



SERIOUS CASE REVIEW

Under Chapter VIII

‘Working Together to Safeguard Children’

In respect of the Serious Injury of

Case No.2010-11/3

What is a Serious Case Review?

Serious Case Reviews shed light on whether lessons can be learned about the way local professionals and agencies work together in the light of a serious injury or child death where abuse or neglect are suspected.

Serious Case Reviews focus on improving practices that safeguard and promote the welfare of children.

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EXECUTIVE SUMMARY

1. INTRODUCTION

- 1.1 In January 2011 a twenty year old male nursery worker came to the attention of West Midlands Police as a result of an accusation by a thirteen year old girl of on-line grooming. Examination of his computer revealed many indecent images, including a serious assault of a child in a Birmingham nursery which he had recorded on his mobile phone. He was arrested, charged and subsequently convicted and sentenced to life imprisonment after admitting two charges of rape, sixteen counts of causing or inciting a child to engage in sexual activity, twenty five of making indecent images and three of distributing images of children.
- 1.2 As a result of the arrest Birmingham Safeguarding Children Board agreed that the case met the criteria for a serious case review. A serious case review panel was appointed, chaired by the independent chair of the Birmingham Safeguarding Children Board, and an independent overview author appointed. Individual management reviews were completed by the following organisations:
- West Midlands Police.
 - The nursery (known in this report as the nursery).
 - Ofsted.
 - Birmingham City Council – Children’s Social Care. The scope of this report was later extended to include Local Authority Designated Officers (LADOs) and Early Years Services.
 - Heart of Birmingham Teaching Primary Care Trust in respect of GP involvement.
 - The College attended by the Perpetrator.
- 1.3 All individual management reviews were scrutinised by the panel, action plans agreed and work started immediately on addressing issues identified within the individual management review reports.
- 1.4 There was significant delay in finalising the review due to the resignation of the panel chair; the panel was chaired in the interim by a senior manager from Birmingham City Council and an overview report presented to Birmingham

Safeguarding Children Board. In order to ensure sufficient independence in the review process the new chair of Birmingham Safeguarding Children Board commissioned an independent desktop review of the process and the serious case review panel was reconvened with an independent chair. The reconvened panel took account of the findings of the desktop review and finalised the report and action plan. These were received by the serious case review group in April 2013 and approved by the Birmingham Safeguarding Children Board in May 2013.

2. CASE SUMMARY

- 2.1 The nursery opened in 2006 and was graded “good” by Ofsted the following August. The nursery was linked to a community project and was managed by the mother of the Perpetrator, although she had left the nursery by the time that he joined the nursery as a student on placement in April 2008. The nursery was his second placement, which he found through his mother’s contacts. Governance of the nursery was via the community project’s board of trustees, with one of the board being the nominated person for Ofsted registration purposes. In reality, managers of the nursery were viewed by the board as the experts on child care matters and the day to day running of the nursery was left in their hands. There is evidence from the serious case review of close relationships between some parents and staff, with staff being friends with parents on Facebook.
- 2.2 The Perpetrator also worked at the nursery during the second year of his course as he was unable to commence another placement because he had lost his CRB form and a new one had to be applied for. The nursery agreed to take him on as they had sight of a previous CRB check. His qualification was deferred by the college due to lateness in submitting work, although the nursery was apparently unaware of this deferment as he started work as a qualified member of staff in October 2009 prior to receiving his certificate in February 2010.
- 2.3 In March 2009 the nursery had been graded “satisfactory” by Ofsted and this inspection had not identified the lax recruitment processes including the Perpetrator working without a CRB check.

- 2.4 It was after the Perpetrator had started work as a qualified worker that concerns began to be expressed amongst the staff team about the “special” relationship that he had with the child who is the subject of this review (Subject Child); a child who was known to be adversely affected by family issues. Students on a local child care course also commented to their college tutor that they had heard of a male member of staff at The nursery who had been taking children into the adult toilet on his own and sitting them on his lap. The complaints by the students were passed to the Local Authority Designated Officer (LADO) team (the team that deals with allegations people who are in a position of trust and work with children) at Birmingham Children's Social Care. Further enquires revealed the name of the Perpetrator and Subject Child but there is no evidence that records identified that Subject Child had been recently known to Children's Social Care, nor of any further action being taken at this point. The records were available but it appears that a search was not made.
- 2.5 In August 2010, Ofsted received and investigated with the local authority an anonymous complaint detailing significant concerns about the Perpetrator's relationship with Subject Child and worries that the previous manager was aware but had taken no further action. The outcome of this investigation (which did not involve speaking to the Perpetrator) was that the nursery was given a notice to improve various aspects of practice including the safeguarding policy, ensuring appropriate qualifications amongst the staff group, organising systems to ensure each child received a challenging learning experience and making improvements in assessing learning priorities and planning. The new nursery manager took immediate steps to act on Ofsted's requirements.
- 2.6 Three days after the investigation by Ofsted and the Local Authority the Perpetrator contacted Ofsted to complain about the standard of safeguarding practice within the nursery including concerns about Subject Child. At the request of the local authority LADO team Ofsted forwarded the complaint by the Perpetrator in writing. No further action in respect of the nursery was taken, with neither Ofsted nor the Local Authority apparently analysing the possible motives for the complaint being made at that point. Children's Social Care did, however, commence an initial assessment in respect of Subject Child and received

previous incident forms from the nursery, including one where Subject Child had cried out whilst in the presence of the Perpetrator. Children's Social Care were reassured by Subject Child's mother who told the social worker that Subject Child was no longer attending the nursery.

2.7 The Perpetrator's offences within the nursery came to light following a police investigation into allegations made by a thirteen year old girl in August 2010 that an unidentified male was trying to persuade her to engage in sexual activity over the internet. This investigation eventually led to the Perpetrator's computer which contained images of the abuse of a young child within the nursery. When confronted with the evidence, the Perpetrator admitted the offences. He also admitted abusing young women via chat rooms both before and after the contact abuse with the young child in the nursery. Twenty three victims were identified although, according both to the Police and the Perpetrator, this is a vast underestimation.

2.8 The Perpetrator was sentenced to life imprisonment with a minimum sentence of fifteen years, reduced to thirteen and half years after appeal. He subsequently told the serious case review that the abuse of the child had taken place in the bathroom which was located off the room in which he worked. Mobile phones were not permitted in the nursery but were kept in staff pockets in the kitchen area. On the two occasions when he filmed the abuse he was bringing the child in from the outside play area to go to the toilet and had to pass through the kitchen and was therefore able to retrieve his phone from his pocket. It is notable that the Perpetrator also told the review that his first student placement had been in a school where he did not abuse and had appreciated the clear rules that were in place.

3. REVIEW FINDINGS

The offending behaviour of the Perpetrator

3.1 It is clear that staff within the nursery, Ofsted and the Local Authority were aware that the Perpetrator was known to have a special relationship with Subject Child. Any such "special relationships" within a setting should be scrutinised and particular attention paid to situations where the child may be considered

particularly vulnerable.

3.2 The Perpetrator made it clear to the review that abuse would not have happened on another placement because of “rules”. Attention therefore needs to be paid to enhancing external inhibitors within nurseries, including:

- Effective recruitment processes that move beyond a focus on CRB checks to an exploration of motivation and value base. This will give a clear message to potential staff that abuse will not be tolerated.
- Ensuring the physical environment achieves a balance between a respect for privacy and reducing opportunities to abuse.

3.3 Since the abuse only came to light because of the disclosure made about on line grooming, continuing to promote internet safety must be a priority in the prevention of sexual abuse.

The Governance and Management and quality of care within the nursery

3.4 Robust recruitment procedures are important and need to be fully implemented at all times.

3.5 In this case too much power and control resided with the manager who was seen as the expert in safeguarding. There is a need for effective safeguarding processes and sound safeguarding knowledge across the staff group, including the board of trustees.

3.6 There is a need to ensure that appropriate boundaries are maintained between staff and parents and within the staff group. This is especially important where the setting serves a close knit local community.

3.7 Team cultures are important in developing a safe environment and there is therefore a need to pay attention to developing a team culture where factions or cliques are discouraged and no one person inappropriately assumes a position of power and authority.

3.8 Effective supervision is important and this should support staff in reflecting on any

concerns they may have about the behaviour of a colleague.

Registration and Inspection Processes

- 3.9 Inspections of early years settings need to be rigorous in examining the evidence that policies and procedures are being implemented in practice.
- 3.10 Inspections need to pay attention to the culture and staff relationships within the setting in order to identify where there may be features of a culture where abuse may be more likely to occur.
- 3.11 It is vital that those inspecting settings have an excellent knowledge of the features of child sexual abuse from the perspective of perpetrator and victim behaviour.

The role of Colleges of Further Education in Safeguarding Children

- 3.12 The supervision and assessment of students on placement needs to be formal and recorded by the setting in order that Colleges can be assured that adequate training and supervision is taking place within the workplace.
- 3.13 Students may be well placed to identify both poor practice and potential abuse within settings and Colleges can play an important role in supporting them to make their concerns known, recording them appropriately and following up referrals to Children's Social Care. Current national initiatives to drive up the quality of early years qualifications are therefore an important aspect of developing student self confidence and in improving safeguarding practice.

The role of the Local Authority in preventing abuse within Nurseries

- 3.14 There is a need for effective communication across the three arms of the Local Authority (Early Years, LADO and Children's Social Care) since lack of communication resulted in missed opportunities to collate the accumulating concerns about the Perpetrator and his relationship with Subject Child.
- 3.15 Assessments by Children's Social Care where a child is in nursery should make every effort to integrate information from the nursery into the assessment

process. The Early Years Service should be alerted where nurseries fail to cooperate.

- 3.16 It is vital that staff dealing with referrals in the LADO team are trained, competent and effectively supervised.
- 3.17 There may be the potential for early years development workers to increase their visibility within settings so that staff can route concerns about safeguarding practice through them.

Understanding sexual offending

- 3.18 This case confirms that although there is an established knowledge base about signs and indicators of potential sexual abuse this is not well utilised in practice. Potential barriers to assimilating and using this knowledge need to be understood.

Police response to online sexual offending

- 3.19 This is a complex task and the current state of knowledge is constantly evolving. The resources available to the police to respond to internet abuse do not keep up with the increased incidence. Prioritisation will therefore be a feature of practice.
- 3.20 The link between national responses to online safety and Local Safeguarding Children Boards is an important one in promoting effective local responses.
- 3.21 Police forces should focus on ways of speeding up identification of online groomers who may be working with vulnerable groups.

4. CONCLUSION AND RECOMMENDATIONS

- 4.1 Parents should be able to expect that children in nurseries are cared for within environments where highly skilled staff are supported, both by their own management and external organisations, to focus on all aspects of the needs of children, including their need for safety from sexual harm. Sadly, this did not happen in this case.

- 4.2 Although the responsibility for the abuse must lie with the Perpetrator, it was supported by the combination of a number of interacting factors namely:
- Poor management within the nursery.
 - A failure on the part of Ofsted and the local authority to investigate properly concerns about the Perpetrator's behaviour.
 - A lack of rigour and depth to inspection processes.
 - Missed opportunities to use the assessment process in relation to Subject Child to understand their experience within the nursery.
 - National issues relating to the quality of early years qualifications.
 - Availability of resources to the police to respond to the increasing incidence of internet abuse.
- 4.3 The interaction of these factors resulted in a situation where there were missed opportunities to intervene earlier and prevent the continuation of abuse, both within the nursery and online. It was entirely fortuitous that the offending came to light via a route other than robust responses to concerns within the nursery.
- 4.4 In summary, in order to reduce the possibility of a recurrence of sexual abuse within a nursery environment, there are issues that need to be addressed by all parts of the system. Colleges (supported by national awarding bodies) must ensure that their own processes for awarding qualifications are robust and, alongside this, support any student who has concerns about practice in an individual setting. Those responsible for managing individual nurseries must make sure that the highest standards are maintained in relation to safeguarding practice and create a culture where the voice of everyone in the staff team, including students on placement, is valued and heard. Those responsible for regulation and support (currently Ofsted and the Local Authority) must make sure that their staff are fully aware of the nature of sexual offending, methods used by offenders to gain the trust of their victims and the way in which external controls may inhibit sexual abusers who are motivated to offend. The inspection methods used should ensure that impact of management style on both staff and children is fully addressed. It is also important that both Ofsted and the Local Authority are fully aware of the way in which organisations should work together to prevent the sexual abuse of children for whom they have a responsibility. In this case there

were obvious pointers that should have raised the alarm, yet both Ofsted and the Local Authority failed to recognise them and respond appropriately in a coordinated manner. Roles and responsibilities must be clear where safeguarding concerns within a nursery are to be investigated, most notably between Ofsted, the Early Years Service and Children's Social Care.

- 4.5 Specific recommendations have been made to improve practice. These have been developed into an action plan which is in the process of being implemented and will be actively monitored by Birmingham Safeguarding Children Board.

OVERVIEW REPORT

1. INTRODUCTION

Background to this serious case review

- 1.1 In January 2011 police officers executed a search warrant at an address in Birmingham following an accusation by a thirteen year old girl of on-line grooming. A twenty year old male (known in this report as the Perpetrator) was arrested and identified to be a member of staff at the nursery. An examination of computer storage devices revealed moving footage of the serious sexual assault of a child (known in this report as Subject Child). The Perpetrator was subsequently charged, convicted and sentenced to life imprisonment after admitting two charges of rape, sixteen counts of causing or inciting a child to engage in sexual activity, twenty five of making indecent images and three of distributing images of children.
- 1.2 On the day that the occupation of the Perpetrator became evident, the nursery was immediately closed to allow Police enquiries to continue. Ofsted suspended the registration of the nursery pending full investigation. The nursery subsequently re-opened with different Governance arrangements and a new name. Prior to the conclusion of this serious case review the nursery permanently closed.
- 1.3 Eight days after the arrest of the Perpetrator the serious case review sub group of Birmingham Safeguarding Children Board agreed to recommend to the Board Chair that a serious case review should be undertaken on the grounds that:
- ‘LSCBs should consider whether to conduct a SCR whenever a child had been seriously harmed in the following situations: A child has been seriously harmed as a result of being subjected to sexual abuse **and** the case gives rise to concerns about the way in which local professionals and services worked together to safeguard and promote the welfare of children. This includes inter-agency and/or inter-disciplinary working’.¹*
- 1.4 The independent chair of Birmingham Safeguarding Children Board formally ratified the decision of the serious case review sub group five days later.

¹ HM Government (2010) *Working Together to Safeguard Children* Para 8.11

2. THE SERIOUS CASE REVIEW PROCESS

2.1 A serious case review panel was appointed and chaired by the independent chair of Birmingham Safeguarding Children Board. This panel originally consisted of:

Independent Chair	Chair of BSCB
Asst Director (Safeguarding)	Birmingham CYPF
Designated Nurse	Birmingham and Solihull NHS Cluster
Detective Inspector	West Midlands Police
Early Years & Child Care Manager	Early Years and Child Care Service CYPF

2.2 Following a review of agency records it was agreed that full individual management reviews would be required from:

- West Midlands Police.
- Nursery.
- Ofsted.
- Birmingham City Council – Children’s Social Care. The scope of this report was later extended to include Local Authority Designated Officers (LADOs) and Early Years Services.
- Heart of Birmingham Teaching Primary Care Trust in respect of GP involvement.
- The College in respect of the Perpetrator.

2.3 Reports for information were received from:

- Birmingham City Council Housing.
- Birmingham Community Healthcare NHS Trust in respect of health visitor and school nursing involvement.
- West Midlands Ambulance Service.
- Hospital Trust 1
- Hospital Trust 2.

2.4 Additional information was sought from Hospital Trust 2 as the report indicated that the Perpetrator had applied for a job as a nursery nurse and was successful

at interview, subject to checks, but chose not to take up the post. However, further scrutiny of records by the Trust revealed that a job had not, in fact, been offered and this lack of job offer was not as a result of any concerning information about the Perpetrator.

- 2.5 Following consideration of the integrated chronology it became clear that relevant information from The College included not only consideration of their involvement with the Perpetrator but also information relating to the placement of another student at the nursery. This student knew of concerns about the behaviour of the Perpetrator in the nursery. The college response in relation to the later issue has been hampered by the fact that tutorial notes were destroyed at the time of campus re-location in 2009.
- 2.6 During the process of the review the independent chair of Birmingham Safeguarding Children Board resigned. Since the chair was also the serious case review panel chair there was a hiatus whilst the continued chairing of the serious case review panel was agreed. This also caused delay in commissioning the individual management review of the nursery due to the chair's role in ongoing discussions with potential authors. In the interest of concluding the review in a timely fashion, the Assistant Director Safeguarding assumed the role of chair with the agreement of the panel and it was decided that the nursery individual management review should be undertaken by a member of the Early Years Service who had no direct contact with the nursery.
- 2.7 Following the change in panel chair:
1. The nursery individual management review was completed, although this was hampered by the fact that all the previous nursery records had been seized by the police and were not available. The panel chair made every effort to retrieve the records but it was not possible to do so. The first version of the nursery report did not include staff interviews but the panel felt that these were so important that some further delay to the process was justified whilst these were carried out.
 2. Further information regarding the role of early years development workers

was sought from the Children's Services individual management review author.

