South Lanarkshire Child Protection Committee

Significant Case Review G Nursery, 2014

1. Introduction

This report has been produced in order to identify and share learning which has emerged from a situation of a day nursery worker being convicted of offences against children. Investigation into the possible crimes was triggered by the UK wide Child Exploitation Online Protection Centre [www.ceop.police.uk] and progressed by Strathclyde Police [now Police Scotland]. As the offender lived and worked in the area, this multi agency learning review has been carried out by South Lanarkshire Child Protection Committee [SLCPC].

The aim of the review has been to highlight learning applicable to their systems for the CPC, Adult Protection Committee, local services, and across Scotland and the UK. There are similarities with the findings of other day care and education based Serious Care Reviews, i.e. Birmingham Safeguarding Children Board (SCB) Serious Case Review [2013], Plymouth SCB SCR [2010], East Sussex SCB SCR [2013], and also parallels with other enquiries, conducted over many years now, which have found that professionals and carers in positions of trust, such as foster and residential carers, sports and arts coaches, and health service workers, have used that role to abuse children and vulnerable adults. The situation highlights again that people who seek to abuse children and vulnerable adults will systematically seek access to them by building up relationships of trust, and by placing themselves in roles in which they have power and credibility.

This review does not aim to examine the causality of sexual offending against children and the review team has found it useful, as a focus, to refer to David Finkelhor's framework of pre-condition factors to abuse, and specifically the factor of external inhibitors, i.e. what systems are in place which minimise the potential for abuse to take place. As noted in the recruitment toolkit published by the National

Centre for Excellence in Residential Child Care [2006], 'Abusers typically try to join organisations that lack the awareness and procedures necessary to prevent them carrying out their activities; giving appropriate messages throughout the process is likely to act as a powerful deterrent'.

Pre- conditions to sexual offending [From Finkelhor, D, 1986, CSA: New Theory and Research]

Motivation to sexually offend [offender]
Overcoming of internal inhibitors [offender]
Overcoming of external inhibitors [organisational culture and rules]
Overcoming of victim resistance [in this case, very young children; cannot physically resist, behaviour signs ambiguous, unable to articulate; grooming of adults to obtain trust]

The factor of the characteristics of victims is also relevant to wider learning in that the target group was very young children who would on the whole be unlikely to be able to articulate exactly what was happening to them and where their discomfort could be presented/rationalised as confusion; this aspect has links with the abuse of other vulnerable groups such as disabled children and adults, and other children in out of home care.

2. Strengths and areas of learning

The review considers there were a number of strengths within the systems involved; but also several issues on which specific recommendations have been made, as well as areas of further potential learning and consideration for the CPC, South Lanarkshire Council Education Resources, nationwide agencies and the Government.

Summary of strengths:

- The offender was detected through his use of internet images by the UK wide resource of CEOP and this information was followed up timeously and effectively by Strathclyde Police. Thereby, further offending was stopped. This would have been unlikely some years ago when detection of such crimes depended almost wholly on disclosure by victims and belief by others. This

also reinforces the importance of values and protocols in which children and adults who disclose discomfort about someone are taken seriously as it is likely that many similar situations will not have the availability of concrete evidence such as the images to support children and adults' disclosures.

- Despite the offender pursuing the intention of accessing children to abuse by becoming employed in child care and also by befriending and gaining the trust of children's relatives and colleagues, a number of these resisted his efforts. This would seem to reinforce the value of publicity on awareness of child protection and the obligation on agencies to make it easier for people to report concerns.
- Despite the great and understandable anxiety caused to parents and staff by the revelation of the abuse, the great majority have continued to use the nursery centre and, in the case of staff, continue to provide care which is valued and trusted by parents.
- A number of contributors to the review had been directly affected by having worked with the offender and were open and reflective about the learning they have taken from this experience.
- Following the initial arrest, the Council set up a strong support team which offered access to affected relatives and staff to advice and counselling. There was also a senior multi agency liaison team which based its activities on emergency response knowledge and crisis intervention theory.
- The agencies involved or with responsibilities in this area of work have been open and generous in contributing to this learning review by providing information, including documentation and access to interviews.

