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Developing and implementing a low-level concerns policy: A guide for organisations which work with children

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July 2021 – PLEASE NOTE: in light of changes made to the DfE's revised KCSIE for September 2021, we are currently making changes to our Low-Level Concerns Guidance. Please continue to monitor this link closely - the revised Guidance will be published as soon as possible and in advance of the revised version of KCSIE going live in September 2021. In the meantime, we would encourage you to read through the current version of our Guidance if you have not already done so, as many of the principles will remain the same.

1. Introduction

1.1 Organisational culture is a 'slippery' concept – often referred to but rarely defined. It is culture, however, that sets the context and expectations of all behaviour in an organisation, and a positive culture where concerns can be identified and spoken about openly is a key element of a strong safeguarding system.

1.2 What that means in practice is that ensuring that all those who work with children behave appropriately, and the early identification and prompt and appropriate management of concerns about adults, is critical to effective safeguarding.

1.3 Creating a culture in which *all* concerns about adults (including where the threshold for an allegation is not met) are shared responsibly and with the right person, and recorded and dealt with appropriately, is crucial. If implemented well this should encourage an open and transparent culture; enable organisations to identify concerning, problematic or inappropriate behaviour early; minimise the risk of abuse; and ensure that adults working for or with the organisation are clear about professional boundaries and act within them, in accordance with the ethos and values of the organisation.

1.4 Behaviour which is not consistent with the standards and values of an organisation, and which does not meet the organisational expectations encapsulated in their Code of Conduct, needs to be addressed.[1] Such behaviour can exist on a wide spectrum – from the inadvertent or thoughtless, through to that which is ultimately intended to enable abuse. Where a concern about an individual's behaviour reaches the threshold of an allegation, clear guidance exists (as referred to below) on how organisations should report, record and manage it.[2] Where a concern falls below that threshold the position is much less clear.

1.5 Following Farrer & Co's role as Secretariat to Hugh Davies QC on his independent review in 2014 arising from the criminal conduct of William Vahey at an international school (the Davies Review),[3] and one of his principal recommendations regarding 'neutral notifications,' Farrer & Co has assisted a number of schools with introducing a formal written policy on sharing low-level concerns (as we now call them), or neutral notifications (as some others refer to them), regarding an adult's behaviour towards children. We have also been aware that whilst some schools (and other organisations) may not have introduced a formal policy, they may nonetheless encourage an approach to sharing low-level concerns/neutral notifications.

1.6 We, together with Hugh Davies QC, Marcus Erooga and Katherine Fudakowski, believe – based on empirical evidence and our respective experience – that there is considerable potential in this context to create a safer environment for children, and that there is a need for a revised national approach – in organisations which work with children across **all** sectors – including, for example, schools, charities, and sports organisations. If this is not adopted, such organisations risk enabling the creation of further victims through missed opportunities to identify and effectively intervene in concerning, problematic or inappropriate behaviour.

1.7 This guidance draws on the following to explain how organisations which work with children can develop and implement a written low-level concerns policy, as part of a culture that enables staff to share **any** concerns – no matter how small, and how these organisations should respond to them:

- our experience, inquiries, serious case reviews, and published research – including, for example, that of Marcus Erooga, who considered common factors in organisational child sexual abuse in a review of 20 serious case reviews relating to such abuse in the UK from 2010-2016 (as referred to in more detail on page 4); and
- recent research undertaken by the Safeguarding Unit at Farrer & Co, in conjunction with Marcus Erooga, which involved us designing two versions of a questionnaire – one for schools at which an *approach* is being taken to sharing low-level concerns/neutral notifications **(approach)**, and another for schools at which a *formal policy* exists on sharing low-level concerns/neutral notifications (**policy**). A total of 18 schools responded – 13 of which completed the approach questionnaire, and 5 completed the policy questionnaire (**our research**). Whilst we consider the data obtained to be valuable, we are mindful that there are limitations in terms of the methodology used – including the fact that it is a small sample, and that there are a number of potential 'biases.' Further information on the research and data collated can be found in **Appendix G**.

1.8 We recognise that there is some resistance within the safeguarding field to the concept of anything being a 'low-level' concern; however, we use it

1 As referred to later in this guidance, the Code of Conduct will ideally be informed by the following: Safer Recruitment Consortium (2019) *Guidance for safer working practice for those working with children and young people in education settings* (GSWP), accessed on 8 October, 2019 at https://www.saferrecruitmentconsortium.org/GSWP%20Sept%202019.pdf

2 HM Government (2018) *Working Together to Safeguard Children: A guide to inter-agency working to safeguard and promote the welfare of children* (WTSC), accessed on 8 October, 2019 at https://www.gov.uk/government/publications/working-together-to-safeguard-children--2; Department for Education (2019) *Keeping Children Safe in Education: Statutory guidance for schools and colleges* (KCSIE), accessed on 8 October, 2019 at https://www.gov.uk/government/publications/keeping-children-safe-in-education--2; and, for example, London Child Protection Procedures (LCPP), Part A, Chapter 7, accessed on 8 October, 2019 at https://www.londoncp.co.uk/chapters/alleg_staff.html

3 Davies, H. (2014) *Southbank International School Independent Review arising from the criminal conduct of William Vahey: Interim Report,* London, Farrer and Co, LLP; and Davies, H. (2014) *Southbank International School Independent Review arising from the criminal conduct of William Vahey: Final Report,* London, Farrer and Co, LLP

as a clear and comprehensible term to neutralise the act of sharing a concern which neither meets the allegation threshold set out below, nor is otherwise serious enough to consider a referral to the LADO. We believe that such straightforward and comprehensive shorthand is both necessary and effective in practice.

1.9 Whilst we consider a written 'low-level concerns' policy to be an important part of the suite of safeguarding policies that exists at an organisation which works with children, its successful introduction will be a process rather than an event. Having the confidence of all staff that it will, in practice, be used in the way the policy describes will be a key part of ensuring it is implemented and used successfully. A starting point for any organisation is realistically to assess its own organisational culture, and consider whether it is currently conducive to introducing such a policy and, if not, what action it needs to take to reach that position.

1.10 This guidance focuses on low-level concerns regarding adults' behaviour towards children – including the options of self-reporting by adults, or adults sharing such concerns about the behaviour of other adults. Whilst it does not focus on the sharing of concerns (i) about adults by children, or (ii) in the context of peer-on-peer abuse, or (iii) in the context of adults' behaviour towards adults, we believe that the same fundamental principles should nonetheless apply.

2. Definitions

2.1 Reference in this guidance to:

2.1.1 'staff' should be interpreted *very widely* to mean anyone associated with the organisation – i.e. whether working for or with the organisation, engaged as a paid employee, worker or self-employed contractor, or unpaid member of staff or volunteer. It also includes anyone who is part of the Governance Body;

2.1.2 'Governance Body' means those individuals who are responsible for an organisation's governance – for example, in a school setting, the governors; in a charity, the trustees; and in a sports organisation, the directors;

2.1.3 'Safeguarding Lead' means the person in an organisation with overall safeguarding responsibility. In a school setting, this person is normally referred to as the Designated Safeguarding Lead (**DSL**). The Safeguarding Lead is distinct from the designated officer employed by the local authority to manage and have oversight of allegations across the children's workforce (**LADO**); and

2.1.4 'values guardian' or 'safeguarding champion' are terms that some organisations use to describe members of staff who are specifically selected and trained to be available and to listen to any low-level concerns that staff may bring to their attention, and to share them with the Safeguarding Lead.

3. The distinction between an allegation and a low-level concern

3.1 Allegation

3.1.1 The term 'allegation' means that it is alleged that a person who works with children has:

- behaved in a way that has harmed a child, or may have harmed a child;
- possibly committed a criminal offence against or related to a child; or
- behaved towards a child or children in a way that indicates they may pose a risk of harm to children.[4]

3.1.2 Chapter 7 of Part A of the *London Child Protection Procedures* (**LCPP**) makes it clear that an allegation can also relate to an adult's behaviour outside of work, and their relationships with others, if they:

- have behaved in a way in their personal life that raises safeguarding concerns. These concerns do not have to directly relate to a child but could, for example, include an arrest for the possession of a weapon;
- have, as a parent or carer, become subject to child protection procedures;
- are closely associated with someone in their personal lives (e.g. partner, member of the family or other household member) who may present a risk of harm to child/ren for whom the adult is responsible in their employment/volunteering.[5]

3.1.3 Where the threshold of an allegation is met, there is specific guidance on how organisations should respond:

(a) *Working Together to Safeguard Children* (July 2018) (**WTSC**) states that "…Any allegation against people who work with children should be reported immediately to a senior manager within the organisation or agency. The [LADO] or team of officers, should also be informed within one working day of all allegations

4 This definition is used in: WTSC, Chapter 2, paragraph 4; KCSIE, paragraph 195; LCPP, Part A, Chapter 7, paragraph 7.2.1; GSWP, paragraph 1
5 LCPP, Part A, Chapter 7, paragraph 7.2.3

that come to an employer's attention or that are made directly to the police."[6]

(b) This obligation to report allegations applies to schools and colleges, faith organisations, and voluntary and private sector organisations (amongst others).[7] However, in practice, all organisations working with children should take this action.

(c) *Keeping Children Safe in Education* (September 2019) (**KCSIE**) states that "If staff have safeguarding concerns, or an allegation is made about another member of staff (including volunteers) posing a risk of harm to children, then:

- this should be referred to the headteacher or principal;
- where there are concerns/allegations about the headteacher or principal, this should be referred to the chair of governors, chair of the management committee, or proprietor of an independent school; and
- in the event of concerns/allegations about the headteacher, where the headteacher is also the sole proprietor of an independent school, allegations should be reported directly to the designated officer(s) at the local authority...."[8]

(d) More detailed guidance is set out in Part 4 of KCSIE on handling allegations once they have been reported internally.

(e) Although the guidance in KCSIE is specifically applicable to schools and colleges, it could, as a matter of best practice, be applied to any organisation working with children.

3.2. Low-level concern

3.2.1 A low-level concern is any concern about an adult's behaviour towards a child that does not meet the allegation threshold set out above, or is not otherwise serious enough to consider a referral to the LADO.

3.2.2 A low-level concern is any concern – no matter how small, and even if no more than a 'nagging doubt' – that an adult may have acted in a manner which:

- is not consistent with an organisation's Code of Conduct,[9] and/or
- relates to their conduct outside of work which, even if not linked to a particular act or omission, has caused a sense of unease about that adult's suitability to work with children.[10]

3.2.3 Staff **do not** need to be able to determine in each case whether their concern is a low-level concern, or if it is in fact serious enough to consider a referral to the LADO, or meets the threshold of an allegation. Once staff share what they **believe** to be a low-level concern, that determination should be made by the Safeguarding Lead.

3.2.4 Neither WTSC nor KCSIE provides any formal mechanism for handling concerns about adults working with children that do not meet the threshold of an allegation.

3.2.5 However, it is possible to introduce a mechanism whereby low-level concerns are shared with the Safeguarding Lead, or with the Safeguarding Lead or a values guardian/ safeguarding champion – as appropriate to each organisation. In light of paragraph 50 of KCSIE, as explained further below in paragraph 8.12, **in a school or college**, the Safeguarding Lead should then share any low-level concerns immediately with the headteacher or principal.

3.2.6 The importance of such a mechanism is illustrated by research and reference to inquiries and serious case reviews.

6 WTSC, Chapter 2, paragraph 7
7 Specific statutory duties are placed by Section 11 of the Children Act 2004 on a range of organisations and professionals working with children and families to safeguard and promote the welfare of children. In addition, further safeguarding duties are placed on individual organisations through other statutes, as explained in Chapter 2 of WTSC
8 KCSIE, paragraph 50
9 In some organisations this document is called the Behaviour Policy but reference is made to Code of Conduct throughout this guidance.
10 Concerns which fall short of the allegation threshold might include an accusation that is made second or third hand and the facts are not clear, or the member of staff alleged to have done this was not there at the time; or there is confusion about the account, LCPP, Part A, Chapter 7, paragraph 7.2.10.

4. The importance of sharing low-level concerns

> "Agencies providing services to children [...] should ensure that a culture of openness and trust is fostered within the organisation in which staff can share any concerns about the conduct of colleagues and be assured that these will be received in a sensitive manner."[11]

4.1 Organisational child sexual abuse is an increasingly well-documented and understood phenomenon.[12] It is rare to find cases where the abuse occurred in the absence of preceding grooming by the offender,[13] and whilst not always,[14] it is usually the case that such preparatory conduct was observed and regarded as questionable at the time by others.[15] It is not of course just children who are groomed but also, as multiple cases demonstrate, the potentially protective adults and systems around them.[16]

4.2 Often a striking feature is that such conduct was not shared with the relevant individual at the organisation until after substantive abuse was alleged against the offender. In other respects, potentially questionable conduct, even where shared, is consistently shown not to have either been recorded or available for evaluation as part of a history or pattern of behaviour, or not to have been escalated when a pattern of such behaviour emerged.[17]

4.3 Common factors in organisational child sexual abuse were considered by Marcus Erooga in a review of 20 serious case reviews relating to such abuse in the UK from 2010-2016.[18] He found that:

(a) a factor in 17 cases was a failure of staff and management to understand and implement their safeguarding policies (including around sharing concerns);

(b) emphasised in 14 reviews was the importance of staff and management understanding the dynamics of organisational abuse (including grooming); and

(c) a factor identified in 11 cases was the significance of organisational culture to minimise risk.

4.4 Erooga and colleagues' research with offenders illustrates what organisational offenders can teach organisations about how to prevent abuse and build strong safeguarding cultures.[19] Those interviewed for the research had worked in a range of occupational settings (including schools, sports clubs, army and sea cadet organisations, a choir group and education social work), and had sexually offended against children in organisational positions of trust. Whilst not necessarily causal factors, a number reported *work related stressors* (including lack of support and working long hours), as well as *personal issues* (including having been abused themselves as children, recent loss of intimate relationships, questioning their sexual orientation and a history of self-harm/suicidal thoughts). Some showed patterns of *rule breaking* more generally (including breaches of other rules), in addition to the abuse of children.

4.5 *Grooming behaviours* included direct use of authority to offend, using material or practical benefits for victims, providing support for isolated children, favouring particular children, and use of alcohol, videos or sexual imagery amongst others. The method of commencing the abuse included the *erosion of boundaries*, slow progression to abuse, use of trust and authority, meeting the child's needs (including physical and emotional), and developing relationships with the child's family. Our collective observation is that these concepts are straightforward but staff do not understand them unless there is training based on real life cases (discussed further at 6.5(f)).

4.6 The research questions the view that all offenders are preferential, suggesting instead that whilst some are undoubtedly preferential, others may be considered to be opportunistic and some are situational. *Preferential offenders* are those who have a conscious desire to sexually abuse children, and who either do not see, or are not easily deterred, by obstacles. Jimmy Savile is a classic example of a preferential offender. *Opportunistic offenders* are those who abuse because potential victims are available and potentially vulnerable,

11 Social Services Inspectorate (1994) *'An Abuse of Trust', The Report of the Social Services Inspectorate Investigation into the case of Martin Huston, January 1994,* Belfast, Social Services Inspectorate

12 Kaufman, K., Erooga, M. et. al. (2016) *Risk profiles for institutional child sexual abuse: A literature review,* Royal Commission into Institutional Responses to Child Sexual Abuse, Sydney

13 McAlinden, A-M. (2012) *'Grooming' and the Sexual Abuse of Children: Institutional, Internet, and Familial Dimensions,* Oxford University Press

14 E.g. Scott-Moncrieff, L. and Morris, B. (2015) *Independent investigation into governance arrangements in the paediatric haematology and oncology service at Cambridge University Hospitals NHS Foundation Trust following the Myles Bradbury case,* Cambridge, Cambridge University NHS Foundation Trust (UK)

15 *See Appendix A for examples*

16 E.g. McAlinden, A. M. (2012) *'Grooming' and the Sexual Abuse of Children: Institutional, Internet and Familial Dimensions,* Oxford, Oxford University Press; *Exploring Sex offender Grooming* (2013) by Jim Tanner, Ph.D. KBSolutions Inc. and Stephen Brake, Ph.D.Stephen Brake Associates, accessed on 8th October, 2019 at http://www.kbsolutions.com/Grooming.pdf; Wonnacott, J. and Carmi, E. (2016) *Serious Case Review: Southbank International School,* Hammersmith and Fulham, Kensington & Chelsea and Westminster LSCB; Raynes, B. (2011) *Executive Summary Of Serious Case Review Written About Teacher Mr X,* Hillingdon Local Safeguarding Board; Jones, P. (2016) *Investigation Into Safeguarding Issues At Clifton College Arising From The Prosecution Of X,* Bristol: Clifton College; and East Sussex Safeguarding Children Board (2013) *Serious Case Review: Child G, Brighton,* East Sussex Safeguarding Children Board

17 See Appendix A for examples

18 Erooga, M. (2016) *Creating Safer Organisations: Practical implications of research regarding child sexual abuse in youth serving settings,* Pre-conference presentation at the Association for the Treatment of Sexual Abusers (ATSA) 35th Annual Research and Treatment Conference, Orlando, FL., USA

19 Erooga, M., Allnock, D. & Telford, P. (2012) *Sexual Abuse of Children by People in Organisations: What Offenders can Teach Us About Protection* in M. Erooga (ed.) *Creating Safer Organisations: Practical Steps to Prevent the Abuse of Children by Those Working With Them,* John Wiley & Sons, Ltd

and the organisational setting either inadvertently facilitates, or fails to prevent, abusive activity. *Situational offenders* are those whose propensity to abuse is previously unknown or unacknowledged, and their offending is specific to the set of organisational factors which potentiates their offending.[20]

Boundaries

4.7 Based on the earlier research, Erooga elaborates on the concept of a 'slippery slope' of boundary violations towards abuse, and explains that there are many stages on the slippery slope towards the breach of a boundary within a relationship. Sometimes initial infringements are part of a grooming process but at other times they are made innocently and with good intention. However, once boundaries are breached it then becomes more difficult to restore the relationship to one in which proper boundaries are respected.[21] Furthermore, Erooga emphasises that organisations should not simply concern themselves with safeguarding boundaries. His research indicates that organisations in which boundaries are adhered to *in every respect* in which staff perform their role are likely to be the safest environments for children.