3. The Senior Investigating Officer (SIO) responsible for the police inquiries at the nursery was invited to the panel in order to provide further information from the criminal process that might assist in understanding the events at the nursery. The verbal discussion with the SIO also ensured that any significant gaps in information resulting from non availability of nursery records were addressed. This discussion raised further issues regarding the process by which the Perpetrator obtained his qualification, as well as events at the college and the nursery. This information was felt by the panel to be very significant and required further exploration.
4. Following the discussion with the panel, the Senior Investigating Officer made available to the review the witness statement from the Director of The College, which confirmed that there were likely to be important lessons emerging from further exploration of the involvement of the college in the supervision of placements, and awarding of the final qualification to the Perpetrator. A request was therefore made to The College for an update to their individual management review. This was received but did result in some further delay to the process.
5. The information from the Senior Investigating Officer revealed that the summing up by the judge at the criminal trial included information that confirmed the police view that Subject Child had been abused on more than two occasions by the Perpetrator. Enquiries were made about the possibility of obtaining a transcript of the summing up, but the eventual decision of the chair was that the additional information did not justify the cost.
6. The offender manager responsible for the Perpetrator whilst in custody attended the last serious case review panel meeting in order to ensure that the most up to date information regarding the assessment of the Perpetrator was available to the review.

- 2.8 Following initial presentation of the overview report to Birmingham Safeguarding Children Board, the new chair of the Board was concerned that the final chair of the panel had not been sufficiently independent of organisations involved in the case and that the process of the review may not have been sufficiently robust. Therefore, in order to ensure that there was independent scrutiny of the review and that action plans addressed the most important lessons in the case, the current chair of Birmingham Safeguarding Children Board commissioned an independent consultant to carry out a desktop review of the serious case review process and outcomes.
- 2.9 Scrutiny of the serious case review has highlighted a number of issues that will need to be addressed by Birmingham Safeguarding Children Board in any future reviews, namely:
- Any Panel chair should be independent of all organisations involved in the case.
 - The Panel should not be solely made up of organisations submitting individual management reviews.
 - Where information is not provided by individual management reviews despite request by the panel, this should be escalated to Chief Executives.
- 2.10 The scrutiny of the review did not highlight any major gaps in the analysis and recommendations set out in the original report. It did, however, highlight areas where the report could be strengthened and this has been taken into account in this final version.
- 2.11 Following the desktop review, the serious case review panel was reconvened with an independent chair who was completely independent of the case. The reconvened panel was chaired by a new Chair who has over forty years' experience in Children's Social Care, thirteen of these at senior management level which included management of front line safeguarding services. She retired from a position as Assistant Director responsible for Children's Social Care services in 2010. As well as her social work qualification and registration,

she holds an Advanced Certificate in Child Protection Studies and previously chaired an ACPC and LSCB. In addition, the chair holds a Diploma in Management Studies and a Masters degree in Manager and Organisation Development. Since retirement from her full time post, she has worked as an independent consultant, primarily chairing and authoring Serious Case Reviews.

2.12 The members of the re-convened panel were:

- Head of Child Protection and Review Service
- Detective Inspector West Midlands Police
- Childcare Quality & Sufficiency Manager
- Designated Doctor Safeguarding Children

2.13 The reconvened panel carefully considered a number of issues relating to the process of the original review and concluded that:

- a) There was little to be gained by continuing to pursue nursery records which were held by West Midlands Police and had not been available to the review. Significant information had been given verbally to the panel by the Senior Investigating Officer and staff had been interviewed by the individual management review author. Lessons had been learned and and the imperative was to ensure that the findings of the review were speedily published.

- b) Although it would have been desirable to have had a representative from Education on the panel it was not possible to achieve this at this stage. The first draft report findings had been submitted to the Birmingham Safeguarding Children Board and representatives with Education expertise had the opportunity at that point to comment on the issues raised. The final version would also be scrutinised by the full multi agency partnership.

Terms of Reference and scope of the review (see appendix one)

2.14 Terms of reference were agreed by the panel and are appended to this report. The intention of the terms of reference was to ensure that the review focused on the nursery as a whole, the care and protection of the subject child at the

nursery and how the opportunity arose for a staff member to potentially abuse a position of trust.

- 2.15 In addition, it was clear that consideration needed to be given to any professional involvement with Subject Child and their family in order to determine whether there were any factors that led to the Perpetrator “choosing” this particular child to abuse within the nursery and whether there were any opportunities for professionals to recognise and respond to the abuse. In conducting this part of the review, the panel were mindful to minimise the intrusion into a family whose circumstances would not usually feature within a serious case review. Details of family circumstances have therefore been kept to a minimum within this overview report.

The individual management reviews

- 2.16 All individual management reviews were scrutinised by the original panel and a report on quality submitted to Birmingham Safeguarding Children Board. The main findings from these reviews have been integrated within this report and the individual agency recommendations are set out within the action plan. The panel and overview author are satisfied that the recommendations address the main issues raised within the individual management review reports.

The health overview

- 2.17 As required by Government guidance, a designated health professional reviewed all the information relating to health organisations and submitted a health overview report. No Health agency identified the child as vulnerable and there was no information within any of the health reports leading to the conclusion that action could have been taken to predict or prevent the abuse of the child within the nursery. There are therefore no recommendations made for health organisations by this review.
- 2.18 The Health overview report does mention the desirability of creating better links between health visitors and nursery settings through a named link health visitor. However, no recommendation was made due to difficulties in implementing this measure across the Private and Voluntary Sector. The Early Years Service is

considering how this could be improved.

Parallel processes

- 2.19 This review started at the same time that criminal processes were taking place in respect of the Perpetrator. As a result of the Perpetrator's guilty plea, these came to a swift conclusion and therefore did not contribute to any delay in completing this review.

Family Involvement

- 2.20 The Perpetrator was offered the opportunity to contribute to the review and was seen in prison by the panel chair and safeguarding board business manager. Notes of this discussion were taken and a letter sent to the Perpetrator to confirm the content of the discussions.
- 2.21 The mother of Subject Child was also offered an appointment to meet a member of the panel and the overview author, which was not taken up.
- 2.22 The serious case review panel considered how best to involve the families of children in the nursery in the review, and the overview author offered to meet them after the conclusion of the criminal proceedings. Families had been offered a twenty four hour helpline as soon as the Perpetrator was arrested and were also given an opportunity to give their views about the nursery at the start of the criminal proceedings. Two families came forward at that point but did not offer any additional information and no other child was identified as having been abused. Since the process of contacting families again was delayed due to some of the challenges presented by the review process outlined above, it was no longer possible to use the composite telephone list compiled during the investigation and the nursery had closed. It was therefore the view of the panel that the review should conclude without proceeding further with this aspect of information gathering.

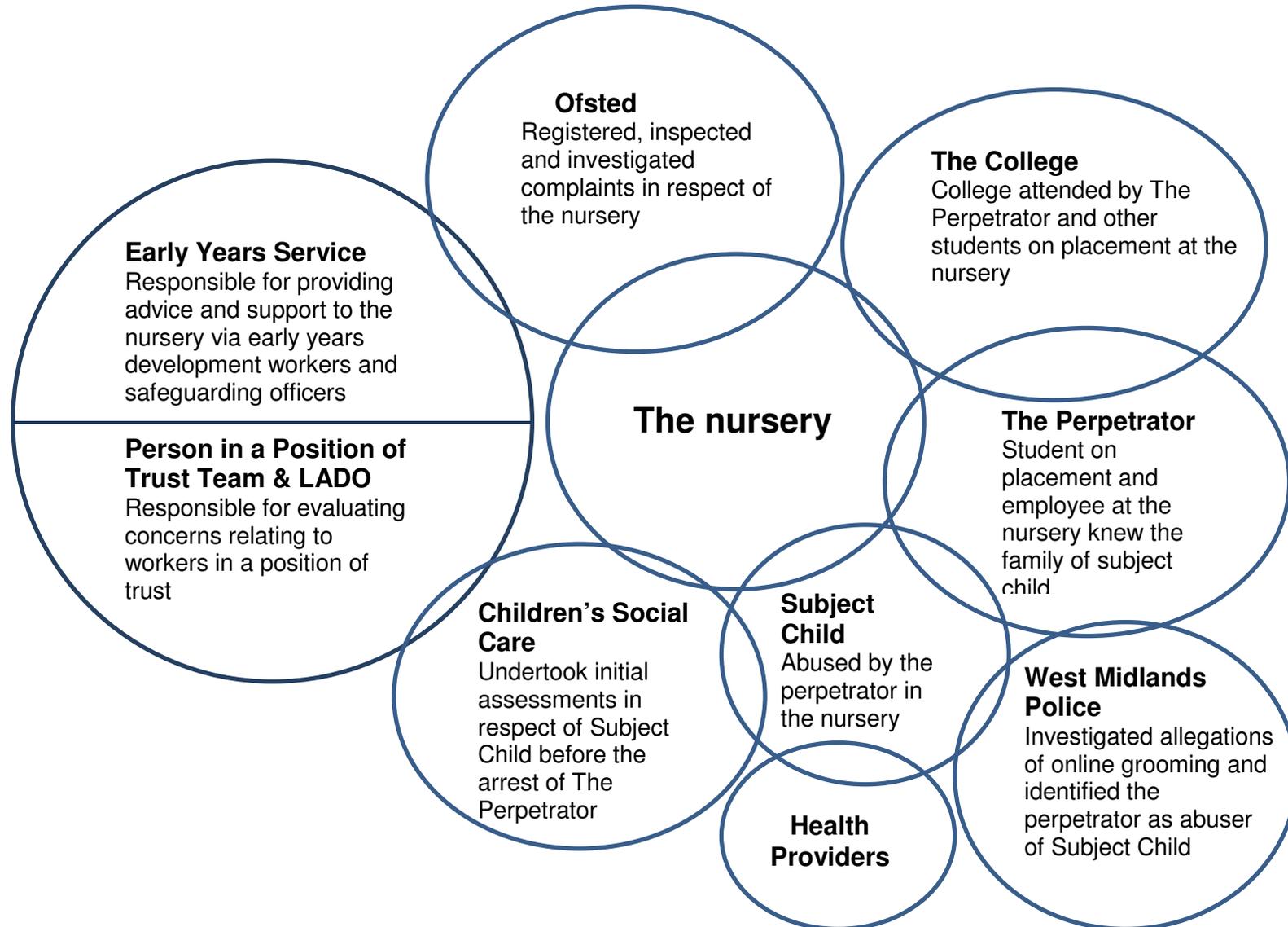
The overview report

- 2.23 This overview report has been prepared by an independent author, who is an independent consultant who qualified as a social worker in 1979 and has an

MSc in social work practice, the Advanced Award in Social Work and an MPhil as a result of researching the impact of supervision on supervision practice. She has been the author of numerous overview reports from 1994 onwards, including the review into events at Nursery Z in Plymouth. Jane has completed the accredited Tavistock Clinic and Government Office London nine day training programme for panel chairs and authors.

3. THE OVERALL CONTEXT FOR THIS REVIEW

3.1 This review involves several overlapping strands of enquiry and professional involvement as set out in the diagram below. The structure responsibilities of each organisation are set out in more detail in the rest of this section.



Family and Social Context

- 3.2 This review was instigated because of the abuse of a specific child in a nursery in Birmingham (known in this report as Subject Child). The family context for this child had only been explored in order to ascertain whether there was anything known to any agency about the child or family that might be relevant in understanding whether the abuse might have been prevented, or the actions of the Perpetrator in respect of this child.
- 3.3 Ethnicity of the family is significant since the Perpetrator tried to suggest that he would not have been able to get close to a number of children in the nursery from Asian/Pakistani/Muslim backgrounds as their religion or culture would have limited physical contact. However, this did not apply to Subject Child who was not from one of the ethnic groups mentioned by the Perpetrator.
- 3.4 The Perpetrator is of white British heritage and had been brought up in the local community. He was known to staff within the nursery before he started there on student placement as his mother had previously been the manager. Prior to the incident the Perpetrator had only had contact with universal services and there are no indications from any records that there was anything unusual or problematic in his background. There was nothing in records from Health organisations or Schools that indicate any issues that should have alerted professionals to any concerns about his behaviour.

The nursery

- 3.5 The nursery operated from a self-contained nursery unit within a Community Project. Ofsted reports refer to there being two play rooms, including one for babies and toddlers and one for pre-school children, as well as a fully enclosed garden available for outside play. The nursery provided child care places for parents who were on training courses organised by the Community Project, as well as servicing the local area consisting of a diverse cultural and economic community.
- 3.6 Governance arrangements for the nursery were via the Community Project's

Board of Trustees who are deemed to be the registered person by Ofsted. The Board nominated nursery lead 1 as the nominated person for Ofsted registration purposes, with a manager responsible for the day to day running of the setting. Nursery lead 1 had been involved in setting up the nursery along with four other local people, one of whom, the mother of the Perpetrator, became the first manager of the nursery. Nursery lead 1 had extensive experience of community work, mainly with elderly people, and therefore relied on the managers as “experts” in child care aspects of the setting. It is, however, the Board of Trustees as the registered person who has ultimate responsibility for determining the suitability of staff in the nursery, other than the manager. The manager needs to be deemed suitable by Ofsted for this role.

Ofsted

- 3.7 Ofsted had a regulatory role in relation to the nursery. The Ofsted individual management review explains that this function is carried out through registration, inspection, investigation of concerns about non-compliance and taking enforcement action. Ofsted’s responsibility for these functions commenced on 1st September 2001, the framework for inspection at this time being determined by the Care Standards Act 2000 and accompanying regulations. During the period covered by this review the framework against which Ofsted regulates and inspects changed and from 1st September 2008 settings were regulated and inspected against the requirements of the Early Years Foundation Stage (EYFS). Following an independent report commissioned by Government,² the EYFS was revised and a new version published in March 2012, for implementation from 1 September 2012.

Birmingham City Council – Children Young People and Families Directorate

- 3.8 Three distinct services within Birmingham City Council, Children Young People and Families Directorate were involved in the circumstances surrounding this review: Children’s Social Care, Early Years Services and the Local Authority Designated Officer (LADO) Team known locally as the Persons in a Position of Trust Team (POT).

² Tickell, Dame C (2011) *The Early Years: Foundations for life health and learning*. Department for Education.

- 3.9 Children's Social Care was responsible for responding to referrals regarding issues in the family of Subject Child that may have affected the child's development, wellbeing and safety. In this case, the child care teams involved were part of the duty and assessment service which responds to referrals and undertakes initial assessments. Social workers within the team carry out the face to face work with families, and are managed by a team manager who has a key role to play in supervising staff and agreeing decisions made.
- 3.10 At the time of the relevant events, the Early Years and Childcare Service sat within the strategy and commissioning directorate of the City Council, with senior management accountability resting with Assistant Director for Performance and Commissioning. They have a statutory duty to provide support, advice and challenge to all types of childcare provision in the City and manage the childcare 'market' to ensure sufficiency. In this case their responsibility was in respect of the nursery provision and the focus of support was to enable the nursery to meet the minimum requirements for Ofsted registration and to work with them to improve quality, using the Early Years Quality Improvement Programme as a focus for improvement activities. Within the team are thirty three early years development workers (now known as early years consultants), who provide support for early years settings, and twelve early years support teachers as well as early years safeguarding officers (one safeguarding officer was in post during the timeframe of this review). All of these professional roles had some input in this case.
- 3.11 The Persons in a Position of Trust Team (the local term used to refer to Local Authority Designated Officers) is responsible for making enquiries where there are concerns about the behaviours of a person in a position of trust (i.e. anyone who carries out work paid or unpaid, on behalf of an agency and has access to children and/or privileged information about children as part of their work). Where the position of trust team is informed of a concern about the behaviour of a person working with vulnerable children this is considered by a principal officer and where the case meets the threshold for intervention the principal officer will trigger a position of trust coordination meeting to bring together all known

information in relation to criminal investigations, child protection and disciplinary processes, and establish a coordinated way forward. (Birmingham child protection procedures para 4.2).

The College

- 3.12 The College has grown from mergers with other smaller colleges in the area. At the time the Perpetrator was a student he attended one of these smaller colleges, firstly on the B-Tech National Diploma in Sport, switching one year later (September 2007) to the CACHE Level 3 Diploma in Child Care and Education. His main college file remained at the original campus but his tutor file was destroyed during December 2010 when the programme manager moved offices. The tutor records were therefore not available to this review.

West Midlands Police

- 3.13 Child protection services within West Midland Police are provided via local Public Protection Units (PPUs). There is one command structure for Public Protection Units (established in April 2010) provided by one dedicated Detective Chief Superintendent, two Detective Superintendents and nine Detective Chief Inspectors.
- 3.14 Within each local Public Protection Unit there are two Detective Inspectors, one responsible for child abuse investigations and another for investigations relating to adult abuse and serious sexual offences. Every Public Protection Unit has a dedicated child online safeguarding investigator.

Health Services

- 3.15 Health provision to those involved in this case included both community-based and hospital services.
- 3.16 Acute hospital services were provided by a variety of local hospitals and GP services were commissioned by the local Primary Care Trust. The health visiting service transferred in December 2010 from this local PCT to Birmingham Community Healthcare Trust who have provided the health visiting report for this serious case review.

4. SUMMARY OF SIGNIFCANT EVENTS

4.1

April 2006	The nursery opened.
Aug 2006	Ofsted graded the nursery "Good".
April – June 2008	The Perpetrator was on student placement at the nursery.
Nov2008 – April 2009	The Perpetrator was at the nursery on work experience and Subject Child started at nursery in early 2009.
March 2009	Ofsted graded the nursery "Satisfactory".
July/Aug 2009	The Perpetrator worked at the nursery providing cover for staff leave.
Oct 2009	The Perpetrator commenced 12 month contract of employment at the nursery.
Nov 2009	Allegation made by a student to the College regarding the inappropriate behaviour of male member of staff at the nursery.
Nov 2009 – Jan 2010 (approx)	Students at the nursery told their College tutor about "poor practice" in their setting.
February 2010	The Perpetrator received qualification – Level 3 Diploma in Childcare and education.
March – July 2010	Evidence of financial problems at the nursery.
May 2010	Incident form completed in the nursery - Subject Child cried out whilst with the Perpetrator in sleep area.
Aug 2010	West Midland Police commenced an investigation after a 13 year old alleged sexual abuse by unidentified male over the internet.
Aug 2010	Anon. complaint to Ofsted by member of staff at the nursery about the behaviour of the Perpetrator towards the subject child. Joint investigation between Ofsted Early Years Professional from Children's Services. The nursery given a "notice to improve".
Aug 2010	Three days after the Ofsted visit to the nursery the Perpetrator made a complaint to Ofsted about safeguarding practice in the nursery and the safety of two children including Subject Child. This resulted in Children's Social Care starting an initial assessment.
End Aug 2010	Subject Child left the nursery.
Oct 2010	The Perpetrator's contract with the nursery extended to January 2011.
Nov 2010	Ofsted inspection graded nursery "good".
January 2011	The Perpetrator arrested.

