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SCOTTISH BORDERS COUNCIL
FRIDAY, 25TH FEBRUARY, 2022

A SPECIAL MEETING of the SCOTTISH BORDERS COUNCIL will be held VIA MICROSOFT

TEAMS on FRIDAY, 25TH FEBRUARY, 2022 at 10.00 AM

J. J. WILKINSON,
Clerk to the Council,
21 February 2022

BUSINESS		
1.	**Apologies for Absence.**	
2.	**Order of Business.**	
3.	**Declarations of Interest.**	
4.	**Findings of Independent Inquiry** (Pages 3 - 70) Consider Findings of the Independent Inquiry in connection with the Council's Handling of School Assault Allegations. (Report and Appendix attached.)	120 mins
5.	**Any Other Items Previously Circulated**	
6.	**Any Other Items Which the Convener Decides Are Urgent**	

NOTES

1. **Timings given above are only indicative and not intended to inhibit Members' discussions.**

2. **Members are reminded that, if they have a pecuniary or non-pecuniary interest in any item of business coming before the meeting, that interest should be declared prior to commencement of discussion on that item. Such declaration will be recorded in the Minute of the meeting.**

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FINDINGS OF INDEPENDENT INQUIRY IN CONNECTION WITH THE COUNCIL'S HANDLING OF SCHOOL ASSAULT ALLEGATIONS

Report by Chief Executive

SCOTTISH BORDERS COUNCIL

25 February 2022

1 PURPOSE AND SUMMARY

1.1 **This report follows the appointment in June 2021 of Andrew Webster QC to carry out an independent investigation into the Council's handling of concerns raised about a former Scottish Borders Council employee who was subsequently charged with five counts of assaulting children and a further charge of abusive behaviour at a school in the Scottish Borders.**

1.2 On 12 February 2022, Mr Webster provided the Chief Executive with his completed investigative report ("the Inquiry Report").

1.3 On 17 February 2022, Mr Webster presented to Council his findings and Members approved the publication of the Inquiry Report.

1.4 This covering report invites Members to accept the recommendations made by Mr Webster and proposes the preparation of an action plan to address the matters contained within those recommendations.

2 RECOMMENDATIONS

2.1 I recommend that the Council agrees:-

(a) to accept the recommendations contained within the Inquiry Report, as detailed in section six thereof ("the Inquiry Recommendations"); and

(b) to note the Chief Executive's intention to prepare a proposed plan of actions aimed at addressing the Inquiry Recommendations and that this plan will be considered at a meeting of Council to be held on 10 March 2022.

3 BACKGROUND

3.1 On 17 June 2021 Council noted the appointment of an independent investigator to consider the handling of concerns raised about an individual who was convicted of assaulting children at a school in the Borders, whilst in the employment of the Council.

3.2 As noted in June 2021, the purpose of the inquiry was to identify any errors or omissions in the actions previously taken by the Council, so that suitable learning can be put in place and changes made to our systems, processes and policies as required.

3.3 On 12 February 2022, Andrew Webster QC, the independent investigator appointed to carry out this inquiry, issued to the Chief Executive his written Inquiry Report. A copy of the Inquiry Report was then provided to Members, who, at a private meeting of Council on 17 February 2022, heard from Mr Webster as to the approach of the inquiry and its findings.

3.4 At the meeting on 17 February 2022, Council approved the publication of the Inquiry Report, as part of the papers for this Council meeting. The Inquiry Report is attached at Appendix 1.

4 THE INQUIRY REPORT

4.1 As previously reported, Mr Webster, in carrying out his inquiry, considered:

- the records, documents and communications held by the Council from the period 2017-2019 in relation to this matter;
- the Council's relevant policies and guidance in place during this period, and at the present time; and
- relevant national guidance and frameworks.

Mr Webster also interviewed 31 individuals relevant to the inquiry.

4.2 In accordance with the inquiry Terms of Reference, the Inquiry Report considers the extent to which the Council addressed concerns raised about the conduct of a staff member within a school, and, in doing so, sets out a timeline of events relating to these concerns. The Inquiry Report, at section 6 (beginning at page 40), then notes the deficiencies that Mr Webster has identified in the handling of the concerns, and of the Council's policy and practice. Mr Webster also provides his recommendations as to the steps that could be taken in order to minimise the risk of similar issues arising in the future.

4.3 It is recognised that Members may wish to explore aspects of the inquiry with Mr Webster, who has agreed to attend Council so as to respond to any questions that Members may wish to direct to him. Following that opportunity, it is anticipated that Members will wish to discuss the Inquiry Recommendations.

5 NEXT STEPS

5.1 It is recognised that there is considerable value in the Inquiry Report insofar as it highlights Council failings and provides an informed timeline of events. However, the full value of the inquiry can only be achieved if appropriate steps are taken to improve the Council's future handling of any such similar cases.

5.2 Accordingly, it is the Chief Executive's intention to prepare an action plan of steps the Council needs to take to address its previous failings, and to meet the Inquiry Recommendations. It is considered that the formation of a "Review Group" is appropriate, made up of key officers within the Council who will be tasked with implementing any actions and to provide regular updates to Members on performance. More information will be provided about this alongside the action plan, should Members accept the recommendations in this report, specifically recommendation (b) as set out above.

5.3 It should be noted that a number of recommendations reference multi-agency documents, such as the Scottish Borders Child Protection Policy. As such, the proposed action plan will consider how to progress such a multi-agency review, including engagement with Police Scotland and NHS Borders, who share statutory responsibility for Public Protection.

5.4 It is recognised that expediency is required regarding the development of an action plan for improvement. However, it should be noted that a number of the recommendations will require some careful planning in order to fully and robustly embed the changes needed. Therefore, if Members agree the recommendations in this report then the outline action plan will come forward at the next available opportunity (indicated to be 10th March). However, it is anticipated that this action plan will be added to and further developed by the Review Group, once formed, and as such Council will want regular updates to ensure work is fully progressing in due course.

6 IMPLICATIONS

6.1 **Financial**
In preparing the proposed action plan, an estimate of the cost to the Council of implementing the said plan will also be prepared, and provided to Council along with the action plan itself.

6.2 **Risk and Mitigations**
The Council has both statutory duties and common law duties of care to pupils in its schools, and to its own staff. The best way to mitigate the risk of breaching these duties, is to accept the recommendations resulting from the inquiry, so that the Council can determine how best to learn from any errors or omissions in the way the Council works.

6.3 **Equalities**
No adverse equality implications are anticipated as a result of the inquiry.

6.4 **Acting Sustainably**
There are no economic, social or environmental effects of carrying out the proposed inquiry.

6.5 **Carbon Management**
There will be no impact on the Council's carbon emissions from commissioning an inquiry into this matter.

6.6 **Rural Proofing**
A rural proofing check is not required for this matter.

6.7 **Changes to Scheme of Administration or Scheme of Delegation**
No changes are required to either the Scheme of Administration or the Scheme of Delegation as a result of the proposals in this report.

7 CONSULTATION

7.1 None

Approved by

Netta Meadows **Chief Executive**

Author(s)

Name	Designation and Contact Number
Hannah MacLeod & Netta Meadows	Principal Solicitor Tel: 01835 825216 Chief Executive

Background Papers:
Previous Minute Reference: Scottish Borders Council, 17 February 2022

Note – You can get this document on tape, in Braille, large print and various computer formats by contacting the address below. Hannah MacLeod can also give information on other language translations as well as providing additional copies.

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REPORT

to

SCOTTISH BORDERS COUNCIL

by

ANDREW G WEBSTER, QC

into the handling by Scottish Borders Council of school assault allegations

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FEBRUARY 2022

1. Introduction

Background to the Inquiry

1.1. LM was a registered teacher in the employment of Scottish Borders Council ("SBC" or "the Council"). In August 2016 LM was appointed to be a teacher of complex needs at one of the Council's primary schools. Prior to that appointment LM had been in the employment of the Council as a teacher for over 30 years and had occupied head teacher positions during that time. As a teacher of complex needs, LM had responsibility for the teaching of children with additional learning needs, including those with social communication and social interaction challenges.

1.2. In October 2017, and just before the school mid-term holiday, a number of school staff approached a service manager at LM's place of employment. They had concerns over LM's conduct towards children in LM's class and alleged various acts of rough treatment, including the grabbing, pulling and pushing of children. Those concerns were said to have arisen since the start of the school year in August 2017.

1.3. Service management commenced a fact-finding exercise. The concerns were reported to SBC education headquarters staff. Information was ingathered. On the resumption of the school term a week later LM was assigned to another location, with no pupil contact. A disciplinary investigation was commenced.

1.4. On 20 December 2017 the disciplinary investigation concluded with LM attending a management counselling meeting with the Commissioning Manager. Following the meeting LM was reassigned to a place of work other than the school.

1.5. No parents were formally informed by the Council of the allegations that had been made or of the disciplinary process

1.6. Rumours began to circulate as to the circumstances of LM's departure from the school. In particular, whether harm had been caused to children. A parent sought information from the school and a SBC Councillor. The SBC Councillor advised the parent that, having spoken to a senior education manager, the rumours were not true. A formal response was prepared by a senior human resources (HR) officer that narrated that concerns had been "fully considered" and that their child's safety in the school "is assured". That information was provided to the parent by

the SBC Councillor. The parent subsequently met with a senior education manager to discuss their concerns.

1.7. In January 2018 the school newsletter advised simply that LM had taken up a new post at another location.

1.8. Rumours and apprehensions persisted. Following media interest in or about April and May 2018 over an alleged "cover-up" and attempts at engagement with the Council, a number of parents approached a Member of the Scottish Parliament for assistance. After meeting parents, a meeting was hosted by the MSP on 1 October 2018, attended by, amongst others, parents of children at the school, a senior education manager and an education officer. The parents sought information as to why they had not been involved in the investigation and whether there was a matter of police interest in respect of any concerns of assault. The parents were advised that matters would be looked into and that that they would be kept informed.

1.9. In the absence of any follow-up communication from the Council and after concern was expressed by a parent as to a "wall of silence" from SBC, certain families were written to by a senior social work manager on 13 November 2018 and advised that a child protection and reviewing officer ("CPRO") would be in touch. A child protection investigation followed and the allegations that had been made in October 2017 were brought to the attention of Police Scotland.

1.10. On or about 7 February 2019 the Council was advised that LM had been charged by Police Scotland with various offences. Latterly LM stood trial on charges of assaulting five pupils at LM's place of work on various dates between 16 August 2016 and 19 October 2017, and on a charge of threatening and abusive behaviour which was likely to cause a reasonable person fear and alarm, contrary to section 38(1) of the Criminal Justice and Licensing (Scotland) Act 2010.

1.11. On 13 May 2021 LM was found guilty, under deletion of parts of the charges, on five charges of assault and of the charge under section 38(1) of the 2010 Act.

1.12. LM was sentenced on 8 July 2021, when a community payback order, with a requirement to undertake 150 hours of unpaid work or other activity, was imposed.

1.13. On 31 March 2021 LM resigned from LM's post with SBC.

1.14. On 4 November 2021, during the course of this Inquiry, it was reported in the national media[1] that SBC had admitted liability in civil proceedings brought against SBC for the actions of LM.

Purpose of the Inquiry

1.15. On 14 June 2021 SBC appointed me to conduct an inquiry with the following purpose:

> "The aim of the Inquiry shall be:
>
> 1.1 to consider the extent to which SBC addressed concerns raised in connection with the conduct of [LM], a former member of staff at [an SBC school], towards children there in the period 2016 -2017.
>
> 1.2 to identify deficiencies in the handling of those concerns, or of policy or practise (*sic*) on the part of the Council in the handling of the concerns.
>
> 1.3 to consider and recommend any steps that could be taken to minimise the risk of similar issues arising in the future."

[1] https://www.bbc.co.uk/news/uk-scotland-south-scotland-59169172

2. The approach of the Inquiry

2.1. There is no prescribed method by which to conduct an inquiry such as this. It is self-evident that it should attend to the Terms of Reference robustly, but fairly. However, it must reflect the matter under investigation and be sensitive to the constraints of time and resources if the report of the inquiry is to serve a useful purpose.

2.2. The Terms of Reference made clear that whilst the purpose of the Inquiry is to consider the extent to which SBC staff addressed concerns raised in relation to the conduct of LM, to identify deficiencies in the handling of those concerns, and to make recommendations for the future, the Inquiry is not to aim to address the conduct of LM or matters of individual staff conduct.

2.3. The Inquiry has approached the establishment of facts, where necessary to fulfil the Terms of Reference, on the basis of the civil standard of proof, that is to say, I have asked whether matters were more likely than not to have occurred.

2.4. The Inquiry has had regard to both documentary evidence and oral evidence from interviewees.

2.5. To provide, as required by the Terms of Reference, a clear timeline of events that addresses the extent to which SBC addressed concerns regarding LM's conduct it is necessary to report what staff members did, and to do so in context.

2.6. For the most part, events were clear from the documentary record.

2.7. At the start of the Inquiry I requested SBC to provide all documentation held by the Council regarding the concerns that were raised as regards LM's conduct. I was advised that departments had been tasked to locate and provide any such documentation and in due course I was provided with approximately 1,000 pages of emails, letters, notes, reports and other documentation that I was advised had principally been ingathered earlier in response to a Subject Access Request that the Council had previously received.