Specific Behaviours

4.8 Tabachnick and Baker's research describes a widely held but erroneous perception that individuals can accurately judge people, or profile a sex offender, and emphasises the need to understand that there is no one profile to describe everyone who abuses a child and the importance, therefore, of a focus instead on specific behaviours.[22]

4.9 If we educate adults to be informed about, and to identify, concerning, problematic or inappropriate behaviour, rather than think they can recognise dangerous people, they can be prepared to act when they observe behaviour which violates a Code of Conduct. They can, as Tabachnick and Baker explain, then draw attention to "the hundreds of small comments, harassments, emotional and physical boundary violations, and other signs that may precede [child] sexual abuse" – what may be considered in the broadest sense to be [part of a conscious, or an unwitting] grooming process.[23]

4.10 In this approach a clear and robust Code of Conduct for the workplace is needed, and there must be a commitment from leadership to adhere to, enforce and reinforce the Code and its expectations, and to address any attempt to bypass policies or procedures – regardless of the person in question's status. Staff should be briefed on the Code of Conduct so that everyone is familiar with it, and clear on the standard of behaviour expected of them – it should be a lived document, seen to apply to all levels of the organisation. Staff should also be trained on specific behaviour to be aware of, and be encouraged and empowered to share any concerns about behaviour that is not appropriate. Intrinsic to this is discussing, during training, real life examples of the consequences of failing to report.

Action points

"It is not whistleblowing, which is the safety net at the end of the process, but mechanisms that allow the confidence to speak out on a day-to-day basis. How do you create that culture? You need a robust framework, policy, training, support and leadership to facilitate dialogue and instil it."[24]

(Sam Monaghan, Corporate Director Children's Services, Barnardo's)

4.11 Whether or not all child sex offenders are in fact preferential, there are several recommended actions that flow from Erooga and colleagues' research,[25] and that organisations can take to minimise the risk of situational offending. They include:

(a) reducing the opportunity and acceptability of concerning, problematic or inappropriate behaviour;

(b) increasing the effort required to offend;

(c) increasing the risk and perception of the risk of detection;

(d) ensuring there are robust and effective staff support systems in place;

(e) not over-relying on DBS or overseas criminal records checks – they are essential (where roles require them, and as a matter of compliance) but are not a silver bullet. A clear DBS check simply confirms that an individual has not been discovered to present a risk to children; it is not predictive about potential risk. Research shows that the majority of organisational child sex offenders did not have a previous criminal record at the time they offended, although

20 Erooga, M. (2018) *Thinking Beyond a Single Type of Organisational Sex Offender'* in M. Erooga, M. (ed.) *Protecting Children and Adults from Abuse After Savile,* London, Jessica Kingsley Publishers
21 Ibid
22 Tabachnick, J. and Baker, K. (2018) *'Engaging the Public through Messaging and Bystander Actions'* in M. Erooga, M. (ed.) *Protecting Children and Adults from Abuse After Savile,* London, Jessica Kingsley Publishers
23 Ibid, p.173
24 Sam Monaghan, Corporate Director Children's Services, Barnardo's, quoted in Charity Finance (April 2016) *Safe Keeping: the implications of historic child sexual abuse allegations*
25 Erooga, M., Allnock, D. & Telford, P. (2012) *Sexual Abuse of Children by People in Organisations: What Offenders can Teach Us About Protection* in M. Erooga (ed.) *Creating Safer Organisations: Practical Steps to Prevent the Abuse of Children by Those Working With Them,* John Wiley & Sons, Ltd

they may subsequently be found to have had numerous previous victims; [26]

(f) the powerful effect of organisational culture – and the importance of clarity and congruence about values and expectations. As the Health & Safety Executive states, culture can best be described as *"the way we do things around here."* [27] What is important is creating a robust, holistic safeguarding culture that everyone endorses and is committed to. As one headteacher commented, *"It is about building a culture of what is and isn't acceptable here. What are we about as a school? What is the staff room like and is everyone buying into that?"* Culture forms the context within which people judge the appropriateness of their behaviour. An organisation's culture will influence human behaviour and human performance at work, and it is vital to recognise the danger of cultural slippage. A Code of Conduct which is understood, accepted and followed by all adults associated with the organisation is integral to this, and strong governance and leadership are vital.

4.12 In addition, all organisations can benefit from using the *Guidance for safer working practice for those working with children and young people in education settings* (**GSWP**), which is used by many local authorities and schools as a reference point for identifying low-level concerns and informing their own Code of Conduct.[28] Although created for schools and education settings, the principles are applicable across all sectors, and as guidance it is held in high regard by professionals within the safeguarding field.

5. What can we learn from serious case reviews?

> "...I would like to stress that our review has highlighted the overwhelming importance of two things for organisations in protecting children – a culture of openness, including a willingness to recognise and accept that abuse could happen in any organisation and a robust structure to support the effective reporting and handling of concerns about behaviour."[29]
>
> (Dame Moira Gibb)

5.1 The importance of educating staff to understand and identify behaviour which is contrary to the Code of Conduct is illustrated by the table at **Appendix A**, which draws together the key features of fifteen cases of organisational child sexual abuse.[30]

5.2 In the cases of teachers William Vahey and Nigel Leat (further details of which can be found in **Appendix A**), a number of staff, parents and pupils discussed concerns with each other or a member of the senior management team. A number of these concerns, taken in isolation, were not treated by the teachers' respective schools as meeting the threshold for reporting to the LADO at the time. For example, Vahey *"undermined other staff and was disrespectful to junior staff,"* and *"gave out chocolates and sweets in class [and] cookies linked to games during evening activities."*[31] Leat *"had favourite pupils within his class [who were] invariably girls, and were variously described by staff members as pupils who were less academically able, emotionally needy or vulnerable and pretty;" "had been taking photographs of children using his mobile phone,"* and *"getting changed for PE in his class [which was] used as a thoroughfare by staff and pupils."*[32]

5.3 Many concerns were not shared with anyone. In the case of Leat, only 11 of the 30 recorded incidents were shared with the school management. All staff interviewed for the Serious Case Review said that it was common knowledge amongst school staff that Leat allowed pupils to be over familiar with him, and *"spoke to and joked with his pupils in a manner which was inappropriate to his role."* As the Serious Case Review explains, staff were sufficiently concerned about Leat's behaviour to attempt to ensure that pupils identified as likely favourites of his were allocated to other classes on the basis that remaining in Leat's class might be emotionally harmful to them. However, these staff did not share all their concerns with the school child protection officer or headteacher at the time. Of those which were shared with the headteacher (who was subsequently prohibited from teaching for life for failing to act appropriately in relation to concerns), he neither acted upon them nor identified a pattern of inappropriate behaviour.

5.4 Neither school had a formal mechanism for sharing, recording or handling low-level concerns. As a result, when they were shared, the concerns were shared with different people and each concern was dealt with in isolation. No one person was aware of all of the concerns, and no-one was therefore able to 'join the dots,' and identify a pattern of inappropriate behaviour. Concerns, therefore, were either dismissed as insignificant or misinterpreted

26 Leclerc, B., & Cale, J. (2015). Adult sex offenders in youth-oriented organisations: evidence on sexual victimisation experiences of offenders and their offending patterns. *Trends and Issues in Crime and Criminal Justice*
27 Health and Safety Executive (2019) *Organisational culture,* accessed on 8th October, 2019 at http://www.hse.gov.uk/humanfactors/topics/culture.htm
28 GSWP, accessed on 8 October, 2019 at https://www.saferrecruitmentconsortium.org/GSWP%20Sept%202019.pdf
29 Wonnacott, J. and Carmi, E. (2016) *Serious Case Review: Southbank International School,* Hammersmith and Fulham, Kensington & Chelsea and Westminster LSCB, (P.4)
30 It is important to note that concerning, problematic or inappropriate behaviour towards/abuse of children is not limited to sexual behaviour, and low-level concerns can of course apply in other behavioural contexts, e.g. emotional.
31 Wonnacott, J. and Carmi. E. (2016) *Serious Case Review: Southbank International School,* Hammersmith and Fulham, Kensington & Chelsea and Westminster LSCB
32 North Somerset Safeguarding Children Board (2012) *Serious Case Review: The Sexual Abuse of Pupils in a First School Overview Report,* Weston-Super-Mare, NSSCB

or, where they were investigated, they were viewed as isolated incidents, and Vahey's and Leat's explanations were accepted.

5.5 These and numerous other cases, including those in the table at **Appendix A**, illustrate the importance of sharing, recording and handling low-level concerns, so that potential patterns of concerning, problematic or inappropriate behaviour can be identified as soon as possible, and appropriate action can be taken swiftly in response.

6. Implementing a written low-level concerns policy – initial points to consider

6.1 Some organisations may feel that they already take an approach to sharing low-level concerns, which they would not want to formalise with a policy. However, we recommend that organisations do introduce a written low-level concerns policy, as it should empower staff to feel that they are abiding by the policy by sharing any such concerns. In addition, an 'approach' can be a very difficult thing to monitor and runs the risk of 'drift.' This is a particular challenge in, for example, a schools group or a national organisation, where it is especially important to introduce principles to minimise the risk of one part of the organisation gradually slipping away from what was agreed to be the right approach by the organisation as a whole.

6.2 A written policy could be presented as a stand-alone policy, or it could form part of an existing Code of Conduct or Safeguarding Policy. As our research shows, a number of schools have adopted a range of these options. Given OFSTED and ISI requirements, some schools may prefer to include a written policy in their Code of Conduct which is less prescribed than the Safeguarding Policy. Whichever option is used, it should be as simple and clear as possible, and include an introduction to the concept and the importance of sharing low-level concerns, an explanation of what the policy is, what its purpose is and what its aims are. A question and answer format, as set out in paragraphs 8 to 13 below can be a helpful way of presenting this and the additional suggested information.

6.3 The way in which a low-level concern policy is implemented is key. Organisation leaders must ensure that their focus is on *designing a policy which is tailored to their specific organisation and implementing it in a way* which will achieve 'buy in' from all staff. Equally, they should recognise that leaders play a key role in communicating the assumptions, values, beliefs, and norms they expect members of their organisation to exhibit.[33] Simply put, if leadership is not seen to adhere to and model the expected values and behaviour of the organisation, a written low-level concerns policy is unlikely to be effective.[34]

6.4 If the time is not taken to do this then organisations risk inadvertently creating suspicion, confusion and mistrust which could be highly damaging to their culture and result in decreased, rather than increased, sharing of concerns. Based on our experience, and the findings from our research, a number of schools have successfully implemented a low-level concerns policy. With respect to our research, in answer to the question on whether staff in the main welcome the sharing of low-level concerns/neutral notifications and regard it as valuable, all of the 17 out of 18 schools that responded confirmed that they do; however, in answer to the question on whether staff in the main have concerns about the sharing of low-level concerns/neutral notifications and do not regard it as valuable, 1 out of the 16 schools that responded confirmed that they do have such concerns and do not regard it as valuable.

6.5 To design and implement a low-level concerns policy in a positive and effective way, organisations should:

(a) consider how each of the questions set out below should be addressed;

(b) carefully consider their use of terminology, including how they name their policy. Some organisations have adopted the term '*low-level concerns policy,*' whereas others have chosen '*neutral notification*.' Our research indicates that a number of schools are using both terms, and some are using neither. We strongly recommend that organisations adopt either term – whichever is considered to be most appropriate according to their particular culture – and that once a decision is made, that term is used consistently to minimise the potential risk of any confusion;

(c) engage and consult with all staff from the outset, so that they can be involved in shaping the policy;

(d) draw on the GSWP (May 2019, and previous versions), and the Code of Conduct, when designing and implementing the policy;

(e) engage with trade union or professional association representatives where relevant, particularly where an organisation recognises a union and/or where their staff are members of one or more unions. Such engagement can improve the quality and appropriateness of the policy, increase staff and union 'buy-in' and

33 Schein, E. H. (1985) *Organizational Culture and Leadership*, San Francisco, CA: Jossey-Bass Publishers
34 For further discussion of the role of leadership see: Erooga, M. (2019) *A clear lead: Why charity leaders must create a safeguarding culture, Civil Society, March*

ensure that any complex issues are dealt with and resolved at the outset, before the policy is implemented. Such engagement was essential in the drafting of the original version of GSWP;

(f) deliver high quality and appropriately pitched training to all staff on (i) the themes of this guidance and, crucially, how organisational based grooming occurs – including on real life cases and with scenario-based discussions, and (ii) the low-level concerns policy – including how concerns should be shared, recorded and responded to. The cases contained in **Appendix A**, and the Safer Working Practice training resource prepared by the Safer Recruitment Consortium, may be helpful, in this regard,[35] as well as the examples detailed in **Appendix B**, which are intended to illustrate the boundaries between low-level concerns and allegations. Effective training is of paramount importance as a key component in the successful implementation of a low-level concerns policy, and can be delivered in a session of one to two hours: understanding promotes acceptance and engagement;

(g) incorporate a briefing about the policy into the induction process for new staff;

(h) provide staff with regular opportunities to discuss the policy and provide feedback including on what is regarded as working well, what would helpfully be modified, and what they may have concerns about;

(i) arrange for a comprehensive review of the policy's implementation after a period (for example, 12 or 18 months) – to measure its impact, and identify and remedy any potential unintended consequences and/or inconsistencies between the policy's stated aims and its implementation in practice; and

(j) separate from this review, the Safeguarding Lead should consult with staff on a regular basis so that any significant issues can be remedied immediately. The Governance Body should also be provided with regular updates.

7. Do any issues under data protection law arise?

7.1 The Data Protection Act 2018 (**DPA 2018**) makes specific provision for the processing of personal data that is necessary for the purposes of safeguarding children from harm (which is widely defined). Our view is that low-level concerns sharing is a reasonably necessary measure, given the importance of raising and logging such concerns identified by, for example, inquiries and serious case reviews. It does raise issues in respect of retention periods, giving references to other organisations, and dealing with data subject requests for access, correction or erasure. Some of these issues are considered immediately and further below, and in more detail in **Appendix D**.

7.2 Dealing briefly here with rights of **subject access**, which for many organisations is one of the key policy considerations against low-level concerns recording: contrary to common belief, there is no stand-alone 'safeguarding' exemption that trumps the subject access right. Nor, on balance, is there a clear or overriding case that there should be. Both employment law (in terms of process and decision-making) and data protection law (with its principles of transparency, fairness, accountability and accuracy) support the idea that staff should understand the information held about them and, if appropriate, be able to correct or feed into it.

7.3 The existence of such a right reinforces the importance of securing 'buy-in' to a low-level concerns policy across an organisation – encouraging self-reporting, cooperation and neutral recording. Being aware that adults about whom a low-level concern has been raised may have rights of access to such records, provided of course that this would not also unreasonably disclose information of children concerned, should act to self-regulate how such records are made. However, data controllers will always be able to prefer children's privacy rights on balance if the circumstances justify it.

7.4 This may have possible consequences for how organisations record information *that relates to a specific child* (who may be identifiable by context if not by name) as part of a low-level concern recorded about an adult. Such records will be easier to withhold and, in some cases, harder to share with the adult in question: this may pose practical issues, where concerns ought to be raised, but does not as such represent a fundamental difference to the position when recording any safeguarding concern.

7.5 Organisations must take their own advice on how to manage such risks, and the DPA 2018 requires that they capture the approach in an '***appropriate policy document***': including how long such information will be retained, how to access or challenge it, and in what circumstances it might be used or shared. Staff must be fully notified of the low-level concern policy and of its purpose, partly for its proper implementation but also under data protection principles (fairness and transparency). Reference to

35 Safer Recruitment Consortium, Safe Working Practice Resource, accessed on 8th October, 2019 at http://www.saferrecruitmentconsortium.org/

a low-level concerns policy should be made in any **privacy notice** applicable to staff.

8. Other specific questions to address when implementing a low-level concerns policy

What is the low-level concerns policy?

8.1 It is a new policy which enables all staff to share any concerns – **no matter how small** – about their own or another member of staff's behaviour with the Safeguarding Lead, or with the Safeguarding Lead or a values guardian/safeguarding champion – as appropriate to each organisation. Safeguarding and promoting the welfare of children is everyone's responsibility.

8.2 The **purpose** of the policy is to create and embed a culture of openness, trust and transparency in which the clear values and expected behaviour which are set out in the Code of Conduct are constantly lived, monitored and reinforced by all staff.

8.3 In order to achieve this purpose, organisations should:

(a) ensure that staff are clear about, and confident to distinguish, expected and appropriate behaviour from concerning, problematic or inappropriate behaviour – in themselves and others, and the delineation of professional boundaries and reporting lines;

(b) empower staff to share any low-level concerns with the Safeguarding Lead, or with the Safeguarding Lead or a values guardian/ safeguarding champion – as appropriate to each organisation, and to help all staff to interpret the sharing of such concerns as a neutral act;

(c) address unprofessional behaviour and help the individual to correct such behaviour at an early stage;

(d) identify concerning, problematic or inappropriate behaviour – including any patterns – that may need to be consulted upon with (on a no-names basis if appropriate), or referred to, the LADO;

(e) provide for responsive, sensitive and proportionate handling of such concerns when they are raised; and

(f) help identify any weaknesses in the organisation's safeguarding system.

