Joint investigation into the handling and management of allegations of professional abuse and the arrangements for safeguarding and protecting children in education services in Pembrokeshire County Council
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Introduction

1. On 10 June 2011, the Chief Inspector Care and Social Services Inspectorate Wales (CSSIW) and Her Majesty's Chief Inspector (HMCI) Estyn wrote to the Chief Executive, Pembrokeshire County Council informing him that they were undertaking a joint investigation into the handling and management of ‘allegations of abuse or causes of concern about a person who works with children’ (as defined in “Safeguarding Children : Working Together under the Children Act 2004”, and referred to throughout the report as ‘professional abuse’). The investigation would take account of allegations of professional abuse and the arrangements for safeguarding and protecting children in education services in Pembrokeshire County Council from April 2007 to March 2011.

2. This report details the investigation into the handling and management of allegations of professional abuse and the arrangements for safeguarding and protecting children in education services in Pembrokeshire County Council. It focuses initially on specific cases and how they were dealt with and it also includes an account of the relevant corporate context. Annex 1 provides information about guidance on safeguarding and strategy meetings. Annex 2 contains a summary of the evidence base for this investigation. The report takes into account comments from the local authority on matters of accuracy and clarification.

Background

3. In October 2010 officials from the Welsh Assembly Government’s Department for Children, Education Lifelong Learning and Skills (DCELLS) and CSSIW met Pembrokeshire’s Chief Executive, Director of Education and Children’s Services, Director of Social Services, and Head of Childcare Commissioning to discuss the handling of a case of professional abuse in a school in the authority. Given the issues arising a set of actions was agreed and in March 2011 DCELLS and CSSIW asked the authority to compile a full list of every allegation of professional abuse in schools and education services in Pembrokeshire from April 2007 to March 2011 and their outcomes.

4. The local authority identified 25 cases of allegations of professional abuse during this period. These were discussed at a further meeting in April 2011, where inspectors from Estyn attended in addition to those people at the first meeting.
5. At this meeting the local authority was asked to undertake an immediate review of these cases. The purpose of this review was clarified in subsequent correspondence as being "to use this information in reaching a judgment about the effectiveness of arrangements to safeguard and protect children receiving education services in Pembrokeshire and to identify whether any specific action in individual cases or general action as a result of this review is needed to address any shortcomings in processes, actions and decisions, and where themes emerge that indicate further work is needed to strengthen arrangements to put in place actions to address this”.

6. DCELLS, CSSIW and Estyn also asked for additional information in relation to the specific cases and areas about which they had significant concerns. Following receipt of the response from the local authority, in their letter of 10 June, the Chief Inspectors made clear to the Chief Executive that "there remain specific cases and areas about which we have particular concerns and the information you have provided is insufficient to enable us to reach a clear understanding of reasons for the decisions and actions taken or inaction, where the authority itself was able quickly to get a full understanding of these matters and take appropriate action. It is important now that we can quickly reach a position where we are able to get a full understanding these matters.”

The investigation

7. This joint investigation was conducted by CSSIW, in relation to the exercise of social services functions, under section 94 of the Health and Social Care (Community Health and Standards) Act 2003 and by Estyn, in relation to the exercise of education functions, the powers being those in section 38 of the Education Act 1997, section 175 of the Education Act 2002, and section 51 of The Children Act 2004. Annex 3 lists the members of the investigation team.

8. Inspectors have examined case files held by social services, education services and corporate human resources and carried out interviews of staff, elected members and others as set out in Appendix 2.

9. During the course of this investigation concerns emerged about the effectiveness of inter-agency child protection practice. As a result, CSSIW and Estyn have held discussions with Her Majesty’s Inspectorate of Constabulary (HMIC). CSSIW and HMIC are undertaking a separate review of inter-agency child protection practice.

Context

10. During the course of this investigation, inspectors had cause to refer back to the authority six of the 14 cases they reviewed because of their concerns about the management and handling of the cases, and the poor decisions taken. In three of these cases there was potentially an
immediate risk of harm to children. Other cases examined revealed shortcomings in practice, decision-making and due process.

11. The local authority has clear responsibilities for safe recruitment as part of their safeguarding duties. This includes undertaking Criminal Records Bureau (CRB) checks and taking up written references for all employees and volunteers working with children. Although some information had been removed for copying, the corporate human resources files examined by inspectors were not properly collated or cross referenced and some were incomplete. Important information about allegations, investigations and their conclusions, and any resulting disciplinary action were missing from several of the files. This failure to maintain accurate files had a direct impact on the authority’s ability to protect children, young people and staff.

12. On the 12 July the Chief Inspectors wrote to the Chief Executive to set out the concerns arising from the interim findings of this investigation. There was further correspondence and a meeting concerning these matters between the Chief Inspectors and the Chief Executive in order to secure satisfactory assurances from the authority about their arrangements to safeguard and protect children during the summer holiday period of July and August. On the 14 July, the Chief Inspectors wrote again to the Chief Executive seeking assurances that the authority had taken appropriate action to address the following immediate concerns.