5. CASE DETAILS

The Nursery

- 5.1 Ofsted registered the nursery in April 2006 following normal registration processes. At this point the Perpetrator's mother was the manager of the setting and an inspection of the nursery by Ofsted in August 2006 graded the overall quality and standards of care in the nursery as "good". The Perpetrator's mother resigned in 2007 to take up a post as manager of another local nursery and was not managing the nursery when the Perpetrator started a student placement there in April 2008.
- 5.2 The next Ofsted inspection of the nursery was in March 2009. This inspection took place under the requirements of the Early Years Foundation Stage which had been introduced in September 2008. The overall quality of provision was deemed to be "satisfactory", with the actions required relating to developing risk assessments and staff awareness of the learning and development requirements of the Early Years Foundation Stage.
- 5.3 During 2010 it seems that the nursery was facing some financial difficulties. A slightly more complex picture emerged following an interview for this review with nursery lead 1 (the member of the Board of Trustees who was the nominated person for Ofsted purposes). Their view was that some of the financial pressures resulted from weak management and leadership around financial controls and absence/attendance monitoring, as well as lack of communication between manager 1 and themselves.
- 5.4 According to information from the Perpetrator uncertainty within the staff team about whether their jobs were safe resulted in problematic relationships, a lot of arguing and a loss of trust as staff were aware they were in competition with each other for jobs. From the information given by the Perpetrator it appears that he may have been seen by the manager as a source of support within the team, some of whom were openly critical of management within the nursery.
- 5.5 Toward the end of May 2010, Ofsted were informed that the nursery was to have a new manager (manager 2). Manager 1 resigned in June and Ofsted

commenced checks on manager 2. A month later Ofsted were informed that in fact manager 3 was to be the new manager.

- 5.6 During this period (early July) a further referral for sustainability support was made to the Early Years Service.
- 5.7 In November 2010 an Ofsted inspection of the nursery took place. Since Ofsted had outsourced the inspection of early years and childcare provision in September 2010, this inspection was undertaken by an inspector from Prospects, the service provider covering the Midlands area. This inspector would have only had available to them background information about the nursery as contained in the Ofsted documentation on their website. Although at this point there had been allegations made to Ofsted about the behaviour of the Perpetrator, the detail of these would not have been known. This situation has now evolved and outsourced inspectors have more information available to them than was the case at the time of this inspection.
- 5.8 The inspector graded the setting as “good” overall. In respect of safeguarding, the inspector noted that the staff had a good understanding of safeguarding children and of their role and responsibilities in reporting concerns, and that the nursery had effective procedures to ensure that children were safe and their welfare was promoted. The inspector also identified appropriate recruitment and vetting procedures. One action was set which related to risk assessments; this had been an action in two previous inspections, and the inspectors at this point did not take account of the failure to act on this issue in upgrading the setting from ‘satisfactory’ to ‘good’.
- 5.9 This inspection took place less than two months before the arrest of the Perpetrator. When he was arrested, Ofsted were notified on the same day. The next day, Ofsted held a case review and the decision was taken to suspend the nursery’s registration, and a suspension notice was hand delivered to the nursery.
- 5.10 Once West Midlands Police had confirmed that Ofsted could start their own

investigations without compromising the police enquiries, an Ofsted inspector spent five days in the setting. During this period, the inspector examined a range of policies and procedures, read files and other records and interviewed the manager and staff who were on site. The Ofsted individual management review notes that it is highly unusual for Ofsted to spend this amount of time in a setting investigating concerns and that it was the recognition of lack of rigour in previous investigations that prompted such an in depth investigation of this concern. The inspection is also noted to be unusual as the inspector gave the manager detailed feedback during the inspection on the effectiveness of policies and procedures within the setting. The individual management review author notes that Ofsted's role is as a regulator, not a provider of detailed advice, guidance and support, as this is the role of the local authority.

- 5.11 The conclusion of the inspector was that there were significant weaknesses in the setting's policies and procedures in relation to safeguarding, safe recruitment, induction and performance management for staff, and the development of risk assessments and effective systems to obtain information from parents about their child. The inspector identified nine actions that the nursery needed to take and the recommendation from the visit was to issue a legal notice. This recommendation was reviewed by a member of the compliance team who changed the response to non statutory actions. The rationale for this was that the registration of the setting was suspended and suspension would not be lifted until actions had been completed. It was noted that the provider had already taken steps to improve policies and procedures whilst the investigation was ongoing.

The Perpetrator as an early years student and member of staff at the nursery

- 5.12 In September 2007 the Perpetrator enrolled at The College for the Level 3 Diploma in Childcare and Education, having enrolled the previous year for a BTEC sports course and changed his pathway of study to childcare. According to the Perpetrator the reason for this change was that the sports course required too much effort. The Perpetrator's first work experience placement commenced (following receipt of a clear CRB check) in a primary school in November 2007 and reports from the school were good. The Perpetrator told

this review that he had not thought about abusing children in the school but there were a number of rules there that would have made it difficult for abuse to take place.

- 5.13 In April 2008 the Perpetrator started his placement at the nursery, where he remained until June 2008. The Perpetrator recalls the organisation of this placement as being very last minute but, as his mother had previously worked at the nursery, it was easier to get a placement there. Again he received a good placement report with one concern relating to prompt timekeeping.
- 5.14 In October 2008, The College identified that the Perpetrator had misplaced his CRB form and he did not therefore start at his second planned placement. He is described in the College individual management review report as being “tardy” in producing the required ID to apply for a new CRB check and he therefore did not attend any placement for two months. During this period the nursery offered to provide him with a second placement, based on their prior knowledge of him and having previously having had sight of his CRB. As discussed below it seems that this placement was in fact treated as work experience and was not formally assessed. The replacement CRB was eventually applied for and cleared in early April 2009, at which point the Perpetrator moved to a school for his final placement of the College course.
- 5.15 The Perpetrator completed his college course in July 2009. During his second year he had been frequently late in submitting work and arrangements were made to support him in completing this. In January 2009 there had been a disciplinary meeting about his poor attendance, resulting in an action plan and report. The reason given for attendance problems at this point was that he had gained employment within the nursery as an assistant and he was having difficulty meeting the demands of both work and college. The disciplinary meeting was therefore aware that he was working at the nursery but this work experience does not seem to be supervised as part of his college course.
- 5.16 By the end of the college course in July 2009 the Perpetrator had completed the required hours of work although there was outstanding theoretical work. It

was agreed that he would complete outstanding work by September 2009 and, following the required marking and moderating procedure, a certificate for the Level 3 Diploma in Childcare and Education was subsequently issued in February 2010.

5.17 At the end of the college course and prior to receiving his certificate the Perpetrator was employed by the nursery during July and August to provide cover for staff leave. It is not clear from nursery records whether he was assumed at this point to be qualified and therefore able to work without supervision. The Perpetrator informed this review that in his opinion they believed that he was a qualified worker and if this was the case it is clear that the correct recruitment procedures, including seeing copies of certificates, were not followed.

5.18 In early October 2009 the Perpetrator started work in the nursery on a twelve month contract. This appointment was made by manager 1 when nursery lead 1 was on leave. Evidence indicates that recruitment procedures were not followed at this point, and nursery lead 1 has reported verbally to the individual management review author that staff were not aware of any interviews taking place for the post and that “all of a sudden the Perpetrator was here again”.

5.19 In October 2010 the Perpetrator’s contract with the nursery had finished. However, due to a grievance over pay it was agreed that his contract should be extended until January 2011 in order to resolve this issue.

Subject Child in the nursery

5.20 Three months after the Perpetrator started work experience at the nursery the Subject Child started at the setting. According to the nursery chronology it was therefore likely that Subject Child was known to the Perpetrator through family connections. However, information from the Perpetrator is that although there was a family connection he had not made the link when he met Subject Child and this was not the reason he singled that child out for special attention.

5.21 During July, August and September 2009 there was Children’s Social Care

involvement with Subject Child due to family difficulties and an initial assessment was completed. The nursery was contacted during this assessment and provided information which suggested that Subject Child had been affected by circumstances within the home. Incident forms were requested by Children's Social Care from the nursery but there is no record that these were received. This review has had sight of incident forms which show that there would have been written information within the nursery which would have been highly relevant to the initial assessment at this time. The case was closed by Children's Social care in October 2009.

5.22 During August 2010 there was continued evidence that Subject Child was living in a household where there were a number of family problems. A referral was received by Children's Social Care who started an initial assessment. As part of the initial assessment process, contact was made with the nursery who confirmed that Subject Child had spoken in nursery about problems in the family home. The relevant incident forms were requested from the nursery. Two days later, an inter-agency referral form was submitted by nursery manager 3 which included a series of incident forms dating from August 2009 detailing concerns about Subject Child. These forms included an incident in May 2010 when Subject Child had cried out whilst in the presence of the Perpetrator. Children's Social Care did raise with mother the concerns contained in the complaint made by the Perpetrator about the nurseries poor safeguarding practice in respect of Subject Child. Mother said these issues had been addressed and also informed the social worker that the child was no longer attending the nursery.

5.23 The individual management review author is critical of aspects of the assessment process at this point and the main issue for this review is that despite the presence of an incident form suggesting Subject Child had been distressed whilst in the presence of the Perpetrator and previous complaints to LADO/Ofsted regarding his behaviour, these events were not linked. The opportunity to consider the possible meaning behind the Perpetrator's complaint to Ofsted so soon after an allegation about his behaviour was lost.

Response to Allegations

- 5.24 In November 2009 a student from The College told a member of staff at the college that she had a friend on placement at the nursery who had been told to watch out for a male member of staff who had been accused of “abusing” children, taking them into the adult toilet on his own and sitting them on his lap. The college staff member contacted the Early Years Team at Birmingham City Council for advice. Following further contact with the Director of the College details were given of a conversation, overheard by a student in the nursery where two members of staff at the nursery were talking about another member of staff who was a male aged about twenty. The staff had commented on him getting too close to one child and an eye needed to be kept on him as “you don’t know what he is doing when he takes [the child] into the music cubicle”. The director of the college said the student did not want to be considered to be stirring things up and was concerned about the effect on her placement. The college had stressed her safeguarding responsibilities and she was willing to talk to a member of staff in the Early Years Team.
- 5.25 The Early Years Team sent a referral form to the LADO Team and also followed up the allegations with the manager of the nursery who attributed the allegations to “bitchy” members of staff. The manager was to speak to all staff members to establish whether they had any knowledge of any allegations against any member of staff, without mentioning the Perpetrator’s name. Information was added to the LADO referral form identifying Subject Child as the “alleged victim” and the records indicate that checks were made on the Children’s Services database. These checks should have revealed that the family had recently been known to Children’s Social Care but did not do so. The records were available but it appears that a search was not made.
- 5.26 There is no further information in the Early Years or LADO team records to indicate the outcome of this referral. There is reference to the college e-mailing children’s service professional 1 to ask “what’s happening” but no evidence that there was any reply or follow up by either party. Further information obtained during interviews for this review has identified that the member of the LADO team taking the referral at this point was a referral and advice officer

who made the decision that there should be no further action without consultation with a principal officer.

- 5.27 The college individual management review also refers to an incident around this time (between November 2009 and January 2010) when two students on placement at the nursery approached the tutor after a session on safeguarding. The students said they were uncomfortable with practice at their setting but were no more specific than that. When asked by the tutor if it was a safeguarding issue they replied that it was more about poor practice. When pressed on the matter they responded that it was more around process and procedure. When they were next seen in class two weeks later the tutor asked them about the concern, they said they were fine and did not volunteer any further information.
- 5.28 In Feb/March 2010 the nursery chronology refers to a member of staff witnessing a private conversation between nursery manager 1 and the Perpetrator on an upstairs landing; an area they would not usually be in. When the Perpetrator asked what is going on manager 1 is reported to have replied "Oh it's just them" and she would "sort it out". It should be noted that following his arrest the Perpetrator admitted to committing one of the offences with Subject Child in January 2010, just prior to this incident and around the time that the two students were expressing unease about practice at the nursery. This was also when he should not have been working at the nursery without supervision as he had not received his certificate of qualification to practice which he finally received in February 2010.
- 5.29 At this time in May 2010 an incident form was completed in the nursery recording that a member of staff who heard Subject Child cry out when alone with the Perpetrator in the sleep area. The records state that the child screamed and said "I want my mummy". There is no evidence that any action was taken by the nursery at this time.
- 5.30 It is clear from the records that manager 1 raised concerns around this time with their early years teaching support service worker about staff in the pre-

school room not working well together. The Perpetrator was one of the staff in this room. The teaching support service worker told the early years development worker of these concerns and said that she knew of the Perpetrator through his mother and that he wanted the nursery to be like the nursery managed by his mother. There is no evidence that the early years development worker followed up this issue and it should be noted that the Perpetrator later admitted committing an offence soon after this event (i.e. June/July 2010) at around the time there was a change of manager in the nursery.

5.31 In early August 2010, an anonymous complaint was made to Ofsted by a member of staff at the nursery. This complaint detailed concerns about the behaviour of the Perpetrator towards Subject Child, including the Perpetrator cuddling her and rocking her for “hours at a time”, “wrapping her in a blanket” and “refuses to leave her”. The Perpetrator was also described as spending time with her to the exclusion of other children and was defensive when it was suggested that he should change his practice. The caller said they had raised the issue with the manager in May/June 2010 and provided a written report. The caller also noted that the child was from a vulnerable family background. The caller was due to leave the nursery as their contract had not been renewed. Evidence provided to this review confirms that staff members had raised this issue with manager 1 on a number of occasions but felt that no action had been taken.

5.32 Ofsted allocated the case to an Ofsted inspector and a compliance team member. The Ofsted compliance team member telephoned the local authority to make a child protection referral, and spoke to a member of the LADO team detailing the concerns. There are no records within the LADO team or the Early Years Team relating to this referral, but the Ofsted individual management review notes that:

“... the local authority’s view was that the issue concerned inappropriate practice and concerns regarding policies and procedures. However, the local authority did suggest a joint visit between inspector 6 and children’s services

professional 1 in order to look at safeguarding practice. It appears that Ofsted did not have a clear understanding of the role and responsibility of the local authority in this joint visit, given that it was not taking the matter forward as a child protection investigation. Ofsted's remit is to investigate compliance with the Early Years Foundation Stage and accompanying regulations and not to follow up a referral about a child protection issue that is made to the local authority.” (Page 20)

- 5.33 When the LADO team received the referral from Ofsted it was their view that it did not meet their criteria and therefore it “was down to Ofsted to visit”.
- 5.34 The visit to the nursery therefore took place between the Ofsted inspector and children’s services professional 1 without involvement of the LADO team. They discussed how they would carry out their visit; the inspector would take the lead in discussions with the manager and assess how the setting was complying with the Early Years Foundation Stage (which includes having an effective safeguarding policy) and children’s services professional 1 would focus on safeguarding practice in the setting. The description of the visit within the Ofsted individual management review notes that the inspector reviewed the safeguarding policy and spoke to staff about their general development, but did not test their knowledge of the policy or ask them how they would deal with safeguarding concerns. The plan for the visit also did not include speaking to the Perpetrator or observing his practice. The inspector spoke directly to the manager (manager 3) about the allegations against the Perpetrator and the manager said that she was dealing with them within the setting and in her view they related to issues of professional practice rather than child protection and she had therefore not referred them to the local authority. This was not challenged by the inspector. Manager 3 appeared unaware of any concerns raised by members of staff with the previous manager.
- 5.35 The only record of the visit by children’s services professional 1 is an e-mail to the early year’s development worker responsible for the nursery and her manager. This noted that “the concern does not quite fit the need for a referral to our POT team” although it did add that it did need to be explored further.

There is no record of any communication between children's services professional 1 and the LADO team at this point.

- 5.36 The outcome of the joint visit was that Ofsted issued a notice to improve requiring the nursery to:
- Implement an effective safeguarding policy.
 - Ensure that staff had appropriate skills and qualifications.
 - Ensure children's individual learning and development needs were met.
 - Observe and assess each child's achievements in order to identify learning priorities and motivating learning experiences for each child.
- 5.37 Following the notice to improve, an early year's development worker visited the nursery and noted that there were no clear professional boundaries between staff and parents and that manager 3 thought that staff were friends with parents on Facebook. The manager 3 is also noted to be "concerned about the welfare of a particular child but also the welfare of staff if concerns were raised." She was advised to contact children's services professional 1 to discuss a way forward. There is no record that this consultation took place.
- 5.38 Three days after the Ofsted visit to the nursery, the Perpetrator made a complaint to Ofsted. The complaint involved concerns for the safety of two children in the nursery, including Subject Child. He gave the details of various incidents relating to the children's home circumstances and said incident forms had been filled in within the nursery but not followed up. He told Ofsted that they had visited in respect of a complaint about him, but during this visit the manager had not told the inspector about the missing forms. Ofsted allocated the case to the same inspector and compliance officer as had dealt with the previous complaint and a referral was made to the local authority LADO team within two hours of receipt of the complaint from the Perpetrator. During a conversation between the LADO team and the Ofsted compliance officer, the LADO team member agreed that they would contact the nursery to obtain details of the children concerned and follow up the allegations concerning difficulties in the family. They subsequently e-mailed the compliance officer to say they had spoken to the manager who had only been in post a short while,

but had gone through some incident forms on file and made two referrals to the local authority. Ofsted records note that one of the children named by the Perpetrator (Subject Child) was already known to the local authority and they were taking no further action. There is no evidence that the previous complaint about the behaviour of the Perpetrator was discussed at this point and consideration given as to the possible significance of this complaint following so swiftly after concerns had been raised about his own practice.