2.8. During the Inquiry additional documentation was produced by various staff member interviewees. Whilst frustrating not to have been provided with that

additional information at the start of the Inquiry, the nature of the additional material suggested more a lack of appreciation of the nature of the initial request for documentation, rather than an intention to mislead or withhold. Significantly, the additional information was either volunteered by interviewees or readily provided on request when identified as potentially relevant. The possibility of unseen documentation is always a known unknown in any inquiry, but it seems to me that reasonable efforts have now been made to review such material documentary evidence as remains.

2.9. To understand better the documentary record I interviewed a number of individuals who either appeared to me from the material available to be likely to be able to assist the Inquiry, or who had responded to a public invitation made at my request to contribute to the Inquiry.

2.10. In total, the Inquiry interviewed 31 individuals, including 8 parents, and received several written responses, including from the office of the Children and Young People's Commissioner Scotland. Some interviewees provided further documentary material to the Inquiry. Some individuals were invited to a second interview once a broader picture of events had developed and further lines of enquiry were identified. Some interviewees commented on matters beyond the Terms of Reference, but in general interviewees were facilitating and offered valuable assistance to the Inquiry. I have also met with senior officials to discuss processes, departmental hierarchies, and other evidential matters and to liaise over the delivery of this Report.

2.11. The documentary record providing a clear framework for the Inquiry, the interviews were intended to ensure parents and other interested parties had the opportunity to contribute fully. Interviews with current and former members of SBC staff were intended to allow me to better understand the documentary record and to obtain an insight into the reasons why decisions were taken. Standing the Terms of Reference and the direction that the Inquiry not aim to address individual staff conduct I did not consider it necessary for interviewees to provide formal statements. Indeed, I determined that such an approach might well be counterproductive in encouraging participation. Notes of interviews were taken by myself and a solicitor from Ledingham Chalmers LLP who were instructed to assist in administrative matters. Where their evidence appeared material, interviewees were given the opportunity to comment on the note taken by the solicitor. Some

interviewees took the opportunity to do that. Those comments have been taken into account.

2.12. I have intentionally provided limited information as to the identification of which children were the subject matter of particular allegations. I do so not only because in the Terms of Reference I am directed not to aim to address LM's conduct, but rather how concerns regarding LM's conduct were addressed; but also because without unnecessary specification, the possibility of identification of the children concerned can be minimised.

2.13. In reporting, the challenge has been to identify deficiencies in the Council's approach without addressing matters of individual staff conduct. As I am not to aim to address the latter, where evidence on a material issue is disputed, such as whether individuals knew a certain fact, I have simply noted the conflicting or unclear evidence. In doing so I have been conscious of the need to seek to protect individual rights in any disciplinary proceedings that may follow this report. Therefore the narrative provided on those matters is intentionally general.

2.14. In that light I have also sought to anonymise so far as possible individuals referred to. Of course, those intimately involved in the facts may in the light of information already in the public domain believe it is possible to identify individuals. With that in mind, and out of an abundance of caution, where it was thought possible that interviewees might be subject to indirect criticism outside of the Report, the solicitors wrote to those individuals and advised of the evidential matters that might be relied upon and invited any comments.

2.15. Various invitees responded and where relevant their comments have been included in the preparation of this Report. Some who responded expressed concern that the notice given was inspecific. Some sought sight of this Report, or parts of it, before commenting. As already noted, there is no prescribed manner in which to conduct an inquiry such as this. The touchstone is fairness: have those who may perceive they may be criticised in a final report been given a fair opportunity to respond either during the Inquiry's investigations or at least, once a full picture is known, before the Report is finalised. During the interviews I drew the attention of certain interviewees to the possibility they and their conduct might be particularly identified and criticised outside of the Inquiry's Report, and in anticipation of that possibility offered them a pre-emptive opportunity to comment. That opportunity

was repeated in correspondence. A similar opportunity in correspondence was offered to other interviewees who, at the end of the Inquiry, it was considered might be subject to particular identification and external criticism but with whom it had not been raised during interviews. As the issues of fact from which criticism might be drawn were in short compass and related to personal knowledge, no great detail was required and they ought to have been capable of an expedient response.

2.16. For the reasons I have already given, this Report does not individualise criticism. In the light of the discussions referred to and the invitations extended, it is not considered necessary in the terms of fairness for the Report to be seen by individuals before its presentation to the Council.

2.17. I record here my gratitude to all those who contributed to the Inquiry.

3. Parental concerns

3.1. It is appropriate that I begin with a consideration of the concerns of parents of children who were in LM's class.

3.2. Several parents gave up their time to speak to the Inquiry. They offered perceptive insight into their children. Recognising that whilst each child is a unique individual with their own character, challenges and behaviours, a common theme was that the children had limited or no ability to communicate verbally. Furthermore, the children would as a consequence of a combination of particular developmental, learning and behavioural disorders demonstrate, to a varying degree, compulsive behaviour and repetitive movements.

3.3 For these parents, effective communication from school was fundamentally important for their ability to care for their children when at home. Clear and candid communication of what was happening at school provided an essential tool to assist in understanding and dealing with behaviour out of school. For example, it was explained that each child had a book in which matters of significance or potential relevance would be written down and conveyed back and forth between school and home to allow parents and school staff to better understand the children's moods and behaviours. The absence of these books, or at least pages from them, from the time when the concerns regarding LM's conduct arose, was commented upon with frustration by some of the parents interviewed.

3.4. Despite the importance of communication for these parents, none was formally advised by the Council of the true nature of the concerns in respect to LM's conduct in their children's classroom. Such formal information as they possessed had come from other sources, such as the Scottish Borders' child protection unit, from Police Scotland, or from the Crown Office and Procurator Fiscal Service.

3.5. The parents reported different experiences as to when they became aware that there might be concerns as regards LM's conduct. Some parents only discovered there was a concern in respect of their child when approached by members of the child protection unit in the latter part of 2018. Some became aware after seeing a newspaper article in or about April 2018 that raised concerns as to the circumstances of a teacher's departure from the school. Others spoke of having heard earlier rumours of LM having been suspended, although they also spoke to variously being

told that LM was on leave, that they had a new job; and was "off ill". One parent stated that they were was told by a school manager that LM was "off sick with family issues."

3.6. One parent explained that they had been able to meet with a senior education manager at the end of 2017 to discuss the rumours and said that they had been advised that "it had all been a misunderstanding".

3.7. When asked to describe their feelings on becoming aware from the press that there might be concerns over staff conduct at their children's school, those parents who had noted the news article gave descriptions including of being "horrified" and "heart-broken".

3.8. To compound their disbelief, they gave a consistent narrative of an absence of meaningful response to enquiries to the Council as to what may have happened. One parent reported speaking to a service manager on the day the story broke only to be advised by the service manager that they "couldn't speak" about it. Others spoke to seeking communication with the Council to no avail, and of eventually approaching an MSP for assistance.

3.9. The MSP having facilitated a meeting with a senior education manager, individual recollections of that meeting varied, but more than one parent recalled the parents explaining changes in their children's behaviour. The parents were advised at the meeting that an investigation had taken place. Some recalled being assured by the senior education manager that not a hair on any of the children had been harmed, or alternatively that not one child had been harmed. One parent recalled another parent having to ask whether child protection and or the police had been contacted.

3.10. As for discovering at that meeting that there had been an investigation and that no-one had been advised of it, one parent said, "Not knowing made me feel a hundred times worse … Having no communication felt that they did not have children's backs at all."

3.11. A common theme for some was that they reported that they had been concerned about changes in their children during either 2016 and/or 2017, but that when raised with LM or a service manager they had been assured that there were no

issues. One parent reported that LM had enquired whether the problem might lie at home. One parent reported observing unexplained bruises on their child. In retrospect these parents now questioned whether these observations were in any way related to the concerns that were subsequently identified. That caused distress over potentially not having been in a position at the time to best understand and help their children. That distress was exacerbated by still not knowing the full extent of what had happened to their children in LM's classroom, notwithstanding the criminal proceedings.

3.12. One parent described as "disgusting" the idea that the Council had a report before it but did not find that the conduct of LM was such as to justify a conclusion that LM had assaulted children, as the court subsequently found. Another was "angry" at the absence of any prompt communication, observing frustration with the Council because they "had a right to be told, as it was [their] child."

3.13. Concerns were also expressed as to the manner in which the criminal proceedings had progressed, but that is outside of the remit of the Inquiry.

3.14. One interviewee said that they had been met with a "wall of silence" from the Council. More than one feared a cover-up, noting that LM had a close family member who worked within the senior education team at the Council.

3.15. The absence of any apology from the Council was noted.

3.16. Having interviewed the parents, my impression is that their disappointment, frustration and anger, common as it was to all, was genuine; and in the light of the factual background that I will shortly set out, in my view, not unreasonably so.

4. Relevant SBC Policies

4.1. SBC has established policies that it follows in relation to both child protection and employee conduct. Such policies were in place in 2016 and 2017, although have been subject to minor amendments since then.

Scottish Borders Child Protection Procedures

4.2. The *Scottish Borders Child Protection Procedures* ("*the CP Procedures*") in 2016 and 2017 drew heavily from the national guidance then in place from the Scottish Government: *National Guidance for Child Protection in Scotland 2014*[2]. Under the leadership of the Scottish Borders Child Protection Committee, a child protection unit existed, with multi-agency representation, including from SBC's Social Work Team, NHS Borders and Police Scotland.

4.3. Within the *CP Procedures* "child protection" was identified as meaning protecting children from child abuse or neglect entailing the risk of significant harm.

4.4. Whilst that general position was forward looking in terms of protecting against future risk, the *CP Procedures* went on to recognise the issue of potential past harm:

> *"[equally], in instances where a child may have been abused or neglected but the risk of future abuse has not been identified, the child and their family may require support and recovery services but not a Child Protection Plan. In such cases, an investigation may still be necessary to determine whether a criminal investigation is needed and to inform an assessment that a Child Protection Plan is not required."*

4.5. The determination of whether "significant harm" existed was recognised in the *CP Procedures* as a matter of judgment:

> *"In order to understand the concept of significant harm, it is helpful to look at the following definition:*

[2] Now, *National Guidance for Child Protection in Scotland 2021.*

- *'Harm' means the ill treatment or the impairment of the health or development of the child, including, for example, impairment suffered as a result of seeing or hearing the ill treatment of another. In this context, 'development' can mean physical, intellectual, emotional, social or behavioural development and 'health' can mean physical or mental health.*
- *Whether the harm suffered, or likely to be suffered, by a child or young person is 'significant' is determined by comparing the child's health and development with what might be reasonably expected of a similar child."*

And whilst recognising that a single traumatic event, for example a "violent assault" might constitute significant harm, the *CP Procedures* highlighted that:

> *"[more] often, significant harm results from an accumulation of significant events, both acute and long-standing, that interrupt, change or damage the child's physical and psychological development."*

4.6. In the light of the multi-factorial nature of the professional assessment of "significant harm" the *CP Procedures* identified that:

> "*Where there are concerns about harm, abuse or neglect, these **must** be shared with the relevant agencies [which included the Child Protection Unit] so that they can decide together whether the harm is, or is likely to be, significant."*

4.7. The *CP Procedures* highlighted the individual responsibility of staff members:

> "***What to do if you have concerns about a child***
>
> ***Key points***
>
> *Child Protection is everyone's responsibility. If you are worried about a child's safety you must make a telephone referral immediately to the Integrated Children's Service locality team covering the area in which the child lives.*
>
> ***Share your concerns***
>
> *Although it is important to share your worries and ask for advice you should not be dissuaded by other staff or a line manager if you remain concerned. Contact the Integrated Children's Services locality team, police or the Child Protection Unit for advice immediately. The Child Protection Unit only accepts contact from professionals. Members of the public should contact Integrated Children's Services or the police.*

You should not be dissuaded by a manager if you are concerned you should always share the information. (sic)

If you remain concerned

If you are concerned about a child you must not hope that someone else makes a referral, you must follow these procedures."

4.8. As to discussing concerns with a line manager, staff were advised:

"To decide what to do next you should talk to the designated manager within your own agency. This will probably be your line manager, though it could be a designated person with child protection responsibility. Share your concerns and discuss any differences of opinion. However you must refer or ask a Child Protection and Reviewing Officer for advice if you disagree with your manager – ***it is your responsibility and you should not be dissuaded if you believe a child to be at risk of harm."***

4.9. The *CP Procedures* set out what was to happen when a child protection concern was advised. An Inter-agency Referral Discussion (IRD) was to take place, where possible with participants from the agencies represented in the child protection unit, to determine whether to start an inquiry. An IRD could be initiated by a Child Protection and Reviewing Officer, an NHS representative or a police officer alone. The decision could be to undertake a single or joint agency investigation; to proceed directly to a case conference to determine protection measures; or to take no further action.

4.10. The *CP Procedures* provided specific guidance in respect of allegations against staff and service providers. That guidance was:

"A line manager (in the case of schools, the head teacher, for a playgroup the chair of the committee and for a private nursery the nursery manager) will require to make initial enquiries to clarify the nature of the allegation. Where there is ANY doubt, this will be discussed with the duty Child Protection and Reviewing Officer.

Consultation should take place at an early stage between the line manager of the alleged abuser and a Child Protection and Reviewing Officer with a view to reaching agreement on the next appropriate step.

