Findings of Serious Case Reviews involving nursery settings

Serious Case Reviews [SCR] are 'undertaken when a child has suffered significant harm or death as a result of serious physical or sexual abuse and where there are concerns about the way local professionals and agencies have worked together to safeguard and promote the welfare of the child'[p4, Plymouth Early Years Service, 2011]
The purpose is to understand the culture that allowed the abuse to take place in the first place and remain undetected. From this, recommendations are made to improve inter agency working and safeguarding practices.

There have been two SCR that have involved nurseries, due to the perpetrator being employed by the settings. In 2010, one involved a Plymouth setting and the other in 2011 in Birmingham. These reviews were about how the nursery settings were organised, which allowed opportunities for abuse to take place within the workplace.
Each case is different in terms of crime committed but there are some common themes that ran through them. This was picked up by the SCR for Birmingham in 2011 and is noted in their report.

It is important that other childcare settings are aware of the findings of the reviews, to allow them to reflect on what is in place in their workplace, the culture in which it operates and how children can be safeguarded in the best possible way.

Some changes will have taken place already within settings, due to the review of the EYFS, changes to the inspection format and the guidance for Ofsted Inspectors, reflecting a lot of the recommendations from the reviews.
This article will highlight some of the practices and common themes that emerged from the review, providing settings with an opportunity to audit how well they safeguard children in their setting.

In both cases, neither perpetrator was arrested for abuse due to whistle blowing from the nurseries, even though concerns had been raised by different people and agencies. There crimes only came to light, because of other external investigations.

Main Themes

Recruitment procedures
Procedures were not followed even though CRB were taken up, no formal interviews took place in one instance. The Birmingham setting allowed the worker to work as a student as they had seen sight of his CRB previously, even though another setting had refused to take him without an up to date one.
Settings were based within close communities so the workers were either known to the manager or other people within the setting. This led to an assumption that they were suitable.

In one instance the manager was recruiting staff, when as the organisation legally responsible, it should have been the committee/trustees.

Management of the settings

It became clear in both reviews that there were no clear lines of accountability from the Trustees or Committee to the workforce. There was no supervision for the manager, which allowed no time for concerns or operating issues to be discussed and recorded. There were no clear lines or procedures for staff reporting of any concerns, especially if, once raised, the manager had not acted on these concerns. In the Plymouth nursery, even though it was operated by a board of Trustees, parents thought the manager was the owner.

Systems for performance management/ regular supervision and appraisals were not robust and did not feed into improving the quality of the childcare or motivation of the staff.

The committee/trustee were not aware of their legal responsibilities under Ofsted, as registered childcare providers and had little knowledge of the requirements of the EYFS, thus making it impossible to know if the setting was operating safely and as a quality setting.

Management of the day to day childcare

The manager of the setting is the link between the committee/owner and the staff. Areas that caused concern were the weak links between the trustees and the manager as highlighted in the management of the setting. This impacted on the manager being competent to lead a setting and also afforded her power in the setting to dismiss concerns that were raised by staff. Staff training needs were not highlighted and supervisions weak or non existent, which left children, staff and trustees in a very vulnerable position.

Ratio's-

One of the settings worked over ratio's consistently. This was not picked up by Ofsted and Early Years. It was suggested that the setting had a system that alerted the manager to a 'professional visit' and staff were deployed either, from the sister setting next door or other rooms, to make ratios appear correct. Staff need to be aware that by colluding in working over ratio's they are putting children and themselves at risk, and providing opportunities for abuse to take place. Low staff morale and increased stress levels are the more usual outcomes of this practice.

It also impacts on staff's ability to supervise children, which was an area of concern picked up in Plymouth's report.

Special relationships –

In both settings the perpetrator had a 'special relationship' with the child. It was picked up by staff that the worker was spending a lot of time with a particular child but this was not acted upon or challenged. Having a 'special relationship' should not be confused with the key person role.

