Stanbridge Earls School Review Report

Overview

This report is made pursuant to an Inquiry to consider the inspection history of Stanbridge Earls School from January 2011 to January 2013. The Inquiry was set up in the light of safeguarding concerns raised by the parents of two pupils at the school and the conclusions reached by a First-Tier Tribunal in respect of the school in January 2013. It summarises the outcomes of an internal review which was carried out to consider Ofsted's involvement during this period and the three inspections that took place.

The internal review concluded that each of the inspections conducted during this period was problematic but for different reasons. Each failed to get underneath concerns at the school. This report provides a detailed summary, including findings and recommendations, for consideration by the Inquiry.

Introduction

Ofsted's aim is to ensure, through effective inspection and regulation, that outcomes for children and young people are improved by the receipt of better care, services, and education. Improved outcomes can only be achieved if children are safe from harm. Therefore, safeguarding the welfare of children is part of our core business. In this regard, Ofsted has an overarching statutory duty to have regard to the need to safeguard and promote the rights and welfare of children set out in s117(2) (a) and s119(3) (a) of the Education and Inspection Act, 2006.

The legal basis for the inspection of welfare in residential special schools is set out in the Children Act 1989 as amended by the Care Standards Act 2000. In inspecting, Ofsted gives consideration to statute and the National Minimum Standards for residential schools; the Education (Independent School Standards) Regulations; and statutory guidance published by the Department for Education.

Working together to safeguard children (2010) sets out how organisations and individuals should work together to safeguard and promote the welfare of children and young people. Part I of *Working together* is statutory guidance. It states that: 'Ofsted inspects against the extent to which schools and colleges fulfil their safeguarding responsibilities…"

The purpose of inspection is two-fold: inspectors report on the extent to which a school meets the National Minimum Standards for boarding or residential special schools, and makes qualitative judgements about the quality of the school's provision and outcomes in the areas set out in the inspection evaluation schedule. All of the National Minimum Standards for boarding and residential special schools are covered by the evaluation schedule.

Inspectors use descriptors to guide their judgements about the quality of a school's provision and outcomes. They reach a summative judgement of the overall effectiveness of the boarding experience.

Background

Stanbridge Earls School is an independent residential special school, regulated by the Department for Education (DfE) and inspected annually by Ofsted, and more frequently at the DfE's request. The educational provision at the school is inspected by the Independent Schools Inspectorate; the welfare provision is inspected by Ofsted.

On 15 January 2013, a First Tier Tribunal, Special Education Needs and Disability, published its report of a hearing in November and December 2012 into the claim by Child C, against the Trustees of Stanbridge Earls School, as the responsible body.

In summary, the case was one of discrimination arising in consequence of disability.

The Tribunal found: [152] *It is admitted that the school was unable to manage Child C's conduct to keep her safe. We agree, but not with the submission that the school took all reasonable steps to do so.*

The Tribunal's report says: [178] *We are satisfied that the claim has revealed cause for grave concerns about management, multi professional relationships and communication, educational provision and safeguarding at Stanbridge Earls School…[179]We note professor McColgan's submissions that Ofsted has made unannounced inspections and rated the school outstanding… we have real doubt as to whether the outcome would be justified if Ofsted had known of the failures identified in the present claim*.

However, the substantive matters considered at the Tribunal were known to individuals at Ofsted. They were set out in a detailed complaint that was received in October 2011. The complaint was from SEN Legal acting on behalf of Child C's parents. It raised concerns about the robustness of the June 2011 welfare inspection which found the school to be 'Outstanding' overall, including an 'Outstanding' judgement for safeguarding. The concerns sparked a more limited 'emergency inspection' in January 2012 which concluded that the school met the National Minimum Standards. Following a second safeguarding complaint, in February 2012, Stanbridge Earls was the subject of a full welfare inspection in May 2012 brought forward at the request of the DfE. The inspector found it to be 'Outstanding' overall, including an 'Outstanding' judgement for safeguarding.