- Four cases were detailed for further follow up action by the authority.
- Every person employed by the authority in whatever capacity who would be in contact with children and young people over the summer were required to have an up to date CRB check and satisfactory written references on file. If CRB checks and references were found not to be satisfactory, appropriate actions would need to be taken by the authority.
- Appropriate risk assessments were to be carried out where needed and proper risk management plans were to be in place for council run activities for children over the summer period.
- If there were any new allegations of abuse of children by someone employed by the authority over the summer holiday period, the authority would need to provide assurance that the Chief Executive, or in his absence the Director of Social Services, would oversee any investigation and ensure that appropriate action would be taken.

13. On the 21 July the Chief Inspectors received a letter from the Chief Executive, which they discussed at their meeting later that day. The Chief Executive explained the actions being taken and the Chief Inspectors again raised further concerns. The Chief Executive responded formally to the Chief Inspectors on the 25 July.
14. The Chief Inspectors sought further clarification on the authority’s actions for three of the four cases. The Chief Executive was asked to respond further in writing as a matter of urgency.

15. It was of concern that, of the 642 staff who were identified by the authority as potentially working with children over the summer holiday period, 18 (2.9%) staff were found not to have an active CRB check, 41 (6.4%) staff were found not to have the required written references. Of these 41 staff, 8 had one reference only and the remaining 33 had no written reference at all. This meant that in all 9.2% of staff potentially working with children for the summer period either didn’t have the required CRB check or written references in place. The authority took appropriate action to ensure that these staff would not have direct contact with children until the satisfactory CRB checks and references were received.

16. The Chief Executive confirmed that the authority:

- had already started work to undertake these checks for all school staff before the start of next school term in September 2011.
- had completed an audit of the risk assessments and risk management plans for council run activities over the summer period. The authority’s analysis of the risk assessments was provided to the inspectorates on 8 August.
- had put arrangements in place for senior management oversight of any new allegations of professional abuse and for the strengthened senior management oversight of new CRB checks.

17. Pembrokeshire County Council and Dyfed Powys Police have been asked to review all 25 cases to ensure that all appropriate actions have been taken, and to report their findings to the inspectorates.
Case file audit

18. The inspectorates requested clarification and further information in relation to 17 of the 25 cases of alleged professional abuse in education services reported by the authority in the period from 2007 to 2011. Of these 17 cases, 14 were then examined in more detail. In the 14 cases reviewed the age of the children involved ranged from three to 16 years. Almost half of these cases related to more than one child. Thirty five per cent of cases involved children with additional learning needs including special educational needs. The 14 cases reviewed related to allegations made against a range of staff including: headteachers, teachers, learning support assistants, youth workers and administrative support staff.

19. Two cases were treated by the authority under the framework of organised or multiple-abuse procedures defined in the guidance document ‘Safeguarding Children: Working Together under the Children Act 2004’ as:

“abuse involving one or more abuser and a number of related or non-related abused children. The abusers concerned may be acting in concert to abuse children, sometimes acting in isolation, or may be using an institutional framework or position of authority to recruit children for abuse”.

20. Both these cases involved children in education settings, one involved primary aged children, the other secondary aged children.

Findings from the investigation of cases

The child protection strategy meeting process

21. A child protection strategy meeting is the framework for managing allegations against professionals. This includes where there is reasonable cause to believe a child is suffering, or is likely to suffer, significant harm and also allegations that might indicate that the individual is unsuitable to continue to work with children in their present position, or in any capacity. The guidance ‘Safeguarding Children: Working Together under the Children Act 2004” states:

“This should be used in respect of all cases in which it is alleged that a person who works with children has:

- behaved in a way that has harmed a child, or may have harmed a child;
- possibly committed a criminal offence against or related to a child; or
- behaved towards a child or children in a way that indicates s/he is unsuitable to work with children.”

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“The strategy meeting therefore may have to consider up to three strands in the consideration of an allegation:

- a police investigation of a possible criminal offence;
- enquiries and assessment by children’s social services about whether a child is in need of protection or in need of services;
- consideration by an employer of disciplinary action in respect of the individual.”

22. Strategy meetings were generally convened appropriately. However, in two cases the thresholds for child protection intervention were not recognised and in both cases social services did not immediately accept the referral.

23. In more than half of the cases the strategy meetings were poorly recorded. Minutes of the meetings were not always on file and there was a general lack of clarity regarding information sharing, action planning, decision making and outcomes. The minutes did not demonstrate a robust process that included professional challenge and a clear focus on the child.

24. In five cases the strategy meeting failed to recognise the wider safeguarding implications arising from them. These included a failure to take account of the implications by making suitable adjustments to policy, procedures and governance arrangements. This left children potentially vulnerable to further harm or abuse.

25. Unusually almost all cases were undertaken as single agency investigations and, in a few cases, this was despite a decision in the strategy meeting to undertake joint investigations. The lack of joint working adversely impacted on decision making and the management of the cases. In one case the process failed to protect both the children and the staff involved.

26. When strategy meetings were reconvened, there was little evidence that agencies were held to account for their actions in how well they had followed through the decisions of the previous meeting.