- 5.39 The LADO team member asked Ofsted to send details of the complaint in writing and there is a letter on the LADO file from the Ofsted inspector outlining the concerns of the Perpetrator regarding the two children, including Subject Child. The letter stated that incident forms had been completed and that Nursery manager 1 had not “apparently spoken to the LADO regarding these incidents and since she had left the nursery the incident forms had vanished”. The letter concluded “please keep us informed about any action that you take, including if you intend to hold a strategy meeting. We can then decide whether it is necessary for us to attend.” Three days later the LADO team sent a copy of this letter as an e-mail attachment to the Children’s Social Care team covering the home address of the children referred to by the Perpetrator. This e-mail stated “We will not be holding a LADO meeting regarding this as it is about their procedures, the information will be forwarded to the Early Years Safeguarding Team”. There is no evidence that this occurred.
- 5.40 Throughout August 2010 there was action being taken within the nursery by manager 3 following the Ofsted notice to improve. Although Ofsted concluded that the actions taken to improve were sufficient, the Early Years Service continued to support the nursery and held a “support for settings” meeting in September. It is important to note that the notes of the September meeting do not make any reference to the complaint to Ofsted made by the Perpetrator. The action from the meeting related to ensuring staff had the necessary training.
- 5.41 Following this meeting a “support for settings visit” took place and it was noted that staff behaviour was discussed and the need to be vigilant at all times. This

would seem to refer to the complaint regarding the Perpetrator.

Police response to allegations of sexual abuse

- 5.42 It was at the start of August 2010 that a thirteen year old contacted West Midlands Police alleging that an unidentified male (apparently a fourteen year old youth) was trying to persuade her to engage in sexual activity over the internet. Her family's computer was seized and the case allocated to a local Public Protection Unit investigator. This investigator was the local Child Online Safeguarding Team single point of contact for the Public Protection Unit covering the victim's home address. Due to the assessment that this case was within the category of a low level of concern, the investigation was not referred to the central Child Online Safeguarding Team but was managed at a local police station.
- 5.43 During the next week there were several contacts between police and the victim, with the outcome that she was prepared to speak informally, but not give a formal interview. As the police assessed that the informant was at no continuing risk from the offender and there was no evidence of other risk factors requiring safeguarding action, work began to identify the location of the registered address whose e-mail had been used by the alleged offender. This process took approximately one month with the address being identified on 10th September 2010.
- 5.44 During mid-September, West Midlands Police located the Perpetrator's address as the registered address of a person whose e-mail address had been used in the offences committed against the thirteen year old girl. Intelligence checks of known occupants showed no known history of concerns likely to heighten the risk posed by the offender who at this time was still thought to be a fourteen year old youth. These checks do not reveal the age or the occupation of the inhabitants of the address. Since this address was in a different Public Protection Unit area to that of the victim, the case was transferred towards the end of September. The child protection sergeants considered the known intelligence and concluded that their own Child Online Safeguarding Team Single Point of Contact (DC1) should progress the enquiry.

Due to DC1's annual leave and sickness, the enquiries did not start until early November. These enquiries included checks with the Central Child Online Safeguarding Team and help to identify the residents of an address through the systems used by Revenue and Customs, council tax records, education and other sources. These checks were returned at the end of November.

5.45 The police intelligence checks that were returned at the end of November did not reveal anything that raised the level of concern or the risk assessment for the enquiry. It was, however, evident that a search warrant would be needed and a team from the Operational Support Unit to assist in securing the premises and searching for evidence. No unit was available until 5th January 2011.

5.46 On 5th January officers executed a search warrant at the Perpetrator's address and he indicated that he did have knowledge of the offence. His computer was seized and images of the sexual abuse of Subject Child taking place at the nursery found. When confronted with the evidence the Perpetrator admitted to having committed the offences at the nursery in January 2010 and June or July 2010. The nursery was closed to enable police forensic examination to take place.

6. REVIEW FINDINGS

6.2 The findings within this section have been derived from careful analysis of the information within the individual management review reports and panel discussions. They have been grouped to reflect the main themes arising from the review and address the original terms of reference.

What can we learn from the offending behaviour of the Perpetrator that might prevent such abuse in the future?

6.3 The ultimate responsibility for abuse in this case clearly lies with the Perpetrator, and the serious case review panel has attempted to understand

the nature of his offending in order to identify any factors that might be relevant to improving the identification and response to such cases in the future. The following information has been drawn from information given verbally to the panel from the Senior Investigating Officer in the criminal proceedings as well as the interview with the Perpetrator himself, who was keen to contribute to the review and is aware that the information he gave could be made public. It should be noted that at the time of the interview the Perpetrator had not received any therapeutic input in prison, and therefore his account is likely to have been influenced by the distorted thinking that allows offenders to justify their abusive behaviour.

- 6.4 The Perpetrator in this case had no previous criminal history or any contact with the police prior to his arrest. There has also been no contact during his childhood with any agencies other than those providing universal services.
- 6.5 The Perpetrator abused young women via chat rooms (MSN) on the internet both before and after the contact abuse of the child in the nursery. There is no evidence of contact abuse with any other child.
- 6.6 He told the review that within ten minutes online he could find someone who would do what he wanted them to do and that social networking sites were “like e-bay for teenagers”. The police identified twenty three victims and according to the Perpetrator this is likely to be a vast underestimation. The youngest victim known to the police from his internet offending was aged twelve and some victims may have been described as vulnerable. His approach to internet offending was to develop fictitious pseudonyms and to coerce his victims to perform sexual acts, threatening them with exposure to others if they did not want to continue to comply with his requests. According to the evidence recovered by police there was an escalation of the severity of abuse over time and at the time of the arrest there was evidence of the most severe forms of abuse. There was no evidence that the images of this abuse were shared with others, although the Perpetrator also downloaded indecent images which were shared with at least three other people.³

³ In the UK for the purposes of sentencing, five categories of images are used from least severe (one) to most severe (five). The perpetrator had some images at level five.

- 6.7 The behaviour of the Perpetrator in relation to internet offending clearly re-enforces the need for continued focus on ways of increasing internet safety, as well as the education of parents and young people about the risks associated with chat rooms on the internet. This is a national rather than a local issue and CEOP (Child Exploitation and Online Protection Centre) clearly plays an important role in driving developments forward. Schools and Local safeguarding Children Boards also have a key role to play in educating parents and young people in their own areas.
- 6.8 In addition to understanding the nature of internet offending, one important consideration is how often abuse took place within the nursery and the conditions that made this possible. According to the Perpetrator, he abused Subject Child on two occasions approximately six months apart and in between times focused his abusive behaviour on the internet. The abuse of Subject Child was recorded on his mobile phone and later uploaded to his computer. The recording of the abuse appears to have been solely for his own use as there is no evidence at all that the images of the abuse of subject child were shared with others. According to the Senior Investigating Officer, evidence from the two images captured on the mobile phone would suggest that these were not isolated occurrences and that although they were the only instances recorded, it is most likely that the abuse of Subject Child within the nursery occurred several times between the two events. This was referred to in the summing up by the Judge at the trial. If this is the case, there are serious implications in respect of the conditions within the nursery which allowed the abuse to take place.
- 6.9 The physical layout of settings has been identified as a possible factor in abuse within organisations⁴ and in this case, the Perpetrator told the review that the abuse took place in the bathroom which was located off the room in which he worked. The children had been playing outside and Subject Child wanted to go to the toilet. Layout is significant in relation to the recording of the abuse on the

⁴ Erooga et al (2012) *Towards Safer Organisations* 11. www.nspcc.org.uk/Inform/resourcesforprofessionals/sexualabuse/safer-organisations_wda89439.html

mobile phone as, although mobile phones were not permitted in the nursery, they were kept in staff's coat pockets which hung in the kitchen area. The room within which the Perpetrator worked was off the kitchen and it was relatively easy for him to retrieve his phone and use it to film the abuse.

6.10 The Perpetrator told the review that his abuse of Subject Child was not related to the fact that there was a family connection. However it is clear that the child was known to be adversely affected by family issues and therefore was likely to be receptive to the special attentions of an adult. Information from the Perpetrator also identified that, unlike children from other ethnic groups, there were none of the inhibiting factors relating to the family not wanting a male member of staff to undertake intimate care tasks with their child.

6.11 One well documented model for understanding sexual offending is the "four preconditions" model described by Finkelhore (1984).⁵ Using this model sexual abuse occurs when the offender is motivated to abuse, is able to overcome the internal and external inhibitions that might prevent them from acting and finally is able to overcome the child's resistance. It is beyond the scope of this review to speculate on the motivation of the Perpetrator or the way in which he was able to overcome his internal inhibitions that might have prevented him from abusing others; that will be the focus of a therapeutic programme. In addition, research by Finkelhore into abuse within nurseries⁶ suggests that motivation may be less of an issue since the abuse may be opportunistic, and a key factor is the availability and vulnerability of the children. This is significant in this case, as what does emerge from consideration of the Perpetrator's offending behaviour is that there were insufficient external inhibitors both within the nursery and in the on-line environment. It is significant that the Perpetrator referred to the "rules" that would prevent abuse in a school setting which were not present in the nursery. In addition there was a lack of understanding by the professionals in contact with the nursery of the dangers of special attention being paid by one member of staff to a child who may be vulnerable due to their family circumstances. Learning from the review therefore needs to focus particularly on why this was the case and there were insufficient external

⁵ Finkelhore, D. (1984) *Child Sexual Abuse: New Theory and Research*. NY: The Free Press

⁶ Finkelhore, D et al (1988) *Nursery crimes: A study of Sexual Abuse in Daycare*. Newbury Park: Sage

inhibitors in place to prevent offending behaviour.

- 6.12 The above is confirmed by recent research into sexual offending within organisations⁷, which highlights the need to understand the interaction between the disposition of the perpetrator and those situational factors which may make abuse more likely. These research findings challenge the widely held view that those who abuse children within organisations are “paedophiles” who deliberately gain employment within organisations where they can abuse children. The picture is far more complex than that and resonates to some degree with Finkelhore’s *et al* research. Erooga *et al* (2012) argue that implication is that:

screening for offences, or for sexual interest in children, is not likely to be effective for such potential abusers. If so, a selection process which reviews attitudes to children, individual motivation to work with them, or in their interests, and so partly focuses on potential inhibitors to acting on any emergent sexual interest in children may be more indicative (page 30)

This has implications for recruitment processes within settings as well as within such as colleges who act as gatekeepers into the early year’s profession.

6.13 *The Offending behaviour of the Perpetrator – what can we learn?*

1. Any “special relationships” within a setting should be scrutinised and particular attention paid to situations where the child may be considered particularly vulnerable.
2. Attention needs to be paid to enhancing external inhibitors within nurseries including:
 - effective recruitment processes that move beyond a focus on CRB checks to an exploration of motivation and value base;
 - ensuring the physical environment achieves a balance between a respect for privacy and reducing opportunities to abuse.
3. Continuing to promote internet safety must be a priority in the prevention of sexual abuse.

⁷ Erooga, M *et al* (2012) *Towards Safer Organisations ii*. London: NSPCC. www.nspcc.org.uk/

What does the Governance, management and quality of care within the nursery tell us about the features of a safe environment?

- 6.14 The nursery was managed by a Board of Trustees, with nursery lead 1 the nominated person for Ofsted purposes. In reality, the evidence suggests that nursery lead 1 relied heavily on the expertise of the nursery manager and had little involvement in the day to day running of the setting. Technically, the Board had responsibility for staff recruitment, yet there is no evidence that the Board or nursery lead 1 took any part in recruitment procedures.
- 6.15 The review has been hampered by the lack of access to records held with the nursery but there is sufficient information from other sources, including the Perpetrator and staff interviews, to indicate that in respect of the Perpetrator proper processes were not followed. He apparently worked at the nursery as a qualified worker before he received his certificate, without a formal interview and sight of a current CRB clearance. It appears these lax processes were more widespread within the setting as the Ofsted inspection following the incident identified problems with recruitment procedures. It is worrying that they were not identified as problematic during previous Ofsted inspections, with the Ofsted inspection in March 2009 describing recruitment processes as “robust”.
- 6.16 There is also evidence from the Children’s Social Care and Nursery individual management reviews that the quality of safeguarding practice within the nursery, and its understanding of its role and responsibilities was poor. The nursery did not respond to a request from Children’s Social Care for information when they were undertaking an initial assessment. It is unacceptable that when manager 3 finally sent a referral through to Children’s Social Care in respect of Subject Child there were a number of incident reports going back to the period when manager 1 was in post that had not resulted in a previous referral. Ironically when the Perpetrator contacted Ofsted it was, with good reason, to complain about the general quality of safeguarding practice.

Sexual abuse will be less likely in situations where standards of safeguarding practice are high and the message is given clearly that alleged abuse of children either in the setting or the community will be taken seriously. This was not the case in the nursery.

- 6.17 Staff interviews have shown that staff working within the nursery did not feel confident in their safeguarding knowledge and when they had received training this had not focused specifically on nursery settings or on abuse by people in a position of trust. Despite a lack of confidence in their knowledge base, a number of staff raised concerns about the practice of the Perpetrator but did not see any evidence that they were taken seriously.
- 6.18 There is also evidence from staff interviews that during the period that the abuse took place, staff supervision arrangements were inadequate and individual staff did not have the opportunity to reflect on their concerns about the behaviour of the Perpetrator and explore with a senior member of staff what constituted safe practice in their environment. Since the incident, a programme of training for supervisors in early year's settings has been delivered across Birmingham, and staff interviewed for the nursery individual management review reported that the availability and quality of supervision had much improved. It will be important for Birmingham Safeguarding Children Board to evaluate the impact of this training across the early year's sector.
- 6.19 There are similar issues emerging from this review to those identified in the case of Nursery Z in Plymouth⁸. This would indicate the likelihood that they are issues that may be relevant across the nursery sector rather than a one-off occurrence. In both instances the nursery served a closely knit community from which many of the staff were recruited. Relationships existed between staff and between staff and families outside the setting, for example, some staff families being friends with parents on Facebook, in the case of the nursery. Whilst communities are important in supporting and sustaining families and promoting children's need for security and consistency of care, the

⁸ Plymouth Safeguarding Children Board (2010) *Serious Case Review Overview Report Executive Summary in respect of Nursery Z*
http://www.plymouth.gov.uk/serious_case_review_nursery_z.pdf

potential risks need also to be acknowledged and sufficient safety mechanisms put in place.

- 6.20 It is notable that the Perpetrator assumed considerable power within the staff group and in relation to Subject Child. This was apparently due to his personality and behaviour as well as the fact that his mother was an ex-manager of the nursery and current manager of one nearby. He was described by staff as knowledgeable about childcare, popular with the children but also argumentative and reacting negatively to any challenge about his practice. There is also some evidence from staff interviews that there was a reluctance to challenge him because of his gender, in case this was seen to be discriminatory.
- 6.21 In addition, there was also disquiet within the staff group and the development of factions or cliques which resulted in the manager seeing the Perpetrator as a source of support and failing to respond to the concerns of others about his behaviour. In this instance and in that of Nursery Z, the necessary safety mechanisms including robust staff recruitment processes, strong performance management, whistle blowing processes and a culture where no one person could assume inappropriate power within the staff group were not in place.
- 6.22 The lack of supervision of the Perpetrator, failure to understand the risks of “special relationships” with individual children, the physical environment with easy access to a mobile phone and the culture within the setting have been commented on above. No one factor alone can be held responsible for failing to prevent the abuse. Instead, all of these factors came together to create an environment where the external factors that might have inhibited the Perpetrator from abusing the child were missing.
- 6.23 Individual settings therefore need to review their governance, recruitment, induction, whistle blowing and supervision arrangements and ensure that the prevailing culture within the establishment is one where the safety of children is of the highest priority. The evidence from the literature as well as this case would indicate that the prevention of opportunistic offending is crucial and that

attention needs to be paid to developing a culture and climate where external controls contribute to the prevention of abuse. It is notable that the offences took place during a period where the nursery was poorly managed, and the message given to the Perpetrator from recruitment procedures onwards was that “rules” were lax and that safeguarding was not a high priority. This prevailing culture had the effect of providing an ideal environment for abuse, as well as silencing any members of staff who may have had concerns.

6.24

The Governance and Management and quality of care within the nursery – what can we learn?

1. The importance of robust recruitment procedures which are fully implemented at all times.
2. The need for effective safeguarding processes and sound safeguarding knowledge across the staff group, including the Board of Trustees.
3. The need to ensure that appropriate boundaries are maintained between staff and parents and within the staff group where the setting serves a close knit local community.
4. The need to pay attention to developing a team culture where factions or cliques are discouraged and no one person inappropriately assumes a position of power and authority.
5. The importance of effective supervision which supports staff in reflecting on any concerns they may have about the behaviour of a colleague.

What can we learn about the effectiveness of the registration and inspection processes in an early years setting?

6.25

It is notable that despite “good” or “satisfactory” Ofsted inspections, when the setting was subject to more detailed scrutiny, there were clearly areas for improvement. This was particularly the case when the inspection team went into the setting after the arrest of the perpetrator.

