeguard and promote the welfare of children;*
- *identify clearly what those lessons are both within and between agencies, how and within what timescales they will be acted on, and what is expected to change as a result; and*
- *improve intra- and inter-agency working and better safeguard and promote the welfare of children.*

2. ARRANGEMENTS FOR THE SERIOUS CASE REVIEW

2.1 A number of key steps needed to move the SCR forward could not be taken until criminal proceedings had been completed. Consequently, although the SCR was formally initiated early in 2013, it was not completed until December of that year, when those proceedings had been concluded and relevant people who had given evidence in the trial were able to contribute to this review.

2.2 The LSCB constituted a panel (the Panel) to manage and oversee the conduct of the review. The membership of the Panel is set out at Appendix A. In line with the guidance in place at that time two independent people were appointed in connection with the review: Mr Ron Lock, to lead the review, and

[1] Despite the fact that this case attracted a great deal of publicity the SCR Panel judged that it would be inappropriate that this public document should identify the individuals involved.

[2] Working Together to Safeguard Children (2010) – referred to in this report as "Working Together" – is a government publication containing statutory guidance on how organisations and individuals should safeguard and promote the welfare of children and young people, in accordance with the Children Act 1989 and the Children Act 2004. It has been revised while this review has been in process and replaced by Working Together to Safeguard Children (2013). Most of the agencies completed their submissions to this review before Working Together 2013 was in place. This Overview Report has taken account of the revised guidance but there are no specific implications from the revision for the content of the report.

Mr Kevin Harrington to write this Overview Report. Further details are at Appendix B.

2.3 It was determined that the agencies listed in the table below should contribute to the review. Agencies with substantial contact were required to submit full Individual Management Reviews (IMR) whereas agencies with less significant or less recent involvement provided reports for background information. The most important IMRs were those submitted by police, children's social care services and Child G's school.

AGENCY	**NATURE OF CONTRIBUTION**
Sussex Police	Individual Management Review (IMR)
East Sussex County Council, children's social care services, referred to as CSC	IMR
Child G's school, referred to as School D	IMR
The family's General Practitioner	IMR
East Sussex Healthcare Trust (Community Services)	IMR
Hastings & Rother Clinical Commissioning Group	Health Overview Report
East Sussex Healthcare Trust (Acute Services)	Background report
Sussex Partnership NHS Foundation Trust	Background report

2.4 The government has introduced arrangements for the publication[3] in full of Overview Reports from Serious Case Reviews, unless there are particular reasons why this would not be appropriate. This report was written in the anticipation that it would be published. It will still be appropriate that some confidential information is not disclosed. Consequently the information in the report is limited so as to:
1) take reasonable precautions not to disclose the identity of the child or family.
2) protect the right to an appropriate degree of privacy of family members.
3) avoid the possibility of heightening any risk of harm to this child or others.

2.5 Anonymised Terms of Reference for this SCR are attached at Appendix C. They are drawn from the statutory guidance contained in Working Together. The period covered by this review is from September 2010, when Child G came to the notice of some of the agencies involved in this review on an unrelated matter, until September 2012, when she returned to her family.

[3] See Working Together 2013

3. METHODOLOGY USED TO DRAW UP THIS REPORT

3.1 This Overview Report relies on

- The agency IMRs, background information submitted and subsequent Panel discussions and dialogue with IMR authors.
- The report from a "Safeguarding Review", an independent exercise carried out by School D after these events came to light.
- The views of Child G's mother, discussed in section 5 below.
- Some information emerging from the trial of Mr K.

3.2 It is now clear that School D did not keep any formal contemporaneous records of the events under review. Information was initially submitted to this review on a tabular timeline document, which was drawn up soon after the abduction of Child G. This was accompanied by three documents, pro formas headed "Child Protection Incident / Welfare Concern Form". This review was at an advanced stage when it became clear that these pro formas were not contemporaneous – although they were dated variously in March, May and July 2012. The Panel noticed that they were inaccurate, in particular referring to the outcome of an event in April on a pro forma dated in March.

3.3 This was raised by the SCR Chair with the school and further investigations were carried out. It was confirmed by the school that all the documentation had been completed after Child G was abducted. One of the school's two teachers with particular responsibility for safeguarding (ST1) told the SCR that the decision to backdate the forms was made jointly by herself and her colleague (ST2), the Deputy Head Teacher (DHT), the Head Teacher and the Executive Head Teacher[4] . The Executive Head Teacher described this, in a letter to the Chair of the SCR, as a misunderstanding arising from the fact that they had not been asked to provide contemporaneous records.

3.4 It is a matter of concern that the school should have provided its evidence to this review in the way that has come to light. It is a fundamental and obvious premise that the accuracy and propriety of records will be a cornerstone of an exercise such as this. This is discussed further below.

3.5 This report consists of

- A factual context and chronology.
- Commentary on the family situation and their input to the SCR.
- Analysis of the part played by each agency, and of their IMR.
- Closer analysis of key issues arising from the review.
- Conclusions and recommendations.

3.6 The conduct of the review has not been determined by any particular theoretical model. However the review has been carried out in keeping with the underlying principles of the statutory guidance, set out in Working Together 2013, detailed below: The review

[4] A Head Teacher with responsibility for more than one school.

- *recognises the complex circumstances in which professionals work together to safeguard children;*
- *seeks to understand precisely who did what and the underlying reasons that led individuals and organisations to act as they did;*
- *seeks to understand practice from the viewpoint of the individuals and organisations involved at the time rather than using hindsight[5];*
- *is transparent about the way data is collected and analysed; and*
- *makes use of relevant research and case evidence to inform the findings.*

4. A BRIEF CHRONOLOGY OF KEY EVENTS

4.1 This section of the report briefly describes the events under review and the background to those events. Further detail is then provided at appropriate points throughout the report.

4.2 Child G lived with her mother, Ms C, her mother's partner, and other children of the family. Throughout the period under review Child G was in full time education at School D. The family have no significant history of contact with police, health or social care services outside the matters detailed in this report.

4.3 In 2010 Child G came to the attention of some agencies involved in this review because of a matter unconnected to these events. A supply teacher from another school had made inappropriate remarks to a number of pupils, and in particular Child G. He had asked pupils including Child G for their addresses, and, at another school, had made drawings of pupils, one of which contained an explicitly sexual reference. This situation was managed under formal child protection arrangements, led by the Local Authority Designated Officer[6] (LADO). It did not lead to any further action by police, health services or CSC but the school followed up, using the appropriate employment procedures and national regulatory arrangements, with the employment agency which had provided this supply teacher.

4.4 In February 2012 Child G went on a school trip to America. Mr K was one of the members of school staff leading the trip. It was during this trip that evidence first emerged which was suggestive of an inappropriate relationship between Mr K and Child G. Mr K denied this to senior staff. No other agency was informed. Some information was given to Child G's mother who was said to be satisfied with the way the school had dealt with the situation. There is no record that Child G was spoken to although ST1 has reported doing so. The Head Teacher was made aware of the concerns at the beginning of March.

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

[6] The LADO is an officer (or officers) in every local authority with responsibility for acting and advising on safeguarding concerns in respect of people whose employment brings them into contact with children.

4.5 On the same day that the school contacted Ms C about this, she and Child G consulted the family GP about a number of issues relating to Child G's health and emotional well-being. Mr K was not mentioned. The GP suggested that the school counsellor might be able to assist but did not feel any further action or treatment was indicated.

4.6 A school nurse also saw Child G around this time and made a referral to Child & Adolescent Mental Health Services (CAMHS) in respect of a possible medical condition. CAMHS offered an appointment to Child G but she did not attend. CAMHS notified the School Nurse of this and wrote to the family inviting future contact but there was no further CAMHS involvement.

4.7 During March there were two incidents of Child G truanting from the lesson she should be attending and making her way to Mr K's classroom. The Deputy Head spoke to Mr K about this. In May senior school staff became aware of Mr K and Child G using Twitter to communicate with each other. The content of those communications was clearly indicative of an unprofessional relationship. School staff discussed this with the LADO who, on the basis of the information shared, advised that it was not a matter of child protection, requiring a multi-agency response, but something which the school could deal with.

4.8 There were two meetings between Mr K and senior school staff during June, in which they discussed how Mr K could be supported in dealing with Child G's interest in him. In July two former students came to the school and raised concerns about the relationship between Mr K and Child G. Mr K denied to school staff that there was any truth in these allegations and no further child protection action was taken. It was agreed that Mr K himself should contact Ms C to reassure her and he did so.

4.9 Two months later the father of another pupil contacted police, reporting that Child G had an inappropriate photograph of Mr K on her phone. A number of other children were said to have seen this. This led to an investigation under formal child protection procedures. Child G and her mother were interviewed. Child G denied the allegations. Her phone was seized and an initial inspection revealed no cause for concern. Ms C said she did not believe the rumours. Mr K was not interviewed.

4.10 The following day Ms C understood that Child G was staying overnight with a school friend. However she did not come to school the morning after that. In the late morning Ms C was routinely notified by the school of her daughter's absence. It transpired that Child G had only stayed with her friend until the early evening of the previous day and that her whereabouts thereafter were not known. Ms C reported her missing to police.

4.11 Police made extensive enquiries and established that Mr K and Child G had left the country together. Child G had used Mr K's wife's passport. They were identified and detained in Europe just over a week later. Police enquiries revealed further evidence indicating that there had been a continuing sexual relationship between them, at least from soon after Child G's 15th birthday.

4.12 Mr K was brought back to the UK in custody and charged with the abduction of Child G (taking a child without lawful authority). He denied the charge so that she and other witnesses were required to come to court and give evidence. He was found guilty of that offence and received a prison sentence of 12 months. He then admitted a number of charges of sexual activity with a child under 16 years of age and was further sentenced to 54 months in prison – a custodial sentence of five and a half years in total.

5. THE FAMILY

5.1 Child G

5.1.1 Child G was offered an opportunity to meet with the author of this report while it was being drawn up but did not wish to do so. She did come to a meeting with her mother to discuss the key findings from the review.

5.2 Ms C

5.2.1 Ms C was keen to contribute to this review and met the author of this report, and a Panel member, to do so. She was able to describe in detail what and when she knew about the events under review. As described throughout this report there are some key issues and events where her account cannot be reconciled with evidence provided by the school to this review.

5.2.2 Ms C wanted to emphasise how grateful she was for the support she received from police, from the point at which it became clear that her daughter had been abducted. She told us that she appreciated not just all that had been done but the way in which it was done – "they really care". She also commended the support provided by the social worker from the local authority.

