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Child Sexual Abuse in Schools:

lessons from history, guidance for the future

Commissioned by the Independent Schools Council

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1.1 Introduction

Primary and secondary schools have been shown to be settings in which child sexual abuse has occurred in the past and can still occur today. The sheer amount of time spent by children in schools, the extent of contact time between children and teaching staff (and other staff in schools), and the innate power imbalance between children wanting to succeed and teachers responsible for helping them, makes it unsurprising that experiences of child sexual abuse in wider society are mirrored in school settings.

A school can provide a closed and hierarchical environment in which a perpetrator can develop and create opportunities, aided by both the formal and informal power and status that the role bestows. Cases of non-recent CSA demonstrate how some perpetrators have used their personal characteristics such as charisma, charm and an apparent dedication to a child/ren's education or welfare to groom children, their colleagues, parents and governors to enable and conceal their abuse.

Notably, however, whilst school settings today are highly regulated and inspected when it comes to safeguarding, the same was not true 20 or more years ago. This is illustrated by the prevalence of non-recent abuse cases from that era which have come to light, particularly during the last ten years in which it has become easier for survivors of abuse to raise concerns about their experiences. Though even today, the majority of victims of CSA do not disclose the abuse they have suffered due to their fears of not being believed, of being seen or feeling to be complicit in the abuse or of the consequences for them, their family, or the perpetrator of disclosure.

Abuse, however, is a complex subject. Policies and procedures go a long way towards protecting young people, but of fundamental importance too is an awareness of the emotional and institutional frame in which abuse takes place. Learning from the past is vitally important. Whilst safeguarding procedures and reporting protocols are very different today, the nature of the teacher/pupil relationship, the power imbalance, the circumstances in which abusive relationships can develop, and the cultural, organisational and even geographical blind spots which could exist in any school - and which can facilitate abuse - are potentially little different now from the past. The purpose of this guidance therefore is to attempt to encapsulate in one document some thematic lessons which we – as professionals working in safeguarding and schools – think can be drawn from our own and others' experiences.

1.2 Context

It is important to put child sexual abuse in the education sector in context. It is true that CSA occurs most frequently within the family. The figure, we believe, is up to 30% of all cases, although in reality, the true number is not known due to the difficulty of detection and lack of reporting. There is also online abuse, a growing and more recent phenomenon. However, abuse within institutions is highly significant. The last 40 years, since the North Wales Children's Homes scandal, has seen sector after sector hit by safeguarding scandals. Churches, children's charities, overseas aid charities, children's homes, care homes, young offenders' institutions, the armed forces, the entertainment industry, and sports bodies and clubs – most recently football – have all woken up to their past or present in terms of child abuse. And it is not just children who have been harmed in these organisations. The #MeToo campaign has brought into the public domain reports of sexual harassment of those working or seeking to work in sectors and professions where there is an inherent imbalance of power between the most junior and most senior. It is not just adults who pose a risk to children in education. Statistically, a child is much more likely to suffer abuse from a peer than from an adult. Nevertheless, taking this context into account some important questions arise. What does research show about the prevalence and patterns of CSA

generally? What is the impact of the institutional and legislative response? What are the types of environments in which abuse can, or is more likely to, occur? What are the common failings either in preventing or handling abuse which have emerged across sectors? What solutions have other sectors found to improve their safeguarding? And what can the education sector learn from this?

1.3 Prevalence of CSA

In terms of prevalence of CSA, in the 2015–16 Crime Survey for England and Wales – the first edition of this survey to ask adults whether they were abused as a child and by whom – 7% of all adults reported experiencing some form of sexual assault before the age of 16. Sexual assaults by a 'person in position of trust or authority' (e.g. teachers, doctors, carers or youth workers) accounted for 6% of the total. There also appear to be gender differences according to the type of institution, with boys more likely than girls to be abused in Christian institutions and in secure residential settings. The number of boys in these settings may help to account for this, with more boys than girls in secure residential settings and more roles historically for boys in churches (e.g. as choir or altar boys). This has implications for staff in understanding the potential impacts on male victims, and the need for support that meets the needs of boys and men. Known victims of institutional CSA are older on average than those abused in other settings. This may be partly because older children are more likely to have unaccompanied involvement with some institutions. Some studies suggest that victims of institutional CSA may experience more severe abuse over a longer duration and are more likely to be abused by multiple offenders than those abused in family settings. Once a pattern of CSA is established it can go on into adulthood for victims, with victims trapped by feelings of guilt and complicity for years. Disabled children, who are at greater risk of abuse generally, are also more vulnerable to CSA in institutional settings. There is no specific research into whether factors such as ethnicity and sexual orientation affect children and young people's vulnerability to institutional CSA.

There is also no clear picture as to what, if any, differences exist between those who commit offences in institutional settings and those who offend in other settings. Both types are similar in terms of their own previous experience of sexual or physical abuse, mental health problems, substance abuse, sexual preoccupation or emotional identification with children. The one difference appears to be that those convicted of institutional CSA are less likely to have previous sexual offence convictions. However, this is probably a reflection of the then CRB and now DBS requirements which probably deter those with convictions. Another study found that those who abused children with whom they worked had more education, lower levels of psychopathy or antisocial personality disorder, and fewer problems with drug or alcohol use than other extra-familial offenders.[1] This may not be overly surprising given the need in the workplace setting for an offender to hold down a job. This makes identifying a perpetrator of CSA in a school setting very difficult as they are able to present as able, helpful and charismatic; the qualities of a good member of staff. Research from Erooga in 2012 and Shakeshaft in 2004 indicates that teachers who sexually abuse students are often respected, even celebrated, and who have gained the trust of children, parents and the community.

1.4 Research into CSA typology

CSA which takes place through a trusted relationship outside of the family is one of several categories of CSA identified in current typologies. Following the establishment of the Centre of Expertise on CSA,

[1] Key messages from research on institutional child sexual abuse Di McNeish and Sara Scott DMSS Research September 2018 Centre of Expertise on CSA https://www.csacentre.org.uk/resources/key-messages/institutional-csa/

whose aim is to reduce the impact of CSA through improved prevention and a better response, there is ongoing research into CSA offending typology and emerging evidence on prevalence and typologies of both victims and perpetrators (https://www.csacentre.org.uk/). Most of the available research about institutional CSA relates to sports and youth justice settings, residential care, schools and religious institutions. Those who commit CSA in an institutional setting frequently have multiple victims. The Independent Inquiry into Child Sexual Abuse **(IICSA**) has created an opportunity for all organisations to learn from non-recent CSA through its publications**.** More recent understandings of institutional CSA include the ways that organisational cultures can facilitate, perpetuate and compound abuse, which may be committed by individual or multiple abusers (peers as well as adults). There is also online abuse and abuse within institutions – for example the BBC, schools (public and state), residential care homes and religious institutions – which often draws publicity for a variety of reasons.

In 2018 Henschel & Gran conducted a landscape analysis of 361 published school employee sexual abuse cases in the United States from 2014, noting factors such as offender and victim characteristics, type of incident, technology use, location of offence, and resulting disciplinary actions by schools and law enforcement. They showed that offenders were most often male and general education teachers, with approximately a quarter identified as athletic coaches. The perpetrators' average age was 36 years, while the average age of victims was 15. More than half of incidents took place at school or school-related events. The nature of school employee sexual abuse most often involved physical contact; however, technology (i.e. cell phones, computers, cameras/video recorders, and storage devices) played an important role in three out of four cases. The outcomes of these cases were also informative with over half of offenders being placed on administrative leave or resigning immediately following their arrest and almost all were convicted of their crimes.

Research shows that the key resource a perpetrator has is 'Power and Control'. The source of that power and control could be internal – the power and charisma a person has through their personality, wealth, skills or reputation – or external in terms of being derived from their role, whether they are a teacher, priest, sports or TV personality. In working with schools, we have been struck by how many victims described the awe they had of their perpetrator, frequently describing how they wanted to be special to or were fearful of crossing them. This is also reflected by victims in religious settings where the goodwill of the priest is important to the family, spiritually and often materially, or in elite music, sport or drama where the tutor or coach may hold the key to the child's future success or failure.

It is rare that CSA occurs without the victims, their families and staff in institutions being groomed by the perpetrator. Perpetrators when interviewed in prison describe how easy this is, to establish trust through treats, attention, special treatment and secrets. The list is not exhaustive as a perpetrator will shape their grooming behaviour to the needs of the specific victim and institution, such as always being the helpful member of staff. In a non-recent CSA review in a school there were clear examples where a child had been offered a biscuit and a glass of pop in a quiet room with what they described as 'comfy chairs'. This was enough to make them feel special. Then the perpetrator listened to them and the child believed they understood them. From here it became straightforward to create secrets to bind the victim to the perpetrator.

CSA requires the compliance of the victim, and often the people around them and sometimes the organisation within which it occurs. This compliance is rarely given voluntarily, but is usually obtained by charm, persuasion, influence, power and force - emotional and/or physical, delivered or threatened. Silence and ongoing compliance are then obtained and maintained by the perpetrator by that power and the fear exerted over the victim, and if needed, the environment. Once achieved compliance is relatively easy to maintain, sometimes with just a look, and many victims of CSA feel complicit and guilty. Some are even protective of their abusers. *Jeremy Forrest,* a teacher in a well performing state school, absconded with a 14-year-old pupil to France having convinced his victim that they were in love. *Forrest* had skilfully spoken with the pupil's parents, who accepted their 14-year-old vulnerable daughter had a crush on him. He also spoke to his colleagues who believed his account of her as 'hounding him'.

Forrest thereby actively reframed his abuse with him becoming the victim. His victim then complied with and promoted this narrative as it meant in doing so she could protect him.

1.5 Institutional response

The **key feature** in terms of institutional CSA and its likelihood is the **behaviour of the institution itself**, both in failing to prevent the abuse and in its response to disclosure. The trauma of the abuse is frequently compounded by responses from people associated with the institution, who find it impossible to believe that such abuse could have occurred or who deny the abuse in order to protect the institution. Disclosures from survivors have frequently been met with disbelief, denial, concealment and victim-blaming by institutions seeking to protect themselves from litigation or loss of reputation. Such behaviour can re-victimise survivors and traumatise them further. Another source of vulnerability is one in which the organisation's culture does not enable staff members to report concerns they have about other staff members, or things they have heard or seen that worry them. For instance, when an act is not obviously abusive or sexual, or in which staff feel someone to be 'untouchable' and this inhibits reporting, such as a very experienced teacher held in high regard whose behaviour is seen as 'old school' in that he or she touches pupils in a 'caring way'. Status is a recurring theme, charismatic priests or teachers who were seen by their families as important with high status such that children did not disclose abuse or a football coach with the ability to make stars of the young players.

The behavioural traits of perpetrators described above can be normalised due to attitudes and beliefs that responsible people in institutions (i.e. people like us) hold. This then affects the behaviour and thinking of the responsible people, helping them to make sense of and accommodate to a dissonance they are consciously or unconsciously feeling. A range of discourses have been identified that enable human beings to do this, from those of deflection (where abusive behaviour is dismissed or minimised), denial (where the harm done by abuse is denied) and disbelief (where there is outright rejection of the idea that abuse could have occurred). The discourses of power and belief (where the abusive use of power is recognised and survivors' testimony believed) is not always the first reaction. This is why in creating a safeguarding culture a school has to change its mindset from believing itself as a place where CSA would not occur to **believing that it can happen here.**

For those heavily committed to a school, it is hard for them **to think the unthinkable** as Keeping Children Safe in Education from 2014 on requires. In *Forrest*'s case, repeated concerns had been raised in the preceding nine months before the child was abducted but the paedophile teacher's narrative had been accepted by those around him.

1.6 An environment in which abuse can occur

Any school which does not recognise the risk of CSA or the role its own culture can have in facilitating or mitigating that risk, is likely to be an unsafe environment for children. We think that as a starting point, every school governor should ask themselves whether the following factors exist in their setting:

- individuals who, relative to pupils, are in positions of power and may be hard to challenge. These may also be staff who are hard to manage or particularly popular
- the potential for an individual to abuse their position for gratification
- the opportunity to groom a victim to engage in some form of sexual activity by securing time alone with that child or group of children

- the possibility of favour being offered in return for cooperation
- the possibility of loss of favour in the absence of cooperation
- fear of retribution or embarrassment for raising the alarm
- a culture in which rules can be broken and rule breakers (especially those who are more senior) are not held to account
- where there are no concerns as it 'does not happen here'

with the result that concerns are not raised and the conduct remains unchecked and underground.

We suggest that any school governor who answers no to more than five of these questions is either not being honest with themselves or runs a school of safeguarding perfection. The reality is that it is impossible to run a school without some of these risks. The environment in which abuse can occur is typically one which does not recognise itself as being at risk.

This then leads to the question that if the same risks, almost by definition, exist in all schools, what environment can school leaders aspire to which mitigates those risks? For anyone wanting to better understand the types of environment in which institutional abuse has been found to occur, we suggest they read the work of Marcus Erooga whose research - previously whilst at the NSPCC and now as an academic and safeguarding consultant - is widely acknowledged as authoritative. An excellent introduction to his work can be found in two NSPCC publications from 2009 and 2012 aptly named Towards Safer Organisations and Towards Safer Organisations II.

1.7 Institutional child sex offenders

Marcus Erooga (and in the 2012 study also his co-authors Debra Allnock and Paula Telford) makes many important points:

- Most abusers do not have previous criminal records - so whilst criminal checks are important to detect those that do, they can never be regarded as a panacea.
- Organisations should not make the mistake of pigeon-holing offenders (as the tabloid press frequently does). Whilst "preferential" and incredibly destructive offenders like Savile exist who have a predisposition to abuse and seek out roles which provide access to children or vulnerable adults, they are thankfully relatively rare.
- Erooga's research, which has involved in depth interviews of institutional child sex offenders, highlights the more common risks of what he terms the "opportunistic offender" who is inclined to abuse but who will be deterred by fear of the risk of detection if they perceive it to be real.
- Erooga also identifies the "situational offender" who is someone with no conscious or subconscious sexual attraction to children but who has reacted to their environment and gone on to offend against a child. As Erooga puts it in the case of situational offenders "the motivation for crime is supplied by the situation and the offence may represent an aberration in an otherwise law-abiding life. Situational offenders generally have no other criminal involvement and their offending will be a relatively isolated event, often committed as a reaction to cues". Erooga

illustrates this vividly by the following quote from an offender whose sense of isolation contributed to the environment in which she offended:

> "*to me I think the main factor in my offending was the sense of isolation I had in that school. ... although it was a very big school with a huge number of students and staff, I did feel quite isolated, I think. Partly because of how the department was and how people didn't seem to interact ... and also ... physically it was sort of on the corner of the site ... But any issues that arose ... I didn't know who to speak to about them, I didn't feel I could talk to my Head of Department because he wasn't effective in addressing anything*."