As each agency has its own disciplinary procedure, consideration will have to be given at an early stage whether or not the employee should be suspended from duty pending the investigation. Equally, it is important that the employee is treated fairly and that their rights are respected.

If the Child Protection and Reviewing Officer determines that a formal referral should be made in accordance with these procedures, the Child Protection and Reviewing Officer will be responsible for ensuring that the police are consulted before interviewing the staff member subject to allegation. It is important to note that these procedures and the conduct of any criminal investigation will take precedence over disciplinary or other internal procedures.

Disciplinary procedures may proceed independently of any child protection investigation but interviews of the child concerned should be kept to a minimum.

The Child Protection and Reviewing Officer will report all referrals involving a member of staff to the head of Integrated Children's Services who will liaise with senior officers of other agencies as appropriate.

Where a child protection investigation is instigated, the following points should be noted:

- *Those involved in the immediate line management of the employee, or liaison with the carer concerned, should not conduct any part of the enquiry without reference to the Child Protection and Review Officer.*
- *If the decision is made not to suspend the alleged perpetrator, the need to remove children from their care must be considered. Any decision must be clearly recorded.*
- *Parents or guardians of the children concerned should be kept informed of any developments in such an enquiry.*

At the end of the investigation process the lead officer, Child Protection Committee must be notified by the agency representative who dealt with the situation using the enclosed form."

Disciplinary Procedures for Misconduct

4.11. The SBC *Disciplinary Procedures for Misconduct* ("*Disciplinary Procedures*") was first published in 2015 and was revised on 25 October 2017.

4.12. The Disciplinary Procedures provided that cases of "minor misconduct", were to be "normally handled through counselling by line managers initially, rather than through disciplinary action." "More serious conduct" was to be the subject of a

two-stage procedure. Firstly, a fact-finding exercise or investigation in relation to concerns raised was to be undertaken. Such an investigation was to ingather evidence to allow a management decision to be taken on whether the concerns related to conduct; and if so, to determine to either dismiss the case, refer the matter for counselling (i.e. with the relevant line manager), or to conduct a second stage disciplinary hearing at which facts would be determined and, in the light of the same, a disciplinary conclusion reached.

4.13. The *Disciplinary Procedures* also identified indicative conduct that could result in disciplinary action. Abusive or threatening behaviour towards any person, and minor abuse of authority were identified as acts of misconduct. Physical assault and serious abuse of authority or trust were identified, amongst others, as potentially amounting to gross misconduct. (see Appendix 7 of the *Disciplinary Procedures*)

4.14. The *Disciplinary Procedures* identified three stages of management of conduct: Stage 1 – day to day line management; Stage 2 – fact finding and investigation; and Stage 3 – formal disciplinary hearing; and provided as regards any investigation (at § 9.2):

> *"If it is apparent that the issue is minor and readily corrected through discussion between the manager and his/her employee, Stage 1 above should be followed. If, however, the investigation indicates that an issue is more serious, Stage 3 below should be followed."*

4.15. Any investigation was identified as likely to take a working week, or in more complex cases no longer than 6 weeks, but could possibly take longer.

4.16. The policy also provided that in the cases of professional misconduct the relevant professional bodies were to be notified.

4.17. To assist those who might have to carry out an investigation under the *Disciplinary Procedures*, separate guidance was provided, and continues to be provided, in the form of *Guidelines on Conducting Investigations* ("the *Guidelines*").

4.18. The *Guidelines* provided that if the need for an investigation had been identified the relevant line manager was to commission "*at least one investigating officer, normally two because when conducting interviews the use of a second investigator or*

at least as a notetaker is essential to ensure sufficient and accurate notes can be made and to protect against any misunderstanding". It was recommended that at least one investigator must be independent of the section/office where the alleged incidents occurred.

4.19. A specific direction was given as regards concerns relating to child protection:

> *"HR and/or Legal Services must be sought in cases involving child protection and vulnerable adults' issues."*

The current iteration of the Guidelines provides merely that "*Advice from the HR Case Management Team must be sought …"* in such circumstances.

4.20. The *Disciplinary Procedures* also provided that the commissioning line manager was to chair any disciplinary hearing. The commissioning manager was to provide the investigating officer with a clear remit. The investigating officer was only to compile sufficient information and evidence for a management decision to be reached on whether a disciplinary hearing is necessary:

> *"S/he should limit him/herself to collecting relevant information and in no way attempt to draw conclusions about potential disciplinary action or otherwise stray into the business of the disciplinary hearing."* (§ 15.5, now substantially repeated in § 13.5)

4.21. At § 17.1 the *Disciplinary Procedures* further provided that where a line manager had concerns about an employee's professional conduct, his/her integrity, or suitability for a position of trust in relation to children … the manager must notify HR and /or legal services and consider notifying the appropriate third party organisation. (now § 15.1. with the reference to legal services deleted).

4.22. In relation to the General Teaching Council for Scotland, the *Disciplinary Procedures* identified that the Public Services Reform (General Teaching Council for Scotland) Order 2011 states that the GTCS must be notified by an employer of the following:

- A registered teacher who is dismissed for misconduct
- A registered teacher who is dismissed for incompetence

- If a teacher resigns or abandons their position in circumstances, but for their abandonment or resignation they would have been dismissed for misconduct, or dismissal for misconduct would have been considered by the Council
- The teacher resigning, or abandoning his position, after being informed by the employer that a disciplinary hearing is to be held by the employer in respect of the teacher's alleged incompetence.

4.23. Also, in relation to the application of the Protection of Vulnerable Groups (Scotland) Act 2007, the *Disciplinary Procedures* provided that the Council has a duty to report to Scottish Ministers if, amongst other reasons, an individual has harmed a child or placed a child at risk of harm and as a consequence was transferred to a position within SBC which is not a position involving work with children.

5. The Facts

5.1. The first purpose of the Inquiry is to consider the extent to which SBC addressed concerns raised in connection with the conduct of LM.

5.2. The Terms of Reference for the Inquiry require the establishment of a clear timeline of events.

5.3. What follows are the Inquiry's findings of fact, reached on the balance of probabilities, presented as a timeline. For the most part, events could be distilled from emails, correspondence and other documentation and there was little difference between interviewees as to the sequence of events. Also, for the most part, my impression was that interviewees were trying to assist the Inquiry and were credible and reliable. Where there was a significant difference in the evidence presented to the Inquiry that touches upon individual conduct, that difference is simply highlighted, without a view taken as to what occurred.

Raising of concerns: 5 and 6 October 2017

5.4. Thursday 5 October 2017 was the last day of school at LM's place of work before the October mid-term break. LM's teaching day with children was until 12.00 noon. Children in LM's class were to attend mainstream schooling in the afternoon.

5.5. Before the start of the school day five school staff members approached a service manager (Service Manager 1) with concerns about the conduct of LM. The general tenor of the concerns was noted by Service Manager 1. It was noted that LM's behaviour had changed since summer and the staff members were concerned that LM was "*overly heavy handed with children, rough with them, shouting at them when not doing as requested or touching something*". It was also noted that some children had been left crying.

5.6. Particular allegations that were noted (and noted as not being the totality of the concerns raised) were that LM had:

- very roughly pulled a child that was grabbing another child and backed that child very roughly into a chair,
- roughly pushed a child into their chair causing the child to cry,
- dragged a child across a gym hall on the child's knees,

- pulled a child across a classroom floor,
- roughly pulled children to activities they were not keen to do, and
- held a child's head and chin whilst telling the child to be quiet.

5.7. Service Manager 1's note also recorded that some of the school staff felt anxious if LM was left alone with the children. It was noted that a child had been observed by a school staff member the previous day to be sitting alone with marks in their shoulder area after LM had been left alone with the children. It was noted that the assumption at the time had been that the child had been rubbing on something. It was also noted that the marks had gone by the end of the school day and that the parents had been told.

5.8. It was also noted that a parent of a child had commented to a school staff member that the child had said at home "*school hit me, boom*" and that the child was observed as saying "*boom*" when "*something rough happened in class*".

5.9. Concerns were also noted as to the sharing out of food from a child's lunchbox.

5.10. The Service Manager 1 reported the concerns to their line manager, Service Manager 2. No instruction was given to remove LM from the classroom. Service Manager 2 requested further information and Service Manager 1 prepared a typewritten note of the meeting with the school staff. That typewritten note recorded the allegations set out above and four further allegations:

- that on 13 September 2017 Service Manager 1 had observed LM pulling a child in a "*rough manner, by one arm to his feet*",
- that on 21 September 2017 another staff member had raised with Service Manager 1 concerns raised by other staff members that LM had handled children "*in a rough manner that they didn't feel comfortable with*". It was noted that Service Manager 1 had determined to monitor the situation,
- that on 22 September 2017 Service Manager 1 had observed LM back a child against a wall in a "*rough manner*", in response to which LM had been instructed "*gently please*", and
- that on 27 September 2017 Service Manager 1 had observed LM pulling a child to their feet and moving them "*a little roughly*" a few times to a food tasting activity.

5.11. To the Inquiry, Service Manager 2 stated that they did not consider that they had authority to remove LM from LM's place of work. Further, they wanted advice as to how best to proceed. They were due to attend at SBC headquarters ("HQ") that day for other reasons. A meeting did take place between Service Manager 2 and, in the absence of their own line manager, a more senior education officer at HQ. There was a dispute in the evidence provided by those interviewees as to whether Service Manager 2 spoke with the senior education officer at HQ during the afternoon of Thursday 5 October 2017 or on Friday 6 October 2017. The senior education officer recalled being provided with the allegations "formally" by email, described as a record of a conversation between the school manager and the school staff. Although the Inquiry did not have sight of any email, both Service Manager 2 and the senior education officer recalled advice being given to obtain more detailed information. The documentary records that have been retained demonstrate that by 4:11 pm on 5 October 2017 Service Manager 2 emailed a request for more information to Service Manager 1, including of any concerns arising before "the holidays", and a request that the school staff prepare individual reports as soon as possible. The conclusion of fact drawn by the Inquiry is that meeting took place on 5 October 2017 and that the senior education officer was advised of the terms of the typewritten note by Service Manager 1 during that afternoon.

5.12. The senior education officer's recollection to the Inquiry was that the concerns that were raised by the service managers were of conduct on the part of LM that was "*quite aggressive in terms of shouting and also [LM's] handling of the children*".

5.13. The senior education officer took advice from the Council's HR department. Following input from a senior HR officer, the instruction given by the senior education officer to the Service Manager 2 was to undertake further "fact finding".

5.14. To the extent that was not already in hand, further information was subsequently provided.

Mid-term break: (9 – 15 October 2017)

5.15. On Monday 9 October 2017 a short, typed report from one school staff member (SM1) was provided to Service Manager 1 and emailed to Service Manager 2 who in turn emailed it the following day to the senior education officer. The senior education officer emailed it to the senior HR officer on 10 October 2017,

5.16. That report alleged that LM had:

- yanked the shoes off a child who had sought assistance in tying their laces up and had thrown the shoes into a corner, saying that they were "*sick of this*",
- grabbed a child firmly by the shoulders, shaking the child, shouting in the child's face "*you will do it spoiled brat*", leaving the child with "*a tear*",
- grabbed a child, who had declined a request to sit, by the shoulders and pushed the child hard down onto a chair causing the child to cry,
- grabbed a water jug off a child whilst shouting in the child's face to leave it alone,
- grabbed a child who was lying on the floor by the arm and dragged the child to their seat, and
- shared the contents of a child's lunchbox with others.

5.17. At the end of the day on 9 October 2017 another report from a school staff member (SM2) was received by Service Manager 1. On 10 October 2017 it was emailed to Service Manager 2 , who in turn emailed it to the senior education officer, who in turn copied it to the senior HR officer.

5.18. That report alleged that LM had been observed:

- gripping a child's shoulders firmly, shaking the child and shouting "*you do it, you do it*" in respect of an attempt to have the child put sandshoes on; and then forcing the child's hands to their feet repeating "*you do it*" whilst the child was crying,
- taking a child who declined a request to sit by the arms and forcing the child onto a chair causing the child to cry,
- shouting at a child who was crying,
- shouting in the face of another child,
- cupping a child's head and chin and forcing the child to their chair shouting "*sit down when you're told*", and
- sharing the contents of children's lunchboxes.

5.19. On Sunday 15 October 2017 the senior education officer emailed the Service Manager 2, with proposed wording for an email to be sent to LM before the start of the school day the following morning. That wording referred to a number of allegations having been made regarding LM's handling and management of children in the classroom. It proposed that LM meet the senior education manager at a

location other than LM's normal place of work at 9:00 am., advising that cover had been arranged to accommodate LM's absence and that someone from "HR" would also be present.

5.20. Also on Sunday 15 October 2017 a third report was provided by a staff member (SM3) to Service Manager 1. That report alleged that LM:

- tugged at a child and shouted at the child "*you do it*" in relation to the putting on of a gym shoe; and further pulling the child down by the arms shouting "*you do it you lazy boy*" resulting in the child being brought to tears,
- grabbed a child who had grabbed LM from behind and forcefully pushed the child down on to a seat, causing the child to say "*boom school hit me*" twice,
- pushed a child down onto their chair after the child declined to sit down, and
- shared the contents of a child's lunchbox with other children.