5.2.3 She was outspoken in her dissatisfaction with School D, and her comments were measured and thoughtful. She was deeply concerned by the specific mistakes made, the many missed opportunities to protect her daughter and by the reliability of some of the information provided by school staff to this review. However, her greatest regret was that she felt undermined as a parent by the school's management of this situation. They had not adequately informed and involved her. The consequence of the school's approach was that
"they didn't allow me the opportunity to intervene".

5.2.4 When discussing the outcomes of the review Ms C indicated a willingness to be directly involved in action which agencies might be taking to follow up the lessons learned.

6. THE AGENCIES

6.1 The General Practitioners

6.1.1 Prior to the events leading to this review Child G had little contact with her GPs. She saw the GPs once during the period under review. The GP did not feel she needed onward referral at that stage, except that it was suggested that she might contact a school counsellor. The IMR concludes that
"Concerns regarding physical and emotional health were appropriately assessed and actioned. There were no child protection concerns".

6.1.2 This account fits the pattern reported by other services, of Child G's health and conduct raising no significant cause for concern before the events leading to this review.

6.2 East Sussex Healthcare Trust (Community Services)

6.2.1 The involvement of this Trust arises from Child G seeing the School Nurse during the period under review. This was on one occasion in March 2012[7], soon after the school trip to the USA. Child G was referred to the School Nurse by ST2 in the aftermath of the first concerns about a relationship with Mr K. Child G had spoken to ST2 and mentioned matters which might indicate emotional disturbance or unhappiness.

6.2.2 The referral from ST2 made no specific reference to any concerns about the relationship with Mr K but described the matters mentioned by Child G. The School Nurse saw her the day after she was referred and noted that she *"presented as clean and tidy, she did not appear overly nervous and was open in sharing information regarding (the reasons for referral)".*

6.2.3 The School Nurse nonetheless, with the consent of Child G and her mother, made a referral to Child and Adolescent Mental Health Services (CAMHS). An appointment was offered about a month later – not an unusual or inappropriate delay in responding to low level concerns - but was not kept. CAMHS wrote to the family inviting further contact if they felt that would be helpful. The School Nurse was informed of this but did not take any further action. That would again not be unusual in the circumstances – the concerns were not urgent and, since the first contact, there had been no further involvement by the School Nurse.

6.2.4 The only other issue arising from this review for the school nursing service relates to a Strategy Discussion[8] held in September 2012, following the discovery of inappropriate photographs of Mr K. No representative from health services was invited to that meeting.

6.2.5 At that time in East Sussex health professionals would only be invited to such a meeting if it were known that the situation to be discussed involved specific health needs. In this case it would in fact have been appropriate to invite the School Nurse because of her earlier direct contact with Child G, which may have been significant. However the School Nurse was not contacted and her brief involvement only emerged subsequently.

6.2.6 In any event this situation has changed with the implementation of the 2013 Working Together guidance, which states that
"A local authority social worker and their manager, health professionals and a police representative should, as a minimum, be involved in the strategy discussion".

[7] School D has reported an earlier referral but this appears to be an error.
[8] Strategy Discussions are part of the national arrangements for determining how agencies - principally police and the local authority - should respond to child protection concerns.

Local agencies are now making arrangements to ensure that there is compliance with the new requirement, so that health professionals are routinely involved in such meetings.

6.2.7 Overall then the involvement of the school nursing service in these events was minimal and no particular issues arise from it. However the IMR notes that since these events there has been an improvement in the relationship between the school nursing service and School D:
"(There had been) problems in…accessing suitable rooms for health assessments and …difficulties in offering a drop-in service and sexual health advice to pupils. Opportunities to inform the staff and pupils about the school nursing service…were blocked. However, since the incident, there have been several improvements in the communication processes between school staff, SENCO[9], welfare staff and the School Nursing Team".

6.3 East Sussex Healthcare Trust (Acute Services)

6.3.1 This agency did have some contact with family members during the period under review and has reported that contact to the SCR. It is not relevant to the events under review.

6.4 Sussex Partnership NHS Foundation Trust

6.4.1 This agency manages CAMHS and has submitted a brief report confirming the facts of the referral to them in March 2012 and the appointment consequently offered but not kept by Child G.

6.5 Hastings & Rother Clinical Commissioning Group - Health Overview Report

6.5.1 Arrangements in place when this review was initiated required that all SCRs should include a Health Overview Report – a report prepared by the organisation responsible for the commissioning of health services locally. In this case the Health Overview Report was submitted by the Hastings and Rother Clinical Commissioning Group.

6.5.2 The Health Overview Report comes to the same conclusions as those reached separately by the various health services in their IMRs.
"All health agencies appeared to have positive professional working relationships with Child G and her family. The services offered were in the context of a universal service which was wholly appropriate".

[9] Special Educational Needs Co-ordinator – a teacher with particular responsibility for co-ordinating and developing a school's provision for children with special educational needs.

6.6 East Sussex County Council – Children's Social Care Services

6.6.1 Children's social care services (CSC) were first aware of Child G in 2010 when she was one of the girls targeted by a supply teacher, an event quite separate from the matters leading to this SCR. The CSC involvement was that the LADO chaired the Strategy Discussion which decided how the agencies should respond to those events.

6.6.2 There were some weaknesses in the way in which this matter was dealt with. There was insufficient detail in the actions agreed. There was a lack of emphasis on exploring the consequences for the young people involved of what had happened, and any treatment or support that they might need. There was no effective co-ordination after the Strategy Discussion and it was left to one agency – the school – to conclude the agencies' response to the referral. There was then no action to confirm that the school had followed up in the way that had been agreed. This is mentioned here because there are similarities with the agencies' actions in relation to Child G in 2012 – a lack of detail in planning and follow-up and a failure to consider the broader implications of the concerns raised.

6.6.3 The local authority's first involvement in the events under review here was in May 2012, when the LADO was approached for advice by School D after the concerns relating to Mr K's use of Twitter. On the basis of the information provided the LADO judged that this was an internal matter for the school to deal with rather than something requiring a co-ordinated approach under child protection arrangements. The young person's name was not given to him, or sought by him (so that no connection could have been made with the 2010 incident).The LADO made no record of this consultation.

6.6.4 CSC's operational involvement commenced as a result of the report to police in September. CSC were contacted by police on the Monday, a Strategy Discussion was held the following day and a joint visit made to the family the day after that. CSC then terminated their involvement, re-opening the case when it became clear that Child G was missing.

6.6.5 The Strategy Discussion was attended by a Detective Constable (DC1) from the police Child Protection Team (CPT), a social worker (SW1), the LADO, who chaired the meeting, and, from the school, the Head Teacher, ST1 and a personnel officer. The meeting was informed by the school staff about the incidents in February, May and July and how the school had responded. The meeting also heard from ST1 and the Head Teacher that Mr K's marriage was in difficulties and that as early as January 2012 (before the trip to America) he had been known to have slept in his car.

6.6.6 The notes of the Strategy Discussion refer to the Deputy Head having told Mr K

"that he should not seek support from a young girl".

ST1 told the meeting about a pupil refusing to go to Mr K's class as the pupil said he was a "*pervert*". The notes of the meeting also state that

"The Head Teacher said there had not been any previous concerns about Mr K".
The notes make no reference to events in March, nor to Mr K having been seen holding hands with Child G, although ST1 had told Child G's mother about this in March. These matters are significant and are discussed further below.

6.6.7 The actions agreed at the meeting were:

- ST1 would identify the two ex-pupils who had raised concerns in July and seek further details of the issues relating to the "Twitter incident".
- Head Teacher to try to ascertain Mr K's current address and pass it to DC1.
- Police and social worker to make a joint visit to Child G's home, that day or the following day, to seize her phone and computer and speak with her and her mother
- Mr K and other staff at the school were not to be informed of these matters until police agreed to this.
- Personnel Officer to make contingency arrangements in the event of action against Mr K.
- A further Strategy Discussion would be held in a week's time.

6.6.8 The CSC IMR notes that the meeting (and the meeting held in 2010) did not consider the safety or welfare of any young people other than Child G. There was evidence that the teacher in the 2010 incident had approached or considered approaching a number of young people. In 2012, although there was only evidence of Child G being targeted by Mr K, it was alleged that other pupils had seen inappropriate images of him.

6.6.9 It would have been appropriate for the meeting to think more broadly about the situation, the effect on other pupils and on the school community as a whole – not to make any detailed plans at that stage but to begin to draw out the possible wider implications of the concerns raised. As the IMR points out, not only was this a safeguarding weakness, it was also a missed opportunity to consider
"how the group of students could be supported and educated in relation to these issues in order to ensure they were all managing the situation and to build resilience in them and open up discussions between staff and students about these sorts of issues".

6.6.10 The interview subsequently conducted by DC1 and another social worker (SW2) was not carried out in compliance with standard safeguarding requirements. Child G and her mother were not interviewed separately. That is a routine expectation in child protection enquiries of this nature and there was no good reason not to do so here. It seems that the investigators were swayed by what they felt was a relaxed and open relationship between mother and daughter.

6.6.11 Child G is described as follows:
"She did not appear anxious or as if she were hiding anything and the social worker reports having no concerns about her presentation".

Child G denied having any sort of relationship with Mr K. She denied that there had ever been physical contact between them.

6.6.12 Ms C said that she knew about what was said to be Child G's "crush" but that she did not believe anything improper had happened. She confirmed that she had spoken directly to Mr K who had reassured her of this. Ms C also said that she routinely checked the content on her daughter's phone and had once seen inappropriate pictures of Child G. Child G had told her that this had been a trivial incident she and some other girls had been involved in.

6.6.13 The investigating social worker has reported that she was influenced by considerations arising from Child G's involvement in the situation in 2010. On that occasion Child G was
"able to recognise the appropriate boundaries between staff and students".
The social worker has reported that this contributed to her view that Child G could be interviewed in the presence of her mother.

6.6.14 This is surprising. CSC had not been directly involved in the previous matter and this member of staff had no detailed knowledge of what had happened then, or in the family subsequently. In fact this social worker had not attended the Strategy Discussion the previous day, but had been briefed by a colleague who had attended. If a reliance on what happened in 2010 really had been such a determining influence on how to conduct this interview, that would be a matter of concern. It seems more likely that this reflects a rationalisation, after the event, of the failure to conduct separate interviews.

6.6.15 Following the interview and the completion of routine checks with all agencies it was judged by the social worker and her manager that there was no continuing role for CSC at that stage. Police had further enquiries to make, but no immediate actions for social workers had arisen from the initial investigation. The IMR suggests that
"it may have taken some time for the forensic information to have become available and there were no identified immediate risks… There was no role for a social worker at that time. This is consistent with expected East Sussex practice that cases are closed when there is no current social work role or active intervention and re-opened if new information comes to light".