An emergency inspection of safeguarding was carried out in January 2013 following receipt of the Tribunal's report. Ofsted found that the school was not meeting the National Minimum Standards. The DfE served a notice and closely monitored the situation.

Terms of Reference

Sir Michael Wilshaw, Her Majesty's Chief Inspector, established an Inquiry on 24 January 2013 to review the inspection history of Stanbridge Earls School from January 2011 to January 2013. This Inquiry was chaired by Baroness Sally Morgan, the Chair of Ofsted's Board, and comprised HMCI and two non-executive Board members. The Inquiry commissioned an internal review to report back findings and make recommendations. The review was carried out by Lorraine Langham, Chief Operating Officer, with support from a small internal team.

The review comprised desk research, compilation of evidence and a detailed chronology, together with interviews with the key people involved where they were still employed by Ofsted. As this was an internal review, the team did not seek to contact external parties, including former employees. The documents which underpin and support the review are attached to this report at Annex A and Annex B. Due to the confidential and sensitive nature of the documents in Annex B, it is not intended that the contents should be made available outside Ofsted and they will not be shared with any third party or circulated more widely than the review team. Those in Annex A are a matter of public record.

Evidence to inform the desk review was gathered from teams and named individuals who were known to have been involved in the inspection and complaints history of the school. A formal request was made in order to gather information they held for the purposes of the review, dating back to January 2011.

Information gathered included inspection frameworks, guidance and policies in use throughout the period in question. All email correspondence relevant to the case and still held by individuals and teams was also closely scrutinised. A review of logs and correspondence held by teams in Complaints and Compliance, Investigation and Enforcement was undertaken. This included reviewing information held on various data systems.

Information about the wider context within which safeguarding matters were overseen was also gathered. This included a review of the role and purpose of the cross-remit Safeguarding Group which operated and ceased to operate during the period in question. The review team also looked at papers and minutes of the Executive Board relating to the role of this Group.

Where questions arose regarding the veracity of inspections, these were subject to investigation by one of Her Majesty's Inspectors. The review team are grateful for this support and advice and to the HMI for undertaking the Evidence Base Reviews (EBR). An EBR looks at the inspection evidence bases, inspection frameworks and guidance in use at the times of the inspections and other relevant documentation,

including parental questionnaires. They look at what happened and what conclusions were reached, compared to what should have happened, and seek to address whether the judgements reached are reasonable based on the evidence.

Evidence Base Reviews were carried out in relation to the June 2011, January 2012 and May 2012 inspections. The reports from this work are among those documents set out in Annex B and have been considered in detail by the review team.

The following documents were reviewed by the team:

- Ofsted and ISI inspection reports for Stanbridge Earls school from 2007 – 2012
- Inspection documents including:
  - The framework for inspecting boarding and residential provision in schools
  - Conducting inspections of boarding and residential provision in schools
  - Evaluation schedule for the inspection of boarding and residential provision in schools
  - National Minimum Standards (NMS)
  - Inspecting residential provision in boarding and residential special schools
  - Reference guide to the key standards in each type of social care service inspected by Ofsted
  - Benchmarking guidance on making social care inspection judgements
  - Criteria for making judgements
  - Conducting additional inspections of independent schools
- Serious Incident Briefings produced between November 2011 and January 2013.
- Compliance, Investigation and Enforcement case history log for Stanbridge Earls school 2011 – 2013
- Complaints case history for Stanbridge Earls school 2011 - 2013
- Evidence bases for the inspections undertaken (where these were still held) and all retained materials
- Tribunal report re Child C, published in January 2013
- Letters of complaint in relation to two children (dated October 2011 and February 2012)
- Correspondence between staff within Ofsted
- Correspondence between Ofsted staff and DfE staff

- Information related to Ofsted's cross-remit Safeguarding Group, including minutes of the Group, papers and minutes from the Extended Executive Board and Operations Executive Board and update reports to the Executive Board relating to the work of this Group.

Such information was used to form a chronology and develop hypotheses and questions to be explored further through interviews.