Definitions

8.4 The policy should clearly define who it applies to – i.e. all 'staff' (as stated on page 2), and any individuals with a significant role to perform in the context of sharing low-level concerns – i.e. Safeguarding Lead, and (if appropriate) values guardian/safeguarding champion, and should include the definition of an allegation and low-level concern (as stated on pages 2 and 3) – to provide a clear distinction between these for staff. Some organisations may also find it helpful to explain the position via a traffic light system, as set out in Diagram 1 in **Appendix C**.

8.5 Although it is important that staff feel comfortable with, and are clear about, the concept of low-level concerns, and know what to do if they have such a concern, they **do not** need to be able to determine in each case whether their concern is a low-level concern, or if it is in fact serious enough to consider a referral to the LADO, or meets the threshold of an allegation. As explained below, once staff share what they **believe** to be a low-level concern, that determination should be made by the Safeguarding Lead (as set out in Diagram 2 in **Appendix C**).

Who should staff share low-level concerns with?

8.6 It is critical that all low-level concerns are ultimately received by the Safeguarding Lead. Having one recipient of all such concerns should allow any potential patterns of concerning, problematic or inappropriate behaviour to be identified, and ensure that no information is possibly lost.

8.7 The simplest way of ensuring that this happens is to train staff to share all low-level concerns directly with the Safeguarding Lead.

8.8 It is important that low-level concerns are shared with the Safeguarding Lead as soon as reasonably possible and, in any event, within 24 hours of becoming aware of it (where the concern relates to a particular incident) – although it should also be emphasised that it is never too late to share a low-level concern.

8.9 If the Safeguarding Lead is absent for any reason, low-level concerns should be shared with a clearly identified 'deputy,' who should ensure that they inform the Safeguarding Lead immediately on their return.

8.10 If any low-level concern relates to the behaviour of the Safeguarding Lead, it should be shared with the headteacher or principal (in the case of schools), or the CEO of an organisation.

8.11 As an alternative option, staff could share any low-level concerns with selected individuals from across their organisation who are specially selected, trained and championed as values guardians/safeguarding champions. We believe that if implemented properly, this role has real

potential value by helping to avoid the sharing of low-level concerns as possibly being seen as a 'top down' initiative. It should be emphasised that we understand that a key part of schools' success where they have introduced such a role is that it is truly 'cross-grade', and is not about having a range of senior figures in this role – people at all levels of the organisation should be sought. We are aware that in one school group this includes a teaching assistant and someone on the domestic staff, and at one school the Head Groundsman (amongst others). Staff could be encouraged to share – within the same timeframe stipulated above – any low-level concern with either the Safeguarding Lead or a values guardian/safeguarding champion – whoever they feel most comfortable talking to. If such a system is introduced, then in order to minimise the potential risk of information being lost or mistranslated, the careful selection and appropriate training of values guardians/safeguarding champions will be essential – to ensure that any low-level concerns shared with them are appropriately responded to, recorded and immediately passed on to the Safeguarding Lead. Similarly, this system must be made as clear as possible to staff by the organisation during consultation, briefing and/or training on its low-level concerns policy.

8.12 As stated (at paragraph 3.2.5) above, **in a school or college**: (i) while all staff should share any low-level concerns, in the first instance, with the Safeguarding Lead, or with a values guardian/ safeguarding champion and, if so, for them to pass any such concerns on to the Safeguarding Lead immediately, the Safeguarding Lead should then, in light of paragraph 50 of KCSIE, share the low-level concerns immediately with the headteacher or principal, and (ii) if any low-level concerns are in fact shared with the headteacher or principal in the first instance, then the headteacher or principal should immediately share them with the Safeguarding Lead. In either case, the Safeguarding Lead should remain responsible for all of the relevant actions stipulated in this guidance, and in Diagram 2 in **Appendix C** (unless the headteacher or principal considers, in the particular circumstances, that they should be responsible for any such actions and, if so, they should inform the Safeguarding Lead accordingly).

Should staff who share concerns be able to remain anonymous?

8.13 If the staff member who raises the concern does not wish to be named, then the organisation should respect that person's wishes as far as possible.

8.14 However, there may be circumstances where the staff member will need to be named (for example, where it is necessary in order to carry out a fair disciplinary investigation) and, for this reason, anonymity should never be promised to members of staff who share low-level concerns. Where possible, organisations should try to encourage staff to consent to be named, as this will help to create a culture of openness and transparency.

Should staff share concerns about themselves (i.e. self-report)?

8.15 Occasionally a member of staff may find themselves in a situation which could be misinterpreted, or might appear compromising to others.

8.16 Equally, a member of staff may, for whatever reason, have behaved in a manner which, on reflection, they consider falls below the standard set out in the Code of Conduct.

8.17 Self-reporting in these circumstances can be positive for a number of reasons: it is self-protective, in that it enables a potentially difficult issue to be addressed at the earliest opportunity; it demonstrates awareness of the expected behavioural standards and self-awareness as to the individual's own actions or how they could be perceived; and, crucially, it is an important means of maintaining a culture where everyone aspires to the highest standards of conduct and behaviour.

How should low-level concerns be shared and recorded?

8.18 Staff should be given the option of sharing their low-level concern verbally with the Safeguarding Lead (or deputy if necessary) in the first instance, or with a values guardian/safeguarding champion, or of providing them with a written summary of it. Organisations may wish to provide staff with the option of completing a simple low-level concerns form, an example of which is appended at **Appendix E** .[36]

8.19 Where the low-level concern is provided verbally, the Safeguarding Lead (or deputy), or values guardian/ safeguarding champion, should make an appropriate record of the conversation, either contemporaneously or immediately following the discussion.

8.20 Sound professional judgement should be exercised by them in determining what information is necessary to record for safeguarding purposes. The name of the individual sharing the low-level concern, and their role, should be stated, as should the name of the individual about whom the concern is being raised, and their role within the organisation at the time the concern is raised. If the latter individual has an opposing factual view of the incident, this should be fairly recorded

36 Some practical guidance is given, at the end of Appendix D, on the different data security considerations that might arise according to how the low-level concerns are shared.

alongside the concern. The record should include brief context in which the low-level concern arose, and concise details (which are chronological and as precise and accurate as possible) of any such concern and relevant incident(s). The record should be signed, timed and dated.

How should a low-level concern be responded to by the Safeguarding Lead?

8.21 Once the Safeguarding Lead has received the low-level concern, whether directly or from their deputy, or from one of the organisation's values guardians/safeguarding champions – and **in a school or college**, the Safeguarding Lead has shared the low-level concern immediately with the headteacher/principal, they should:

(a) speak to the person who raised the concern (unless it has been raised anonymously), regardless of whether a written summary, or completed low-level concerns form has been provided;

(b) review the information and determine whether the behaviour (i) is entirely consistent with the organisation's Code of Conduct and the law, (ii) constitutes a low-level concern, (iii) is serious enough to consider a referral to the LADO, or (iv) when considered with any other low-level concerns that have previously been raised about the same individual, should be reclassified as an allegation and referred to the LADO/other relevant external agencies;

(c) where the Safeguarding Lead is in any doubt whatsoever, they should seek advice from the LADO – on a no-names basis if necessary;

(d) speak to the individual about whom the low-level concern has been raised (unless advised not to do so by the LADO/other relevant external agencies, where they have been contacted);

(e) make appropriate records of:

- all internal conversations – including with the person who initially shared the low-level concern (where this has been possible), the adult about whom the concern has been shared (subject to the above), and any relevant witnesses;
- all external conversations – for example, with the LADO/other external agencies (where they have been contacted, and either on a no-names or names basis);
- their determination (as above at 8.21(b));
- the rationale for their decision; and
- any action taken.

8.22 The Safeguarding Lead's approach should also be informed by the following:

8.22.1 **If it is decided that the low-level concern in fact amounts to behaviour which is entirely consistent with the organisation's Code of Conduct and the law:**

(a) it will still be important for the Safeguarding Lead to inform the individual in question what was shared about their behaviour, and to give them an opportunity to respond to it;

(b) in addition, the Safeguarding Lead should speak to the person who shared the low-level concern – to provide them with feedback about how and why the behaviour is consistent with the organisation's Code of Conduct and the law;

(c) such a situation may indicate that:

- the Code of Conduct is not clear;
- the briefing and/or training has not been satisfactory; and/or
- the LLC policy is not clear enough.

If the same or a similar low-level concern is subsequently shared by the same individual, and the behaviour in question is also consistent with the Code of Conduct, then an issue may need to be addressed about how the subject of the concern's behaviour is being perceived, if not about the behaviour itself, and/or the organisation may need to look at the implementation of its LLC policy.

8.22.2 **If it is decided that the current concern is low-level:**

(a) it should also be responded to in a sensitive and proportionate way – on the one hand maintaining confidence that such concerns when raised will be handled promptly and effectively whilst, on the other hand, protecting staff from any potential false allegations or misunderstandings. Any investigation of low-level concerns should be done discreetly and on a need-to-know basis;

(b) most low-level concerns by their very nature are likely to be minor. Some will not give rise to any ongoing concern and, accordingly, will not require any further action. Others may be most appropriately dealt with by means of management guidance and/or training;

(c) in many cases, a low-level concern will simply require a conversation with the individual about whom the concern has been raised. It has long been understood that lasting change in behaviour is least likely to be achieved by an approach experienced as critical or threatening (Miller & Rollnick, 1991);[37]

(d) what Erooga has described in presentations as a 'values-based conversation' is more likely to be effective, and help maintain a positive professional relationship with the member of staff concerned. Such an approach is characterised by a spirit of genuine enquiry. For example, *"I am sure you subscribe to our organisational values, so help me understand how you came to behave in a way which is not in keeping with those, so that we can understand what actions or support you might need so that we can both be confident that it will not happen again..;"*

(e) any such conversation should include being clear with the individual as to why their behaviour is concerning, problematic or inappropriate, what change is required in their behaviour, enquiring what, if any, support they might need in order to achieve and maintain that, and being clear about the consequences if they fail to reach the required standard or repeat the behaviour in question. Ongoing and transparent monitoring of the individual's behaviour may be appropriate. An action plan or risk assessment which is agreed with the individual, and regularly reviewed with them, may also be appropriate;

(f) some low-level concerns may also raise issues of misconduct or poor performance. The Safeguarding Lead should consider whether this is the case – taking into account any advice from the LADO, and consulting HR on a no-names basis where necessary – and, if so, to refer the matter to HR. Any such referral should be made by the Safeguarding Lead having received the low-level concern and not by individual staff members. Equally, it is essential that there is close liaison and appropriate information sharing between the Safeguarding Lead and HR, so that an holistic view of the individual can be taken. Where a low-level concern does not raise misconduct or poor performance issues, it will not be a matter for HR;

(g) as explained earlier in this guidance, an organisation's written low-level concerns policy should apply to **any** adult working for or with the organisation – so that low-level concerns can be self-reported by and/or shared about them. However, how an organisation then responds to a low-level concern may be different depending on the individual who is the subject of the concern's employment status with that organisation (i.e. whether an employee, worker, self-employed, contractor, Governor, Trustee, Director or volunteer). The organisation's response will need to be tailored accordingly, in respect of which they may wish to seek specialist legal advice;

(h) some concerns may trigger the organisation's disciplinary, grievance or whistleblowing procedures, which should be followed where appropriate. Where low-level concerns are raised which in fact require other internal processes to be followed, it is sometimes difficult to determine how best to investigate the concern and which procedure to follow. Organisations should exercise their professional judgement and, if in any doubt, they should seek advice from other external agencies including the LADO;

37 Miller, W. R. and Rollnick, S. (1991) *Motivational interviewing: Preparing people to change addictive behaviour*, New York: Guilford Press

(i) if HR advise that the organisation's disciplinary procedure is triggered, organisations **must** ensure that the individual has a full opportunity to respond to any factual allegations which form the basis of a disciplinary case against them. If an organisation ultimately disciplines or dismisses a staff member for cumulative alleged 'breaches' of the Code of Conduct which were not brought contemporaneously to the individual's attention, and to which they have not had a proper opportunity to respond, clearly there will be a lack of fairness and the risk of a finding of unfair dismissal by an Employment Tribunal.

Staff therefore need to be trained to understand that when they share what they believe to be a low-level concern, the Safeguarding Lead will speak to the adult who is the subject of that concern – no matter how 'low' level the concern may be perceived to be, to gain the subject's account – and to make appropriate records (see 8.20 and 8.21 (e) above), which may be referenced in any subsequent disciplinary proceedings.

8.22.3 **However, if it is decided that the current concern:**

- in and of itself is sufficiently serious (and perhaps having followed consultation with the LADO (and on a no-names basis if necessary)), **then it should be referred to the LADO;**
- **when considered with any other low-level concerns that have been shared about the same individual, should be reclassified as an allegation**, then the allegation should be dealt with in accordance with the organisation's Safeguarding Policy or, if separate, Managing Allegations Against Staff Policy, and Part 4 of KCSIE (which, whilst applicable to schools and colleges, also constitutes best practice for other organisations; all organisations (including schools and colleges) will, in any event, be required to comply (in all matters relating to safeguarding) with the relevant procedures stipulated by their Local Safeguarding Partnership (formerly LSCB).

9. How should low-level concerns be held?

9.1 Whereas KCSIE requires schools and colleges to keep allegations on staff personnel files unless they are malicious, no guidance exists, in KCSIE or otherwise, on the storing of records relating to low-level concerns.

9.2 Organisations should retain all records of low-level concerns (including those which are subsequently deemed by the Safeguarding Lead to relate to behaviour which is entirely consistent with the Code of Conduct) in a central low-level concerns file (either electronic or hard copy). Where multiple low-level concerns have been shared regarding the same individual these should be kept in chronological order as a running record, and with a timeline alongside (an example of which is appended at **Appendix F**). These records should be kept confidential and held securely, with access afforded only to a limited number of individuals such as the Safeguarding Lead, and the individual they report to (e.g. headteacher/CEO); and senior HR officer, and the individual they report to (e.g. Head of HR).

9.3 The Safeguarding Lead may store the central low-level concerns file with his/her other safeguarding and child protection records. The rationale for storing such records on a central file, rather than in staff members' personnel files, is that (a) it makes it easier to (i) address possible issues referred to at 8.22.1(c), and (ii) review the file and spot any potential patterns of concerning, problematic or inappropriate behaviour; and (b) it reassures staff and encourages them to share low-level concerns.

9.4 Some low-level concerns may also involve issues of misconduct or poor performance, or they may trigger an organisation's disciplinary, grievance or whistleblowing procedures. Where these issues would ordinarily require records to be made and retained on the staff member's personnel file, this should be done in the normal way, in addition to the records of the low-level concern(s) being retained in a central low-level concerns file.

9.5 If a low-level concern in and of itself is deemed to be serious enough to consider a referral to the LADO and, perhaps following consultation, a referral is made to them, then records relating to the low-level concern should be placed and retained on the staff member's personnel file.

9.6 If a low-level concern (or group of concerns) is re-classified as an allegation, all previous records of low-level concerns relating to the same individual should be moved from the central low-level concerns file to the staff member's personnel file, and retained in accordance with Part 4 of KCSIE – which requires schools and colleges to

produce a clear and comprehensive summary of all allegations (except those which are found to have been malicious), details of how the allegation was followed up and resolved, and a note of any action taken and decisions reached, to be kept on the confidential personnel file of the staff member, and a copy provided to them.

10. Should the central low-level concerns file be reviewed?

10.1 The Safeguarding Lead should review the central low-level concerns file periodically to ensure that all such concerns are being dealt with promptly and appropriately, and that any potential patterns of concerning, problematic or inappropriate behaviour are identified. A record of these reviews should be made.

11. How long should records of a low-level concern be kept?

11.1 KCSIE does not provide guidance on the retention of low-level concerns. In our view, therefore, low-level concerns should be retained on an organisation's central low-level concerns file unless and until further guidance provides otherwise.

11.2 However, when a staff member leaves and/or takes up new employment, that creates a natural point at which the content of the file may be reviewed to ensure it still has value (either as a safeguarding measure or because of its possible relevance to future claims), and is therefore necessary to keep.

12. Should a low-level concern be referred to in a reference?

12.1 KCSIE prohibits schools and colleges from referring to unsubstantiated, malicious or false allegations in references. No guidance exists in this context, in KCSIE or otherwise, on the treatment of low-level concerns.

12.2 If other organisations follow KCSIE as best practice, low-level concerns should not be referred to in references unless they relate to issues which would ordinarily be included in a reference, for example, misconduct or consistent poor performance. It follows that a low-level concern which relates exclusively to safeguarding (and not to misconduct or poor performance) should not be referred to in a reference. In our experience, this has been important in ensuring an open and transparent culture with staff.

12.3 However, where a low-level concern (or group of concerns) has met the threshold for referral and found to be substantiated, it should be referred to in a reference.

12.4 KCSIE states that allegations which are proven to be false, unsubstantiated or malicious should not be included in employer references. Likewise, a history of repeated concerns or allegations which have all been found to be false, unsubstantiated or malicious should also not be included in any reference.

12.5 Since KCSIE is only applicable to schools and colleges, other organisations are not so constrained as to the content of references, but they should remain aware of their legal obligations and duty of care in giving accurate references.

13. What is the role of the Governance Body (to which a written low-level concerns policy should also apply)?

13.1 The Safeguarding Lead should regularly inform the Governance Body about the implementation of the low-level concerns policy and any evidence as to its effectiveness. For example, by including reference to it in any safeguarding reports, and providing any relevant data.