6.6.16 In general it will be preferable to maintain the momentum of a joint investigation until it is clear that a joint approach is no longer necessary. That provides greater continuity and stronger continuing lines of communication between agencies.

6.6.17 Moreover at this point it was also decided by CSC managers that the Strategy Discussion would not now be re-convened as originally planned. The rationale for this is unclear. The LADO, who had led the original meeting, had gone on holiday, so was not consulted. Nothing had arisen from the interview which could not have been anticipated. It seems a premature decision, particularly as the agencies were all said to accept that there was substance to the allegations made:

"The LADO's first comment upon interview for this report that there was a shared agreement between all the professionals involved at the strategy meeting on 18/09/12 that this was serious and the information was such that they considered that the allegations were likely to be true".
The decision to cancel the follow-up meeting suggests that, following the interviews, professionals had become less convinced that the concerns had substance. However, even setting aside subsequent developments, it will have been more appropriate to have kept to the original plan whereby the agencies, represented by those who had actually been involved in the investigation, would re-convene to agree a way forward.

6.6.18 The absence on leave of the LADO may have been a factor in the changed arrangements, although there are well established cover arrangements. He has subsequently indicated that his preference would have been to stick to the original plan. He has suggested that he would have expected at least a telephone conversation on his return from leave, if the plan were to deviate from his original recommendations. The CSC IMR accepts that it would have been preferable to proceed as originally agreed.

6.6.19 This then is a second example of an investigation being left for one agency (on this occasion police) to follow up and conclude, with no clear arrangements for the other agencies to be informed, the LADO to be advised of the outcome and the LADO to determine that the matter had been dealt with appropriately. The LADO and his employing organisation cannot be responsible for doing what the individual agencies and organisations should have done. Equally they must accept the responsibilities which sit with their central role in this network of duties and obligations.

6.6.20 The issue of recording of events and communications between agencies is discussed below, with reference to School D. It is a subject that arises also in respect of the LADO and it is agreed that the LADO made no record of his involvement in this case when he was contacted in May about the use of Twitter.

6.6.21 It is in the nature of the LADO's role that there will be numerous occasions when schools and other agencies seek to "sound out" the LADO about matters which might require further action. It will often be the case that those making enquiries will wish to do so in a way that does not trigger any formal procedures – these can be delicate situations where agencies want to avoid causing unnecessary problems for a colleague, or generating an investigation which might subsequently be seen as an over-reaction.

6.6.22 The LADO told this review that his normal practice when asked for advice would be to have a discussion and then ask the enquirer to send an email confirming the contact. He would then reply so that there was a written record of the communication. This is unsatisfactory. No professional should rely on someone who consults them to make a record of that consultation. The IMR advises that a working group has been established to assist the LADO in developing more reliable recording systems. That may be necessary but the underlying issue here is not a procedural one – the LADO is

personally and professionally responsible for ensuring that consultations are conducted and recorded appropriately.

6.6.23 The review considered the possible factors underlying the concerns around the involvement of the LADO in these events. It is a demanding role, often an isolated one, with responsibility for advising and guiding large numbers of individuals and organisations on a wide range of potentially problematic and difficult decisions. Many of the requests for advice will be made “on the hoof” rather than as formal referrals. Often the advice needed and provided is straightforward, which can make it more difficult to identify those cases which are more complex. However, in this case it is recognised that there were weaknesses, both in professional practice and in administration, which meant that the independent leadership of this investigation was not as thorough as it might have been.

6.6.24 As with a number of the comments about agencies’ actions in this report, it is accepted that a different approach to the planning of the investigation and the way it was followed up may not have made a difference to the subsequent developments in the case. It is possible that Mr K may still have abducted Child G once he realised that formal investigations were underway. However the principal aim of this review is to identify issues that would help agencies in comparable situations in the future, which is why these matters are highlighted.

6.7 Sussex Police

6.7.1 Police first knew of Child G as a result of the events during 2010. The police IMR is concerned that the overall management of the allegations at that time was not sufficiently thorough. There were a number of specific steps which could have been taken by police to ensure that the decisions on how to proceed would be better informed:
“the strategy discussion did not agree a plan to establish if any criminal offences had been committed or were likely to be committed”

6.7.2 There is no evidenced link between the events leading to this review and these concerns from 2010. However the police analysis does highlight a lack of appropriate curiosity across the agencies, which is in keeping with evidence emerging from the events leading to this review.

6.7.3 Police were the first agency to learn of the events which brought matters to a head in 2012. The concerns about the inappropriate photograph of Mr K were passed to the police Child Protection Team (CPT) who asked local police to carry out initial investigations. They received this information on a Friday afternoon, visited and interviewed the informant immediately. (The informant was in fact the father of the young person who had actually seen the images, as had two other students: police should ideally have spoken to the young person herself). The officer then passed the information to the police school liaison officer, requesting that further enquiries be made and the CPT informed. The school liaison officer would not be at work until Monday.

6.7.4 In order to comply with the Sussex Police Child Protection Policy, all investigations into allegations against persons working with children should be carried out directly by the CPT. Some officers interviewed for this review have said that this is impractical, as the CPT is a relatively small unit. It may be appropriate that "mainstream" officers can undertake those initial enquiries but Sussex Police need to resolve this gap between what is procedurally required and what can happen "on the ground". They are following this up as a consequence of this SCR.

6.7.5 In any event the initial information gathered did not indicate that Child G was at immediate risk and the decision to gather further information was reasonable. However the reason for delaying feedback to the CPT until the following week is unclear. The CPT could have been contacted on the Saturday. While they would probably not have taken immediate investigative action, there was no reason to delay informing them of the allegations made until the Monday.

6.7.6 On the Monday the liaison police officer for the school immediately recognised the potentially serious nature of what had been described and spoke to the CPT. That team then followed up swiftly and liaised with other agencies so that the Strategy Discussion was convened the following day and the interview of Child G and her mother was carried out the day after that. In relation to the nature of the allegations, this was a satisfactory timescale.

6.7.7 Police were represented at the Strategy Discussion by the Detective Constable, DC1, who went on to interview Child G and her mother. This was again a procedural breach of the force's policy, which is that police should be represented at such meetings, when there are concerns about abuse by a professional, by a CPT Detective Sergeant. Officers interviewed for this review reported that this was also an unrealistic expectation for a small team. Again, if procedural requirements are honoured more in the breach than the observance, it is appropriate to reconsider those arrangements, and the police IMR confirms that this is being followed up.

6.7.8 The IMR details a number of weaknesses in the conduct and outcomes of the Strategy Discussion, which
"did not agree contingencies to be considered based on the outcome of the joint visit…or of any criminal investigation …(and) failed to provide any direction as to what should happen if any images were found on Child G's phone, what should occur if any images were not obviously on her phone or if she had made any disclosure about Mr K. Nor did it discuss what action would be taken against Mr K if offences were disclosed".

6.7.9 The Strategy Discussion also failed to draw together and evaluate all the evidence that was held by the agencies. The school described the incidents of ex-pupils reporting their concerns about the nature of the relationship between Child G and Mr K, and the fact that a pupil had referred to Mr K as a pervert. However these reports were not considered and analysed in detail, indicating, as the police IMR suggests
"an apparent lack of professional curiosity by …all agencies"

6.7.10 Subsequently, as described above, the interview of Child G and her mother did not meet routine requirements in that they were not seen separately. The police IMR explains why, from a police perspective, this should have been done, even if it were anticipated that Child G would not make a full disclosure:
"There was a history of … inappropriate contact…during which time Child G had been spoken to about it by her mother and denied the relationship. It was therefore important to provide Child G with an opportunity to talk without having to lose face in the presence of her mother. It is unlikely that Child G would have disclosed the full circumstances but (she) may well have inadvertently provided additional information to enable a better risk assessment to be made".

6.7.11 During the course of the interview DC1 was told by Ms C that she had looked at Child G's phone and found inappropriate images of her daughter. Child G had "laughed this off", explaining it in terms of harmless fun with female school friends. The IMR comments that
"This provided a further concern. The explanation provided to her mother by Child G may have been true but (was) improbable, the more likely reason having regard to the history … was that she and Mr K were exchanging inappropriate images of each other."
This was significant new information from the interview which was not given sufficient weight in the continuing investigation.

6.7.12 The interview provided some evidence which eased the concerns of the investigators. Child G was bright and personable and absolutely denied any abuse. Her mother was clear that she did not believe the story. Although they were not seen separately they came across well in the interview, both individually and together. There was certainly no indication that Child G was at risk of significant harm, such that urgent action was needed. However no explanation for the current and continuing allegations had emerged and there were still clear lines of investigation for police to pursue.

6.7.13 The next step was to ascertain whether indeed there were inappropriate photos of Mr K on Child G's phone. Child G made no objection to her phone being removed by police, another reassuring factor at that point. The procedurally correct approach would then be to submit the phone to the police "Hi Tech Crime Unit" (HTCU). The HTCU can examine mobile phones to extract current and deleted images if they have not been written over. They would have had a completion target of doing this within approximately a week from the date of submission to them. They can respond immediately but what was known at that stage would not have indicated that degree of urgency.

6.7.14 In fact CPT officers did not do this. DC1 discussed the situation with a Detective Inspector (DI1) and they decided to view the phone themselves. The officers examined the phone and found nothing of concern. On that basis the police investigation took what proved to be an inappropriate turn. The phone was still to be sent to the HTCU for a full examination but, the following

day, police advised ST1 that they would not at that point be interviewing Mr K, or seizing his phone and that
"it was for the school to instigate their disciplinary procedures (as) no criminal offences had been disclosed by Child G and … it was a third party complaint at that time".
In fact, subsequent examination of Child G's phone has revealed that it did contain inappropriate images. For an appropriately trained investigator these were not difficult to find.

6.7.15 Although procedurally incorrect, because it potentially compromised any future evidential trail, the decision taken by DI1 to inspect the phone was understandable and has been explained as follows:
"he considered the legal implications and decided it was appropriate and in the best interests of getting to the truth as soon as possible to view the photos immediately rather than wait for the mobile phone unit to produce an evidential report".

6.7.16 The IMR goes on to suggest that
"DI1's decision to examine the phone had no impact on Mr K abducting Child G - to the contrary had the image been found it may have resulted in further police activity that may have prevented (the abduction)".
This is correct although it might equally be the case that Mr K, learning of the seizure of the phone, anticipated that the incriminating material would be discovered more promptly and the abduction was accelerated.

