

Our Bravery Brought Justice

Child Practice Review of Neil Foden, Former Headteacher at Ysgol Friars in Bangor

A summary for pupils and families



Children should always feel safe in school. Adults who care for them must work together to stop abuse and harm.

But in this situation – that didn't happen as it should.

What happened

In September 2023, a pupil from Ysgol Friars in Bangor showed staff messages and images on her phone. Some were sexual, and some showed her in the Headteacher's car. She said she had been in a "relationship" with Foden the Headteacher for months – though this was not a real relationship. Foden was in a position of power so it was abuse.

The messaging number matched his phone.

That same day, Foden was arrested.

Afterwards, more pupils came forward to the police about being abused.

Foden was sent to prison for 17 years — where he is now.

What is child sexual abuse?

Child sexual abuse is when a child is forced or pressured into sexual activities. It is a serious crime. It is never the child's fault.

We are the **North Wales Safeguarding Board**. Our role is to help protect children and adults across the region. We work with schools, police, services, and other organisations to:

- prevent abuse, neglect, and harm
- make sure people who have been harmed get the right support
- learn lessons when things go wrong, so it doesn't happen again.

This is a serious and terrible crime that should never have happened. Everyone needs to know what went wrong, so it doesn't happen again.

So, in July 2024, we started this **Child Practice Review** after a referral from Cyngor Gwynedd and North Wales Police. This summary explains:

- what went wrong
- what opportunities were missed
- what lessons must be learned
- what actions will make things safer in the future.



You can read the full review here:

northwalesafeguardingboard.wales/gwynedd-child-practice-review



About this Child Practice Review

This case has been widely reported in the media. It's impacted lots of pupils, families and communities. It's also impacted professionals across different councils and services.

So, to make sure the review was fair and independent, the Chair (leader) and Reviewers for this report were chosen from outside North Wales. They had no links to the schools or the services involved.

⚠ The young people's details are kept anonymous to protect their safety.



This report refers to the girls that experienced sexual abuse as Child A, B, C, D, E, F, G.

Foden also physically abused and used restraint on 4 boys. In this report they are called Child H, I, J, M.



The review includes everything that happened between **January 2017** — the first concern recorded about Foden to **30 September 2023** — the day Foden was arrested and the days after.

Timeline

-  **1997** Foden becomes Headteacher Ysgol Friars.
-  **2017** Foden goes to tribunal for bullying staff.
Complaint made about manipulating exam results. Complaint upheld.
-  **2018** Concern raised about Foden's behaviour with Child C.
-  **2019** Concern raised about Foden's relationship with Child A.
-  **2020** Foden has Child A and Child C in school during Covid lockdown. Child G complained Foden was too physically close.
Foden was found guilty of professional misconduct for bullying staff and issued a 2-year reprimand.
-  **2021** Foden appointed Head of another School. Allegation of unreasonable force against Child I and Child J and inappropriate behaviour with Child G.
-  **2022** January – Foden returns to both schools. Spoken to about his behaviour. No written records of events or Foden's response.
-  **2023** September — Child D tells staff about sexual abuse. Foden is arrested.
There are no written records of many of these discussions, or of Foden's response.



What Happened in This Review

There were many concerns raised about Foden from:

- staff at both schools
- different social workers from various local authorities
- professionals from many organisations including NSPCC, CAMHS, and health care staff
- parents and carers.



Over 12 months the reviewers met with and talked to **140** people.

Involving school staff

In July 2024, the reviewers talked to staff members as quickly as possible. They met and talked to 80 staff.

Involving parents and carers

Parents were told about the review and given an email address if they wanted to be involved.

Involving those who experienced the abuse

At the heart of the review are the young people who were abused and harmed by Foden. The Reviewers offered to meet them at a time or place of their choosing. They could bring family or a trusted adult and did not have to get involved if they didn't want to.

Some took part — some didn't.

Checking information

The Reviews looked at evidence from:

- Ysgol Friars
- Gwynedd Social Services, Education services and Children and Family Services
- NSPCC
- Sexual Assault Referral Centre
- North Wales Police
- BCUHB — Hospital records, GP records, CAMHS and Child Health Records
- Neighbouring Local Authorities.