Summary of areas of recommendation and potential further consideration

Overall, these are about the heightening of child protection systems for children when they are away from family care. They include;

- Safer recruitment of permanent and temporary staff
- Improving the consistency and depth of understanding of the dynamics of abusive intentions for senior, front line management and front line professionals.

- Considering further the most effective approaches to understanding and expectations of the best balance of professional and personal boundaries
- Considering further the more systematic inclusion of parents in the structure of day care services and nurseries.
- Considering further the best approach to external and internal staff management to ensure as far as possible the paramountcy of the well being of children

3. Context

G Nursery Centre is a large early years day care and education centre with 106 full time equivalent places, provided to a number of children under 3 and to 3 and 4 year olds; it is located in and owned by the large local authority of South Lanarkshire, and managed by the Council's education service. The service is registered and inspected by the Care Inspectorate and HMIE. Several years ago it combined an existing community day nursery with a pre-school education service.

In January 2012, officers of Strathclyde Police attended the nursery in order to request that M, a qualified member of its early years staff registered with the Scottish Social Services Council, accompany them to his home to identify his computer and other equipment which was to be examined. This happened as a consequence of the Child Exploitation Online Protection Centre having notified Strathclyde Police of the accessing of images of child pornography and a search warrant had been obtained. The subsequent enquiries found a very substantial number of such images and that a contact crime had been committed against 2 young children under 5 years whose family M had befriended via his employment. One child, aged under 5 years, who had spoken to their parent, was able to speak about what had happened in the context of a joint police and social work investigative interview and there was corroborative evidence of the crimes on the equipment examined.

M was immediately suspended from his employment. Following subsequent enquiries he was charged with having sexually abused a child who attended the nursery, M having built up a relationship of trust with the child's family via his employment. In February 2012 he was dismissed from his employment by the

Council and entered a guilty plea in May 2012 to charges relating to the possession and making of indecent images and the contact offences and was sentenced to a period of imprisonment.

The police enquiries found no evidence that children had been abused within the nursery setting itself nor that there was any involvement in the events by any other member of staff, nor of M having a connection to any network of offenders.
M had been employed by SLC initially in 2009 as a temporary employee. He had previously worked in other industries then had gained a qualification in early years care, initially accessing an open entry Men into Child Care course. He registered with the Scottish Social Services Council, further to his successful completion of the HNC course, which included several placements in nurseries.

The G nursery did not close at any point so that children and families' routines were not disrupted and the setting became the main base for a multi disciplinary support and liaison team provided by the Council for relatives and staff.

During the police enquiries, and a series of support sessions set up for relatives and staff in the period following M's arrest, it emerged that M had made regular efforts during the time of his employment there and in previous settings to befriend relatives and colleagues and thereby to gain access to children outside the nursery via activities such as babysitting. A number of parents had resisted these efforts. It was also noted by the police that around the time of his arrest he had made an enquiry to the Council about the possibility of adoption. It also emerged that several colleagues had raised concerns with internal managers about some of his behaviours which had not been in line with nursery protocols but these had not been passed on to or further discussed with external managers.

4. The SCR process

4.1. South Lanarkshire Child Protection Committee set up a review group to consider the circumstances of these offences in December 2012 which advised the CPC and the Chief Officers Group that an SCR should be carried out. The core contextual guidance followed is that for Child Protection Committees in Scotland on Conducting

Significant Case Reviews (2007), and the National Guidance for Child Protection in Scotland (2010).

4.2 The SCR Sub Group consisted of the independent CPC Chair, Lead Officer and Administrator, and representatives of the Education and Social Work services of SLC, Police Scotland and NHS Lanarkshire; this group drafted terms of reference after the CPC had agreed that an SCR should be undertaken. An independent reviewer was appointed to carry out interviews and relevant reading, be involved in detailed discussions with the sub group on the analysis of information and to draft the report.

4.3 .Before finalising the terms of reference for the review, the Chair and Lead Officer conducted a consultation on the terms of reference with parents whose children had been at the relevant Council nurseries during the time of M's employment. 447 parents and relatives were contacted by letter inviting them to contribute should they wish to do so. 5 parents, one grandparent and one front line member of staff contributed by speaking to the Chair and Lead Officer. The Terms of Reference were added to as a result and then agreed by the CPC.