6.26

In August 2006 the Ofsted grading was “good”; however, although no concerns about recruitment were identified by Ofsted in 2006, by 2008 it is clear that

safer recruitment processes were not being followed as the Perpetrator started at the nursery without CRB clearance.

- 6.27 The Ofsted visit in August 2010 as a result of the anonymous complaint against the Perpetrator did identify the need to improve safeguarding policy and ensure that staff had appropriate qualifications, training, skills and knowledge. This situation should have been picked up by previous inspections.
- 6.28 In November 2010 Ofsted grading was “good” but in January 2011 detailed scrutiny as a result of the arrest of the Perpetrator revealed that the nursery was not meeting a number of requirements relating to the safeguarding and welfare of children, including an effective safeguarding policy, induction training for new staff, performance management system and an effective whistle blowing policy. This should have been picked up during the November 2010 inspection.
- 6.29 The above calls into question the effectiveness of the inspection arrangements in scrutinising how well the setting safeguarded children from harm both within their families and the organisation. The section on safeguarding within the guidance to early years inspectors current at the time of this review⁹ focuses on safeguarding policies and procedures in relation to CRB checks. Whilst these are important, there is little in the guidance to help inspectors in gathering some of the “soft intelligence” which would enable them to evaluate the setting against factors associated with a system where abuse is less likely, namely:

*Organisational commitment to a clearly articulated set of values and desired organisational behaviours with children’s welfare and wellbeing at their core. Alongside the values, organisations will have defined methods to put into practice and to monitor the effectiveness of these values and behaviours.*¹⁰

- 6.30 Policies and procedures may be in place, but inspections need to be able to explore their impact on how well child centred values are articulated and

⁹ Ofsted (2011) *Conducting Early Years inspections*. Ref No. 080164.

¹⁰ Erooga (2009) quoted in Erooga et al (2012) *Towards safer Organisations* 11 page 26 www.nspcc.org.uk

displayed by behaviour within the staff team. Staff teams who are in conflict, and focused on their own needs rather than those of the children, are unlikely to be in environments where constructive challenge of each other's practice will be seen as a positive contribution to the wellbeing of children. The nursery individual management review makes the point that a more holistic inspection could be facilitated through strengthening the communication routes between Ofsted inspectors and development workers as well as drawing on the knowledge of other agencies that provide support to settings.

6.31 There is a need through the inspection arrangements to ensure that the registered person in a nursery (in this case nursery lead 1) has the right experience and training to carry out their role. In this case nursery lead 1 only attended supervision, recruitment and safeguarding training after the arrest of the Perpetrator. It is apparent that due to this lack of child care knowledge and experience they gave nursery manager 1 too much autonomy and failed to scrutinise their practice adequately.

6.32 The understanding of all Ofsted inspectors about safeguarding practice needs to be of the highest quality, particularly in relation to the link between organisations' behaviour and sexual abuse.

6.33 As well as flaws in the inspection system the review also has highlighted the need for clarity in the roles and responsibilities between Ofsted and the Local Authority where a complaint is made about the behaviour of a member of staff. The Ofsted compliance officer and member of staff from the Early Years Service appear to have been confused as to their respective roles when investigating the complaint against the Perpetrator. This resulted in a focus on procedures and general standards within the nursery rather than specifically the concerns about his behaviour.

6.34 *Registration and Inspection Processes – what can we learn?*

1. Inspections of early year's settings need to be rigorous in examining the evidence that policies and procedures are implemented in practice.
2. Inspections need to pay attention to the culture and staff relationships

within the setting in order to identify where there may be features of a culture where abuse may be more likely to occur.

3. It is vital that those inspecting settings have an excellent knowledge of the features of child sexual abuse from the perspective of perpetrator and victim behaviour.

What can we learn about the role of Colleges of Further Education in safeguarding children?

- 6.35 The role of the College in this case relates to:
- 1 Their role in training and assessing the Perpetrator as fit to practice as a qualified child care worker.
 - 2 Their response when concerns were raised by a student on placement in the nursery about the behaviour of the Perpetrator
 - 3 Their response when two students raised non-specific concerns about practice in the nursery.
- 6.36 Information about points one and three above are contained within the College individual management review. That review does not explore the issue raised in point two, since there are no college records in respect of this, and this analysis therefore draws on information within the Children's Social Care report in respect of that incident.
- 6.37 There is nothing in the information received for this review that should have alerted the college that the Perpetrator was unfit to work with children at the time he applied for the level 3 child care course. It seems that his school records were satisfactory and there was nothing to indicate that he should have been refused entry to the programme.
- 6.38 The serious case review panel and the overview author were left with a number of concerns about the way in which the Perpetrator obtained his qualification, particularly the role of the second work experience placement in the nursery and whether this was assessed. This would appear to be consistent with the interim and final reports by Professor Cathy Nutbrown into early education and

childcare qualifications¹¹ which highlighted the variation in routes to qualification at that time, and limitations in the practice-based learning on offer.

6.39 As described earlier in this report, the Perpetrator started work experience at the nursery but the status of this placement is unclear. From the College individual management review it appears that they were not aware that he had made this private arrangement and presumably it did not count towards the number of hours' work experience required by CACHE, the awarding body. During this period the perpetrator was working at the nursery as an unqualified worker and it would have been the responsibility of the nursery to supervise his work. How the Perpetrator eventually managed to accumulate sufficient assessed work experience hours when he was not officially in placement for several months is hard to understand, although the individual management review confirms that by the time he received his certificate he had met all the requirements of the awarding body CACHE.

6.40 The college have not specified within their individual management review the assessment criteria used within placement to assess the Perpetrator's fitness to practice and who was responsible for supervising and assessing his work. However, it is clear from the interim report of the Nutbrown review that there were no nationally agreed standards and that numbers of placements hours and quality of assessment were likely to vary from course to course. Parents leaving their children within nursery settings would no doubt assume that staff's competence to undertake the practical tasks associated with day to day child care had been thoroughly assessed before they obtained their qualification. The evidence presented to this review would indicate that this is not always the case. If, during his time at the nursery, his work was being supervised and assessed by manager 1, it now appears that she was relying on him as a source of support and inappropriately defended him when concerns were raised about his practice, rather than investigating and challenging him appropriately.

¹¹ Nutbrown, C. (2012) *Review of Early Education and Childcare Qualifications* and Nutbrown, C. (2012) *Foundations for Quality; The independent review of early education and childcare qualifications* www.education.gov.uk/nutbrownreview

6.41 The information contained within the college director's witness statement at the time of the criminal proceedings also raises an issue concerning the route to qualification referring to the Perpetrator's attendance as "absolutely shocking and unless there are extenuating circumstances I am very surprised he was allowed to continue with the course".

6.42 In November 2009 the College acted appropriately by contacting Children's Services when they were alerted by students to concerns about the behaviour of a male member of staff in the nursery who had been "accused of abuse", and in following up via e mail to ask what was happening. However, when they did not receive a reply from Children's Services it would have been good practice to persist with the enquiry. In both this review and that of Nursery Z in Plymouth students were well placed to identify concerning practice and they should always be taken seriously and all concerns followed through. The fact that there are no records of this incident within the college that have been able to inform their individual management review is a cause for concern; such potentially serious issues should be well documented and the failure to do so may have been a factor in the lack of persistence in following up with Children's Social Care.

6.43 *The role of Colleges of Further Education in Safeguarding Children – what can we learn?*

1. The supervision and assessment of students on placement needs to be formal and recorded by the setting in order that Colleges can be assured that adequate training and supervision is taking place within the workplace.
2. Students may be well placed to identify both poor practice and potential abuse within settings and Colleges can play an important role in supporting them to make their concerns known, recording them appropriately and following up referrals to Children's Services.
3. Current national initiatives to drive up the quality of early year's qualifications are an important aspect of improving safeguarding practice.

What can we learn about how the local authority can most effectively prevent abuse within nurseries?

- 6.44 Birmingham Children's Services were involved in three aspects of this case.
1. The Early Years Service in providing advice and support to the nursery.
 2. The Local Authority Designated Officer Team.
 3. The Social Work Team responsible for responding to referrals concerning the welfare of a child.
- 6.45 The overwhelming impression is of lost opportunities to join up information from the three different parts of Children's Services. For example:
- The work with Subject Child as a potential Child in Need was at no point integrated with the concerns emerging about the Perpetrator's relationship with the child in the nursery.
 - Information that emerged regarding the behaviour of the Perpetrator was not collated by the Early Years Service and the LADO team and used to inform the enquiry following the anonymous referral to Ofsted.
 - The early years development worker who was informed that there were staff relationship problems centring on the Perpetrator appears to have been unaware of previous allegations concerning him that were known within the early years Service and to the LADO team.
- 6.46 This lack of integration of information across services and teams appears to be partly driven by poor record keeping, partly by ineffective systems and processes that automatically ensure cross referencing of information and partly by errors in decision making.
- 6.47 One significant error was the response to the concerns by a student who had overheard concerns about the behaviour of the Perpetrator. The student should have been spoken to directly, rather than the early year's professional contacting the manager. The LADO team were aware of this course of action and should have advised against it, as well as identifying that the Subject Child was known to the department. In respect of the quality of decision making

within the LADO team Children's Services quickly recognised problems in practice within the LADO team and took steps to ensure all decisions are now made by appropriately experienced staff.

- 6.48 The effectiveness of communications between individual parts of the Local Authority and the nursery varied. The Early Years Service, in isolation from the rest of the system, clearly supported the setting in addressing any issues identified by Ofsted as in need of improvement. There may be potential for strengthening their role as when interviewed, manager 3 stated that it would have been helpful for development workers to have had "stronger presence" in the nursery. If staff had known who their development worker was, they could have approached them for advice when manager 1 did not act on their concerns regarding Subject Child.
- 6.49 It is clear that there could have been better communication between social workers carrying out initial assessments and the nursery. During the first initial assessment brief information was obtained from the nursery, yet at this time more robust liaison and scrutiny of incident forms would have revealed concerns about the Perpetrator's behaviour towards Subject Child. Social workers did not seek detailed written information and the nursery did not offer relevant information to social workers. It seems that neither party recognised the potential significance of information held by the nursery to an assessment of need.
- 6.50 The Children's Services individual management review has analysed in detail ways in which the assessment process in relation to Subject Child's home circumstances could have been improved. The most significant issue for this review was the failure to consider adequately all relevant incident forms when a referral was made by the nursery early in September 2010. These included the incident which referred to Subject Child crying out when being looked after by the Perpetrator. There is no indication that these were properly reviewed since there was no discussion with the LADO Team, nor did alarm bells ring when Mother commented to a social worker that she was concerned about a male member of staff's relationship with Subject Child. The social worker

conducting the initial assessment did not ask Mother for the name of the member of staff nor request that she elaborate on her concerns. Whilst by this time it would have been too late to prevent the abuse of Subject Child who had left the nursery, there was an opportunity to put together all known concerns about the Perpetrator some four months before his final arrest.

6.51 The Children's Social Care individual management review clarifies that over the periods corresponding with this review there was a staff vacancy rate within Children's Social Care of 17-20% for qualified social work staff and the service was working towards a re-modelling. Although the Children's Social Care individual management review does not specifically discuss the impact of the organisational context on work with this case it could be assumed that this may have contributed to the less than optimal practice in this case.

6.52 *The Role of the Local Authority in Preventing abuse within Nurseries – what can we learn?*

1. There is a need for effective communication across the three arms of the Local Authority (Early Years, LADO and Children's Social Care) since lack of communication resulted in missed opportunities to collate the accumulating concerns about the Perpetrator and his relationship with Subject Child.
2. Assessments by Children's Social Care where a child is in nursery should make every effort to integrate information from the nursery into the assessment process. The Early Years Service should be alerted where nurseries fail to cooperate.
3. It is vital that staff dealing with referrals in the LADO team are trained, competent and effectively supervised.
4. There may be the potential for early year's development workers to increase their visibility within settings so that staff can route concerns about safeguarding practice through them.

What can we learn about professionals' understanding of sexual offending?

6.53 With hindsight it appears incredible that the allegations against the Perpetrator in mid-2010 did not lead to more robust action to investigate the concerns, including speaking to the child concerned. The investigation by the Ofsted inspector and children's services professional 1 was inadequate and does not appear to have been based on a sound knowledge of sexual offending. The subsequent complaint made by the Perpetrator to Ofsted so soon after the allegation made against himself does not appear to have rung any alarm bells, yet in retrospect much fuller consideration should have been given to the meaning of this behaviour.

6.54 There are generally concerns about the adequacy of the current professional response to child sexual abuse, with figures within England and elsewhere showing a sharp reduction in investigations in recent years.¹² There may be many reasons for this but some commentators have argued that the cause stems from lack of professional confidence, linked to a reduction in the quality and quantity of training available. In this case the "special" relationship between the Perpetrator and Subject Child, along with behaviours that should have caused alarm, were not seen as warranting further investigation by front line staff, or more worryingly, Ofsted and specialist professionals within the Local Authority.

6.55 *Understanding sexual offending – what can we learn?*

1. This case confirms that although there is an established knowledge base about signs and indicators of potential sexual abuse this is not well utilised in practice.
2. Potential barriers to assimilating and using this knowledge need to be understood.

What can we learn about Police responses to on-line sexual offending?

6.56 On first analysis it appears worrying that West Midlands Police took five months from the allegation made by the thirteen year old girl of online

¹²

grooming to the arrest of the Perpetrator and realisation that he worked in a nursery. It is unlikely that this delay resulted in further abuse of the child as they were about to leave the nursery at that point, however, that was fortuitous rather than planned.

- 6.57 The police enquiries do need to be understood within the context of resources available to the police, a high volume of work related to internet crime and the need to constantly risk assess and prioritise their work. From 2009 - 2011 referrals to the local Child Online Safeguarding Team rose by 66% and it was not until July 2011 that the team centralised and there was some increase in staffing to take account of the rise. When viewed in this light the delay is more understandable and in this case it was the assessment of police officers that there was no immediate risk to the safety of the thirteen year old who had disclosed the abuse and therefore other cases were prioritised for immediate action.
- 6.58 This case in fact involves an offender who, whilst grooming young girls on the internet was also abusing a young child in the nursery, confirming the challenges involved in categorising offenders in terms of risk. Unless there is a very large re-allocation of resources from other areas of policing into the investigation online sexual offending, risk assessment and prioritisation will continue to be necessary and may not always be completely accurate.
- 6.59 There are, however, some ways in which practice could be improved, which may speed up the identification of online groomers who may be working in vulnerable positions. The police individual management review identified the need to make enquiries to ascertain whether CRB checks have been applied for at the address of a potential offender as if there is evidence of checks this would indicate that they are working with a vulnerable group. This was included as a recommendation in the police individual management review.
- 6.60 An important feature of this case was that the eventual abuse of the child in nursery only came to light because a young person told her parents about the abuse she had experienced from the Perpetrator online. This was not an

isolated incident as subsequent information has revealed the prolific nature of the Perpetrator's online offending and there are likely to have been many young people in a similar situation who did not speak about the abuse. Although the focus of this review has been the abuse within the nursery, the conclusion must be reached that internet safety is inextricably linked to the wider prevention of child abuse and that current initiatives such as those led by CEOP are integral to improving practice.

6.61 At a national level, the crucial work of CEOP in promoting internet safety and avenues whereby young people can disclose abuse needs to be continued. It is crucial that strong links are maintained with Local Safeguarding Children Boards in order to facilitate effective local campaigns that reach parents and young people. The resources available to police to manage inquiries in a field where demand is rising rapidly is also a policy issue with decisions needing to be made about the relative priority that needs to be given to this work against other demands.

6.62 *Police response to online sexual offending – what can we learn?*

1. This is a complex task and the current state of knowledge is constantly evolving.
2. The resources available to the police to respond to internet abuse do not keep up with the increased incidence. Prioritisation will therefore be a feature of practice.
3. Police forces should focus on ways of speeding up identification of online groomers who may be working with vulnerable groups.
4. The link between national responses online safety and Local Safeguarding Children Boards is an important one in promoting effective local responses.

7. CONCLUSIONS

7.1 Parents should be able to expect that children in nurseries are cared for within environments where highly skilled staff is supported, by both their own

management and external organisations, to focus on all aspects of the needs of children, including their need for safety from sexual harm. Sadly, this did not happen in this case and although this is a review of one nursery setting, this, combined with the findings of the nursery Z review in Plymouth, indicates that there is a continued need for developing awareness of the ways in which children in early years settings can be kept safe.

7.2 Although the responsibility for the abuse must lie with the Perpetrator, it was supported by the combination of a number of interacting factors namely:

- Poor management within the nursery.
- A failure on the part of Ofsted and the local authority to investigate properly concerns about the Perpetrator's behaviour.
- A lack of rigour and depth to inspection processes.
- Missed opportunities to use the assessment process in relation to Subject Child to understand their experience within the nursery.
- National issues relating to the quality of early years qualifications
- Availability of resources to the police to respond to the increasing incidence of internet abuse.

7.3 The interaction of these factors resulted in a situation where there were missed opportunities to intervene earlier and prevent both the continuation of abuse within the nursery and online. It was entirely fortuitous that the offending came to light via a route other than robust responses to concerns within the nursery. Significant missed opportunities were:

1. The Local Authority did not respond appropriately to concerns expressed by a College student about the potentially abusive behaviour of the Perpetrator towards a child in November 2009. The student was not spoken to.
2. The College did not ensure that the above concerns were followed up by the Local Authority.
3. The assessment of need in respect of Subject Child in 2009 did not gather information from the nursery.
4. Ofsted inspections of the nursery in March 2009 and November 2010 did not pick up failure to implement effective recruitment and selection

procedures or to notify Children's Social Care where incident reports suggested a child might be at risk of harm.