27. Where the organised or multiple-abuse framework was used it was difficult to determine how decisions were made. In one case the minutes of strategy meetings do not provide a clear account of why senior managers in the senior strategy group did not agree with the concerns of front line staff in the operational strategy meeting about how the investigation should have been conducted. There was a lack of clarity about the relationship between the two groups. This led to a loss of direction in addressing the multiple issues presented.

28. Information provided by the authority indicates that decisions were made outside the strategy meetings that were not formally reported. It
was not clear how the different processes related and important issues were left unresolved. This resulted in a lack of clarity, coherence and multi-agency ownership of the cases, with children and staff left potentially vulnerable.

29. These cases highlight tensions between some of the agencies and a lack of shared perspective on safeguarding.

**Suspension**

30. A strategy meeting should ensure that the possible risk of harm to children posed by an accused person is evaluated and managed. This may include employers having to suspend the individual. Suspension should be considered in any case where there is cause to suspect a child is at risk of significant harm, or the allegation warrants investigation by the police, or is so serious that it might be grounds for dismissal. The power to decide to suspend a member of staff is vested only in the employer.

31. Safeguarding Children: Working Together under the Children Act 2004 states that:

“Where a strategy discussion or initial evaluation discussion concludes that there should be enquiries by social services and/or an investigation by the police, local authority social services should canvass police views about whether the accused member of staff needs to be suspended from contact with children, to inform the employer’s consideration of suspension”.

32. Where an employer decides not to suspend, the guidance highlights that employers should be:

”Encouraged to undertake a risk management assessment that should be shared with the members of the strategy group”.

33. The following issues about the use of suspension were identified within the 14 cases. Although suspension was considered by the authority in half of the cases, it is not clear why it was also not recorded as a consideration in some of the other cases.

34. In three of the cases a decision was taken not to suspend the accused member of staff. This decision was made despite the views of social services or the police to the contrary.

35. Regulations 16 and 28 of the ‘Staffing of Maintained Schools (Wales) Regulations 2006’ provide that it is the governing body and/or head teacher who have the power to suspend any person employed or engaged to work at the school. Despite that, in two cases, both the previous and the current Director of Education have taken the decision
not to refer the issue of a possible suspension of a member of staff to the governing body.

36. In cases involving schools there was little evidence that the designated child protection link governors were routinely invited to attend relevant strategy meetings. Excluding governors from strategy meetings means that if the authority makes a decision not to suspend a member of staff the governing body may not know about the matter.

37. There was limited evidence that formal risk management assessments were shared between professionals in strategy meetings. In some instances oral updates were provided. In two cases the authority decided to assign staff to different duties in a new location rather than suspend them. Although this had the effect of removing the individual from direct contact with children, it continued to give them access to information about children and remain in a position of authority and trust. In these cases, the reasons for the move and the on-going status of the employees were unclear. This led to confusion among work colleagues about the reasons for the move, and served to undermine the seriousness of the allegations. It also left other staff and colleagues vulnerable as no clear guidance was provided regarding their ongoing contact with the individual who could exercise continuing influence.

Disciplinary

38. In some cases the authority has not handled its disciplinary processes for dealing with staff accused of professional abuse well.

39. Disciplinary action was taken in half of the cases although evidence indicates that it would have been appropriate to consider it in two other cases.

40. In one case, which was managed under the organised or multiple-abuse frameworks, no disciplinary action was taken despite the assumption expressed by one partner agency that disciplinary matters would be dealt with by the authority subsequent to an independent review. In another case the authority confirmed that its own written record of the outcome of the disciplinary hearing was inaccurate when inspectors referred this case to them.

The local authority culture

41. The chief officers management board (COMB) is the forum at which chief officers meet, and where important management business is discussed. However, this group has no formal basis; there are no standing agenda items, and no formal records of meetings. As a consequence there are no systems which collate information and report to COMB, on important safeguarding concerns and disciplinary issues in the education services and schools.
42. Within the sample of cases examined a range of concerns about the approach taken by senior local authority officers and governing bodies were identified.

- Managers have minimised serious safeguarding concerns.
- Substantial differences between the detail of what had been recorded in the strategy meeting and what was recorded in the disciplinary record.
- The duty to safeguard children has been outweighed by the consideration of the previous good record of staff.
- Alleged and proven harmful behaviour and abuse were not effectively confronted or risks assessed and managed.
- Managers inappropriately considered redundancy, resignation or retirement instead of assessing and managing risks.

**Human resource issues**

43. Failure in dealing with the cases identified significant shortcomings in human resources systems.

44. Within the sample of cases examined the following range of failures were found.

- After being made redundant, staff have been re-employed without any references being sought, despite known concerns within the authority.
- The authority has failed to deal appropriately with subsequent allegations following previous disciplinary action.
- A school provided false information in a reference for a former member of staff stating that they had resigned their post when in fact they had been dismissed for sexual misconduct with a young person. A second reference then minimised the sexual misconduct. A further allegation of sexually inappropriate behaviour was later recorded on file. There was no record of whether these matters had been identified and acted on.
- CRB checks and references have not been effectively and consistently screened.
- A few cases that should have been managed as child protection investigations were instead dealt with as staff development matters.
- Human resource files were incomplete and poorly maintained, disciplinary issues and allegations against professionals were not routinely recorded on personnel files in accordance with guidance, thereby limiting management oversight of individuals who might present a risk to children.