6.7.17 In any event the learning point is that police, and CSC allowed themselves to be falsely reassured by the apparent absence of incriminating evidence. Although the phone was still to be sent to the HTCU, what had been a problem requiring a multi-agency approach was now being left with the school for any immediate follow-up. This was despite the knowledge that the school had consistently avoided or been dilatory in dealing with concerns about this relationship since February.

6.7.18 The school was not notified of the outcome of the interviews and the decisions taken by police and CSC, an error arising from a lack of detail in the plans agreed at the Strategy Discussion. As the police IMR comments
"the school would have needed to know the result of the joint visit before Child G attended school to facilitate proper management of the pupil and staff member concerned".
Arrangements should have been made for either CSC or police to feed back to the school. However the situation was not clarified for the school until ST1 contacted police in the middle of the morning on Thursday, the day after Child G and her mother had been interviewed.

6.7.19 Police were not then told by the school that Mr K had called to say that he was unwell and would not be coming to work. The IMR identifies the implication:
"reporting sick following a joint visit… was indicative that he had been made aware of the police involvement".

If police had been aware that he was not at school it may be that they would then have investigated further and identified the preparations being made for the abduction of Child G.

6.7.20 Child G was reported missing to police by her mother on the Friday and the IMR describes how this report was appropriately assessed and dealt with:
"When Child G was reported missing (the Duty Inspector) took control from the outset… When the Inspector had reasons to suspect that Child G and Mr K may have gone missing together he raised her to being a High Risk Missing Person at the appropriate time…A Detective Inspector took control of the Criminal Investigation alongside the Missing Person Investigation. The school and local authority Head of Safeguarding were kept informed of developments appropriately".
This was a comprehensive response which reflected the serious nature of the matter reported.

6.8 School D

6.8.1 This review has identified serious concerns about School D's management of the situation involving Mr K and Child G. Over a period of some seven months there were a number of missed opportunities by school staff to recognise or acknowledge that there was a significant problem arising from Mr K's conduct, and that child protection intervention was necessary. Then, the process of confirming what happened and why it happened has not been straightforward. There are conflicting accounts of the facts of some aspects of the case. In all the circumstances the Panel has agreed that it is appropriate that this report should describe the events, and the evidence received by the Panel, in greater detail than might otherwise be felt necessary.

6.8.2 The first evidence of cause for concern about Mr K came to light in February following the trip to the USA. Two pupils approached the Head of the Upper School (HUS) on 24/2/12 and reported rumours that Child G had a "crush" on Mr K since the trip to America. HUS spoke to Mr K and gave him advice about maintaining professional boundaries. HUS told ST1 about this and she is said to have also spoken to Mr K about professional boundaries the following week.

6.8.3 There is no record of anyone speaking to Child G although the IMR author was subsequently told that ST1 did speak to her in the presence of senior (male) members of staff. As the IMR comments
"This situation might not have been conducive to Child G being able to express herself given the sensitive nature of the issue".

6.8.4 HUS is said by the school to have referred Child G on 24/2/12 to be seen by the School Nurse. The reason for the referral is recorded as being to discuss health issues and "*how she is feeling*". There is no record of the School Nurse receiving any referral at this time or seeing the child. There is then a record, on 28/2/12, of HUS contacting Child G's mother, Ms C,

apparently principally to discuss Child G's health. During that conversation he spoke to her about the issue of Mr K. Ms C is recorded as viewing this as a "typical teenage crush" and not feeling concerned about it – it was noted that she
"did not want it blown out of proportion".

6.8.5 Ms C says that HUS did not contact her but that she did receive a call from ST1. Ms C says that ST1 told her that there had been rumours of an inappropriate relationship between Mr K and Child G. She remembers ST1 telling her that there had been an incident in which Mr K had taken Child G's hand, to reassure her when she had become distressed about a medical issue. Ms C reports that she was told that the rumours had been investigated and that they were found to be untrue.

6.8.6 On 28/2/12, after the reported conversation with ST1, Ms C took Child G to see their GP, where they discussed a number of issues relating to Child G's health. The GP noted that she reported feeling "emotionally very stressed" and suggested that they might contact a counsellor at her school, but the GP did not feel that any further action was necessary.

6.8.7 A school Child Protection Incident Form[10] (which we now know was completed after Child G's abduction) then includes a record that on 8/3/12 (a Thursday) ST1 liaised with the Head Teacher who was "made aware of incidents to date". The form does not refer to anything else happening on 8/3/12 and that section of the form is closed, dated 10/3/12.

6.8.8 However it is known from other records that on 8/3/12 a teacher, Teacher 1, emailed ST2. The email advised ST2 that Teacher 1 had heard students saying that Mr K and Child G had
"got close during the trip to (America) and had been caught holding hands".
ST2 told Teacher 1 that she would follow this up and, that day, she emailed ST1 and HUS. The email recounted what she had been told and also said that Mr K had taken Child G out of a class, claiming that this was so that he could provide additional maths tuition. Notes presented to this review in September 2013 by ST1 referred to a Senior Management Team meeting on Thursday 8th March 2012, which was also mentioned on the time line provided by the school to this review. Present at this meeting were the Head Teacher, Head of Year (HOY) and ST1. HOY talked about '*Child G [being taken)] out of (a lesson) to Maths class*' and '*discussed crush/rumours*'

6.8.9 The school has been unable to provide adequate information about the provision of additional tuition. The IMR reports that
"staff were unable to state precisely if Child G had been formally offered Maths booster lessons by Mr K, who had requested these, how many had been held, how long the sessions had lasted until and whether there had been any parental agreement".

[10] The local authority's guidance to schools states that
"The use of a standard "Child Protection Incident / Welfare Concern" form for all staff irrespective of their role in school / educational establishment… is required".

Setting aside any child protection issues it must be a matter of concern that a school should be so unable to account for how staff and students were using their time.

6.8.10 ST1 reported to this SCR that she had met with Mr K on 9/3/12[11] and again discussed the need to maintain professional boundaries. On the following Wednesday, 14/3/12, HUS emailed ST2 to ask if arrangements had been made for Child G to see the School Nurse. ST2 contacted the School Nurse that day and the nurse saw Child G the following day,15/3/12. That contact is discussed above in section 6.2.

6.8.11 On 29/3/12 HUS emailed the Deputy Head Teacher and ST1 to advise that there had been two incidents (recorded on CCTV) of Child G not attending her class but going instead to the room where Mr K was teaching. The chronology submitted to this review by the school states that this was *"despite Mr K being warned about the need to keep professional boundaries".* That comment implies that Mr K was in some way complicit in her not being in her class or, perhaps, that colleagues feared that he might not be able to conduct himself in a professional way. In any event it clearly reflected a concern about his conduct rather than that of the child.

6.8.12 That concern emerges similarly from notes, presented to this review by ST1 in September 2013, of a discussion between her and Mr K. Those written notes are as follows:
"*Why did he ask for Child G from (her lesson)"*. Mr K's response was that they "*needed to do revision session in class"*. ST1 responded by commenting on "*how this fuelled further gossip*". (This incident appears to have taken place after Child G had already taken the exam but that does not appear to have been identified as a concern at the time). ST1 then spoke about "*hand holding on plane*" to which Mr K said that he was "*Not holding hand but tapped her hand on his shoulder*". Finally they
"*went over professional boundaries again".*
Two people holding hands is very different from a girl tapping a teacher's shoulder. That comment was a significant discrepancy in accounts of events but this inconsistency was not identified or followed up in any way.

6.8.13 On 30/3/12 the Deputy Head Teacher met with Mr K and subsequently sent an email confirming their discussion in which it had been agreed that Mr K would

- send Child G away if she tried to approach him in his classroom.
- keep his classroom door open at all times.
- not be alone with Child G

6.8.14 Following the meeting, adjustments were also made to Child G's school timetable so that she had a different maths teacher. However, as with

[11] There is a discrepancy about when this meeting took place. The school's "time line" states that the meeting took place on 8/3/12. There is no reference to it on the Child Protection Forms. ST1's notes place the meeting at 9/3/12.

the issue of extra tuition, the school's record keeping on this matter is inadequate:
"there was some discrepancy surrounding the precise dates that Mr K ceased to be Child G's Maths tutor. No exact date was known by the school. One senior manager stated that this had been shortly after the Easter break, but ST1 stated clearly that this did not take place until June 2012".
It is a further cause for concern that, on the basis of ST1's recollection, the school allowed this continuing opportunity for Mr K to promote the abusive relationship.

6.8.15 The Child Protection Incident Form, first dated 8/3/12, is concluded with a section noting that the Deputy Head Teacher had met with Mr K *"to agree supportive strategies for Mr K to manage Child G's behaviour".* This section of the form is dated 30/3/12 and also includes a note that Child G had not attended an appointment at CAMHS made for her by the School Nurse. However the appointment offered by CAMHS was not until 18/4/12. After this inconsistency was identified by the SCR Panel, demonstrating that the form could not be a contemporaneous record, the Executive Head Teacher, in a letter to the SCR Chair, confirmed that this form and all other records offered by the school had been filled in after the abduction, and that this had been known by the whole Senior Management Team. This is discussed further below.

6.8.16 The overwhelming concern arising from the matters detailed above is the lack of alertness to child protection implications. There was one very significant piece of evidence – that they were reported to be seen holding hands – which clearly indicated inappropriate conduct by the teacher. Indeed ST1 had spoken to Child G's mother about the pair holding hands. That evidence was supplemented by the account of Mr K taking Child G out of a class she should have been attending. These matters were known to a number of members of teaching staff, including the most senior staff and staff with particular child protection responsibilities. Mr K was advised about "professional boundaries", implying that in some way he had breached or was in danger of breaching those boundaries.

6.8.17 Yet the response to the situation appears to have been determined entirely from the perspective of a teacher at risk of false allegations. This sort of "fixed thinking" is repeatedly identified as a factor in situations which lead to SCRs:
"Once a view had been formed there was a reluctance to revise a judgement"[12]
What was known by the end of March clearly constituted cause for concern sufficient that school staff should have at least raised the matter with the LADO. That is not a judgment which relies on hindsight.

6.8.18 On 22/5/12, for the fifth time, school staff were alerted to evidence indicating an improper relationship between Child G and Mr K. Again this evidence was raised by other students. A student in the same year as Child G

[12] Biennial analysis of Serious Case Reviews 2005-2007, Brandon et al UEA 2009

told ST1 that she had seen correspondence between Child G and Mr K on Twitter. ST1 made no formal written record of this meeting but has provided copies of handwritten notes, apparently detailing what the student reported seeing, including three specific comments:
"*marriage falling apart*", "*separate rooms*" and "*miss you*".