- Any steps to creating a safer environment must therefore involve creating systems which not only limit the chances of preferential offenders securing or remaining in work but also of reducing the likelihood of opportunistic or situational offending.

1.8 Grooming

Grooming is an important and complex area and one which has been studied in some detail. In many cases of CSA when they came to the fore, the offender has exhibited traits of grooming the victim and colleagues and the immediate environment prior to committing the offence. Whilst certainly true of preferential offenders, both opportunistic and situational offenders may exhibit traits of grooming behaviours once they pass the point at which they are willing to offend. There is no definitive guide to or definition of grooming, but in our view the checklist produced by the Council of International Schools is as good as any. This identifies the following stages of grooming:

- Target victim – sizes up vulnerability; identifies love/attention child seeks; assesses emotional neediness.

- Gain victim's trust – watches and gathers information; easily mixes with child and adults (caretakers; coaches; teachers); uses positional authority/proximity; may allow child to do something not permitted by parent to foster secrecy (sweets, staying up late, alcohol or drugs, viewing pornography); "you can tell me anything"; "I'll tell you a secret if you tell me one"; "If anyone was to find out that would be the end of us…"

- Gaining trust of others – normal/nice person; be a great teacher; go the extra mile; quick conversation with adults about lies/misdeeds of child to sow trust/mistrust.

- Filling a need - becoming more important to child; gifts; special attention; favouritism; special trips/activities. Demonstrating to a child they are only person who understands or appreciates them.

- Isolating the child - wedge between child and caregivers; loved or appreciated in a way not even the parents could provide (could be a positive male role model); parents may reinforce this by their own appreciation of the relationship e.g. by buying gifts, reading books to them, baby-sitting, taking them on trips, in-jokes or having a unique language.

- Gradually sexualising the relationship: desensitising – tickling; playful touches; hugs; talking as if adults (about marital problems, conflicts, etc); adult jokes and innuendo; swimming (skinny-dipping), sitting on their bed and cuddling, 'play' medical examinations.

- Maintaining control – secrecy and blame – child may feel costs of losing material needs or that special relationship, emotional consequences of exposing; keeps pushing – child may signify he/she is uncomfortable; offender says he is profoundly sorry and gains more access. For example, parents lose child. Fear of perpetrator and consequences if relationship is revealed, fear of effects on family in material and/or reputational terms. This can have particular impact in 'closed' communities, such as boarding schools or religious communities, or communities in which faith is important and highly respected in the community.

Any school looking to create a safe environment requires an understanding of how to identify the traits of grooming and of the type of environment in which grooming behaviours can occur. And by grooming we are not merely referring to the grooming of potential victims – it is as much the grooming of fellow staff members, other pupils, parents, governors or indeed of the whole institution. This makes raising a concern even harder should another colleague feel uncomfortable with certain behaviours. It was found in relation to *Vanessa George* that '*her power base within the setting and her capacity to draw other members of the staff team into her world effectively silenced them'*. Schools are far from immune from this risk, and a failure to identify the signs of institutional grooming often represents a missed opportunity of preventing CSA.

2. Recurring themes of CSA in schools

Whilst generalisation or pigeon-holing is always dangerous when examining something as complex as CSA in institutional settings, the work we have done in schools does highlight some clear themes and patterns which to us have been a factor in the resulting abuse which has occurred. Whilst many of these themes are evident from non-recent cases of CSA, it is striking how in published and other reports the themes remain in more recent cases. We explore some of these enabling themes/factors below and illustrate them by reference to published reports summarised in the appendix which is attached.

2.1 "Kings in own kingdoms"

In our experience, a common factor in institutional CSA has been that the institution has allowed the abuser to become a king in his or her own kingdom. In a school setting, which more than many is hierarchical in structure, roles such as a head teacher, a head of department (particularly one with its own building, staff and extra-curricular activities such as music, sport, drama), or a housemaster/mistress are quite capable - if occupants are not held accountable - of enabling "kings in their own kingdoms". Even in schools with a 'flatter' management structure this phenomenon has been seen with perpetrators allowed to create their own rules due to their length of service, experience, special skills, hold over other staff members or even just their charisma However past cases of CSA in schools demonstrate that the risk goes far beyond those in management roles. Because of the nature of classroom teaching, any teacher can make their classroom, club, or activity their own kingdom – whether that is by binding in their pupils into a culture of blind loyalty, secrecy or dependency ('what goes on in class stays in class') or access to treats, alcohol, or trips out, (thereby creating a sense of belonging), or simply through protecting their activities from observation or oversight.

This was very much the case in the abuse perpetrated by *William Vahey* who worked at an independent school in London. Shortly after arriving in school he set up his "travel club" which ran exotic residential trips abroad. He chose the staff and pupils who attended, he devised the rules and ratios, he controlled all communication with parents, and he insisted on taking charge of any medical issues which arose on the trip. What no-one realised was that he was drugging students on these trips and abusing them when they were unconscious, recording the abuse on photographs. He successfully resisted any meaningful oversight of his trips, often refusing to complete risk assessments and other forms until the last minute. He was found to be operating in 'plain sight', for example making no secret of medical issues which had arisen overseas with children's parents but winning their gratitude by presenting himself as the person who had come to their child's aid. When challenged by staff for his over-zealous attention to pupils, staff commented that his considerable charm could quickly turn to threats. *Vahey* thereby created his own school trip kingdom in which he could not be challenged, and he ran these trips for five years without his extensive CSA being found out.

Jonathan Thomson-Glover worked at an independent day and boarding school in Bristol. His abuse of children over a 16-year period included his use of a holiday cottage which he owned and to which his favourite pupils were chosen to go and stay. In the holiday cottage he placed hidden cameras in bathrooms or bedrooms where over a period of many years he recorded illegal images of children. He was also convicted of abusing two boys at the same holiday cottage. *Thomson-Glover* was seen as a strong character, handsome and popular with students and parents – and lower-level concerns about him went inadequately challenged. His trips to his holiday cottage with children were known to parents, but if anything, they showed more concern about their children being left out of these trips than the other way around. This illustrates how winning over parents can help secure the boundaries of a king's kingdom.

Robert Stringer's abuse of girls in a state primary between 2003 and 2009 was facilitated by the prestigious drama club which he set up and led. He used this club to test out the resistance of children

he targeted for abuse. Within the confines of the drama club he went largely unchallenged. Yet whilst several staff had concerns about this, he was difficult to manage, flouted school rules, and instilled fear in others through his own behaviour (e.g. shouting). *Stringer's* offending spanned two head teachers, neither of whom effectively challenged him. Parents meanwhile were so desperate to get their children into his drama club that they even petitioned for his return to school when he was eventually suspended (as an aside it is instructive how frequently this parental reaction occurs, until the point at which offending is proven). So, neither *Stringer's* managers nor his pupils' parents dared enter his territory.

2.2 High performance environments

Schools by their very nature are competitive environments, and at the top end are often seeking to enhance the performance of the most academically, musically or sportingly gifted children. The recent IICSA hearing into music schools for example has focused on some of the inherent risks in high performance, one on one tuition, where pupils and their parents are desperate to succeed and that success is in the hands of their teachers who are often the only ones capable of coaching to such a high level. The prize that the child may excel on a national or world stage can lead to parents being less vigilant and even grateful for the attention shown to their child by a teacher. But the risk is by no means limited to music. Sports, drama, academic work and other activities are equally vulnerable. Physical contact can be an essential part of teaching an instrument, coaching a backhand or directing an actor and a 'safe touch' approach needs to be fully articulated and understood by both teachers and children. The use of digital technology in the field of arts and sport is one of particular risk. The use of video and still images of children is seen as normal and is done often without permission. These can easily be misused and exploited in these settings and abusive images made and exploited using such situations as covers. The Australian Royal Commission looked into the case of *Grant Davies* who abused nine children of both sexes. *Davies* was the co-founder and principal dance instructor of RG Dance Studios in Sydney – a studio renowned for its winning culture and whose students often claimed top prizes at competitions. This created a highly competitive atmosphere which required long hours of attendance, conforming to rules about behaviour both at the studio and outside of it (e.g. diet). *Davies* encouraged obedience to him in order to achieve success in the world of competitive dance and was idolised by his victims and their families.

In the world of football *Eddie Heath* is one of the most prolific abusers of children to have emerged since former footballers such as Andy Woodward came forward. In *Heath's* time at Chelsea FC as a scout in the 1970s he ensured he had extensive access to boys and young men desperate to make it in football. But it was not just they who were desperate, it was frequently their families. As one survivor stated: *"My parents liked Eddie Heath and saw him as a charming, good man. They really valued the opportunity I had been given by the Club. I was the great hope for the whole family."* With this imbalance of power normal inhibitors of boundary crossing diminish, so that when *Heath* invited boys back to his house, sometimes even overnight, children and families complied. *Heath* was also the classic king in his own kingdom. Many of his survivors recall that it seemed *"no-one was watching him"* and although he behaved like no other adult at Chelsea FC *"it seemed he did not care"* and other adults *"turned a blind eye to it".* Survivors would later say that *'he would just turn up'*, that '*he was always around*' and that "*whenever you were in the shower, he would flick you with a towel*". He had his own 'den' within the club where he sometimes abused his victims. Many survivors of *Heath's* sexual abuse lived with this toxic secret believing for up to forty years they were somehow responsible for the CSA they suffered because they were 'good looking' or 'vulnerable' because of family problems. Only in 2019 when the independent review commissioned by Chelsea FC was published did they discover that *Heath* was a prolific paedophile who saw all children as potential victims and contact with them as potential opportunities to sexually abuse.

2.3 Remote or isolated locations

It seems so simple, but with rare exceptions CSA does not take place in open public locations. Grooming may take place there with fleeting physical contact but abuse typically takes place in a location where the abuser can be confident of no interruptions. *Heath* and *Thomson-Glover* are examples of abusers who used their homes as the ideal location for acts of abuse. For schools today it would clearly be seen as unacceptable for a pupil to visit the home of a teacher, save in very controlled circumstances. But schools need to look at their own buildings and campuses for rooms, areas or buildings which could facilitate abuse by a determined abuser. *Vanessa George* is known to have abused babies and very young children at a nursery in Plymouth between 2008 and 2009. Unlike other staff at the nursery, *George* chose not to use the general nappy changing areas, but to use a cubicle with a full door. She justified this on the basis that she could not bend to change nappies. Her position of power within the staff group was such that although staff became increasingly concerned about her crude language, discussion of extra marital relationships and showing indecent images of adults on her phone, they felt unable to challenge her. *Vahey* was an offender who sometimes, in order to avoid interruption, drugged not just his victims but others. His modus operandi also included the drugging of individual pupils. When they started to show symptoms of exhaustion, *Vahey* volunteered to look after them in his hotel room or tent. Like *George*, staff who tried to question him were met with an aggressive and defensive response, to the point that staff became fearful to do so (or those staff were simply not selected by *Vahey* for his next trip). *George* and *Vahey* are notorious offenders, but in our experience of CSA in schools, geographical location has often been a significant enabling factor in the abuse. It could be a music school located in its own building which is open but not staffed out of teaching time, or an art room up in the loft space which children and staff can work out of hours, or backstage in a theatre when out of hours rehearsals give 'permission' for a staff member and pupil to be there, or it could simply be a staff member's car. We recommend that every school should carry out a risk assessment of its own site, and its own practices (e.g. *George*), and its out of school activities and trips (e.g. *Vahey*) to identify locations or practices which could enable CSA.

Hally was an art teacher at Brynteg High School, a former grammar school with a proud reputation of having produced more British Lions than any other school in the UK. By providing a 'safe haven' in a school environment *Hally* was able to create his own kingdom. He made full use of the locks on the doors of the art room, the storeroom and the photography darkroom to abuse pupils. *Hally* was considered an important mentor: an excellent art teacher with results to match. *Hally* would regularly take chosen boys on their own on trips to London to museums and art galleries. Certain boys in particular were always welcome in the art room, where they could drink tea and listen to 'cool' music on the cassette player. Victims describe him operating in plain sight with there being "*a cult"* developed around him. There was an unwritten art room manifesto, where he imposed his musical tastes and political leanings on the art room boys.[2]

Most modern built schools have as their starting point in design no blind corners, primarily to reduce bullying but also to limit places where individuals can have 'secret conversations' concealed from sight. They have classroom doors with windows, so privacy generally is not available in the classroom. In older buildings this is obviously not the case and privacy can more easily be found, providing opportunities for grooming, intimacy and at worst CSA.

2.4 Culture slippage

Culture slippage is the process described by Erooga whereby an organisation's rules or standards are breached and thereafter the breach becomes normalised whereby the rule becomes more honoured in

[2] https://www.bbc.co.uk/news/uk-wales-48763471

the breach. To have culture slippage there need to be standards or rules in the first place, in order that they can be breached. However, in many cases of non-recent abuse, the fact is that there were no rules. *Heath* would be a prime example of an abuser operating in an environment without management or agreed to rules other than the ones he had created. As king in his own kingdom he set the rules and the standards. But in recent cases of CSA it is more common to see culture slippage and the gradual and ultimately accepted breach of the agreed rules or standards. Certainly, *Vahey's* school trips frequently did not adhere to the agreed rules or norms on risk assessments and staff ratios. The serious case review into *George's* offending revealed a picture in the nursery of wholesale cultural slippage. The nursery was described by staff as dirty and depressing. Recruitment practices were poor. There was poor recording of incidents and little follow-up. Ratios of staff to children were frequently breached and this gave *George* more opportunity to be on her own with a child. As a powerful character she could work to her own rules which, although this caused discomfort in her colleagues, went without challenge. There were no whistleblowing procedures or advice around nappy changing. This was an environment lacking any sense of collective pride, with no scrutiny of the work it was doing, and where disrespectful and dangerous practice went without comment – the very sort of environment where abuse could occur.

The Serious Case Review into *Nigel Leat*, who pleaded guilty to 36 sexual offences against girls (including eight counts of penetration of a child under 13) while working at a state primary school in Somerset between 2006 and 2010, found an environment where reported concerns were not taken seriously or followed up by the Head. Some 30 incidents of inappropriate behaviour reported between 2009 and 2010 ranging from inappropriate lesson content, to changing his clothes in a corridor used by pupils, to touching pupils inappropriately, resulted in nothing more than a single verbal warning. Perhaps inevitably, staff stopped reporting concerns when they felt their reports would not be taken seriously.

The case of *Denis McCarthy* who taught at Rudolph Steiner Kings Langley was considered by a TRA panel in 2019. The TRA decision depicts a culture in which *McCarthy's* inappropriate touching of pupils was not remedied in spite of repeated warnings, and in fact a school touch policy was created which permitted a degree of touch and physical contact. *McCarthy* was prohibited from teaching indefinitely with provision for a review of the prohibition order after three years.

An investigation into the case of *Thomson-Glover* noted that a liberal ethos had developed in the school from its early days and this deterred people from reporting concerns when rules were broken. The fear or apathy of reporting was not limited to staff members but extended to parents who lacked confidence in the school's complaints procedure and did not want to 'rock the boat' in case their child suffered as a consequence.