13.2 The Governance Body should also review an anonymised sample of low-level concerns at regular intervals, in order to ensure that these concerns have been responded to promptly and appropriately.

14. Conclusion

Our belief that there is a need for a revised national approach – as set out in our guidance – in organisations which work with children across all sectors – is not based on theory. We certainly do not need any more serious case and practice reviews to decide how best to address concerning, problematic or inappropriate behaviour by adults towards children. There is now more than sufficient empirical evidence to justify the implementation of a formal written low-level concerns policy by organisations which work with children across **all** sectors, and fact that the recording of such concerns is essential in practical terms to ensure effective and informed safeguarding. If implemented and used successfully, it should promote a healthy, informed and more effective protective culture.

APPENDICES

Appendix A

Table of key features of 15 cases of child sexual abuse in organisational settings

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

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

Education Sector[38]

Case and source of information	**1. Vanessa George** Not for profit nursery (UK) for children aged 2+ and babies under 1 year. Plymouth Safeguarding Children Board (2010) *Serious Case Review re Nursery Z*. Plymouth, Plymouth Safeguarding Children Board.
The perpetrator	Female nursery worker. Aged 39 when sentenced in 2009. *Known* to have abused babies and children between late 2008 and June 2009. Concerns about Mrs. George's behaviour were raised from late 2008 (she joined the nursery in 2006). Took indecent images of, and sexually abused children at, the nursery where she worked. Sent images of herself abusing children at the nursery to a male who she met over the internet. She did not meet him in person until their trial. A popular member of staff who was described as having changed around the time of the commencement of the abuse. Initially described by the community as happy and bubbly. The SCR states "Although she was not senior in her position, other factors such as her age, personality and length of service could have created an illusion of position of power and encouraged a sense of trust." (Paragraph 5.2)
Known victim(s)	Babies and children under school age – exact ages unknown. Police were unable to identify victims. Victims were too young to report the abuse.
Colleagues	Staff noted changes from December 2008 when Mrs. George started to talk about chasing men and sexual encounters. Mrs. George was noted to not use general nappy changing areas but to use cubicle with full door. Mrs. George justified this on the basis that she could not bend to change nappies. Mrs. George's physical bulk blocked line of sight of her activities. Mrs. George's position of power within the staff group was such that although staff became increasingly concerned about her crude language, discussion of extra-marital relationships and showing indecent images of adults on her phone, they felt unable to challenge her. It is possible that staff believed they had "allowed" the abuse to happen as they had been drawn into her discussions about adult sexual behaviours but had not known how to raise this with others. A student on placement was described as being petrified of the nursery manager, which may have been indicative of the culture of the nursery.

Continued on next page

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

Education Sector[38]

Organisational culture	Staff described the nursery as dirty, depressing and demoralising. There were poor recruitment practices. Roles and boundaries were not clear. Roles of Trustees were not clear. The nursery complaints procedure was not clear. Cliques within staff made it difficult to report or act. There was poor recording of incidents and follow up. There were no whistleblowing procedures nor advice around e.g. nappy changing etc. The ratio of staff to children was frequently breached, allowing Mrs. George more opportunities to be alone with a child. A review of records and staff interviews made it clear that the nursery was not able consistently to provide a safe, positive environment for the children in its care. Staff had little or no knowledge of sexual abuse or offending.
Family and community	Parents thought the manager was the owner of the nursery, which was not the case. Governance arrangements were poor. Parents did not know how to make a complaint. Parents and nursery workers socialised together – blurring boundaries. The nursery manager was also a Governor of the school that the nursery was associated with, and a foster carer, meaning the community expected that she would understand safeguarding, which in turn made it more difficult to challenge the ethos of the school.

Education Sector[38]

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

Education Sector[38]

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

Education Sector[38]

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

Education Sector[38]

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

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

Education Sector[38]

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

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

Education Sector[38]

Case and source of information	**7. Laurie Elizabeth Softley** State Secondary (Academy). Teacher Regulation Agency (TRA) Professional conduct panel outcome November 2018. https://www.derbytelegraph.co.uk/news/derby-news/lifetime-classroom-ban-ecclesbourne-sex-2409856.
The perpetrator	Female music teacher. Aged 34 when prohibited from teaching. The CPS took the decision not to prosecute. Known to have sexually abused a 17-year-old male pupil in 2008 (on more than one occasion), and a second 17-year-old male pupil in 2013 (on more than one occasion). Both cases of abuse were arranged via social media, and involved alcohol and visits to Ms. Softley's home. An investigation was conducted and Ms. Softley was given a final written warning in September 2008. Rumours then existed in school about Ms. Softley's behaviour from 2013. A report in the Derby Telegraph newspaper suggests the behaviours involved swearing and being drunk in charge of an international trip. Comment was made in the TRA conduct panel's recommendations to the Secretary of State regarding Ms. Softley's disciplinary record at the school "Whilst the factual background to these incidents is separate and different to the proven allegation, the panel considers that this history is indicative of previous failures to act in accordance with required standard of conduct."(P.12). The panel found little or no evidence that Ms. Softley had any insight into her actions.
Known victim(s)	Two male pupils. Pupil A, aged 17 in 2008. Pupil B, aged 17 in 2013. Pupil B disclosed in 2017 that Ms. Softley had engaged in sexual activity with him, leading to a police investigation.
Colleagues	In 2013 a teacher overheard pupils discussing rumours of an inappropriate relationship between Ms. Softley and pupil B.
Organisational culture	A final written warning for gross misconduct was given in September 2008 regarding pupil A – following Ms. Softley's admission in a police interview that sexual activity had occurred between her and pupil A. In 2013, an investigation took place regarding pupil B but both he and Ms. Softley denied it. Accounts were sought from other pupils at the school but no direct evidence was found and the matter was closed.
Family and community	Pupils allegedly joked that "She'll buy you a drink – and apparently she'll do more than that." Pupil B said that when she picked him up in her car she was uncoordinated and missed the gears. Pupil B had heard rumours that she had "slept with the lads in the years above me." Whilst at the school Ms. Softley had 'transformed' the music department and was described as a perfectionist.

Sports and Leisure

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

Sports and Leisure

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

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Sports and Leisure

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

Sports and Leisure

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

Health Professionals

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

Health Professionals

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

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

Other Settings

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

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Other Settings

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

Other Settings

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

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Other Settings

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

Other Settings

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

Appendix B

Examples of low-level concerns, and to illustrate the boundaries between low-level concerns and allegations

These examples are not exhaustive, nor will the responses set out below be appropriate in every context. This is because determining the appropriate response to any low-level concern is highly context-specific and depends on a range of factors. The purpose is not, therefore, to provide a template response to any given low-level concern. Rather, it is intended to stimulate discussion, and to provide examples of low-level concerns that might be shared with an organisation, as well as a situation in which low-level concerns might cumulatively amount to an allegation, as well as to illustrate the boundaries between low-level concerns and allegations.

1. Low-level concern shared in a school context responded to under disciplinary procedure

A female teacher aged 38 consumes a large quantity of alcohol at the end of term party. The teacher persuades a 21-year-old male student PE coach, who is on a placement, to join her in some selfies, where they appear to be kissing each other. She posts the photos on her Facebook account which elsewhere identifies the school.

A colleague sees the photos and shares their concern about this verbally with the school's Designated Safeguarding Lead (**DSL**), who makes a record of the information. The DSL shares the concern immediately with the Head.

The DSL reviews the Facebook photographs and speaks with the teacher concerned, who is very embarrassed and apologetic, and agrees to remove the photographs and apologise to the student PE coach.

The DSL considers this to constitute a low-level concern and, as such, does not make a referral to the LADO (given it is not considered to meet the threshold of an allegation). The DSL makes a record of the information initially shared with her, and her conversation with the teacher, and retains the record in a central low-level concerns file. Given the misconduct concerns, the DSL also refers the matter to the HR manager.

The HR manager invokes the school's disciplinary procedure. The teacher admits the allegation of inappropriate social media use, and the teacher is issued with a formal warning, a record of which is kept on her personnel file. If the teacher were to leave before the expiry of the formal warning this should be referred to in any reference in the normal way.

2. Low-level concern shared in a charity context resulting in further training

Mr. Simpson, a volunteer for a charity that provides support for vulnerable children, is part of a group of volunteers accompanying a class of reception age children from a local school on an outing to a local park. During the outing, Mr. Simpson is seen on the edge of the group talking to a child who is on his own for a significant period. He also sits with the same child during lunch, and is seen speaking to the child later in the day when waiting for the parents to collect him. Another volunteer speaks to the charity's Safeguarding Lead (**SL**) about this, as it did not sit comfortably with them, and the SL makes a record of the information shared as a low-level concern.

The SL asks to speak to Mr. Simpson and, during their conversation, asks if he was aware of any behaviour which may have caused any possible concern whilst he was on the outing. Mr. Simpson explains that the child in question was "having a bad day," and he felt he needed some extra support and, new to volunteering, had not come across a situation like this before. He is horrified to hear that someone was concerned about his behaviour.

The SL considers this to constitute a low-level concern and, as such, does not make a referral to the LADO (given it is not considered to meet the threshold of an allegation). The SL also arranges some further training for Mr. Simpson and all the other volunteers. The SL retains a copy of the relevant paperwork (including the SL's record of their initial conversation with the volunteer, and with Mr. Simpson, and of the subsequent action taken) in a central low-level concerns file.

This one-off low-level concern should not be referred to in any reference.

3. Low-level concern in a school context dealt with by management guidance

Several pupils, male and female, in Year 6, approach their Head of Year to say that they feel uncomfortable around Mrs. Brown because she 'touches' them, and they don't like it. When asked if they can explain a little more about what they mean, the pupils tell their Head of Year that Mrs. Brown puts her hands on their shoulder when she is talking to them, and sometimes sits at their table in such a way that their legs touch.

The Head of Year immediately makes a record of their conversation with the pupils, which they promptly share with the school's DSL. The DSL shares the concern immediately with the Head.

The DSL asks to speak to Mrs. Brown, who explains that she is working in very cramped conditions, especially with a group of Year 6 boys who have grown so much that they take up all the space around the table, and that she sometimes puts a hand on the shoulder to get a pupil's attention.

The DSL explains that they understand this is making pupils feel uncomfortable, and refers Mrs. Brown to the school's policy regarding appropriate touch. The DSL then plans for the Year 6 class to use a different room where there is more space.

The DSL considers this to constitute a low-level concern and, as such, does not make a referral to the LADO (given it is not considered to meet the threshold of an allegation). The DSL retains a copy of the relevant paperwork (including the Head of Year's record, and the DSL's record of their conversation with Mrs. Brown, and of the subsequent action taken) in a central low-level concerns file.

This one-off low-level concern should not be referred to in any reference.

4. Self-report of a low-level concern in a sports club context

Mr. Oliver is a coach at a tennis club, and asks to speak to the SL about an incident that took place the previous evening. He tells the SL that, after a tennis tournament in a nearby town, the parents of Jamie Jones contacted him at the last minute to say that they would not be able to pick him up as they had to deal with an emergency at home. Mr. Oliver offered to take Jamie home in his own car, and the parents were pleased to agree to this.

However, Mr. Oliver subsequently realised that this was in breach of the tennis club's Safeguarding Policy, and Code of Conduct – and he is therefore self-reporting this to the SL, and has filled out the club's low-level concerns form.

The SL is of the opinion that this was the best option available to Mr. Oliver at the time, but reminds Mr. Oliver that, should he find himself in such a situation again in the future, he should seek his line manager's or the SL's prior approval to his proposed course of action.

The SL considers this to constitute a low-level concern and, as such, does not make a referral to the LADO (given it is not considered to meet the threshold of an allegation). The SL retains a copy of the relevant paperwork (including the low-level concerns form completed by Mr. Oliver, and the SL's record of their conversation with him) in a central low-level concerns file.

This one-off low-level concern should not be referred to in any reference.

5. A series of low-level concerns in a school context which result in response under disciplinary procedure

Shortly after the start of the summer term, an initial concern is raised by a teacher with the DSL, that he has seen Mr. Stevens, the choir master, shouting at and deriding the young choristers in his care this week – which has led to a couple of them leaving their practice sessions in distress.

The DSL makes a record of the conversation, and shares the concern immediately with the Head. The DSL decides to contact the LADO, in the first instance, to seek their advice on a no-names basis on how best to respond. The LADO agrees that the behaviour is concerning but advises that the threshold of an allegation has not been met.

The DSL asks to speak to Mr. Stevens and informs him about the concern that has been shared about his behaviour. Mr. Stevens apologies profusely, and tells the DSL that over the past week he has been having a difficult time personally, has not been sleeping well, and has been feeling "a bit upset and short-tempered." However, Mr. Stevens appreciates that his behaviour has not been appropriate, will rectify it, and tells the DSL that he also intends to apologise to the children "for his short-fuse."

The DSL considers this to constitute a low-level concern and retains a copy of the relevant paperwork (including the DSL's record of their conversations with the teacher, the LADO, and Mr. Stevens) in a central low-level concerns file. The DSL also refers the matter to the Head of HR who, considering Mr. Stevens' response, notes the situation and does not consider any further action is required at this stage.

However, within a couple of weeks, the same teacher returns to share further concern with the DSL, having witnessed Mr. Stevens shouting at, and belittling, the young choristers again.

The DSL makes a record of the conversation, and shares the concern immediately with the Head. The DSL contacts the LADO, who advises that whilst they agree that the behaviour is, again, concerning, it still does not meet the threshold of an allegation.

The DSL then asks to speak to Mr. Stevens and informs him about the further concern that has been shared about his behaviour. Mr. Stevens is less apologetic, claiming it's not all his fault and expressing some frustration over the choristers' capability. He recognises that his personal circumstances "have a part to play in this."

The DSL considers this to constitute a further low-level concern, and retains a copy of the additional relevant paperwork (including the DSL's record of their conversations with the teacher, the LADO, and Mr. Stevens) in a central low-level concerns file.

The DSL informs the Head of HR who decides to invoke the disciplinary procedure, which results in Mr. Stevens being issued with a warning which is placed on his file, and a management plan is put in place.

At this point, the warning would need to be referred to in any reference should Mr. Stevens decide to leave the school before it expires.

Later that term, a parent contacts the DSL by email about Mr. Steven's behaviour – once again relating to distress caused by him belittling the choristers, and telling them that they are not fit to be part of the next singing competition that they have been practising for.

The DSL shares the concern immediately with the Head. The DSL contacts the LADO again, who advises that the matter still does not meet the threshold of an allegation but that they are becoming increasingly concerned by Mr. Steven's behaviour.

The DSL speaks again to Mr. Stevens, who states that the complaint is unfounded and has only been made because the parent's child was not selected to be a soloist in the competition.

The DSL considers this to constitute a further low-level concern, and retains a copy of the additional relevant paperwork (including the email from the parent, and the DSL's record of their conversation with the LADO, and Mr. Stevens) in a central low-level concerns file.

The DSL informs the Head of HR who, again, invokes a disciplinary investigation. As part of that investigation, Mr. Stevens is told that the school has consulted with the LADO and, while his behaviour does not meet the threshold of an allegation, the LADO has expressed increasing concern about his behaviour. Mr. Stevens is given a final written warning.

If Mr. Stevens were to leave the school prior to the expiry of the warning, this matter would be summarised in a reference making clear the nature of the concern and the action taken.

6. A series of low-level concerns in a school context which cumulatively meet the threshold of an allegation, and result in referral to LADO

Ms. Crompton is a Teaching Assistant (**TA**) who gives support to children with learning difficulties.

Another TA verbally informs the DSL that Ms. Crompton seems to favour working with some children, and won't always work with the others. The DSL shares the concern immediately with the Head.

The DSL speaks to Ms. Crompton who denies that she has done anything wrong. She says that she does exactly as she is directed by the teaching staff, and has no control over who she works with. The DSL considers that the information disclosed does not indicate any behaviour contrary to the school's Code of Conduct, and that no further action is required.

A few months later, a member of teaching staff verbally informs the DSL that Ms. Crompton sometimes makes excuses to take children out of his classroom to work quietly – and that he has already reminded her that this is against school policy.

The DSL shares the concern immediately with the Head. The DSL speaks to Ms. Crompton, who says that she didn't know it was contrary to the school policy and promises not to do it again. The DSL considers that the information shared is a low-level concern, and retains a record of their conversation with the member of teaching staff who shared the concern and Ms. Crompton, in a central low-level concerns file.

Two weeks later, a third member of staff submits a low-level concern form to the DSL stating that "they cannot be sure but think that Ms. Crompton applies make-up and perfume when she is working with teenage boys, and that her behaviour sometimes seems to cross the boundary."

The DSL shares the concern immediately with the Head. The DSL speaks to Ms. Crompton about this, who says she likes to look and smell nice, and "there shouldn't be a problem with that." She denies specifically applying make-up or perfume when working with teenage boys.

The DSL considers that the latest information shared is a low-level concern but is unsure whether, when combined with the previous low-level concern, the allegation threshold has been reached. The DSL contacts the LADO to discuss the two instances. The LADO advises that the threshold of an allegation is not met.

The DSL retains a record of their conversations with the member of staff that shared the concern, with Ms. Crompton and the LADO in a central low-level concerns file.

Six months later, a 17-year-old boy tells his Head of Year that Ms. Crompton always stands near the door of the changing room when they go swimming, and that she has her mobile phone with her. He thinks she may have taken some photos of them all, and of his friend Tom in particular. The Head of Year submits a low-level concern form to the DSL.

The DSL immediately informs the Head. The DSL recognises that the information shared by the Head of Year constitutes an allegation, and makes a referral to the LADO, referring to the allegation and the two previous low-level concerns.