4.4. Terms of reference for the review

The terms of reference agreed for the review were initially drafted by the SLC CPC Review sub group and added to following the consultation process with parents.

- *What lessons can be drawn from reflecting on the management arrangements within the nursery and externally? Are there lessons to be learned about how parents are involved when there are concerns about their children and is there an organisational understanding that sometimes the concerns may relate to issues in the nursery and not in the home?*
- *How can system wide capacity for managing risk in individual establishments be strengthened? Possibly considering:*
    - *Council policies and procedures including any lessons from the way the individual was recruited*
    - *Specialist or senior officer support for the work of establishments*

- *The role of the Performance Development Review process and associated professional development programmes in informing and strengthening practice standards; the nature and frequency of training, to ensure staff actively engage*
- *Whether more needs to be done to facilitate staff and managers being able to raise concerns about colleagues and these being followed up.*

- *Could clues have been picked up from the knowledge of agencies in relation to individual children or practice at the nursery or from concerns raised by parents about their children's behaviour?*
- *How can we continue to improve support for parents, carers and families who have suffered a trauma?*
- *How well did services and agencies work together in response to this case and what lessons can we learn from this experience?*
- *How can we further build public and parental confidence in the early years sector?*
- *Can advice to employees regarding personal and/or non-service-related contacts with families be strengthened?*
- *What further assurances might be needed for the parents/carers and families involved at the time? Is there a case for temporary closure of a nursery in these circumstances?*
- *What further engagement might we require with parents/carers in relation to their knowledge of child protection through public information from the CPC and other sources?*

4.5 The sub group met 5 times during the process to consider the information gathered and emerging themes. The approach taken was to invite closely involved professionals and others to contribute to the learning from this situation and to gather themes from these contributions; it was intended to be an opportunity to consider where systems may be vulnerable and how they might be strengthened as effectively as possible. The sub group agreed some suggestions for further activities, the approach to learning for the CPC and for more widespread

dissemination, and agreed the draft report which was then submitted to the CPC and Chief Officers Group.

4.6 Activities undertaken

4.6.1 Consideration was given to key documents relating to the situation; these included Crown Office/Fiscal and Court documents, records of the recruitment process for M, records kept during the support follow up offered to parents and staff, records of internal disciplinary enquiries, internal policies and procedures, and outlines of training courses.

In addition, key external documents considered included:
Plymouth Safeguarding Children's Board SCR 2010
Birmingham Safeguarding Children's Board SCR 2013
East Sussex Safeguarding Children's Board SCR 2013
Safer Recruitment Through Better Recruitment [Scottish Executive, 2007].
Safer Recruitment Update 2011 Care Inspectorate
National Guidance for Child Protection in Scotland 2010
National Care Standards: Early Years Services
Inspection Reports of G (nursery) 2010 and 2012 and C (nursery) 2010, other SLC inspections, HMIE/Care Commission Inspection 2009.

4.6.2 Interviews [face to face and by phone]
Relatives of children placed in the nursery at the time of M's employment (447 families were again contacted and 5 parents and grandparents took up the offer of an interview with the independent reviewer/or gave comments via the administrator)
Managers who have or had had direct involvement with the nurseries in which M was employed
Senior police officer involved in the enquiry
Senior social work manager and education personnel adviser involved in disciplinary enquiries
SLC external education managers and specialist staff, with direct responsibilities for management and/or support and improvement of the early years service

Care Inspectorate manager
Phone input from college

4.6.3 Education Resources Action Planning Focus Group. This SCR is unusual in that much of the learning is centred on the Council's education service, although the learning itself is applicable to a range of organisations, agencies and settings. Therefore the Executive Director of Education Resources set up a focus group to examine and progress the issues arising. As well as senior education and HR professionals this has initially included the CPC Chair and independent reviewer with further work being progressed under several of the themes emerging by other working groups [e.g. the Residential Child Care service has shared materials on their recruitment and assessment approach so that consideration can be given as to whether some of their processes can be adapted in a proportionate way to some appointments within Education.]