Police evidence

North Wales Police (NWP) shared all the information they had about Foden.

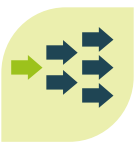


Missed opportunities

The evidence showed us all the opportunities there were to stop Foden and how they were missed.

That helped us spot the issues and what needs to improve so this never happens again.





1: The Power of Status, Reputation and Culture

For almost 30 years Foden was Headteacher in the largest school in Gwynedd. He was well known, had spoken at the Senedd and often asked to speak on local and national media.

Foden appointed himself as Pastoral Lead at the school. He took on the role of oversight of safeguarding matters. He was supported by a member of office staff who wasn't trained in Safeguarding. He also appointed a new Deputy Head and Designated Safeguarding Person. Neither had much safeguarding training or experience.

Evidence showed

Foden challenged anyone who raised a concern about him.
Staff described feeling powerless because "he was [their] boss."

Foden controlled every aspect of the school.
No one felt able to question or challenge him.

Foden created an atmosphere of fear and mistrust. He:

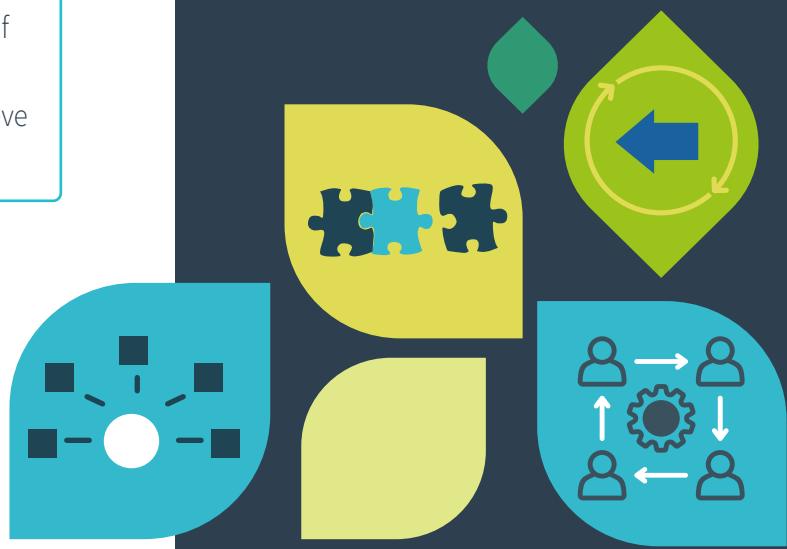
- bullied pupils, parents, and staff
- played people off against each other
- dominated the school governors
- used insecure short-term contracts to keep staff under control
- intimidated parents, who feared their child could be excluded if they spoke out
- dismissed children as dishonest, encouraging staff not to believe their concerns or complaints.

What needs to change



No one should be above challenge.

Schools must be safe for children — not shaped around the power or reputation of one person.





2: Systems and processes

There are Welsh Safeguarding Procedures. These should have been followed. Any case reported should be managed and led by the Local Authority where the adult is employed. Foden was employed by Cyngor Gwynedd.

Evidence showed:

Local authorities disagreed on what should happen and why.

For example: Managers in the neighbouring local authority said certain complaints made would meet the level to trigger an investigation in their area.

Information wasn't shared with professionals in the right ways, at the right time.

Professionals didn't understand safeguarding.

Many concerns were dealt with as 'Foden overstepping boundaries' and needing to change his professional behaviour. They weren't treated as child safety issues to be investigated.

The right people were not present at meetings and decisions were not always shared.

Professionals didn't report their concerns.

Often professionals had concerns but dismissed them as 'just a feeling' because they had no evidence of abuse.

What needs to change



Safeguarding rules must be followed every time.

Concerns must be recorded, shared, and treated as serious — not dismissed as minor behaviour issues.





3: Working together

Working together to keep children safe is essential.