The LADO decides that this pattern of behaviour meets the threshold for a strategy meeting and further investigation. Ms. Crompton is suspended pending an investigation but immediately resigns.

The investigation should continue notwithstanding the resignation, and a conclusion should be reached in the same way as if Ms. Crompton had continued in employment. If the allegation is substantiated it should be referred to in a reference, and consideration given to whether to refer to the Disclosure and Barring Service and Teaching Regulatory Agency.

If the investigation determines that the allegation is unsubstantiated, malicious or false, it should not be referred to in a reference.

7. An allegation in a school context with no history of low-level concerns, which leads to referral to LADO

A male pupil aged 14 tells his form tutor that Mrs. Appleby, the chemistry teacher, has hurt him. He shows the tutor a red mark around his neck. When the tutor asks him what happened the pupil says that Mrs. Appleby had shouted at him, telling him that he should not be wearing a neck chain at school, Mrs. Appleby then approached the pupil telling him that he must take the neck chain off immediately – when he hesitated to do so Mrs. Appleby then grabbed the chain and pulled him to his feet. It is clear from the marks on his neck that force has been used and the boy is upset.

The form tutor records what the boy has said, and asks him to come with him to speak to the DSL. Mrs. Appleby has been at the school for five years and there have never been any previous concerns raised about her. The DSL immediately informs the Head, who decides that this is an allegation of physical assault which reaches the threshold, and the DSL contacts the LADO. The LADO advises that consideration is given to suspending Mrs. Appleby. The LADO also advises that they contact the police and that a strategy meeting will be held. The school is advised by police to ask pupils in the lesson that day to each write an account of what happened in that lesson. As a result, more witnesses come forward, and their accounts corroborate what the pupil said.

The DSL refers the allegation to the Head of HR who decides to suspend Mrs. Appleby (as a neutral act pending further investigation because, if true, the allegation amounts to gross misconduct). The Head of HR initiates an investigation. Mrs. Appleby denies using force, but a number of credible witnesses confirm the male pupil's account. Mrs. Appleby is found to have committed gross misconduct and is summarily dismissed. The school refers the case to the Teaching Regulatory Authority.

The school subsequently receives a reference request for Mrs. Appleby to work as an assistant librarian. The school refers to her dismissal for gross misconduct, and accurately reflects the circumstances surrounding it, in its reference.

Appendix C

Diagram 1: Spectrum of behaviour

Allegation

Behaviour which indicates that an adult who works with children has:

- behaved in a way that has harmed a child, or may have harmed a child;
- possibly committed a criminal offence against or related to a child;
- behaved towards a child or children in a way that indicates they may pose a risk of harm to children.

Low-Level Concern

Any concern – no matter how small, even if no more than a 'nagging doubt' – that an adult may have acted in a manner which:

- is not consistent with an organisation's Code of Conduct, and/or
- relates to their conduct outside of work which, even if not linked to a particular act or omission, has caused a sense of unease about that adult's suitability to work with children.

Appropriate Conduct

Behaviour which is entirely consistent with the organisation's Code of Conduct, and the law.

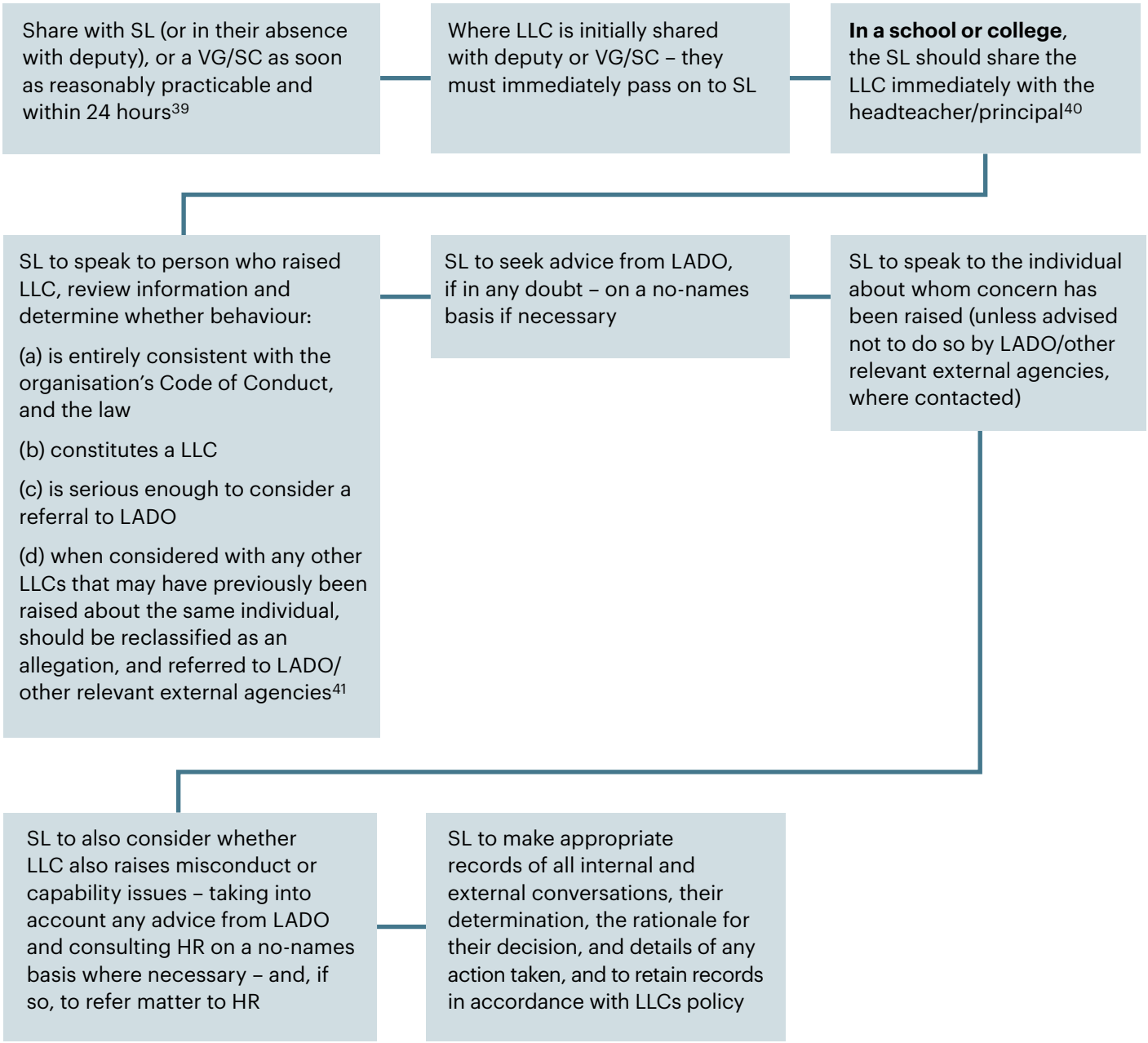
Appendix C

Diagram 2: Sharing low-level concerns (LLCs) – action required by staff, safeguarding lead (SL), values guardians (VGs)/safeguarding champions (SCs)

If member of staff has what they **believe** to be a **LLC** – they should take the below action.

If member of staff has an **allegation** – they should follow the procedure in the organisation's Safeguarding Policy/ Managing Allegations Against Staff Policy.

ACTION REQUIRED



39 Where the LLC relates to a particular incident.

40 This is in light of paragraph 50 of KCSIE. If a LLC is in fact shared with the headteacher/principal in the first instance, then they should immediately share the LLC with the SL. Whether a LLC has been shared with the SL or headteacher/principal in the first instance, the SL should remain responsible for all of the relevant actions stipulated in this guidance and this Diagram (unless the headteacher/principal considers, in the particular circumstances, that they should be responsible for any such actions and, if so, they should inform the SL accordingly).

41 And in accordance with the Safeguarding Policy/Managing Allegations Against Staff Policy, and Part 4 of KCSIE and/or relevant procedures stipulated by Local Safeguarding Partnership (or LSCB if not yet transitioned).

Appendix D

Low level-concerns and data protection

1. The overlap between safeguarding duties and data protection in general terms – duties of record keeping, retention and information sharing – is increasingly well-understood by practitioners. It is addressed by the Data Protection Act 2018 (**DPA 2018**), by statutory and non-statutory guidance provisions within KCSIE, and by DfE guidance on Information Sharing.

2. Although we currently have little in the way of specific DPA 2018 guidance from the Information Commissioner's Office (**ICO**) that is tailored to safeguarding practice, and/or the relevant sectors (for example, schools, charities, sports and religious organisations), the ICO's consultation draft **Information Sharing Code of Practice** (published 16 July 2019) does specifically cite safeguarding of children as a "clear example of a compelling reason" for personal data sharing, as well as recognising the role of regular multi-agency information sharing. The ICO has produced its guidance on the processing of special category data, which acknowledges safeguarding as part of its general guidance on "substantial public interest" conditions for processing, and provides a template for the appropriate policy document.[42]

3. Making records where substantive abuse or neglect is reasonably suspected can be comfortably aligned with the principles of data protection law. However, greater difficulties in (a) confirming the applicable lawful processing ground, and (b) balancing the safeguarding interest with personal data rights, are caused where the conduct in question does not in and of itself amount to an allegation but may, nonetheless, constitute concerning, problematic or inappropriate behaviour towards children, and even more so if it is potentially seen and evaluated as part of a pattern.[43]

4. The importance of sharing low-level concerns is explained in the main guidance, and the value to an organisation is dependent on such concerns being shared, recorded and retained over a period of time.

5. However, the issues that we are aware can arise in practice are:

   (a) staff not understanding possible indicators of organisational based grooming, and thus not sharing concerns about it (a training issue);

   (b) a reluctance by staff to share low-level concerns which, depending on the culture of an organisation, can be perceived as a heavy handed or even inappropriate approach;

   (c) uncertainty as to how and where information provided in the context of low-level concerns may lawfully be recorded and used, under what DPA 2018 ground, and how long it may be retained; and

   (d) which principles or exemptions apply to subject access requests to such (personal) data, and related data subject rights around transparency, erasure, and correction.

   As to (d), a common concern is that on-demand access by data subjects will be counter-productive to the intended objective and risks having a chilling effect on the rate of reporting/recording. We have considered reasons why this may not be so in the main guidance (at paragraph 7).

6. The legal and factual backgrounds (including the General Data Protection Regulation EU 2016/679 (**GDPR**)) have been considered in a longer paper by Hugh Davies QC and Owen O'Rorke, intended for consideration by government departments as the basis for potential guidance and, possibly, a case for some class exemption from subject access rules specific to this practice to be introduced in due course by way of statutory instrument. This Appendix addresses the situation as it currently stands (August 2019).

The intention and effect of the current law and guidance (in overview)

7. The DPA 2018 has made express provision, subject to certain conditions, for processing both Special Category Personal Data of a sensitive nature (SPD) and criminal records data where necessary for safeguarding purposes.[44] This provision (made by way of late amendment to the Data Protection Bill in March 2017) defines safeguarding widely as protecting a child (i.e. under the age of 18), or adult at risk, from neglect or physical, mental or emotional harm, or protecting their physical, mental or emotional well-being.[45]

8. In our view, the clear intention of Parliament in the cited DPA 2018 provisions was to clarify the lawful conditions under which safeguarding professionals

42 Information Commissioner's Office (2019) *Special Category Data*, accessed on 25 November 2019 at https://ico.org.uk/for-organisations/guide-to-data-protection/guide-to-the-general-data-protection-regulation-gdpr/special-category-data/

43 A distinction is made in the main guidance between an allegation and a low-level concern, and a definition is given for each.

44 Paragraph 18 of Part 2 of Schedule 1 Data Protection Act 2018 (DPA 2018).

45 The safeguarding condition at paragraph 18 sits alongside other non-consent SPD and criminal data processing grounds in the DPA 2018 of relevance to safeguarding practitioners, whether new or amended from the DPA 1998. These include obligations imposed by law on employers; functions designed to protect the public from seriously improper conduct; standards of behaviour in sport; preventing or detecting unlawful acts; safeguarding the welfare of those at economic risk; providing support for individuals with a particular disability or medical condition by dedicated not-for-profits; and administration of accounts used in the commission of indecency offences involving children.

operate, and to remove any perceived barriers in data protection law for organisations in keeping children safe. This may be seen in both the new derogations from GDPR, and certain additions or amendments to the sector-specific provisions of the old Data Protection Act 1998 (**DPA 1998**).

9. However, the DPA 2018 has not released organisations or practitioners in this sector from the burdens imposed by GDPR in respect of data subject rights, transparency or accountability more generally. Indeed, the DPA 2018 has provided for some additional safeguards (such as the need for an "**appropriate policy document**" – see further, below) as part of the general requirement on organisations to map out and document the lawful basis for their personal data processing activities. This is all in line with the GDPR requirement that any such national derogations still respect the essence of the right to data protection.

10. The committee's experience is that many organisations, and many individual practitioners, are still uncertain as to how their responsibilities for safeguarding children sit with their obligations under data protection law. Although the DPA 2018 does substantially more to assist practitioners than the DPA 1998 did, the alarmist media coverage of GDPR has left many with the impression that the task of record-keeping and information sharing has got harder since 25 May 2018. This is true to some extent, in terms of administrative burden and the pro-active need to demonstrate compliance, but proving the underlying lawfulness of any processing necessary for safeguarding is now easier than before.

11. Two opposing schools of thought can often be observed among practitioners since GDPR:

(a) one is to believe that "because of GDPR", organisations should not collect, record or share certain information without consent; must delete records routinely; and are under a duty to amend or delete records when so requested by a data subject;

(b) the opposing view that, because child protection "trumps" data protection, safeguarding practitioners are exempt from or can safely disregard GDPR, and/or that safeguarding records are exempted from data subject rights.

12. Of these two, it is clear that (a) – a misguided excess of caution – carries the greater risk to children. However, to disapply data protection law altogether goes against the essence of individual privacy rights, erodes necessary checks and balances, and places organisations at regulatory risk. Additionally, better-prepared organisations who have audited their approach will be better placed to deal with subject access and erasure requests.

13. An area where we believe specific guidance and reassurance is required is in the approach to the recording of potentially valuable information about adults or children – whether by sharing low-level concerns or self-reporting – that does not meet the threshold of an allegation requiring referral to statutory agencies.

The tensions between low-level concerns policies and data protection law

14. Since the DPA 2018 there ought to be little or no tension between the application of data protection law to safeguarding information and the needs, or efficacy, of accepted safeguarding practice. When it comes to sharing and recording low-level, however, there are more nuanced and marginal balancing acts for data controller organisations to consider.

Legal basis for processing

15. In legal terms, not all the personal data that might be recorded as a low-level concern (e.g. small changes in behaviour, favouritism etc.) would necessarily constitute special category personal data (SPD) in isolation. However, it is prudent to consider that all information recorded to a safeguarding file, in a safeguarding context, should be treated as SPD.

16. The effect of GDPR is that, to process SPD, a data controller must satisfy both a condition under Article 6 GDPR and one under Article 9 GDPR. It is not the purpose of this guidance to consider every possible scenario applicable to practitioners, but it seems likely that for the former most data controllers will be relying on Article 6(1)(f) – namely, that processing is necessary in their (or another's) legitimate interests.

17. For the Article 9 condition, the DPA 2018 safeguarding provision works as follows. The necessity of "safeguarding of children and individuals at risk" (including from emotional, physical or sexual abuse and neglect) is a condition under which individuals or organisations are permitted to share, record or otherwise process SPD, even in circumstances where the person to whom such SPD relates has not explicitly (or otherwise) consented to the information being shared. That is provided that:

(a) to obtain explicit consent could not reasonably be expected of the controller, or is not possible, or might risk undermining the safeguarding purpose;

(b) the use of such personal data is necessary for such a safeguarding purpose in the substantial public interest; and

(c) the person or organisation relying on this ground can point to an "appropriate policy document" (see again below) setting out both how its needs meet the relevant condition, and explaining its policy on retention.

18. The EU and UK case law is clear[46] that in this context, both for 17 and 18(b), the word "necessary" does not require that a certain action is absolutely necessary, nor the only means to achieve a purpose. It is rather a case of what is reasonably necessary, applying EU principles of proportionality: that the use of the personal data clearly supports the purpose, is not excessive nor goes beyond what is reasonably required to fulfil the aim – in this case, the protection of children (or adults at risk).[47]

19. Whilst this does mean that controllers ought to use the least amount of personal data necessary to achieve the aim, it should not mean that controllers have to make any compromise in the efficiency of achieving the safeguarding purpose. When applied to low-level concerns policies: if the recording, sharing and retention of the personal data is reasonably held to be necessary in serving a safeguarding purpose, then it ought in our view to fall lawfully within the DPA 2018 condition.

20. There are the following caveats to this rule of thumb:

(a) there may be means for individuals whose personal data is recorded under the policy to object to the processing.[48]

(b) assuming that (in respect of the GDPR Article 9 condition required for the SPD) the data controller organisation is relying on the safeguarding condition under DPA 2018, it must first establish that explicit consent is not possible, or could reasonably be expected, for the controller to obtain without prejudicing the safeguarding purpose; and

(c) depending on the precise scope of the policy adopted by the organisation, the nature of the information held may be borderline in terms of the balance between value to the safeguarding purpose, and personal privacy intrusion – namely, the risk of "gossip" or prurience.

21. Provided that the safeguarding purpose is a valid one and those affected are fully notified of the policy, any difficulty in showing the legal basis can, in our view, be overcome by judicious means of a Data Protection Impact Assessment (**DPIA**) – a self-assessment tool – alongside relevant policies.

