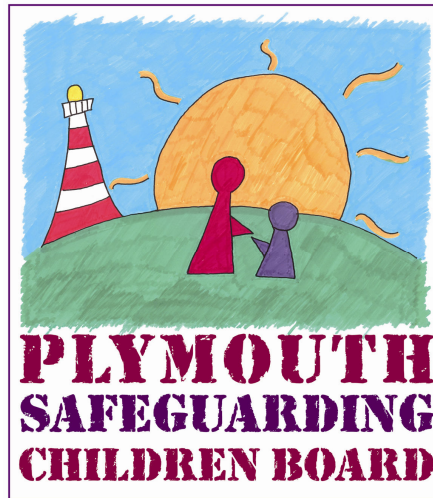


**Plymouth Safeguarding Children Board**



**Serious Case Review**

**Overview Report**

**Executive Summary**

**in respect of**

**Nursery Z**

**March 2010**

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# 1 INTRODUCTION

## Background to the review

- 1.1 This serious case review relates to the allegations regarding the sexual abuse of children in a nursery (nursery Z) in Plymouth, and the subsequent conviction of a female nursery worker, K. In line with Government guidance<sup>1</sup> this executive summary aims to accurately reflect the full report whilst protecting the identity of children, family members and others. Due to the particular circumstances surrounding this review the executive summary is deliberately detailed in order to ensure transparency and enable the public, including the families affected by these events, to understand as fully as possible the findings of the review.
- 1.2 Z had been a nursery since 1994. Its status was an unincorporated not-for-profit association, 'owned' by a committee of trustees and managed by the nursery manager from July 2002. K joined the staff group in September 2006. Enquiries led to the arrest of K on the evening of 8<sup>th</sup> June, 2009, after photographs of a sexual nature, which showed a nursery Z tee shirt and appeared to have been taken in the toilet area of Z, were discovered on the computer of a 39 year old male (H) in the north of England. The nursery was closed the next day pending police enquiries and has not reopened. K, H, and a further female from the Nottingham area were convicted at Bristol Crown Court in October 2009. K was sentenced on 15<sup>th</sup> December, 2009 and received an indeterminate sentence, with the stipulation that she be held in custody until she is no longer considered a danger to the public. The minimum jail term she will serve is seven years.
- 1.3 Following K's arrest, agencies in Plymouth immediately came together to provide support to parents of children who had attended the nursery, and commissioned the NSPCC to provide support to the staff group.
- 1.4 On 12<sup>th</sup> June 2009, the independent chair of Plymouth Safeguarding Children Board, Jim Gould, decided that a serious case review should be undertaken in accordance with *Working Together to Safeguard Children (2006)* which was the Government guidance current at that time. (This has since been superseded by new guidance in 2010). This decision was taken at an emergency meeting of the Safeguarding Board called due to the unprecedented circumstances of this case. The decision to commence this review was therefore made by the independent chair of the board in consultation with all partner agencies.

## Terms of reference and scope of the review

- 1.5 Government guidance clearly states that the purpose of a serious case review is to establish what lessons can be learned and use these lessons to improve intra and inter agency working.

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<sup>1</sup> HM Government (2010) *Working Together to Safeguard Children*: London: Department for Children Schools & Families

*Serious Case Reviews are not inquiries into how a child died or was seriously harmed, or into who is culpable. (“Working Together” para 8.7)*

*Nor are Serious Case Reviews part of any disciplinary inquiry or process relating to individual practitioners. (“Working Together” para 8.8)*

The focus of the review is therefore on understanding what happened, why it happened and how such an event might be prevented in the future.

- 1.6 Most serious case reviews focus on a family situation, and the circumstances of this review are therefore unusual. The scope and terms of reference were thoroughly discussed with Government Office South West who provided advice and guidance before they were agreed with the full Plymouth Safeguarding Children Board. It was decided that the focus of this review would be the nursery as a whole rather than the individual children attending the nursery since the police have not been able to establish which children were abused by K.
- 1.7 It was established that the purpose of this review is to look critically and analytically at individual and organisational practice, in order to establish whether there are lessons to be learned about the way professionals, agencies and the independent sector worked to safeguard children in the nursery setting, what those lessons are, and how they can be acted on to improve the safeguarding of young children. Specifically the scope of the review was determined as:
1. To address whether local and national procedures, policy, guidance and regulations have been followed in relation to the quality of care, safeguarding and protection of children in the setting and in relation to the inspection of standards.
  2. To identify and consider any information or concerns that children’s services agencies, individual professionals, identified educational establishments and the Church had about K that may have indicated that she posed, or might pose, a risk to children.
  3. To identify and consider any information or concerns that children’s services agencies (Health and Children’s Social Care and Early Years) had in relation to the setting.
  4. To consider whether any such information was shared in a timely manner and in accordance with statutory and good practice guidance, whether appropriate assessment of risk was carried out and if not, why not.
  5. To examine the recruitment processes carried out by employers of K where she was employed to work with children, to identify any gaps in vetting processes or breaches of recruitment policy (including for voluntary staff) and good practice applicable at the time.

6. To identify the areas of strengths and weaknesses in the child protection policies and practices, the training, staff development and general and child protection supervision provided for K and staff within the setting.
7. Plymouth Safeguarding Children Board recognises that it would be helpful for this review to understand the information gathered during the investigation from the 9<sup>th</sup> June 2009, to the conclusion of the criminal proceedings. This Serious Case Review will be conducted in two parts, in order not to compromise the outcome of criminal proceedings and to avoid issues of disclosure.
8. The Serious Case Review will incorporate information gathered by all parties during the investigation. Plymouth Safeguarding Children Board will review and amend the Terms of Reference as required.

1.8 The specific terms of reference for individual management reviews were agreed as follows:

Individual management reviews should:

1. Review the history of Z day care centre, including the links to schools, the Church and Plymouth Children's Services, from the time it first registered as an independent nursery, until the arrest of K on 8<sup>th</sup> June 2009, specifically commenting on what was known about :-
  - The daily routine and operation of the centre to include how children made use of and moved around the rooms in the centre
  - The experience of a child in the nursery at ages, 6 months, 2 years and 3 years
  - The fabric and resources of the nursery and its fitness for purpose
  - The standard of administration and record keeping at the centre
  - The finances of the nursery and the utilisation of funds
  - The means and type of communication with parents.
2. Identify how the centre was staffed from 2006, when K was first employed, until the arrest of K in 2009. To include visiting professionals, voluntary workers, trainee child care workers and work experience students.
3. Identify whether the nursery met the linguistic, cultural, ethnic needs and additional needs arising from disability and educational needs.
4. Assess whether the nursery met the standards of education and care for the children placed there.
5. Identify any concerns about the standard of care or education at the nursery over the last 3 years, how these were raised and the way in which these were addressed.
6. Review how the manager of Z discharged her duties in the safeguarding of children in her care with respect to:-

- The existence of an approved child protection policy and how this was shared with staff and parents
- Adherence to safe recruitment policy
- Adherence to approved staffing ratios
- Training of staff in child protection
- Child protection supervision
- Safety of the environment
- Arrangements for intimate care
- Existence of completed risk assessments
- Maintenance of a incident log to include actions taken
- Communication with parents
- Any policy for staff raising issues of concern about staff behaviour, or other staff concerns

7. Review the Inspection Process, including:

- 1 How this contributed to the safeguarding of children.
- 2 What evidence there is of children's educational attainments being met and any recommendations associated with this.
- 3 Identify any actions determined by the Inspection process, noting the review of the implementation.
- 4 Review the evidence and judgment in the inspection regime, with particular reference to safeguarding.
- 5 Review advice given to the nursery and clarify whether any recommendations were acted on and any subsequent arrangements/recommendations that followed.

8. For each agency to review any information held in respect of K in order to understand if there were any opportunities to identify that she may be a risk to children.

**The serious case review process**

1.9 The Plymouth Safeguarding Children Board established a Serious Case Review Panel to oversee the process of the review. The Independent Chair of the Panel was Mike Craddock, a former senior manager in Children's Social Care.

Panel members were:

Designated Doctor Safeguarding Children, NHS Plymouth  
 Designated Nurse Safeguarding Children, NHS Plymouth  
 Safeguarding Manager, Children's Social Care, PCC  
 Detective Chief Inspector, Devon and Cornwall Constabulary  
 Early Years Adviser, Early Years Service, PCC  
 Children's Centre Manager, Action for Children

1.10 The following agencies that had had contact with the nursery were requested to provide individual management reviews:

- 1 Education (Early Years)
- 2 Ofsted
- 3 Children's Social Care
- 4 Devon and Cornwall Constabulary
- 5 Plymouth Hospitals NHS Trust
- 6 NHS Plymouth Primary Care Trust
- 7 The Church whose premises the nursery used
- 8 The primary school
- 9 The secondary school and work experience placement provider.

1.11 Due to the pending criminal proceedings, it was agreed that the review should take place in two stages. During the first stage it was not possible to interview staff from the nursery or families of the children attending the nursery. It was also not possible to examine documents that had been seized by the police for use in the criminal proceedings or to complete the individual management review in respect of the nursery. The nursery individual management review was commissioned from an independent agency following the conviction of K in October 2009.

1.12 The following additional information was obtained by the panel and was used to inform the overview report:

- The pre-sentence report in respect of K
- The psychiatric report for the court
- Financial records from Z
- Staff interview notes prepared by the Z individual management review author
- A report by the NSPCC of the support programme for nursery staff following the closure of the nursery.

1.13 An independent overview author was commissioned, who prepared an interim report in November 2009. However, due to unforeseen circumstances, it was not possible for the original author to complete the review. A new author was appointed in December 2009 and this overview report has been prepared by Jane Wonnacott, Independent Consultant, In-Trac Training and Consultancy Ltd.