When there's a concern about an adult working with children, people should act quickly. Professionals should know what to do and how to do it, even if different areas of Wales use different systems. There's lots of guidance and advice available to help them.

Evidence showed:

Actions were delayed.

When there was a concern, no action was taken until the referral form was completed. Nothing happened to concerns reported by phone or email, until the form was complete and accepted.

There was a different understanding about the threshold (level) for taking concerns further.

Professionals working across different local authorities that made referrals felt the concerns about Foden should have been investigated. Professionals at Gwynedd felt that from the evidence and information they had, it didn't meet the threshold.

The referral form system was not flexible, easy to find or easy to use.

The referral form for adults working with children is the same as the one for children at risk. This made it difficult to include all the information needed. Forms were returned to professionals asking for more information, sometimes several times when a phone call would have been faster.

There was a breakdown of trust and respect between professionals and services.

The way concerns were managed showed different practices and ways of working.

What needs to change



Services must work together properly.

Professionals should act fast, trust each other, and focus on what's best for the child — not just the paperwork.





4. Restrictive Practices and Use of Force

There are laws about how and when you can hold or restrain a child. It should only happen as a last resort and to keep a child safe.

The Review looked at evidence about where Foden and other staff at Ysgol Friars used physical force to restrain male pupils.

Evidence showed:

There were unlawful levels of physical restraint.

Restraint was used as punishment to show who was in control and cause fear, rather than as a last resort. These occasions were not recorded or shared with the local authority.

Foden made it clear he was right to use restraint this way.

He made using restrictive practice normal and denied any issues or harm to pupils.

Staff were afraid to speak up.

When someone reported a concern, it wasn't kept private. Foden was told who reported what.

Staff were encouraged to film restraint.

They used their mobile phones to film incidents. The school has a policy for physical restraint, but they didn't follow it.

There were no follow-up checks on injured children and no trauma support.

Children were not given a medical or physical check after they had been held down by force. When parents of one child asked the school for counselling they were ignored which goes against guidance.

Parents did not feel that their complaints were understood or respected.

They were often afraid to follow up on a concern because they didn't want their child to be excluded from school.

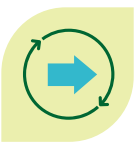
What needs to change



Restraint must only ever be used to keep a child safe — never to punish or control.

Staff need proper training, clear rules, and children must get support if they've been hurt.





5: Leadership Failures

Schools have Governors. They set the vision for the school and make sure children and young people are safe. The Headteacher is accountable to them.

Evidence showed:

Foden had too much control.
He was too involved in how the school was run, how policies were written and made too many decisions on his own. Governors' meetings included the managers that Foden chose. They influenced decisions and were difficult to challenge.

The school operated under its own safeguarding policies that Foden had written.
Foden used these policies to defend his actions. There was no evidence that local authority or the school Governors challenged these.

Decisions were made without the right people or following guidance.
For example, in 2021 Local Authority officers agreed that Foden should be suspended while there was an investigation. The Chair of Governors decided not to suspend Foden but asked him to work from home. Evidence showed that Foden was involved in that decision. The Chair of Governors hadn't been told the truth or given the right information. Foden was the one who wrote a letter from the Governor saying that Foden 'posed no risk to any pupils'.

Governors were not empowered and the attitude 'was agree or leave'.
Governors didn't challenge Foden and relied on him for advice. They depended on him and this gave him control. For example, one Governor raised concerns but soon after, Foden found out and made it too difficult for him to stay, so he left.