45. The ‘Safeguarding Children: Working Together under the Children Act 2004’ guidance says:
“It is important that employers keep a record of any allegations made on a person’s confidential file and also record details of how the allegation was followed up and resolved including details of any action taken and decisions reached. A clear and comprehensive record will enable accurate information to be given in response to any future request for a reference. It will also provide clarification in cases where a future CRB disclosure reveals “soft” information from the police that an allegation was made that did not result in a prosecution, and it will prevent unnecessary re-investigation if, as sometimes happens, allegations re-surface after a period of time”

Risk-management assessment – individuals

46. The risk management assessments of individuals, following disciplinary action are inadequate for the protection of children. Copies of the risk management assessments are not routinely kept on the central human resource files. No information regarding the oversight and monitoring arrangements has been recorded in the personnel files. There has been no line management and reporting system in place to support managers supervising the risks. It was identified that in one case the manager undertaking the monitoring, although experienced in their professional role, had only limited child protection training.

Risk-management assessment – off-site activities

47. In two cases allegations were made following off-site trips. The risk assessments in one case did not address the safeguarding issues relating to the particular group of children involved, or the activities undertaken. The limited nature of the assessments left both children and staff vulnerable, as was highlighted in the resulting complaint.

Training and Policy

48. The majority of cases identified a range of staff training issues in several aspects including child protection, behaviour management, restraint and whistle blowing.

49. Within the sample of cases examined a range of training and policy issues were identified. These include:

- a lack of awareness of child abuse indicators and what to do if there are concerns about a child;
- allegations of sexual behaviour or grooming which highlight the need for specific training in relation to identifying, understanding and managing this risk;
- the adaptation of child protection policy to permit the unlawful physical examination of children.
- a lack of confidence within the governing body to make appropriate challenges in matters concerning the safeguarding of children and child protection policy;
- the authority has undertaken a comprehensive roll-out of basic awareness Tier 1 training which is to be commended. However, the local authority and managers have not evaluated the impact of this training. Instead they have assumed that this improved practice;
- issues regarding a lack of understanding of the boundary between appropriate restraint and assault or abusive behaviour;
- restraint training that has been provided by staff who had not been trained as trainers to undertake this skills training;
- inappropriate use of restraint of children by professionals;
- a lack of strategic leadership, effective governance and appropriate policies for the use of restraint as a form of behaviour management including record keeping, and proper incident reporting;
- ineffective quality assurance systems for child protection in schools and education services;
- poorly applied policies to support whistleblowers.

Engagement with parents

50. ‘Safeguarding Children: Working Together under the Children Act 2004’ states that:

“Parents or carers of a child or children involved should be told about allegations as soon as possible if they do not already know of it. They should also be kept informed about the progress of the case, and told the outcome where there is not a criminal prosecution. That includes the outcome of any disciplinary process”.

51. In half of the cases reviewed there was no evidence that parents had been given the full information regarding an allegation. In one case a school specifically rejected the recommendation of the strategy meeting to inform parents of allegations made against staff in respect of their children as it would “cause problems for the school”. In another case although parents were told of concerns they were not made aware of significant corroborative evidence which would have enhanced their understanding of the issues involved. In the same case it was recorded that parents felt unable to complain as they believed it could result in a loss of service for their child. There was little evidence that parents or carers had been helped to understand the process, told the result of the inquiry or disciplinary process or helped to understand the outcomes reached. This lack of transparency raises questions as to whether the protection of the child is always given priority over the reputation of the authority.

Voice of the child

52. Issues were identified regarding the credibility given to an allegation made by children against a professional. The voice of the child was
often absent in strategy meetings and children were either not spoken to or their concerns were not given full credence in about half of the cases, including the appropriate use of achieving best evidence interviews. In four of the cases the child’s reported “difficult behaviour” became the focus of the strategy meetings rather than the allegation against the professional. There was little evidence that children had been helped to understand the process, told the result of the inquiry or disciplinary process or helped to understand the outcomes reached. Overall there was little or no evidence in these cases of a rights-based approach to safeguarding children in education.

The role of the Pembrokeshire Local Safeguarding Children’s Board (LSCB)

53. None of the cases reviewed was reported to the LSCB. As a result there was little transference of learning from the management of the fourteen cases. This included cases dealt with under the organised or multiple-abuse procedures framework which should have been referred with a view to conducting a serious case review.

Findings from the investigation about corporate leadership and systems

Leadership and management - the role of elected members

54. Senior local authority officers do not provide elected members with the information necessary to ensure they are able to discharge their responsibilities for safeguarding.

55. Senior managers’ written reports do not routinely include information about important child protection matters for which members are ultimately responsible. There is an over-reliance on informal discussion between senior managers and between senior managers and elected members that masks important issues. As a result, there is no means to identify particular safeguarding themes and trends.