### **Family Involvement**

1.14 In January 2010, a series of three open meetings were set up for families to meet the overview author and contribute to the review. Seven families were seen, discussions were transcribed and their comments have been incorporated into the body of this report. Subsequently, two of the parents submitted further comments to the review via a senior outreach worker at a local family centre. The review panel would like to extend their thanks to these families for their invaluable insight into the day to day experience of families and children attending the nursery and suggestions as to how such abuse

could be prevented in the future.

- 1.15 K's husband has been offered the opportunity to contribute to this review, but feels that, due to the traumatic circumstances, he is not able to do so at this time. K has continued to refuse to give any further information regarding her offences, and the panel agreed there would be little to be gained by the overview author interviewing her as part of this review process.

### **Involvement of Nursery Staff**

- 1.16 Twenty two members of nursery staff who had been working at the nursery at the time of K's arrest were offered the opportunity to be interviewed by the author of the nursery individual management review. A further eight invitations were sent to staff previously employed by the nursery. Thirteen people accepted the invitation to be interviewed. All interviews were transcribed and the notes agreed by the member of staff concerned.

## **2 NURSERY Z**

- 2.1 Z nursery opened as a community facility for morning and afternoon sessions in September 1992 in the basement of the local Primary School, with access to its own outside space. In 1994, the nursery was registered by Devon County Council to provide sessional pre-school and full day care for children aged over two years, with before and after school care for pupils of the school. This unit is known throughout this report as Z1. The most recent certificate of registration for Z1 was issued on 18<sup>th</sup> September 2008.
- 2.2 In December 2002, a second unit (Z2) opened in a neighbouring separate church hall. This smaller unit provided places for babies aged under one year. The most recent certificate for Z2 was issued on 15<sup>th</sup> March 2008.
- 2.3 The management of the nursery was completely separate from the school. The nursery was an unincorporated not-for-profit association, jointly managed by a board of four trustees. One trustee was noted by Ofsted to be the nursery manager although the manager has since disputed that this was the case. The fourth trustee is known to be deceased. It is significant that the trustees who were interviewed by the nursery individual management review author were unaware of their responsibilities to the nursery, and no trustee meetings took place. One trustee was unaware of the fact that her name was recorded as a trustee of the nursery. Staff interviewed were unclear about the status of the nursery and the names of the trustees. The nominated person representing the association for registration purposes was the nursery manager and parents interviewed during this review had considered the manager to be the owner of the nursery.
- 2.4 K was deputy special educational needs co-ordinator for the nursery, but the author of the Z individual management review did not gain the impression that this gave her any special status within the staff group. Staff referred to the



special educational needs co-ordinator, rather than K, as the expert in special educational needs.

- 2.5 The manager of the nursery was also an approved foster carer for Plymouth City Council. There was therefore substantial involvement with the fostering team from Plymouth City Council Children's Social Care, whose role it is to assess and support approved foster carers, and work with children placed with the nursery manager in her foster carer role. However, the fostering team had no formal role in relation to the standards of care within the nursery.
- 2.6 Z was registered by Ofsted who took over the responsibility for regulating all early years child minding and childcare setting from local authorities on 1<sup>st</sup> September 2001. On this date, all registered childcare providers and child minders, previously judged by local authorities to be suitable to provide registered childcare, were deemed suitable by Ofsted under regulations supporting the transfer of responsibility for regulation to Ofsted. Providers and staff of Z1 were therefore deemed suitable by Ofsted as they had previously been considered suitable by Plymouth City Council.
- 2.7 The current requirements for registration of childcare provision are set out in the National Standards and associated regulations and, since September 2008, in the Early Years Foundation Stage and other regulations set out in the Child Care Act 2006. When Ofsted's regulatory role commenced in September 2001, this was defined by the Children Act 1989, introduced by Part 6 of the Care Standards Act 2000, and accompanying regulations. Ofsted inspected Z1 and 2 in line with statutory requirements.
- 2.8 The Early Years Service, unlike Ofsted, is not a registration or regulatory authority. Plymouth City Council's Early Years Service works within the statutory framework defined by the Child Care Act 2006, and is expected to support settings to improve by offering information, advice, support and challenge. There was regular contact between Plymouth Early Years Service and Z.
- 2.9 It is important to note that if a setting in the opinion of the local authority's Early Years Service fails to improve and maintain improvement, the Early Years Service can only make a complaint to Ofsted regarding a setting if there is evidence of a breach of compliance with the statutory regulations. There is no other mechanism for Ofsted and local authorities to have a two way exchange of information. The local authority can withdraw funding from Early Years providers but would only consider doing this if there was an "inadequate" judgment from Ofsted.
- 2.10 In July 2008, Z1 moved from the school basement to the former reception area of the primary school, and consisted of a smaller nursery base than before, with outside space that was shared with the school children. Z1 used the school hall for lunches, occasional story times and the after school club. The previous site had been open plan and the children had been visible from all angles, but the children were less visible in the new site. Nappy changing took place in the toilet area which could be seen from the area of the main room where staff

prepared snacks with the children. According to the manager, the toilet door was usually propped open as it was a heavy door and she was concerned about children trapping their fingers in it as it closed. There were four cubicles in a row, one with a full sized door, and three others with a half door. Most staff changed nappies on the main nappy changing area easily visible to other staff; K, however, started to use the cubicle with the full door, saying she could not bend down due to her size. Although the door was open her body blocked the line of vision from the nursery to the child.

- 2.11 The physical environment of Z1 was described in several reports as cluttered and this is confirmed by the police photographs taken following K's arrest. The Early Years Service consistently worked with Z regarding removing clutter and encouraging the development of a more appropriate environment. However, since Z1 met the requirements of the Early Years Foundation Stage, and therefore passed Ofsted inspections, there was little leverage available to the local authority to insist on improvements.
- 2.12 Conditions within Z2 are a cause for concern. There are reports of the floor being dirty and staff describing the atmosphere and environment as depressing and demoralising. In order to change a nappy staff would have to take the baby some way up the corridor to the toilets and the changing area, leaving the other member of staff on their own. When the serious case review panel visited Z2 they were shocked at the conditions and felt they were not suitable for young babies.

### **3 K**

- 3.1 K started working at the nursery in September 2006. There are no records of an advertisement, interview or references for the post, but there are copies of a CRB check, health screening, a contract letter, a statement of particulars and pay roll forms. The nursery manager had been a Governor at the school for twenty four years, and knew K and her two children through school. There was no formal interview prior to her appointment at Z, although the nursery manager did talk to the teacher with whom K had been working.
- 3.2 K became deputy special educational needs co-ordinator (SENCo) at Z. There is no evidence of a formal job description for the role of SENCo, but the nursery individual management review does comment that K had training for this role.
- 3.3 K's GP records do not record anything of significance. The individual management review notes that K at no time during her consultations revealed anything that would have given rise to concern about her behaviour towards children. She was not known to have any mental health or psychological difficulties. Her consultations with the GP were all related to her general health and well-being.
- 3.4 Within the nursery, K is generally described as a popular member of staff. The nursery manager did tell the review that K 'changed' from approximately December 2008. She is described as from that point always seeming to be on

the internet, and chasing men. The nursery manager heard that K had offered a man sex for doing her MOT, and that she had sex with a man on the moors for money. The nursery manager confronted K about this, but there is no evidence that K's behaviour changed as a result.

#### **4. HISTORY OF PROFESSIONAL INVOLVEMENT WITH Z DAY NURSERY**

- 4.1 Z was registered by Devon County Council as an independent setting in August 1994. Ofsted assumed responsibility for registration and inspection in September 2001 and Z was registered with Ofsted. No visit from Ofsted took place at this point but a transitional inspection visit took place on 28<sup>th</sup> January 2002 when registration continued with eight actions imposed to ensure Z met National Standards. These actions to meet the new standards were considered by Ofsted to be within the range considered acceptable at the time of transition.
- 4.2 In June 2002, an application was made to Ofsted to register Z2. Registration was completed on 5<sup>th</sup> December 2002.
- 4.3 During 2002 and 2003 this review found four potential child protection issues relating to children attending the nursery. Three involved possible issues within the family and in each instance there is no clear evidence of how child protection procedures within the nursery were followed, although in one case it seems that a referral was made to Children's Social Care. The third case involved a possible issue to do with care within the nursery and was appropriately referred to Ofsted by Children's Social Care. Ofsted required the nursery to review child protection policies and send a report as to what had happened. The documentation regarding this was received by Ofsted one year later. The response was deemed adequate and the case was closed.
- 4.4 In May 2003, a member of Plymouth early years advisory team visited the nursery and encouraged the manager to improve teaching and learning through developing planning and assessment. Further visits in January, February, June, and November 2004 provided general support to the nursery with a particular focus on improving planning processes for the children.
- 4.5 The Ofsted record for the inspection of Z1 on 15<sup>th</sup> January 2004 comments that the nursery was satisfactory in relation to safeguarding. Eight recommendations were set for Z1, including :
- Ensure the behavior management policy includes a statement on bullying
  - Develop the child protection policy to include procedures to be followed in the event of an allegation being made against a member of staff or volunteer and ensure all staff are aware of child protection procedures
  - Ensure all policies are complete, reviewed when scheduled, and ratified by the trustees, in particular: complaints; employment; equal opportunities; and child protection.
- 4.6 The inspection of Z2, also on 15<sup>th</sup> January 2004, resulted in a satisfactory judgment. However, there was evidence that the senior staff's knowledge of

procedures was lacking, and the child protection policies incomplete. Actions were set requiring the Registered Person to:

- Develop the child protection policy to include procedures to be followed in the event of an allegation being made against member of staff or volunteer, and ensure all staff are aware of child protection procedures.