22. Beyond the legal basis, however, are the burdens placed on organisations by rules of accountability such as data subject rights and additional "appropriate policy documents".

The need for an Appropriate Policy Document

23. In order to rely on the DPA 2018 safeguarding provision cited above, an organisation must have an "appropriate policy document", demonstrating that it understands how the legal basis applies to it, and setting out their rationale and period for retention. It will need to be in place when the processing is carried out (and for at least 6 months thereafter); reviewed at suitable intervals; and made available on request to the ICO.

24. As part of its November 2019 guidance on the processing of special category data, the ICO has developed an appropriate policy document template, although it highlights that using this exact form is not a requirement.[49] An organisation may choose to have a stand-alone policy, such as the ICO template; or it may prefer to document its use of the safeguarding data processing condition within its existing policies around safeguarding, retention and/or data protection (including any low-level concerns policy). The important point is that these policies are all internally consistent, and refer to each other where relevant.

Retention of safeguarding files

25. A key element of such a policy would be **retention**. In the case of *R (C) v Northumberland County Council [2015] EWHC 2134 (Admin)*, the court:

(a) firmly upheld the data controller council's policy to keep safeguarding records for long periods – not simply to defend historic claims (for which limitation periods may be set aside) or allow the children concerned access in later life, but moreover for the purpose of protecting children;

46 See for example Lady Hale at para. 27 in *South Lanarkshire Council v Scottish ICO [2013] UKSC 55*

47 It is an unfortunate necessity of the DPA 2018 safeguarding ground that it is limited in its application to children (meaning those under 18) or adults with specific care needs, and so organisations that continue to have duties of care to individuals turning 18 may need to identify another legal ground to process relevant special category information about them. However, it may still be adequate if the sharing of information concerning an adult will have a protective function for others: especially where those others are themselves children who might come into contact with them.

48 Depending on the GDPR Article 6 condition relied on by the organisation to process the personal data: e.g. if the organisation is relying on consent that may be withdrawn; or if the processing is conducted under legitimate interests (in which case it must be balanced against any overriding rights or interests of the data subject).

49 Information Commissioner's Office (2019) *Special Category Data*, accessed on 25 November 2019 at https://ico.org.uk/media/for-organisations/documents/2616286/appropriate-policy-document.docx

(b) did not favour any requirement under long retention for regular historic file review, on grounds of "considerable additional burdens" to the "experienced child protection... workers" who are qualified safely to carry them out; and

(c) relevant to both points above, noted: "one of the primary reasons for retention is that information may take on a new significance in the light of later events".

26. Nothing in GDPR or DPA 2018 has changed the position since 2015 in terms of the principles of retention of personal data, or appropriate periods: the new law simply requires organisations to be more transparent and accountable in how this is done.

27. However, organisations lack guidance in understanding what categories of safeguarding record these principles apply to. Do they concern historic case files only; and/or records of low-level concerns, and/or allegations (i.e. that require referral to statutory agencies); or might (indeed should) they apply to other files and records retained for a primary safeguarding purpose but which do not record a low-level concern or an allegation?

28. Related to this question of what constitutes a safeguarding record, guidance is also lacking as to where low-level concerns should be recorded: whether as part of the ordinary child or personnel file; on the child protection or safeguarding file; or in a separate file (most likely still maintained by the Safeguarding Lead). In the context of schools and colleges, the question arises as to whether this would they fall within what should under KCSIE ordinarily be transferred on in the event a child moves schools.

29. Building from paragraph 25(c) above, it is a critical element inherent in records of low-level concerns that they may take on a new significance in the light of later concerns and/or events, and hence must be retained for long periods to have real value. This is the case whether or not the significance is immediately apparent; but any "just in case" retention policy needs to be weighed against:

(a) the possibility of relatively petty or prurient pieces of information being recorded, including by hearsay or through an excess of caution;

(b) the more tenuous relationship such information may have with the legal requirement of necessity set out above, particularly for individuals where no more concerning, problematic or inappropriate behaviours have manifested in the interim; and

(c) the likely discomfort and intrusion staff may feel in knowing that the information is being retained (whether self-reported or shared about them).

30. In addition to protocols (see paragraph 11 of the main guidance), records of low-level concerns may require layered retention periods. For example:

(a) records of low-level concerns as they relate to children (e.g. in a peer-on-peer risk context) or their parents might have limited value once the child has left the care of an organisation, and may come off the file, provided the Safeguarding Lead has taken a view about what needs to be shared with the Safeguarding Lead at the new organisation;

(b) low-level concerns about adults who work with children may continue to have relevance for the length of a working and/or volunteering life, and hence to future employers (etc.); but again organisations need to give careful consideration of whether to refer to any low-level concern in a reference – as discussed in the main guidance.

It is recognised that (a) is not the focus of this guidance, but it is anticipated that the principles may in due course have wider application to all areas of safeguarding practice.

31. We would recommend that, whenever staff leave an organisation (as well as considerations around the giving of references in paragraph 12 of the main guidance), the low-level concerns policy specifies that any record of low-level concerns that may be kept about such person is subject to specific review in terms of:

(a) whether some or all of the information contained within any record may have any reasonably likely value in terms of any potential historic employment or abuse claim so as to justify keeping it, in line with normal safeguarding records practice; or

(b) if, on balance, any record is not considered to have any reasonably likely value, still less actionable concern, and ought to be deleted accordingly.

Culture and Code of Conduct

32. The challenge of getting 'buy-in' from staff about the benefits and application of a low-level concerns policy is not only a necessity for proper practice and a happy and functional organisation, but also a GDPR Article 13 requirement under the transparency principle: data subjects (including staff, children and parents) must be provided with clear information about how their personal data will be collected and for what purpose, and how long it may be held.

33. Our experience is that, properly managed and communicated, staff typically see the benefits in self-reporting (as well as self-training and reflection), as well as the merit in a collegiate culture of sharing low-level concerns about peers where everyone understands the role they play in being watchful and responsible. To mitigate the risk of abusive or malicious sharing, as well as the pain of subject access, records must be fair and neutrally stated. This has to be approached culturally and in training for Safeguarding Leads and other staff.

34. We are further of the view that, even where an apparent concern is not found to be in breach of an organisation's Code of Conduct, this may not extinguish its value as a piece of potentially relevant safeguarding information. If so, it could still be kept on the low-level concerns file: if it is reasonably necessary, justifiable and relevant for a safeguarding purpose, the lawful basis to process it remains.

Data subject rights

35. It is one thing for an organisation to consult with its staff on and implement a low-level concerns policy. It is another to maintain the policy under the burden of data subject rights, in the event that staff object or require disclosure: single objection or erasure may undermine the record's value.

36. **Rights of erasure or objection**. This guidance is not the place for a detailed analysis of the available justifications for refusal; but the summary position with these rights is that they generally can, and therefore ought to be, resisted (as with any other type of safeguarding record) where low-level concerns are shared and recorded fairly and in good faith for a safeguarding purpose.

37. **Right of rectification**. The ICO takes a helpful position in terms of how organisations might deal with complaints about inaccurate information where accounts are disputed: for example, contemporaneous records, recorded in good faith, that might have value notwithstanding that the data subject disputes them. An ICO-approved response in such situations is to include a record of the data subject's objection, or contrary account, alongside the original record in a fair and neutral manner. This way its quality as evidence or information can be properly and fully assessed by those who come to review the file in the future.

38. **Subject access**. The existing ICO Subject Access Code of Practice has not been updated since the DPA 2018, but contains a note stating that it will be soon. It is to be hoped that among those new points considered will be the new Child Abuse Data exemption (see paragraph 39a below), along with issues for certain practitioners in an education, health or social services context concerning what is termed the "Assumption of Reasonableness" (see paragraph 46 below).

39. The subject access exemptions most likely to be relevant (albeit that they should not be assumed to apply in a blanket manner) are:

(a) the rule against needing to disclose confidential references;[50]

(b) the Child Abuse Data exemption,[51] where a person with parental responsibility has made the request on behalf of a person under 18 (with or without the child's authority, depending on the age and maturity of the child) but the personal data consists of information as to whether that child may be at risk of, has been or is subject to child abuse (widely defined to include sexual abuse, physical and emotional neglect, ill-treatment, and non-accidental physical injury) and the data controller deems that disclosure would not be in the child's best interests. However, this only applies in that narrow context (i.e. protecting a child as against a parent) and not more generally (e.g. to deny another adult access to their own personal data to protect a child);

(c) if the matter concerns education, social services or medical data[52] and disclosure risks "serious harm" to any individual (a high bar);

(d) where the organisation performs certain functions designed to protect the public (e.g. from seriously improper conduct or unfitness; or where those at work may pose a risk to the health or safety of other persons), but only where disclosure is likely to prejudice the proper discharge of that function;[53] and

(e) if any third-party privacy rights[54] can be argued (notably those of the child) – but only to the extent they would be identifiable in relation to their own personal information in the particular record concerned, by context or otherwise. In other words, this exemption

50 Paragraph 24 of Part 4 of Schedule 2 DPA 2018
51 Paragraph 21 of Part 5 of Schedule 3 DPA 2018
52 See throughout Parts 3 and 4 of Schedule 3 DPA 2018
53 Paragraph 7 of Part 2 of Schedule 2 DPA 2018. Please note this exemption is not easily applied to all organisations with safeguarding responsibilities: they need not be public bodies, but the function must be of a public nature and in the public interest. It is also the ICO's view, although this is nowhere in statute, that the function should be the core activity of the organisation (i.e. regulatory in nature), and that the exemption should not be used to protect internal grievance, complaint or disciplinary functions.
54 Paragraph 16 of Part 3 of Schedule 2 DPA 2018. Please note this would be of no application if only the adult himself/herself was identifiable from the record, or part thereof, even if there was concern for the safety of a particular child or children. Any separate personal data of the adult would be disclosable.

could apply if more than one person's data could be inferred from how a low-level concern is recorded (even if not explicitly named), unless it were still reasonable in all the circumstances to disclose their personal data to the requester.

40. Contrary to widespread belief in some quarters, however, there is no general "safeguarding record" exemption that could be used to protect records about staff from access by those staff members. Nor, as set out in paragraph 7 of the main guidance, is this in our view needed, for the following reasons:

(a) information that could identify specific children should not be disclosed to staff making subject access requests, and this is quite lawful to withhold under existing rules;

(b) similarly, the identity of the person sharing the low-level concern could also be withheld under subject access, if they have not given their consent to their own data being disclosed to the requester and it is not otherwise reasonable to do so (although it may necessarily emerge in the context of a procedure or claim under employment law). This may not be straightforward, however, if it is likely to be clear in context who shared the low-level concern. The issues here should be made clear in the low-level concerns policy, and may be for the Safeguarding Lead to discuss with the person sharing the low-level concern; and

(c) in our view, the policy reasons in favour of transparency with affected staff about low-level concerns – as well as the need for such concerns to be fair, accurate and (where appropriate) raised directly with the person in question – tend to outweigh any benefits of "covert" recording.

41. If the low-level concerns policy is operating properly, then its contents under a subject access request should not come as a surprise to the person about whom such a concern has been recorded. There may be a risk that a request is made before a low-level concern has been adequately raised with the adult in question: but, as long as the order of things is consistent with the applicable policy, then the controller will be able to make the case for the actions taken.

42. Organisations should not feel unduly burdened by introducing policies intended to assist in the protection of children. This is best approached by transparency, training, and a careful approach to sharing low-level concerns (as also discussed in the main guidance). Equally important, from an employment perspective (both in terms of process and staff trust), is providing clarity about how this information may be used. Collection of such data must be transparent and raised with individuals so that, if necessary, it can be challenged.

43. Properly managed, a low-level concerns policy should not substantially increase the volume burden in subject access. But it is also our experience that, beyond the purely administrative burden, there may be a reluctance to share due to the embarrassment and distress (both to individuals and controllers) that a low-level concerns policy may cause, risking unwarranted reputational damage to individuals. In some organisations this understandable fear may have a chilling effect on the sharing and recording of low-level concerns.

44. However, subject access can fairly be viewed as a necessary form of checks and balances for data controller organisations to record such information fairly and neutrally. Despite the considerable burdens on organisations caused by subject access, there is a strong privacy interest in supporting this right, protected (for the time being at least) in UK law as a fundamental right under Article 8(2) of the Charter of Fundamental Rights of the European Union (EU Charter). The more impactful and personal the information, as here, the greater the need for organisations to be accountable to affected individuals.

45. **Children's rights of access or erasure**. The main guidance focuses on sharing low-level concerns about adults' behaviour towards children, not on concerns being raised about children in a peer-on-peer context, or in assessing their vulnerability. However, should identifiable data about specific children be contained in information held in a record of a low-level concern about an adult's behaviour towards them:

(a) this is something the controller may withhold in respect of a request made by the adult in question; but

(b) this could be disclosable upon request by that child or (depending on age, circumstances, and the child's best interests) someone with parental responsibility for the child.

46. It is worth noting that, in a schools context,[55] the DPA 2018 "Assumption of Reasonableness" has the effect that personal data of staff should not be

55 As well as in other contexts around social care and health. However, this rule currently lacks clarity and should perhaps be treated with caution pending further case law or commentary by the ICO.

anonymised or withheld under a subject access request made by or on behalf of a child in their care, where it would otherwise be disclosable under that child's subject access rights.[56]

47. For this reason, where possible, and unless this would diminish its safeguarding value, low-level concerns recorded as against an adult should be recorded separately from identifying details of the child if organisations (not limited to schools) believe that the staff member in question should fairly and safely be protected from access to their low-level concerns record by parents or pupils.

48. **Data Security**. GDPR more generally requires that data controllers have security measures (both technical and organisational) that are appropriate to the nature of the data and processing. The most critical aspect, given the highly sensitive and potentially damaging nature of the information contained in even low-level concerns, is to maintain and enforce a need-to-know-only access policy. Aside from any rights of access by individuals about whom concerns have been reported (as above), this would be limited to appropriate, trained persons with a specific and appropriate role in the safeguarding team or – potentially – those providing human resources or legal support, where lawful and necessary.

49. All controllers are not alike in resources, but the affordability of readily available password protection and encryption software means that the digital retention and, where necessary, onward sharing of such information should be made adequately secure. Such steps should already be in place for allegations reporting. Within the low-level concerns policy itself, thought must be given to the most appropriate and secure means of sharing concerns by staff with the Safeguarding Lead, or with a values guardian/safeguarding champion, without making it sufficiently difficult as to discourage reporting or self-reporting.

50. This may best be carried out by means of a face-to-face meeting (see paragraph 8.18 of the main guidance), whether or not supported by a form such as that at **Appendix E**. That way, control and oversight of record-keeping can remain with the Safeguarding Lead. When a policy permits forms or concerns to be submitted (by whatever means) remotely, or in total anonymity, this raises more practical challenges in maintaining appropriate levels of security for organisations to consider. Electronic submissions, for example, would be better handled via a secure portal and not by allowing concerns or forms to be transmitted by – or worse, remain on – general email servers.

56 Paragraph 7 of Part 3 of Schedule 2 DPA 2018: this is the rule that there should be a starting assumption that school staff, health workers and social workers can expect no rights of privacy under subject access. However, the limits on its application are unclear and – absent ICO guidance – there is the risk that its literal interpretation would lead to inadequate protection of the rights of these adults.

Appendix E

Example low-level concern form

Low-Level Concern Form

Please use this form to share any concern – no matter how small, and even if no more than a 'nagging doubt' – that an adult may have acted in a manner which:

- is not consistent with [Insert name of the organisation] Code of Conduct, and/or
- relates to their conduct outside of work which, even if not linked to a particular act or omission, has caused a sense of unease about that adult's suitability to work with children.

You should provide a concise record – including brief context in which the low-level concern arose, and details which are chronological, and as precise and accurate as possible – of any such concern and relevant incident(s) (and please use a separate sheet if necessary).
The record should be signed, timed and dated.

Details of concern

Name of staff member: **Department & Role:**

Signed: **Time & Date:**

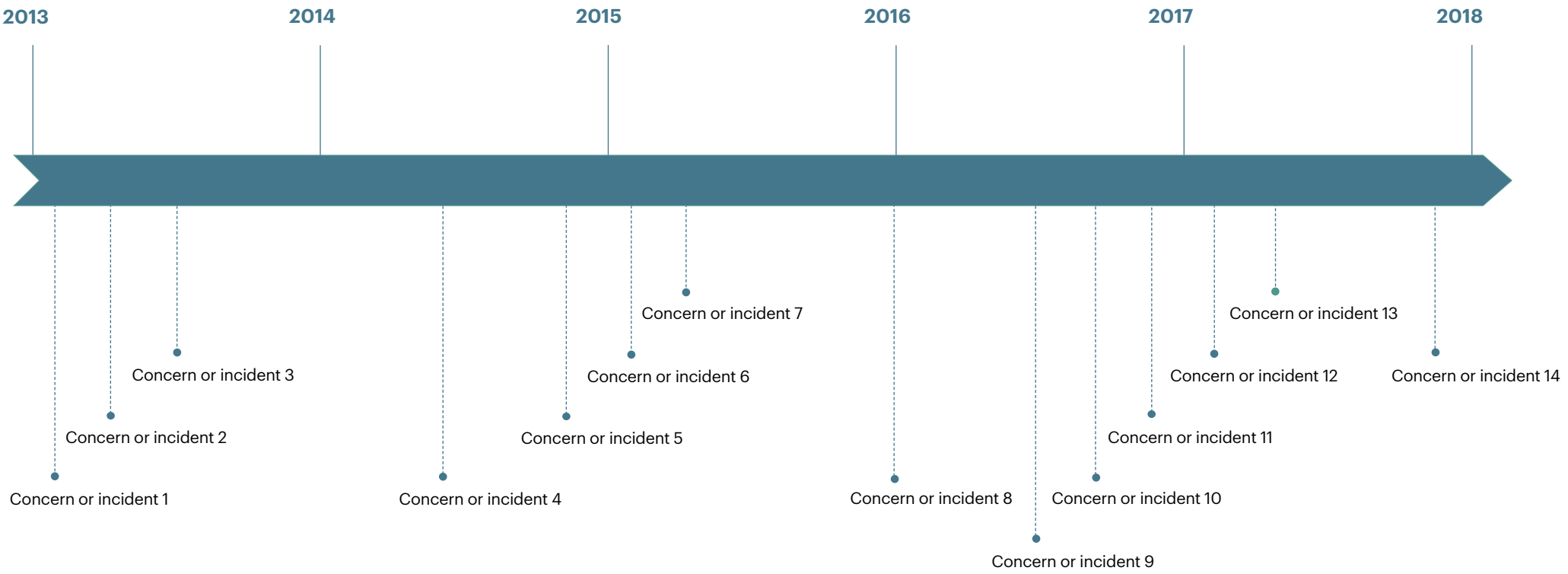
Received by	**At: (Time)**	**On: (Date)**
Action Taken: (Specify)		

Signed:	**Time & Date:**

This record will be held securely in accordance with [Insert name of the organisation] low-level concerns policy. Please note that low-level concerns will be treated in confidence as far as possible, but [Insert name of the organisation] may in certain circumstances be subject to legal reporting requirements or other legal obligations to share information with appropriate persons, including legal claims and formal investigations.