6.8.19 ST1 contacted the school's IT services to enlist their support in accessing Child G's Twitter account, where they found nothing of concern. Again this was an inappropriate response to the reports received. It immediately locates the cause for concern with the child rather than the teacher, despite the nature of his comments detailed in the previous paragraph. The child was therefore the focus of the investigation, rather than the teacher. The three quotes detailed above, particularly "*miss you*", unequivocally indicate an inappropriate relationship. ST1's notes indicate that the Head Teacher was informed of these matters.

6.8.20 Even without the context of the previous concerns the school's response to this evidence of conduct which clearly flouted professional boundaries was subdued. ST1 met with Mr K the following day and advised him to adjust his Twitter account so that pupils could not use it to communicate with him. There is no formal record of this meeting but ST1 has provided a handwritten note, dated 23/5/12, which might be a record of a meeting with Mr K. It contains the comment "No (heavily underlined) Twitter messages with Child G".

6.8.21 The IMR author takes a clear view:
"It was evident … that the specific incident relating to the Twitter message did indicate a likely relationship … which was well beyond a teenage crush and therefore should have triggered a more detailed and urgent investigation by the school".
I agree with that except to add that any investigation should not now have been carried out by the school but as a formal investigation under child protection procedures. The IMR also suggests that, even setting aside the subsequent events, this situation might have prompted disciplinary action under employment procedures against Mr K. That may have been difficult to pursue in the absence of any clear "e-safety" policy which would serve to protect both students and staff. That is discussed further below.

6.8.22 There is no formal note of any discussion of this situation with Child G. However the author of the school's IMR was told that ST1 spoke to Child G and that a meeting took place in which ST1, the student who had raised the concerns and Child G were all present. This did not allow Child G the opportunity to talk openly but the content of the interview is of even greater concern than the way it was conducted. Although there is again no formal record ST1 has provided copies of hand-written comments made on a sheet of paper from her diary on which she has written
"Discussed with Child G to stop hounding Mr K in corridors…Find own-age boyfriend".

This starkly illustrates how blinkered the approach to this situation was, and how, in the face of mounting evidence to the contrary, the child continued to be identified as the problem.

6.8.23 The significance of this incident is heightened because there had been a previous problem in this school, in 2008, when a member of staff used social media to "groom"[13] a student. The IMR comments
"It does seem highly unlikely given the high profile nature of the incident in 2008, that the school would not have had at least a greater understanding and heightened awareness of the use of social media as a means to groom children and young people. Any potential lessons learnt from previous experiences do not appear to have been embedded within the school".

6.8.24 There is contradictory evidence in relation to the other two aspects of following up this reported concern – contacting Child G's mother and taking professional advice. The school has reported that, between 1/6/12 and 12/7/12 seven calls were made to Ms C. None was answered and the school reports that messages were left for her on each occasion. This account is supported by the school's automated telephone log in that there is a record of seven calls to Ms C, each lasting some 30 seconds. Ms C recalls only that a message was left on her phone on 11/6/12 - she can be clear about that date because of other significant events in the family in June. Ms C did not return the call immediately but did so three days later, leaving a message for ST1. Ms C reports that they then each made one more unsuccessful attempt to make telephone contact, after which no further action was taken. The school did not attempt to contact Ms C in writing until, by their account, 12/7/12. This was more than six weeks after these aspects of the case came to light and appears to have been prompted not by the concerns about the teacher's inappropriate use of Twitter but, as described below, by a further report of an improper relationship. Setting aside the discrepancies in the detail it is agreed that there was never any direct contact between Ms C and the school and that she was not made aware of the concerns relating to Twitter at this time.

6.8.25 In respect of taking professional advice, the school report that between 23/5/12 and 25/5/12 ST1 made *"repeated attempts to call the LADO for advice on how to proceed"*
but that
"telephone calls and messages left for the LADO were not responded to in a timely manner".
The LADO, by the nature of his job, is often away from his desk. However he has reviewed his records from that time and has found no emails or messages from the school. The school has records of three telephone calls to the LADO's number but it is not clear that any messages were left. The LADO's administrative support staff have no record of taking any messages.

6.8.26 Neither the LADO nor the school have made any formal record of what happened when the LADO did speak with ST1 which is most likely to have

[13] Child grooming refers to action deliberately undertaken with the aim of befriending and establishing an emotional connection with a child, to lower the child's inhibitions in preparation for sexual exploitation of that child,

been on 25/5/12 (a Friday). The school's timeline states that there was a telephone conversation in which the LADO advised that
"if there was no tangible evidence of grooming there were insufficient grounds for external intervention".
The IMR from CSC reports, on the basis of the interview with the LADO for this review, that
"The LADO advised that it was an internal matter for the school as no allegation had been made and that they should meet with Mr. K and set clear expectations and boundaries with him".
There is an email dated 28/5/12 from the DCPT to the LADO thanking him for his advice.

6.8.27 So, there are no reliable records but it seems that the immediate concern, the use of Twitter, was not put to the LADO as something that had happened in a context of other concerns about an inappropriate relationship. In any event, the failure to draw together all the facts known at this stage was a significant missed opportunity to understand that there was mounting evidence of a continuing, improper relationship between a teacher and a pupil.

6.8.28 On 12/6/12 the Deputy Head Teacher
"met with Mr K to catch-up with concerns about home-life and review previous action points".
There are no notes of this meeting but subsequently
"ST1 and other members of staff continued to monitor including on 22nd June 2012 Mr K's Head of Department talked to Mr K to see if any department support was needed in light of the rumours".

6.8.29 As these quotes illustrate, these steps were focussed on Mr K's perceived needs, including concerns about his situation outside school – school staff were aware that his marriage was in difficulties. Child G appears to have been viewed as an aggravating factor for a colleague under pressure. The continuing support offered to Mr K by the school is impressive but entirely informal - there is no evidence of awareness of how procedures can and should be used to protect staff who may be falsely accused. There is also no evidence of any support or appropriate concern for Child G.

6.8.30 The IMR refers to the school's response to Mr K's conduct and lack of professionalism:
"(the Twitter issue) did constitute a significant breach of professional boundaries by Mr K and at the very least should have initiated the first stages of disciplinary proceedings against (him) by the school as evidence showed that he had been spoken to on at least three occasions prior to this incident about the need to maintain professional boundaries with Child G, which had clearly been ignored".
This is an important comment. According to the Child Protection Form (B) the Head Teacher and Executive Head Teacher were aware of these events. Even if there had been no substance to the deeper concerns about the relationship with Child G, there appears to have been a complacency about such unprofessional conduct by a member of staff.

6.8.31 The school did take one initiative in response to Child G's perceived needs – she was referred by the Deputy Head of the Upper School to 'Safe Around Sex' workshops that were being run in School by the Targeted Youth Support (TYS) service. This information was initially provided to this review by the TYS and is not mentioned in the timeline prepared by School D. The TYS was not given any specific information about the reason for referring Child G. The Deputy Head has subsequently explained that his decision to make this referral was
"based solely on wider welfare concerns that the school had about Child G, not as a direct result of continuing rumours about her crush on Mr K".

6.8.32 But there was no substantial evidence of "*wider welfare concerns*" for Child G. There was certainly no evidence of promiscuity or that Child G was at risk because of any sexual activity apart from the rumours of the relationship with Mr K – which the school had dismissed as untrue. It is difficult to understand the thinking which prompted this referral: the school has reported that Child G fitted a "profile" of young women who had become pregnant soon after leaving school, in that she was vulnerable, quiet and naïve. She was certainly vulnerable but this response continued to locate any continuing problem with Child G rather than the teacher who was abusing her.

6.8.33 On 11/7/12 two ex-pupils came to the school and spoke to a member of staff, Teacher 2, expressing concern that there was an improper relationship between Child G and Mr K. No formal record was made of this but ST1 has supplied cursory notes which include the comment
"Picking her up after work experience".
Again, this is highly suggestive of a relationship being promoted by the teacher, not a teacher being pursued by a child. ST1 saw Mr K the following day. There is then a record by ST1 in the "response / outcome" section of the second Child Protection Incident form stating that
"ST1 met Mr K who denied everything and was visibly distressed that Child G telling (sic) lies about him and that the same historic rumours were being brought back up".

6.8.34 The action said to be taken in response to this was that a letter was sent by ST1 to Ms C on 12/7/12 and the Head Teacher was kept informed. There is no record of how the Head Teacher was kept informed or by whom. There was no discussion with Child G. Ms C denies ever having received such a letter but the school file which she has been given does contain a letter dated 12/7/12 from ST1 which states that ST1 has made "numerous attempts to contact you" and asks that she contact the school "as a matter of urgency".

6.8.35 In any event, this was the sixth indication of cause for concern about the relationship between Child G and Mr K. The matter was raised by ex-pupils with no reason to make a false allegation. The report of Mr K picking her up from work experience cannot be explained in terms of inappropriate conduct by Child G. Yet the staff involved, including the Head Teacher, appear to have been oblivious to the possibility that Child G was indeed being abused by Mr K.

6.8.36 ST1 has reported that she subsequently spoke to Mr K and suggested that he contact the two ex-students to discuss why they had made these allegations. This suggestion flies in the face of common sense but the fact that it was made by a teacher with a particular responsibility for child protection is a matter of even greater concern.

6.8.37 In fact Mr K told ST1 that he would contact Child G's mother instead and Ms C has confirmed that Mr K did so. She describes him telling her that Child G was pursuing him to such an extent that he was worried that this would damage his career. At one point in the conversation he became tearful. This contact can now be understood in terms of Mr K's "grooming" of her family to conceal the truth about his relationship with Child G. Ms C has reported that she entirely accepted what Mr K was telling her and subsequently rebuked her daughter for behaving in such a way.

6.8.38 The IMR author refers to recent research by the NSPCC[14] to illustrate the extent to which "early warnings" can be seen in this case. These included:

- A pupil receiving special attention or preferential treatment or additional help – Child G was receiving additional booster lessons in Maths by Mr K
- Excessive time spent alone with pupils – Child G had recently been on a school trip with other pupils to Los Angeles with Mr K (and they were seen holding hands)
- Frequently spending time with a pupil in private or isolated areas – Child G had been caught truanting in school and found in Mr K's classroom
- Using texts, telephone calls or other social media networking sites to communicate inappropriately – they were communicating via Twitter
- Other pupils are suspicious – concerns were repeatedly disclosed by pupils at the school

Yet, as the IMR comments
"at no point does any evidence point to staff within the school re-evaluating the initial assumptions they had made in the context of additional information being brought to them".