5. Commentary on issues and learning

5.1 Recruitment of staff to work with young children in day care settings, including temporary staff

5.1.1 M was appointed as a temporary member of staff following South Lanarkshire Council's recruitment and selection process. This involved an online application form followed by online "branching" and "screening" questionnaires designed to eliminate candidates who do not meet the essential competencies of the job and add value to the shortleeting process. Thereafter, shortleeted candidates are invited to interview where there are agreed competency based questions put to the candidates. Criteria in the selection process included presentation, interpersonal skills, motivation, and relevant experience. ID is checked and references are taken up and verified.

In M's case the interview was very brief, recorded as 10 minutes. M was scored low by the two interviewers but the decision was initially recorded as to recommend appointment 'with reservations' then revised as two positive references were received, one being from a recent placement supervisor. M had a relevant

qualification and the Enhanced Disclosure check was clear [although this was not recorded on the interview record]. It was noted that he received a copy of the Council Code of Conduct. He then went on to have several temporary and part time contracts in Council nurseries before obtaining a full time permanent post in G.

A key issue here was the brief interview afforded to someone to work directly with young children. There was no concern about the competence and qualifications of the interviewers themselves and it was recognised that the process was compliant with current national guidance which covered basic standards for day care of young children. However, review contributors have reflected that the time taken in the interview was not sufficient to enable dialogue to take place on motivation in any depth. While interviews alone do not present the fullest evidence, a more extensive use of this tool in itself may have illuminated the immediate response the interviewers had about the candidate. It was also noted that reasonable assumptions can be made that by the time a candidate has reached a stage of full qualification, their motivation and relevant aspects of their background will have been addressed, but that in fact it is possible for day care workers not to have had their motivation tested in this way.

After some time working as a temporary member of staff in three Council nurseries, some of this part time, M was confirmed in a permanent, full time post. In hindsight, managers who worked with him felt there was nothing much that would have caused great concern before his confirmation in post other than some perceptions of him being a bit lazy and unkempt. These managers described the continuing distressing impact on them of his betrayal of the children, parents, colleagues and the trust given to him.

Several contributors to the SCR also observed that there were undercurrents about the employment of male workers in pre-school settings which, traditionally have been almost exclusively staffed by women. These are cultural issues which it was felt needed to be tackled through training.

5.1.2 The sub group has considered the guidance document, Safer Recruitment Through Better Recruitment [Scottish Executive, 2007] and the related update in

2011. This guidance states that it does not need to be applied to the recruitment of early years staff but may be useful for employers in this sector. [Section 1, para 7, page 4.] The working group which drew up the guidance did not contain a direct representative from the Association of Directors of Education in Scotland, although a number of early years services are managed or commissioned by local authority education services. It did however comprise representatives from other bodies with experience and responsibility for early years' services. The guidance lays out a Foundation level of standards and encourages organisations to move towards the approaches outlined in Part 2, Higher Level, although it is also stated [in bold type] that employers are not obliged to do so as a result of the guidance. This is in the context of the list of services which are included in the guidance being those provided to some of the most vulnerable members of society and it is not clear why the guidance is reserved about its application. A brief update in 2011 noted that Safer Recruitment was an Inspection Focus Area for the Care Inspectorate during its activities for 2009/10.

The issue of recruitment processes for work with young children was also addressed in the Birmingham SCR and there are a number of parallels in the concerns and recommendations in that report, e.g. over-reliance on a clear criminal conviction check as an indicator of safety; lack of exploration of motivation and values before appointment. It was noted that entry to qualifying courses in early years work does not require a screening process beyond a PVG in order for the student to have direct contact with children in placements. While there is evidence, e.g. from the Care Inspectorate manager who contributed to the review and police contributors, that it is much more common now for police to alert care agencies to concerning behaviours by employees or carers, the process is only able to highlight patterns or incidents that become known. PVG registration is however in itself no guarantee that every relevant incident will be notified to employers.

Recommendations on recruitment:

For SLC: that the education service takes account of the Higher level of the Safer Recruitment Guidance and applies it, where appropriate, to its employees including temporary staff who work directly with children.