A further example of culture slippage is that of *Laurie Elizabeth Softley*, a secondary state schoolteacher known to have abused two 17-year-old male pupils. Whilst at school, *Softley* was described as a perfectionist and was said to have "transformed" the music department. Rumours had persisted among pupils and staff of inappropriate relationships with pupils. Lesser misconduct was also alleged, for example buying pupils drinks, giving them lifts in her car, swearing and being drunk in charge of an international trip. *Softley* had received a final written warning in 2008 for admitting in a Police interview to sexual activity with a pupil (the CPS took the decision not to prosecute). She was then found to have gone on to offend against a different 17-year-old pupil five years later, who disclosed her conduct in 2018. In reviewing her conduct, the Teaching Regulation Authority (**TRA**) found "*whilst the factual background to these incidents [contained within her previous disciplinary record] is separate and different to the proven allegation, the panel considers that this history is indicative of previous failures to act in accordance with the required standard of conduct*".

Culture slippage was also identified by the Australian Royal Commission in its Investigation into Institutional Responses to CSA. *Jonathan Lord* was a childcare assistant at a YMCA childcare centre in Sydney who, aged 26, was convicted in 2013 of 13 offences against children involving 12 boys between

the ages of six and ten. During *Lord's* time at the YMCA, he repeatedly breached their policies, including their child protection policies. He babysat for children (which some other staff also did) and attended outside activities with children – both in breach of express YMCA policies. He sometimes allowed children to sit on his lap and he used his mobile phone to groom children, again in breach of YMCA policy. No staff member or parent ever reported his conduct. The culture had slipped to such an extent that his conduct had become normalised.

2.5 Victims' inhibitions to seeking help

Relied upon by perpetrators of CSA, the well-known fact that victims are reluctant to tell others what has happened is a very significant enabling factor, not only to CSA occurring but to it continuing. For schools to understand this they need to listen to the voices of survivors of CSA. Here follows a series of quotes from different survivors who are describing after the event why they did not tell anyone what was happening:

> *"I was terrified. I was afraid my parents wouldn't believe me. He was very clever at manipulating people."*
>
> *"I was bruised but I had to conceal what happened."*
>
> *"How could I tell them (my parents)? Would they believe me? It would be devastating for me, so I kept silent. I believed if he touched me my brothers would be safe."*
>
> *"I could not tell my mother or older brother. I felt frightened and embarrassed and worried about my brother's probable reaction."*
>
> *"I did not tell anyone else about what happened to me. He had a good relationship with my parents, and I was aware there would be consequences if I said anything."*
>
> *"I did not see the point in telling anyone. I thought [he] was untouchable."*
>
> *"As a child I was embarrassed and sure that no-one would believe me. I also thought that if I told it would stop my chances of realising my dream."*
>
> *"I did not tell anyone about him touching me. I felt guilty and dirty. I was scared of the consequences of speaking out. I knew he was influential."*
>
> *"I did not tell any of my friends, family or others about what he had done to me. I did not think I would be believed. I did not know how to describe what had happened* and was worried I would get into trouble."

Every single one of these quotes is from a different survivor of CSA, given independently. For many, an added barrier to seeking help can be the turmoil CSA can cause as a young person is already struggling to understand their sexuality and gender identity. The message from these survivors is so clear it does not need elaboration. But it is equally clear that for so long as culture exists in any school where children worry about not being believed, about getting into trouble, or do not have the language or understanding about the conduct they have witnessed or experienced, that is a school with a high risk culture, where abuse is more likely to occur, and once it has occurred to continue.

Research has raised issues of stigma and masculine shame that cause male victims of CSA to be even more silenced than female survivors (Corbett, 2016). It has also been highlighted (e.g. in Brayley et al,

2014; Harper and Scott, 2005) that professionals are less likely to recognise signs of abuse in boys, which may be 'externalised' (as aggression, for example) rather than 'internalised' (as mental health difficulties etc). Professionals working with children and young people need to remain mindful that boys too experience CSA, including in adolescence, and that they may present with different behaviours from girls.[3]

2.6 Failure to report by the school

The role of the Local Authority Designated Officer (**LADO**) was introduced within "Working Together to Safeguard Children" guidance in 2006 and has been developed over time to meet changing national guidance contained within Keeping Children Safe in Education (**KCSIE**). Backed up by inspection, the statutory guidance ensures that schools are reporting allegations of inappropriate behaviour by adults. As further safety nets the TRA and DBS regimes also require the referral of teachers and staff members in schools generally, whenever they are dismissed for relevant misconduct (including safeguarding allegations) or where they resign in circumstances in which they might have otherwise been dismissed. Settlement or compromise agreements in cases of safeguarding allegations have effectively been outlawed by KCSIE.

Before coming to look at the current regime and reflecting on its effectiveness, it is important to look back at the 1970s and 1980s – a period when, other than the wish of the victim or duty of a good citizen to report a crime to the Police, there simply was no obligation to report allegations of CSA. This unquestionably led to widescale brushing under the carpet of such allegations, and cases from this era where the subject of the allegation was not reported and was instead permitted to resign quietly and continue his or her career elsewhere are numerous. The non-recent abuse inquiries in football and religious organisations see this lack of reporting as a desire by institutions to protect their reputation, letting the perpetrators off the hook and even colluding with the perpetrator – enabling the risk to be passed on to other organisations and other children. It was a deplorable state of affairs – not limited by any means to schools but across society as a whole as demonstrated by IICSA – and there are a great number of survivors who are owed apologies for the way in which society failed to protect them, or to tackle those who had abused them.

However, the current system – whilst infinitely better and more effective – is, like any human system, prone to the risk of failure through malpractice or simple human error. Confusion over when an allegation is an allegation is probably the principal error which is made. In the case of *Vahey*, there had been reports by some parents of inappropriate conduct – for example permitting children to watch pornography or taking a child into his hotel room to look after him. However, the relevant staff at the school did not regard these as allegations which were reportable to the LADO because the parents had made it clear that they were not complaining formally about it and did not want action taken.

The latter point, namely the perception and approach of parents, is one which comes up frequently. Parents may be so concerned at the prospect of their child becoming a victim or witness in a criminal prosecution, that their reaction to the school's suggestion of referral to Police or LADO is often to plead or demand that no referral is made. Indeed, it is not only a fear of involvement of their child in a criminal prosecution which acts as an inhibitor – sometimes it can be their own doubts of their child's account or a fear of consequences for their child in school through 'having made a fuss'. Today, we think there are few schools who would allow themselves to be dissuaded from reporting by parents. But the fact is that educating parents and managing their expectations of a school's obligations to make external referrals remains a challenge. A 'no surprises approach' is always better in that parents from their first contact with a school should know that taking safeguarding seriously requires a school to be part of a multi-

[3] https://www.csacentre.org.uk/documents/st-marys-case-file-review/ page 34

agency response to CSA. From the outset being clear in all public facing materials what protecting children means will also serve to deter perpetrators of CSA from approaching your school. IICSA[4] in 2018 identified that schools failing to protect children when there is a lack of engagement with local authorities and safeguarding boards lead to schools becoming isolated and closed from the rest of society and failing to seek assistance and support from external bodies.

The issue of mandatory reporting is unquestionably one which will be looked at carefully by IICSA. Putting the arguments for and against to one side, it is worth noting that even such a law would not eliminate the potential for human error or malpractice – although it would create clearer consequences for the school or the individual. But one is still left with the question of when an allegation is an allegation, or a concern a concern? Our practical advice to schools remains to refer anything which reaches even the low threshold of niggling doubt to allow that concern to be seen in the light of other agencies' information / intelligence. This can usefully be understood as 'if you have to think twice, refer it'.

2.7 Confusion between criminal and internal disciplinary processes

A common theme in some of the most serious cases of repeated CSA in schools is the confusing or merging in schools' minds between the criminal and internal disciplinary process which work to two different standards of proof. Too many times a criminal investigation by the Police into an allegation of CSA has resulted in a decision, somewhere along the line, not to prosecute, and what has followed on the part of the school has been a decision to reinstate the adult subject of the allegation – sometimes with restrictions on their activities, sometimes without any restrictions.

In fairness to schools, this is not an easy situation. Often (though not always) the school has little direct evidence of the allegation, and such evidence which there has been is in the hands of the Police – who historically have been reluctant to reveal it. However, that is not always the case, and, in our view, the following mistakes have often been made:

- Where there is in the school's possession evidence of inappropriate conduct on the part of the staff member, the school has failed to investigate that conduct from a disciplinary perspective in circumstances where the Police have decided to take no further action themselves. An opportunity to discipline or dismiss (and make onward TRA/DBS referral) has thereby been missed and a perpetrator may then move on to another school.

- The school may have failed to consider properly why the Police are not proceeding with a prosecution. The most common reason has been the pupil's (or his/her parents') refusal to cooperate with a prosecution. That has then been taken by some schools as a reason not to investigate from a disciplinary perspective. That is both wrong and dangerous. Where any allegation of CSA has been made by a pupil, it follows that if the Police are not going to investigate or prosecute further, the school is able to do so – with or without the consent of the pupil or his/her parents. Of course, sensitivity to the pupil and his/her family is needed, but a school cannot sensibly allow such a serious allegation to remain uninvestigated – if not by the Police, then by it or by the LADO.

- Schools have in the past sometimes failed to grasp that a staff member's actions do not need to be criminal in order to merit dismissal or other disciplinary action. Take for example the case of a teacher who is found to have had a sexual relationship with an 18-year-old pupil. No crime has

[4] https://www.iicsa.org.uk/key-documents/7747/view/child-sexual-abuse-residential-schools%3A-a-literature-review-november-2018.pdf

been committed provided that at all times the pupil was 18, but it is an example of straightforward gross misconduct viewed from the perspective of the school's own disciplinary procedures. And from a safeguarding perspective, a teacher who crosses a boundary with an 18-year-old pupil may pose a risk to children in his/her care under the age of 18. Once again, a case such as this would warrant a referral to the TRA, which is likely to issue a prohibition order.

There is not much to be gained by illustrating these common failures with particular cases – in part because it has been so common historically, but also because such situations are not hard to spot. A school should always be alerted to and fully briefed by its LADO on any Police investigations of CSA relating to any of its staff members, whether within or outside of the school confines (e.g. downloading in private of indecent images of children). Advice from the LADO nowadays will rarely allow schools to make the types of mistakes of old. And schools which are alerted to such situations can now take proper advice and consider whether to carry out their own disciplinary investigation or suitability assessment of the staff member concerned.

2.8 Failure to recognise adult vulnerability or inadequacy

Vulnerable staff may be more susceptible to engaging in destructive or anti-social behaviours such as substance abuse, or in extremis CSA. One of the CSA convicted offenders interviewed by Marcus Erooga was asked whether she could ever have imagined before she offended that she would have gone on to engage in CSA. Her response was "*No way, I worked in a school for five years and it never entered my head. If someone had said to me you would do this in a couple of years' time, I would have just laughed and said 'don't be so stupid'. Now, when I think about it, it makes me feel sick and I have to live with that".* The same offender, in trying to explain her crime went on to say "*I think I was so low at the time and it was a bit of attention I think. And that's how I got into that. I'd just had a cancer scare and I didn't communicate with my husband as I should have done".* This is echoed in the Archdiocese of Birmingham hearing before IICSA where evidence submitted to the Inquiry highlighted that some young inexperienced Priests often were working long hours, isolated from their peers and grew inappropriately close to children over time seeking emotional warmth and then sexual intimacy which they did not perceive as CSA.

Clearly not all adults who commit CSA are vulnerable; the majority are sophisticated in their grooming and sexually abusive behaviour. Indeed, at the preferential end of the spectrum there may be little sense of vulnerability at all on the part of adults who are determined to offend and willing to manipulate the vulnerable in order to do so. No one would be likely to describe *Vahey*, *Leat, George, Forrest* or *Thomson-Glover* as in any way vulnerable. For these offender types staff identifying the signs of institutional grooming is key. However, for situational offenders, whereas Erooga states their offending will be a relatively isolated event, often committed as a reaction to cues, it is the cues to which schools have to be alert. Vulnerability can be one such cue in these circumstances.

It is worth drawing a parallel with adult perpetrators of emotional abuse in this context. It is acknowledged as a common characteristic of perpetrators of emotional abuse that they have a sense of inadequacy about themselves so that they bolster their self-esteem by criticising others. The American psychologist Dr Deborah Serani states: "*Teachers who are bullies have the same characteristics as other bullies. They are sadistic and petty, gaining self-esteem through the humiliation of others. In the school environment a teacher-bully will shame a child in front of classmates, often using their position of authority in abusive ways. Maybe an extra assignment or denying your child breaktime becomes the vehicle for bullying."*

2.9 Failure to recognise vulnerable children

That children are vulnerable in themselves is recognised in our society by its need to protect them through legislation. Some adult victims of CSA in a school setting have reported feeling already distant from their families when 'sent away' to school at age 7 and that this feeling remains and leaves in them a need for and any form of comfort and attention. The fact of children being away from home, for example, may increase their vulnerability. Hence residential schools or residential trips can increase risk.

Illness and disability increase vulnerability and can provide opportunities for the perpetrator to be on his or her own with the victim. This was very much *Vahey's* modus operandi. The cases of *Myles Bradbury* at Addenbrookes Hospital and *Larry Nassar* at Michigan State University both illustrate medical professionals' ability to use children's vulnerability and their own professional positions in order to abuse. The Archdiocese of Birmingham hearing at IICSA examined evidence of priests being granted lone access to children recovering in hospital from either surgery or serious illness, and it was sometimes during these visits that they abused and groomed the children. In one case a Priest drew the curtains around the bed on a public ward. Such behaviour was accepted due to the status and prestige that the role of Priest carried. Priests were not challenged at any point by any staff member. Neither did the victims report the abuse until years later.

Some schools have a population of children whose backgrounds or conditions make them additionally vulnerable. Disability and special educational needs are acknowledged to be factors which increase vulnerability and result in a heightened risk of abuse. The serious case review into Stanbridge Earls School concluded "*the crux of these complex events is that some vulnerable girls were not adequately protected" and "the school staff and trustees generally were not sufficiently alert to the needs of vulnerable girls, when that was an apparent area of risk*".

So, whether the vulnerability is additional to the factors of their age and development and is persisting (as would be the case in a child with a disability or special education needs) or passing (such as in the wake of bereavement, divorce or separation) or even when the vulnerability is seen as lower level (homesickness, friendship problems, performance anxiety, examination nerves) schools need to recognise that with that vulnerability children become more susceptible to grooming and abuse, whether that be peer on peer abuse or CSA (whether at school or at home) or any other form of abuse, such as physical, emotional or online abuse.