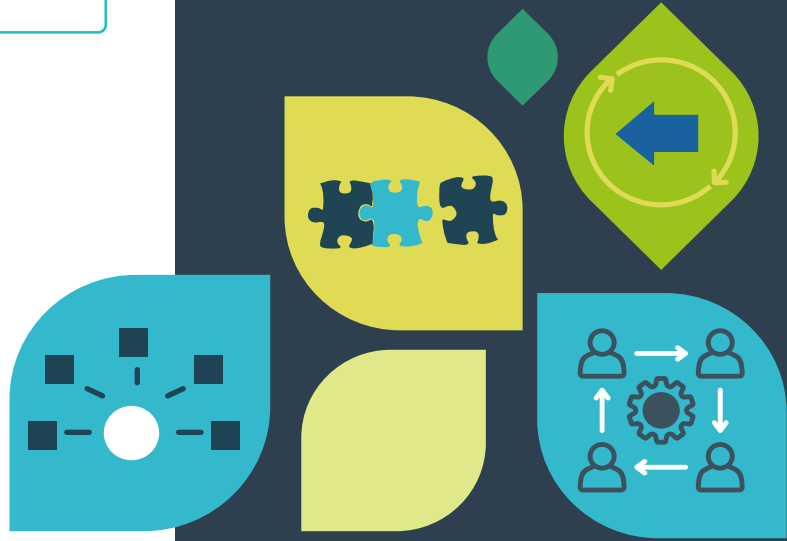
The Governors didn't have enough safeguarding training.
In March 2019 Cynfor Gwynedd commissioned an investigation by an Independent Complaints Panel (ICC). They found that the Governors 'lacked an understanding of the issues in front of them and were overly dependent on the opinion of the Headteacher or Senior Staff.'

Complaints and concerns were not handled in the right ways.
Often Governors were not told about allegations and Foden made decisions without them.

What needs to change



School governors must understand safeguarding and be ready to challenge poor leadership.
One person should never control everything.





6. Crisis Planning and Emergency Response

Senior leaders managing safeguarding in schools and services need to have a clear plan on how they deal with an emergency, including what to do if a child reports abuse. The priority is to keep children safe.

Evidence showed:

There was no plan for how services work together in an emergency.

The school, Local Authority Children and Families Services and Educations Services had no plan in place to respond to a crisis.

The police were not called straight away when Child D was at risk.

Instead, she was kept in a cupboard for several hours in an attempt to protect her. The school should have contacted the police immediately.

Foden was not blocked from the school.

He was able to delete evidence. There was no thought that he may be a threat to other children at the school.

The school had no emergency plan.

When Child D told staff what had happened there was a lack of co-ordination. Staff were in shock and unsure what to do. The Deputy Designated Safeguarding Person got advice from Gwynedd Children and Families Services and Educations Services. They were told to fill out the referral form and send copies of messages. This put Child D at risk as Foden was at the school.

They didn't follow school policy to call the County Designated Officer for Safeguarding or the Chair of Governors.

Communication was not clear or organised.

When the school contacted the Police, they thought Foden was unaware what was happening. So, the Police recorded 'There is no suggestion from the caller that there was immediate risk to necessitate an urgent response'. This meant that Child D and other pupils were at risk.

There's no record of who contacted the Governors or how other professionals were informed.

What needs to change



When a child speaks up, the response must be quick, calm, and safe.

All schools and services need a plan to deal with emergencies properly.





7: Training

Schools and colleges in Wales have a legal duty to protect children. This includes having at least one Designated Safeguarding Person (DSP).

Evidence showed:

The DSP's at the school didn't have safeguarding training.

Foden appointed DSP's who were weak and who depended on him for advice and decision making. They didn't have experience or safeguarding training.

The Local Authority didn't check if the DSP, Governors or staff had safeguarding training.

They also didn't challenge Foden's attitude to training or rules.

Children didn't understand grooming and how it links to sexual abuse.

Some of Foden's victims began to understand he was grooming and abusive by searching the internet and social media. Some victims had friends who warned them that Foden's behaviour was inappropriate. One had a friend who encouraged them to speak to an adult. This should be part of the curriculum so children understand how to spot the signs and who to contact if they feel they are at risk.

What needs to change



Staff and governors must be trained to spot grooming, abuse, and risky behaviour – and know how to respond.

Children need to learn about this too.





Main Issue: Not Listening to Children

The review found that professionals didn't listen to children's concerns. They didn't talk to children after a referral to find out their experience. For example, when concerns were raised by the NSPCC about Foden's behaviour with Child A the Local Authority never talked to the child.

It takes courage to speak up and challenge an abuser, and children need to be listened to.

What needs to change



Children must be listened to, believed, and taken seriously.