- 4.7 Z's records note that Ofsted were notified by staff during their inspection visit that a child had left the premises unaccompanied, and that Ofsted required the nursery to provide a report. The whole record of this incident is not available via Ofsted due to data storage policies in place at that time, but it is clear that Plymouth Early Years Service were not aware of this notification to Ofsted.
- 4.8 The incident above should be seen within the context of information given to the overview author at the parents' consultation meeting regarding a child having been found outside in the road with other children after the gates of the nursery had been left open. Another parent noted that he had arrived to collect his child and found the gate to the nursery unlocked, and children playing in the courtyard without any supervision.
- 4.9 Following assessment in line with Fostering Services Regulations 2002 reg. 27, the nursery manager was approved as a foster carer. The fostering team noted that she received relevant training such as child protection through her work at the nursery, although this review found that this is not always backed up by nursery records. There were no concerns regarding the manager as a foster carer and children placed with her responded well to their placements. The fostering team believed that a positive aspect of the placement was the fact that the children could attend nursery with her, avoiding separation whilst she was at work. However since their carer was the manager of the nursery with wide ranging responsibilities their day to day care, including taking them to contact visits with their parents, was frequently carried out by nursery staff.
- 4.10 Support and encouragement to improve planning processes continued to be the focus of visits from the early years advisory team in 2005 and in September team records show that there was concern that progress had been limited.
- 4.11 There are three child protection issues recorded in 2005 and 2006 all involving possible abuse within the families of children attending the nursery. There is no evidence that they were referred to Children's Social Care.
- 4.12 In January 2006 concerns about the nursery within the early years service continued particularly in relation to the way staff responded to boisterous behaviour. The Inclusion Advisory Service subsequently delivered in-house behavioural management training to the staff as a matter of priority and no further concerns in relation to behaviour management were observed by early years staff in their subsequent frequent visits to Z.
- 4.13 The need to improve planning for the children at the nursery did however continue to be a concern within the Early Years Service as well as other issues relating to the general experience of children within the nursery. Concerns were also noted about the standard of cleanliness and depressing atmosphere in Z2

and there were queries within the early years team regarding how receptive the manager at the nursery was to advice.

- 4.14 In the spring of 2007 the early years team began an internal process of categorising settings so that those settings requiring additional support could be identified, as well as sharing concerns and examples of good practice across the early years team (known as 'RAG' categorizations – red, amber, green). Z1 and Z2 were categorised as red and amber respectively, because of the continuing need for additional support, and concerns about management and the setting's ability to adapt to the early years' best practice.
- 4.15 On 18<sup>th</sup> April, 2007, an Ofsted special report gave Z1 an overall grade of satisfactory, and a number of recommendations were made in respect of quality and standards of care, including:
- Further develop the sick children's policy to clarify that sick children will not be accepted
  - Further develop lost and uncollected child policy to ensure that procedures in the event of a child being lost are specific and not ambiguous
  - Ensure the contact details for the regulator are included in the complaints policy and further develop the complaints log to include all of the elements required by the regulations
  - Provide parents with up to date information about the settings policies and procedures and ensure that they are given adequate information about the children's activities
  - Develop robust procedures to ensure the ongoing suitability of staff
- 4.16 In July 2007, the early years team reviewed both Z1 and Z2 under the recently introduced RAG rating. Z1 continued to be RAG rated red, and Z2 remained at amber.
- 4.17 At a foster care review in November, 2007, the nursery manager was praised for her exceptional care to all her age ranges, and her immense experience in caring and working with children in the nursery setting was acknowledged.
- 4.18 A general support visit by early years team took place in November 2007 and following a further visit in December, Z1 remained RAG rated red and Z2 amber.
- 4.19 In December 2007 a telephone report was made to Ofsted by a parent regarding a member of staff being verbally abusive to them in front of other adults. The nature of this complaint fell within a category that Ofsted felt it reasonable to ask the nursery to investigate and provide a report. Z provided a response to Ofsted one month later which this was considered by Ofsted to be incomplete, as there were no copies of the Z complaints policies. The end of this compliance investigation was in May 2008, almost six months since the original complaint. There was no indication from the early years chronology that they were aware of the complaint received by Ofsted or the subsequent investigation.

- 4.20 There was a routine Ofsted inspection of Z2 on 25<sup>th</sup> February. The Ofsted judgment was that overall the quality of care was good.
- 4.21 A further early years visit in March 2008 to Z1 was more positive than previously, and staff were noted to be more enthusiastic, which had a positive impact on the children. At the end of March 2008, and again in December 2008 the RAG rating for Z1 had increased to amber, and Z2 was also rated amber.
- 4.22 During 2008, Children's Social Care received a referral expressing concern about the manager's care of a foster child. The fostering social worker followed this up with a home visit where care of the baby was observed to be good. The concerns were therefore deemed to be unfounded.
- 4.23 There is however no record that the early years team were made aware of this referral and the subsequent enquires.
- 4.24 In March 2009 a parent made a telephone complaint to Ofsted regarding a member of staff shouting at a child and causing that child and other children to be frightened. The management of the nursery held a meeting but decided to take no further action, and referred the mother to Ofsted if she was not happy about the outcome. Children's Social Care held a strategy meeting on 10<sup>th</sup> March to consider the allegations. There is no record in the early years chronology that they were aware of this complaint, or asked to attend the strategy meeting. The decision of the strategy meeting was that no child protection enquiries under s47 (Children Act 1989) should take place. The nursery manager and a supervisor agreed that they would visit the unit more often, review procedures, and assess the competency of the staff member.
- 4.25 The action of Ofsted in response to this complaint was to ask the nursery to investigate and provide a report. Despite repeated requests for the report by Ofsted, it was not received until 13<sup>th</sup> June 2009.
- 4.26 By the end of March 2009, Z1 and Z2 were both rated red on the RAG system. There were concerns about management, quality, inclusion and sustainability. The setting had not made any progress towards improving observation and planning and there was little opportunity for staff to reflect on their practice. There were concerns about the quality of paperwork submitted to obtain extra support for specific children and the fact that little use had been made of advice and support from the early years inclusion assessment service.
- 4.27 On 8<sup>th</sup> June 2009, K was arrested and the nursery was suspended. Following her arrest, agencies in Plymouth worked effectively together to develop a media strategy and plan for supporting the families affected by the incident. This strategy remained in place and provided support through to the trial and sentencing.
- 4.28 In addition to the support strategy for parents, the NSPCC were commissioned to provide support for staff. One group meeting took place attended by eight staff members. More sessions were offered but not taken up. The staff meeting

highlighted the low level of knowledge within the staff group regarding females who pose a risk to children.

## 5 THEMES ARISING FROM THIS REVIEW

### The role of K within the nursery

- 5.1 It is not for this review to speculate on the origins of K's sexually abusive behaviour and why she abused the children at Z. However, it has become clear that there is no evidence that K had a sexual interest in children prior to the commencement of her internet relationship with H, and it is therefore unlikely that a sexual interest in children would have been apparent prior to K 'meeting' him. It has been important for this review to understand more generally the environment that allowed the abuse to take place, K's role within the staff team, and whether there are any lessons to be learned that may assist in preventing similar abuse in the future.
- 5.2 K has been described by staff as both "*horrible*" and more often "*the life and soul of the party*". The predominant view is of a popular member of staff both with parents and other members of the staff team. The Z individual management review comments that:
- "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 ... It is also the case that K is of the ability to behave in a highly manipulative manner and hence gain high levels of trust in others"*
- 5.3 It is quite clear that K had gained a position of trust with the manager, who allowed her to babysit for her foster children. Some staff referred to K being one of a clique. Her 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 were unable to challenge her.
- 5.4 Another reason for lack of challenge within the staff group proposed by the nursery individual management review author is that colleagues experienced feelings of guilt and discomfort at having been exposed to this increasingly inappropriate material. By even being shown sexualised pictures it is possible that staff believed they had "allowed" it to happen and consequently did not know how to raise this with others. By drawing others partially into her activities, K made challenge even less likely and may have interpreted the behaviour as implicit support.
- 5.5 What has become clear is that K was an emotionally vulnerable woman who was working in an environment where she was able to supply images of the sexual abuse of children to further her 'relationship' with H. It is possible that other staff working in early years settings may also have a degree of emotional

vulnerability. Proper recruitment procedures using value based interviewing<sup>2</sup> should assist in identifying where the emotional vulnerability of staff may be a risk factor affecting their capacity to provide a safe environment for children in their care. In the case of K, the fact that the manager had not been trained in safer recruitment procedures, the informality of the recruitment processes and lack of formal staff supervision within the nursery, did not allow vulnerabilities to be identified and managed within the work environment.