Nationally: that the Government carries out a review to update the Safer Recruitment Guidance and considers how the Higher level could apply to all appointments of staff who work with children and other vulnerable people, in the public, voluntary and private sectors, including temporary and agency staff. This Higher level would then be reflected in the requirements for registration and scrutiny by the Care Inspectorate and HMIE.

Areas for further consideration

- that the Council more widely fully considers the Safer Recruitment guidance and how it can be applied, where appropriate, to other staff roles where employees have access to or responsibility for services for potentially vulnerable members of the public.
- Nationally, there might also be more scrutiny of the suitability of individuals to access qualifying courses and of the responsibility of learning institutions to make the interest of children the paramount consideration when allocating places.
- It is recognised that measures which seek to minimise risk cannot completely ensure safety, but learning from situations such as this can be continually shared and applied and should influence recruitmant practice nationally for employees and volunteers.
- This situation illustrates that a perpetrator may use his employment to gain access to children outside his workplace which heightens the need for safer recruitment for employees who would not normally work with children alone or only have indirect access to them. Grooming is not just a process which is carried out on the internet – in this case the perpetrator tried to groom parents he came into direct contact with to gain access to their children.

5.2 Training and awareness of child protection

5.2.1 A number of issues have emerged during the review process about the content and consistency of child protection training for education staff. As is a common structure, there is reliance on briefings to front line staff ‘cascaded’ by senior managers and induction on basic ‘who to report to’ procedures, focusing on parental

abuse. Whereas contributors reported clear knowledge of reporting to and confidence about contacting the social work service when there was a concern about a parent, and experienced their responses as helpful, there was patchy understanding of the dynamics of abusive or harmful behaviours and that could come from colleagues.

Within staff child protection awareness training there was little distinction made between basic briefings on the content of procedures, and training based on experiential adult learning principles. While a Child Protection aide memoire ‘card’, widely distributed to staff, and other procedural documents have content about raising concerns about colleagues with managers, and for managers, about passing on concerns when there is risk of abuse, some managers commented on not having had input or scenario based dialogue on this topic as part of their own training.

There is a systematic mandatory training programme for heads and employees; this is more substantial for heads. However, there are clear weaknesses identified by contributors to the review (not sufficiently scenario based; not covering risks from colleagues/employees) and in its routinised nature (such as a focus on basic annual updates which can encourage assumptions that staff groups already have the knowledge base).

There are inevitable weaknesses in a cascade approach; many heads clearly give this priority while others may not, and within the expectations of education services, heads are expected to take responsibility for this with advice provided from central management. Updated and new guidance and knowledge from reports such as SCRs was disseminated mainly via heads of school/nursery meetings so that the level of onward briefing to other managers and front line staff could depend on the individual understanding and commitment of the manager present at these events and could also omit sufficient discussion on how the issues might affect local groups and services.

5.2.2. Contributors commented that accessing education or multi agency programmed courses could be based on individual responsibility despite the establishment of a twice yearly Performance Development Review system for

individual staff. There were a number of reports of training opportunities not being taken up due to staffing pressures; there was comment on high ‘no show’ patterns on courses. There are examples where staff have not participated in significant training. Some contributors who had undertaken more extensive and /or multi disciplinary child protection training outwith their immediate setting commented on the value of this in ‘seeing the bigger picture’, in hearing about difficult experiences others had faced and learnt from, and how other professionals could help in addressing problems.

5.2.3. There also seemed to be some confusion arising from courses that are part of the ‘Getting it Right for Every Child’ initiative which had been undertaken by many staff and which always draw attention to child protection as a key element of the wider promotion of well being. A careful distinction needs to be drawn so that participants are aware that separate child protection training is also needed

Many contributors noted that most courses did not address discomfort about colleagues or others who were not a child’s relative.

5.2.4 There was some evidence of low level awareness in the early years service of the National Child Protection Guidance [2010] and other relevant publications such as the Plymouth SCB SCR; again the content and quality of briefing seemed dependent on individual managers so there was no assurance for the council as an employer of consistent knowledge of the key guidance in these important documents nor discussion about the implications for individual services.