The part played by a child's vulnerability is recognised by the World Health Organisation which, amongst the factors which it identifies as risk factors that make children vulnerable to CSA include:

- Unaccompanied children
- Children in foster care, adopted children, stepchildren
- Physically or mentally handicapped children
- History of past abuse
- Poverty
- War/armed conflict
- Psychological or cognitive vulnerability
- Single parent homes

- Social isolation (e.g. lacking an emotional support network)
- Parents with mental illness, or alcohol or drug dependency

In an independent school setting, children are frequently aware that their parents are investing financially and emotionally in their success. This can be an added pressure, both to excel and to make the best of their time at the school, and in turn this can be an added vulnerability. Every school ultimately has pupils who at various times will be feeling vulnerable for some reason or another. Schools need to be able to detect who they are and construct and implement individual care plans.

2.10 Lack of effective record keeping and sharing

Countless serious case reviews, whether in the education or other sectors, have criticised the poor record keeping of the organisation where the abuse occurred. They have also typically highlighted low-level concerns (or more serious concerns) which, had they been properly recorded and viewed in their entirety by the person charged with safeguarding responsibility, might have raised the alarm at an earlier point. There are two distinct deficiencies here – the first is the failure to maintain a single record of all concerns relating to a staff member, and the second is not to provide that information to the right individuals who are empowered to act on them.

In the case of *Vahey* confusion in responsibilities between different senior teachers with pastoral roles meant that different concerns were delivered to different managers. As Hugh Davies QC summarised in his review of the case, "*reports went through different channels and these channels never came together. The unfortunate but predictable result was that the Principal and DSL knew nothing of Vahey's conduct on Trips D and I and the Deputy Principal conversely knew nothing of the conduct reported on Trips G and K*". No one manager had the complete picture.

A similar picture emerged in the review undertaken of *Jimmy Savile's* crimes at Stoke Mandeville Hospital. The review reported that the full extent of *Savile's* non-consensual sexual behaviour remained unknown to the senior members of the hospital staff. This was in part due to informal and weak complaints procedures and general information management deficiencies. Further, this was an environment where each ward and department managed its own complaints internally with very little being brought to the attention of senior management. It would be very easy to imagine this arising in, for example, a residential school setting where individual houses were allowed to run their own distinct disciplinary environment, whether for house staff or pupils. It is significant in this regard that in many of the instances of non-recent abuse in a children's home run by the Catholic Church, there was an absence of any recording relating to the children's physical or emotional wellbeing or events that were significant to them. The lack of recording or obligation to record removed a safeguard and a level of restraint on staff working with these children.

2.11 Drowning out the voice of the child

The expression that children should be seen and not heard was never intended in jest. Often associated with the Victorians, it in fact emanates from the 15th century. But there can be little doubt that vestiges of that attitude remained in existence well into the 20th century, including within schools. Repeated cases of non-recent CSA illustrate the fact that allegations by children within their institutions were commonly greeted with disbelief. If they were investigated (many were not) and any sort of credible explanation given by the alleged perpetrator, there was rarely any doubt as to whose evidence weighed more heavily in the responsible adult's mind. Even sometimes when the evidence was compelling, it was not unusual

for the child to be removed from school for the "offence of promiscuous behaviour". What was as common was for the teacher or staff member to be quietly moved on to another school where other children could and often did fall victim. An investigation into children's homes run by the Catholic Church found a number of instances in which children who had made allegations of their being abused by a local Priest stated they were physically and sometimes sexually abused by the Nuns looking after them in the home as a punishment for their 'blasphemy'. Of course, any allegations were not passed on. In most cases the victim was silenced, sometimes ran away or was moved to another Home.

The Australian Royal Commission's investigation into *Geelong Grammar School* unearthed numerous examples of allegations of CSA by pupils which, when considered alongside plausible denials by longstanding staff members, were consistently ignored or doubted, even to the extent of not being reported to anyone else such as the Police. We would recommend watching the ABC news coverage in which the then Head describes the "dilemma which he faced between the allegations made by a senior and responsible student and the statement made in response by a senior and responsible member of staff". We do not regard *Geelong Grammar* as an outlier in this respect because this tendency to disbelieve children at the outset is one which is found in many cases of non-recent CSA.

Absent throughout these cases was a willingness to listen to the voice of the child. Trite though that expression can sound, it actually means little more than to treat a child's concern seriously and act on it. Yet time and time again the child's voice was drowned out in the mind of the school by louder voices whether in the form of reputational or legal concerns, out of concern for the alleged perpetrator's career, or simply because the staff member's voice was regarded as more credible and hence believed.

Any teacher knows how delicate a child's confidence in authority can be. If children discern that reporting concerns either results in no action or even makes things worse, then they will quickly retreat behind a wall of silence. That is not confined to concerns of CSA, but to peer on peer abuse, bullying, or even issues of their own mental health. Nor is it confined to children who have been the victims of, or are suffering from, any of the above. Children's friends may be more likely to be confided in or simply to hear the rumours but if they perceive that reporting results in either detriment or inaction, they are unlikely to bother. A 'telling culture' where children feel that they can report concerns, even niggling concerns, whether about themselves or their peers, is a significant protective factor. A former headmistress of a London girls' school took comfort in this regard from the fact that she positively referred to her girls as "blurters" – if there was something concerning them, especially about the wellbeing of a friend, they tended to "blurt it out". That spoke volumes about the culture of the school. Conversely, a culture of silence will leave concerns underground, and, in those circumstances, abuse can perpetuate for months before it finally comes to light.

IICSA's review of a children's home run by the Catholic Church heard evidence that Priests who were known to abuse were feared and known by the children, and most children tried to avoid known predators, and certain events such as 'Film Club' known to be the time of greatest risk of being abused. Correspondingly, new children were known to be likely targets. Despite all this informal knowledge at child level no adults were told.

2.12 Governance failure

If there is one factor which in our view is more often present than others in cases where institutional CSA has been found to occur, it is where there has been a failure of governance – which need not be a catastrophic failure, but can be as simple as a lack of principled moral leadership. By principled moral leadership we mean strong safeguarding governance driven by the clear and publicly stated desire by governors to put the welfare of children at the heart of everything which a school does.

In the countless cases of non-recent CSA in institutional settings which have come to society's attention in recent years, it has been a common theme that those in charge – at the very top of the organisation's leadership – were simply not focused on children's wellbeing. Football clubs in the 20th century are perhaps the most pertinent example. They were on one level quite understandably focussed on success on the football pitch. No boards of clubs were spending time in the 1970s or 1980s discussing or putting in place safeguarding measures to protect children in their nascent academies. Ultimately, however, senior executives in an organisation will follow the steer or the priorities of their directors or trustees. If they know that child welfare is the top of that leadership's priorities, then they will prioritise it. If conversely, they know that directors or trustees never discuss children's welfare, then they know that they will never be held to account for it and will be inclined to prioritise those other areas which they will be asked about at the next board meeting.

In the case of *Vahey*, the serious case review identified governance failure as a significant contributor to his abuse. In fact, there were two bodies nominally with governance roles over the school where he worked and confusion between them as to which was responsible for safeguarding. As a consequence, the Principal of the school was not adequately held to account in this important area. In the Australian Royal Commission's report on CSA at *Geelong Grammar* between the 1980s and 2004 the Commission took evidence on the governance of the school. Not only were there no policies or documents evidencing a requirement on the part of the three heads over that period to report allegations of CSA to the governing body, the Head between 1980 and 1995 gave evidence that he regretted the fact that he had not reported numerous allegations or concerns of possible CSA to his governing body (or to anyone else) during that period. The impression given was of a Head left to take critical decisions on his own without the support of, or being held to account by, his governors.

At a different level, the governance of both *Oxfam* and *Save the Children* relating to safeguarding of children and of staff has been called into question by recent events with the Charity Commission conducting statutory investigations into their governance. In *Stanbridge Earls* the trustees were identified as having failed to identify the risks associated with the vulnerable girls in the school. The point is that it is for trustees and directors to identify and assess safeguarding risk, to approve strategies to address those risks, and to hold their senior executives to account for implementing the agreed safeguarding strategies, policies and procedures intended to mitigate risk. Too often this priority has either not been recognised or been paid lip service. The lack of principled moral leadership from the top has unwittingly facilitated CSA within their organisations.

In the education sector, before school governing bodies put safeguarding at the heart of their governance agendas, which in reality was not until the early part of this century, CSA was always likely to, and did, occur. Practices which would never be contemplated today, such as covering up abuse or moving alleged perpetrators on with anodyne references, could in those days take place because governance of schools implicitly permitted it by its lack of focus on safeguarding and welfare. Regulation and inspection of schools in the area of safeguarding without doubt has achieved a 'nudge effect' of cultural change in school governance which is now a strong protective factor for children. In some cases, of course, perpetrators can infiltrate into these top positions involving governance and become even more powerful and manipulative. This illustrates the need for staff to be aware that abuse and cover up can take place at any level, and why in safeguarding there is the mechanism of bypassing the Head or even the Chair of Governors if there is the possibility that they may be implicated or involved in some way in the allegation. An example from IICSA's hearings into abuse within the Catholic Church involving a school illustrates the point; a male pupil stated he was abused by the local priest in the library of an open plan school during school hours. He stated he made an allegation to the headmaster soon after but was not believed and no action was taken. Eventually the child was moved by his mother to another area and school for reasons not connected with his allegations. He returned years later to the same school to enrol his own child. He found to his horror that the same priest was now on the Board of Governors of that school.

3. Reducing the risk

3.1 The impact of regulation and inspection

The discovery of the existence and indeed prevalence of neglect and abuse of children including CSA has led to significant legislation from the 1950s onwards. This was part of a wider move towards recognising that children were not the property of their families but the responsibility of the state and that the state has a duty to ensure they are protected. This process continues. It has been continually informed by developments and changes in societal attitudes and understanding and by contemporary scandals such as the Victoria Climbie case which in large part led to the introduction in 2006 of "Working Together to Safeguard Children". This was the first document to establish expectations and standards across all sectors working with children.

Knowledge, understanding and expectations have changed significantly over these years and with it practice relating to children. In terms of attitudinal shift, it is noteworthy that the notion that children should and need to be protected from sexual predation only began in the late 1860s and legislation to do so dates from the 1920s onwards. Within that the first legislation that was gender neutral was in 1960; prior to that the law had only sought to protect girls, reflecting the lack of awareness of CSA in society generally. It was not until the late 1990s that we developed the language necessary to describe and discuss CSA both within the ranks of professionals and between victims and professionals. The term 'child sexual abuse' only entered common usage within the last 20 or so years with the World Health Organisation providing a definition in 1999.

One only has to look at the transformation in terms of safeguarding in schools over the last 20 years to realise that regulation and inspection can help to lift an entire sector to a new level. Thirty years ago school governors did not discuss safeguarding at their meetings; there were no safeguarding governors or designated safeguarding leads; staff had no safeguarding induction, training or code of conduct; low-level concerns about staff were not addressed and serious allegations all too often ended in a settlement agreement and an agreed reference enabling staff to pick up their careers – and abuse – elsewhere. None of this is possible from a regulatory perspective now due to a form of regulatory "triple lock" in the form of the statutory guidance Keeping Children Safe in Education (KCSIE), the OFSTED/ISI inspection regime, and the reporting obligations placed on schools to their local authority, the DBS and the TRA. This combination quite simply gives schools no option but to comply or to fail their OFSTED or ISI inspection. Certainly, it is not fool proof, and a poorly governed and led school will still be an unsafe place for children and abuse can still happen in the best-managed and governed schools. But in our experience the chances today of serious concerns going unnoticed, the likelihood of any school not reporting allegations or concerns about inappropriate behaviour to their Local Authority or Police, and the chances of a teacher removed on safeguarding grounds not being reported to DBS/TRA is low. As for the practice of passing staff members accused of abuse onto others with a cheque and a benign reference, that has been virtually eradicated unless a Head is wilfully ignoring the law and willing to lose their job in the process.

Here are some examples of how statutory guidance in the education sector has solved specific safeguarding problems which had previously been perennial issues:

Issue	Statutory Guidance (KCSIE) Requirement
Obtaining frank references	Must both ask for and provide details in references of any safeguarding concerns.
Timely reporting to authorities	Must report all allegations to their local authority within 24 hours and all historic allegations to the Police.
Use of settlement agreements	Must not be used whenever there has been a safeguarding allegation.
Moving perpetrators on	Must report the dismissal (or resignation when dismissal is contemplated) of teachers for safeguarding reasons and other instances of gross misconduct to the TRA which has the power to bar from teaching (and publishes its decisions online). This is on top of DBS reporting obligations.
Training	Must train all staff annually and staff and governors with specific safeguarding responsibilities to a higher level.
Governance	Must appoint a safeguarding governor and governors as a whole must take steps to ensure full implementation of all safeguarding duties under the guidance. Governors to regularly review safeguarding referrals and low-level concerns thematically.

As importantly KCSIE is a living piece of statutory guidance which is revised each year to address emerging issues and common problems. So, every year schools have to revise their policies and practices in line with KCSIE.

For charitable schools, the Charity Commission has issued numerous pieces of safeguarding guidance in the recent years. Top of trustees reading list should be the regulatory alert to charities on safeguarding. Under this trustees are advised to undertake a thorough review of their charity's safeguarding governance and management arrangements and performance if one has not been done in the last 12 months. They are also advised to disclose to the Commission any serious safeguarding incidents, complaints or allegations which have not previously been reported. The Charity Commission's serious incident regime does represent another safety check on reporting by charitable schools. Given that any referable safeguarding concern arising from the child's schooling is reportable as a serious incident, there is in that an additional means of cross-checking that charitable schools are referring incidents appropriately.