Supervisions –

These are a fundamental part of safeguarding and the EYFS describes why they must take place. Many settings struggle with finding the time for this and

hope that a ‘catch up’ or an ‘open door policy’ will suffice. These do have there place but in both settings no formal processes were in place, thus not providing the time and confidentiality for staff to voice their concerns or for practice to be challenged and vulnerabilities identified.

Staff knowledge and training

The members of staff were not confident in their knowledge of child protection and this did not equip them to keep children safe. Training was either outdated or, knowledge gained was not embedded in the culture of the setting, so staff did not understand their duties, when an incident occurred or the day to day practice of how to keep children safe, thus making them incompetent. In the case of the Plymouth nursery, in work the NSPCC did afterwards, they highlighted the low level of knowledge within the staff team regarding females who pose a risk to children.

It was also highlighted that in working with children everyone should be aware that potentially an abuser may already be employed by the organisation. This is not to create a panic but to raise awareness of people’s responsibilities in relation to the children in their care.

Staff were also reluctant to follow up any child protection concerns that had identified due to ‘repercussions from parents’. This is perhaps a reflection of the culture of the setting, poor confidence in staff in their knowledge of child protection and the not seeing the child’s safety as paramount.

Students

It is important that students have a voice. They are observing practice with fresh eyes and management and colleges should empower students to ask questions and voice their concerns. In Birmingham, the students on placement raised concern about the settings quality, but these were not followed up in a robust manner, so there was no final outcome and the sharing of information between Colleges/ Early Years/Ofsted was weak.

Physical environment

This has to reflect the need for privacy and dignity for children **and** reduce the opportunity for abuse to take place. Again, a robust whistle blowing procedure and an open culture in the setting goes alongside this.

Social media

This is now a part of everyday life and many settings use it to promote their setting. In the reviews, some parents and staff were communicating using social media, not on a professional basis but as friends. This makes boundaries very blurred and can compromise the integrity of the setting and confidentiality, for staff, parents and children.

Culture of the setting

Staff cliques were highlighted in the reports. This stopped people whistle blowing on each other when poor practice was observed. It allowed positions of power to be cultivated within the staff team [mainly by the perpetrator]. Cliques can create tension within the team and are not always obvious to a manager. [which is why supervision is vital] however children are very adept at picking up tensions, which will impact on their wellbeing.

Policies
Intimate care – this policy was not in place. It is acknowledged that this may not have stopped the abuse but it would have laid out clear guidelines on how staff were to apply personnel care, and provided the staff with an opportunity to identify any risks and how they could be reduced.

A whistle blowing policy is vital to inform staff and parents [and older children] that children's needs come first, and are above and beyond friendship groups and protecting the business. The policy has to be understood and owned by everyone linked to the setting, including visitors. It has to have a clear process that includes, what will happen, how the whistle blower will be supported and the outside agencies that will be involved.
It is now a requirement to have a mobile phones policy as part of safeguarding. Staff were not allowed personal mobiles at one of the nurseries and they were to be kept in staff pockets in the kitchen area. However this was accessible on the way to the children's bathrooms, so was very difficult to up-hold and monitor. The lack of whistle blowing culture within the setting would have added to the opportunity.

Plymouth had in place PLA policies but these had not been adapted to reflect the setting, and although they had been signed by the manager there was no evidence that they had been discussed at staff meetings and adopted by the workforce.

Parents
Themes emerged about communication with parents – there was little communication with parents about their children and how they had been at the nursery. Even information such as accidents or incidents where often left on 'post it notes'. Parents were also not aware who their child's key person was, denying them the opportunities to share information. Parents had not seen and were not aware that there was a nursery prospectus. This would have enabled them to know what to expect from the nursery and be aware that policies such as Safeguarding and How to Complain are in place and taken seriously by the setting.

Ofsted and the Local Authority
Many of the concerns raised regarding the failings of the Ofsted inspection format have been rectified and implemented. One of these is an improvement in joined up working and sharing of concerns with the Local Authority. We are now informing Ofsted of low level concerns i.e. if a satisfactory/ requires improvement/ inadequate setting do not want us to support them or if a setting is in breach of the statutory requirements. It is important that Ofsted is aware if a setting does not wish the LA to support them in improving practice as this may indicate that no outside agency is going into the setting to observe and challenge practice and support staff.