### **The experience of families whose children attended the nursery**

- 5.6 Only seven families were represented at the sessions with the overview author. It was thought by the panel that most felt that the trial had been a point of “closure” and they now wished to look to the future. Involving families in such circumstances in serious case reviews does therefore present challenges. At the point they may have wished to contribute they were unable to do so due to the potential that they could be called as witnesses. The fact that most now feel at a position where they wish to move on is likely to be testament to the very comprehensive support package that was put in place by Plymouth City Council and partner agencies from the time the abuse came to light through to the trial and sentencing. Families continue to be offered support and are connected with service provision such as children’s centres where appropriate.
- 5.7 There was much consistent information obtained from the families who were seen, and, although they cannot be taken to be representative of the whole parent group, common themes emerged.
- Generally children were happy to be at the nursery (with one notable exception).
  - Staff were friendly.
  - The fact that the nursery used the facilities of the primary school was an advantage as it was hoped that this would ease the transition to school at age five.
  - There were some concerns about security with one child having been found on the road, and the gates on occasion being unlocked.
  - There was little communication between the nursery and parents regarding their child/ how they were at nursery etc. When there was something to communicate such as a child had fallen over the information was often received on a “post it” note. Children rarely took work home.
  - Parents thought the nursery was owned by the nursery manage.
  - No parent knew who their child’s key worker was.
  - No parent had seen a prospectus.
  - No parent knew where to go to with a complaint.
  - Parents who now have children at other nurseries can recognise the lack of structure in Z.
  - It would be helpful to have a leaflet explaining what to look for when

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<sup>2</sup> Erooga, M. (2009). *Towards safer organisations: selection and recruitment procedures to help safeguard children*. NSPCC inform [www.nspcc.org.uk/inform](http://www.nspcc.org.uk/inform)



choosing a nursery.

- 5.8 In relation to the lack of knowledge amongst parents regarding their child's key worker, the review identified that staff tended to move between Z1 and Z2. This fluidity of staffing deployment would have affected the key worker system and possibly explains why parents were unaware of who their child's key worker was.
- 5.9 The general picture that emerged is of a relaxed environment lacking in structure. Parents mostly had little cause for concern as their children seemed happy to be at Z. However, the parents interviewed did not feel involved in their child's life at nursery and there was little evidence of effective communication between the nursery and parents. There was, for example, no newsletter or similar form of communication. Any day to day concerns by parents were raised with nursery assistants rather than the manager, and the lack of any confidential space to speak was a cause for concern to parents interviewed. Having now seen other settings, parents are aware of some of the shortcomings of Z and feel that they would have benefited from more specific guidance about how to choose a nursery.
- 5.10 The Z individual management review notes that, as a result of the nursery having developed as a community based resource, there was a degree of friendship between staff and some parents who socialised together. It is possible that parents who were part of this friendship network would not have felt the same way about lack of communication with staff as those who contributed to this review.

### **The experience of children who attended the nursery**

- 5.11 There is evidence that for a number of children, their experience at Z was positive, and that this was recognised by external visitors. The staff have been described as 'pleasant, keen and welcoming' and the children 'were looked after well'. Parents generally described their children as being happy at nursery, and there are examples of staff interacting well with the children.
- 5.12 However, there is also evidence emerging from this review that, for some children, nursery was not always a positive experience.
- 5.13 One parent told the review that her child had never settled at the nursery, and she eventually removed them from the setting. The experience of Z had resulted in the child fearing any contact with the nursery environment.
- 5.14 It is the view of the Z individual management review author that a child would have been aware of the tension in the environment around them. Tension that was a product of cliques amongst the staff. There are comments within one staff interview that the nursery was not a nice place for children.
- 5.15 The review received information which described children being poorly supervised, and having to lie on the floor and rest for fifteen minutes with one

staff member, while the rest had their cups of tea in another room. Lack of proper supervision by staff, as well as the individual needs of the children not always being recognised, is a theme in reports received for this review.

## **Governance and accountability**

- 5.16 One of the striking features of this review has been the weak governance framework and lack of clear lines of accountability within the nursery. This is likely to be a feature of other similar early years settings which have developed incrementally within local communities.
- 5.17 An unincorporated organisation<sup>3</sup> does not have its own legal identity and has no existence or personality separate from its individual members. Members of the organisation make their own rules which are usually laid out in their democratic “constitution” which is a written document signed by the members. The constitution ensures that:
- An organisation’s aims are clear and agreed by its members
  - There are mechanisms for making decisions and resolving disputes
  - There is accountability for running different aspects of the organisation
- 5.18 A management committee with officers (chair, treasurer, secretary) is usually elected to run the organisation on behalf of its members. There is no corporate liability and members carry risk personally for any loans and contracts they have signed. There is a view that this way of working is unlikely to offer a long term solution if an organisation intends to sign contracts or take on employees.
- 5.19 A recent publication<sup>4</sup> by the Scottish Law Commission has highlighted the unsatisfactory situation in relation to such organisations across the UK noting that:
- The law relating to unincorporated associations and clubs is widely regarded as being in an unsatisfactory state. Many people who join clubs or devote time to the management of voluntary associations are unaware of the personal liabilities which they may incur simply by becoming a member or committee member.*
- 5.20 Although Z was described as an unincorporated organisation there is no evidence of any document which could be described as a constitution. There were said to be four “trustees” who Ofsted record as having signed an agreement. Not all the trustees were aware that they had this role and it is clear that the running of the nursery was left to the manager. The parents interviewed for this review were unaware of the existence of any trustees and

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<sup>3</sup> See [www.netlawman.co.uk/info/unincorporated-associations.php](http://www.netlawman.co.uk/info/unincorporated-associations.php)

<sup>4</sup> Scottish Law Commission (November 2009) *News Release: Recognising the Existence of Associations and Clubs* [www.scotlawcom.gov.uk](http://www.scotlawcom.gov.uk)

most thought the nursery was a private setting owned by the manager. The manager herself said that she had thought that charitable status had been applied for and was surprised to find after the closure of the nursery that this was not the case.

- 5.21 The lack of clarity surrounding the responsibilities of trustees and the status of the nursery has left trustees in a vulnerable position.
- 5.22 There is no evidence that Ofsted ensured that the nursery was operating in line with the requirements of an unincorporated organisation. In fact there is evidence that Ofsted advised the nursery manager on her recruitment processes (i.e. the need to advertise rather than use word of mouth) whereas responsibility for recruitment should have been the board of trustees. The lack of formal trustee meetings did not allow proper sharing and discussion of any financial issues and planning for improvement.
- 5.23 Given the importance of ensuring that the organisations that deliver services to potentially vulnerable groups have robust structures and systems in place to ensure lines of accountability are clear, such loose arrangements as were apparent in Z led to confusion and a lack of clarity about to whom issues of concern should be referred. It was plain from meetings with parents conducted for this review that they were unclear about to whom they should go if they were dissatisfied about any aspect of the nursery provision. Most of the parents said they would raise any issues with staff and if they were very dissatisfied they would remove their child. Some of the issues raised by parents at the parents meetings were very serious including:
- a child found wandering in the road
  - unlocked gates
  - a breach of confidentiality

It is concerning that they were unaware of how to address these issues.

- 5.24 Z did not have a whistle blowing policy, and interviews with staff also identified a lack of knowledge about where to go to with concerns. Since staff interviewed were unaware of the existence of trustees they would not have considered this to be a viable route. This confusion over the status of the nursery and the complete lack of oversight by those who were ultimately responsible, resulted in an environment within which lines of accountability were unclear, there was no supervision or oversight of the manager's practice, and neither parents or staff knew how to raise issues that might have been relevant to the safety of the children within the setting.

### **Safeguarding children within the nursery**

- 5.25 The nursery individual management review highlighted many areas where practice within Z was less than satisfactory in providing a safe environment for

the children.

- 5.26 Policies and procedures in relation to child protection were inadequate, having been lifted without adaptation from the Pre-School Learning Alliance documentation. The policy was signed by the manager but had not been properly adopted at a staff meeting. There was no whistle blowing procedure and no evidence that staff knew where to go with any concerns about a colleague. There was no guidance in relation to nappy changing/intimate care, and although this may not have prevented the abuse, transparency and discussion about the issue within the staff group will have given a clear message that potential risks were recognised, and child protection was a high priority.
- 5.27 The general picture in relation to staff training is that most staff had not attended the Plymouth Safeguarding Children Board multi-agency training and if they had done so it was a long time ago. Lack of training, combined with an inadequate policy and procedure framework, did not provide the context within which the manager could be confident that appropriate action would be taken in relation to child protection issues.
- 5.28 The opportunity to give a clear message to the wider community that child protection was at the heart of nursery practice was lost, because Z did not ensure that all parents received a prospectus setting out the nursery's responsibilities in relation to child protection. From the documents available to the review it appears that child protection concerns in relation to the children were not always followed up due to concerns about 'repercussions' from parents. It appears that when Social Care asked the nursery to inform parents of a referral the nursery found this response less than supportive and it led to reluctance to refer in the future. Social Care could have perhaps provided more support to the nursery in discussing with Z staff how to find the most appropriate way to work with parents in these circumstances.
- 5.29 Lack of supervision of the children has been identified by this review, and parents described worrying episodes where gates were unlocked and a child was found in the road. A more general lack of supervision was also identified in the early years report, and this contributed to the red RAG rating.
- 5.30 The issue of staff ratios has emerged as a concern. Although both Ofsted and the Early Years Service expressed satisfaction with staffing, a thorough examination of the records by the Z individual management review author has revealed that both Z1 and Z2 were out of ratio on a number of occasions. For example, from April 2008 – June 2009, Z2 was recorded as out of ratio on eighty three occasions, and K was on duty on thirty five of these. This would have considerably increased the opportunity for K to be on her own with the children. This information regarding ratios is at odds with that recorded by the early years team, and it is possible that the apparent lack of staffing is due to poor record keeping. However, one parent has informed the review that staff would monitor who was at the gates and if the visitor appeared official then a staff member would take a group of children into the school to ensure that numbers appeared less in the nursery. This information is anecdotal and

should be treated as such but, should this have been occurring it would explain the discrepancy between the records and the perception of official visitors.