56. The Leader regularly meets the Director of Education and senior officers within the education department, to discuss ongoing and emerging issues. However, these meetings do not routinely raise the important safeguarding issues within the education services and schools. Generally cases are only discussed when they may have a high media profile and cause reputational damage.

57. The responsibilities of the cabinet member for children, learning and Welsh language cover both education and social services, and the lead role for corporate parenting. The cabinet member is chair of the Children’s and Young People's Partnership (CYPP) Board and chair of one core aim group. He has a good first-hand knowledge of the day-to-day workings of the education department and its schools.
58. There is a comfortable working relationship between the cabinet member and senior managers within the education department. The ‘open door’ culture encourages regular informal meetings and the exchange of information. There are also weekly meetings between the cabinet member and the Director of Education. However, these meetings do not have formal agendas and nor are they recorded.

59. The lack of agenda items and minutes for the regular meetings with the Director of Education means the cabinet member is unable to challenge the education department senior managers appropriately, because there is no audit trail that can be used to hold them to account.

60. These meetings do not routinely include child protection issues or cases of alleged professional abuse. A case is only raised when it may become high profile locally. This means that at times the cabinet member is unsighted on these issues, and is therefore not helped to exercise his role as lead member for children for safeguarding.

61. Elected members do not challenge officers to seek more information and they are not sufficiently aware of safeguarding issues within the authority. They consider that the authority takes safeguarding very seriously, but are poorly informed and do not appear to know the questions they should ask.

62. Elected members are not made aware of the important safeguarding issues which the education department needs to address. In one high-profile case the only information elected members reported that they had was from the national press.

63. Safeguarding is rarely an agenda item at scrutiny and cabinet meetings. The children and families overview and scrutiny committee does not receive regular reports from the education department or the LSCB and rarely calls for specific information. It sets up working groups to look closely at particular issues, for example, following a serious case review. However, it has been unsighted regarding the issues arising from the range of professional abuse cases considered in this investigation.

64. Many elected members are also school governors. Their overview of safeguarding mainly relates to their knowledge of these issues in their own school. This means that they do not have the breadth of understanding needed to discharge their responsibilities for safeguarding in the authority. Members have received training in corporate parenting and many have attended Tier 1 training. However, while child protection training has raised members’ basic awareness, it has not led them to challenge the absence of information about safeguarding.
Leadership and management – the role of senior officers and managers

65. There has been a lack of oversight at the most senior level within the authority of the management and handling of cases of alleged professional abuse in education services.

66. The chief officers management board (COMB) meetings are the forum at which chief officers meet, and where agreements which impact on service planning, resource allocation and strategic direction for the council are discussed. There are no standing agenda items, and no formal records of meetings.

67. Although chief officers can raise any issue, without a standing items agenda for COMB, important issues such as safeguarding are not routinely part of the chief officers’ consideration and evaluation. Without formal records of discussions and decisions, COMB is not open to oversight by elected members. This prevents elected members from exercising their key role in holding the executive and officers of the council to account.

68. The Chief Executive and chief officers interviewed have been unable to evidence how they are effectively discharging their shared corporate responsibilities for ensuring that children are safe in the authority’s schools and education services. When challenged about their record in responding to some of these cases, chief officers have sought to deflect some of the responsibility. For example they have cited a lack of specific guidance from the Welsh Government and the existence of positive regulatory and inspection reports as the reasons why they have either been unaware of the failings within the authority or why they have been slow to deal with these issues.

69. However, this is no excuse for the local authority failing to take full responsibility to ensure that it safeguards and protects children in its schools and education services. Chief officers must assure themselves and the authority through rigorous self-assessment and quality assurance processes that all their services include safeguarding arrangements are robust and effective.

Education service

70. The previous and the current Director of Education have not provided the leadership and management needed to ensure that the education directorate has discharged its safeguarding responsibilities well enough.

71. The authority prepared a self-evaluation report for the recent local authority education service for children and young people (LAESCYP) inspection (July 2011). The authority’s own analysis of its performance in the section on safeguarding is too positive. It does not recognise
well enough all of the areas where it underperforms in discharging its
duties for safeguarding children in its education services. There has
been a lack of urgency in addressing significant shortcomings in some
of the cases reviewed which has left children vulnerable to further harm
and staff vulnerable to further allegations.

72. The approach taken towards managing safeguarding cases across the
education department is too fragmented. Although a database for
recording strategy meetings and monitoring actions for education was
developed in September 2010, there is no effective system in the
education department to ensure cases of professional abuse by staff
are rigorously followed. Record keeping is distributed across the
department, with little or no managerial oversight to ensure cases are
adequately resolved and responsibilities for on-going risk management
are discharged.

73. An advisory teacher for safeguarding has been appointed to help raise
the profile of safeguarding in education. However, senior managers do
not have consistent expectations of this post, or its role and
responsibilities. There are no formal reporting arrangements, and
accountability and support are poor. The link between this post and
social services in relation to safeguarding is not well developed. As a
consequence the post holder’s work is undertaken too much in
isolation, and the education department’s systems for managing
safeguarding continue to lack sufficient rigour. For example, recent
internal protocols in the education department for managing
safeguarding allegations were not agreed between directorates. As a
consequence guidance to education staff about referrals was unclear.
The authority has now recognised this and withdrawn them, as they
were insufficiently clear about the status of the All Wales Child
Protection Procedures.