Their voices matter — and speaking up should never be ignored or brushed aside.

Learning from mistakes — making a safer future

The recommendations aim to stop abuse, help victims, and make sure that professionals move quickly when they notice something is wrong.

Recommendations to improve listening to children

➡ All organisations should:

- review their policies and make sure they include listening to children
- be able to show evidence of the systems they use to listen to children to their Board and Regulators
- make sure staff are trained to spot behaviour changes that might signal grooming.

➡ Schools must record any changes in a child's behaviour and report concerns.

➡ Professionals should, when a referral is made:

- look at the child's records and consider if they are at risk
- speak to the child and their social worker.

➡ Cyngor Gwynedd should:

- consult with pupils to find the best ways to get support and report concerns or worries
- make sure there are clear contact details of who to contact in schools.

➡ Welsh Government should use the curriculum to make sure pupils understand grooming behaviours and know how to report issues to an adult.

➡ All local authorities should:

- show evidence that they support victims of trauma
- make sure nothing stops victims of abuse having their right to an education.





Recommendations for working together and managing concerns

➡ Welsh Government should:

- make sure the Wales Safeguarding Procedures include the lessons learned and the voice of the child
- make sure guidance includes how to deal with concerns across local authorities and when to investigate
- consider making schools develop an 'Adult Conduct of Concerns Policy' and have guidance on safe working practice
- make sure the National Strategy for Preventing and Responding to Child Sexual Abuse considers the findings of this review.

➡ Safeguarding Boards should:

- get local authorities to confirm that professionals have training and supervision
- review local authority reports on how they managed allegations at least once a year
- develop a standard referral form for concerns about adults in a position of trust.

Recommendations to support training

➡ Professionals and volunteers working with children must have training that:

- helps them 'think the unthinkable' and understand that 'it could happen here'
- helps them think what if I am right?' rather than 'what if I am wrong?' when they have a concern
- raises awareness about how to report their concerns.

➡ Welsh Government should develop and deliver training for professionals working across services on this review.

➡ School staff, volunteers and Governors should have to do training on sex offenders and grooming.

➡ Safeguarding Boards should get local authorities to confirm that:

- staff have training on how to manage concerns about adults working with children
- they have clear, easy-to-understand Whistleblowing policies for staff to use.



Recommendations for Governors of Schools in Wales

➡ Welsh Government should:

- review how schools are run
- make sure Governors understand their roles and responsibilities for keeping children safe
- develop and deliver a system that measures the culture of a school
- clearly set out that Governors must keep accurate records of safeguarding decisions
- make sure that school Designated Safeguarding People have supervision sessions with qualified Social Workers.

Recommendations for managing an emergency

➡ **Welsh Government should** get local authorities to confirm that they have a clear plan for how services will work together in a crisis.

➡ **Local authorities' plans** should include:

- arrangements for victim care, securing evidence, and managing offenders
- ways to share information
- processes so evidence is checked in the right ways
- on-site support for children and adults.

➡ **Social Workers and the Police should** work together to make sure evidence and information consider safeguarding as well as crimes.

Recommendation for Restrictive Practices

➡ **Welsh Government should** update their guidance about filming restraint by adults, and how filmed records should be kept.

Recommendations for Safeguarding Partners

➡ **Betsi Cadwaladr University Health Board should:**

- consider ways to share CAMHS data and concerns with local authorities to spot children at risk
- be able to show that health professionals get advice and know how to protect a child who come to appointments with an adult that isn't their parent or carer.





Thank you for reading

We know this has been difficult to read. For many, it may bring up painful memories and emotions. This review was written so that what happened is recognised, and the lessons are not lost.

Children should always feel safe at school — and it is the responsibility of adults to protect them.

If you've been affected by anything in this review, talk to someone you trust. You can also connect with:

Childline

☎ 0800 1111
www.childline.org.uk

NSPCC

☎ 0808 800 5000
nspcc.org.uk

MEIC

☎ 08088 023456
www.meiccymru.org

You can also connect with us at: northwalessafeguardingboard.wales