Outcomes and Conclusions

It is important to understand that safeguarding policies and procedures will not prevent abuse. What they do is put out very clear signals to people that the setting and the culture of the workplace takes its responsibility for safeguarding very serious. It recognises its duty to keep children safe, protect and listen to them and supports staff in being able to do so. This provides a first barrier to someone thinking of applying for a job or in a situation where they feel there may be an opportunity to abuse. Secondly they provide a framework for staff to understand what their responsibilities are, voice concerns, challenge inappropriate behaviour, know where to go for advice and feel supported.

In Ofsted's 'Conducting Early Years Inspections' Ref 120087 inspectors are asked to check 'whether all staff have been trained to understand the settings safeguarding policy and procedures and the training enables staff to identify possible signs of abuse and neglect at the earliest possible opportunity and to respond in a timely and appropriately way'.

Creating a safe culture is the responsibility of the owner and/or manager and everyone has to feel part of this. When this is in place, not only do staff benefit, but also parents and children.

It provides an environment where:

- All are able to express themselves
- All feel accepted
- Listened to
- Given time and mutual respect.

This, by default, creates a safe environment for children, characteristics which are described in the Plymouth review as:

- Staff are respectful to all employees as well as children
- Staff are open about discussing good and poor practice
- Blame only happens in extreme circumstances
- Leaders model appropriate behaviour

Staff should be able to be open with each other and management about what is occurring in the setting, both good and poor practice and be able to challenge each other constructively. Many staff will need to be empowered to enable them to be able to do this.

We need to move to a practice that is critically reflective based on 'what is it like for a child in this setting'.

Multi agency training is an area that was recommended by Plymouth City Council as 'allowing practitioners and their managers to understand their own roles, the roles of other agencies, and improves confidence and ability to follow an effective information sharing process.' [p14, Plymouth Early Years Service, 2011.]

The importance of nurseries having links with Health Visitors is also highlighted.

Staff attending training should not just ‘tick a box’ but the training should be followed up by what it means to the setting – for the children, parents and staff, including owners/committees etc. This needs to include possible abuse by people in a position of trust.
If safeguarding is a subject that is openly discussed in the setting, in supervisions and staff meetings, staff will be empowered to take ownership of it. An understanding of Safeguarding needs to run throughout the setting, including owners/committee members/cooks/cleaners. This should include what constitutes safe practice in their environment.
Whistle blowing procedures are more likely to be effective if staff know procedures are followed, their concerns will be taken seriously and they will be supported.

Friendships with parents need to be on a professional level. This prevents the collusion of parents and staff that may have a negative effect of the setting or the child. Settings need to think how this can be put in place so it is manageable and effective. The use of social media makes this more difficult to control but if staff and parents understand why it is in place, with a clear policy and procedure, it should be effective. It is important that parents are welcomed into the nursery, but this should not compromise the settings ability to protect children and adhere to confidentiality.
Parents need to feel they have a voice and they are kept fully informed about their child and the setting.

Recruitment needs to move beyond DBS as the marker of a ’safe worker’ to robust recruitment and induction processes, that allow a persons values and motivation in working in childcare to be questioned. The whole process of meaningful references and gaps in employment needs to be robust. If staff are dismissed from a setting or leave before they can be dismissed, then the registered person needs to be aware of their referral duty to the DBS [Disclosure and Barring].

We already have, since these reviews, improved communications and systems between Ofsted, Early Years Services and the LADO and this is a positive move. Another area that was raised was the importance of Early Years teams working with colleges to enable dialogue to take place if students have concerns about practice at a placement, even if this is just to support the colleges and student to inform Ofsted.

I believe that communication underpins all the recommendations that came out of the reviews. All organisations need to share information, as far as legally possible, when there is the slightest of concerns, as you never know what information someone else holds in constructing a bigger picture as to what is happening in a child’s world. Ultimately Ofsted are the registering body and can remove registration but that is only one small part of keeping children safe.

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References

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