3.2 Organisational/cultural solutions

Erooga illustrates with one powerful quote from an offender just how much impact an organisation's culture and systems can have on reducing the risk of abuse. This quote comes from an offender who

was known to have offended in two separate organisations but not in a residential children's home where he had worked. As Erooga notes: "Having been through a treatment process during a lengthy custodial sentence he was able to reflect on his own behaviour and attributed the change to his pattern of offending in the home to a positive child-centred organisational culture and adherence to expectations of staff behaviour:

"I think they just had good staff and good rotas, there was always lots of people about ... I just can't imagine looking back at it that you would ever have asked if you could (take kids out) – it wouldn't have been part of the norm ... it just wasn't in that environment ... that was a good environment in terms of ... child protection, yeah absolutely ... you know it's all the same things – there was boundaries, professionalism..." "

Creating or simply maintaining this safe environment is not easy and it involves a great deal more than introducing policies and procedures – albeit those do play an important role. It may sound basic, but the starting point to any solution is to identify the reasons for past failings and find ways of curing them. Whilst the common themes identified above are not a comprehensive list of every failing which has contributed to CSA in schools, it is a start. Any school governors examining their safeguarding systems and culture today can ask themselves the question of whether any of those themes could be present in their school today. It would be surprising if any school was so confident about its governance, systems and culture as to be able confidently to say no. In which case, it becomes a case of looking at what they do have, or can put, in place in order to prevent any of these enabling factors to develop or continue. The following are examples of some of the solutions introduced in schools in recent years:

- a code of conduct which establishes clear boundaries which all individuals working in an organisation, from most senior to most junior, are expected to comply

- an environment in which all employees, no matter how senior, are held to the highest standards of behaviour in every respect and boundary breach is avoided or checked

- an open culture where pupils, their peers, staff members, parents, witnesses – or anyone who just senses something is wrong – feel able to share concerns of inappropriate conduct, from the most serious allegations to low-level concerns, with a clearly identified manager with responsibility to receive and act on such concerns

- a protocol whereby statutory authorities are informed promptly – whether that be local authorities when an adult has behaved inappropriately towards a child and the Police where an employee may have committed a sexual offence against an adult or a child. But more than this, an approach and relationship with the LADO whereby the threshold for reporting to the LADO is set at a low-level, and that in the case of any doubt whatsoever a referral will be made

- policies and procedures which entrench all of the above backed up by a whistleblowing policy if those front-line policies and procedures prove ineffective

- a system and culture of governance which ensures management fully implements safeguarding systems and no-one is ever left unaccountable

- employment practices which ensure that individuals found to have committed serious misconduct of this nature are dismissed and their references for future employment reflect that (as distinct from bare fact references or settlement agreements with agreed references)

- a school site where potentially dangerous locations, buildings, rooms or practices are identified and made safe/r

- a school management and structure where no kings in own kingdoms can develop or be tolerated, meaning that everyone is subject to active line management and even difficult or maverick characters are not seen as beyond management

- governance which wears pupil welfare on its sleeve – and the actions which it takes and the things it says leave staff, pupils and parents in no doubt as to its priorities

- a pastoral regime (both of pupils and staff) which identifies and monitors vulnerability, and provides meaningful support to those individuals working with other agencies (such as children's social care and NHS) as appropriate

3.3 Low-level concerns

We believe that one solution which schools may wish to consider carefully is their approach to the monitoring and recording of low-level concerns relating to adult behaviour with children. There are clearly any number of situations which could arise in a school setting which would not be properly referable to the LADO on their own – and even if one were to refer them would run the risk of sinking a LADO in information overload. Take the example of a teacher who is observed walking with a child back from the games pitches, well behind all the other pupils, to the main school buildings. There are any number of potentially legitimate explanations for this, but to another staff member observing it could raise an alarm bell – be that body language or intensity of conversation, or simply because the Staff Code of Conduct states that staff members should not be alone with a child without another adult nearby and that is in effect the case here. That single event is clearly not referable to a LADO but what if this teacher is repeatedly observed escorting one pupil on a solo basis? If each of these instances is not recorded, it follows that no action will be taken to investigate it. If conversely, each is seen as a low-level concern and recorded centrally – in a way in which the DSL can observe a pattern – then it provides the opportunity for patterns of conduct to be spotted, investigated and acted on appropriately. The chances are that in this instance there is a perfectly good explanation, and indeed the teacher may be providing important coaching or pastoral support. But even if that is the case, the teacher would still benefit from being made aware of how their actions could be misinterpreted. In other words, taking action on low-level concerns is the surest way of maintaining the integrity of a Code of Conduct and preventing culture slippage. A culture where all staff feel empowered by their leaders to check and challenge their colleagues is both supportive and safer for all.

The regulatory and data protection aspects of low-level concern reporting and recording are addressed in detailed guidance from Farrer & Co. This is an important but complex area which is worth of serious consideration whether by way of introduction of written policies and systems or by way of a school culture to which one aspires.

3.4 A move to safeguarding risk assessment

Children and young people will always take risks, they have a need to do so to grow into rounded adults. Our role as a wider society is to ensure that they can do so within a safe context. The responsibility of keeping pupils safe is not something to be left up to government, regulators and inspectors. Yes, regulation can help lift a whole sector as described above, but ultimately each school is different, faces different risks and probably has its own particular culture. The goal in schools should not just be to comply with whatever regulation applies, but to go beyond compliance. There is ultimately no substitute for safeguarding being scrutinised at an individual school level. As part of any safeguarding risk

assessment, governors or trustees could be asking themselves a series of questions in respect of their own schools:

- What are the safeguarding risks faced by pupils and others coming into contact with the school?
- Of those risks, which are the most serious and which the most probable?
- What mitigation measures has the school put in place to reduce those risks and have those measures been properly implemented?
- Are there other measures the school can be taking to reduce risks of harm and if so when can they be implemented?
- Are there emerging risks which the school should be planning for? If so, how will they be managed?
- What can the school do to go beyond management of risk? What more can be done to promote wellbeing?

Every independent school governing body already maintains a risk register, on which safeguarding probably occupies one or two lines. We believe that governing bodies could be developing a risk register relating to safeguarding risks alone and recording the steps which they are putting in place to mitigate each of these risks. A safeguarding risk register is a way of formalising all of the above and allows for open scrutiny and sign off by all levels within a school. This could be a task delegated to school senior management but reviewed regularly by governors. It is also a helpful process which allows governors to maintain a strategic oversight of their school's approach to safeguarding risk.

Ultimately, a school's approach to safeguarding comes down to strong moral leadership from the board of governors. If safeguarding is a clear priority at governor level, it will inevitably become a priority of senior management, and so on down the line. If within a school a strong **culture** is established by the actions and decisions of those at the top, and if that culture is maintained and cultural slippage is recognised and acted on, then the school will inevitably be a safer one for pupils, staff, volunteers and all who interact with it.

3.5 Safeguarding crisis management

Safeguarding crises are an area where bad decisions made in haste are dangerous and can be hard to unravel. There are inevitably competing interests at play from the welfare of the pupil, to ensuring continued operation of the relevant school activity, to managing effective communications with stakeholders. History has taught us that in a crisis, schools have sometimes concentrated on some interests at the expense of others. In the 1960s to 1980s there is little doubt that organisations across all sectors, including schools, placed their own reputational interests above the interests of the child. This tendency needs to be resisted and with this in mind, the attached safeguarding crisis checklist (here) is recommended to all schools – the aim of which is always to place the safeguarding of the child first, but to keep management/HR and communications aligned.

Schools could consider developing their own tailored safeguarding crisis management plans, perhaps using the attached checklist as a starting point. Having done so, rather than keeping the resulting plan as a dry document, we would recommend that schools run occasional safeguarding crisis scenarios as practice runs, and that any such practice run tests the organisational responses at all levels, from class teacher to chair of governors. Why not involve your LADO in such an exercise if they are willing?

3.6 Conclusion

We strongly recommend that this guidance is read by any governor, head, DSL and bursar aspiring to lead their school effectively in what is an area which should go to the core of its existence. Our aim is not to provide a silver bullet or checklist which can be used like a cookie cutter in different schools. It is more about helping to develop an effective mindset for school leaders to approach safeguarding risk successfully. Anyone with no more than a passing knowledge of health and safety knows the importance of investigating accidents or near misses and taking corrective action to reduce future risk. That, we think, is the approach which school leaders should take to safeguarding failures or near misses within their own school.

We hope that school leaders can apply some of the lessons identified in this document in their own schools and look to some of the common solutions or recommendations made here. That said, almost the single most important factor is that they apply their minds to these questions within their own school setting and address safeguarding risk in a bespoke manner. Whether that risk is of adult CSA, peer on peer abuse, extremism (political, environmental or religious) or external risk reflecting the context in which the school operates (such as gang violence or knife crime), the same principles apply. Ultimately there is no substitute for those who are responsible believing **it can happen here,** putting their minds together to address the problem and propose solutions.

We would like to thank the Independent Schools Council for encouraging and supporting the creation of this guidance. Its contents are of course of equal application to maintained schools and academies which face exactly the same risks.

Biographies

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In employment law David has consistently been rated amongst the top-rated UK employment lawyers by Chambers and Legal 500. He advises institutional employers on the discrete handling of potentially high-profile employment cases. He is also acknowledged to be one of the leading employment law advisers to senior executives, typically advising on PLC board and private equity moves and departures. Outside of employment law, David advises leading independent schools and focuses on issues relating to staff, pupils and parents – from sensitive dismissals to pupil exclusions and parental complaints. David is also probably the most experienced safeguarding lawyer in the country. He founded the firm's Child Protection Unit (now known as the Safeguarding Unit) in 2015 which advises organisations either working or coming into contact with children. These include schools, universities, charities, churches, visitor attractions, sports clubs and the medical sector. David advises on the full range of safeguarding issues, from creating safer systems to handling live cases and carrying out retrospective reviews. He is particularly well known for his role in advising on the Southbank International Vahey case where he led the Farrer & Co team in conducting the Independent Review of Hugh Davies QC.

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Jan Pickles OBE

Jan is a freelance Safeguarding Consultant with a background in Policing, Social Work and Probation. She chairs the UK Advisory Board at the Centre for Expertise on Child Sexual Abuse and is a member of the National Safeguarding Board for Wales. Jan has authored numerous recent reviews into historic and current CSA in Education and Sport as well as wider Safeguarding Reviews for Local Authorities and other agencies.

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Mary Breen
Schools Adviser

In the new role of Schools Adviser, Mary provides support and guidance to schools, working alongside our team of education and safeguarding lawyers. She gives practical, school-focused advice, assisting heads, senior staff and governors. She brings a unique insight into this role, based on her experience of headship at St Mary's Ascot over the past twenty years.

Prior to St Mary's Ascot, Mary was Head of Physics at Eton College and has taught at Wellington College and the Abbey School Reading. She has served as a Governor at six schools and is a Member of the Charters School Board. She has been a member of the Girls' Schools Association (GSA) Inspections Committee and Boarding Committee, the Committee of the Catholic Independent Schools Conference (CISC) and the National Committee of the Headmasters' and Headmistresses' Conference (HMC).

Mary has delivered sessions on strategic planning, development campaigns, sustaining leadership and preparing for headship at GSA, HMC and CISC new heads and national conferences and has spoken at the Boarding Schools Association (BSA) national conference.

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Sarah Fletcher is currently High Mistress of St Paul's Girls' School. She was previously head of Kingston Grammar School and of City of London School.

Sarah has taught in a number of schools at home and abroad: boarding, day, single-sex, co-educational, state and independent. She was director of studies at Rugby School then deputy head with responsibility for safeguarding. She has a strong interest in curriculum reform and in encouraging creativity in teaching and learning and was involved from the outset in the development of the Extended Project Qualification and the Cambridge Pre-U, sitting on the Pre-U Steering Committee from inception to launch.

Sarah is a school governor and a board member of The School and Family Works, a social enterprise company which operates in state primary schools to support families in resolving deep seated familial and behavioural issues. She was closely involved in the Warwickshire Children, Young People and Families Partnership Forum alongside the Warwickshire School Learning and Education Sub-Committee. She has delivered seminars and lectures on pastoral care, mental health, teaching, curriculum reform and school management.

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Appendix A – Table of Fifteen Cases of Child Sexual Abuse In Organisational Settings

With due credit for cases 1 – 5 which originally appeared in Wonnacott J and Foster J, Shaw H (2018) *After Savile: Implications for Educational Settings in Protections* in Erooga M (ed) *Protecting Children and Adults from Abuse After Savile* (see footnote 1) and to Marcus Erooga for cases 6 – 15 which appear in Safeguarding Unit, Farrer & Co (Adele Eastman, Jane Foster, Owen O'Rorke and David Smellie), Marcus Erooga, Katherine Fudakowski and Hugh Davies QC (2020) *Developing and implementing a low-level concerns policy: A guide for organisations which work with children*

Appendix A

Table Of Fifteen Cases Of Child Sexual Abuse In Organisational Settings

This table contains examples of fifteen cases of child sexual abuse by adults in organisational settings which were subsequently the subject of a public enquiry or published external review.

Its purpose is to illustrate that it is rare for cases of organisational child sexual abuse to occur without there having been preceding concerns observed by others. It also highlights other relevant issues about the circumstances of the abuse.

Education Sector[1]

Case and source of information	**1. Vanessa George** Not for profit nursery (UK) for children aged 2+ and babies under 1year. Plymouth Safeguarding Children Board (2010) ***Serious Case Review re Nursery Z***. Plymouth, Plymouth Safeguarding Children Board.
The Perpetrator	Female nursery worker. Aged 39 when sentenced in 2009. ***Known*** to have abused babies and children between late 2008 and June 2009. Concerns about Ms. George's behaviour were raised from late 2008 (she joined the nursery in 2006). Took indecent images of, and sexually abused children at, the nursery where she worked. Sent images of herself abusing children at the nursery to a male who she met over the internet. She did not meet him in person until their trial. A popular member of staff who was described as having changed around the time of the commencement of the abuse. Initially described by community as happy and bubbly. "Although she was not senior in her position, other factors such as her age, personality and length of service could have created an illusion of position of power and encouraged a sense of trust."
Known victim(s)	Babies and children under school age - exact ages unknown. Police were unable to identify victims. Victims were too young to report the abuse.
Colleagues	Staff noted changes from December 2008 when George started to talk about chasing men and sexual encounters. Ms. George was noted to not use general nappy changing areas but to use cubicle with full door. Ms. George justi fed this on the basis that she could not bend to change nappies. Ms. George's physical bulk blocked line of sight of her activities. Ms. George's position of power within the staffgroup was such that although staff became increasingly concerned about her crude language, discussion of extra-marital relationships and showing indecent images of adults on her phone, they felt unable to challenge her. It is possible that staff believed they had "allowed" the abuse to happen by having been shown sexualised pictures of adults and consequently did not know how to raise this with others. By drawing others partially into her activities. Student on placement was petrified of the nursery manager.

Continued on next page

Education Sector[1]

Organisational culture	Staffdescribed the nursery as dirty, depressing and demoralising.
	Poor recruitment practices.
	Roles and boundaries not clear.
	Roles of Trustees not clear.
	Complaints procedure not clear.
	Cliques within staffmade it difficult to report or act.
	Poor recording of incidents and follow up.
	No whistle blowing procedures or advice around e.g. nappy changing etc.
	Ratio of staff to children frequently breached, allowing Ms. George more opportunities to be alone with a child.
	Review of records and staffinterview made it clear that was not able consistently to provide a safe, positive environment for the children in its care.
	Staff had little or no knowledge of sexual abuse or offending.
Family and community	Parents thought the manager was the owner of the nursery.
	Governance arrangements were poor.
	Parents did not know how to make a complaint.
	Parents and nursery workers socialised together - blurring boundaries.
	Manager's role as governor of the school (and foster carer) made it difficult to challenge the culture of the nursery.