Appendix F

Example timeline where multiple low-level concerns are shared regarding the same individual



Appendix G

Commentary on neutral notifications/low-level concerns questionnaires

Introduction

Following Farrer & Co's role as Secretariat to Hugh Davies QC on his independent review in 2014 arising from the criminal conduct of William Vahey at an international school (the Davies Review)[57] , and one of his principal recommendations regarding 'neutral notifications,' Farrer & Co has assisted a number of schools with introducing a formal policy on sharing low-level concerns (as we now call them) regarding an adult's behaviour towards children, or neutral notifications (as some others refer to them). We have also been aware that whilst some schools may not have introduced a formal policy, they may nonetheless encourage an approach to sharing neutral notifications/low-level concerns.

We believe that there is considerable potential in this context to create a safer environment for children but did not have specific information about the number of schools that are taking an approach to, or have introduced a formal policy on, sharing neutral notifications/low-level concerns, or – other than in a small number of cases – what their experience of this has been to date. The only feedback we had received was largely anecdotal.

In an attempt to understand the position better, and to continue to develop our thinking in this area, Farrer & Co, in conjunction with Marcus Erooga, designed two versions of a questionnaire – one for schools at which an approach is being taken to sharing neutral notifications/low-level concerns (**approach**), and another for schools at which a formal policy exists on sharing neutral notifications/low-level concerns (**policy**). The questionnaires were identical apart from the inclusion of a small number of questions which were specific to the particular questionnaire in terms of the adoption by schools of an approach/policy. These were distributed to all of the school clients and contacts on the mailing list of Farrer & Co's Safeguarding Unit.

A total of **18 schools** responded – 13 of which completed the approach questionnaire (although, as explained below, within that questionnaire a number in fact confirmed that their school has not created an approach), and 5 completed the policy questionnaire.

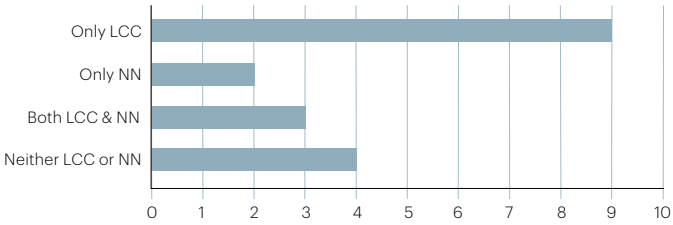
What follows is a discussion of the key findings from those questionnaires. Where there are no significant differences between the two groups of respondents, the commentary relates to all of the questionnaires returned, otherwise the specific group (approach or policy) is indicated. It should be noted that not all respondents answered every question, so where figures are given, the number of respondents to that question is indicated – for example, if only 15 of the 18 total questionnaire respondents answered a particular question, and of those 15 a total of 12 answered 'yes', the result will be shown as 12/15.[58]

Key findings

Terminology – neutral notification or low-level concern

As referred to above, one of the principal recommendations from the Davies Review was the implementation of neutral reporting – referred to by him as 'neutral notification'. However, the term 'low-level concerns' is also now used by some organisations (including schools), as well as by Farrer & Co. As explained in the main guidance, it will be for each organisation to carefully consider which term they consider to be most appropriate according to their particular culture. We strongly recommend that organisations adopt either of the terms, as opposed to both, and that once a decision is made that the term should be used consistently – to minimise the potential risk of any confusion.

1. Does school use the term
(i) low-level concern (LCC);
(ii) neutral notification (NN)?



In our sample, 9/18 schools used the term 'low-level concerns' only, 2/18 used 'neutral notification' only, 3/18 used both terms, and 4/18 used neither term. Three of those did not indicate whether they used an alternative term and, if so, what. The fourth school, which completed the approach questionnaire, in response to the question "If your school uses another term, what is it?" stated "*Concerns that fall below threshold for LADO reporting*. (*More a category than a 'term'!*)"

1 of the 9 schools which only uses the term 'low-level concerns' explained that the rationale for doing so was: "*To encourage an open and strong culture of safeguarding;*" whilst other schools explained that it was due to "*Use of standard terminology. Self-explanatory;*" "*Staff understand what it means;*" and "*Reflects fact that the individual brings this forward.*"

57 Davies, H. (2014) *Southbank International School Independent Review arising from the criminal conduct of William Vahey: Final Report*, London, Farrer and Co, LLP

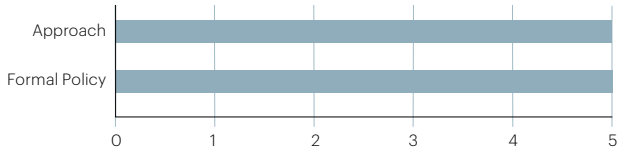
58 Use of percentages has been avoided as with such a small sample they run the risk of 'flattering' the statistics – 1 of 2 respondents is clear, if that is represented as 50% of respondents the picture is potentially distorted.

1 of the 2 schools which only used the term 'neutral notification' commented *"We use the term during training but don't have it written in our safeguarding policy, is the term 'low level' too subjective?...We previously called it 'self-referral' but that had a negative connotation hence the change to neutral notification."* The second school commented *"Neutral is better than LLC because it makes it clear that the notifier is not expected to judge the level of concern. It also makes clear that concerns of any and all kinds are invited to be shared."*

1 of the schools which uses both the term 'neutral notification' and 'low-level concern' stated, in response to the rationale for its choice of term *"Neutral notification conveys what it says on the tin!"*

Approach or policy

2. Has school (i) created an approach to sharing NNs/LCCs; (ii) introduced a formal policy?



Of the **13 out of 18** schools that completed the approach questionnaire, in response to the question on whether they had created an approach to sharing neutral notifications, **5** confirmed they had, and **8** confirmed they had not.

An interesting picture then emerges from the wider data – for example:

› **the 5 schools that confirmed (as above) that they had created an approach, responded to the question on whether they are considering introducing a formal policy and – if so/not – why, as follows:**

- *"Yes...For greater clarity about the sharing and storing of notifications"*
- *"No...It is already integrated in the staff code of conduct, which is a formal policy. That is a good place for it to sit, as often an [sic] NN is considered against behavioural expectations set out in the code"*
- *"No...We have reporting culture – if you see anything that makes you pause and think, you report it on the basis that your concern plus someone else's concern gives us a fuller picture. This is part of our safeguarding policy and applies to concerns about pupils or staff"*
- *"Yes...Because we want to be sure staff recognise [sic] importance and that procedures are clear"*
- *"No...If it is was felt to give real clarity [sic]"*

› **the 8 schools that confirmed (as above) that they had not created an approach, responded to the same question as follows:**

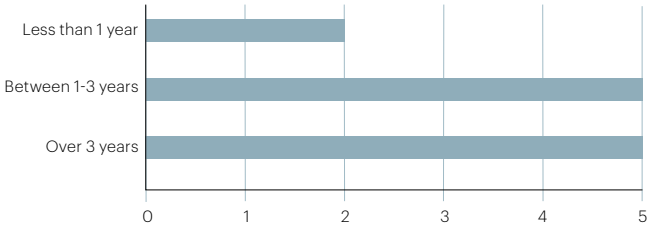
- *"Yes...In order to make it open, transparent and understood by all staff"*
- *"Yes...To make it clear to all"*
- *"Yes...We are aware of the positive benefits of doing so"*
- *"No...Sharing of concerns is already part of culture and built into the Safeguarding Policies rather than a stand alone sharing of concerns policy"*
- *"No...Not at this stage – we would want to be sure that we did not inadvertently create a climate of non-disclosure. We feel we have the opposite at the moment – that staff trust the 'system' in terms of investigating concerns fairly and objectively. We worry that a formal policy would have the unintended consequence of creating a culture of reluctance to come forward for fear of passing on what could turn out to be a false allegation. However, we can see the benefits in using the term 'neutral notification' to strengthen what we already do"*
- *"Yes...To formalise the approach"*
- *"No...It is not no, but ongoing"*
- *"Yes...Prompted by your email"*

Of the **5 out of 18** schools that completed the policy questionnaire, in response to the question on whether they had introduced a formal policy on sharing NNs/LLCs, **all 5** confirmed that they had.

Of these schools, 1 confirmed that their policy is a stand-alone policy, and 4 confirmed that it is contained within their safeguarding policy; none of these schools, therefore, confirmed that their policy is contained within their code of conduct or elsewhere (which were other available options as a possible response).

Implementation

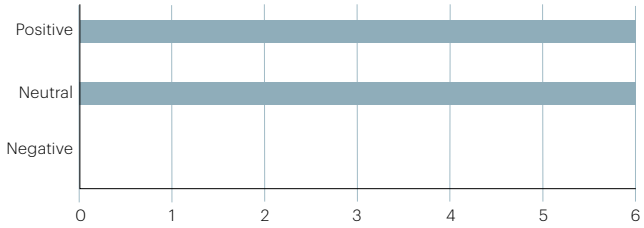
3. Approximate period for which approach/policy has existed



As would be expected, the position varied with respect to the length of time that the schools had either adopted an approach or had a policy in place. For 2/12 it was during the last 12 months,[59] for 5/12 between 1-3 years, and for 5/12 for over 3 years.[60]

Initial reaction by staff

4. Initial reaction by staff to school's proposal for sharing NNs/LCCs



In terms of the initial reaction (largely) by staff to their school's proposal for sharing NNs/LLCs, in schools where a policy exists, 3/5 confirmed it was positive, and 2/5 that it was neutral (with no schools confirming that it was negative); and in schools which responded to the approach questionnaire, 3/7 confirmed it was positive,[61] 4/7 that it was neutral (with no schools confirming it was negative).

Consultation

In schools where a policy exists, 3/3 indicated that they had consulted with staff prior to introducing the policy, and 1 of those 3 also consulted a professional association. Of the schools which responded to the approach questionnaire, 3/3 indicated that they had consulted with staff, and none with a professional association. None of the 6/18 schools which responded to this question across the two questionnaires indicated that they had consulted with a trade union.

Briefing

In schools where a policy exists, 4/5 confirmed that they provided a briefing on the introduction of their policy, and 1/5 confirmed that they did not. Of the schools that provided a briefing, 3/4 confirmed a briefing had been given was given to Governors, teaching staff, and non-teaching staff;[62] while 1/4 gave a briefing only to teaching and non-teaching staff.

Of the schools which responded to the approach questionnaire, 5/8 confirmed that they had provided a briefing prior to the introduction of their approach,[63] whilst 3/8 confirmed that they had not.[64] Of the schools that provided a briefing, 4/5 confirmed a briefing had been given to Governors, teaching staff, and non-teaching staff;[65] while 1/5 gave a briefing only to teaching and non-teaching staff.

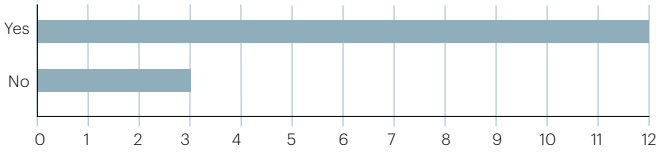
Training

In schools where a policy exists, 4/5 confirmed that initial training had been provided on the policy, and 2/5 confirmed that further training had been provided. Of the schools that provided training, 2/5 confirmed training had been given to Governors, teaching staff, and non-teaching staff;[66] while 3/5 gave training only to teaching and non-teaching staff. 1 of the schools that had provided a briefing on the introduction of their policy confirmed that it only provided further training, which may indicate that it considers the briefing to have constituted initial training; whilst 1 of the schools confirmed that it had not provided a briefing but had provided initial training.

Of the schools which responded to the approach questionnaire, 5/6 confirmed initial training had been given on the sharing of NNCs/LLCs, and 2/6 that further training had been provided.[67] Of the schools that provided training, 1/5 confirmed training had been given to Governors, teaching staff, and non-teaching staff;[68] while 4/5 gave training only to teaching and non-teaching staff.[69] 1 of the schools that had provided a briefing confirmed that it only provided further training,[70] while 1 of the schools confirmed that it had not provided a briefing but had provided initial training.

Clear understanding

5. Do staff in the main have a clear understanding of what type of behaviour may constitute a NN/LCC



59 However, it should be noted that 1 of these schools had responded "no" to the question on whether it had created an approach to sharing neutral notifications/low-level concerns.
60 As above.
61 2 out of these schools had responded '"no" to the question on whether they had created an approach to sharing neutral notifications/low-level concerns.
62 1 of the schools that had confirmed a briefing had been given did not answer this question.
63 1 of these 5 schools had responded '"no" to the question on whether they had created an approach to sharing neutral notifications/low-level concerns.
64 2 of these 3 schools had responded '"no" to the question on whether they had created an approach to sharing neutral notifications/low-level concerns.
65 3 of the schools that had confirmed a briefing had been given did not answer this question.
66 This data does not distinguish between 'initial' and 'further' training.
67 1 of these 2 schools had responded '"no" to the question on whether they had created an approach to sharing neutral notifications/low-level concerns.
68 This data does not distinguish between 'initial' and 'further' training.
69 1 of the 5 schools that confirmed they gave (initial) training did not respond to this question.
70 This was a school that had previously responded "no" to the question on whether it had created an approach to sharing neutral notifications/low-level concerns.

Whether as a result of a briefing and/or training on the schools' approach/policy, or in the absence of either, 12/15 respondents thought that the staff in the main have a clear understanding of what type of behaviour may constitute a NN/LLC, whilst 3/15 did not. There was no discernible pattern related to this.

1 of the 3 schools whose staff did not have a clear understanding had a policy on which staff had been consulted prior to its implementation, and on which there had been no briefing but there had been initial training; in terms of the 2 schools that had completed the approach questionnaire, 1 had confirmed that they have not created an approach and that staff had not therefore been consulted, nor provided with a briefing or training; and the second school confirmed that they have created an approach, the introduction of which had not been preceded by consultation, but on which staff had been given a briefing and initial training.

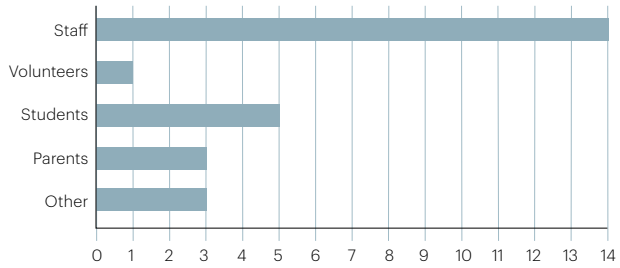
Sharing neutral notifications/low-level concerns

A high proportion of respondents (15/18) indicated that neutral notifications/low-level concerns had been shared regarding the behaviour of other adults working in the school, with 3/18 schools confirming in the negative.

4 out of the 15 schools where neutral notifications/low-level concerns have been shared, have a policy in place, and 3 out of those 15 have an approach. 8 out of the 15 schools which answered the approach questionnaire do not have an approach but have had neutral notifications/low-level concerns shared with them.

Of the 18 schools which responded to this question, 1 school with a policy, and 2 schools with an approach, have not yet had any neutral notifications/low-level concerns shared with them.