- 5.31 The literature review prepared for this review<sup>5</sup> identified the characteristics of safe settings as:
- Staff are respectful to all employees as well as children
  - Staff are open about discussing good and poor practice
  - Blame only happens in extreme circumstances
  - Leaders model the appropriate behaviour
  - Staff are knowledgeable about the vulnerability of the children whom they look after and aware that abusers may already be in the employ of the organisation
  - Children are listened to
  - Staff are empowered to challenge poor practice
  - Parents are encouraged to be involved in their child's plan and welcomed to the setting
  - Whistle blowing procedures are in place and staff know how to use them.
- 5.32 If Z is assessed in relation to these characteristics it can be seen that there are a number of areas which both the manager and the external regulator should have identified as in need of improvement. Of particular significance are staff knowledge, staff challenging poor practice, the involvement of parents in planning for their children and the presence of whistle blowing procedures.

### **Relationship between the nursery and the wider safeguarding network**

- 5.33 There is evidence that Z did not act on incidents that should have prompted a referral to Children's Social Care. Whilst this could be explained by a lack of adequate procedure, or failure to understand and follow procedures, there is also some evidence that Z did not feel supported by Children's Social Care once a referral had been made.
- 5.34 The Z individual management review author was told that the usual response from Social Care was to say that the nursery needed to get the parent in and talk to them. This was clearly perceived by the nursery as problematic as it "involved repercussions." The nursery manager described these repercussions as being sworn at, or parents sending their child to another nursery. On one occasion when Children's Social Care did respond by visiting the nursery this also involved the parent removing the child from the Z.
- 5.35 Improved actions by the nursery in respect of child protection responsibilities would have been enhanced by an improved relationship with Children's Social Care. It appears that Social Care underestimated the impact on the nursery of informing parents of their concerns. The opportunity for greater dialogue with social workers as to how to follow up concerns, and support in dealing with the

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<sup>5</sup> Barry Raynes, Jim Wild & Caroline Thompson *Literature review conducted for part 1 of the LT serious case review.*

aftermath (possibly via the Early Years Service), needs to be explored.

- 5.36 Parents informed this review that they had never seen a prospectus or any other written information about the nursery. Whilst this may not have prevented the anger experienced by parents when child protection concerns were raised, a prospectus given to all parents clearly setting out Z's child protection responsibilities and procedure would have at least been a point of reference in such situations. It also would have given the message clearly that this was a setting which took its child protection concerns seriously.
- 5.37 Previously the nursery manager had found the liaison health visitor to be a source of support in such situations, but she was informed by the health visitor that the link could not continue due to confidentiality issues, i.e. information about the children could not be shared. The PCT notes that the 'Health Visiting Core Assessment Framework 2004' outlines the role of health visitors, including the aim of the nursery liaison health visitor, which is to 'build a mutually respectful professional relationship between health visitors and nursery staff for the purpose of promoting optimal development and health for the children and families registered at the nursery'. The individual management review notes that within Plymouth the national framework does not appear to have been adhered to, implemented or ratified. The report also notes that "there is no current ratified visiting nursery policy or clear understanding of the role of the health visitor within nurseries".
- 5.38 With no liaison with health visitors and a perceived lack of support from social care in respect of child protection issues, the impression is of a nursery who felt isolated from the wider safeguarding network.

### **The manager's role as foster carer and nursery manager**

- 5.39 A theme throughout the chronology is the blurring of boundaries between the nursery manager's role as manager of the nursery and foster carer for Plymouth City Council. It appears that it was assumed that foster children attending nursery was "a good thing" as the children would not be separated from the nursery manager when she was at work. There was no challenge to this view and understanding of the impact on the children of receiving much of their day to day care by staff within the nursery.
- 5.40 The fostering service relied on the child protection training that they assumed the nursery manager would have received in her role as nursery manager. There is also an implication within the reports that the fact that the nursery manager was a foster carer was seen as a protective factor in respect of child protection issues within the nursery. Despite the reliance by the fostering service on child protection knowledge gained through her role as nursery manager, there is no evidence that the nursery manager received sufficient child protection training for her early years role and, in any case, this training would not have covered all the relevant aspects necessary for her as a foster carer. Assumptions were made without proper checking or follow up.

- 5.41 There is no evidence that the early years advisory team were included appropriately in discussions with Children’s Social Care. They were not involved in the strategy meeting called when it was alleged that a member of staff had shouted at a child, whereas the advice and assessment team, and the fostering team, were included in discussions relating to this. Foster children were encouraged to attend Z at the same time that the Early Years Service had significant concerns about the quality of provision at the nursery. This boundary confusion and lack of role clarity across teams is significant to this review as it contributed to an overall culture of lax systems and processes within which K was able to operate.

### **Identifying unsafe environments – the role of Ofsted and the Early Years Advisory Service**

- 5.42 The findings of this review are at variance with the findings of the Ofsted inspections of Z1 and Z2. Through staff interviews and discussions with parents, as well as a review of the records, it is apparent that Z was not able consistently to provide a safe, positive environment for the children in its care. This would indicate that either the individual inspections were not rigorous enough, or the framework for inspection is not adequate.
- 5.43 An issue that has been identified by this review that may have contributed to the discrepancy is the lack of communication pathway between the Early Years Advisory Service and Ofsted. The Ofsted report notes that the managers at Z on occasions sought advice from Ofsted, and clearly stated to inspectors that they lacked some management skills to drive improvements forward. Ofsted note that *“there were no opportunities for this information to be passed on to local advisers and there is no evidence to show that managers did seek help directly.”* Within the early years individual management review it is clear that advisers had clearly identified concerns about the management of the nursery and were working hard to provide support. Regular support visits were made and there was a concerted effort over several years to assist the nursery in improving its planning processes. The chronology provides ample evidence that despite support, suggestions for improving practice were not acted upon.
- 5.44 It has become clear from this review that whilst the Early Years Service had many concerns about the nursery there was no formal mechanism for informing Ofsted, since they did not reach the threshold of a breach of regulations. Similarly Ofsted had no means of discussing with Early Years the support need of the nursery. It is notable that whilst Early Years had the nursery identified as red or amber on its own rating system, Ofsted inspections were good or satisfactory.
- 5.45 Separation of the regulatory and support functions has, in this case, resulted in a situation where the professionals who had the best knowledge of the day to day running of the establishment and the challenges it was facing were unable to alert inspectors to areas of concern. The early years team are in the invidious position of being expected to work closely with nurseries to assist their improvement, but having no means of alerting the regulatory authorities

where there are issues that are of concern.

- 5.46 The responsibility for identifying when a setting does not reach the required standard rests with Ofsted, yet this review highlights the limitations of the Early Year Foundation Stage in providing a framework for inspecting the safeguarding capabilities of the nursery. The Ofsted report states that Ofsted does not inspect the culture of a setting, yet it has been well known for many years that it is unsafe cultures within institutions that lead to child sexual abuse being more likely. Utting (1997)<sup>6</sup> reviewing safeguards for children living away from home notes:

*“Keys to success are leadership, a clear and achievable job, a philosophy owned by staff and continuity. The culture of an institution, the role of the head, gender issues and sexual relationships are all important issues”* (p117)

- 5.47 Although Z was a day care setting this is equally relevant and the inspection regime should have been able to take an overall look at the culture of the organisation and assess how effective it was likely to be in providing a safe environment. The culture that has emerged from this review is one where governance and accountability were unclear, safeguarding frameworks (policies and procedures) were not fit for purpose and outside challenge and support was not always welcomed. It is also now known that there was a high tolerance of inappropriate sexual references within the workplace, and due to the perceived power of a “clique” within the staff group, this became impossible to challenge.

- 5.48 The Ofsted guidance for inspectors conducting early years inspections<sup>7</sup> provides limited guidance to assist inspectors in identifying some of the less tangible aspects of organisational culture that might indicate an unsafe environment. The guidance in relation to safeguarding states:

*A judgement on how well children are safeguarded should be based on evidence drawn from across all elements of the Early Years evaluation schedule.*

*A starting point for judging how well children are safeguarded is a discussion about the setting’s safeguarding policy and procedures with the provider and, in the case of group care, the named practitioner who has lead responsibility for safeguarding children if this is different from the provider.*

*Inspectors must check that the provider has robust systems in place for recruiting and checking the suitability of any staff/assistant he or she employs. Inspectors should make sure that an enhanced Criminal Records Bureau disclosure and associated identity check has been obtained for each member of staff/assistant. Where, rarely, recently recruited staff are in post and the outcome of checks are not yet known, inspectors should confirm that a Criminal Records Bureau disclosure and identity check was applied for at the point of employment. They should make sure that they are satisfied with the*

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<sup>6</sup> Utting, W (1997) *People Like Us* London. DOH

<sup>7</sup> Ofsted (2009) *Conducting Early Years Inspections* Ref no. 080164



*arrangements for supervision. P32*

- 5.49 The focus of the Ofsted guidance is on recruitment, CRB checks and policies and procedures. In the case of Z there is evidence that even though these were unsuitable or not followed, this was not sufficient to cause Ofsted inspectors concern, and it is not clear that all the relevant documentation was seen during the inspection. For example, it is evident that Z's child protection policy is lifted directly from the Pre-School Learning Alliance and was not adopted at a staff meeting. It was known by Ofsted that proper recruitment procedures were not followed, with recruitment often being by word of mouth with no advertisements or interviews. The setting was asked to improve on this but did not do so.
- 5.50 The inspections by Ofsted in this case were not rigorous enough in challenging policies which were not fit for purpose, or identifying where there were gaps. Several policies were not signed or dated or adopted at a staff meeting, and there were missing procedures. Inspectors were aware of deficits in relation to recruitment and had made a recommendation to the nursery in 2007 that these should be more robust; in 2009 this recommendation had not been implemented by the manager. Inspections should establish that the key person system is in place<sup>8</sup> yet it is clear from interviews with parents that none was aware of a key person system, or knew who that person might be for their child. Ofsted have noted within this review that there needs to be an improvement in the timely conclusion of compliance events and this is linked to an appropriate recommendation.
- 5.51 Inspection reports by Ofsted recorded that the setting worked closely with local authority advisers, yet there is now evidence that there was reluctance on the part of Z to act on advice given. More rigorous inspection and communication with the local authority, combined with a reflective inspection process which considered the implications of accumulating concerns underpinned by an understanding of safe environments, may have helped to identify more clearly ways in which Z was not providing sufficient safeguards for vulnerable children. The current system, which does not allow effective communication between early years advisers and Ofsted, facilitated a situation where, although there were significant concerns regarding Z's capacity to deliver a safe and effective service, there was no mechanism for taking action.
- 5.52 There are important questions regarding whether the current inspection framework is adequate in respect of safeguarding children due to:
- No requirements specified in relation to staff supervision
  - No requirements specified in relation to safeguarding training
  - No requirement specified in relation to the nature of staff interviews i.e. the importance of value-based interviewing
  - Lack of attention to the overall culture of an organisation which may indicate risk. For example, over reliance on friendship networks, a reluctance to accept advice, and lack of practice challenge through performance appraisal

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<sup>8</sup> Ofsted (2009) *Conducting Early Years Inspections* Ref no. 080164 Page 38

- No specific requirements for a whistle blowing policy or intimate care policy.