1 Information on cases 1-5 originally appeared in Wonnacott, J., Foster, J. and Shaw, H. (2018) After Savile: Implications for Education Settings in M. Erooga, M. (ed) ***Protecting Children and Adults from Abuse After Savile***, London, Jessica Kingsley Publishers

Education Sector[1]

Case and source of information	**2. Robert Stringer** State Primary (UK). Raynes, B (2011) ***Executive Summary of Serious Case Review Written About Teacher Mr X,*** Hillingdon Local Safeguarding Children Board.
The Perpetrator	Male; joined the school as a newly qualified teacher. Committed suicide when due for trial in 2010, aged 56. Known to have abused girls between 2003 and 2009. Concerns about Mr. Stringer's behaviour were raised in 1998 - the year he joined the school. Charged with 25 offences against four girls between 2000-2007. Set up and led a prestigious drama club. Used this to test out the likely resistance of children he targeted for abuse. Difficult to manage, he flouted school rules and his lessons were known to lack structure.
Known victim(s)	Girls under 13 years old, the youngest aged 9. Known to have favourites. Pupils aware that Mr. Stringer had access to a large knife used in drama productions. Pupils sought status through selection for roles in the drama club. Pupils were told he would go to prison if they disclosed and no-one would then be able to look after his disabled wife.
Colleagues	Head and colleagues found Mr. Stringer "difficult". Instilled fear in staff through behaviour e.g. shouting at them. Staff expressed concerns about Mr. Stringer's relationship with pupils in the drama club. Anonymous referral made to the Head. Reported concerns included suspicious photos on Mr. Stringer's computer and showing 15 rated DVD with explicit sex scenes to year 5 (9-year-old) pupils. This latter concern was reported by the parent of another child. Two teachers who attended safer recruitment training informed the Head that Mr. Stringer "ticks all the boxes of the exercise ***profile of an abuser***".
Organisational culture	Mr Stringer's offending spanned the tenure of two Head Teachers. Weak leadership of the first Head and personal distractions of the second Head fostered a culture where safeguarding was not taken seriously. Lack of record keeping meant patterns of behaviour were not identified.
Family and community	Parents were desperate for their children to get into the drama club which Stringer used to foster strong relationships with parents. Parents petitioned for Mr. Stringer to return to the school when suspended. Mr. Stringer had strong backing from the governing body making it difficult for second Head to challenge him.

Education Sector[1]

Case and source of information	**3. Nigel Leat** State Primary (UK). North Somerset Safeguarding Children Board (2012) ***Serious Case Review: The Sexual Abuse of Pupils in a First School Overview Report***, Weston-Super-Mare, NSSCB.
The Perpetrator	Male; joined the school as a mature newly qualified teacher, who had previously worked as a musician and music teacher. Aged 51 when imprisoned in 2011. Known to have abused girls between 2006 and 2010. Concerns about Mr. Leat's behaviour were recognised from the time at which he joined the school in 1996. Pleaded guilty to 36 sexual offences including 8 counts of penetration of a child under 13. Possessed 30,500 indecent photographs and 720 indecent films. Despite having been acting senior teacher at the school for 6 months and, at various times appointed as lead coordinator or in a support role to lead coordinator for a range of subjects, he was known to have a lax approach to teaching and classroom discipline.
Known victim(s)	Female primary school victims, the youngest aged 6 years. Mr. Leat had favourite pupils, all female, to whom he gave privileges and presents. Targeted those as favourites those academically less able, vulnerable and "pretty". Two pupils reported to the school that he kissed them and touched their legs but the abuse only came to light after a pupil made a disclosure to her mother.
Colleagues	30 incidents of inappropriate behaviour reported between 1999-2010, ranging from low-level issues around content of lessons to touching pupils inappropriately. It was "common knowledge" that Mr. Leat made inappropriate jokes. Staff were unaware of safeguarding procedures and internal training had not enabled them to identify Leat as an abuser. Non-professional staff made complaints, for example, Mr. Leat having a child on his knee, and having an erection whilst holding a child. The only action in relation to any of these concerns was a single verbal warning.
Organisational culture	Evidence of poor relationships in school. Not all staff felt they were treated equally. The school culture did not put children first and discouraged open communication. There was evidence of a hierarchical culture where junior staff did not feel they would be taken seriously and the Head teacher not rigorously following up concerns.
Family and community	School community not particularly local - parents may not have shared concerns with each other. School not seen by external agencies as needing support leading to false sense of security in the parent group.

1 Information on cases 1-5 originally appeared in Wonnacott, J., Foster, J. and Shaw, H. (2018) After Savile: Implications for Education Settings in M. Erooga, M. (ed) ***Protecting Children and Adults from Abuse After Savile***, London, Jessica Kingsley Publishers

Education Sector[1]

Case and source of information	**4. Jeremy Forrest** State Secondary (UK). East Sussex Safeguarding Children Board (2013) ***Serious Case Review: Child*** G, Brighton, East Sussex Safeguarding Children Board.
The Perpetrator	Male teacher. Aged 30 when convicted in 2013. Known to have abused one female pupil during 2012. Concerns about Mr. Forrest's behaviour were raised over a period of 9 months before the abduction of his victim in September 2012. Developed an older "boyfriend" relationship with a teenage girl. Set up additional lessons and contacted via social media.
Known victim(s)	One female pupil aged 14-15 who was already known to have been vulnerable from contact with a previous abuser when aged 12.
Colleagues	Accumulating concerns, aware of "inappropriate relationship", used Twitter to communicate with pupil. Colleagues supportive and reluctant to believe he might be an abuser. Mr. Forrest seen as the victim of pupil's infatuation. Teacher noted in diary "Discussed with Child G to stop hounding Mr K in corridors…Find own-age boyfriend".
Organisational culture	Safeguarding not high on agenda in spite of recent case of abuse in the school which resulted in a member of staff being imprisoned. A "Head in the sand" approach to safeguarding and assumption that allegations were false. Adult focused culture where pupil's voices were not heard. Victim seen as the problem.
Family and community	Mr. Forrest spoke directly to parents of the pupil to reassure them there was no relationship. Parents accepted daughter had a "crush".

1 Information on cases 1-5 originally appeared in Wonnacott, J., Foster, J. and Shaw, H. (2018) After Savile: Implications for Education Settings in M. Erooga, M. (ed) ***Protecting Children and Adults from Abuse After Savile***, London, Jessica Kingsley Publishers

Education Sector[1]

Case and source of information	**5. William Vahey** Secondary private / International (UK). Davies. H. (2014) ***Southbank International School Independent Review arising from the criminal conduct of William Vahey: Final Report,*** London, Farrer and Co, LLP. Wonnacott, J. and Carmi. E. (2016) ***Serious Case Review: Southbank International School,*** Hammersmith and Fulham, Kensington & Chelsea and Westminster LSCB.
The Perpetrator	Male teacher. Identified as an abuser in 2014. Committed suicide aged 64 in 2014 prior to being apprehended by the FBI. ***Known*** to have abused 54 secondary aged boys between 2009 and 2013 (possibly having offended for decades in a career that involved teaching in number of international schools). Concerns about Mr. Vahey's behaviour were raised during his first week at the school in 2009. Previous history in the USA (1969) of abusing children not picked up in pre-employment checks. Ran a prestigious 'travel club' involving residential trips abroad. On trips Mr. Vahey drugged victims, many of whom were not then, and are still not, aware that they were abused. Aligned himself with those in power making it difficult to challenge behaviour that may have caused concern. Abuse came to light after Mr. Vahey had left the school and was working abroad when a domestic maid stole a data stick containing images of his abuse.
Known victim(s)	Abused boys aged between 12-14 years. Chose either very popular pupils or those with some vulnerability. Pupils were 'chosen' or selected to go on trips and trips were used as a way for him to be alone with pupils. Pupils joked that Mr. Vahey was a "paedo" but his popularity and mechanism for abusing boys when they were drugged meant that no formal allegations were made.
Colleagues	Some staff were uneasy about Mr. Vahey's behaviour but put it down to his "informal style". Not universally popular with staff but was difficult to challenge as he aligned himself with those in power. Staff were overtly threatened that he could use his wife's influence (she held a high-profile position in the professional community) to damage their careers. Training on safeguarding had focused mainly on abuse within the family and did not equip staff to understand indicators of abuse in their own organisation or how to report them. ***Continued on next page***

1 Information on cases 1-5 originally appeared in Wonnacott, J., Foster, J. and Shaw, H. (2018) After Savile: Implications for Education Settings in M. Erooga, M. (ed) ***Protecting Children and Adults from Abuse After Savile***, London, Jessica Kingsley Publishers

Education Sector[1]

Organisational culture	Laissez-faire and relaxed under first headship. Changes in leadership, management and proprietors caused uncertainty and rifts in staff group. This diverted attention from any concerns about Mr. Vahey. Over-reliance on external inspection regimes rather than reflective practice with clear lines of accountability concerning governance to scrutinise effectiveness of safeguarding practice.
Family and community	Mr. Vahey quickly normalised behaviours such as being alone with children and manipulating staff ratios for trips. Popular with parents and students - Mr. Vahey came second in teacher popularity ratings. Families from abroad may not have been familiar with child protection expectations and procedures in UK and were provided with very limited information. School a strong social hub for families from abroad where school perceived as “part of the family”.

Education Sector[1]

Case and source of information	**6. Jonathon Thomson-Glover** Independent boys' day and boarding school (UK). Jones, P. (2016) ***Investigation into Safeguarding Issues at Clifton College Arising from The Prosecution Of X,*** Bristol: Clifton College.
The Perpetrator	Male Housemaster, teacher and former pupil of the school. Aged 53 when convicted in 2016. ***Known*** to have abused secondary aged boys over a period of 16 years. Also took covert indecent photographs and video of male and female pupils. Concerns about Mr. Thomson-Glover's behaviour were raised from 1999 onwards. Convicted of taking indecent images of pupils between 1998-2004. 330 tapes recovered by Police. Secretly installed cameras. Groomed pupils through providing friendship, beer, pizza, socialising and encouraging them to break school rules. Sexualised relationships through "banter" and discussing his own sexual relationships. Befriended adult carers and Head teachers. Described by boys as behaving like a friend rather than a teacher.
Known victim(s)	Boys - described as "good looking, naughty, sporty" were favourites. "Chosen" to go and stay at holiday cottage owned by Mr. Thomson-Glover, where he also abused two boys. Victims were also chosen to socialise with Mr. Thomson-Glover in his (school) study, where alcohol was consumed. In 2003 pupils complained about Mr. Thomson-Glover sleeping in the school boarding house, locking the kitchen and drinking alcohol.
Colleagues	Colleagues noticed blurred boundaries between pupils and Mr. Thomson-Glover. An Education Psychologist was concerned about favourites and Mr. Thomson-Glover fitting the profile of an abuser. Several allegations were made about Mr. Thomson-Glover being tied up in his study by pupils in a state of undress. A cleaner reported Mr. Thomson-Glover wrapping a boy in cellophane as a prank. Concerns were expressed by non-teaching staffwho could see Mr. Thomson-Glover's behaviour was different from other staff. Complaints were diluted, lost or disbelieved as they went up the management chain.
Organisational culture	Liberal ethos in school had developed from its early days and this deterred people from reporting concerns when rules were broken. Favouritism part of school culture. Culture of "informally socialising". Culture of "pranks" in the school. Lack of curiosity or consideration that it could happen here.

Continued on next page

1 Information on cases 1-5 originally appeared in Wonnacott, J., Foster, J. and Shaw, H. (2018) After Savile: Implications for Education Settings in M. Erooga, M. (ed) ***Protecting Children and Adults from Abuse After Savile***, London, Jessica Kingsley Publishers

Education Sector[1]

Family and community	Permeable boundaries with families, some of whom would make private visits to Mr. Thomson-Glover's holiday cottage. Some parents complained that trips were only for favourites. Lack of confidence in the complaints system by families in late 2000's – did not want to" rock the boat" in case it was taken out on pupil. Head and Mr. Thomson-Glover seemed to be friends.

Education Sector[1]

Case and source of information	**7. Laurie Elizabeth Softley** State Secondary (Academy). Teacher Regulation Agency Professional conduct panel outcome November 2018. https://www.derbytelegraph.co.uk/news/derby-news/lifetime-classroom-ban-ecclesbourne-sex-2409856
The Perpetrator	Female music teacher. Aged 34 when prohibited from teaching. CPS took the decision not to prosecute. Known to have sexually abused 17-year-old male pupil in 2008 (on more than one occasion), and a second 17-year-old male pupil in 2013 (on more than one occasion). Both cases of abuse were arranged via social media, and involved alcohol and visits to Ms. Softley's home. Investigated and given a final written warning in 2007. Rumours then existed in school about Ms. Softley's behaviour from 2013. Comment was made on behalf of the Secretary of State regarding Ms. Softley's disciplinary record at the school "***whilst the factual background to these incidents is separate and different to the proven allegation, the panel considers that this history is indicative of previous failures to act in accordance with required standard of conduct***." The panel found little or no evidence that Ms. Softley had any insight into her actions. A report in the Derby Telegraph newspaper suggests the behaviours involved swearing and being drunk in charge of an international trip.
Known victim(s)	Two male pupils. Pupil A, aged 17 in 2007. Pupil B, aged 17 in 2013. Pupil B disclosed in 2017 that Ms. Softley had engaged in sexual activity with him, leading to a police investigation.
Colleagues	In 2013 a teacher overheard pupils discussing rumours of an inappropriate relationship between Ms. Softley and pupil B.
Organisational culture	Final written warning for gross misconduct given in 2008 re pupil A - following Ms. Softley's admission in police interview that sexual activity had occurred between her and pupil A. In 2013, an investigation took place re: pupil B but both he and Ms, Softley denied it. Accounts were sought from other pupils at the school but no direct evidence was found and the matter was closed.
Family and community	Pupils allegedly joked that "She'll buy you a drink – and apparently she'll do more than that". Pupil B said that when she picked him up in her car she was uncoordinated and missed the gears. Pupil B had heard rumours that she had "slept with the lads in the years above me". Whilst at the school Ms. Softley had 'transformed' the music department and was described as a perfectionist.