5.2.5. Although there was comment on the busyness of the service and time pressures which affected access to training and team dialogue, there were examples of nurseries where the managers were clear about their organisational responsibilities to prioritise and use effectively the allocated in service days for centres when no children were present, allocation of time for ‘twilight’ learning sessions, the flexibility of shift systems and the contracts made for staff to attend individual external training. Contributors to the review from other agencies commented that rotas could be used to enable relevant multi agency contributions to courses and in service events. The review also noted that there is a range of

alternative training models in operation within Scotland, e.g. 1 and 2 day courses for child protection coordinators and service managers; 2 – 3 hour sessions delivered on or off site by experienced trainers and that the content and logistics of these could be consulted.

Recommendations on training

- There should be sufficiently in depth mandatory multi agency training for all promoted post holders, such as Team Leaders, Deputes, Heads and external managers/specialists. Within this, prominence should be given to opportunities to discuss exemplars of more complex situations which might arise, and which allows education professionals to experience this opportunity with colleagues who have similar responsibilities in other professions.
- Education Resources should consider how best to achieve effective methods and participation in its child protection awareness training for its early years staff and ensure that staff recognise the importance of this training for a service which is being entrusted with the care of young children. The content and methodology of this should be reviewed to ensure that adult learning principles are used which will encourage understanding of how power dynamics and grooming [such as the abuser in this case used in building relationships] are deployed by those who seek to exploit others.
- It is recognised that such a review may require more intensive resources and therefore the focus should be on training and opportunities for discussion for heads of services. The review also needs to consider how compliance with mandatory training can be evaluated and linked to the personal development process.

Areas for further consideration

Education Resources may wish to further develop child protection training models already being used locally and nationally and considered effective, both for brief awareness sessions and managers' courses.

It may be helpful for all CPC agencies to clarify the difference between training in child abuse awareness with general well being and curriculum training delivered under the GIRFEC umbrella.

The CPC may wish to scrutinise its relationship with individual agencies in this area; whether more can be done to support the use of the multi agency programme; and, whether it covers sufficiently the areas discussed in this section and could be developed to more extensively cover multi agency core training for managers. The CPC should seek to ensure that the national Child Protection Workforce Development programme is brought to the attention of all agencies and agreement reached on how to strengthen consistent multi agency participation.

The Care Inspectorate may wish to consider the evaluation of the actual learning outcomes and impact on cultures of child protection training.

Organisations running or delivering relevant services throughout Scotland should consider whether the content and methodology of their child and adult protection training covers issues such as the possibility of trusted carers and employees being harmful to service users, and the dynamics of grooming of service users, colleagues and staff.

5.3. Management systems

5.3.1 A number of contributors commented on the complexity of the interface between the roles and levels of autonomy of nursery managers, external managers and Quality Link Officers. It was noted that the services provided in these settings had developed from a number of different traditions including professional social support for vulnerable parents; pre-school education; and, substitute child care for working parents. The emphasis in the education service, reinforced by the implementation of Curriculum for Excellence, is on internal autonomy of establishments. This creates a considerable challenge for external and internal managers and specialists in achieving a balance of individual internal autonomy, external accountability and consistency of approaches. [See Appendix 1 for a summary of the SLC education service management and improvement structure]

It was noted that the management team at G had been seen as vulnerable and additional support resources were being provided to them during the time M was employed there. A number of contributors reflected on whether, with hindsight, there had been sufficient focus on the possible impact on the staff group as a whole and thereby on the secure running of the service on behalf of the children. This as an issue that Education Resources is now addressing. The Care Inspectorate senior manager spoken with reaffirmed that they contiunually examine learning reviews such as this, as well as research knowledge, and one of the current interests is in developing methodology to evaluate cultures within organisations.

5.3.2 SLC is a large employer and service provider, and parents and others commented that it would be helpful if the role of external managers and professionals and links to them were made more explicit. Some thought that ways might be found for external managers and QLOs to be more visible to front line staff and parents with the aim of making it more clear where responsibilities lie. A parent commented that you were just grateful when you had to go out to work that you were given a place and this could affect how you might take up issues. Other than helpful individual discussions with some parents on their personal issues, involvement seemed to be based mainly on semi social events, Walking Tours and Curriculum input, rather than parents being part of a structure where they could contribute and be included in dialogue on approaches and protocols, be part of staff selection etc. As recruitment interviews for front line staff often take place in block sessions, it may be worth looking at how a parental influence can be brought into the process.