5. The joint visit by Children's Services and Ofsted in response to an anonymous complaint about the behaviour of the Perpetrator towards Subject Child focused on policy and procedure and general standards of practice rather than directly addressing the concerns.
6. The assessment of need in respect of Subject Child August 2009 did not consider information on a nursery incident form which noted that Subject Child had cried out whilst in the presence of the Perpetrator.

7.4 In summary, in order to reduce the possibility of a reoccurrence of sexual abuse within a nursery environment, there are issues that need to be addressed by all parts of the system. Colleges (supported by national awarding bodies) must ensure that their own processes for awarding qualifications are robust and alongside this support any student who has concerns about practice in an individual setting. Those responsible for managing individual nurseries must make sure that the highest standards are maintained in relation to safeguarding practice and create a culture where the voice of everyone in the staff team is valued and heard including students on placement. Those responsible for regulation and support (currently Ofsted and the Local Authority) must make sure that their staff are fully aware of the nature of sexual offending, methods used by offenders to gain the trust of their victims and the way in which external controls may inhibit sexual abusers who are motivated to offend. The inspection methods used should ensure that impact of management style on both staff and children is fully addressed. It also important that both Ofsted and the Local Authority are fully aware of the way in which organisations should work together to prevent the sexual abuse of children for whom they have a responsibility. In this case there were obvious pointers that should have raised the alarm, yet both Ofsted and the Local Authority failed to recognise them and respond appropriately in a coordinated manner. Roles and responsibilities must be clear where safeguarding concerns within a nursery are to be investigated, most notably between Ofsted, the Early Years Service and Children's Social Care.

7.5 Finally at a national level there must be a continued focus on ways of improving internet safety for young people, since it was the action of one young woman in reporting internet abuse that led to the eventual conviction of the Perpetrator in this case.

8. ACTIONS TO IMPROVE PRACTICE

8.1 Although the final overview report was delayed, agencies that contributed to the review acted swiftly on their own recommendations and the action plan attached sets out the work that has already been undertaken to improve practice. For example, West Midlands Police have implemented a process which will ensure that during investigations into on line offending, steps are taken to identify at an early stage whether the alleged offender is likely to be in a position of trust with children. Both the College and Ofsted have implemented all their recommendations.

8.2 Children's Social Care informed the reconvened panel that the LADO team had reviewed all their documentation in order to ensure that it was clear and concise. Team processes have also been amended in order to ensure that referrals are only taken by professional staff on duty rather than business support staff and that professional staff oversee all decisions made. The Head of Service now receives a weekly report regarding live cases, training has been attended by all staff and an audit has been undertaken of end to end processes, recording and thresholds.

8.3 Within the Early Years and Child Care Service, a number of actions have been taken to improve and embed safeguarding knowledge, practice and processes, including the writing, storing and sharing of information. Staff across the service have received safeguarding training commensurate with their level of responsibility and the panel were informed that this has greatly improved the confidence and competence of staff in responding to safeguarding concerns. In addition, safeguarding is written into personal development plans and monitored in supervision. There is evidence of positive co-operation between the LADO team and the Early Years and Childcare Service with jointly

delivered training on the Position of Trust process.

8.4 A marked improvement in safeguarding practice within the Early Years and Child Care Service has been noted to include:

- All early years' consultants feeling confident in using the safeguarding procedures and signposting providers.
- A marked improvement in the way safeguarding and Position of Trust referrals are completed.
- Information stored securely and an audit trail provided of information to share as and when required.
- The Early Years Quality Improvement Support Programme further developed to include a strand specifically for safeguarding. This is used by early year's consultants during support visits to settings. There is evidence that settings value information shared in this way.

8.5 It should also be noted that since this review took place, the investigation into actions of Jimmy Saville has been undertaken. Awareness of the issues relating to offenders in a position of trust has therefore increased, as have referrals to the LADO team. This would seem to indicate improved confidence that concerns will be listened to and taken seriously.

9. OVERVIEW REPORT RECOMMENDATIONS

9.1 The following recommendations are in addition to the recommendations made within the individual management reviews. They address issues that, in the view of the panel and overview author were not adequately addressed within the individual management reviews as well as recommendations that relate to more than one organisation.

9.2 *The review found no evidence that the Perpetrator's practice as a student was thoroughly assessed within a nursery setting and additionally the panel were not satisfied that there was sufficient rigour in the final assessment to award early years qualification.*

9.3 **Overview recommendation one**

Colleges and Universities providing early years qualifications should consider the learning from this case and ensure that their appraisal system for students evaluates course work and practice placements for evidence of application and understanding of Child Protection Procedures and an assessment of their suitability to work with children

9.4 *The review found that when Ofsted inspectors responded to allegations concerning the behaviour of the Perpetrator in the nursery and the subsequent complaint by the Perpetrator himself, they did not use current knowledge relating to sexual offenders in order to inform their response.*

9.5 **Overview recommendation two**

Ofsted to consider the learning from this review and apply it accordingly to the methodology in use, training of and skills of inspectors, and embed it into the Inspectors own cultural and professional skills as regards safeguarding practice and what constitute a safe environment

9.6 *The review found that role and responsibilities were not clear in the joint response to the allegation about the Perpetrator's behaviour by Ofsted and the Birmingham Children's Services Early Years Professional. In addition Ofsted professionals were unclear about the correct route for referral when there were concerns about home circumstances of a child within the nursery.*

9.7 **Overview recommendation three**

Ofsted and Birmingham Children's Services should ensure that effective liaison is undertaken where there are child protection concerns in Early Years Settings to coordinate intervention.

9.8 *The review found that Early Years professionals supporting the nursery and responding to allegations concerning the Perpetrator's behaviour were insufficiently focused on the risks that could be posed by a person in a position of trust and supporting staff in escalating their concerns.*

9.9 **Overview recommendation four**

Early Years development workers should receive Safeguarding training, which includes a module on the risk that can be posed by persons in position of trust, how to support settings in making a referral or raise concerns about a colleague.

9.10 *The review acknowledged the key role that internet chat rooms played in the offending behaviour and eventual arrest of the Perpetrator.*

9.11 **Overview recommendation five**

Birmingham Safeguarding Children Board should review local internet safety education campaigns to ensure children, young people and parents are aware of the dangers that internet chat rooms can pose.

9.12 *Information about Subject Child within the nursery was not incorporated into assessments carried out by Children's Social Care.*

9.13 **Overview recommendation six**

Where a child is subject of an assessment by Children's Social Care and attending a nursery or day care setting, information from the setting must be incorporated into the assessment and the assessment shared with the setting.

9.14 *The nursery in this case did not adhere to safer recruitment procedures*

9.15 **Overview recommendation seven**

Early Years settings should demonstrate adherence to 'Safer Recruitment' best practice, to prevent unsuitable people working with children and young people.

9.16 *Birmingham Safeguarding Children Board require all agencies to provide confirmation that professional learning from this case has been taken forward.*

9.17 **Overview recommendation eight**

Those Organisations that completed an IMR are required to provide evidence that action has been taken to address individual and management practice which has fallen below expected professional standards.

10. HEALTH OVERVIEW RECOMMENDATIONS

10.1 There are no recommendations specifically for health commissioners from within the health overview report.



Red overdue
Green Pending
Black completed

Serious Case Review Action Plan in respect of Case BSCB 2010-11/3

Date Commenced: 10.05.2013

The recommendations have been ratified by the BSCB. Agencies subject of the recommendations will ensure that identified actions are implemented by the agreed target date. The BSCB will receive progress reports from named agencies within 6 months. BSCB will monitor the implementation of recommendations and audit compliance.

Recommendation (SMART)	Agreed by Agency Lead	Action Required by Agency	Implementation Lead & Agency	Target date for completion	Summary of Action Taken & Date Received	Monitoring & Feedback	QA&A Audit, Progress & Finalisation date
<p>Recommendation 1 Colleges and Universities providing early years qualifications should consider the learning from this case and ensure that their appraisal system for students evaluates course work and practice placements for evidence of application and understanding of Child Protection Procedures and an assessment of their suitability to work with children</p>	BSCB on behalf of I Birmingham University and College Principals	<p>A) Independent Chair of BSCB to write to Colleges and Universities providing Early Years qualifications highlighting the key learning to arise from this case and seek formal confirmation that the recommendation has been implemented</p> <p>The appraisal systems should be able to assess:</p> <p>1. The student's values, attitudes and motivation to work with young children.</p>	<p>All Birmingham University and College Principals Birmingham Metropolitan College, Bournville College, Joseph Chamberlain Sixth Form College, South & City College Birmingham, University College Birmingham (UCB), Birmingham City University,</p>	<p>30th June 2013</p> <p>30th September 2013</p>		<p>Serious Case Review Sub Group will monitor progress on a quarterly basis and provide an overview of progress to the Strategic Board</p> <p>Evidence required</p> <p>1) Independent Chair letter</p> <p>2) Outcome of Section 175 Audit</p>	

		<p>2. Their capability in working effectively with the staff team.</p> <p>3. Their understanding of the features of a safe environment designed to protect children from harm.</p> <p>4. Their skills in providing a safe environment for children in their care.</p> <p>5. Their understanding on inappropriate sexual behaviour and how to identify this</p> <p>B) Universities and colleges should have a policy of retention of tutorial notes appertaining to students undertaking Early Years qualifications.</p> <p>C) BSCB to seek evidence of implementation and compliance with this recommendation through the section 175 safeguarding in education institutes audit 2013/14 programme</p>	Newman College University, The University of Birmingham and The Open University				
				.31 st December 2013			
<p>Recommendation 2</p> <p>Ofsted to consider the learning from this review and apply it accordingly to the methodology in use, training of and skills of inspectors, and embed it into the Inspectors own</p>	Ofsted	A) Independent Chair of BSCB to meet with Ofsted to share findings and discuss implementation of below key actions;	Ofsted Safeguarding Lead	30 September 2013	Jane Held Independent Chair had an initial meeting with Ofsted representative on 13 th June 2013 to discuss findings from the case, the	Serious Case Review Sub Group will monitor progress on a quarterly basis and provide an overview of progress to the	

<p>cultural and professional skills as regards safeguarding practice and what constitute a safe environment</p>		<p>B) Ofsted to review and revise inspection framework for Early Years settings to take account of the findings of this case.</p> <p>C) Ofsted to Issue guidance to early years settings of changes arising from the review of the inspection framework</p> <p>D) Review current training programme, policies and procedures and guidance provided to inspectors around sexual offending and grooming. This should include the ways in which the environment could allow opportunistic offending and offenders may overcome the resistance of children in their care.</p>			<p>recommendations and key actions in relation to Ofsted.</p> <p>The inspection framework was reviewed and revised in September 2012.</p> <p>Ofsted provided training to staff and issued them with guidance about the new framework.</p> <p>Ofsted will continue to take into consideration the findings from this case as they make further reviews to the framework.</p> <p>COMPLETED</p>	<p>Strategic Board</p> <p>Evidence required</p> <p>1) Ofsted inspection framework for early years settings</p> <p>2) Copy of Ofsted guidance into early years setting changes</p> <p>3) Ofsted Inspectors safeguarding training programme</p> <p>Finalised 21.08.2013</p>	
<p>Recommendation 3 Ofsted and Birmingham Children's Services should ensure that effective liaison is undertaken where there are child protection concerns in Early Years</p>	<p>Strategic Director of Children Young People & Families</p>	<p>A) Ofsted to review their national guidance to clarify that where there are concerns about a child in an early years setting they should contact the Local</p>	<p>Strategic Director of Children Young People & Families</p> <p>Ofsted</p>	<p>30 June 2013</p>		<p>Serious Case Review Sub Group will monitor progress on a quarterly basis and provide an overview of progress to the</p>	

Settings to coordinate intervention.	Ofsted	<p>Authority's Children's Services Department's child protection referral service in the first instance to make the relevant referral. (in Birmingham the Local Authority Information, Advice, and Support Service)</p> <p>B) Local Authority Early Years professionals should be made aware that where Ofsted are conducting an investigation in an early years setting the Ofsted inspector has a responsibility for planning the visit. Where a member of staff from the Local Authority is also present that they should ensure that they are clear about their expected role in the process and discuss any ambiguities with the Ofsted inspector before the visit is carried out.</p> <p>C) Ofsted and Local Authority to undertake awareness raising of the implementation of current Ofsted protocols in relation to child protection concerns in</p>	Safeguarding Lead		Ofsted have confirmed that awareness raising has been undertaken with Ofsted inspectors	<p>Strategic Board</p> <p>Evidence required</p> <p>1) Ofsted protocols have been reviewed by the panel</p>	
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		<p>to receive safeguarding training in 2013/14. A copy of the TNA to be shared with BSCB learning and development sub group</p> <p>D) Evaluation of training to evidence early years development workers application of training in practice setting makes a difference</p>		31 st March 2014	<p>Early Years Centres use the guidance in this strand to engage in discussions with settings when conducting support visits. This enables them to include developing safeguarding practice and procedure in the settings focused improvement plan that is monitored at agreed timescales between the EYC and the setting.</p> <p>COMPLETED</p>		
<p>Recommendation 5 Birmingham Safeguarding Children Board should review local internet safety education campaigns to ensure children, young people and parents are aware of the dangers that internet chat rooms can pose.</p>	Independent Chair BSCB	<p>A) Policy and Procedures Sub Group to review the E-Safety policy</p> <p>B) Birmingham Safeguarding Schools Group to review and make recommendations on</p>	<p>Chair of Communications and Public Engagement Sub Group and Chair of Policy and Procedures Sub Group, Chair of Birmingham Safeguarding Schools Group</p>	<p>10th May 2013</p> <p>30th September 2013</p>	<p>Section 29 (E-safety) has been reviewed by Policy and Procedure Sub Group in February 2012 and is available on the BSCB website.</p> <p>The Board have planned for consultation events with Head Teachers, School</p>	<p>Serious Case Review Sub Group will monitor progress on a quarterly basis and provide an overview of progress to the Strategic Board</p> <p>Evidence required</p> <p>1) E-Safety Policy</p> <p>2) Birmingham Safeguarding School Group Recommendations</p>	

		<p>the effective delivery on E-Safety through the schools curriculum.</p>			<p>Governors and Designated Senior Persons in Autumn term to re-establish a safeguarding schools group to disseminate good safeguarding practice amongst educational institutes. The new group will be commissioned in taking forward the learning from this case.</p>	<p>3) Section 175 Audit Outcome</p> <p>4) Recommendations made by Communications and Public Engagement Sub Group</p>	
		<p>C) Section 175 Safeguarding Educational Institutes Audit 2013-14 to seek evidence that E-Safety forms part of the schools curriculum</p> <p>D) Communications and public engagement sub group to review internet safety educational campaigns and make recommendations to the strategic board on how best to enhance</p>		<p>31st December 2013</p> <p>31st October 2013</p>	<p>BSCB reviewed the findings from Section 175 audit 2012/13 at the Board on 12.07.2013 – the audit programme for 2013/14 will incorporate the learning from this Serious Case Review.</p> <p>Communications and public engagement sub group have place guidance on internet safety on the BSCB website.</p> <p>Progressing but</p>		

		children, young people and parents awareness throughout Birmingham			not yet completed		
<p>Recommendation 6</p> <p>Where a child is subject of an assessment by Children's Social Care and attending a nursery or day care setting, information from the setting must be incorporated into the assessment and the assessment shared with the setting.</p>	Strategic Director of Children, Young People and Families	<ol style="list-style-type: none"> 1. Director of Children's Social Care to review and revise practice guidance on scope and feedback on the assessment process. 2. Audit of sample of referrals in relation to pre-school children to confirm that checks undertaken when completing an assessment in relation to an individual pre-school child include evidence of contact and information sharing with the early years setting. 3. Results of the audit to be reported to Performance and Quality Assurance Sub Group with an accompanying action plan. 	Director of Children's Social Care Children, Young People and Families	<p>30th June 2013</p> <p>31st October 2013</p> <p>31st December 2013</p>	<p>BCC are developing a single assessment framework, which will go out to consultation to all key partners in July 13 with planned implementation September 2013</p> <p>Ongoing</p>	<p>Serious Case Review Sub Group will monitor progress on a quarterly basis and provide an overview of progress to the Strategic Board</p> <p>Evidence required</p> <p>Assessment Guidance</p> <p>Audit outcome</p>	
<p>Recommendation 7</p> <p>Early Years settings should demonstrate adherence to 'Safer Recruitment' best practice, to prevent unsuitable people</p>	Strategic Director of Children, Young People and Families	A) Birmingham City Council to review 'Safer Recruitment' practice within the Annual Check of training and support for Early Year settings.	Director of Children's Social Care Children, Young People and Families	31 st October 2013	Progressing but not yet completed	Serious Case Review Sub-Group will monitor progress on a quarterly basis and provide an overview of	

working with children and young people.						<p>progress to the Strategic Board</p> <p>Evidence required Ofsted Inspection Report</p> <p>Outcome of Birmingham City Council Annual Check process</p>	
<p>Recommendation 8 Those Organisations that completed an IMR are required to provide evidence that action has been taken to address individual and management practice which has fallen below expected professional standards.</p>	<p>Chief Executive and Chief Officers from all Agencies Completing IMRs:</p>	<p>Each agency to produce an anonymised summary of action undertaken to address individual and management practice which has fallen below expected professional standards.</p>	<p>Agency Human Resource Leads</p>	<p>19th July 2013</p>	<p>Written confirmation has been received from all 6 organisations that action has been taken to address any individual learning or management practice.</p> <ol style="list-style-type: none"> 1) Birmingham City Council, Early Years and Childcare 2) Birmingham City Council, Children's Social Care 3) Birmingham City Council, Persons in Position of Trust Team 	<p>Serious Case Review Sub-Group will monitor progress on a quarterly basis and provide an overview of progress to the Strategic Board</p> <p>Evidence required Confirmation Letter</p>	

					4) Ofsted 5) Birmingham Metropolitan College 6) West Midlands Police COMPLETED		
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Implementation of IMR Recommendations in respect of BSCB 2010-11/3
Date commenced 31st March 2011

Red overdue
Green Pending
Black completed
Blue Unevaluated

The below recommendations have been ratified by the Strategic Lead for each agency, who will be responsible for ensuring they are fully implemented by the agreed target date. The BSCB will receive quarterly progress reports from named agencies. BSCB will monitor the implementation of recommendations and audit compliance prior to case finalisation.