The staff member also reported that since coming back from the summer holidays LM had "*begun to loose (sic) their temper quite quickly with the children*", had "*picked*" on two children. The staff member expressed concern about LM being left alone with those two children.

Monday 16 October 2017

5.21. The report received from staff member SM3 the previous day was copied to Service Manager 2 at 8:29 am, who in turn copied it on to the senior education officer and the senior HR officer at 10:56am.

5.22. The senior education officer and the senior HR officer met with LM as had been proposed the previous evening. A note prepared for that meeting recorded "*feedback*" as including *"being overly heavy handed with the children, handling them roughly, shouting at them when not doing as requested or if touching something when they shouldn't"*. The note also identified that a formal investigation under the Council's disciplinary policy was a possible, if not likely, outcome. Further, the note set out the option to find alternative working arrangements for LM whilst any investigation was ongoing; or to seek approval for special paid leave.

5.23. There appears to be no minute of that meeting. However, in the light of events the following day, it seems that a decision was taken to require LM to not return to LM's place of work, and for an investigation under and in terms of the

Council's *Disciplinary Procedures* to proceed. How LM would be otherwise deployed or placed on leave appears to have been deferred for further consideration.

5.24. Also on 16 October at 10.00 am the Service Manager 1 received two more reports from school staff members. They were emailed to Service Manager 2, who emailed them to the senior education officer and the senior HR officer at 10:58 am that day.

5.25. The first report (from SM4) alleged that LM had:

- dragged a child along the gym hall floor by his arm whilst the child was on his knees, and
- lifted a child from the floor and put the child on a chair whilst the child was screaming.

5.26. The second report (from SM5) alleged that LM had:

- shouted at a child to leave LM's computer mouse alone and to sit down,
- grabbed the sweatshirt of a child and pulled the child across the room, pushed them onto a chair and shouted at the child to sit down,
- grabbed the wrists of a child whilst standing over the child, and
- yanked an elastic band out of the mouth of a child with force.

5.27. Later in the day on 16 October 2017 the senior HR officer sent an email at 2:09 pm to a senior HR manager seeking an opportunity to discuss and obtain advice. The email referred to *"Allegations of inappropriate behaviour and conduct toward pupils in [LM's] class"* and to *"concerns over how [LM] spoke and managed pupils in [LM's] class"*. The senior HR officer recorded that their "*guidance*" was that an investigation needed to be commissioned, but that there ought to be a discussion about whether the case warranted special paid leave. As an alternative, it was noted that there was a view held by the senior education officer and one of the service managers that there may be benefit in having LM involved in a non-classroom post outwith a school setting. The senior HR officer also recorded that LM was "*devastated to hear about the concerns raised and doesn't recall handling or speaking with pupils in the way that is being presented*." Later still that day emails were exchanged between the senior HR officer and others with a view to the identification of a suitable role for LM.

Tuesday 17 October 2017

5.28. On 17 October 2017, the senior HR officer advised the senior education officer that given the seriousness of the allegations a school setting for LM was not appropriate. A non-classroom, non-school post was identified.

5.29. The senior education officer then wrote to LM a letter, approved by the senior HR officer as appropriate, to formally advise LM that in accordance with the Council's *Disciplinary Procedures* LM was to remain away from LM's place of work because of "*allegations that you have acted and spoken inappropriately towards pupils in your role as an Additional Needs Class teacher*" and that the allegations were to be investigated under the *Disciplinary Procedures*. The letter advised that rather than being placed on Special Paid Leave, LM was to attend at the identified alternative place of employment the following day.

5.30. The decision to proceed under the *Disciplinary Procedures* followed a meeting or meetings between the senior education officer, a senior education manager and a senior social work manager.

5.31. Recollections differed as to what was discussed between those officers. One interviewee stated to the Inquiry that "being rough with a child" "might" have been mentioned. They recalled being instructed to identify someone to conduct what was described as "an HR fact-finding investigation". They identified someone outside of education as LM had a close family member who worked within the senior education team at the Council. Another recalled only discussions around practice issues and of asking whether any child had been harmed and of being told "no". They recalled no discussion about "heavy handed" conduct. Another said the allegations were fully discussed.

5.32. No documentary evidence was produced to the Inquiry that recorded what was discussed or what was instructed to be done at this point in time. As these differences touch on personal responsibility, I reach no conclusion as to which was more likely than any other to properly explain what was discussed. I am, however, able to conclude that those members of staff were at least aware that there was an issue regarding a teacher in respect of conduct involving at least one child that necessitated an HR investigation, and in my view by reasonable implication,

disciplinary investigation. Further, it can be noted that the senior education officer had the staff member reports and Service Manager 1's report.

5.33. The evidence to the Inquiry of the social worker who was identified to investigate (the Investigating Officer) was that they were not asked to be an investigating officer under the Disciplinary Procedures. Instead, they said, they were simply asked to gather information on behalf of the senior management team because of a close personal relationship between LM and someone "high up" in the education team. They said that they assumed that the concerns had already gone down the child protection route and observed that it was difficult to comprehend otherwise when the task they had been instructed to undertake had come from their manager (in social work) and a senior social work manager.

Investigation: 18 October – 9 November 2017

5.34. Whatever the perception of the Investigating Officer, on Wednesday 18 October 2017 they commenced their investigation by requesting interviews with school staff and Service Manager 1. Three interviews were conducted on Friday 20 October 2017. Four further interviews took place on Monday 23 October 2017 and LM was interviewed on Friday 27 October 2017. The Inquiry notes that the records of interview were recorded as "Note[s] of Investigation Meeting" in a form that conformed to the style of such notes as required by the *Guidelines*, including with declarations referring to the prospect of disciplinary hearings.

5.35. Evidence ingathered on 20 and 23 October 2017 included allegations (which may have related to the same incident observed by more than one person) that LM had:

- put a hand over child's mouth and told the child to shut up,
- grabbed a child by the tops of their arms or shoulders, pushed them down and pulled the child towards their shoes, causing the child to cry,
- grabbed a child, who was grabbing another child, by the arms and pushed the child down into their seat whilst saying "*no*" after which the child said "*boom, school hit me*",
- forced a child down into their chair causing the child to cry and rub the backs of their legs and bottom,

- grabbed a child who was particularly active by the back of their head and cupped LM's hand under the child's chin after which the child said "*boom, school hit me*",
- on various occasions shouted at children,
- dragged a child by their wrists and elbow across a floor "*like a bag of tatties*" after a music activity. It was said that this had been commented upon to another staff member and that the other staff member would speak to a service manager,
- grabbed a child up from the floor by the arm to get the child to participate in an activity,
- yanked the shoes off a child who was attempting to re-tie shoelaces and threw the shoes behind LM into the corner of the room whilst saying "*I'm sick of this*",
- grabbed a child by the child's sweatshirt and dragged the child across the floor in a manner that was "*rough*", and
- gripped a child by the wrists to stop the child from moving.

5.36. There was evidence to suggest that some of these incidents had been witnessed by more than one member of staff.

5.37. It was noted in the records of interview that at least one of the interviewees had stated that they had begun to have child protection concerns after three weeks of incidents.

5.38. Another interviewee was noted as stating that after a team meeting two weeks before the "end of term" school staff had raised with them concerns regarding LM's conduct. They had then, a week later, but at the first opportunity, informed a service manager. The service manager confirmed to the Investigating Officer that school staff members had raised concerns with them.

5.39. The service manager was also noted as having observed LM handle the children "*more roughly that I'd consider appropriate*."

5.40. The Inquiry noted consistent evidence from both school staff, service managers and parents who were interviewed that the sensory needs of the children with additional needs could entail more physical contact than is the case with children without such needs. It was explained that rubbing or gentle hand pressure

can be calming for some children. The disciplinary investigation noted that too, but with a caveat. The service manager who was interviewed commented:

> *"Our Team Teach training is not necessarily up to date. Training is done in-house, its not formal. One member of staff attended Team teach training last year. It is not always pertinent to our children with their low level of cognitive understanding. We look at guiding children and we handle them more than children in the mainstream system. We always have to be gentle, considering sensory needs, where some of them like to be rubbed and pressure. Some like this on the hips and shoulders as hands on from an adult. This can be done with weighted blankets and adult pressure for comfort and reassurance but not in conflict situations as restraint. Generally in conflict situations you would step back and allow the child to get to their feet or gently support them to their feet. The line of work is vague and there is no single appropriate response to challenging behaviours, unlike behaviour support which has a straightforward process for dealing with challenging behaviour."*

And also:

> *"There may be instances when we may use 'force' when handling a child.*
>
> *If a child is in danger, then we would move them which may be more forcefully e.g. a child sitting down in the middle of the road and refusing to get up.*
>
> *Another instance would be if the child was causing a considerable obstruction e.g. myself and [a school staff member] 'lifted' a child from a busy shop recently when they refused to move from the floor. We each took an arm to move them on but then lifted their legs and effectively lifted them out.*
>
> *Another instance would be if a child runs off and it was a potentially dangerous situation e.g. heading off through an open door. The adult with them would attempt to prevent them from doing so and may take hold of them with more force than normal.*
>
> *In these cases the adult would act instinctively or make a conscious decision to be more forceful but it would not be through personal frustration or agitation as it appeared in the situations I personally witnessed and reported in my statement."*

5.41. On 27 October 2017 the Investigating Officer interviewed LM. The record of that interview noted, amongst other things:

- that LM stated that LM had not undertaken a behaviour management course with Team Teach,

- LM had, however, dealt with additional needs children in previous posts,
- LM was studying a Postgraduate Certificate on Collaborative Working: Education and Therapy, before commencing in post, and
- LM's view was that the children's needs meant that there was a lot of physical contact.

5.42. LM was also noted as having denied shouting at the children, but accepted that they would use a louder voice to get LM's point across. LM denied pulling a child's arms down to their shoes. Although asked about the allegation that LM forcibly pushed a child down into their seat, no specific explanation of events was noted. It was noted that LM could not remember any incident when a child was pushed down onto their seat and hurt their bottom. As regards the allegation of throwing shoes LM was noted as saying LM did throw the shoes, which were muddy, but not with force; and that LM might have said "I'm sick of this", but in a low voice. LM's evidence was noted as having thrown the shoes behind LM, a metre in distance. LM was noted as having no recollection of grabbing a child by the arm and dragging the child to their seat, nor of dragging a child the length of the gym floor hall before removing the child from the room. LM was also noted as having had no recollection of any incident of pulling a child to their feet when out on a walk, but did recount an incident of pulling a child away from a river's edge.

Report of the Investigation: 9 November 2017

5.43. The Investigating Officer presented their report ("Investigation Report") to the senior education officer (as the Commissioning Manager of the report) on 9 November 2017. In like manner as the Notes of Investigation Meeting, the report was presented in a form that conformed to the style of report required to be produced by an Investigating Officer under the *Guidelines*. It was shared with the senior HR officer who had been assisting the senior education officer/Commissioning Manager previously.

5.44. The report distilled twelve specific concerns drawn from the evidence ingathered during the investigation. The report's narrative summarised the evidence supportive of each allegation and highlighted when evidence was available from more than one source. On those occasions it noted a consistency of descriptions given by witnesses in relation to (i) the allegations of grabbing a child by the shoulders and pulling the child's upper body down towards the child's feet in

an attempt to have the child put on gym shoes; (ii) forcibly pushing a child down into their seat; and (iii) forcibly pushing another child down on to their chair causing the child to cry and rub their bottom.

5.45. In addition the Investigating Officer recorded their impression that school staff appeared to have been taken aback by what they said they had observed, which led them to "internalise" what they had witnessed.

5.46. On 20 November 2017 the senior education officer emailed LM to advise that they had the Investigation Report and were taking guidance from HR.

Parental concerns: 8 December 2017

5.47. Whilst the Investigation Report was before the Commissioning Manager, on 8 December 2017, a parent of one of the children in LM's class, emailed a service manager over concerns that LM was absent due to an investigation into *"inappropriate man handling of a child"*. It was said this information had come from a member of staff at a different school. The parent raised concerns that their child had been commenting *"school's hurt me, bang"* at home and sought reassurance that nothing untoward had happened to their child.

5.48. A service manager sought advice from an education officer as to how to reply and that request was emailed to the senior HR officer previously involved and copied to the Commissioning Manager. The response from the senior HR officer was that the Investigating Officer's report was *"nowhere near fit for purpose"* and needed to be redrafted.

5.49. A service manager responded to the parent the same day, and by reasonable inference on advice, that they were unable to comment on reasons for staff absences but extended an invitation to the parent to come into school to discuss any specific concern regarding their child.

5.50. On 10 December 2017 the parent emailed a service manager again, expressing a right to know if their child had come to harm or if someone had been rough with them.