The review team was asked to address the following matters:

- Did Ofsted staff act properly and in accordance with expectations at that time (values, policies, frameworks, guidance, the law)?
- How did Ofsted use the information it held? Were the right people briefed?
- Did managers provide appropriate oversight to ensure matters were joined up and work was of high quality?
- Was each critical event handled appropriately (timely, focused, proportionate)?
- Did each inspection collect the proper evidence in light of the requests from the DfE (i.e. was it thorough)? Were the judgements reasonable and appropriate in light of what was known?
- Was Ofsted's understanding of relationships/bullying appropriate and did it use evidence as a trigger for further inquiry? How did it get underneath the concerns being raised?
- Were the systems and processes that support Ofsted's work effective? What happened and what should have happened?
- Were the boundaries between DfE, local authority, police, inspectorate, and the wider system within which Ofsted operates understood and action appropriate?
- Are there matters that need to be looked at under Ofsted's disciplinary procedures?

It is important to remember that, between January 2011 and January 2013, Ofsted's requirements for inspections of welfare provision at independent boarding schools (as set out in our published frameworks) have changed. It has issued two new frameworks for the inspection of boarding in residential special schools and the National Minimum Standards (NMS) have also been revised. This review looked at the frameworks and NMS operating at the time.

Findings

The Inspections

The three inspections in June 2011, January 2012, and May 2012 were flawed but for different reasons. As a result, the judgements were not safe in the light of what

was known at that time. Inspectors did not use information as a trigger for further inquiry and failed to get underneath the serious safeguarding concerns being raised.

The June 2011 inspection was not carried out in accordance with Ofsted standards, policies, frameworks, guidance and expectations. This inspection was overly reliant on the 2010 inspection. The previous evidence base and judgement of 'Outstanding' was used as the starting point and the inspection was carried out to see if this was still justified. This was not expected practice and is unacceptable. This inspection did not sufficiently consider the evidence presented, including concerns raised by parents in the parental questionnaires. Issues regarding health, privacy, overcrowding and bullying were not sufficiently explored.

The inspection did not get underneath the safeguarding issues which had already begun to emerge in the school. The inspector did not give sufficient weight to the risk posed by a change of head and the expansion of the school, including the different types of disability amongst the pupils.

Although this matter came to light in October 2011, and was confirmed by independent reviews of the evidence base at the time, this was not appropriately dealt with by managers. It should have been considered under Ofsted's disciplinary procedure. Instead, the matter was wrongly closed when the complaint was considered to be 'withdrawn'. A further review of the evidence base conducted as part of this review concluded that the inspection and the judgements were indeed unsafe.

The scope of the January 2012 inspection changed via emails with the DfE. The final scope did not seek to get underneath the safeguarding concerns raised by SEN Legal in October 2011. The scope was not challenged at a critical moment. This was a serious mistake.

While the January 2012 inspection was conducted properly, it did not look at the key concern of safeguarding as the inspector had been advised that this was being investigated by the Police and the Local Authority Designated Officer in Hampshire and was not to be the focus of her inspection. The inspection was carried out in accordance with the scope agreed with the DfE and produced an unpublished advice note in accordance with the policy operating at the time.

Senior managers were relying on the January 2012 inspection to get underneath the concerns about the June 2011 inspection. It did not do this. There was no systematic follow-up or appropriate senior management oversight. The matter was inappropriately considered closed even though the outcome had not addressed these concerns.

The May 2012 inspection was designed to look at the concerns relating to Child C and subsequent, similar concerns relating to the second complaint. In spite of the DfE's clear commission, there is no evidence that this inspection looked into the October 2011 complaint in any detail. Instead, it considered that this complaint had already been examined in the January 2012 inspection. The inspection viewed the

matter as closed, which the review team found to be a significant error of judgement.

The evidence base review commissioned by the review team concludes that this was a poorly conducted inspection which failed to get underneath the issues; the judgements are therefore unsafe. The inspection did not meet the standards expected of an HMI.