Recommendation (SMART)	Action Required by Agency	Implementation Lead for Agency	Target Date for Completion	Summary of Action Taken & Date Received	Monitoring & Feedback	QA&A Audit, Progress & Finalisation date of IMR Recommendations
Ofsted						
1. Ensure that administrative colleagues and inspectors record and retain information and events on the RSA to: <ul style="list-style-type: none"> ensure the continued accuracy of information about the registered person and its associations Provide an effective audit trail for decision-making, including management sign-off. 	Ofsted <ul style="list-style-type: none"> Prepare checklist and guidance for completion by inspectors on all regulation and inspection visits to ensure that information is checked during registration/ regulation visits and relayed to National Business Unit (NBU) as part of the toolkit 	Director, Education and Care	31 August 2011	Accuracy of information on registration including roles within provisions <ul style="list-style-type: none"> Prepare checklist and guidance for completion by inspectors on all regulation and inspection visits to ensure that information is checked during registration/ 	Safeguarding Leads in agencies have been closely monitoring implementation of key actions. Further evidence of implementation will be provided to the Department for Education Safeguarding	Progress is reviewed monthly by the Serious Case Review Sub Group to ensure effective implementation of agency action, the below areas have been identified for consideration as part of the finalisation process. Agency action to be reviewed by Serious Case Review Sub

	<p>evidence.</p> <ul style="list-style-type: none"> • Prepare guidance for NBU in terms of the updating of RSA records to show correct • Draft guidance for inspection service providers (ISP) / compliance investigation and enforcement (CIE) staff on who signs off the actions included in a notice to improve (NTI) and who signs off the response by the provider to the NTI associations. • Draft guidance for CIE staff on who sign off decisions to change the enforcement step proposed by the inspector (for example where this changes from issuing a Welfare Requirements Notice to a NTI). 			<p>regulation visits and relayed to national Business Unit (NBU) as part of the toolkit evidence. 23 September 11. Implementation in progress</p> <ul style="list-style-type: none"> • Prepare guidance for NBU in terms of the updating of RSA records to show correct associations. 23 September 11. Implementation in progress. ▪ Decision making-sign off Draft guidance for inspection service providers (ISP) / compliance investigation and enforcement (CIE) staff on who signs off the actions included in a notice to improve (NTI) and who signs off the response by the provider to the NTI. Feb 2012: ▪ Draft guidance for CIE staff on who 	<p>Group in due course.</p>	<p>Group on 19/10/2012 Finalised</p>
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				<p>signs off decisions to change the enforcement step proposed by the inspector (for example where this changes from issuing a Welfare Requirements Notice to a NTI).</p> <p>23 September 11</p> <p>COMPLETED</p>		
<p>2. Ensure that inspectors – including those employed by Ofsted’s early years inspection service providers - always access all necessary information before they carry out their visit, including:</p> <ul style="list-style-type: none"> • details of all actions set at previous visits • Any concerns about individuals associated with the setting that need to be pursued. 	<p>Ofsted</p> <ul style="list-style-type: none"> • Review and revise where necessary, in consultation with information assurance colleagues, the information given to ISP inspectors to ensure they have access to all necessary information prior to conducting an inspection. <p>Review and update the relevant section contained in review and consider all previous notices to improve and other</p>	<p>Director, Education and Care</p>	<p>31 August 2011</p>	<p>Access to full information by ISP inspectors</p> <ul style="list-style-type: none"> ▪ Review and revise where necessary, in consultation with information assurance colleagues, the information given to ISP inspectors to ensure they have access to all necessary information prior to conducting an inspection. <p>Feb 12: Implementation in progress for Sept 2012</p> <p>Review of information before commencing an inspection</p>	<p>Safeguarding Leads in agencies have been closely monitoring implementation of key actions.</p> <p>Further evidence of implementation will be provided to the Department for Education Safeguarding Group in due course.</p>	<p>Progress is reviewed monthly by the Serious Case Review Sub Group to ensure effective implementation of agency action, the below areas have been identified for consideration as part of the finalisation process.</p> <p>Agency action to be reviewed by Serious Case Review Sub Group on 15/02/2013</p> <p>Finalised</p>

	<p>enforcement actions before commencing the inspection.</p> <ul style="list-style-type: none"> ▪ <i>Conducting early years inspections</i> (planning the inspection) to make explicit the requirement for inspectors to review and update guidance in <i>Registration and suitability handbook</i> on when and how inspectors should enquire about causes for concern, the lines of questioning and the recording of evidence 			<ul style="list-style-type: none"> ▪ Review and update the relevant section contained in <i>Conducting early years inspections</i> (planning the inspection) to make explicit the requirement for inspectors to review and consider all previous notices to improve and other enforcement actions before commencing the inspection. ▪ Review and update guidance in <i>Registration and suitability handbook</i> on when and how inspectors should enquire about causes for concern, the lines of questioning and the recording of evidence. ▪ January 13: <p>COMPLETED</p>		
<p>3. Provide further training for staff carrying out compliance, investigation and enforcement work to ensure inspectors:</p> <ul style="list-style-type: none"> • always follow investigation procedures 	<p>Ofsted</p> <ul style="list-style-type: none"> ▪ Review and amend guidance in <i>Compliance</i> 	<p>Director, Education and Care</p>	<p>30 September 2011</p>	<p>Investigation procedures</p> <ul style="list-style-type: none"> ▪ Review and amend guidance in <i>Compliance</i> 	<p>Safeguarding Leads in agencies have been closely monitoring</p>	<p>Progress is reviewed monthly by the Serious Case Review Sub Group to ensure effective</p>

<ul style="list-style-type: none"> • carry our effective joint working with other agencies • Always base decisions on first-hand evidence. 	<p><i>investigation and enforcement handbook</i> on planning the investigation, making clear that inspectors must consider in their planning the full range of powers they need to exercise, including any direct observations of or interviews with staff in settings.</p> <ul style="list-style-type: none"> ▪ Review and amend as appropriate, the guidance in the <i>Compliance, investigation and enforcement handbook</i> on joint visits with other agencies, to include <ul style="list-style-type: none"> ▪ establishing the purpose of the joint visit ▪ clarity of roles in terms of the investigation ▪ Pre and post visit communication between the joint parties. ▪ Strengthened existing guidance (<i>Compliance and</i> 			<p><i>investigation and enforcement handbook</i> on planning the investigation, making clear that inspectors must consider in their planning the full range of powers they need to exercise, including any direct observations of or interviews with staff in settings.</p> <p>23 September 11.</p> <p>Joint working with other agencies</p> <ul style="list-style-type: none"> ▪ Review and amend as appropriate, the guidance in the <i>Compliance, investigation and enforcement handbook</i> on joint visits with other agencies, to include <ul style="list-style-type: none"> ○ establishing the purpose of the joint visit ○ clarity of roles in terms of the investigation ○ pre and post visit 	<p>implementation of key actions.</p> <p>Further evidence of implementation will be provided to the Department for Education Safeguarding Group in due course.</p>	<p>implementation of agency action, the below areas have been identified for consideration as part of the finalisation process.</p> <p>Agency action to be reviewed by Serious Case Review Sub Group on 09/11/2012</p> <p>Finalised</p>
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	<p><i>investigation handbook/Conducting early year's inspections</i>) to make clear that any form of action set by Ofsted must be based on evidence gathered by us and our evaluation of the evidence (i.e. not to rely solely on information passed to us by other agencies).</p> <p>Training for CIE</p> <ul style="list-style-type: none"> ▪ The Early Years and Childcare team in Development/ Strategy directorate (in consultation with the CIEI team) to: <ul style="list-style-type: none"> ○ prepare further training on the issues identified elsewhere under this recommendation and ensure arrangements are put in place to deliver the training. 			<p>communication between the joint parties.</p> <p>23 September 11</p> <ul style="list-style-type: none"> ▪ Strengthened existing guidance (<i>Compliance and investigation handbook/Conducting early year's inspections</i>) to make clear that any form of action set by Ofsted must be based on evidence gathered by us and our evaluation of the evidence (i.e. not to rely solely on information passed to us by other agencies). <p>23 September 11.</p> <p>Training for CIE</p> <ul style="list-style-type: none"> ▪ The Early Years and Childcare team in Development/ Strategy directorate (in consultation with the CIE team) to: <ul style="list-style-type: none"> ▪ prepare further training on the issues identified elsewhere under this recommendation ensure 		
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				arrangements are put in place to deliver the training. October 11.		
				COMPLETED		
4. Develop a clear process for staff in the compliance, investigation and enforcement team to escalate and report concerns about child protection decisions made by the local authority.	<p>Ofsted</p> <ul style="list-style-type: none"> ▪ Establish a process and draft letter for contact with the relevant Director of Children's Services to be used to highlight our concerns and challenge a decision not to take forward a Sec 47 investigation. <i>End of September: completed</i> • Establish a process through which such concerns/letters can feed into the local authority safeguarding inspections. 	Director, Education and Care	30 September 2011	<p>Challenge to a child protection investigation decision by a local authority</p> <ul style="list-style-type: none"> ▪ Establish a process and draft letter for contact with the relevant Director of Children's Services to be used to highlight our concerns and challenge a decision not to take forward a Sec 47 investigation. End of September 11: Completed ▪ Establish a process through which such concerns/letters can feed into the local authority safeguarding inspections. End of September: letters to DCS to be added to whistle blowing spreadsheet. SDA gather information 	<p>Safeguarding Leads in agencies have been closely monitoring implementation of key actions.</p> <p>Further evidence of implementation will be provided to the Department for Education Safeguarding Group in due course.</p>	<p>Progress is reviewed monthly by the Serious Case Review Sub Group to ensure effective implementation of agency action, the below areas have been identified for consideration as part of the finalisation process.</p> <p>Agency action to be reviewed by Serious Case Review Sub Group on 09/11/2012</p> <p>Finalised</p>

				<p>from this spreadsheet prior to local safeguarding inspection and will add this to the pre inspection briefing. Nick Gadfield PO whistle blowing confirms.</p> <p>20 October 11.</p> <p>COMPLETED</p>		
Children's Social Care						
<p>1. Children's Social Care should ensure that the recording of Initial Assessments in the Client Case Records section of a child's electronic case file ceases immediately and the correct electronic form documentation is used.</p>	<p>1. Instructions should be issued to all Children's Social Care staff to ensure that Initial Assessments are always recorded on the required electronic format and not included in electronic Client Case Records documents.</p> <p>2. Compliance should be monitored through the Case File Audit process.</p>	<p>Assistant Director - Vulnerable Children and Assistant Director – Safeguarding.</p>	<p>31.05.2011.</p>	<p>Confirmation at the induction meeting held on 31st May 2011 that initial assessment are always recorded on 'e' records. Initial Assessment's are recorded on Care First as primary recording system. However, if this is printed out and written on (it becomes a different document) - would then need to be scanned onto the child's 'e' record.</p> <p>COMPLETED.</p>	<p>Safeguarding Leads in agencies have been closely monitoring implementation of key actions.</p> <p>Further evidence of implementation will be provided to the Department for Education Safeguarding Group in due course.</p>	<p>Progress is reviewed monthly by the Serious Case Review Sub Group to ensure effective implementation of agency action, the below areas have been identified for consideration as part of the finalisation process.</p> <p>Agency action to be reviewed by Serious Case Review Sub Group on 19/10/2012</p> <p>Finalised</p>
<p>2. Children's Social Care should undertake an urgent review of the arrangements for the</p>	<p>1. The current implementation of 'E'</p>	<p>Assistant Director - Vulnerable</p>	<p>31.05.2011.</p>	<p>All scanning has ceased. Induction for Integrated</p>	<p>Safeguarding Leads in agencies have</p>	<p>Progress is reviewed monthly by the Serious Case Review</p>

<p>retention of 'paper' documentation received by or generated by social work teams and the requirements for such documents to form part of the child's electronic case record.</p>	<p>Records within Children's Social Care must include requirements, in compliance with corporate guidance, about the arrangements for the storage of any paper documentation that is not 'scanned' into electronic case files immediately upon receipt and clear protocols established to ensure such documents can be readily retrieved.</p> <p>2. A practice standard should be agreed to set out the circumstances and timescales under which any 'paper' records (reports, correspondence, inter-agency referrals etc) may be stored before 'scanning' for inclusion on a child's 'electronic' case file record.</p> <p>3. Consideration must be given to the resources required to effect this change in practice.</p>	<p>Children and Assistant Director – Safeguarding.</p>		<p>Access Teams and First Response took place on 8th & 9th September 2011.</p> <p>IAT Managers and Area Managers expectation is that this is how it should be from now on – confirmed at the induction.</p> <p>COMPLETED</p>	<p>been closely monitoring implementation of key actions.</p> <p>Further evidence of implementation will be provided to the Department for Education Safeguarding Group in due course.</p>	<p>Sub Group to ensure effective implementation of agency action, the below areas have been identified for consideration as part of the finalisation process.</p> <p>Agency action to be reviewed by Serious Case Review Sub Group on 19/10/2012</p> <p>Finalised</p>
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	4. Consideration must also be given to the need to incorporate the backlog of 'paper' records onto children's electronic case files.					
Early Years and Childcare						
1. That the LADO and a designated Early Years senior manager should give consideration to the need to review a sample of the safeguarding referrals made to Children's Services Professional 1 to evaluate the quality of decision making and resulting actions.	<p>1. Consideration of the information presented in this IMR indicative of the need for a review.</p> <p>2. Agree:-</p> <p>i. Terms of reference.</p> <p>ii. Identification of process, sampling and timescale for review.</p> <p>1. Report findings.</p>	Assistant Director - Safeguarding and Head of Commissioning.	Completion by 30.06.2011.	A review has been carried out by Head of Service Child Protection of all Children's Services Professional 1 referrals.	Safeguarding Leads in agencies have been closely monitoring implementation of key actions.	Progress is reviewed monthly by the Serious Case Review Sub Group to ensure effective implementation of agency action, the below areas have been identified for consideration as part of the finalisation process.
				COMPLETED	Further evidence of implementation will be provided to the Department for Education Safeguarding Group in due course.	Agency action to be reviewed by Serious Case Review Sub Group on 19/10/2012
2. The Children Young People and Families Directorate Leadership Team should consider the need to commission a thorough review of safeguarding practice within, and the safeguarding advice and training offered to, Private, Voluntary and Independent early years settings.	<p>1. The recommended review should include:</p> <p>i. An evaluation of whether the management of PVI safeguarding services should</p>	Interim Service Director Children's Social Care and Service Director Strategy and Commissioning.	31.08.2011.	The Head of Service Child Protection has provided training & awareness for Private & Voluntary & Independent Nurseries. 400 approx. practitioners attended.	Safeguarding Leads in agencies have been closely monitoring implementation of key actions.	Progress is reviewed monthly by the Serious Case Review Sub Group to ensure effective implementation of agency action, the below areas have been identified for consideration as part
				COMPLETED	Further evidence of	Finalised

	<p>be integrated within Children's Social Care.</p> <p>ii. The quality of safeguarding practice.</p> <p>iii. Compliance with Persons in a Position of Trust procedures.</p> <p>iv. The provision of and quality of safeguarding training.</p> <p>v. The purpose, use and value of 'Incident Forms'.</p> <p>vi. The role of the Early Years Safeguarding Officer: Including; workload, capacity, management and supervision.</p> <p>vii. Whether this role should be incorporated into the Persons in a Position of Trust team.</p>				<p>implementation will be provided to the Department for Education Safeguarding Group in due course.</p>	<p>of the finalisation process.</p> <p>Agency action to be reviewed by Serious Case Review Sub Group on 19/10/2012</p> <p>Finalised</p>
<p>3. Action should be taken to ensure the consistent use of 'Incident Forms' in PVI settings.</p>	<p>1. The review should :-</p> <p>i. Evaluate the purpose, use and efficacy of</p>	<p>Assistant Director – Safeguarding and Head of Service – Strategy and Commissioning.</p>	<p>30.06.2011.</p>	<p>The Head of Service Child Protection has provided training & awareness for Private & Voluntary & Independent Nurseries. 400 approx.</p>	<p>Safeguarding Leads in agencies have been closely monitoring implementation of key actions.</p>	<p>Progress is reviewed monthly by the Serious Case Review Sub Group to ensure effective implementation of agency action, the</p>

	<ul style="list-style-type: none"> ii. Subject to i. standardise the format of and guidance for the use of these documents. iii. Revise and re-issue guidance to include purpose, ensure the quality of recording, management oversight, involvement of parents and retention. 			practitioners attended. COMPLETED	Further evidence of implementation will be provided to the Department for Education Safeguarding Group in due course.	below areas have been identified for consideration as part of the finalisation process. Agency action to be reviewed by Serious Case Review Sub Group on 19/10/2012 Finalised
4. Action should be taken to review the role of the Early Years Safeguarding Officer.	<ul style="list-style-type: none"> 1. Evaluation of the Early Years Safeguarding Officer's :- <ul style="list-style-type: none"> i. Workload. ii. Capacity. iii. Referral and recording documentation. iv. Recourse to advice. v. Supervision. 	Assistant Director – Safeguarding and Head of Service – Strategy and Commissioning.	31.08.2011.	A review has been completed - two early years staff being based in Position of Trust but outward facing. COMPLETED	Safeguarding Leads in agencies have been closely monitoring implementation of key actions. Further evidence of implementation will be provided to the Department for Education Safeguarding Group in due course.	Progress is reviewed monthly by the Serious Case Review Sub Group to ensure effective implementation of agency action, the below areas have been identified for consideration as part of the finalisation process. Agency action to be reviewed by Serious Case Review Sub Group on 19/10/2012 Finalised
Safeguarding Service – Persons in a Position of Trust Team						
1. That the Safeguarding Service should	1. Action is required	Assistant Director	31.07.2011.	Internal Audit has completed an	Safeguarding Leads in	Progress is reviewed monthly by the