5.51. In the absence of a response, that email and the earlier email was copied to an SBC Councillor on the evening of 11 December 2017. The SBC Councillor immediately emailed a senior education manager to appraise them of the parent's approach. Specifically, it was said in the email that "*the rumour is that children have been harmed and there is an investigation."* The SBC Councillor enquired as to what measures were in place to discuss matters with parents. Shortly thereafter a senior education manager responded to the SBC Councillor by email and advised that there was an investigation about a member of staff in hand. It was stated "*We are not allowed to release any form of statement or any information to parents at any point of the investigation*". In addition there was an offer to provide more information and a statement the following day. A later email that evening also advised the SBC Councillor *"I can reassure you tomorrow when I see you and provide you with a script to give to parents."*

5.52. That the SBC Councillor and a senior education manager discussed matters on 12 December is a reasonable inference of fact in the light of the offer the night before and a text sent on 12 December 2017 by the SBC Councillor to the parent in the following terms:

> *"Right, just off the phone to our [senior education manager]. While I cant (sic) tell you much about the ongoing investigation I can reassure you that the rumours that you have heard are not true. What I have suggested is that [a senior education manager, their deputy, a senior education officer] and possibly myself come round next week for an informal chat about everything. First of all to give you some reassurance about the [the place of education and the child] … I will send you a proper email of council speak tomorrow but that will be gist of it. But I can assure you that the stories you have heard are Chinese whispers…. So be reassured …"*

5.53. On 14 December a senior HR officer provided draft wording for an email to be sent by the SBC Councillor. The Councillor adopted the proposed wording and sent a text to the parent as follows:

> *"Official response*
> *I refer to your e-mail in which you raised concerns about your [child's] wellbeing at [the place of education].*
> *These concerns have been fully considered by Senior Officers within the Council's Children & Young People department, who have reviewed arrangements within the school.*

Having done so they, and I, are content that [your child's] safety within the school is assured.
To provide further reassurance of that [a senior education manager] will come out to see you to talk through any concerns further. …"

5.54. On 14 December 2017 the parent's emails to a service manager of 8 and 10 December 2017 were copied to an SBC administrative staff member for forwarding to the senior education manager. Later that day the SBC Councillor was asked to provide the parent's address for the benefit of the senior education manager's secretary, as "*[the senior education manager] would like to arrange to meet with [the parent] to discuss concerns*." An invitation was then sent on behalf of the senior education manager to the parent.

5.55 On 19 December 2017 the SBC Councillor asked the senior education manager for a briefing to be given to the local members. The senior education manager replied by email the same day stating that they had spoken to a senior HR manager and had been advised not to send out a "*comms of Members*", but to alert members in a face-to face meeting. They stated their intention to do so that Thursday after the Council meeting. They stated that they would, by then, have met with the parent raising concerns (on the Wednesday afternoon).

5.56. On 20 December 2017 a senior education manager and an education officer met with the parent. The education officer's recollection was that the parent was advised that the investigation could not be commented upon. The parent's recollection of the meeting was that the concerns were described as a *"big misunderstanding"*, that the rumours were untrue and that nothing had happened. The senior education manager's position was that they were not at that time aware of the content of the Investigation Report. It was said that it would have been inappropriate for them to be aware in the light of the prospect that they might have to consider any appeal against disciplinary action arising from the investigation in due course. Further, they said that in such discussions that they had about the concerns and the investigation those discussions had been about practice concerns on the part of LM and there had been no reference to harm. They said they had asked whether anyone had been harmed and had been advised, no. Their position to the Inquiry was that had they been aware of harm they would have referred matters to child protection. The parent observed to the Inquiry that they had sought a minute of that meeting, but none had been provided. No minute was provided to

the Inquiry by the Council in response to the Inquiry's request for all relevant documents.

Disciplinary meeting with LM: 20 December 2017

5.57. Also on 20 December 2017, the Commissioning Manager formally met with LM, with the support of a senior HR officer. The meeting followed discussions between the Commissioning Manager and the senior HR officer as to how to proceed in the light of the Investigating Officer's report. Additional information regarding LM was sought and obtained by the senior HR officer. That officer also prepared draft points for discussion at the meeting which had been identified beforehand as a management counselling meeting. The Inquiry has not seen any documentary evidence recording why the decision was taken to conclude matters with a management counselling meeting. However, the reasonable conclusion to be drawn from email correspondence preceding the meeting is that the decision was at least taken by the Commissioning Manager with the knowledge of the senior HR officer. The Commissioning Manager in evidence to the Inquiry described receiving a *"strong steer"* from the senior HR officer to proceed in that manner after the senior HR officer had discussed matters within the HR department, including with another senior HR officer. Further, the Commissioning Manager said to the Inquiry that the decision to so proceed had been discussed with and agreed by a senior education manager. The senior education manager said to the Inquiry that whilst they were aware of the disciplinary process, they were not advised of the substance of the Investigation Report at that time. Whatever was discussed, the meeting took place and the Commissioning Manager determined to conclude matters with a management counselling meeting.

5.58. A letter from the Commissioning Manager to LM dated 21 December 2017 recorded the conclusion of the disciplinary investigation. The letter was provided to the Commissioning Manager in draft by the senior HR officer. The letter refers to the management counselling meeting the day before and narrated that "*You acknowledged your responsibilities in all of this and were clear that you understood the seriousness and the need for matters to be investigated*". Reference was made to the GTCS Code of Professionalism and Conduct. Re-deployment possibilities were discussed and Continuing Professional Development training need was identified. In conclusion it was said "*having taken into account all the circumstances surrounding*

this matter I confirmed my decision to take no further action notwithstanding this management counselling discussion."

5.59. In December 2017 a newsletter to parents advised that LM was still off work and that LM's class was being covered by another teacher.

5.60. LM returned to work on 8 January 2018, to the alternative post that had been found in October 2017. However shortly thereafter LM was deployed to another teaching post elsewhere within the SBC education estate, with pupil contact.

5.61. It is of note that on or about 27 September 2018 concerns arose as to LMs' "*manner*" towards a child in that new post. LM's conduct in 2018 is outwith the remit of this Inquiry. I was advised by the Council that it had become apparent during the period of the Inquiry that those concerns had not been raised with the child protection unit at the time, but that has now been done.

5.62. Following the relocation of LM, a parent became aware of LM's move from LM on 10 January 2018. On 12 January 2018 a service manager sought advice from a senior education officer as to what to say to parents as regard LM's departure in the light of a parent having advised a staff member that they were aware that LM was working elsewhere. The suggestion made was a reference be made in the school newsletter to parents, simply advising that LM had taken up a new post. LM suggested a communication to staff and parents.

5.63. The January 2018 school newsletter advised that LM "*has now taken up a new post and we wish [LM] well."*

Press interest: 26 March 2018 and 27 April 2018

5.64. On 26 March 2018 a press enquiry was directed to SBC over claims of a "cover-up", in respect of complaints made against LM, including of assaulting and verbally abusing children. It was alleged that a full investigation had been carried out by an officer of the Council and that LM had been removed from post, but that staff had been told not to discuss the case with parents and no parents had been told of the complaints, the investigation or the outcome.

5.65. The senior HR officer who had assisted the Commissioning Manager advised an education officer to work with a senior education manager and "comms" around a response. In a subsequent email to a senior HR manager, the senior HR officer observed *"I reminded them that we don't comment on individual staff matters but appreciate they may want to issue a statement around our commitment to child protection, safety and reporting methods where there are genuine concerns."*

5.66. After an article appeared in the *Peebleshire News*, another SBC Councillor emailed a senior education manager on 27 April 2018 and requested to be copied in to any communication to parents. In response the senior education manager emailed the SBC Councillor and others the same day and advised *"[we] did not send a letter to parents and do not plan to. This matter has been mis-reported on a number of fronts eg the manager of the base and one of my officers met directly with staff to keep them updated on more than one occasion. There is one parent who raised concern – I did meet with the parent – who was re-assured that no further action was required."* The email went on: "*a full investigation did take place and there was no case to answer*."

MSP interest: May 2018

5.67. Having been approached for comment by the press, an MSP arranged a meeting with various parents. That took place on or about 14 May 2018. Parents drew attention to changes in their children's behaviour that, in the light of rumours that were circulating as to the circumstances of LM's departure, were of concern. The MSP engaged in correspondence with the Council and sought further information from the parents.

5.68. On 22 June 2018, a senior education manager emailed the MSP and advised that two parents had communicated with SBC about LM's departure. It was said that only one parent had a child in LM's class and that parent was content with the response of the Council to the concerns raised.

5.69. On 1 October 2018, at the request of the MSP, a meeting was hosted by the MSP at which the senior education manager, an education officer and five parents attended (representing the interests of four children). The parents explained the changes in their children's behaviour that they had noted whist in LM's class in the light of the information and fears that of which they were aware. A note of the meeting records that the parents wanted to know why they had not been involved in

the investigation into LM, what procedures were not followed (*sic*) and whether there was a matter of police interest in respect of alleged assault. The senior education manager undertook to investigate and advised that a senior social work manager would take matters forward and an education officer would email the parents to confirm next steps.

5.70. The MSPs' evidence to the Inquiry was that the senior education manager presented as being shocked and genuinely surprised upon being advised of the parent's concerns during the meeting. The senior education manager's evidence to the Inquiry was that they were not aware of the allegations of harm to children before that meeting.

5.71. At 4:01pm on 1 October 2018 Service Manager 2 emailed the senior education manager and the education officer Service Manager 1's typewritten report and the 5 school staff members' reports. The were copied to the senior social work manager who had been identified as the officer who would take matters forward at 10.38pm.

5.72. At 8:56pm on 1 October 2018 the education officer emailed the MSP, and others, to thank them for their attendance at a meeting that day and advised that advice was being taken as to the opening of a new investigation following the concerns raised. The officer advised that they would provide an update by email.

5.73. In the absence of any update, on Friday 12 October 2018 a parent emailed the education officer who had undertaken to provide an update with a request to be advised as to progress. This was passed to the senior social work manager who was investigating further.

5.74. On 15 October 2018 the senior social work manager determined that there would be a referral to the child protection unit in the light of an allegation of assault. The officer prepared a draft document to be sent to parents and provided it to a senior social worker in the child protection unit for consideration. The letter was considered by the senior social worker to be inadequate, responding "*is this a serious document*" and commenting upon the inadequacy of information proposed to be supplied to parents.

5.75. The senior social worker in the child protection unit requested more information but it was not until 22 October 2018 that they received a copy of the

Investigation Report prepared by the Investigating Officer in November 2017. The copy received bore proposed amendments, principally introducing additional information from the available evidence. The senior social worker considered the Investigation Report to be incomplete and requested any further information that was available. They identified a justification in the parents' concern over not being involved. On receipt of the Investigation Report, they emailed the education officer and the senior social work manager and enquired:

> *"… there must have been some sort of documentation that satisfied [the Commissioning Manager] the investigation had been concluded with actions taken and that it had reached an end - surely? This will need to be unpicked and managed very carefully as the parents are justified in complaining about lack of involvement in this case as it was not just a case of the teacher's presentation requiring some HR input – [LM's] conduct was described as harmful. I think you said the children are non-verbal so the observations of the staff are more crucial – and seem to be corroborated by more than one member of staff observing misconduct on several of the occasions reported"*

5.76. On 23 October 2018 the education officer emailed the MSP's office and advised that SBC was ingathering information and that they would be back in touch.

5.77. On 23 October 2018 the senior social worker in the child protection unit approached the Investigating Officer directly for any further available documentation. The Investigating Officer replied on 24 October 2018 with a copy of the report they had presented to the Commissioning Manager and HR. The Investigating Officer advised that they had been asked to make a number of changes and that the Commissioning Manager was to be in touch, but that never occurred.

5.78. On 29 October 2018 the senior social worker in the child protection unit emailed the senior social worker manager who had been investigating matters following the meeting on 1 October 2018 and identified various allegations that in their view ought to have been dealt with through child protection procedures. They highlighted allegations of grabbing, pulling, forcibly pushing, dragging, handling roughly and cupping of a child's head and chin as actions that could have harmed a child. They stated:

> *"This should have been dealt with through CP procedures, with each child being subject to IRD and parents involved in that process. So the questions asked by*

parents at their meeting on 1 October at the Tontine is a valid one – they should have been involved and procedures were not followed."

In response, the senior social work manager sought a meeting with the senior social worker.

5.79. On 31 October 2018 a parent emailed an education officer, asking for information as to progress. The parent asked if the police had become involved, what policies were being followed and for confirmation that the matter was being treated as a child protection matter. Concern was expressed over a "wall of silence".

5.80. That email was responded to on Friday 2 November with an undertaking to get back "early next week". On Monday 5 November 2018 an update was sought by the education officer from the senior social worker in the child protection unit.

5.81. On 7 November 2018 the senior social worker in the child protection unit responded and advised of a need to advise parents that procedures were not followed and that they should have been informed.

5.82. On 9 November 2018 the senior social worker in the child protection unit emailed Police Scotland with the investigation notes and other documents. That senior social worker also emailed an education officer to ask if any other complaints had been raised against LM since LM's move to LM's new place of employment.

5.83. On 12 November 2018 the senior social worker in the child protection unit emailed the senior social work manager, the Commissioning Manager and others to advise that the child protection unit were ready to undertake an investigation, but that no contact with the parents would take place until the MSP was advised, the education department had written to the parents and LM was informed that an investigation was to progress.

5.84. On 13 November 2018 a senior social work manager wrote to certain parents to advise that a Child Protection and Reviewing Officer would be in touch, further to the *CP Procedures*.

5.85. On 14 November 2018 a CPRO commenced preparatory work for an IRD.

5.86. On 19 November 2018 Police Scotland identified a need to see the statements from staff. That request was actioned the same day.

5.87. By 7 December 2018 the CPRO had met and prepared a summary of meetings that they had with families. It noted that the families had been made aware that the IRD would be concluded as there was no ongoing risk, but that the police investigation would continue.