6.8.39 On Monday, 17/9/12, the school became aware of the allegation to police that there was an improper photograph of Mr K being circulated by pupils and that this was linked to the allegation of an improper relationship with Child G. The following day the Head Teacher, ST1 and the school personnel officer represented School D at the Strategy Discussion.

6.8.40 The minutes of the meeting contain information from the school which has not been recorded anywhere else. Firstly ST1 reported that another child had refused to be taught by Mr K, calling him a "*pervert*". ST1 also reported that at one point, after the concerns about use of Twitter came to light, the Deputy Head Teacher spoke to Mr K

[14] Safeguarding in Education, NSPCC (2013)

"offering him support over his marriage breakdown, and told him that ***he should not seek support from a young girl*** *(*my emphasis***)".***

6.8.41 These matters are significant. The fact that another pupil was known to have called Mr K a pervert indicates that school staff were aware that there were wider rumours about Mr K's sexual conduct, not just about inappropriate behaviour by Child G. This knowledge did not lead to any action, and does not appear to have been taken into account by any member of staff in deciding how to respond to the issues involving Child G. Then, the fact that the Deputy Head rebuked Mr K for looking to Child G for support also indicates some acceptance that Mr K was behaving inappropriately, despite advice given to him about professional boundaries.

6.8.42 Following the Strategy Discussion the school effectively became an observer of the unfolding events and played no active part. Indeed, as described above, a lack of detail in planning the investigation meant that they were not kept adequately advised of events.

6.8.43 As mentioned above, School D responded proactively to the concerns arising from this case and from other events and situations with safeguarding implications by proactively commissioning a "safeguarding review". This was led by professionals external to the school with specialist, relevant experience. It was an intensive exercise, carried out over a period of months, and culminating in April 2013. It may be significant that, for understandable logistical reasons, it did not involve students or their parents.

6.8.44 That review, which considered the situation in the school after the events leading to the Serious Case Review and the consequent publicity, was generally positive about the school's safeguarding arrangements. It noted that *"This review did not find evidence of any significant or systemic failings in safeguarding ... There were areas for further development and learning identified in order for the school to achieve best practice and recommendations have been made accordingly. There was wider learning identified for inter-agency working to achieve best practice within East Sussex and recommendations have been made accordingly".*

6.8.45 That review did not consider the specifics of this case because this SCR was in the process of doing so. However the judgment quoted above does not sit easily with the key issues arising for the school from this SCR. Clearly the SCR is about only one young person and one relatively unusual set of events, but it has investigated those circumstances in great depth. Some of the failings identified in this SCR are both significant and systemic. There is accordingly a recommendation from this report that the findings of School D's safeguarding review are re-visited, with specific reference to the key issues emerging from this SCR.

7. KEY ISSUES

7.1 Why these events have led to a Serious Case Review.

7.1.1 There has been a great deal of media coverage of the events leading to the imprisonment of Mr K. Some of that coverage has been sensitive to the effects of these matters on the family of Child G, though much of the publicity has sensationalised the events. One theme in the coverage has been a sanitisation of what happened, presenting this as a story of true but thwarted love.

7.1.2 It is right to challenge that presentation. Child G was 14 years old when Mr K first sought to form an unprofessional relationship with her. This should not be seen as a relationship based on mutual consent – it was founded in an abuse of the power he had as a result of his age and status. Child G was then sexually exploited and the sexual exploitation of children is child sexual abuse. She was abducted – that is, she was illegally removed from her parent. The abduction was perpetrated by a member of a respected profession. Mr K took opportunities afforded to him by his professional position as a teacher to abuse a child, despite the consequences for her, her family, the school, the teaching profession and indeed his own family. The judge, summing up in the criminal trial, remarked that
"I have seen nothing in the evidence which shows that at any stage you tried to provide proper boundaries between yourself and her, to discourage her, or let other staff deal with the matter appropriately… you subjected her family to appalling distress and concerns for her safety. You made no attempt to think of their welfare or let someone know she was safe".

7.1.3 These matters are unusual and do not immediately fit with the guidance on circumstances which should lead to a SCR being conducted. But the decision to carry out an SCR was carefully considered and the LSCB Chair took that decision while recognising that the statutory requirement at the time was not necessarily met. She acknowledged that Ms C felt that there should be an open investigation into what had happened. She further noted that there had been a great deal of media coverage and public interest in what had happened. She felt that it was right that a full and transparent review should be carried out, to demonstrate publicly that the agencies involved had thoroughly considered these events and were responding appropriately to the issues arising. Even though the events under review are unusual the review has identified broad themes and learning points which can assist the promotion of good safeguarding practice.

7.2 The information provided to this review by School D

7.2.1 This review has identified serious concerns about the ways in which information was recorded, stored, retrieved and provided to us by School D. Those concerns are detailed in the previous sections of this report. They emerged gradually during this review and were substantiated when it was well advanced. There may have been no intention to mislead but the Child

Protection Forms were submitted to this review without any indication that they were not contemporaneous records. It was through the SCR's investigations that it became clear that these were not contemporaneous records, that they were the only documentation of the events and that they had not been compiled until after the abduction. There has been no adequate explanation of why that was not made clear at the outset other than, effectively, to say that "we were not asked".

7.2.2 It was at best naïve not to realise that the review needed to see original documentation. Significant time was wasted before realising that there were no contemporaneous school records. It then became difficult to trust the records which were provided when they were found to contain errors and omissions. This became a particular concern when hand written notes taken at the time of events were eventually seen and it was established that critical information – for example, that Mr K was picking Child G up from work experience - had not been included in the Child Protection Forms.

7.2.3 The Chair of Governors of the school has commissioned an independent enquiry to inform a decision as to whether any action should be taken under the school's disciplinary procedures. That enquiry has confirmed many of the matters set out in this report.

7.2.4 In summary it is the clear view of the SCR Panel that the school's recording has been inadequate and fed in to this process in a way that was unhelpful. Nonetheless the SCR Panel has agreed that it has been possible to draw together a sufficiently accurate account of events to inform this report and the judgments it contains.

7.3 Recognising abuse

7.3.1 The failure of staff to identify the abuse and exploitation of Child G was a wide-ranging one. The review has not brought to light any evidence at all of any staff who had any clear concerns about Mr K's conduct. All the specialist and senior staff in the school seem to have reconstructed the events into misconduct by Child G. Mr K became the victim. Even when reporting to this review after Mr K's imprisonment, there was evidence of some school staff failing to recognise the child protection implications in some of the earlier events.

7.3.2 This is a matter of concern in itself, and one this school must address, because, as demonstrated above (and taking account of further information arising from the criminal proceedings) the evidence of the developing relationship was substantial and widely known or suspected in the school community.

7.3.3 Understanding how professionals responded to the emerging evidence in this case may be assisted by an analytical approach referred to by the Social Care Institute for Excellence (SCIE) in their work on SCRs. The "garden path syndrome" describes the way in which people accommodate new and developing information within the assumptions they have already

made about a situation. Here the general mindset from the outset was that a student was behaving inappropriately towards a teacher and the accumulating information to the contrary was dismissed or not recognised.

7.3.4 This set the parameters for the way in which new information was evaluated. It was underpinned by a broader set of assumptions about the way young people behave, the way in which teachers conduct themselves, the vulnerability of teachers to false allegations, and sympathy for an apparently engaging teacher who was known to be experiencing personal difficulties outside school. Yet the possibility that there might be cause for concern for Child G's safety was never considered.

7.3.5 That "garden path" hampered any critical evaluation of events. In particular it did not provide a context for individuals with demanding responsibilities to share concerns or, if they did not have concerns, for that to be challenged. This developing situation was not known to only a few staff. Many teachers, at the most senior level, had some awareness of what are now recognised as causes for concern but failed to reflect on that.

7.3.6 There was no formal supervision structure in place for staff with safeguarding responsibilities. Such an arrangement would have provided an opportunity to critically challenge or re-evaluate assumptions and decisions taken, and identify the growing body of evidence which clearly showed that child protection thresholds had been reached.

7.3.7 It is significant that the first recommendation from the school's safeguarding review, commissioned and completed before this review and before the criminal proceedings were concluded, is that it should *"promote a more positive culture of challenge and professional curiosity within the staff group, in order to achieve the ability to consider and proffer a differential hypothesis for presenting concerns".*
That recommendation is heavily underlined by the issues arising from this SCR.

7.4 Listening to young people

7.4.1 Safeguarding concerns were raised or came to light seven times, including the final report to police. On five of those occasions concerns were raised initially by young people – the only exceptions were the instances of Child G being seen on CCTV in locations where Mr K was teaching.

7.4.2 The fact that none of these reports led to investigation is of concern. Despite corroborative evidence the reports were dismissed, even though there was no indication that any of them were malicious or sensationalist. There is no suggestion that the reports were made by students with any reason for causing trouble either for Child G or Mr K, nor from students with any "track record" of making unwarranted claims. There was not any context at that time of Child G being bullied or harassed by other young people. There does not seem to have been any attempt to understand why concerns were

being repeatedly raised, beyond a “knee jerk” reaction of blaming the child for harassing a teacher.

7.4.3 Serious Case Reviews frequently identify failures to listen to the “voice of the child” and explain those failures in terms of organisational culture, inadequate training, manipulative parents and a range of other contributory causative factors. The child in this case may have been so caught up in this particular situation that she would have been unlikely to disclose any cause for concern. But if the young people who were raising concerns had been heard, there were a number of opportunities for interventions which might have prevented the events leading to this review.

7.4.4 The emerging concerns were not raised appropriately with Child G herself. In fact, even when there was a formal child protection investigation by experienced police and CSC officers, Child G was not seen alone. In school there was never an occasion when a member of teaching staff sought to talk to her privately, and without accusing her of wrongdoing, about her broader health and well-being. Even if all the incorrect assumptions made by school staff were true – that this was an immature young person with a “crush” on a teacher – one might have expected that someone could have tried to explore this and assist her.

7.4.5 One cannot extrapolate from this one case to conclude that there is any structural weakness in the communications between staff and students at this school, or in the school’s pastoral care. In fact there is much evidence to the contrary, set out not least in the safeguarding review commissioned by the school and completed earlier this year. Equally though school staff need to reflect on how they were deceived and misled over a period of months, by an unsophisticated and careless abuser, who did little to cover his tracks.