<p>take account of the findings of this IMR and make changes to the Persons in a Position of Trust Team procedures, process, database and documentation.</p>	<p>to ensure the effective recording and subsequent retrieval of referral information, decisions and action taken:-</p> <ul style="list-style-type: none"> i. Decisions on all referrals are made by / signed off by a Principal Officer, Persons in a Position of Trust Team. ii. All referral information is taken by social work qualified staff. iii. Cross referencing of referral information in terms of the personal details of Persons in a Position of Trust; all names, aliases and address(es), their workplace(s); alleged victims; dates of incidents etc to improve the reliability and ability to retrieve this information. iv. Recording of all 	<p>- Safeguarding.</p>		<p>independent review of Position of Trust process.</p> <p>Birmingham Audit 20/09/11 – initial feedback received limited assurance, minimal actions. Head of Service Child Protection reviewed all cases that were closed at referral point.</p> <p>A study day was taken to agree new process and procedures.</p> <p>Updated 22 October 2012</p> <p>Internal Audit has completed an independent review of Position of Trust process. Birmingham Audit 20.09.11 – initial feedback received limited assurance, minimal actions. Head of Service Child Protection reviewed all cases that were closed at referral point. Process has been a study day was taken to agree new process and procedures.</p>	<p>agencies have been closely monitoring implementation of key actions.</p> <p>Further evidence of implementation will be provided to the Department for Education Safeguarding Group in due course.</p>	<p>Serious Case Review Sub Group to ensure effective implementation of agency action, the below areas have been identified for consideration as part of the finalisation process.</p> <p>Agency action to be reviewed by Serious Case Review Sub Group on 19/10/2012</p> <p>Finalised</p>
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	<p>checks of the Person's in a Position of Trust referrals database undertaken in respect of new referrals.</p> <p>v. Recording of Care First database checks in respect of; all alleged child victims of alleged abuse; and of alleged perpetrators.</p>			<p>In light of the review, the Position of Trust process has been reviewed and all referrals are signed off by a qualified social worker. The Head of Service randomly samples cases on monthly basis to ensure thresholds of intervention are in line with policy and procedure. Assistant Director receives a monthly report on all open cases.</p> <p>All referrals which were closed down in the preceding 12 months were reviewed by the Head of Service to ensure correct action was undertaken.</p> <p>Database has been amended to ensure cross referencing of referral information in terms of; workplace; name; address. All child victims of alleged abuse are inputted into Care First.</p> <p>Audit report will be sent once finalised.</p>		
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				COMPLETED		
2. That the LADO should initiate consultation with Ofsted to ensure that all referrals concerning Persons in a Position of Trust made by Ofsted to the local authority are made in writing and addressed to the LADO or a designated Principal Officer – Persons in a Position of Trust Team.	<ol style="list-style-type: none"> Liaison with Ofsted as recommended. Ensure recording of decisions taken, action agreed and by whom in order to ensure there is a clear audit trail. 	Assistant Director - Safeguarding.	31.05.2011.	<p>Assistant Director Safeguarding has discussed with OfSTED and reiterated the process referrals to Children's Social Care and agreed that this would be followed up in writing.</p> <p>COMPLETED</p>	<p>Safeguarding Leads in agencies have been closely monitoring implementation of key actions.</p> <p>Further evidence of implementation will be provided to the Department for Education Safeguarding Group in due course.</p>	<p>Progress is reviewed monthly by the Serious Case Review Sub Group to ensure effective implementation of agency action, the below areas have been identified for consideration as part of the finalisation process.</p> <p>Agency action to be reviewed by Serious Case Review Sub Group on 19/10/2012</p> <p>Finalised</p>
Children Young People and Families Directorate						
1. The findings of this IMR should be used to inform decisions about whether any Children, Young People and Families Directorate staff should be subject to capability or disciplinary investigations.	1. Application of relevant Birmingham City Council procedures.	Interim Service Director Children's Social Care.	Current.	<p>Appropriate action has been taken with staff involved.</p> <p>COMPLETED</p>	<p>Safeguarding Leads in agencies have been closely monitoring implementation of key actions.</p> <p>Further evidence of implementation will be provided to the Department for Education Safeguarding Group in due</p>	<p>Progress is reviewed monthly by the Serious Case Review Sub Group to ensure effective implementation of agency action, the below areas have been identified for consideration as part of the finalisation process.</p> <p>Agency action to be reviewed by Serious Case Review Sub Group on 19/10/2012</p>

					course.	Finalised
West Midlands Police						
Child abuse and COST investigators to conduct CRB checks routinely as part of the intelligence process where offences are alleged or suspected in an on-line enquiry	(a)Amendment to be made to the investigative flowchart for on-line offences. (b)West Midlands Police to raise a request with PND implementation team that consideration be given to including a functionality on PND which would allow searches for CRB checks.	Detective Superintendent PPHQ	June 2011	DI COST team to implement changes and send e-mail notification to all PPU staff and supervisors involved in child protection and on-line investigations DC PPHQ to raise this request with the PND team. The IMR identified that when police receive intelligence that online offending has been traced to a service user household, there are several risk factors to be considered including whether anyone in the household has access to children. The knowledge that a CRB check has been requested by a member of the household could indicate that they have access to children which will raise the risk assessment. A check of CRB databases was not routine practice. The COST DI has now audited intelligence checks carried out by	Safeguarding Leads in agencies have been closely monitoring implementation of key actions. Further evidence of implementation will be provided to the Department for Education Safeguarding Group in due course.	Progress is reviewed monthly by the Serious Case Review Sub Group to ensure effective implementation of agency action, the below areas have been identified for consideration as part of the finalisation process. Agency action to be reviewed by Serious Case Review Sub Group on 19/10/2012 Finalised

				the team and is satisfied that CRB systems are checked to indicate whether a CRB check has been done/requested on all incoming intelligence packages. COMPLETED		
How will the effectiveness of this recommendation be monitored?	<p>1. Publication of amended documents and e-mail relating to action (a)</p> <p>2. Monitoring by COST and PPU supervisors to ensure CRB checks completed on future enquiries.</p> <p>3. Submission of written request to PND to be attached and any response received</p>	Detective Superintendent PPHQ	December 2011	<p>PPHQ to initiate a survey of compliance six months after changes are completed. Flow chart available.</p> <p>DI has confirmed that this is a routine enquiry on all COST intelligence packages.</p> <p>At present PND does not have the capacity to include further search criteria without national agreement. This proposal is therefore not viable.</p> <p>COMPLETED</p>	<p>Safeguarding Leads in agencies have been closely monitoring implementation of key actions.</p> <p>Further evidence of implementation will be provided to the Department for Education Safeguarding Group in due course.</p>	<p>Progress is reviewed monthly by the Serious Case Review Sub Group to ensure effective implementation of agency action, the below areas have been identified for consideration as part of the finalisation process.</p> <p>Agency action to be reviewed by Serious Case Review Sub Group on 19/10/2012</p> <p>Finalised</p>
Birmingham Metropolitan College						
1. Develop a system for on-line applications to speed up the process	System to be developed and implemented	Amenda Sun	July 2011	System established and procedure agreed COMPLETED	Safeguarding Leads in agencies have been closely monitoring implementation of key actions.	Progress is reviewed monthly by the Serious Case Review Sub Group to ensure effective implementation of agency action, the

					<p>evidence of implementation will be provided to the Department for Education Safeguarding Group in due course.</p>	<p>consideration as part of the finalisation process.</p> <p>Agency action to be reviewed by Serious Case Review Sub Group on 19/10/2012</p> <p>Finalised</p>
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TERMS OF REFERENCE

Aim

To review the circumstances leading to the incident that caused the serious sexual abuse of this child and establish what lessons are to be learned from the case about the way in which local professionals and organisations work individually and together to safeguard and promote the welfare of children.

To identify clearly what those lessons are both within and between agencies, how and within what timescales they will be acted on and what is expected to change as a result.

To improve intra- and inter-agency working and better safeguard and promote the welfare of children.

Most serious case reviews focus on a family situation, and the circumstances of this review are therefore unusual. It was decided that the focus of this review would be the nursery as a whole and the care and protection of the subject child at the nursery and how the opportunity arose for a staff member to potentially abuse a position of trust.

Process

A Serious Case Review Panel with an Independent Chair has been commissioned to manage the process. An Independent Author of the Overview Report has been appointed. Membership of the Panel will include representatives from:

- Independent Chair BSCB (SCR Panel Chair)
- Children's Social Care
- West Midlands Police
- Children's Health Services – (Designated Nurse Team)
- Early Years

Time Period

For the nursery the review should cover from when the nursery opened in 2006 reviewing the history of the nursery, to include details from when the alleged perpetrator was first employed there. For the subject child the SCR should focus on the period between (June 2009 the date the child started at the nursery) up to (January 2011 the date the alleged perpetrator was arrested). The history of the sibling of the subject child should be reviewed over the same period i.e. June 09 – January 11. For the alleged perpetrator from his commencement of further education in respect of child care.

The Review should also consider relevant information relating to agencies contact with the alleged perpetrator and the victim's parents and sibling outside that time frame as far as it impacts on the assessments in relation to this case.

Scoping the Review – Key Issues

The review will consider agencies and nurseries contact with Mother and Father in relation to the parenting of the Subject Child, the Subject Child on their own, the alleged perpetrator, and the perpetrators mother in relation to her involvement with the nursery.

Health Overview report author to discuss specific issues with the SCR Overview Report writer to the extent of which contact with Universal Health Services e.g. GP should be included.

The Overview Report will consider relevant research and similar Serious Case Reviews i.e. Plymouth LSCB where circumstances were similar, to identify good practice and maximise learning.

The Panel will consider how and when the most appropriate method of securing family members involvement with the SCR process. Adhering to BSCB's guidance on the involvement of family members and being mindful of the criminal

investigation. The Panel Chair will be responsible for arranging liaison with the family with the support of West Midlands Police Family Liaison Officer.

The existing process of informing parents in respect of the SCR will be extended to included parents of other children who attended the nursery.

Consideration has been given to the racial, cultural, linguistic and religious background to this case and there does not appear at this stage to be any factors that impact on immigration status.

BSCB will obtain legal advice as necessary. Current BSCB legal advice relating to SCRs and other publication will be adhered to.

Birmingham East and North PCT will notify the SHA of the Serious Case Review through the Sudden Untoward Incident system.

Relevant information to emerge from criminal proceedings will be taken into account by SCR Panel. The police representative on the panel will be responsible for liaising with the CPS.

Public and media enquiries will be handled by the Chair of BSCB.

At the conclusion of the Serious Case Review agencies arrangements will be made for all staff involved in the case to be debriefed and the BSCB will disseminate the key learning from the case through a series of targeted seminars.

Any urgent actions arising during the course of the review should be urgently acted upon prior to the publication.

Scope and format of individual management reviews

Analysis of involvement

Consider the events that occurred, the decisions made, and the actions taken or not taken. Where judgements were made, or actions taken, which indicate that practice or management could be improved, try to get an understanding not only of what happened but **why** something either did or did not happen. Consider specifically the following:

Individual Management Reviews (IMRs) and Other Reports

- Individual Management Reviews to be requested from all agencies or organisations in Birmingham who have had contact with the Mother and Father in relation to the parenting of the Subject Child, the Subject Child on their own, the alleged perpetrator. The perpetrators mother in relation to her involvement with nursery the above should complete individual management review, including a comprehensive chronology in line with BSCBs guidance (copy attached).
- Individual Management Reviews will also be sought from Ofsted and Early Years at the time of the incident as to the circumstances of any intervention they have had with the nursery and family.
- Information reports to be sought from the Charity Commission and the Regeneration Project at the time of the incident as to the circumstances in any intervention they have had with the nursery and family.
- The final overview report will take into account information from the criminal proceedings, the Charity Commission Review and any other independent enquiry being held.

Issues to be addressed within the IMR

The review should address both 'generic issues' set out in "Working Together" and the 'specific issues' identified in this particular case.

The Generic Working Together to Safeguard Children 2010 Terms of Reference

- Were practitioners aware of and sensitive to the needs of the children in their work, and knowledgeable both about potential indicators of abuse or neglect and about what to do if they had concerns about a child's welfare?
- When, and in what way, were the child(ren)'s wishes and feelings ascertained and taken account of when making decisions about the provision of children's services? Was this information recorded?
- Did the organisation have in place policies and procedures for safeguarding and promoting the welfare of children and acting on concerns about their welfare?
- What were the key relevant points/opportunities for assessment and decision making in this case to the child and family? Do assessments and decisions appear to have been reached in an informed and professional way?
- Did actions accord with assessments and decisions made? Were appropriate services offered/provided, or relevant enquiries made, in the light of assessments?
- Were there any issues, in communication, information sharing or service delivery, between those with responsibilities for working during normal office hours and others providing out of hours services?

- Where relevant, were appropriate child protection or care plans in place, and child protection and/or looked after reviewing processes complied with?
- Was practice sensitive to the racial, cultural, linguistic and religious identity and any issues of disability of the child and family, and were they explored and recorded?
- Were senior managers or other organisations and professionals involved at points in the case where they should have been?
- Was the work in this case consistent with each organisation's and the LSCB's policy and procedures for safeguarding and promoting the welfare of children, and with wider professional standards?
- Were there organisational difficulties being experienced within or between agencies? Were these due to a lack of capacity in one or more organisations? Was there an adequate number of staff in post? Did any resourcing issues such as vacant posts or staff on sick leave have an impact on the case?
- Was there sufficient management accountability for decision making?

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:

- 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.

- To identify and consider any information or concerns that children's services agencies, individual professionals, identified educational establishments had about the alleged perpetrator that may have indicated that they posed, or might pose, a risk to children.
- To identify and consider any information or concerns that children's services agencies (Health, Children's Social Care and Early Years) had in relation to the setting.
- 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.
- To examine the recruitment processes carried out by employers of the alleged perpetrator where they were 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.
- To identify the strengths and weaknesses in the child protection policies and practices, the training, staff development and general and child protection provision provided the alleged perpetrator and staff within the setting.
- Identify and consider safeguarding procedures with regard to ongoing use of multi-media equipment and the impact this has on the safety and wellbeing of children in either nursery or nursery care

Specific issues to be addressed by all agencies

In addition to the above generic terms of reference, please also address the following issues in your IMR, relevant to this specific case. These are to be addressed by all agencies providing an IMR:

- Whether any agency or individual was aware of the practice of the alleged perpetrator.
- Whether any agency was aware of any concerns around the contact between the alleged perpetrator and the subject child outside of the nursery

Additional specific terms of reference to be addressed by Early Years and separately the nursery:

Review the history of the nursery, including the links to the Regeneration Project, the Charity Commission and Birmingham Children's Services, from the time it first registered as an Independent Nursery, until the arrest of the alleged perpetrator in December 2010, specifically commenting on what was known about:-

- The daily routine and operation of the nursery to include how children made use of an moved around the rooms in the nursery
- The fabric and resources of the nursery and its fitness for purpose
- The standard of administration and record keeping at the nursery
- The finances of the nursery and the utilisation of its funds
- The means and type of communication with parents and in particular with the Subject Child
- Identify how the nursery was staffed from 2006 when the nursery opened. To include visiting professionals, voluntary workers, trainee child care workers and work experience students.
- Identify whether the nursery met the linguistic, cultural and ethnic needs and additional needs arising from disability and educational needs.
- Assess whether the nursery met the standards of education and care for the children placed there.
- 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.
- Review how the manager of the nursery discharged their duties in the safeguarding of children in their 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 an incident log to include actions taken
 - Communication with parents
- Any policy for staff raising issues of concern about staff behaviour, or other staff concerns

In addition the nursery should consider all points on the above and

- The nursery to consider the function of Early Years development workers and Ofsted

Additional specific terms of reference to be addressed by (Ofsted):

Review the inspection process, including:-

- How this contributed to the safeguarding of children.
- What evidence there is of children's educational attainments being met and any recommendations associated with this.
- Identify any actions determined by the Inspection process, noting the review of the implementation.
- Review the evidence and judgment in the inspection regime, with particular reference to safeguarding.

- Review advice given to the nursery and clarify whether any recommendations were acted on and any subsequent arrangements/recommendations that followed.

Additional specific terms of reference of the Local Authority Designated Officer.

- Were there any identified concerns in relation to the nursery?
- Were there any identified concerns in relation to the alleged perpetrator?
- Detail of the communication between the LADO and Ofsted

Additional guidance is also available to IMR Authors

IMR Template

- IMR Guidance Notes
- Ofsted judgement exemplars
- BSCB – Good practice guidance
- IMR – Audit Tool

The Chair of Serious Case Review Panel will provide a briefing to IMR authors to focus on analysis of involvement and the specific issues and broader safeguarding factors.

In determining the terms of reference and scope of the review, consideration had to be given to the various interlocking elements as set out in section three below. It was acknowledged from the start that the main focus of the review was to be on the nursery, the role of the Perpetrator and whether the abuse of Subject Child could have been prevented in this setting. In addition, the review would need to determine whether there was any known history in relation to the Perpetrator that would have indicated he was a risk to children, and whether action should have been taken by any agency to prevent the abuse of both Subject Child and others he groomed over the internet.