5.88. An Inter-agency Referral Discussion was ultimately concluded on 10 December 2018.

5.89. On 7 February 2019 SBC were advised of charges that were being brought against LM.

5.90. On 2 April 2019 the senior social work officer responded to an email from the MSP, to advise that they could not meet parents in the light of the ongoing police investigation.

5.91. On 13 June 2019 Disclosure Scotland wrote to SBC further to the Protection of Vulnerable Groups (Scotland) Act 2007 as to the propriety of a referral under section 2 of that Act.

5.92. On 14 June 2019 a senior HR officer responded to Disclosure Scotland and advised that the Council had reviewed its records and considered that LM did not meet the referral criteria set out in ss 3, 4 and 5 of the Act.

5.93. As matters thereafter passed principally into the realm of criminal investigation and beyond SBC's investigation, the Inquiry concludes the timeline at this point, save to record that LM left the employment of SBC in March 2021.

6. Deficiencies and recommendations

6.1. Having established the extent to which SBC addressed concerns raised in connection with the conduct of LM, I turn to the second and third purposes of the Inquiry: the identification of any deficiencies in the handling of those concerns, or of policy or practice on the part of the Council; and recommendations as to steps that could be taken in order to minimise the risk of similar issues arising in the future. I take those two issues together.

Child protection

Welfare of children

6.2. Article 3(1) of the United Nations Convention on the Rights of the Child ("UNCRC") provides:

> *"In all actions concerning children, whether undertaken by public or private social welfare institutions, courts of law, administrative authorities or legislative bodies, the best interests of the child shall be a primary consideration."*

6.3. Although a binding obligation in international law, the spirit of that obligation is incorporated into national law. For example, when considering whether to make an order regarding parental responsibilities or parental rights Scottish courts are directed to regard the welfare of the child concerned as its "*paramount consideration"* (Children (Scotland Act 1995, section 11(7)(a)). The legislation goes on to provide that when carrying out the duty under s. 11(7)(a), the court shall have regard to:

> *"s. 11(7B) … (a) the need to protect the child from—*
>
> *(i) any abuse; or*
>
> *(ii) the risk of any abuse,*
>
> *which affects, or might affect, the child;*
>
> *(b) the effect such abuse, or the risk of such abuse, might have on the child;*
>
> *(c) the ability of a person—*
>
> *(i) who has carried out abuse which affects or might affect the child; or*
>
> *(ii) who might carry out such abuse,*

to care for, or otherwise meet the needs of, the child; and

(d) the effect any abuse, or the risk of any abuse, might have on the carrying out of responsibilities in connection with the welfare of the child by a person who has (or, by virtue of an order under subsection (1), would have) those responsibilities.

(7C) In subsection (7B) above—

"abuse" includes —

(a) violence, harassment, threatening conduct and any other conduct giving rise, or likely to give rise, to physical or mental injury, fear, alarm or distress;

(b) abuse of a person other than the child; and

(c) domestic abuse;

"conduct" includes—

(a) speech; and

(b) presence in a specified place or area.

6.4. The national policy response to the UNCRC, "Getting It Right For Every Child" (GIRFEC) is a child focused approach to putting the rights and wellbeing of children and young people at the heart of services that support them.

6.5. Further thereto, the Children and Young People (Scotland) Act 2014, in placing responsibilities on public bodies, including local authorities, to address UNCRC requirements, identifies as the rights of children the rights and obligations set out in the UNCRC (and the first and second optional protocols to the UNCRC). Article 19 of the UNCRC provides:

> *"1. States Parties shall take all appropriate legislative, administrative, social and educational measures to protect the child from all forms of physical or mental violence, injury or abuse, neglect or negligent treatment, maltreatment or exploitation, including sexual abuse, while in the care of parent(s), legal guardian(s) or any other person who has the care of the child.*
>
> *2. Such protective measures should, as appropriate, include effective procedures for the establishment of social programmes to provide necessary support for the child and for those who have the care of the child, as well as for other forms of prevention and for identification, reporting, referral, investigation, treatment and follow-up of instances of child maltreatment described heretofore, and, as appropriate, for judicial involvement.*

6.6. It is in that context that the Ministerial Foreword to the current National Guidance for Child Protection in Scotland 2021 begins with two apposite overarching principles:

> *"The safety and wellbeing of children and young people, including unborn babies, is paramount. Our children and young people have the right to be protected from all forms of harm and abuse."*

6.7. In the light of that international and national approach to the protection of children, it seems to me appropriate that I approach my consideration of the Council's actions with the same principles in mind:

- **The safety and wellbeing of children is of paramount importance.**

- **Children have the right to be protected from harm and abuse.**

6.8. It would negate the importance of those propositions to seek to define a list of actions that do or do not constitute harm to children. It is easy to identify egregious examples of physical harm: burning, poisoning, scalding or hitting a child. However, abuse can arise in many ways, physically and emotionally. It may arise as a consequence of a single act or from the accumulation of a number of actions. It may arise from conduct directed towards a child, but also from conduct observed by a child but directed to others. National guidance at the relevant time in respect of the subject matter of the Inquiry (*National Guidance for Child Protection in Scotland 2014*) and today (*National Guidance for Child Protection in Scotland 2021*), rightly in my view, does not seek to prescribe what is harmful.

6.9. It is my view that in the absence of a compelling concern as to immediate harm, actions such as the grabbing, pushing or pulling of a pupil, roughly or otherwise; shouting in the face of a school pupil; or the holding a pupil's chin and head whilst telling them to be quiet, is clearly conduct that gives rise to at least *prima facie* concern of harm to the child and potentially to other children around the child ("conduct of concern"). It seems to me that such conduct in an education setting is anathema to a supportive learning environment. I find reassurance in that view in noting that when the child protection unit was finally appraised of the allegations made against LM, it took the view that such conduct crossed the threshold of concern to justify investigation.

Protection of children

6.10. The Council had in place, and continues to have in place, policies intended to ensure that conduct of concern in relation to children is considered and acted upon where necessary by appropriate agencies. The *CP Procedures* to which the Council adhered, and continues to adhere, provided for a child protection unit, with multi-agency representation, to determine whether a child protection investigation should take place and if so whether a child protection plan should be implemented. With representatives including from social work, health and the police engaging in a collaborative assessment of concerns when intimated to the unit, relevant expertise could, and can, be brought expediently to hand to determine the appropriate response. Where potential criminal conduct and a need for a criminal investigation is apparent, the interaction of such an investigation with other welfare and disciplinary investigations can be considered and the response tailored accordingly. Further, if no child protection plan is identified as necessary going forward (for example, in the absence of any identified future risk to any particular child), the need for accountability for past actions could still be addressed by the agencies involved, including Police Scotland. Past accountability might also inform the issue of future risk to other children and steps that may need to be taken to manage or exclude that risk.

6.11. In my view, standing its terms, **the *CP Procedures* provided an institutional infrastructure that, had it been properly acted upon, was likely to have brought concerns to the attention of the child protection unit at the time the concerns (or as they might also be described once communicated to others, the allegations) were presented to service management.**

Core policy principles

6.12. For the *CP Procedures* to be effective, the child protection unit needs to be advised of concerns. Not every concern intimated to the child protection unit will result in a child protection plan. Some concerns intimated to the unit may not even be deemed appropriate for investigation. But they can be recorded; and in the event of similar concerns being reported, decisions can be re-visited.

6.13. The importance of the provision of information to the child protection unit is reflected in the terms of the CP Procedures in two core principles; that:

- "*child protection is everyone's responsibility*";

  and the general provision that

- *"[where] there are concerns about harm, abuse or neglect, these **must** be shared with the relevant agencies [which included the child protection unit] so that they can decide together whether the harm is, or is likely to be, significant."*

Conduct of concern and core policy principles

6.14. **I am firmly of opinion that conduct of the nature alleged against LM in October 2017 raised concerns as to harm or abuse as to justify consideration under the *CP Procedures*. In my view, taken together, they clearly crossed the threshold of concern of harm and ought to have been reported to the child protection unit at that time. That did not occur.**

6.15. I am not to aim to address matters of individual staff conduct, and do not do so. But that direction in the Terms of Reference is, in many ways, nothing to the point. **Where failures in prompt intimation to the child protection unit have occurred because of judgments made by staff, so far as the children affected, their parents and the wider public are concerned, those failures are failures of the Council and should be addressed as such.**

6.16. Therefore my view is that **the concerns regarding LM's conduct clearly ought to have been reported by the Council to the child protection unit when reported to service managers in October 2017.** (I will discuss below earlier apprehensions.) It may have been the case that immediate risk to children in LM's class had been dealt with by the commencement of the school mid-term break and, over the break, the decision to relocate LM. However, as noted, child protection is not merely about immediate risk, but also long term welfare of children and past accountability.

Failure in intimation to the child protection unit

6.17. Whilst concerns as to LM's conduct towards children came to a head before a school manager on or about 5 October 2017 **it was not until October 2018 that details of the concerns were intimated to the child protection unit**. When they were intimated to the child protection unit, the concerns were, in my view, promptly and sympathetically acted upon. However, **one year (if not longer) was a reprehensible period of time for intimation to the child protection unit to take place.**

Prior to 5 October 2017

6.18. Whilst I have addressed the Council's handling of the allegations brought to a head on 5 October 2017, it is right to acknowledge that the alleged conduct of concern was said to have occurred prior to then. During the disciplinary investigation it was said that concerns existed during the preceding school year.

6.19. With the passage of time it is not possible to identify precisely the dates of all of the alleged incidents, and therefore it is not possible to comprehensively set out the sequential timing of them. However, my view is that any single alleged incident of conduct such as that described in para. 6.9 above ought to have been recognised as crossing the threshold of concern and ought to have been intimated to the child protection unit at the time the alleged conduct was said to have been observed.

6.20. However, it is prudent at this point to observe that the consistent evidence before the Inquiry was that the **advice and training given to school staff members was that child protection concerns were to be directed to a designated child protection co-ordinator within institutions (*c.f.* the child protection unit)** That advice and training sat with the *CP Procedures* that contained specific provisions in respect of allegations being made against members of staff. That specific advice made reference to line managers requiring to make initial enquiries to clarify the nature of the allegation. Therefore, to the extent that initial concerns were ultimately raised by school staff members with a service manager but no further, in the light of the absence of any push back on the appropriateness of reporting from the service manager, the limited reporting was, in my view, understandable.

6.21. Further, advice and training provided by the Council to employees further to the *CP Procedures* was seen by the Inquiry to refer to "significant harm" as a threshold to child protection action. Whilst such a threshold is relevant in the context of determining whether to take action upon child protection concerns that have been raised, it may have imparted a threshold for concern as to justify reporting that contributed to hesitancy in reporting, especially of isolated incidents by front line staff.

6.22. I am conscious that one of the consequences of this report may be that consideration will be given to instituting disciplinary investigations and proceedings against SBC employees. I can only hope that if that does occur, the observations I make here may inform the Council's approach.

6.23. However, standing the nature of the conduct ultimately alleged on and after 5 October 2017 it seems to me that in the light of the *CP Procedures* **the alleged concerns in respect of LM's conduct that were raised on 5 October 2017 ought to have been brought to the attention of the child protection unit by the Council at the time they were said to have been witnessed.**

6.24. I return to consider my conclusion that the concerns regarding LM's conduct clearly ought to have been reported by the Council to the child protection unit when reported to service managers in October 2017, which I consider to be a more significant failing on the part of the Council. **That deficiency remained ongoing until the allegations were finally intimated to the child protection unit in October 2018.**

6.25. However it would be remiss to simply conclude that there was a deficiency in approach on the part of the Council simply in the failure to identify a need to refer to the child protection unit when the allegations were first communicated to the service manager. **On and after 5 October 2017 there were various points in time when in my opinion the Council compounded its failure to report promptly.**

6.26. It is relevant to note these missed opportunities as it gives insight into a potential reason for the prolonged failure to report.

6.27. **In my view those points of time were:**

- **when the allegations were advised by Service Manager 1 to Service Manager 2 on 5 October 2017.** Service Manager 2 was advised of the concerns/allegations yet did not report matters to the child protection unit. It may be that they considered that raising their concerns with their line manager was sufficient, but they did not follow through on whether notice had been given by their superior to the child protection unit. The same might be said of the Service Manager 1.

- **when the allegations were advised to the senior education officer on or about 5 October 2017**. The senior education officer and a senior HR officer were copied into the service manager's record of the allegations raised by school staff, yet neither reported to the child protection unit. The senior education officer took administrative responsibility for managing the concerns/allegations and eventually became the Commissioning Manager under the Council's *Disciplinary Procedures*, but did not report. They may have taken advice from the senior HR officer, but it seems to me they ought to have been aware of the core principles of the *CP Procedures* and complied with them. It also seems to me that the officers in the HR department ought to have appreciated that in addition to the Council's *Disciplinary Procedures* the *CP Procedures* were also engaged. If nothing else, they ought to have been aware of the direction in the *CP Procedures* that they were to take precedence over any disciplinary or internal procedures. Yet, apparently no referral to the child protection unit was identified as necessary in the advice tendered.