### **Students on placement**

- 5.53 The chronology notes that fifteen students were placed by the secondary school for work experience at the nursery. These placements were co-ordinated through an Education Business Partnership.
- 5.54 The secondary school individual management review documents appropriate processes for setting up the placement, and all students receive weekly visits from the school tutors during which they are able to raise any concerns. Information on safeguarding is delivered to the students as part of their course content.
- 5.55 There is only one recorded cause for concern regarding the placement in 2006/7, when students expressed dissatisfaction with being asked to undertake tasks such as sharpening pencils and cleaning toilets. These were considered to be outside the expectations of their role, and the placement was suspended.
- 5.56 An interview with an ex-student, as part of the Z individual management review, revealed a deep level of dissatisfaction with Z, and concerns regarding inadequate supervision of the children, staff ratios not being adhered to and staff “cliques”. She said that she was “petrified” of the nursery manager, as were many of the children. When this student spoke to her tutor she was told “you have not got long left”. The perspective of students who come in from outside with a fresh pair of eyes can be invaluable in challenging accepted practice. Tutors need to take full account of any concerns raised by students on placement and take action where this appears warranted. In this case it would have been appropriate at the very least to have a three way meeting with the nursery to explore the issues raised by the student. Effective communication and liaison between tutors and the early years team might also provide a safety net in these situations. The recommendation within the secondary school individual management review addresses this issue.

### **The relationship between the nursery and the primary school**

- 5.57 Although formally the relationship between the nursery and the primary school was one of ‘landlord/tenant’, and the school had no responsibility for standards of care within the nursery, the fact that they shared some facilities gave parents the impression that the nursery was linked to the school.
- 5.58 Parents spoke of choosing the nursery because of its close links with the school, and the fact that the transition from nursery to school would be eased due to their child’s familiarity with the school environment. The after-school club ran from the school hall, and all the children at the nursery joined the older children at the school hall, where room dividers were placed to separate the older children from the younger.

- 5.59 A parent has informed this review that she approached the primary school on many occasions with her concerns about Z. The primary school individual management review also notes that school staff did have concerns about behaviour management at Z and that this was, on one occasion, raised directly with Z staff. The Early Years Advisory Service were also informed, although concerns were not put in writing.
- 5.60 It seems that due to the nursery manager's status as a Governor of the school this may have affected the way in which both concerns about practice and other issues were addressed. The primary school individual management review notes:
- "The dual roles of the nursery manager as a Governor of the school may have led to issues being handled in ways that were less formal than the norm for co-located organisations."*
- 5.61 There were many positive reports about the dedicated contribution of the nursery manager to the governing body over a long period of time, and this may have contributed to a situation where it was difficult to raise concerns about the operation of Z.

### **Staff Supervision**

- 5.62 It is evident that staff supervision did not take place at Z. Unlike the requirements in the residential inspection standards, there is no requirement within the Early Years Foundation Stage that staff should receive regular one to one supervision. This is despite the known vulnerability of very young children. The guidance for Ofsted inspectors<sup>9</sup> does state that they should satisfy themselves with arrangements for supervision, but gives no further guidance as to what these arrangements should be. Government guidance<sup>10</sup> identifies that effective supervision is important for many practitioners involved in day to day work with children and families. Research into lessons from serious case reviews has concluded that supervision is important in assisting practitioners in coping with the emotional demands of the job, as well as enabling them to reflect on the meaning of their gut feelings.<sup>11</sup> Staff working at Z were becoming increasingly uncomfortable and worried about K's behaviour yet had nowhere to go with these feelings.
- 5.63 In this case, formal supervision processes may have provided an opportunity for staff to explore their concerns regarding K openly talking about her sex life and showing staff images on her mobile phone which were totally unsuitable for a nursery setting.

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<sup>9</sup> Ofsted (2009) *Conducting Early Years Inspections* Ref no. 080164

<sup>10</sup> HM Government (2009) *Working Together to Safeguard Children – Consultation*: London: Department for Children Schools & Families.

<sup>11</sup> Brandon et al (2008) *Analysing child deaths and serious injury through abuse and neglect: what can we learn?* London: DCSF

- 5.64 It is noticeable that although several staff felt very uncomfortable with the conversations instigated by K, they did not feel able to challenge for fear of being seen as “prudish”. Supervision by a competent supervisor may have provided a forum where, within a safe environment, these feelings could have been aired.
- 5.65 Supervision would also have provided a forum for ensuring staff training needs were met. There had been no opportunity for any member of staff through supervision or appraisal to reflect on the knowledge they needed to do their job and identify where there might be gaps that needed addressing thorough staff development opportunities. It is noticeable that staff interviewed for this review reported either no child protection training or a course many years ago. K, is reported as saying that she attended child protection training years ago when she was working at the playschool. She had none at Z.

### **Meeting the needs of minority groups**

- 5.66 The area served by Z is predominantly a white working class community. There are no significant concerns identified from inspection and other visits regarding the nursery’s capacity to meet the needs of children from outside their core client group. There is, for example, a note that toys and books appropriately reflected a range of cultures. It is reported that the nursery did accept support in respect of meeting the needs of children from minority ethnic groups. For example they accepted support for a family with English as an additional language, and are described as on a 1:1 basis being caring and mindful of children’s diverse needs.
- 5.67 Disabled children can be particularly vulnerable to abuse<sup>12</sup> and the early years individual management review identifies that children with learning difficulties and disabilities attended Z. SENCo staff are described as attending appropriate training for their role but it is not clear whether this would have included any input on child protection issues and disabled children. Since most staff had not attended recent child protection training it cannot be said with confidence that the staff team as a whole would have sufficient awareness of this topic.
- 5.68 In respect of disabled children, one parent of a disabled child did express satisfaction with Z and said that they had specifically chosen Z rather than a nearer nursery as they felt their child’s needs would be met. There is evidence that the Special Educational Needs Co-ordinator and the Deputy Special Educational Needs Co-ordinator (K) did attend specialist training and staff were aware of how to access appropriate support. However, it is apparent from staff interviews that the manager gave specialist staff little support or advice and support was needed from the Early Years Service in developing Individual Education Plans. It is not acceptable that there was no special educational

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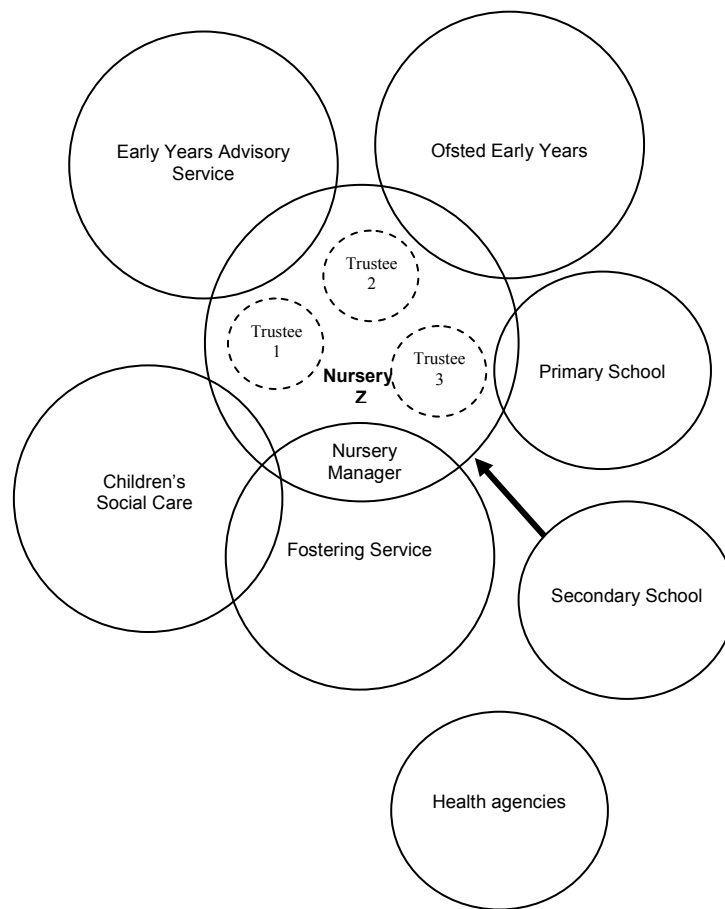
<sup>12</sup> Sullivan, P.M., Knutson, J.,F. (2000) ‘Maltreatment and Disabilities: a population based epidemiological study, *Child Abuse and Neglect* 24 (10)

needs budget as required by the Early Years Foundation Stage, but generally the information provided to this review does not raise significant concerns about provision for disabled children or those with special educational needs.