74. The senior managers within the education department have not
exercised adequate oversight in relation to safeguarding of the
education services that are directly managed by the local authority.
For example, the management committee for one of these services
had not met for a substantial period of time. This left children and staff
vulnerable due to the lack of accountability to and direction from the
management committee. Despite the introduction of a new
management committee, the minutes of these meetings indicate that
attendance remains variable, with only five people attending all
meetings. There has been no representation from the police and
inconsistent representation from social services and the youth
offending service. Minutes provide little evidence of rigour and
challenge.

75. The education department has taken over two years to review its policy
and guidance about restraint, intervention and use of ‘time out’. There
is currently no interim written policy or guidance in place to govern the
use of restraint, intervention and ‘time out’, or the recording of their use and protocols for informing parents.

76. The Behaviour Support Service (BSS) staff have received training in restraint and intervention techniques. BSS staff are not trained to teach restraint techniques. However, with the approval of the education department, BSS staff cascade this training on request to other teaching staff in Pembrokeshire schools. The education department has not systematically evaluated the restraint training given to its staff. It does not know the impact of the training, or whether the techniques promoted are the most appropriate ones, or if they have been effective in managing pupils’ behaviour. This leaves both children and staff vulnerable.

Human resources

77. Chief officers and senior managers have not exercised adequate oversight of the personnel function in relation to safeguarding across the authority. Policies and procedures to ensure the safe recruitment and vetting of staff across the education service are not robust and have resulted in unsafe practices. There is an over-reliance on systems that are not fit for purpose. This means that there is no effective monitoring and evaluation to check that they meet requirements fully. In consequence, mistakes are not always identified and this puts children at increased risk of harm.

78. Although the authority has procedures to check newly appointed and existing staff with the CRB, these are not monitored well enough and allow the opportunity for error. The responsibility is distributed across directorates, which has led to inconsistent decision-making in relation to safeguarding issues.

79. Further, the authority has not sought references for some of its employees.

80. No-one in the human resources (HR) department or elsewhere in the authority has a complete overview of details of all staff employed by the authority in its education services and schools. This is because staff records are incomplete and there are no systems to bring this information together. Staff files are kept off-site and the contents are not always checked. The absence of a searchable staff database where information is collated and can be cross-referenced so that information can be analysed and assessed is directly contributing to the authority’s inability to protect children properly.

81. In schools, governing bodies are responsible for the safe recruitment of staff. Schools do not always ensure the local authority has copies of all employment documents and written references for each employee.
82. The authority’s policy on the provision of references for employees and ex-members of staff is not clear and there is no central oversight of references provided by the authority. This means that the authority does not ensure that all relevant information is passed to other employers.

83. In some of the cases reviewed, education officers and governing bodies have considered the severance of or relocation of staff who may pose a risk, rather than deal with the safeguarding issues through rigorous disciplinary and risk management process. This potentially displaces the problem where staff pose a risk to children’s safety and leaves them vulnerable to potential abuse from staff. The problem is compounded by the absence of robust risk assessments and risk management plans.

84. There is no systematic policy or procedure for record keeping if an allegation is made against a member of staff, particularly if the allegation is unsubstantiated. Evidence is not always filed and records do not always provide accurate details of how issues were followed up and resolved. As a result, the reasons for some decisions are unclear and trends are not recognised. There is too much reliance on oral information.

85. The level of seniority of officers responsible for chairing disciplinary hearings is set too low. The authority’s policy governing disciplinary procedures does not specify a knowledge of safeguarding and relevant training as a requirement for those managing disciplinary hearings where there are potential child protection concerns. Officers who have only received Tier 1 training are not well enough equipped to understand the risks involved in managing and monitoring difficult cases. There are no review mechanisms to consider investigations and decisions made other than via the staff appeals’ procedure. HR managers are not routinely involved in disciplinary cases in schools and do not have an overview of these cases and their outcomes.

Social services

86. Statutory guidance on the ‘Role and Accountabilities of the Director of Social Services June 2009: Welsh Assembly Government’ states:

“4.8.5 Whilst all staff have a responsibility to safeguard and promote the welfare of children, the Director of Social Services remains the senior officer within the Council with final and indivisible accountability for this. In relation to vulnerable adults the statutory basis for this responsibility is less clear cut and firm than with children. However, the responsibility for taking the lead in ensuring effective local procedures rests with Social Services for which the Director is accountable”.

87. The Director of Social Services has not provided the leadership or challenge needed to clarify and implement the respective safeguarding
responsibilities of his post, and those of the Director of Education and Children’s Services and the Head of Childcare Commissioning, and how these should work together.

88. Social services has not effectively supported the education department to discharge its safeguarding responsibilities in dealing with cases of alleged professional abuse. There has been a lack of rigour in the child protection process in some of the cases examined, including decisions taken outside the formal strategy meetings. Records of strategy meetings are not always kept on social services case files.