- **when initial investigations resulted in a decision to institute disciplinary procedures on or about 16 October 2017.** Having identified an immediate need for fact finding in order to determine how to proceed, by Monday 16 October 2017 and the resumption of the school year, further reports had been obtained from school staff members and a decision fell to be made as to how to proceed. The decision taken by the senior education officer with advice from the senior HR officer was to proceed with a disciplinary investigation. It seems to me that in the light of the, by then, well documented allegations and need for a determination as to how to proceed, the opportunity arose to refresh consideration of the need for a child protection unit intimation. It is again concerning that despite taking advice from a member of the HR

department, the senior education officer was not reminded that a referral to the child protection unit was necessary.

- **when an Investigating Officer was appointed on or about 16 October 2017.** A senior social work manager was tasked with the identification of an appropriate officer. A social worker was considered appropriate in the light of the nature of the concerns (a teacher's conduct towards at least one child) and the fact that a close family member of LM was a member of the SBC education HQ team. It seems to me that it might reasonably have been expected of a senior social work manager appraised of a concern in relation to a teacher's conduct towards a child and mindful of the core principle of personal responsibility to have been put on inquiry as to whether a child protection concern lay at the heart of the reason for the disciplinary investigation.

- **whilst the Investigating Officer went about the investigation.** The Investigating Officer ingathered evidence from school staff and a service manager. They were appraised of the initial report of the service manager and the school staff. As a social worker and mindful of the core principle of personal responsibility, it seems to me reasonable to have expected the Investigating Officer to have been alert to the question of whether the concerns had been reported to the child protection unit and if necessary to have acted upon that personal responsibility .

- **when the disciplinary investigation was reported on or about 9 November 2017.** In like manner as at 16 October 2017, consideration of the terms of the Investigation Report provided a further opportunity for the senior education officer/Commissioning Manager with support from the senior HR officer to refresh consideration of the need for intimation to the child protection unit.

- **when a senior education manager met with a parent on 20 December 2017.** By 20 December 2017 a senior education manager was aware that a parent had raised concern as to the "*inappropriate man handling of a child*" with a school manager and a SBC Councillor. Although in evidence to the Inquiry the senior education manager's position was that there was no discussion of harm at the meeting, a concern of harm to the child had been raised in the correspondence that resulted in the meeting. The concern of harm was

serious and a matter that was of concern to an elected Member. Recollections of what was discussed at the meeting varied, but in my view that is nothing to the point. What is significant is that the Council had information of *prima facie* harm to children in LM's class. Matters having focused to a meeting with a parent in respect of a serious concern, for the parent, the elected Member and the Council, it seems to me to be reasonable to have expected Council officials attending the meeting to have been fully appraised of the evidence that was available in order to properly inform the parent. Whether by failure to provide information or a failure to enquire (on which I express no view), the parent was misinformed. For want of proper preparation for that meeting, the opportunity was missed to identify conduct of concern that ought to have been reported. In reaching that view I recognise that as a line manager a senior education manager may have to keep a distance from the fact-finding investigation that was carried out under the disciplinary procedures, but the welfare of children is paramount and I do not consider that such concerns would justify the retention of information from, or a reluctance to enquire on the part of, a senior education manager in the light of concern of harm that had been raised.

- **when the disciplinary procedures were concluded, resulting in the meeting with LM on 20 December 2017.** In like manner as at 16 October 2017 and on or about 9 November 2017, determination of how to proceed with disciplinary procedures provided a further opportunity to refresh consideration of the need for intimation to the child protection unit.

- **when press enquiries of a "cover up" were advised to the Council in March 2018.** Disregarding the emotive terms used in the press enquiry, standing the essence of the enquiry, which was of an allegation of assault and verbal abuse of children, and the importance that ought to be afforded to the welfare of children, it seems to me that not just an opportunity, but also the need, for the Council to re-examine its decision-making arose. The matter raised was serious. It raised potential criminality. It raised an issue as to probity in the management of the welfare of children. It went to the probity of the information provided to a parent in good faith by officials and an elected Member.

- **when initial concerns were raised by an MSP in or about June 2018.** Although initial concerns were raised by the MSP with the Council in or about June 2018, intimation of the allegations to the child protection unit did not occur until October 2018 following a meeting with the Parliamentarian and parents. In like manner as the press enquiry, and in the light of the accumulation of interest, it seems to me that the Council ought to have reappraised its decision making on receipt to the MSP's concerns.

6.28. Further, after the meeting with the MSP and parents on 1 October 2018 it was not until 12 October 2018 that the Council, through a senior social work manager, determined to refer matters to the child protection unit. It was not until 12 November 2018 that the child protection unit was satisfied that it had received proper information from the Council to determine to proceed with an investigation. Bearing in mind (i) that on 1 October 2018 the Council had not only the initial reports from the school staff members and Service Manager 1, but also the report of the Investigating Officer and their records of interview, and (ii) the concerns had been raised by parents as to the Council's expedition and candour, I am of opinion that **the period of time taken by the Council after 1 October 2018 to put the child protection unit into a position whereby it could commence its investigation was excessive.**

Why was there a delay in reporting?

6.29. No interviewee suggested to the Inquiry that they had consulted the *CP Procedures* and had as a consequence concluded that as a result of any particular provision that a reference to the child protection unit was not appropriate. It therefore seems reasonable to conclude that the terms of the *CP Procedures* did not directly contribute to the delay in reporting, although that is not to say that had they been consulted a different result would have occurred. I comment on that below.

6.30. Where explanations were provided by interviewees for their reasons for not referring they were diverse. They included:

- viewing the conduct as "maybe just a bad day", or "over very quickly"
- perceiving isolated conduct as not sufficiently serious to justify immediate action,
- taking the view that no one had been harmed because no one had been hurt,

- responsibility for action was seen to be deferred to advice or action from above, or
- responsibility for action was seen to be a matter believed to have been dealt with or as ought to have been dealt with by those below.

It also seems to me that the mid-term break may well have had an influence. With teaching at an end, immediate future risk of harm was not an issue. Some interviewees could offer no explanation as to why the matter had not been referred to the child protection unit.

6.31. It is in my view possible to distil three common threads that weave through the preponderance of the Council's actions when looked at in the round.

6.32. **Firstly, there was widespread, though neither universal nor consistent, failure to recognise the significance of the conduct being alleged.** For example, single events were seen as concerning, but not so concerning as to justify reporting. To the credit of some, when multiple concerns were apparent, action was taken, but then others also failed to appreciate the significance of what was being alleged, notwithstanding the accumulation of concerns. References to harm as entailing only physical harm and momentary conduct as insignificant were alarming. It seems to me that whatever training had been provided to staff, it had failed to embed an understanding of the rights of children not to be subjected to conduct such as was alleged. It had also failed to embed an understanding that such conduct, at the very least, is conduct that is of concern requiring appropriate consideration.

6.33. One interviewee commented that the disciplinary investigation failed to recognise the complex needs of the children and that may have contributed to a failure to comprehend the gravity of the conduct. For my part, I am at a loss to understand when grabbing, etc. a child other than to protect against immediate harm would ever be acceptable. It seems to me that in seeking to coerce behaviour in children with communication and other sensory challenges in such a manner, the unacceptable nature of the conduct is all the more egregious.

6.34. It was conspicuous that more than one interviewee commented that training concentrated on looking for child protection concerns arising from outside an education setting, such as at home. No one recalled training specific to child protection issues arising in an education setting.

6.35. **Secondly, there was widespread, though neither universal nor consistent, failure to appreciate that the welfare of the children was a paramount consideration.** There was a widespread, though not universal, failure to look beyond the staffing horizon. Rather than assess the concerns in terms of what was required for child safety in the round, the concerns were seen as a staff conduct matter, to be addressed as such. As a consequence, issues of past accountability and the risk to children other than those in respect of whom particular concerns had been identified, including the need to be alert to those matters and to act, was missed. References to the best interests of children and that children's interests were a paramount consideration in how staff approached their responsibilities was conspicuously absent in discussions with almost all staff interviewees.

6.36. **Thirdly there was widespread failure to appreciate the importance of individual responsibility in relation to child welfare concerns.** It is conspicuous that despite a significant number of people being aware of one or more allegations, or being in a position to ask whether there were child protection concerns, no one chose to invite the child protection unit to investigate until October 2018. Assumptions appear to have been made that others had acted on the concerns and had raised child protection concerns, with the result that no one did so for over a year.

6.37 Why was this so? The interviewees spoke to child protection training within the Council. The absence of specific training on child protection concerns arising in the workplace was commented upon. It seems to me however, that cannot be a complete answer to the question. The training ought to have instilled the core concepts of the *CP Procedures* highlighted earlier. In the light of the widespread failures identified above, whatever the content of the training provided, the **training clearly had not effectively conveyed the core principles of personal responsibility and the reporting of concerns of harm to the child protection unit.**

6.38. **Nor in my view had training sufficiently imparted a proper understanding of what may constitute harm, or an understanding that child protection is not simply about managing immediate risk for identified children, but also about recognising broader risks going forward and the possibility of criminal responsibility**.

Effect of delay in reporting to the child protection unit

6.39. I am satisfied, in the light of the approach of the child protection unit to the allegations when they were finally referred to it, that had those allegations been reported earlier an earlier investigation would have been instigated. Furthermore, it is likely, standing the nature of the allegations, that action would have been taken to cease LM's pupil contact. When that would have occurred, in the light of the variables, is speculation. However, the prospect of an earlier removal from a pupil facing role gives rise to the possibility that the alleged conduct of concern might have been impossible due to removal. Therefore I cannot exclude the possibility that **the delay in reporting may have caused unnecessary harm to children**.

6.40. What is clear is **that the delay in reporting undoubtedly caused unnecessary distress for parents**. I find it unlikely that had the child protection unit been informed of the concerns that it was informed of in October 2018 in November 2017 at the conclusion of the disciplinary investigation, if not before, the processes that commenced after notice was given would have commenced earlier. The parents' uncertainty during the substantial part of 2018, if not the whole of that year, could have been avoided

6.41. Against that background, it seems to me that **there were significant failings in child protection training within the Council in 2016 and 2017**. Work needs to be done to better embed with staff a proper understanding of the rights of children, especially in the education environment; and also of the core principles of child protection. I therefore make the following recommendation:

6.42. **Recommendation 1 - The Council reviews and improves its child protection training for staff.**

In particular, emphasis should given to:

(i) understanding the rights of children to be protected from harm,

(ii) the personal obligation of staff to report concerns of harm and not to assume or trust that others have done, or will do, so,

(iii) the importance of acting upon single incidents of concern, and

(iv) the relevance of child protection procedures beyond the assessment of risk and protection against harm to identified children.

Further, training should be given specific to the identification of, and necessary action upon, concerns arising in the workplace.

Is the current iteration of the CP Procedures sufficiently clear?

6.43. I am not satisfied that it can confidently be concluded that the current iteration of the *CP Procedures* are sufficiently clear. I reach that conclusion as the *CP Procedures* do, on occasion either narrow the appreciation of risk too narrowly, or dilute the core principles of individual responsibility and the need for reporting.

6.44. An example of the former can be found where the *CP Procedures* currently poses the question: "[what] to do if you have concerns about a child" and advises that if concerned about "a child's safety" an employee must make an immediate referral. Such a reference may tend to suggest to a reader that the concerns to be alert for relate to individual children going forward, rather than a broader appreciation of risk to others informed by actions that have already occurred. Where immediate risk for a child is removed, the driver for reporting may be thought to have waned.

6.45. An example of the latter can be found in the context of the specific guidance in respect of allegations against staff. The current *CP Procedures* narrate that a line manager will require to make initial enquiries to clarify the nature of the allegation and *if there is any doubt*, this is be discussed with the duty CPRO. No express requirement is placed on the line manager to refer concerns to the child protection unit and the reporting to a line manager might be perceived as adequate if the line manager considered that there is nothing to report. Furthermore, the apparent requirement simply to raise concerns with a line manager dilutes the message of personal responsibility on the part of the employee reporting.

6.46. Whilst on one view these are matters of detail (and for that reason I do not attempt to set out an exhaustive list of what could be re-drawn), it is appropriate that I make a further recommendation as regard the *CP Procedures* to minimise the risk of lack of understanding and comprehension.

6.47. **Recommendation 2 - The Council reviews and seeks to improve the *Scottish Borders Child Protection Procedures*.**

In particular, consideration should be given to better emphasis being given to:

(i) clarifying the broader relevance of child protection measures beyond the identification and management of future risk for identified children, and

(ii) reinforcement of the core principles of individual responsibility and need to report in all situations, including where concerns of harm arise in respect of Council staff or in a workplace setting.

Disciplinary proceedings

6.48. I now turn to the specific matter of the disciplinary proceedings that were undertaken. I will consider the process and then the decision.

Process

6.49. The disciplinary investigation was entrusted to a member of SBC's social work staff with no connection to LM. The Investigating Officer's position to the Inquiry that they were not an investigating officer under the *Disciplinary Procedures* sat dissonantly with the reality of the documentation that they produced during their investigation, which bore the format and approach required by the *Guidelines*. In the event, the investigation appeared to proceed as anticipated under the *Guidelines*. The *Disciplinary Procedures* recommended "normally two" investigating officers, to allow for note taking and to protect against misunderstanding. The Investigating Officer was assisted by a note taker and so I find no shortcoming in the appointment of a single Investigating Officer. Inquiry interviewees who had been spoken to during the disciplinary investigation commented upon how they were invited to review the records of their own interviews with the Investigating Officer. That was appropriate and fair. The disciplinary investigation came to a conclusion with a report to the Commissioning Manager within four weeks. Bearing in mind that the *Disciplinary Procedures* recommended a one to six week period for investigation, I find the time taken to have been a reasonable time in the light of the nature of the enquiries that had to be made in respect of multiple allegations. There was evidence that the report of the Investigating Officer was viewed by the senior HR officer assisting the Commissioning Manager as sub-standard and the Inquiry had sight of changes to the report that were proposed, but were apparently not

made. However, it was not proposed that the substance of the report, set out above, be materially diluted on the key information set out above.