1 Information on cases 1-5 originally appeared in Wonnacott, J., Foster, J. and Shaw, H. (2018) After Savile: Implications for Education Settings in M. Erooga, M. (ed) ***Protecting Children and Adults from Abuse After Savile***, London, Jessica Kingsley Publishers

Sports and Leisure

Case and source of information	**8. Jerry (Gerald) Sandusky** Penn State University (USA). Freeh, L. Sporkin, S. and Sullivan, W. (2012) ***Report of the Special Investigative Council Regarding the Actions of The Pennsylvania State University Related to Child Sexual Abuse Committed by Gerald A. Sandusky,*** Washington DC; Freeh, Sporkin and Sullivan, LLP.
The Perpetrator	A male football coach at Penn State University (PSU), and founder of the Second Mile Foundation, a non-profit organisation which served underprivileged and at-risk youth. In those roles Mr. Sandusky was a nationally known celebrity in the sports community. The Second Mile Foundation was praised as a "shining example" of charity work by U.S. President George H. W. Bush in 1990. Aged 68 in 2012 when convicted of abusing 10 boys and young men between 1994- 2008 ***Known*** to have abused boys and young men between 1994 - 2008. An allegation about Mr. Sandusky's abuse was first made in 1998.
Known victim(s)	Since Mr. Sandusky's conviction further allegations of his abuse of boys and young men have been made. He targeted potential victims through the football programs in which he was a leading figure and through his Second Mile Foundation.
Colleagues	Several staffmembers regularly observed him showering with young boys, none reported this behaviour to their managers. Some of the offences for which Mr. Sandusky was subsequently convicted occurred during this time. Concerns about Mr. Sandusky's behaviour were reported to PSU managers after this time but were not appropriately responded to or acted upon.
Organisational culture	The independent review noted a "total and consistent disregard by the most senior leaders at Penn State for the safety of Sandusky's child victims" (P.14). Further, 4 senior figures at PSU actively "concealed Sandusky's activities form the Board of Trustees, the University community and authorities." (P.14).
Family and community	Mr. Sandusky was well known in the community and highly regarded for his work with youths. The inquiry describes a culture of reverence for the football program (of which Sandusky was a key element) "…that is ingrained at all levels of the campus community" (P.17).

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Sports and Leisure

Case and source of information	**9. Grant Davies** RG Dance Studio, Sydney (Australia). Royal Commission Investigation into Institutional Responses to Child Sexual Abuse (2017) ***Report of Case Study No. 37: The response of the Australian Institute of Music and RG Dance to allegations of child sexual abuse***, Commonwealth of Australia, Sydney.
The Perpetrator	Male co-owner (with his sister), and principal instructor of, a nationally known dance studio in Sydney, Australia. Aged 41 when convicted in 2015. ***Known*** to have abused girl and boy students from 2002. Allegations of abuse were first made against Mr. Davies in 2007. As well as sexually assaulting students, Mr. Davies took indecent photographs of them and exchanged thousands of explicit text messages with two young female adolescent victims and their mother. In 2015, Mr. Davies pleaded guilty to 28 charges relating to child sex offences over a period of 13 years against adolescent female and dance students. Sentenced to 24 years imprisonment, and to serve 18 years before being considered for parole. Had both hierarchical power as co-owner and principal dance instructor and was an organisational and national dance community celebrity. Mr. Davies used his positional and ascribed authority to enable him to make rules that enabled his abusive behaviour. This included giving private tutoring in a secluded location and to be generally regarded as 'above suspicion', despite concerns arising about aspects of his behaviour e.g. choregraphing sexualised dance routines.
Known victim(s)	Male and female students aged between 10-14 years. Mr. Davies encouraged obedience to him in order to achieve success in the world of competitive dance and was idolised by many of his victims and their families. One parent described the dance students as being 'on a constant emotional roller-coaster', with Mr. Davies encouraging the children to push themselves to extremes in their performance to please,rather than anger, him. Students felt emotionally blackmailed by Mr. Davies or were otherwise afraid of him.
Colleagues	Mr. Davies' only significant colleague was his sister and co-owner. Other dance instructors were also employed at the studio, but overall it appears that by conflating the success of the dance studio and individual students' achievements with sexualised practices (e.g. not allowing underwear or a G-string while performing) Mr. Davies was able to divert concern about his behaviour.
Organisational culture	A key element of the studio culture was its reputation for having a 'winning' culture, with students often claiming top prizes at competitions. This engendered a highly competitive atmosphere which required long hours of attendance, conformity to rules about behaviour at the studio and outside of it (e.g. diet). This led to a high level of compliance with Mr. Davies' expectations and gratitude to him for what was achieved.

Continued on next page

Sports and Leisure

Family and community	Two mothers of Davies victims were separately complicit in the abuse. One was subsequently convicted and imprisoned for taking and sending naked, indecent photographs of her two daughters to Mr. Davies. The other mother was described as "obviously acquiescing" to Mr. Davies' grooming of her daughter and was given a suspended prison sentence. Students and teachers who expressed concern were accused of telling lies or labelled as 'troublemakers'. The inquiry also found that: (i) parents were groomed to comply with Mr. Davies' wishes; (ii) reports of child sexual abuse were not made in a timely manner, or were otherwise hindered because Mr. Davies' standing and position within RG Dance intimidated students and families; and (iii) students and parents felt a strong desire to succeed in dance and feared that non-compliance with Mr. Davies' behaviour would have a negative impact on the students' dance careers.

Sports and Leisure

Case and source of information	**10. Professor Victor Makarov** The Australian Institute of Music (AIM), Sydney (Australia). Royal Commission Investigation into Institutional Responses to Child Sexual Abuse (2017), ***Report of Case Study No. 37: The response of the Australian Institute of Music and RG Dance to allegations of child sexual abuse***, Commonwealth of Australia, Sydney.
The Perpetrator	Male Professor of Music. Aged 51, when arrested in February 2004. Known to have abused boys between 2002 – 2004. Allegations of abuse were first made in 2004. Arrested in February 2004 and charged with sexual offences against two male students. In May 2004, he was charged with a further 19 charges of child sexual assault in relation to an additional three male students. The offences took place at the Institute and Professor Makarov's home. In a total of four trials Professor Makarov was convicted of 26 charges, ranging from gross indecency to aggravated indecent assaults and aggravated sexual intercourse with a minor. He was sentenced to a total of 12 years' imprisonment.
Known victim(s)	Male students aged from 13-17 years. One student victim gave evidence that over time his family became very close to Professor Makarov's family and bought him presents for his birthday, Christmas and when he went on overseas trips.
Colleagues	
Organisational culture	At the time of the allegations against Professor Makarov, AIM did not have any policies, procedures or systems in place concerning the prevention, handling and receiving of complaints, and the conduct of investigations of allegations of child sexual abuse, and it provided no training to staff on reportable offences. When AIM was made aware of an allegation by one of Professor Makarov's students they suspended Professor Makarov for a weekend. After he was charged with the offences and bailed AIM decided that he should continue to work but be supervised at all times. Despite advice to the contrary this was apparently due to a view that AIM was in a 'legal bind' between the risk of prejudicing Makarov's interests at trial and child protection. The New South Wales Department of Education and Training subsequently advised that Professor Makarov was rated a 'high level of risk' but this did not prompt AIM to change its position not to suspend him.
Family and community	

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Health Professionals

Case and source of information	**11. Dr. Myles Bradbury** Addenbrookes Hospital (UK). Scott-Moncrieff, L. and Morris, B. (2015) ***Independent investigation into governance arrangements in the paediatric haematology and oncology service at Cambridge University Hospitals NHS Foundation Trust following the Myles Bradbury case,*** Cambridge, Cambridge University Hospitals NHS Foundation Trust (UK).
The Perpetrator	Male Consultant Paediatric Haematologist at Addenbrookes' Hospital, Cambridge, UK. Aged 42 when convicted in 2015. Known to have abused boys between 2007 – 2013. In 2005 Dr. Bradbury purchased a video with images of naked people, including children. Interpol were made aware of this in 2010. Behaviours of concern at Addenbrookes Hospital were identified in retrospect, but not recognised as significant at the time. Dr. Bradbury was sentenced to 22 years imprisonment in 2015, reduced to 16 years on appeal in 2016.
Known victim(s)	Dr. Bradbury pleaded guilty to 28 offences against children, committed over some 3.5 years against 18 male patients aged between 10-15 years during medical examinations. As well as sexual assaults, the offences included voyeurism by secretly filming patients with a camera concealed in a pen during medical examinations. Two were offences of possession of 16,000 indecent images of children of a similar age to the patients he abused.
Colleagues	The inquiry indicated that no-one interviewed as part of their and the police investigation, including the families of victims, as well as Trust staff, had raised any concern about Bradbury's behaviour with the Trust, or with anyone else, nor were they aware of anyone else raising a concern. Dr. Bradbury justified not adhering to usual practice and rules by suggesting his 'adjustments' to schedules and protocols were in his patients' best interests - e.g. non-chaperoned to appointments to spare boys' embarrassment. The inquiry concluded "We consider that the staff on the (unit) are not to blame for failing to be suspicious of Dr Bradbury's behaviour" (P. 13).
Organisational culture	Dr. Bradbury had hierarchical power as a senior medical practitioner, and this was the basis of his ability to circumvent agreed policies and safeguarding rules. The inquiry was generally positive about the Trust, and observed that it had "robust and effective safeguarding governance arrangements, going to Board level" (P. 13).
Family and community	Dr. Bradbury was involved in church and Scout groups in the community, and was described as "a man of great charm and persuasiveness" whom everybody trusted. Dr. Bradbury abused vulnerable patients and exploited the doctor /patient relationship to conceal the abuse. When one victim raised concerns with his mother, she responded: "He's a doctor, it must be necessary."

Health Professionals

Case and source of information	**12. Dr. Larry Nassar** Michigan State University, USA Gymnastics and the US Olympic Committee (USA). McPhee, J. and Dowden, J. (2018) ***Report of the Independent Investigation: The Constellation of Factors Underlying Larry Nassar's Abuse of Athletes***, New York, Ropes and Gray
The Perpetrator	Male team physician and national medical co-ordinator for the USA Gymnastics national team for 20 years. He was also a physician at the School of Osteopathic Medicine at Michigan State University - where he treated the School's gymnasts and other athletes and the team physician to Holt High School, Michigan. Aged 56 when convicted in 2017. ***Alleged*** to have abused girls since 1994. Concern about Dr. Nassar first expressed, by a parent, in 1997. In 2017 and 2018, Dr. Nassar was convicted of 10 charges of sexual offences against female adolescent patients and of possessing 37,000 child abuse images, as well as a video of him molesting underage patients. In three separate trials in Federal and State courts during 2017 and 2018, Dr. Nassar was sentenced, cumulatively, to between 140 and 360 years in prison.
Known victim(s)	Subsequent to Dr. Nassar's conviction, a financial settlement was reached in relation to 332 victims of his sexually abusive behaviour, and it is estimated that overall Dr. Nassar committed thousands of acts of abusive behaviour with over 400 adult and minor victims. Dr. Nassar used physical force, feigned friendship and concern, and the imposing nature of his national position and reputation to enable him to commit acts of abuse which were often physically painful for his victims, as well as to keep them from reporting.
Colleagues	Dr. Nassar's power was derived from his hierarchical and positional authority as the National Medical Coordinator for US Gymnastics, as the most senior physician in the organisation and a Professor of Medicine at Michigan State University. His 20-year position with US Gymnastics created organisational celebrity as the foremost medical expert in the sport. Dr. Nassar used his position and power to justify a medical need for vaginal 'manipulation' as a routine part of his treatment regime, to justify seeing patients unchaperoned, and persuading victims that their discomfort with his procedures was justified. Dr. Nassar used his position and his reputation to convince his patients, their parents, and other physicians that these treatments were medically appropriate, even after complaints were made. During his trial it was concluded that they were in fact primarily for his sexual gratification.

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Health Professionals

Organisational culture	The independent investigation suggested that Dr. Nassar acted "within an ecosystem that facilitated his criminal acts." It goes on to state that "Numerous institutions and individuals enabled his abuse and failed to stop him, including coaches at the club and elite level, trainers and medical professionals, administrators and coaches at Michigan State University, and officials at both United States of America Gymnastics and the United States Olympic Committee. These institutions and individuals ignored warning signs, failed to recognise textbook grooming behaviours, and on occasion dismissed clear calls for help from those being abused by Dr. Nassar. Multiple law enforcement agencies, in turn, failed effectively to intervene when presented with opportunities to do so." (P.2-3).
Family and community	When survivors first began to come forward publicly, some were shunned, shamed, or disbelieved by others in their own communities.

Other Settings

Case and source of information	**13. Jonathan Lord** YMCA, New South Wales (Australia). Royal Commission Investigation into Institutional Responses to Child Sexual Abuse (2014)***, Report of Case Study No. 2 YMCA NSW's response to the conduct of Jonathan Lord,*** Commonwealth of Australia, Sydney
The Perpetrator	Male childcare assistant at a YMCA childcare centre at Caringbah. Sydney, Australia. Aged 26 when convicted in 2013. ***Believed*** to have abused boys from 2009. In 2009 Mr. Lord was dismissed from a YMCA summer camp in the USA for "questionable behaviour" with an 8-year-old male camp attendee. Later that year he started work at the YMCA childcare centre YMCA in Sydney as a childcare assistant. This is the setting where he committed the offences for which he was convicted. By early 2013, Mr. Lord had been convicted of 13 offences involving 12 boys: (i) eleven counts of aggravated indecent assault on a person under 16 years; and (ii) two counts of sexual intercourse with a child under 10 and under authority. Mr. Lord was sentenced to 10 years' imprisonment, with a non-parole period of 6 years.
Known victim(s)	While employed with YMCA NSW, Mr. Lord groomed and sexually abused several boys, aged between 6 and 10 years, at YMCA NSW and elsewhere. Many of hisoffences were committed on YMCA premises and during excursions.
Colleagues	Mr. Lord regularly breached YMCA NSW child protection policies: he was regularly babysitting and attending outside activities with children from YMCA NSW. Both were prohibited activities for all childcare staff. Although some staff and parents knew that Mr. Lord babysat for children outside YMCA hours, they never reported his conduct. In fact, other staff also babysat YMCA children, as didthe manager. A further area where Mr. Lord repeatedly breached policies was allowing children to sit on his lap, sometimes when other staffwere present. He also used his mobile phone at work to groom children so he could offend against them. Both these activities were in breach of YMCA NSW policy. YMCA Caringbah staff did not identify this behaviour as contrary to the policies. ***Continued on next page***

Other Settingss

Organisational culture	During the period of Mr. Lord's employment, YMCA NSW had over 80 policies in place, and many referred to child sexual abuse and maltreatment. However, the Commission heard expert evidence that the policies were too complex, and sometimes inconsistent and inadequately communicated to staff and parents. Overall, the Commission concluded that YMCA Caringbah did not have an effective system for ensuring that staff and parents were aware of and understood its child protection policies, and that there was a serious breakdown in the application of YMCA NSW's child protection policies at YMCA Caringbah. The extent of the policy breaches identified suggests a breakdown in communication between management and staff. Although YMCA NSW did have a reporting system, it was ineffective. Some junior staff stated that they felt uncomfortable speaking to their managers, or worried that nothing would be done about their concerns. In its report, the Commission's concerns were such that it recommended that the YMCA consider whether the General Manager of Children's Services, and the Chief Executive Officer, were fit and proper to hold those positions.
Family and community	Mr. Lord was a generally popular and well-liked member of staff. However, when one mother of a child to whom he showed inappropriate images complained, she did not consider that she received an appropriate response and he went on to commit further offences after that time.