Complaint Handling

Ofsted's response to SEN Legal's concerns regarding Child C's experience at Stanbridge Earls School in October 2011 was muddled. Handling the matter as two separate concerns, a Complaint Against Ofsted and a Complaint Against the School meant that there was an absence of a holistic view of the complaint and the fundamental issues of substance were overlooked in the gap between the two processes.

There was no overview of the issues raised, senior managerial accountability for resolution was not established, and too many people were involved in two separate strands of work without clear ownership and lines of accountability. The prevailing culture at the time of copying many people into emails created confusion as to who should do what; senior managers did not clarify responsibility and actions required.

There was insufficient managerial oversight of how the concerns relating to the two complaints (dated October 2011 and February 2012) were handled. Where individual decision-making was reasonable, follow through was too limited. No minutes were taken at key meetings which allowed for different interpretations of actions required and slippage. Colleagues did not do what was expected of them and senior managers did not systematically check. Too much was assumed and left to trust which allowed for misunderstanding and poor follow through.

Systems and processes

In order to gain a complete picture, inspectors had to look into two systems, the Regulatory Support Application and CRM (the Customer Relationship Management system). This process created an unacceptable margin for error. The systems that supported the inspections were adequate but far from ideal; the lack of a single provider view meant that inspectors had to look for information; it was not readily provided to them. Some information was not available to inspectors at the point of inspection; that which was available was not signposted clearly enough, although it could be found within the time available for preparing for inspection.

The lack of case management and ownership was a cause of concern. Processes in Compliance, Investigation and Enforcement, Complaints Against Ofsted and Complaints Against Schools teams were inadequate. This led to high levels of activity without coherence and ownership. Although individual teams tracked their actions, no-one joined up and provided an overview. Processes and deadlines got in the way when the right thing to do was stand back. Staff did not appropriately identify and manage the business as usual risks inherent in their work.

There was no clear process for joining up and escalating concerns. The second complaint should have been a significant trigger for senior management action.

There was insufficient clarity about what action should follow a Serious Incident Briefing and who was responsible for it.

Organisational Structure and accountability

Incremental organisational changes led to blurred lines of accountability and matters, which should have been addressed, were not. Ownership of this case was not clear and information and intelligence were not joined up as part of the managerial role. Crucially, at the time of these concerns at a corporate level, a significant safeguarding group ceased to be Director-led and stopped meeting, and experienced social care personnel departed leaving an organisation-wide gap in the leadership of safeguarding. While there is no evidence that it would have made a difference in the case of Stanbridge Earls, the oversight of safeguarding was diminished at the time these events took place. Safeguarding has to be everyone's business but also needs leadership.

Managerial action regarding the 2011 inspection should have been formalised in accordance with our policies.

Quality Assurance

Quality assurance processes were too focused on the quality control of the report rather than ensuring high quality inspections rooted in evidence. Opportunities to assess and address the poor quality of some the inspection work were therefore missed.

Relationships

The boundaries between the DfE, local authority, police and the wider system within which Ofsted operates were insufficiently understood. There did not appear to be a clear protocol including how and when concerns must be escalated. The reliance on others to have effectively investigated the complaint led to a significant gap. Ofsted expects these matters to be considered by the Local Safeguarding Children Board. In addition, key individuals failed to recognise the wider concerns that were exemplified by the individual cases and did not therefore see these were matters for Ofsted.

Recommendations

Structure

1. Ofsted should restructure social care work with a stronger focus on the use of information and intelligence in the regions. The national allocation of work should be strengthened and supported by localised case management within the new regional structure with clear lines of accountability.

   Action: Deputy Director, Social Care; full implementation by January 2014.

2. The three existing teams Complaints Investigation and Enforcement/National Business Unit /Complaints Against Schools (CIE/CAS/NBU) should be merged so that work does not fall down the gaps the gaps at the boundaries. Roles and responsibilities should be clarified and made explicit.

   Action: Deputy Director, Strategy, Policy and Performance; Proposals by May 2013; full implementation by September 2013.