### **The abuse in context**

- 5.69 Z was a setting firmly based within the community it served, and there appear to have been strong personal ties between some staff and parents. This is a strength, but the dangers also need to be acknowledged and appropriate safeguards put in place. The strength of the setting appears to have been in the perceived friendly atmosphere, the fact that staff seemed happy in their work, and children became used to visiting and using the facilities of their local primary school. The dangers are that boundaries become blurred and parents are unable either to see or challenge practices that may indicate inappropriate care. Additionally, the manager's strong community links enabled her to recruit within the community without following proper recruitment procedures. In order to draw on the strengths of a local community facility it is therefore important that there are external agencies which challenge standards of practice.
- 5.70 The diagram below identifies the way in which Z had links with various parts of the child care system. However, it is clear that the system as a whole was fragmented and this fragmentation led to a situation where channels of communication were either not in place or were not used to understand the factors which might have been affecting the functioning of the nursery.

5.71



5.72 Although there was fragmentation between key parts of the system such as Ofsted and Early Years, within other parts of the system boundaries were absent or distorted. For example, the nursery manager's role as Governor of the school distorted the landlord/tenant relationship between the school and Z and may have resulted in concerns about finance and practice within the nursery not being raised. The lack of boundaries between staff and some parents, and a general blurring of the manager's roles as foster carer and nursery manager contributed to a situation where controls were lax. Children were taken to contact by inappropriate adults, safe recruitment processes were not adhered to, and poor practice could continue.

5.73 K's power base within the setting and her capacity to draw other members of the staff team into her world, thus effectively silencing them, might have been more apparent had effective internal controls been in place. The lack of supervision has been commented on above, and this was combined with a lack of performance management, appraisal and a staff team who blurred the boundaries between their personal and professional lives. That is not to say that strong personal friendships within a staff team are always dangerous, in fact they may be positive. However, in Z there is evidence that the blurring of boundaries directly affected the care given to the children, with descriptions of staff ignoring children whilst discussing their personal lives.

- 5.74 Messages from enquiries into abuse in residential care have identified that abusers will flourish in situations where institutions are isolated.

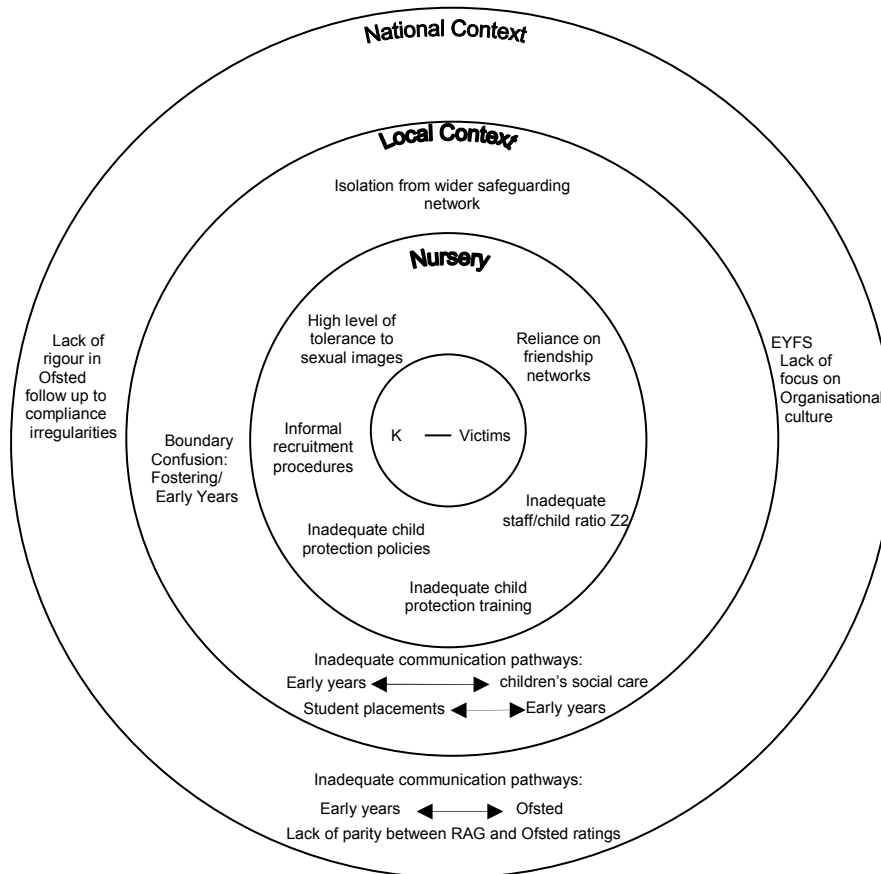
*The context in which abuse occurred usually involved an exclusion or absence of outside contact.....and a lack of effective scrutiny by external managers.*<sup>13</sup>

There were features of the nursery “going it alone” and a reluctance to accept advice. At times the nursery gave the impression of compliance through accepting suggestions for improvement although, these were not implemented. With hindsight this could have been seen as a form of false compliance and alerted the regulators to a culture where unsafe practice could develop.

- 5.75 An overriding impression from this review is therefore of a setting which was generally isolated and resistant to change. Ofsted’s requests for reports were not completed within timescales; there was a lack of adequate response to suggestions made by the Early Years Service, and inconsistent engagement with parents whose children attended the nursery. Despite local knowledge within the early years team that there were concerns about the nursery, the external regulation through Ofsted’s inspection against the Early Years Foundation Stage requirements was inadequate in identifying persistent failings within the nursery and enforcing action to secure improvements.
- 5.76 Z provided an ideal environment within which K could abuse. The lack of effective external controls, a setting where management was weak, and a blurring of boundaries across several groupings resulted in a situation where the opportunity to abuse was available (see figure below).

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<sup>13</sup> Support Force for Children’s Residential Care (1996) *Final Report to the Secretary of State*  
Department of Health: HMSO



**Opportunities to identify that K may be a risk to children.**

- 5.77 There is no indication from this review that any professional could have reasonably predicted that K might be a risk to children. All the evidence currently points to K having no sexual interest in children until she made contact with H via the internet. There is, however, evidence that she is an emotionally vulnerable woman who used the opportunity presented by her employment for her own ends.
- 5.78 There were opportunities to identify the inappropriateness of explicit sexual references made by K to other staff, as well as the images of adult pornography that she held on her mobile phone in the nursery. Some staff became drawn into her world through engaging in conversation and although now describing their discomfort at her behaviour, it is clear that her power within the staff group was such that staff felt unable to challenge. This power appears to have been derived from her “bubbly”, “larger than life” personality and ability to manipulate others.
- 5.79 The escalation of K’s inappropriate behaviour should have prompted a response by the manager of the nursery but it did not do so. There appears to have been a complete lack of recognition of the seriousness of the boundary violation, and a culture within a nursery where explicit sexual references in conversation were the norm.



- 5.80 Changes in K's behaviour, including the use of the cubicle to change nappies rather than the general changing area, were not seen as significant. This is in the context of a staff group who had little or no knowledge regarding sexual offending, had not attended child protection training, and were working in a culture where there was no whistle blowing procedure.
- 5.81 There had been no opportunity to explore K's potential vulnerabilities through value based interviewing or indeed any interview procedure. She was known to the manager and appointed following an informal discussion between the manager and a teacher in the primary school with whom K had been working. This is not in line with accepted good practice and, whilst an interview may not have identified any cause for concern, it would have been an additional safeguard in this situation.

## **6. LESSONS LEARNT**

- 6.1 One important lesson to come out of this review has been the positive impact of an effective family support strategy in situations of potential multiple abuse. There is evidence that organisations across Plymouth worked extremely well together to provide support to the families affected by the arrest of K. Pressure was taken off the families by the appointment of a community spokesperson who could talk to the media and a series of meetings was arranged to keep families informed. Support is continuing with families having access via family support services to appropriate help such as that supplied by children's centres.
- 6.2 It is clear that providing effective support to staff in such situations is more of a challenge. The report from the NSPCC notes that one learning point from their involvement is that the impacts on the colleagues of suspected sex offenders are various, and this needs to be factored in to planning support services at an early stage. A range of options should be available as not all will wish to partake in group activities.
- 6.3 The important role that the Early Years Service can play in identifying poor practice within nursery settings has been a key lesson from this review. There is evidence of much good practice by the Early Years Service, who made strenuous efforts to work with Z to improve the experience of the children attending the nursery. The chronology and individual management review from the Early Years Service provide evidence of excellent record keeping which has greatly facilitated this review's understanding of day to day practice within Z. The review therefore reinforces the importance of record keeping in the Early Years Service, not only for future use but also to track a process of intervention within an organisation.
- 6.4 One tangible lesson that has come out from this review has been the danger of mobile phones within day care settings. However, whilst stopping staff carrying mobile phones is an important preventative measure and will mean that images cannot easily be transmitted electronically; this alone will not prevent abuse taking place. What has become apparent from this review is that there were a

number of interacting factors which came together to support a culture where such abuse was possible. Ultimate responsibility for the abuse must rest with K, but there are important lessons that can be learnt that might make similar abuse less likely in the future. All those working within Early Years settings as well as those responsible for support and inspection must be mindful of the need for organisations to:

- Operate safer recruitment procedures, including value based interviewing
- Have effective policies and procedures in place which are communicated to staff, including child protection and intimate care
- Encourage open discussions amongst the staff group about good and poor practice and facilitate constructive challenge of each other
- Ensure that safeguarding is openly discussed and staff are aware of the possibility that abuse might happen within their workplace
- Have effective whistle blowing procedures
- Have safeguards in place where boundaries may be blurred through friendship networks amongst staff and parents
- Encourage communication and contact with parents and ensure they are kept well informed about their child's day to day experiences

- 6.5 This review has identified the urgent need to develop effective staff supervision within Early Years settings. With no formal structures allowing staff to reflect on their own work and practice within the nursery there was no opportunity for any discomfort with K's increasing sexualised behaviour to be aired. Lack of supervision also meant there was no effective means to manage performance and challenge inappropriate behaviour such as use of mobile phones within the nursery. The Early Years Foundation Stage makes no requirement for supervision to be in place. This needs to be changed as a matter of urgency.
- 6.6 The lack of governance and accountability within Z is an area of concern, particularly as there are likely to be many Early Years settings in a similar situation. Lack of clarity regarding the status of unincorporated institutions, and confusion regarding the roles and responsibilities of trustees needs to be addressed within national Early Years guidance. Ofsted needs to ensure that organisational structures are fit for purpose and provide sufficient oversight and safeguards.
- 6.7 The separation of the regulator (Ofsted) from Early Years Services providing support to local settings led to the regulator being unaware of local concerns regarding practice within the nursery. At present the communication pathway is not sufficiently flexible to allow appropriate sharing of information which could inform a judgement about safe practice. The Early Years Foundation Stage does not provide a sufficient clarity regarding organisational cultures and practices which may indicate an environment which is failing providing sufficient safeguards for vulnerable young children. In addition, where the nursery was recognised to be failing, the Ofsted inspection process did not ensure compliance in achieving and maintaining improvement
- 6.8 Early Years Services within the Plymouth area were not sufficiently integrated with social work teams in Children's Social Care. They were not invited to a strategy meeting relating to a member of nursery staff and there is little

indication that there was effective communication between the fostering team and Early Years regarding the nursery manager in her role as foster carer. It is concerning that it was deemed good practice for foster children to attend a nursery which was receiving additional support from Early Years due to concerns about the standards of practice. Assumptions were made by the fostering service regarding the knowledge that the nursery manager had gained in her nursery manager role which were not based on fact.

- 6.9 This review points to a lack of understanding within the nursery regarding sexual abusers and appropriate boundaries that should be in place within day care settings. Staff did not recognise the escalation of K's sexualised behaviour as a potential warning sign, and felt unable to challenge when they felt uncomfortable with her overt sexual references and sharing of adult sexual images with the staff team. This applied to the manager and supervisor as well as the nursery assistants. There is an urgent need for staff working in Early Years settings to receive the training necessary to assist them in recognising potential signs of abuse and become confident in responding when worried about a fellow staff member's behaviour. It is important that child protection training is sufficient, both on qualification training and within the workplace.
- 6.10 As well as the organisational culture that allowed the abuse to take place, the additional factor that should not be overlooked is the role of the internet in providing the opportunity for vulnerable and dangerous people to meet each other and be encouraged in abusive behaviour that they may not have otherwise considered. The additional risks posed by the availability of technology which may provide additional opportunities means that the safeguards within any organisation need to be strong, and provide the framework within which professionals and parents can challenge inappropriate behaviour.

## **7 OVERVIEW REPORT RECOMMENDATIONS**

### *Local Recommendations*

- 7.1 Plymouth Safeguarding Children Board should require Plymouth Early Years Services to target for safeguarding audit by July 2010 those settings which have been identified as requiring additional support. A report of the findings of this audit should be reported immediately to Plymouth Safeguarding Children Board who should ensure any appropriate action is taken in the light of any deficiencies.
- 7.2 Plymouth Safeguarding Children Board should require Plymouth Early Years Services to provide an annual safeguarding report summarising the findings of the safeguarding audit. This should include information on how many Early Years staff have attended multi-agency child protection training.
- 7.3 Plymouth Safeguarding Children Board should ask Plymouth Early Years Service to develop and publicise guidance for staff on what to do if they are worried about safeguarding issues within their setting.

- 7.4 Plymouth Safeguarding Children Board should ask the Family Information Service to work with parents to review the leaflet regarding what to look out for when choosing nursery provision, and ensure it is distributed widely.
- 7.5 Plymouth Safeguarding Children Board should incorporate lessons from this review into a “good practice” document and circulate this to all Early Years settings by July 2010.
- 7.6 Plymouth Safeguarding Children Board should write up for publication their experience of managing alleged abuse within a nursery setting in order to assist other Local Safeguarding Children Boards who may experience similar circumstances in the future.

#### *National Recommendations*

- 7.7 A communication pathway should be established between Early Years Advisory Services within each Local Authority and Ofsted in order to ensure that local intelligence informs the inspection process.
- 7.8 The Early Years Foundation Stage safeguarding requirements should be reviewed and strengthened in order to identify the characteristics of unsafe organisations. Further guidance should be issued to Early Years Ofsted inspectors to assist them in identifying where these characteristics may exist and this should include a requirement that safer recruitment procedures including value based interviewing take place.
- 7.9 The Early Years Foundation Stage should set out specific requirements for child protection training including training which considers both sexual abuse and the recognition of abuse within the workplace.
- 7.10 The Early Years Foundation Stage should include a requirement for Ofsted inspectors to clarify the status of the facilities they inspect and seek evidence that they are operating in accordance with their recognised status.
- 7.11 The Early Years Foundation Stage should require all Early Years settings to provide regular 1:1 staff supervision from a trained supervisor.
- 7.12 Government should review and consider changing the status of day care settings operating as unincorporated bodies in order to ensure that governance and accountability arrangements are fit for purpose and are sufficiently clear to enable parents and professionals to raise concerns and challenge poor practice.

## **8. RECOMMENDATIONS FROM INDIVIDUAL MANAGEMENT REVIEWS**

*The following recommendations have been accepted by the serious case review panel.*

### **Children’s Social Care**

- 8.1 All foster carers who are currently approved will have their safer caring agreement updated to include two named individuals who have been subject to CRB checks and interviewed by staff.
- 8.2 Form F assessments will be scrutinised by managers with focus on the fostering task and what children in care need as opposed to how foster carers might fit a child into their lifestyle.
- 8.3 Unannounced visits to be placed on activities on the workers' desk top and completed one every 6 months.
- 8.4 The fostering managers to refresh the team on its policy and procedures in dealing with both child protection concerns and concerns from other agencies
- 8.5 Child's social worker to be reminded that feedback for the review must be presented in time for the review to enable a full discussion.
- 8.6 A chronology of life events for foster carers will be presented for all reviews
- 8.7 A clear criteria and format will be developed concerning re-assessment of a foster carer following significant events
- 8.8 Training for supervising social workers in relation to 'Professional Dangerousness'
- 8.9 Reports to be run via Integrated Childrens System for the managers to identify any unannounced visits not completed
- 8.10 Policy and procedures to take account of any changes recommended in this review
- 8.11 Fostering handbook to be updated to include further information about the procedures for babysitting and respite.
- 8.12 The service manager and team managers for fostering will look at how to specifically address in the assessment process and/or in reviews the relationship between the fostering task and if a foster carer is employed. They will look at foster carers who were approved before the changes in criteria with regard to under 5's and also at how to reassess if employment is taken up after approval.
- 8.13 A process with regard to the provision of nursery/day care to be looked at in relation to Children in Care. How decisions are made; if a child should attend/how often/and the quality of the provision. The role of birth parents in choosing nursery provision for their children who are in care.
- Police**
- 8.14 Public protection training relating to risk management of all safeguarding areas will be delivered to all front line staff in 2010.

### **Early Years**

- 8.15 All Early Years teams to have regular supervision which always includes a safeguarding element.
- 8.16 All Early Years settings to have at least one visit each year focusing on welfare requirements
- 8.17 Early Years settings to complete a similar safeguarding audit to schools once a year
- 8.18 The monitoring and quality assurance of Early Years settings should include all provision e.g. extended services
- 8.19 Any pooling of resources, as well as information, should highlight the proper attribution across the service.
- 8.20 Clear communication channels should be established with all parts of the children's service.
- 8.21 A formal record of safeguarding observations/discussions should be included on all visit reports.

### **NHS Plymouth Teaching Primary Care Trust – Health Visitor**

- 8.22 Review and implement the 'Visiting Nurseries' policy

### **Ofsted**

- 8.23 Revise procedures for responding to complaints/comments to ensure timely conclusion of compliance investigations and visits are considered when a complaint about the safety of a child is made; where a visit is not deemed appropriate, the reason for this should be recorded.
- 8.24 Ensure that safeguarding concerns are always considered in the context of the full history of the provision and are prioritised when determining the timings of inspections.
- 8.25 Extend the use of case tracking to all inspections of non domestic day care settings.
- 8.26 Improve information sharing with local authority to inform scheduling of inspections and investigation of compliance investigations related to safeguarding concerns.
- 8.27 Ensure that information contained in inspection evidence is retained to inform the next full inspection of provision.

### **GP Surgery**

- 8.28 Check whether the practice computer system will allow the Patient Registration template to be amended to enable site of schooling/work to be captured for

patients.

### **Primary School**

- 8.29 Training for school staff and Governors.
- 8.30 Item on Full Governors agenda with Governor with specific responsibility for Safeguarding re[porting to all governors on a termly basis.
- 8.31 To consider implications for safeguarding in future co-location of Early Years provision.
- 8.32 To further develop protocols for visitors to the school site.
- 8.33 For the induction of all volunteers to include the school safeguarding policies and procedures.

### **Secondary School**

- 8.34 To ensure stronger links between work experience organisations and LA Early Years teams to share information on setting quality.