6.50. As noted at § 4.19, the *Guidelines* at the time required HR and /or Legal Services advice to be sought in cases involving child protection and vulnerable adult's issues (the current iteration of the *Guidelines* mandates advice be sought from the HR Case Management Team.) That advice appears in connection with the guidance on identifying who should investigate, rather than the process of investigation. By the time of the Investigating Officer's appointment there was HR involvement and so I find no failure to comply with the policy that was in place in that regard.

6.51. However, **the absence of any express and clear requirement in the *Disciplinary Procedures* or the *Guidelines* to refer concerns as to staff conduct that includes conduct towards children to the child protection unit is a significant omission.** I was advised by one interviewee that HR procedures now include a check whether concerns have been raised with child protection. That is a welcome development and should be formalised. A requirement within the *Disciplinary Procedures* and the *Guidelines* to refer disciplinary conduct that relates to conduct involving children to the child protection unit would provide a protection against omission by oversight. It would seem prudent to ensure such a requirement at the stage of embarking upon disciplinary action where the involvement of children is known. Further it would be prudent in the light of evidence that has been adduced to include a requirement during and upon the conclusion of any investigation, for an assessment to be made of whether any action was directed towards children; and, if so, to require referral.

6.52. **Recommendation 3 - The Council reviews and improves its *Disciplinary Procedures* and *Guidelines on Conducting Investigations*.**

In particular, there should be a clear requirement:

(i) to refer conduct under consideration for disciplinary action (whether minor or otherwise) that relates to conduct involving children to the child protection unit by an identified officer, and

(ii) to require formal consideration (a) in the course of and (b) at the end of any investigation of whether the subject of the disciplinary investigation has

related to conduct involving children; and if so to require referral to the child protection unit by an identified officer.

6.53. Further, whilst any confusion on the part of the Investigating Officer as to their role appears not to have made a material difference to what was expected of an investigator under the *Disciplinary Procedures*, it does raise the risk that future investigating officers might not appreciate the specific role that they are being asked to perform, or the performance standards to be expected of them. It would be prudent to formalise such appointments and to consider whether any such appointments should only be made in respect of individuals with training as to the requirements of the role.

6.54. **Recommendation 4 – The Council reviews its *Disciplinary Procedures* and *Guidelines on Conducting Investigations* to provide for the appointment of investigating officers to be made in writing to the officer, with clear directions as to the allegation to be investigated and with express reference to the *Disciplinary Procedures* and the *Guidelines*.**

6.55. **Recommendation 5 – The Council reviews its *Disciplinary Procedures* and *Guidelines on Conducting Investigations* to consider whether only suitably trained officers may be appointed as investigating officers.**

Substantive decision

6.56. The Investigation Report highlighted that there was corroborative evidence for three of the allegations that had been made against LM. Further, it noted that there was evidence of other allegations that were of a similar nature to those three. The Investigation Report reached no conclusion of fact, but in terms of the *Disciplinary Procedures* that was appropriate: the investigation was to inform the Commissioning Manager what disciplinary route to take.

6.57. The decision of the Commissioning Manager was to resolve the disciplinary action with a management counselling meeting. Whilst the letter sent to LM records aspects of the management counselling discussion that took place it does not record the reasons why that course of action was considered appropriate. There is no explanation of how relevant considerations were weighed in the reaching the decision to proceed in that way.

6.58. To the Inquiry, the Commissioning Manager stated that they had particular regard to the absence of any prior concerns as to LM's conduct and acted upon the "*heavy steer*" of the HR department to resolve matters as they did. A senior HR manager recalled that the HR discussion was focused "*through the lens of poor practice*", noting out of character behaviour on the part of LM. The HR view was that the issues raised were about practice within the classroom and that they could be managed going forward.

6.59. Without a record of what was weighed in the balance when considering how to proceed, it is not possible to express a concluded view of the reasonableness of the decision reached. Furthermore, to conclude that the decision was unreasonable would be to potentially prejudge a review of judgment that may have to take place elsewhere. This Inquiry is not to address individual staff conduct.

6.60. However, it is right to note that these were serious multiple allegations, potentially demonstrating a course of conduct towards children, for which, if proved, the prospect of dismissal was a real possibility. The evidence was disputed, but there was a mechanism to resolve that dispute and to impose significant sanction: a formal disciplinary hearing. Why then was this not considered appropriate?

6.61. The *Disciplinary Procedures* then (and now) offer some guidance on what amounts to "misconduct" and what amounts to "gross misconduct" that might have assisted the Commissioning Manager and informed the HR advice that was given. **However, that the *Disciplinary Procedures* neither then, nor now, expressly assist with an understanding of whether conduct involving children might amount to misconduct or gross misconduct was, and is, a significant omission.** Had reference been made, a different disciplinary decision might have reached. That should be remedied.

6.62. **Recommendation 6 - The Council reviews and improves its *Disciplinary Procedures* to provide guidance as to the seriousness of inappropriate conduct involving children when considering of what amounts to misconduct and gross misconduct.**

Communication with parents

6.63. I turn now to consider the Council's interactions with parents in the light of the concerns raised. The communication challenges of the children in LM's class raised particular issues. Parents that the Inquiry spoke to were eloquent in describing the challenges they faced in identifying causes of distress in their children, with a view to addressing the same to ensure their children were happy and well cared for. The school communicated with parents by means of individual notebooks for each child that would travel between school and home to record issues of relevance or potential relevance. For these parents, proper and full communication from the Council was of the utmost importance.

6.64. The Council's approach, spoken to and seen in correspondence, was that it was not appropriate to disclose the disciplinary investigation or the result of the disciplinary proceedings, because they related to staff disciplinary matters. That approach seems to have weighed heavily the potential adverse consequences to staff members if allegations proved to be unfounded.

6.65. However, (1) recalling that the welfare of children is a paramount consideration, (2) that the allegations that were made in October 2017 were serious, and (3) parents were reliant on information from the Council as to welfare issues concerning their children, **I am firmly of opinion that not advising parents of the allegations against LM when they were made in October 2017 was an erroneous balancing of interests that persisted until matters were acted upon by the child protection unit.** In that regard too, sight should not be lost of my conclusion as to when the child protection unit ought to have been advised. It is likely that had that intimation occurred in October 2017 the parents would have been advised during the course of the child protection unit's investigation.

6.66. **Recommendation 7 – The Council should review and improve the processes for communication with parents of children with communication challenges.**

In particular, it should:

(i) do so in the light of the principle that the welfare of children is a paramount consideration, and

(ii) consider establishing thresholds and protocols for communication where allegations of conduct of concern involving children have been made.

Specific communication in response to concern raised by a parent

6.67. It is also appropriate that I consider the communications sent by a SBC Councillor to a parent in December 2017 in the form of a text message assuring that rumours as to manhandling on the part of LM were not true, followed by a further text message containing the Council's formal response, prepared by the HR department, that the matter had been fully considered and that the parent's child's safety was assured.

6.68. In evidence to the Inquiry a senior education manager denied that they had advised the SBC Councillor that the allegations were untrue, observing that they were unaware of the detail of the allegations. Their evidence was that they merely advised the SBC Councillor that an investigation was ongoing and they drew the Inquiry's attention to the content of an email they sent to the SBC Councillor on the evening of 11 December 2017 that did indeed narrate that an investigation was ongoing and that if any allegations are made then they had to be investigated to see if they were true or not.

6.69. I note that the text message from the SBC Councillor to the parent refers not to an email, but to being "just off the phone" with the senior education manager and so there is evidence of communication beyond the email. I am unable to draw any conclusion as more likely than any other as to what was truly communicated between the senior education manager and the SBC Councillor that evening. What is clear is that **the information communicated to the parent in the first text message was not correct as the Council had significant evidence, albeit not in the knowledge of the SBC Councillor, of conduct that could easily be encompassed in the description "manhandling".**

6.70. The second text sent by the SBC Councillor contained the response formulated in draft by a senior HR officer. It was a carefully worded draft response in that it referred to the child's safety within the school as being assured. That could be construed as referring to ongoing safety, and as LM had been removed from the classroom. it had a basis in fact. However, in the context of the concern that had been raised as regards *past* conduct **it lacked the candour that the best interests of the child demanded.**

6.71. Shortly after the text messages the parent met with a senior education manager and an education officer. Again, recollections of what was discussed at that meeting differed. However, it is clear that at that time the Council had the evidence ingathered during the disciplinary investigation and that initially provided by the school staff members and the service manager, which included evidence of conduct involving the parent's child. The senior education manager's evidence to the Inquiry was that they remained unaware of the details of the investigation and that it would have been inappropriate for them to have become aware of the content of the investigation lest they were obliged in the future to review the disciplinary decision that was taken following the investigation. However, as the meeting had been convened to discuss the parent's concern that there had been inappropriate conduct on the part of LM, I find it remarkable, to say the least, that the senior education manager was not provided with or went on enquiry as to what the available evidence was. Whatever the reason (on which I express no view), having regard to the welfare of the child being a paramount consideration, in my view **the Council failed to advise the parent at that meeting of the evidence that had been ingathered in respect of their child**.

6.72. Finally on the matter of communication, it is a matter of concern that after the meeting held on 1 October 2018, it was not until 13 November 2018 that the Council advised parents that a child protection investigation would take place, by advising that a CPRO would be in touch.

6.73. It appears that little was done in the first two weeks after the meeting on 1 October 2018, and that matters were only progressed when correspondence was received from parents asking about progress. Whilst matters were moved forward after the parental enquiry, it appears that no communication was made to the parents until 2 November 2018, and then only after a further enquiry as to progress had been received. That second enquiry referred to a "wall of silence" on the part of the Council. I consider that in the circumstances that was a reasonable criticism to have made, especially in the light of the parent's heightened apprehensions as to their children's well-being by the communication challenges that their children faced. **Having undertaken to keep parents advised, the time periods before further communications followed were unacceptable.**

6.74. Taking these matters together, with a view to avoiding similar circumstances I have the following recommendation.

6.75. **Recommendation 8 – The Council reviews its corporate position on the disclosure of information raised in disciplinary proceedings that relates to inappropriate conduct involving children in the light of the principle that the welfare of children is a paramount consideration; and provides appropriate guidance to staff in the light of that review.**

Record keeping

6.76. It became apparent during interviews with SBC staff that some advice that was tendered and some actions that were determined, although ultimately presented by or taken by individuals, followed broader departmental discussions. Those discussions related to either how best to proceed or to inform. Conspicuously absent from the documentation retained by the Council, at least as provided to me, were notes or records of these discussions. Further, where key decisions were taken there was no note or record of the considerations that played in their determination. For example, whilst there is a record of the outcome of the management counselling meeting with LM, there is no record of how or why the decision was reached to proceed in that manner. And as noted already, interviewees differed in their recollection of discussions that took place. Without a record of discussions relevant to decision making, **the impression that is left is of a somewhat fluid and informal approach to management.**

6.77. Good record keeping not only provides a means to assess past actions with a view to improving future performance, it can be an aid in itself to good decision making. The act of recording the reasons for a decision can be an effective means of ensuring that all material and relevant considerations are brought to bear. Further, it can be an effective means of ensuring that competing considerations are weighed and balanced and that the reason why a particular result is reached is transparent. It is also an essential prerequisite to good governance, to safeguard the possibility that if errors are made, the reasons for and any responsibility to be attached to those errors can be identified. **Record keeping in this matter was poor. Whether the absences of such record keeping contributed to the delay in reporting matters to the child protection unit may be a matter of speculation, but it made the process of understanding why decisions were taken more difficult to elucidate.** It should be improved.

6.78. **Recommendation 9 – That the Council reviews and improves the process of management decision making.**

In particular, it should:

(i) review or establish protocols as regards the recording of internal meetings, and

(ii) review or establish protocols as regard the recording of reasons for advice tendered, or decisions taken.

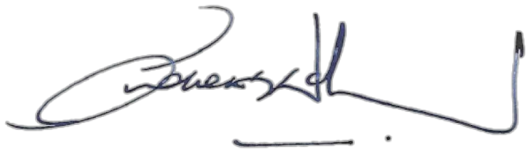
Protection of Vulnerable Groups (Scotland) Act 2007

6.79. Finally, it is not clear to me the basis upon which the Council advised that LM did not meet the criteria for referral under the 2007 Act. Without expressing a view on the need to do otherwise than it has done, I recommend that in the light of the view I take as to the nature of the allegations made against LM, particularly the capacity for them to be characterised as allegations of harm towards children, that the Council revisits its consideration of the need to refer.

6.80. **Recommendation 10 – The Council revisits its consideration of the need to refer LM in terms of the Protection of Vulnerable Groups (Scotland) Act 2007.**

End of Inquiry

6.81. I commend this Report to the Council.



ANDREW G WEBSTER, QC

12 February 2022.

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