7.5 Working with parents

7.5.1 As Ms C has described in her contribution to the review, there was little evidence of the school seeking to involve her in tackling a problem, even in the way that they had defined it, a teacher being harassed by a student. There is conflicting evidence about attempts made to contact her but it is clear that Ms C was only spoken to by a member of teaching staff two or three times in the seven months that her daughter was being abused – and on one of those occasions the person who spoke to her was the abuser. It is also undisputed that some of the evidence of cause for concern – again, even if that were only seen as concern that her daughter was behaving inappropriately – was never shared with Ms C.

7.5.2 It does not seem that senior and specialist staff ever discussed the emerging concerns and agreed how they should be tackled. That may be to do with the specifics of this situation - this review has not heard from any other source that parents are not appropriately included in the life of the school. The school was subject to an Ofsted inspection in November 2012 and its overall effectiveness was found to be good, as was the behaviour and safety of its pupils.

7.5.3 However the review has identified that School D makes almost no use of the Common Assessment Framework[15] (CAF) arrangements. The IMR reports that
"Despite there being a small number of pupils at the school with a CAF, these were all initiated by other outside agencies. During the previous two academic years (2011-12 & 2012-13) the school was one of only three secondary schools across East Sussex who did not initiate a single CAF".

7.5.4 The CAF would have offered structured processes for starting to work with Child G and her mother, based on the school's premise, worrying enough in itself, that a child was seeking to promote an inappropriate relationship with a teacher. One would then expect that this structured approach would have enabled all those involved to identify the real areas of concern and escalate their interventions accordingly.

7.6 Record-keeping

7.6.1 This review has brought to light concerns about routine record-keeping both in CSC and at School D. For CSC the LADO did not have a reliable system for recording enquiries from schools. That has been recognised as a weakness and arrangements are being made to address this. For School D the concerns are different. There are processes in place but, in this case, they were not followed, either by those with key safeguarding responsibilities or by senior staff. It was, the IMR tells us,
"acknowledged that they did not routinely record or note discussions or meetings that they had with pupils".

7.6.2 To differing degrees the heart of the problem lies in the failure to identify that this was a safeguarding situation in the first place, but systems should be robust enough to accommodate that possibility. For the protection of all concerned the use of good quality, standardised recording arrangements needs to be an automatic response to any concern involving a relationship between a teacher and a young person which may be improper.

7.6.3 The use of forms which are headed "Child Protection" may not promote that standardised practice – the implication that a child is being abused may be counter-productive. It may be more useful to have recording and evaluation arrangements which are specific to issues relating to relationships between teachers and young people.

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[15] The CAF was established by the former Department for Children, Schools and Families. It is described as
"a standardised approach to conducting assessments of children's additional needs and deciding how these should be met…The CAF promotes more effective, earlier identification of additional needs, particularly in universal services. It aims to provide a simple process for a holistic assessment of children's needs and strengths; taking account of the roles of parents, carers and environmental factors on their development".

7.6.4 In any event a recommendation from this review will highlight the importance of maintaining accurate written records of any internal meetings which relate to child protection concerns and of any contact with statutory agencies such as LADO and the police.

7.7 E-safety

7.7.1 Mr K used "social media" – specifically, Twitter – to communicate with Child G. This was not "grooming" in the more commonly recognised reference to the process by which an adult with a sexual interest in children will approach a child online, with the intention of developing a relationship with that child. However it was part of the way he promoted the abusive relationship which led this SCR to consider issues around "e-safety".

7.7.2 The Department for Education's website[16] sets the scene:
"Technology enhances learning, and schools and colleges can do much to ensure students get the most from it, by encouraging responsible online behaviour. Involving children and young people in the development of their school's e-safety policy can minimise risk and embed important principles such as

- *keep personal information private*
- *consider the long-term implications of any content posted online*
- *do not upload or post inappropriate, offensive or illegal content to their own or other online spaces*
- *read and adhere to any website's terms of conditions of use – including those around age restrictions."*

7.7.3 Those broad principles can serve as the basis for the development of more detailed arrangements which will include guidance on how teachers should conduct themselves. There are many exemplars[17] easily available that can be used to develop that guidance. It is necessary here because, as the school's own safeguarding review found,
"the school lacks a comprehensive policy or a whole school approach and accountability for e-safety. . It is right that the focus must be on raising staff awareness to keep themselves safe and to avoid any suggestion of wrongdoing which at the same time would make investigating breaching such professional boundaries a clearer exercise. However the main focus must be on a sophisticated approach to conversations and education of pupils to ensure that they understand the complexities of safe relationships, what constitutes an unsafe relationship and how to manage this within and post school".

7.7.4 The guidance will also need to include a policy on mobile phones, which covers searching and confiscation - the intuitive reaction of ST1 in seizing

[16] http://www.education.gov.uk/schools/pupilsupport/pastoralcare/b00198456/principles-of-e-safety
[17] For example, the South West Grid for Learning Trust, an educational trust with a reputation for supporting schools with online safety has developed the following: Z:\SWGfL-School-E-Safety-Template-Policy-(without-appendices)-Oct-2013.docx

Child G's phone in May, and engaging the school's IT services in investigating it, may not have been supported by such a policy.

7.7.5 The school's safeguarding review is right to conclude that *"a more robust response across the school to staff/student contact via social media…might not have interrupted the course of events which followed (but) it might have led those around Child G who may have had knowledge of the relationship to question the relationship and challenge Child G on her actions or report concerns to staff".*

7.7.6 Having said all that, the need for a coherent e-safety policy should not mask more basic failings. Being "friends" with a student on Twitter is as clearly inappropriate for a teacher as being friends in any other sense. There was compelling evidence of inappropriate conduct before the Twitter issue came to light. In a sense the emergence of the inappropriate use of Twitter became another way in which staff rationalised and failed to recognise the evidence of sexual abuse.

8. GOOD PRACTICE

8.1 Under previous arrangements for evaluating SCRs OFSTED[18] suggested that the "best" reviews will identify
"Good practice… with… potential for wider implementation".
This review has not identified any professional practice, during the period under review, which would meet that expectation. However it is right to reiterate that Ms C was very grateful for the diligence and commitment of police and CSC in their work with her after the abduction.

9. SERIOUS CASE REVIEW PROCESS

9.1 As explained above this review was necessarily delayed for criminal proceedings to be completed. The verification of information supplied by School D also led to some extensions to the timescale for the review. Otherwise the process has been straightforward and efficient.

[18] OFSTED SCR Descriptors January 2009

10. CONCLUSIONS: KEY THEMES, MISSED OPPORTUNITIES AND LESSONS LEARNED

10.1 This review is unusual in that it arises solely from the abuse of Child G by her teacher. Child G was not abused or neglected within her family – quite the opposite. There are no key issues arising from the minimal involvement of health services. There are matters for police and CSC, and it is right that those matters are addressed, but the lessons to be learned arise, in the main, from the way in which staff at School D repeatedly failed to see the evidence of Mr K's misconduct or to hear the concerns raised by students.

10.2 It is striking that it was, overwhelmingly, young people who raised concerns about this situation. Those concerns were repeatedly dismissed. Serious Case Reviews have often commented on agencies' failures to hear the "voice of the child" but this has generally been a reference to the abused child. Here the very nature of the abuse, grooming and exploitation, made it unlikely that the victim would raise concerns. Yet agencies, and particularly the school, were too ready to dismiss the reports received from other children. That should lead those agencies to re-consider how they respond, individually and together, to concerns raised by young people.

10.3 This review has tried to identify and understand the factors which contributed to the agencies' inadequate response to the mounting cause for concern. There was, in the school, a sort of "default position" of intuitively supporting a colleague with a corresponding reluctance to believe that the colleague might be an abuser. The most senior staff had some knowledge of the situation: the fact that they did not recognise the safeguarding implications will have sent a signal to other staff, as will the similar position taken by staff with particular child protection responsibilities.

10.4 That judgment on "who to believe" needs to be located in a broader set of professional and societal assumptions about the way young people behave, the way in which teachers conduct themselves, the vulnerability of colleagues / teachers to false allegations and unfounded concerns, a fear that child protection agencies will over-react to concerns, and a sympathy for an apparently promising teacher who was known to be experiencing personal difficulties outside work.

10.5 Most significantly there was no evidence of any attempt by school staff to talk to Child G in a way that was supportive. She was never offered a private discussion with any member of staff after she was seen by the school nurse. She may not have disclosed abuse but she was not given an opportunity to do so until the abusive relationship was firmly established.

10.6 The failure by the school to involve Child G's mother in responding to these events is equally a cause for concern. Even if her daughter were not being abused but was behaving in a way that was damaging to herself and to a blameless member of staff, Ms C needed to know that. She is absolutely right to identify that she was denied the opportunity to assist her daughter.

10.7 It is not suggested that Ms C was deliberately left out of the loop. Nonetheless the failure to involve her was something more than carelessness. It was linked to the reluctance to acknowledge the increasing evidence of an improper relationship, and the tendency to re-formulate that evidence into something more routine, such as an unprofessional (but not seriously harmful) use of Twitter. While there was a significant and mounting weight of evidence of abuse there was a lack of adherence to any formal process within the school for identifying, analysing and responding to the emerging concerns.

10.8 The review has identified some weaknesses in "routine" child protection work in this case, once matters reached that stage. Initial enquiries by police should have been carried out by the Child Protection Team. The Strategy Discussion was not sufficiently thorough and did not plan against potential and predictable contingencies. The subsequent interviews did not comply with procedural requirements in that Child G and her mother were not seen separately. A decision to reconvene the meeting was inappropriately overturned. CSC may have terminated their involvement too speedily. Police may have compromised evidence by examining Child G's phone without recourse to specialist staff. It is right that these matters are identified as learning points even if they may not have affected the course of subsequent events.

10.9 The scope of the agencies' response to the events, once concerns became explicit, was limited. They have all said that the evidence of abuse by Mr K, as considered in the Strategy Discussion, was persuasive. Yet this did not lead to any discussion of the consequences of this for the school more generally. They could not have foreseen the extreme nature of subsequent events but they could have anticipated that the abuse of a child by a teacher would become known and that the consequences of that would need to be carefully managed with the collaboration of all the agencies.

10.10 The review has identified weaknesses in the agencies' arrangements for recording information – a specific issue for the LADO and a much broader range of concerns for the school. There was no contemporaneous recording of any of the emerging concerns for Child G. This is despite the fact that schools have been provided with comprehensive and accessible guidance[19] by the local authority. That guidance, in its introductory comments, notes that there has been a problem, identified in previous Serious Case Reviews, concerning record keeping by schools. This review indicates that at School D lessons had not been adequately learned. The reasons for this are inextricably linked with the continuing failure to recognise that this was an abusive relationship, but the weaknesses identified fall well below the threshold of reasonable practice in relation to record-keeping.