Systems

1. A system giving inspectors all the information at the point of inspection should be urgently established. It should be mandatory to check the system and read complaints and other information held. This should be formally reported in the inspection evidence base. Managers should sample staff's work to check that there is compliance. The Operations Executive Board should receive quarterly reports to ensure that this is put into practice and that there is proper oversight.

   Action: Deputy Director, Strategy, Policy and Performance; Proposals by May 2013; improvements within 6 months; full systems implementation within 18 months.

Processes

1. Processes in CIE/CAS/NBU should be audited by process specialists and redesigned to support the new regional structure. Lessons from this case and others should be used to build better ways of working.

   Action: Chief Operating Officer; audit complete by April 2013; urgent improvements by September 2013; full implementation by January 2014.

2. Case management should be introduced with one clear owner who oversees all aspects of a case to completion within an end-to-end process. Escalation and required action should be clearly set out.

   Action: Deputy Director, Strategy, Policy and Performance; implementation by September 2013.

3. Directors and senior leaders should make sure that they have appropriate systems in place to ensure that their intentions are followed through. Meeting minutes and action logs should be used routinely when important matters are discussed.

   Action: Chief Operating Officer, by September 2013.

Personnel

1. Appropriate follow-up action should take place in accordance with Ofsted's HR policies, including disciplinary policies, where the review has identified that the staff concerned failed to act appropriately.

Action: Deputy Director, People; immediate.

2. All social care staff, Compliance, Investigation and Enforcement, Complaints Against Schools and Complaints Against Ofsted staff and those who handle correspondence/calls to Ofsted should be retrained in safeguarding matters and disability awareness.

3. Senior managers and inspectors should be made aware of the failings in this case and the lessons to be learnt. This involves all Senior Her Majesty's Inspectors and Her Majesty's Inspectors.

   Action: Deputy Director, Social Care; by December 2013.

4. Knowledge transfer should be strengthened to ensure that key risks are identified formally before people leave. High risk posts, such as those related to safeguarding, should have clear and detailed handover arrangements managed through a comprehensive leavers' process.

   Action: Deputy Director, People; by September 2013.

5. A learning and development programme should be put in place to strengthen practice.

   Action: Deputy Director, People; by September 2013.

Quality Assurance

1. Quality assurance should be part of the managerial line. This will strengthen ownership and accountability and will make poor performance more transparent. Quality assurance should include the quality of inspections, inspectors and inspection reports.

2. Managers should routinely sample the quality of inspection work, checking files, looking at the evidence base and through discussion in one to ones. Consistently weak performers should be identified and additional QA put in place to ensure inspection judgements are secure.

   Action: Director, Schools, by December 2013.

Corporate

1. The cross-Ofsted Safeguarding Group should be re-established and led by the Director, Social Care. The detailed knowledge of a social care professional in relation to the safeguarding and child protection issues emerging in any setting, any remit, and any region should be used to improve practice. The Group should report to the Chief Inspector every six months with its action plan and work audited as part of the annual audit plan, and reported to the Audit Committee.

   Action: Chief Operating Officer; by September 2013.

Ensuring secure practice

1. Where concerns have been raised with Ofsted, cases for the last two years should be reviewed across Social Care, Early Years, Complaints and Legal Services teams to ensure that other safeguarding matters have been properly handled, referred to the DfE where appropriate and followed up. Action will then be taken as a result of any cases giving cause for concern.

   Action: Chief Operating Officer, by June 2013.

2. All cases where Serious Incident Briefings have been produced should be reviewed (January 2010 onwards) to ensure appropriate action has been/is being taken and, where this is not the case, followed up as a priority. An interim process to ensure consistency and collation of information across remits should be urgently established.

   Action: Advisor, Safeguarding, by August 2013.

3. Clear processes and guidance relating to SIBs need to be put in place to ensure clarity of what should happen when one is produced and to establish accountability for directing subsequent action. Action and learning arising should be overseen by the Safeguarding Group.

   Action: Adviser, Safeguarding, by June 2013.