Other Settings

Case and source of information	**14. Jimmy Savile** Leeds Teaching Hospitals (UK). Proctor, S., Galloway, R., Chaloner, R., Jones, C. and Thompson, D. (2014) ***The report of the investigation into matters relating to Savile at Leeds Teaching Hospitals NHS Trust, Leeds***; Leeds Teaching Hospitals NHS Trust**.**
The Perpetrator	Male nationally known celebrity in the UK. Sir Jimmy Saville's involvement at Leeds hospitals spanned from 1960 through the 1990s. He volunteered there as a porter and used his celebrity status to take on a role as a fund raiser. He was associated with raising £3.5 million for services at the Infirmary. Aged 84 when he died in 2011. ***Believed*** to have begun abusing in 1962. The last alleged incident at Leeds Infirmary was in 1999. His victims were both male and female children and adults. Reports were made by patient victims to staff from the mid-1960s but allegations were not escalated or followed up. Mr. Savile was never charged or convicted during his lifetime. After his death in 2011 allegations began to emerge about his offending.
Known victim(s)	Sixty accounts of abuse in premises run by the Leeds Teaching Hospitals NHS Trust or its predecessors, were received by the inquiry. Victims ages ranged from 5 years to 75 years. 19 children and 14 adults were patients at the time of their abuse. In addition, 19 members of staff reported abusive or inappropriate encounters with Mr. Savile. The majority of his victims were in their late teens or early twenties. The earliest case was in 1962, when Mr. Savile was 36 years old; the most recent in 2009, when he was 82. Mostly, assaults were opportunistic, and many took place in public areas such as wards and corridors. However, eight cases suggest an element of premeditation: in some instances, this included the grooming of victims and their families over a period of months. Mostly Savile worked alone, but on occasion he was assisted in his abusive behaviour by others. They ranged from lewd remarks and inappropriate touching, to sexual assault and rape. These encounters took place on wards, in lifts, in corridors, in offices, off site in a local café, in his mother's house, and in his campervan.
Colleagues	Only 4 children and 5 adults reported their experiences at the time to staff or a colleague, but for various reasons were either not considered credible or not appropriately escalated. Different levels of the organisation held disparate views of Mr. Savile and his value to them. Among staff in the wards and departments he was tolerated because of his celebrity and popularity with patients. Mr. Savile was, however, seen by many as a nuisance, a disruptive presence in the clinical areas and, towards female staff, a sex pest.

Continued on next page

Other Settings

Organisational culture	Mr. Savile regularly visited wards and departments, both as a porter and as a celebrity. Generally, these would be unannounced visits, at any time of the day or night, and he would chat to patients and staff alike. He was considered to be very popular with patients, and his visits were seen by many as a boost to morale. Mr. Savile used his personal charisma, and national and local celebrity, to exploit a setting where he had considerable formal and informal power and influence. His flamboyant and 'larger than life' persona gave him further licence for eccentric and unconventional behaviour which resulted in him being free to take opportunities to abuse e.g. he was well known for greeting women by kissing their hand, and sometimes licking their arm.
Family and community	He successfully maintained an almost continual presence in the local press associated with his charitable fundraising.

Other Settings

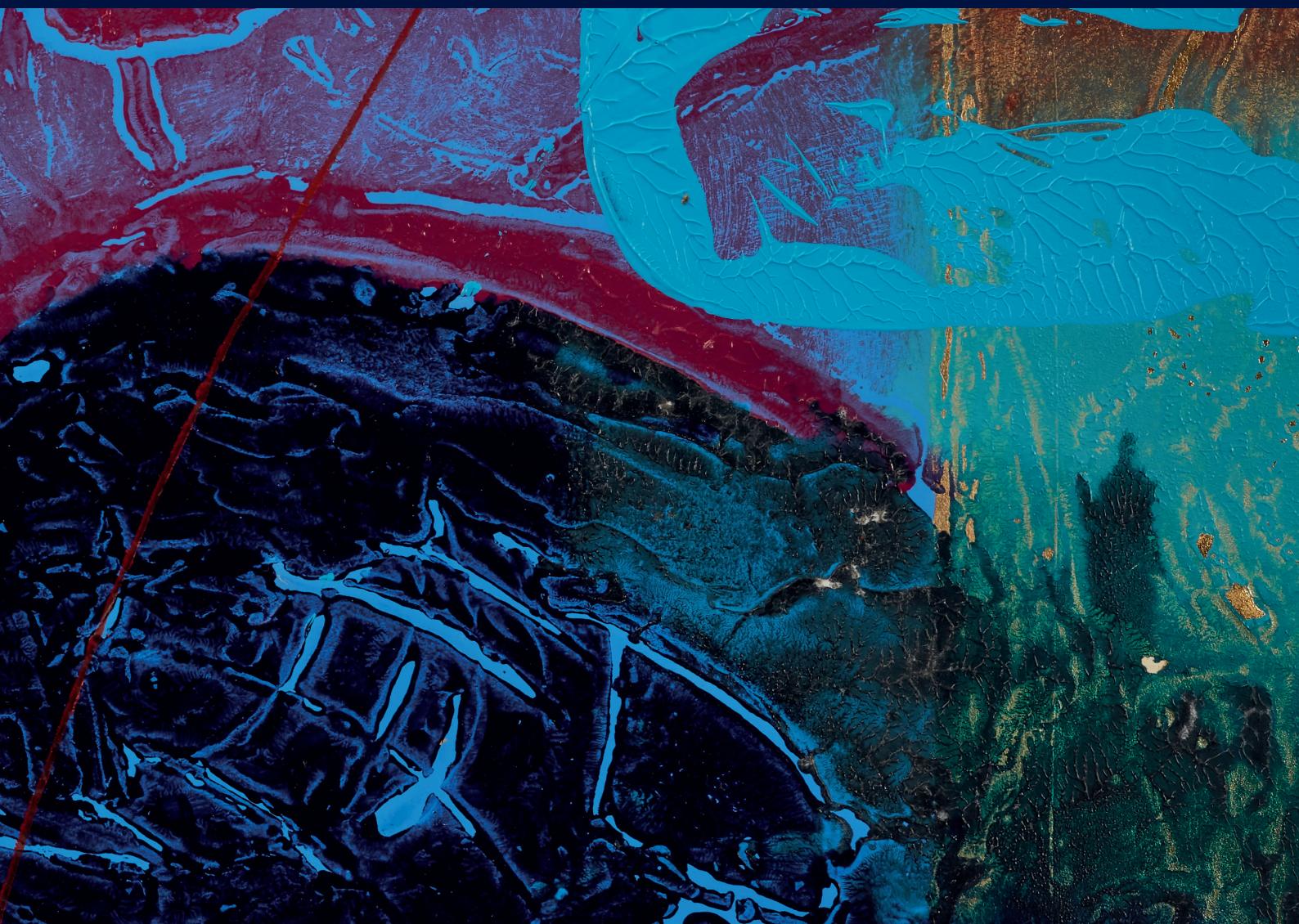
Case and source of information	**15. Jimmy Savile** Stoke Mandeville Hospital (UK). Johnstone, A. and Dent, C. (2015) ***Investigation into the Association of Jimmy Savile with Stoke Mandeville Hospital: A Report for Buckinghamshire Healthcare NHS Trust,*** Amersham; Buckinghamshire Healthcare NHS Trust. Vize, C. and Klinck, B. (2015) ***Legacy Report – Further Investigation into the Association of Jimmy Savile with Stoke Mandeville*** Hospital Amersham; Buckinghamshire Healthcare NHS Trust.
The Perpetrator	Mr. Savile was involved at Stoke Mandeville between 1968 - 1992. He volunteered as a porter, and used his celebrity status to take on a role as a major fund raiser for the hospital, resulting in a newly built unit - for which he raised funds being named after him. Aged 84 when he died in 2011. From his earliest association with the Hospital Mr. Savile inappropriately touched young female staff. The Investigation into Mr. Savile at Stole Mandeville Hospital took the view that enough was known about Savile's personal conduct by the 1970s to have warranted assertive intervention at a senior level. Mr. Savile was never charged or convicted during his lifetime. After his death in 2011 allegations began to emerge about his offending.
Known victim(s)	Mr. Savile is believed to have committed sexual crimes at Stoke Mandeville between 1968 -1992, against 65 female victims and one male victim, aged between 8-40 years – including patients, visitors and staff.
Colleagues	Similar to the experience at Leeds Teaching Hospitals, Mr. Savile seems to have been seen by many as a nuisance, a disruptive presence in the clinical areas and, towards female staff, a sex pest. However, there is no indication of general knowledge of his abusive behaviour.
Organisational culture	The inquiry concluded that it appears that the full extent of Mr. Savile's consensual and non-consensual sexual behaviour remained unknown to the senior members of the hospital staffor several reasons. These included informal and weak complaints and general information management processes, and a hospital where each ward and department managed its own complaints and concerns internally with very little being brought to the attention of the administration. Disorganised and weak management infrastructure led to a silo-based management of the complaints process. This had the effect of preventing complaints from being resolved appropriately, or coming to the attention of the senior administrative tier.
Family and community	Mr. Savile was generally well regarded publicly and described by a local newspaper as the "patron saint of Stoke Mandeville Hospital."

Appendix B – safeguarding crisis checklist

FARRER&Co

Safeguarding Unit 2020

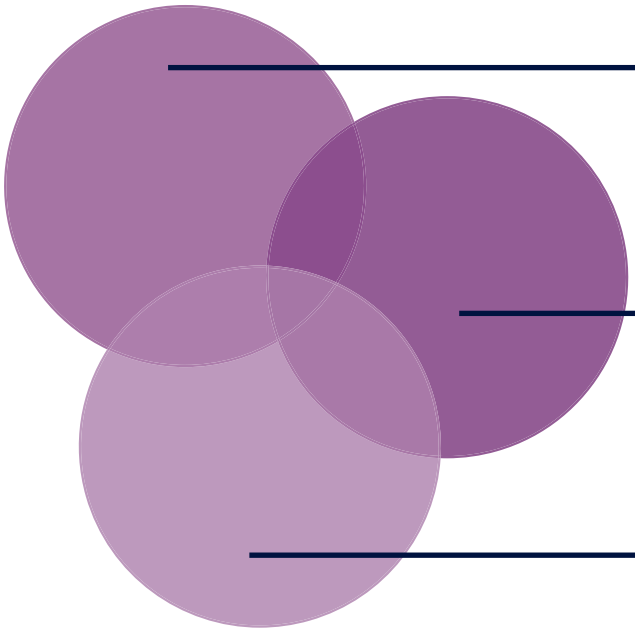
Safeguarding Crisis Checklist



Safeguarding Unit

Farrer & Co's Safeguarding Unit guides and advises organisations either working or coming into contact with children. Our approach is to take best practice and apply it to any organisation charged with the occasional or full time care of children.

Safeguarding crises are complex and involve three different types of response.



Safeguarding

Actions which need to be taken to keep safe any child or adult potentially at risk. This response trumps all others.

Management/HR

The on-going delivery of services to children for whom the staff member was responsible and the HR response to any staff member accused.

Communications

The communication (to the extent possible) of what is happening and the actions the organisation is taking in response to key constituencies (e.g. staff, parents, media).

The most effective management of a safeguarding crisis involves co-ordination of all three.

Whilst the safeguarding response must always come first, simultaneous attention to the other areas of response will create a strong sense of direction and co-ordination, providing the greatest reassurance to stakeholders (the 'sweet spot').

This requires safeguarding leads working in close co-ordination with senior leadership team, the board, HR, legal advisers and internal and external communications teams.

Crisis Checklist - Safeguarding

1. Are any urgent actions needed to safeguard a child or children in an emergency? If so call LADO, Police or other emergency services 999.
2. Are there other children who may be at immediate risk in addition to the child or children in the allegation? If so, notify LADO/Police.
3. Which agencies need to be informed immediately (e.g. LADO, Police, Childrens Services)?
4. Does any other body need to be informed (e.g. Charity Commission or other regulatory body)?
5. What are your immediate next steps? Take telephone advice from LADO/Police/Childrens Services and agree your actions.
6. Will Police be coming on site (e.g. to arrest or conduct a search)? Discuss with LADO and Police the best approach so as not to cause unnecessary anxiety to other children or parents.
7. Who do you need to speak to in order to implement the agreed actions? Speak to them and implement actions.
8. What do you need to say to the child, his/her parents and the staff member concerned now? Agree this with the LADO, Police or Childrens Services as appropriate.
9. Has LADO convened a strategy meeting? If so, decide who attends and what you want to achieve.
10. Work with the authorities not against them. But remember the organisation has priorities too, so identify them in advance and be sure to include them in any discussions around future strategy.

Crisis Checklist - Management/HR

1. Who in the organisation needs to be made aware immediately? Inform them.
2. Where is the staff member now? Is he/she in contact with children and if not when will the next opportunity for contact be? Agree with LADO and/or Police your next steps. Do not inform or suspend the staff member before reaching that agreement – you could be tipping off.
3. Whilst Police investigations are underway how do you ensure the staff member's duties are carried out in coming days and how do you explain his/her absence?
4. If investigation is likely to take some time will you suspend pending outcome of investigations? Discuss with LADO – it is the organisation's decision but LADO's input is valuable.
5. What information is known about the staff member? Ensure you locate and provide all information to LADO or Police (probably at strategy meeting).
6. How long will Police investigation and potential criminal prosecution take? If there is already clear evidence of misconduct consider dismissal.
7. Has crisis shown up any immediate staff training issues (e.g. reporting of allegations or concerns)? If so, organise.
8. Do you need to bring in any additional external resource to assist?
9. If Police/LADO do not pursue the matter themselves conduct your own investigation and risk assessment.
10. Where dismissal of staff member results (or resignation pending outcome of investigation) notify DBS/NCTL or other relevant agencies as appropriate. Never use compromise agreements, agreed resignations or agreed references.

Crisis Checklist - Communications

1. Don't wait for a crisis to happen before you act. Develop a safeguarding risk register and crisis management plan. Agree the constituents and roles of your crisis response team, including specialist legal and communications advisors and spokesperson.
2. Time is of the essence. Agree who is authorised to make final decisions quickly.
3. Ensure coordination between your legal and communication strategies and get advice early in the process.
4. What factors govern or limit communications? Check your safeguarding policies and consider any statutory rules about anonymity. Take advice from the LADO, Police and Children's Social Care services.
5. Don't be in denial – establish the facts and consider the broader context. Are there other issues which can be conflated to suggest a pattern of behaviour?
6. Be honest and transparent. Do not risk being accused of a cover-up or brushing things under the carpet as this will undermine trust.
7. Get the tone right by putting yourself in the shoes of the receiving audience. Explain the actions you are taking and demonstrate care and concern for those affected. Have a plan to ensure it will not happen again.
8. Consider the needs of all your stakeholder audiences and pre-empt their questions by providing them with sufficient information. Provide appropriate lines of communications for them and be responsive.
9. Don't procrastinate. Demonstrating that you are managing the situation well will help retain trust. Stakeholders prefer to hear about issues from you rather than from the media.
10. Don't say anything that you aren't prepared to see in print or online.

Contact Us

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