10.11 There is a further concern, which must be recognised, about the reliability of information the school has supplied to this review, and the fact that some matters cannot be reconciled. It was, at best, an unnecessary impediment to the process of the review that the school did not make it clear

[19] Record Keeping in Maintained Schools.doc

that no records had been kept, nor that records had been made retrospectively but were supplied in a way which led the Panel to believe that they were contemporaneous.

10.12 This section of the report started with an acknowledgment that this was, in some ways, an unusual Serious Case Review. Yet the “headline” issues emerging from the review are not unusual – they are about listening to young people, talking to children who may be victims of abuse, involving their parents purposefully, recording and sharing information reliably and planning interventions more carefully across the agencies.

11. RECOMMENDATIONS FROM THIS SERIOUS CASE REVIEW

11.1 Introduction

11.1.1 These recommendations to the LSCB reflect the key issues arising from this review. Some matters - for example, the level of seniority at which police are represented at meetings – are specific to an agency and have been addressed in the agencies' individual responses to the review. The recommendations arising from the individual agencies' reports are attached in Appendix D. There are no substantial matters arising from this review for NHS agencies and, accordingly, no recommendations.

11.1.2 Agencies have not awaited the completion of this review in order to tackle issues arising from these events. Some of these recommendations, or aspects of them, have been identified and addressed already, as part of an Action Plan.

11.2 Recommendations to the East Sussex Local Safeguarding Children Board

11.2.1 The Board should work with School D, re-visiting the findings of the school's safeguarding review, to ensure that the school can demonstrate

- an appropriate understanding, at all levels of seniority, of safeguarding issues and how to respond to them, including appropriate parental involvement.
- arrangements for the support and supervision of staff with specialist child protection responsibilities.
- compliance with arrangements for the recording of safeguarding concerns and actions taken in response to such concerns.

11.2.2 The Board should develop initiatives which promote the ability of young people in schools to raise safeguarding concerns, and the capacity of schools and other agencies to hear and respond to such concerns.

11.2.3 The Board should use this report and the outcomes of this review in training and development opportunities, particularly for school staff with safeguarding responsibilities:
"What would stop this happening in our school?"

11.2.4 The Board should promote the development of robust "e-safety" arrangements in schools

11.2.5 The Board should require the Local Authority, with input from schools and other relevant agencies, to review the arrangements for the LADO service, with reference to the key issues arising for that service from this SCR.

APPENDIX A: Composition of SCR Panel

Name / Designation	Organisation	Role
Mr Ron Lock	Independent	Panel Chair
Head of Children's Safeguards & Quality Assurance	East Sussex County Council Children's Services	Panel Member
Child Protection and Safeguarding Manager, Protecting Vulnerable People Branch	Sussex Police	Panel Member
Behaviour and Attendance Co-ordinator	East Sussex County Council Children's Services	Panel Member
Designated Doctor for Safeguarding	Hastings & Rother Clinical Commissioning Group	Panel Member
Designated Nurse for Safeguarding	Hastings & Rother Clinical Commissioning Group	Panel Member
Manager	East Sussex Safeguarding Children Board	In attendance
Mr Kevin Harrington	Independent	Overview Report author

APPENDIX B: Details of the Chair of this review and the author of this report

Independent Chair of the Serious Case Review: Mr Ron Lock

Ron Lock is a qualified social worker who has spent all his career in the field of child protection, for most of that time with the NSPCC, finishing in their employment in 2001 as a Regional Head of Child Protection Services. Since then Ron has been an independent consultant in safeguarding children, and has specialised in Serious Case Reviews, to date being involved in more than 70, either as independent chair or overview author. Whilst much of this work has occurred for a number of LSCBs across the South of England, Mr Lock has not previously worked in East Sussex and has not been involved in any earlier Serious Case Reviews which they may have undertaken.

Independent Author of Overview Report; Mr Kevin Harrington

Kevin Harrington trained in social work and social administration at the London School of Economics. He worked in local government for 25 years in a range of social care and general management positions. Since 2003 he has worked as an independent consultant to health and social care agencies in the public, private and voluntary sectors. He has a particular interest in Serious Case Reviews, in respect of children and vulnerable adults, and has contributed to around 40 such reviews. He has not previously worked in East Sussex. Mr Harrington has been involved in professional regulatory work for the General Medical Council and for the Nursing and Midwifery Council. He has served as a magistrate in the criminal courts in East London for 15 years.

APPENDIX C: Terms of Reference for this Serious Case Review

The Serious Case Review considered events in the period from September 2010, when there were concerns about the conduct of a supply teacher at School D, until the date when it was confirmed that Child G had been abducted. The agencies were asked to draw up their Individual Management Reviews around the key issues specified in Working Together, to be considered in all SCRs, namely:

- Were practitioners aware of and sensitive to the needs of the young person in their work, and knowledgeable both about potential indicators of abuse or neglect and about what to do if they had concerns about a child's welfare?
- When, and in what way, was the young person's wishes and feelings ascertained and taken into account of when making decisions about the provision of children's services? Was this information recorded?
- Did the organisation have in place policies and procedures for safeguarding and promoting the welfare of children and acting on concerns about their welfare?
- Did your agency consider that the threshold was reached for any relevant legal intervention at an earlier stage?
- What were the key relevant points/opportunities for assessment and decision making in this case in relation to the Child G and family? Do assessments and decisions appear to have been reached in an informed and professional way?
- Were concerns about this young person shared between the relevant agencies in a timely manner, with appropriate communication and analysis? Should communications be reviewed between agencies, in order to identify if there were issues of concern that were not shared?
- Did actions accord with assessments and decisions made? Were appropriate services offered/provided, or relevant enquiries made, in the light of assessments?
- Were there any issues, in communication, information sharing or service delivery, between those with responsibilities for work during normal office hours and others providing out of hours services?
- Was practice sensitive to racial, cultural, linguistic and religious identity and any issues of disability?
- Were senior managers or other organisations and professionals involved at points in the case where they should have been?
- Was the work in this case consistent with each organisation's and the LSCB's policy and procedures for safeguarding and promoting the welfare of children, and with wider professional standards?
- Were there organisational difficulties being experienced within or between agencies? Were these due to a lack of capacity in one or more organisations? Was there an adequate number of staff in post? Did any resourcing issues such as vacant posts or staff on sick leave have an impact on the case?
- Was there sufficient management accountability for decision making?

APPENDIX D: Recommendations from the agencies' management reviews

East Sussex Children's Services, Social Care

Full compliance with the Child Protection procedures around children and young people being seen on their own as part of a Child Protection Investigation, should consistently be adhered to.

During investigations and ongoing assessments, where communication through mobile phones and computers are an issue, staff should be challenged on their knowledge of the use of social media and advice and assistance should be sought

The LADO needs to complete the piece of work to ensure that recording of the work is always completed and stored appropriately and this should be agreed in consultation with senior managers.

In light of *Working Together 2013*, CSC must identify the most appropriate health professional to be invited prior to convening a Strategy Discussion

East Sussex Children's Services, Education

Re-issue their E-safety and Social Media Guidance to all schools (including primary, secondary, special schools and academies) so that all parties (students, parents and teachers) are aware of the potential pitfalls and dangers when using social media.

Review the Designated Child Protection Teacher training to ensure it includes information about multi-media technologies including social media as a means of grooming children and young people.

School D

The school should update its existing Safeguarding Policy (dated May 2012) detailing all safeguarding procedural changes implemented since May 2012.

The Safeguarding Policy should also make explicit any future procedural changes with a clear time line of their implementation. This document should be ratified no later than December 2013 and reviewed every two years.

Undertake an independent and bi-annual file audit of their child protection cases in line with the school and LSCB's expectations and standards and the findings of these file audits shared with the LSCB.

Be reminded of the importance of their responsibility of maintaining accurate written records that reflect communication and decisions in the assessment process. This should include emphasis on written records of any contact with statutory agencies such as the Police and Children's Social Services.

Be reminded of the importance of ensuring that the wishes, feelings and experiences of the child is at the centre of all assessments and ensure that children's wishes, feelings and experiences are routinely recorded as part of all safeguarding concern.

Arrange Child Exploitation and Online Protection training to all Designated Child Protection Teachers and wider IT staff about e-safety issues and possible safeguarding concerns related to the use of social media and potential for grooming.

Arrange child protection training for the Senior Management Team, Designated Child Protection Teachers and all pastoral care staff on the application of child protection thresholds.

When making a referral to outside agencies share all relevant information relating to the young person being referred.

Sussex Police

Protecting Vulnerable People Branch to perform an audit, in the next 6 months, to establish if CPT officers generally carry out the first response to allegations made against people working with children. This will enable a decision to be made whether to amend the child protection policy.

Head of Protecting Vulnerable People Branch to review, in the next 6 months, the requirement and capability for a CPT Detective Sergeant to attend all Strategy Discussions for allegations made against people working with children.

APPENDIX E: References

Footnotes have been used to indicate specific quotations from or references to research, practice guidance and other documentation. This Overview Report has been generally informed by the following publications

- Working Together to Safeguard Children (2013)
- Working Together to Safeguard Children,(HM Government 2010)
- The Victoria Climbie Inquiry (Lord Laming 2003)
- The Protection of Children in England: A Progress Report (Lord Laming 2009)
- Improving safeguarding practice, Study of Serious Case Reviews, 2001-2003 Wendy Rose & Julia Barnes DCSF 2008
- Analysing child deaths and serious injury through abuse and neglect: what can we learn – A biennial analysis of serious case reviews 2003-2005
- Understanding Serious Case Reviews and their Impact - a Biennial Analysis of Serious Case Reviews 2005-07 DCSF 2009
- Learning together to safeguard children: developing a multiagency systems approach for case reviews. (SCIE 2009)
- The Munro Review of Child Protection: Final Report (HMSO May 2011)
- The Munro Review of Child Protection: Interim Report (HMSO February 2011)
- Publication of Serious Case Review Overview Reports: Letter from Parliamentary Under Secretary of State for Children and Families 10th June 2010
- Social Networking: a guide for trainee teachers and newly qualified teachers (Childnet International 2011)
- Professional Guidance on the use of electronic communication and social media – General Teaching Council, Scotland
- Keeping Children Safe in Education – consultation documents (DfE 2013)
- Child Sexual Exploitation and the response to localised grooming (House of Commons Home Affairs Committee, June 2013)
- Executive Summary, Serious Case Review, Teacher X – Hillingdon Safeguarding Children Board, 2011
- Out of mind, out of sight – Child Exploitation & Online Protection Centre (2011)
- SCR, Daniel Pelka, Coventry LSCB, September 2013