**Inter-departmental and inter-agency relationships**

89. The working relationship and communication between the education department and social services are not effective.

90. There is no robust overall strategic mechanism across all agencies to ensure that cases of professional abuse by staff are rigorously dealt with and followed up. Strategy meetings do not lead to professional challenge between agencies. There are no overall quality assurance mechanisms in place to ensure that planning decisions, actions and conclusions about referrals are robust, and are fully and satisfactorily completed.

**Pembrokeshire’s Local Safeguarding Children Board (LSCB)**

91. The local authority does not do enough to ensure that the LSCB is well informed about the safeguarding issues in education services and schools in Pembrokeshire. The chair of the LSCB receives no regular or formal reports to enable him or the LSCB to make an independent evaluation of the effectiveness of the authority’s safeguarding practice.

**Safeguarding training**

92. The LSCB training sub-group has developed a training strategy for three tiers of training, targeted at different levels of practitioner, manager and other stakeholders. The strategy identifies well the broad range of people who need to know about safeguarding. This includes those working with children and those with responsibility for the management and evaluation of services. However, this strategy is not yet fully implemented.

93. The strategy has broken down well the range of learning objectives at the three tiers and for the differing groups of learners. Tier 1 is a 2.5 hour course, focussed on awareness-raising, making professional links, and letting staff know what to do when making a referral. Tier 1 training has been delivered to approximately 4,700 people since 2008. Tier 2 training focuses more on operational issues and managing safeguarding work and has been delivered to approximately 600 people. Tier 3 is particularly important as it identifies a wide range of
the higher-order skills required for people with management responsibilities which impact on safeguarding. However, this tier of training has not yet been fully designed, and is not yet rolled out to those staff who need it.

94. In delivering Tier 1 training widely, the local authority has assumed that this means that its staff and governors are able to respond appropriately to safeguarding issues. However this level of training only provides staff and governors with signposts to referral and is only at a basic introductory level. The local authority needs to ensure that the safeguarding training it provides is commensurate with the added levels of safeguarding responsibilities of its staff, school governors and elected members in order to equip them with the knowledge and skills they need to effectively discharge these.

Conclusion

95. The investigation concludes that there has been a lack of oversight by elected members and officers, at the most senior level within the authority, of the management and handling of cases of alleged professional abuse in education services.

96. The absence of effective governance in relation to safeguarding and protecting children reflects the specific failures within the culture of the authority as a whole. The shortcomings with the authority’s arrangements to safeguard and protect children are longstanding and systemic. This is indicative of the deep-seated nature of these problems and failings within the authority.

Key issues

97. The duties of the local authority to ensure that children are properly safeguarded and protected from harm are set out in legislation. Section 175 of the Education Act 2002 imposes a duty on a local authority to make arrangements for ensuring that their education functions are exercised with a view to safeguarding and promoting the welfare of children. Section 28 of the Children Act 2004 imposes a duty on local authorities to make arrangements for ensuring that their functions are discharged having regard to the need to safeguard and promote the welfare of children.

98. In fulfilling its responsibilities the local authority should have effective quality assurance systems in place to ensure that the necessary checks and balances are in place to safeguard and protect children. This investigation in focussing on the management and handling of allegations of professional abuse in education services has identified failures across the whole system in the authority to safeguard and protect children.
99. In frontline practice, the issue of rough handling and inappropriate use of restraint and behaviour management techniques has been a significant feature in several of the cases. Not all these incidents have been properly recorded or dealt with.

100. Overall there was little or no evidence in these cases of a rights based approach to safeguarding children in education services in Pembrokeshire. Where allegations of abuse have been reported and subject to child protection procedures, inspectors have found examples where the children affected have not been spoken to or listened to. Parents and carers have not always been given the full information about incidents that affect their children.

101. The first line of checks in the system is effective record-keeping and supervision of staff by managers. The absence of a clear audit trail of decision making and reporting at every level throughout the system in the authority is a marked feature of this investigation. The absence of proper record keeping and evidence for management decisions has meant that no one has a clear oversight of safeguarding and child protection issues in education services.

102. Pembrokeshire operates a culture of trust amongst its staff which is commendable. However, to be effective it must be transparent, underpinned by proper governance arrangements, where information is shared freely and there is robust and constructive challenge. Safeguarding information is not routinely shared with everyone who should know about it. It is appropriate that staff are trusted to get on with their work, but managers need to monitor that agreed decisions and actions are completed and that the quality of the work is good enough. Because of failures to do this, senior managers and elected members do not have a good enough grasp of what is happening, and they rely too much on what they are told.

103. In some interviews with officers their lack of recall of detail of what the outcome of a discussion was and what decisions were made in relation to significant child protection concerns serves to underline the weakness of the system. With no record of what was discussed and what decisions were taken, it is not possible to operate a safe system to protect children.

104. The inspectorate asked chief officers to review the management and handling of the 25 cases at their meeting in April 2011. When interviewed in July no chief officer or senior manager had called in and read through all the files to assure themselves that cases had been handled properly. As a consequence, it wasn’t until inspectors read the files and pointed out the problems that the authority became aware of them and started to take action to deal with these.