Performance management

1. Roles and responsibilities need to be much sharper. The specific responsibilities of operational leads in terms of quality need to be explicitly stated. The current approach of individual Performance and Development Plans needs to be reviewed to ensure we are systematically joining up individual accountabilities to see where the gaps are. Escalation between roles needs to be made explicit and documented so we can always answer the question 'who is accountable for this'.

   Action: Deputy Director, People, by October 2013.

Relationships

1. The relationship with the DfE in this area should be more structured and business like. Consideration should be given to setting out expectations in a clear protocol or memorandum of understanding including the roles and responsibilities of both parties. There should be regular and formal senior level meetings to discuss regulated services, with minutes and formal reports back to HMCI.

   Action: Divisional Manager, Education Policy and Frameworks.

2. The system for making referrals to the LADO/Local Authority should be reviewed to ensure that it is sufficiently robust. Where gaps in the system have

been identified in this report they should be addressed so that serious issues are appropriately dealt with. This would include the role of the LADO, which excludes child on child abuse. In addition, for cases where Ofsted is not satisfied with the response from the LADO, a process should be agreed whereby concerns of a child protection or safeguarding nature can be escalated immediately to the Director of Children's Services for that Authority.

3. Information sharing protocols between Ofsted and the Police should be put in place.

   Action: Deputy Director, Social Care, by December 2013.

Frameworks

1. A review of the safeguarding aspects of all our current frameworks should be undertaken to ensure they are fit for purpose in the light of this case. Consideration should be given to having less prescriptive guidance and more emphasis on encouraging inspectors to use their judgement. Training needs to take place to ensure that the lessons here are understood in practice.

   Action: Divisional Manager, Education Policy and Frameworks.

Next steps

This report was presented to HMCI and the Inquiry for consideration and approval of the recommendations in May 2013. It was then submitted to the Operations Executive Board on 5 June 2013. The findings and recommendations will be disseminated internally to support learning.

A meeting will be offered to the parents of children affected by these inspections and to the school. This will give them the opportunity to discuss the outcome of the review. It will also provide an opportunity for Ofsted to apologise to the parents for the failings that have been identified in this review.

An action plan was submitted for approval to the Operations Executive Board on 8 May 2013 and is being monitored as part of the quarterly reporting until all actions are complete. A further review will take place at the end of June 2014 to formally check on progress and to ensure that the actions have had the intended effect and that no further actions are required to ensure that the changes are fully embedded in Ofsted's practices.

Lorraine Langham
Chief Operating Officer
June 2013 (Updated May 2014)

Annex A

The following documents are available to the public in support of the report:

- Ofsted and ISI inspection reports from 2007 – 2012
- Inspection documents including but not limited to:
  - The framework for inspecting boarding and residential provision in schools
  - Conducting inspections of boarding and residential provision in schools
  - Evaluation schedule for the provision of boarding and residential provision in schools
  - National Minimum Standards
  - Inspecting residential provision in boarding and residential special schools
  - Reference guide to the key standards in each type of social care service inspected by Ofsted
  - Benchmarking guidance on making social care inspection judgements
  - Criteria for making judgements
  - Conducting additional inspections of independent schools
- Tribunal report re Child C, published in January 2013

The documents contained in Annex B were used in the review but are not available outside Ofsted and they will not be shared with any third party or circulated more widely than the review team and Inquiry due to the confidential and sensitive nature of their content.

Annex B

These documents were used in the review but, due to the confidential and sensitive nature of those documents, it is not intended that they should be made available outside Ofsted and they will not be shared with any third party or circulated more widely than the review team and Inquiry:

- Chronology compiled by the review
- Serious Incident Briefings produced in November 2011 and January 2013
- CIE case history log
- Complaints case history log
- Evidence bases for the inspections undertaken in June 2011 and May 2012
- Letters of complaint (dated October 2011 and February 2012)
- Correspondence between staff within Ofsted
- Correspondence between Ofsted staff and DfE staff
- Information related to Ofsted's cross-remit Safeguarding Group, including published minutes of the Group, papers and minutes from Extended Executive Board and Operations Executive Board and update reports to the Executive Board.
- Notes of the interviews with key staff