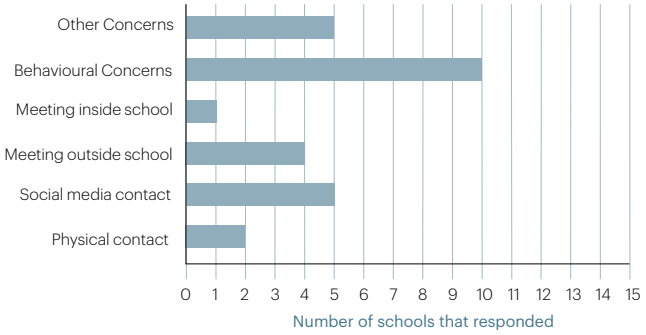
6. Who has shared NNs/LCCs regarding the behaviour of other adults working in the school



15 schools responded to the question on who neutral notifications/low-level concerns have been shared by. The majority of these concerns had been shared by staff – in 14 out of 26 cases, with 5 from students, 3 from parents, 1 from a volunteer, and 3 from other sources.[71]

Main types of behaviour

7. Main Types of behaviour to which the NNs/LCCs that have been shared relate



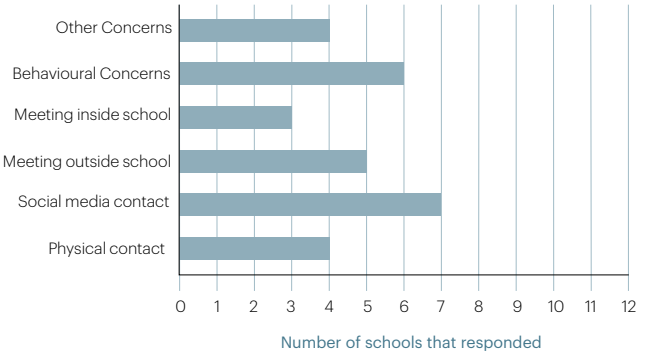
15 schools responded to the question on the main types of behaviour to which the neutral notifications/low-level concerns that have been shared relate. They were able to confirm more than one main type of behaviour, and between them made a total of 27 selections. The most common type of behaviour was stated as being 'behavioural concerns' – selected by 10 schools with social media contact and 'other concerns' next most frequent – respectively selected by 5 schools, with meeting outside school by 4, and meeting inside school by 1.

Schools were asked to specify what 'other concerns' related to, and responded as follows: "Behaviour which is' too matey' with students;" "Misuse of language, inappropriate jokes, behaviour between colleagues;" "Any low-level concerns are logged and considered by the safeguarding team;" "Professionals meetings;" and "Use of personal mobile phone to contact pupils."

Self-reporting

In terms of whether any neutral notifications/low-level concerns had been self-reported, 12/17 schools confirmed 'yes,' 5/17 confirmed 'no,' and 1 school did not respond to the question.

8. Main types of behaviour that have been self-reported



71 Stated by two of the schools as being from the "safeguarding team" and "professionals."

12 schools responded to the question on what the main types of behaviour relate to which have been self-reported. They were able to confirm more than one main type of behaviour, and between them made a total of 29 selections. The most common was stated – by 7 of the 12 schools as being social media contact and the next most frequent as 'behavioural concerns' by 6 schools, meeting outside of school and 'other concerns' was respectively selected by 5, and meeting inside school by 3.

Schools were again asked to specify what 'other concerns' related to, and responded as follows: "*Pre-existing familial/social relationships with pupils/families. Lift shares/Holidays resulting from this;*" *Colleagues coming across students changing in classrooms rather than changing rooms;*" "*Potentially misconstrued occasions/events;*" and "*A girls [sic] changing in the wrong area and a workman seeing her, personal mobile phones for pupil contact, receiving a private letter from a pupil, girls saying 'you're making me feel uncomfortable' [sic] so teacher explaining the scenario. These are a few examples.*"

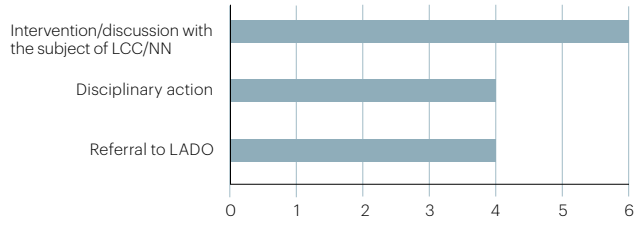
10 schools had received both self-reports and neutral notifications/low-level concerns regarding the behaviour of other adults working in the school.

Outcomes of sharing neutral notifications/low-level concerns and self-reporting

In terms of the outcome of any sharing of neutral notifications/low-level concerns and self-reporting – in respect of which the design of the questionnaires does not allow a distinction to be made – schools were asked whether any safeguarding training requirements for any specific adults, and any patterns of behaviour on the part of any adults had been identified to date; if the answer to the latter was yes, schools were asked whether this had resulted in intervention/discussion with the relevant individual, disciplinary action, or referral to the LADO. 16 of the 18 schools confirmed that neutral notifications/low-level concerns had been shared about others and/or self-reported, the outcome of which included the following:

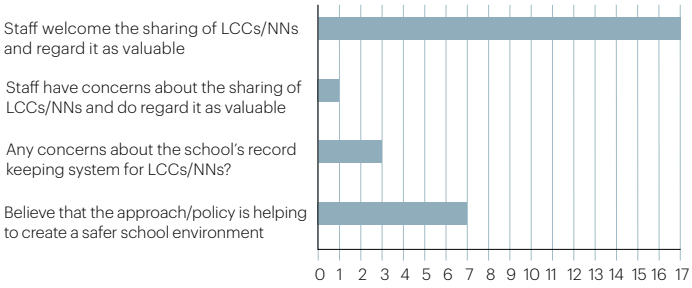
- safeguarding training requirements had been identified in 9 schools (9/18); and
- concerning patterns of behaviour had been identified in 6 schools (6/18), which had resulted in intervention/discussion with the relevant individual at 6 of the 7 schools that responded to the follow-up question (6/7);[72] disciplinary action in 4 of the schools (4/7), and a referral to the LADO in 4 (4/7).

9. Initial reaction by staff to school's proposal for sharing NNs/LCCs



Staff response to the approach/policy

10. Response to school's approach/policy



17/17 respondents confirmed that staff in the main welcome the sharing of neutral notifications/low-level concerns and regard it as valuable, whilst 1/16 indicated that staff in the main have concerns about the sharing of neutral notifications/low-level concerns and do not regard it as valuable.

3/16 have concerns about their school's recording keeping system for neutral notifications/low-level concern.

All 17 of the schools that answered the question confirmed that they believe that their school's approach/policy is helping to create a safer school environment.

Only one school (1/18) reported that they had experienced any malicious/inappropriate use of the approach/policy.

Any further comments or suggestions

In terms of whether the schools had any other comments they wished to make on how the approach/policy is working in practice (for example, whether there are any obstacles to self-reporting and/or sharing neutral notifications/low-level concerns), responses included:

"*Concerns on how LLCs are passed on references. Not stated above but I meet with staff for EVERY single concern raised whether it meets the LADO threshold or not and take a very cautious approach by passing everything via the LADO first. Once I know whether it meets threshold or not I then meet with the member of staff in every case.*"

72 1 of the 7 schools which answered the follow-up question had not been 1 of the 6 which confirmed they had identified concerning patterns of behaviour.

"No – I think all schools should operate NN. Best to introduce in the context of learning from SCRs. [The case of William Vahey which was the subject of the Davies Review] is a powerful example to use, where proper triangulation of concerns could have prevented many children from being abused."

"Having read through this questionnaire I think we do have a system but we don't use the term NN! We will consider whether doing so – with an accompanying formal approach – would strengthen our existing practices."

"We regularly review and refine the approach to reflect school policies [sic] parent feedback, DFE or CSC changes."

"...The culture is shifting and people are becoming more trusting about bringing forward concerns, for example when they perceive that staff might need advice in order to protect themselves from allegations, or when they are concerned that staff are crossing boundaries and behaving inappropriately..."

"I don't think our staff would recognise the formality you imply might exist in reporting a concern. It's just part of what we do to get a context."

"People report things which are not really of concern but potentially could be misunderstood; I take that to indicate that they are comfortable with the process and see it as helpful to them as professionals..."

"Needs to be more widely known. Terminology and thresholds need to be clearer to all."

"There is a degree of bystander apathy, but training is helping with this. Getting people to understand the importance of behaviours and culture has been crucial."

In terms of any suggestions respondents may have had for how the approach/policy could be improved, responses included:

"No except that this has made me consider the approach in my own school; thank you."

"If this is a normal part of a safe culture, and applies to pupils and staff, it is not a threat. We have a self-reporting culture on physical contact as part of that particular policy, to protect staff from allegations and they understand this is in their interests. Staff will report anything they are concerned about, however small and this is mostly done in person. I fill in the form as the DSL, though I have said staff are welcome to. No one has ever taken me up on the form filling. I think person to person is easier, less formal and therefore less threatening."

"We would welcome some exemplar templates/protocols/ training ideas."

"We remind staff annually of the policy in face to face training. We have an 'actions' section on the form [sic] which the DSL makes a note of how we proceed."

"We have made the improvements above this year so none currently but this will be an evolving area I am sure."

A note about the limitations of this methodology

A final note of caution. When considering the results of any research, it is important to bear in mind some important caveats. We think the feedback gained for the questionnaires is valuable, and serves to better inform our understanding about this area. It should be borne in mind, however, that this is a small sample, and that there are a number of potential 'biases.' Respondents are all schools (on Farrer & Co's Safeguarding Unit mailing list), and self-selecting by virtue of having responded. Their experience of using an approach or policy may therefore be different from that of organisations in other settings. It also does not include those schools which, for example, may have implemented an approach or policy, not had a positive experience and do not, for whatever reason, wish to provide information about it.

Whilst none of that invalidates the valuable data gained from this exercise, it does highlight the importance of not generalising the findings from this survey to other settings without careful consideration of their particular context.

Appendix H

Biographies

Adele Eastman, Senior Associate, Farrer & Co

Adele is a Senior Associate in Farrer & Co's Safeguarding Unit. Her expertise is grounded in the two policy reports that she researched and authored for the Centre for Social Justice (CSJ): on educational exclusion, and child protection and mental health.

Adele advises charities (from a UK and overseas perspective), sports organisations and governing bodies, and schools, on wide range of areas including best practice in safeguarding governance, safer recruitment, organisational culture, risk assessments, responding to concerns/allegations, handling safeguarding crises, safeguarding audits/reviews, the Independent Inquiry into Child Sexual Abuse, low-level concerns, peer-on-peer abuse, mental health issues, and on-line safety.

Also committed to thought leadership and innovative practice, Adele has led on the development of this guidance on low-level concerns, and has devised a peer-on-peer abuse toolkit with Dr Carlene Firmin and other experts; she has facilitated the establishment of a safeguarding steering group, which is represented by large national and international charities; and is a member of the DCMS led Domestic Charity Safeguarding Programme Group which is currently overseeing the implementation of new safeguarding measures for domestic charities.

Adele has been a member of the Board of the CSJ since January 2017. She is an adviser to the Board of Trustees of UP Unlocking Potential, and sits on the Advisory Panel of the charity IntoUniversity – in support of which she cycled from Land's End to John O'Groats in September 2017. Adele was previously a Governor of an academy in London, and a Trustee of a grant-making charity.

Jane Foster, Consultant, Farrer & Co

Jane works with the Safeguarding Unit as a consultant providing specialist advice on safeguarding and child protection to clients across the sectors including religious and sports organisations, schools, charities and private clients.

Prior to joining Farrer & Co, Jane was the Tri Borough (Royal Borough of Kensington and Chelsea, London Borough of Hammersmith and Fulham and City of Westminster) Safe Organisations Manager and Local Authority Designated Officer (LADO) for almost eight years. Jane was also co-coordinator of the Pan-London LADO network and sat on the Serious Case Review Panel in relation to William Vahey.

Jane has worked in both local authority education and children's services departments in England and Wales and has been an LSCB trainer in both countries. She has been able to draw extensively on her previous experience of working in schools as a class teacher, designated safeguarding lead, and governor with responsibility for safeguarding both primary and secondary levels in addition to having been a Trustee of a small charity and member of a health services watchdog.

At Farrer & Co Jane focusses on providing high-level specialist safeguarding advice and training to clients across the sectors both nationally and internationally, with a particular emphasis on promoting safe organisational culture and practice, safeguarding in the workplace and managing allegations against adults working with children. She is an accredited safer recruitment trainer.

Jane is a member of the International Task Force for Child Protection where she worked with Farrer & Co and multi-agency partners to develop an international protocol for managing allegations against adults who work with children. Jane is an Affiliated Consultant for The Council of International Schools, and sits on the safeguarding board for a leading sports club.

Owen O'Rorke, Senior Associate, Farrer & Co

Owen is a Senior Associate and member of the Safeguarding Unit, and first qualified with a media, privacy, IP and telecoms background. Before joining Farrer & Co he gained wide experience in data privacy law and confidentiality, IP advisory and commercial contract work in the publishing, film, technology and sports sectors, and these remain key practice areas.

His practice focuses increasingly on data protection and, aside from the commercial applications of data in publishing and marketing, he has gained a strong reputation in a number of sectors, notably sports organisations, schools and charities. He works extensively with governing bodies in sports and education, and has a particular interest in the information law and technology aspects of safeguarding and e-Safety.

David Smellie, Partner, Farrer & Co

David leads Farrer & Co's Safeguarding Unit. He has been heavily involved in advising clients on safeguarding matters over the last 15 years and, as such, he has witnessed the positive impact of regulatory change over the period. David led the Farrer & Co team which acted as Solicitors to the Independent Review by Hugh Davies QC into the criminal conduct of William Vahey in 2014. David has also acted as child protection governor at three schools, and is recognised as the UK's top-ranked schools lawyer in Chambers UK.

Marcus Erooga, Independent Safeguarding Consultant

Marcus is an independent Safeguarding Consultant and past Editor-in-Chief and Associate Editor of the *Journal of Sexual Aggression* (Taylor and Francis), as well as a past Chair of NOTA (the National Organisation for the Treatment of Abusers).

He spent the majority of his employed career in various roles at the NSPCC as a practitioner, team manager and operational Assistant Director as well as service, practice and policy development relating to child sexual abuse and sexual offending.

Since 2012 he has been an independent Safeguarding Consultant working with a range of organisations including NSPCC; the Scout Association; Save the Children International (SCI); Save the Children UK (SCUK); the Methodist Independent Schools Trust; the Methodist Church; the Cognita schools organisation; Ampleforth College and Abbey; Trinity College, Oxford; Addenbrookes Hospital, Cambridge; and Oxfam. He is an experienced trainer and presenter having worked across the UK as well as Canada, Italy, Norway, Singapore and the USA.

Marcus is author of a number of some eighty publications on child abuse and sex offender related issues including five edited books. For the past decade he has had a particular interest in organisational safeguarding, undertaking research about, and with, organisational offenders. His most recent publications include two edited books *Creating Safer Organisations: Practical Steps to Prevent the Abuse of Children by Those Working with Them* (2012, Wiley), and *Protecting Children and Adults from Abuse after Savile: What institutions and Organisations Need to Do* (2018, Jessica Kingsley Publishers) which considers the learning from the 70+ inquiry reports published in the wake of revelations about Jimmy Savile's criminality. In 2019 he co-edited a special edition on the prevention of sexual abuse for the *Journal of Interpersonal Violence* (Sage).

His research experience includes as principal investigator on a research study with people convicted of sexual offences against children committed in professional settings (NSPCC, 2012) and as co-principal investigator (with Professor Keith Kaufman, Portland State University, USA) of a comprehensive literature review of risk and protective factors for institutional child sexual abuse for the Australian Royal Commission into Institutional Responses to Child Sexual Abuse (2016).

He was the expert witness for a Royal Commission case study into sexual abuse of students by the principal in a prestigious Australian dance school in 2016, and is an expert witness for the IICSA (the UK Independent Inquiry into Child Sexual Abuse) investigation relating to residential schools. In 2019 he was made an inaugural NOTA Fellow in recognition of his long-term contribution to the organisation and its work.

Marcus can be contacted at marcuserooga@gmail.com

Katherine Fudakowski, Barrister, Old Square Chambers

Katherine specialises in the complementary areas of employment, education and the regulation of professional misconduct. She is specifically interested and experienced in the law relating to safeguarding and is instructed in every type of case involving allegations of failure to safeguard children or vulnerable adults.

Katherine has acted for survivors of child sexual abuse, for schools, universities, hospitals and charities defending whistleblowing and discrimination claims in the Employment Tribunal and for teachers before the Teaching Regulation Authority. She appears before the Special Educational Needs Tribunal and is regularly instructed to undertake complex independent investigations. She is on the Attorney General's C Panel of counsel.

Katherine was recently seconded to the Farrer and Co Safeguarding Unit to focus on this work and brings to her practice a wide range of experience. Prior to being called to the Bar she worked at the European Commission, with child refugees in Jordan and prosecuting perpetrators of the Rwandan genocide at the United Nations Tribunal in Tanzania. She has been a safeguarding school Governor and charity Trustee and sits on the Camden Council School Appeal Board.

Hugh Davies OBE QC, 3 Raymond Buildings

Hugh Davies QC's principal areas of specialisation are criminal law (including fraud and corporate regulation); police complaints, misconduct and public regulation; inquests; public inquiries; professional misconduct proceedings; the regulation of child protection in institutions; and claims for judicial review arising in each of these areas.

He has extensive experience of prosecuting and defending serious crime of all types, including offences against children. He prosecuted the first allegations of grooming under the Sexual Offences Act 2003, and of causing or allowing the death of a child under the Domestic Violence Crime and Victims Act 2004.

He was Chambers and Partners professional discipline junior of the year in 2009, and QC of the year in 2016.

He was instructed as Counsel to the Inquest into the death of Alexander Litvinenko, the Russian former KGB officer allegedly poisoned by polonium 210 in London in 2006.

In 2011 he was awarded an OBE for services to children and young people reflecting his role as voluntary legal adviser to the Child Exploitation and Online Protection Centre (CEOP). In 2013 he was lead author of an ACPO commissioned multi-specialist report that resulted in the Government enacting legislative reform of the sexual civil prevention order regime in the Anti-Social Behaviour Crime and Policing Act 2014. He advises institutions as to safeguarding responsibilities and performance. He led the independent review into the criminal conduct of William Vahey at Southbank International School, and into RNIB as part of the Charity Commission's statutory inquiry in 2018 – 2019 (publication expected Autumn 2019).

He is presently a member of the DFID led Aid Worker Steering Group exploring how to create and manage an international system of registration for aid workers in international development programmes.

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