105. The over reliance on informal briefings to cabinet members, the absence of formal reporting arrangements by officers and Chief
Executive to elected members, and the lack of challenge and enquiry from elected members on safeguarding and child protection matters in education services has meant that no one has had an overview of these matters. Where there has been evidence that should have been challenged, this has not been made available to members. Senior managers who should have challenged this have not done so and on occasions frontline staff who have tried to do so have not been listened to. This is indicative of a closed, not an open or transparent culture.

106. There is no mechanism in place for regular formal reporting to the LSCB, members and governors about safeguarding issues, actions taken or reviewing outcomes. Even major cases of professional abuse have not been subjected to scrutiny and challenge through these channels.

107. Throughout this investigation the scale of the problems related to safeguarding that have been identified has increased. These have now been found in other functions of the authority.

108. Chief officers, senior managers, and elected members have not identified many of these issues and problems and where they have done so, the actions they have taken have not been effective enough in delivering the improvements needed.

109. The authority has begun to recognise and accept its shortcomings in safeguarding children and it has started to take action to respond to the problems that have been identified by inspectorates.

110. The Leader of the authority had been informed of the immediate concerns. He confirmed that he viewed the issues with the utmost seriousness and his determination to effect the necessary changes to ensure that improving systems for safeguarding children in Pembrokeshire becomes the top priority for the authority.
Annex 1

Safeguarding Children Working Together Under the Children Act 2004

Chapter 12 Allegations of Abuse or Causes of Concern about a Person Who Works With Children.

It contains the following guidance:

“Children can be subjected to abuse by those who work with them in any and every setting. All allegations of abuse or abuse of children by a professional, staff member, foster carer, or volunteer must therefore be taken seriously and treated in accordance with consistent procedures. Local Safeguarding Children Boards (LSCBs) have responsibility for ensuring there are effective inter-agency procedures in place for dealing with allegations against people who work with children and monitoring and evaluating the effectiveness of those procedures.

LSCB member agencies and other organisations that provide services for children, or provide staff or volunteers to work with or care for children, should operate a procedure for handling such allegations that is consistent with guidance.

It is important to differentiate between cases involving issues such as poor professional practice and cases that give rise to child protection concerns (including cases involving abuse of trust). Whilst the former may be handled through disciplinary procedures or other avenues, child protection concerns should always be dealt with through local child protection procedures in line with guidance.”

Chapter 8 Handling Individual Cases

Strategy discussion/meeting

“Whenver there is reasonable cause to suspect that a child is suffering, or is likely to suffer significant harm, there should be a strategy discussion at the earliest opportunity. The child’s safety should not be compromised by any delay.

A strategy discussion may take place at a meeting or by other means (for example, by telephone). In complex types of abuse a meeting is likely to be the most effective way of discussing the child’s welfare and planning future action. In some circumstances, more than one strategy discussion may be necessary. This is likely to be where the child’s circumstances are very complex and a number of discussions are required to consider whether and, if so, when to initiate section 47 enquiries, as well as how best to undertake them. Such a meeting should be held at a key location for the key attendees, such as a hospital, school, police station or local authority children’s social services office.”
The discussion should involve, at a minimum, local authority children’s social services and the police, and other bodies as appropriate (for example, nursery/school and health), including, in particular, any referring agency and, in the case of relevant regulated services, the Care Standards Inspectorate for Wales.”

Annex 2 The evidence base for the investigation

The review comprised:

1) An examination of 25 case files of alleged abuse or cause of concern about a person who works with children in Pembrokeshire education services or schools. The management of these cases was examined in further depth through additional file reading, interviews with practitioners and team managers.

2) Interviews with:

**Elected members**
- Leader of the council;
- cabinet member children young people, learning and welsh language;
- scrutiny vice chair;
- elected members, including cabinet and scrutiny;

**Officers**
- Chief Executive
- Director Education and Children's services
- Director Social Services
- Head of Childcare Commissioning
- Head of Learning Partnerships
- Head of Human Resources
- Human Resources Manager for Education;
- Advisory Teacher for Safeguarding;
- Principal Officer Youth Service;
- Designated Safeguarding Officer for the Youth Service;
- Professional Officer for governor support services
- Head of Behaviour Support Service
List of interviews

Groups teachers and Governors
- school staff which included head teachers, teachers and learning assistants;
- school governors;

Others
- chair and vice chair of the LSCB;
- training sub group of the LSCB /CYP
- police;

3) Examination of a range of files, policies, documents and reports.

Annex 3 The investigation team

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<th>Institution</th>
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<tbody>
<tr>
<td>Katy Young</td>
<td>CSSIW</td>
</tr>
<tr>
<td>Marya Shamte</td>
<td>CSSIW</td>
</tr>
<tr>
<td>Cheryl Beach</td>
<td>CSSIW</td>
</tr>
<tr>
<td>Gerard Kerslake HMI</td>
<td>Estyn</td>
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<tr>
<td>Rosemary Lait HMI</td>
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