5.3.3 There was also reflection that whereas the situation with M was an extreme one, situations will arise in which employees have personal stresses that have an impact on them; the mundane type of scenario would be where there is a risk that a member of staff becomes disengaged and even impatient with the children. Appropriate performance and disciplinary policies are in place. Management systems need to be supportive but sound in how these policies are consistently addressed in a solution focused manner; this should be a strength where there is a clear internal to external management link and potential access to specialists such as occupational health officers, that is possible in a large local authority structure. It needs to be reinforced to all staff that they have a responsibility to pass on concerns

they have about any aspect of their work, including concerns about colleagues; in parallel, senior staff must ensure they are accessible to staff and are alert to such concerns being raised.

Areas for consideration
That Education Resources carry out a review of how its management systems can best keep a focus on the paramountcy of the welfare of children, especially where staff issues may have an impact on this.
Consideration is given to how parents might be involved in contributing to the culture and running of centres.

The Care Inspectorate and HMIE may consider interviewing external managers routinely as part of the inspection process in order to explore how issues such as staff dynamics are addressed; whereas protocols for the physical environment and security of nurseries are fairly clear, assessment of the quality of human interactions is more complex. Boards and managers of large day care companies and voluntary agencies may also wish to explore this area.

5.4 Expectations of relationship boundaries in community settings
5.4.1 An issue that was discussed by a number of contributors was that of the challenge of achieving widespread understanding of the need for caution by staff and parents in their personal and professional relationships without imposing overly rigid rules which are then likely to be undermined.

5.4.2.In this situation, it emerged, during the enquiries made, that M had made many efforts over a period of time to develop friendly relationships with colleagues and relatives of children in order to gain trust and thereby direct unsupervised access, for example by taking children out on play activities outwith his work. It was noted that while these efforts were widespread, he also seemed to focus on parents going through a time of difficulty, e.g. illness, when their usual guard might be lowered. He offered to befriend parents on social media; some refused. There were understandable assumptions that because he was employed as a social care worker he could be trusted and would have been carefully assessed.

5.4.3 There was acknowledgment of the challenges of achieving the best balance for this area of concern especially within a community service setting where many staff and parents are likely to know each other. Suggestions for good practice were again, as in the child protection training issue, about ensuring dialogue based on scenarios rather than just imposing 'rules' and encouraging staff and parents to be open about personal situations so that appropriate arrangements could be agreed with managers. An example given was of the mother of a child being the best friend from school of a member of staff and the mutual expectation being discussed in a meeting with the manager and recorded, i.e. that the parents' personal business would not be inappropriately discussed within the staff group and the member of staff would not gossip to the friend about the nursery or staff members.

5.4.4 It was recognised that this kind of approach should include caution on social media use and in aspects such as using parents' business services. However, some staff with strong local connections still found this concept difficult despite the distress caused by these events. It was thought by some that younger staff and parents have grown up with social media innovation, and confident in its use and benefits, were more aware of the possible dangers, not necessarily of abuse, but of embarrassment if there was, for example, unedited use of social media or in encountering social situations. Some managers who were not local and who therefore had separate social networks were much more comfortable about the need for clear boundaries. A strength was that some parents resisted M's approaches to befriend them; this reinforces the value of national public awareness messaging and also that parents need to be involved and empowered in contributing to the culture of organisations.

Area for consideration

That SLC and other organisations look at best practice in establishing relationship boundaries. Policies need to establish a clear expectation that employees will be transparent, declaring where they have external contacts and interests, and that there will be discussion of particular situations with managers, establishing an organisational dialogue which encourages an understanding of the need for caution. Organisations should ensure that parents and other service users are aware of these policies.

5.5 The complexity of raising concerns about colleagues and managers

It emerged during the enquiries, both by the police and internally, that several staff had raised issues of discomfort with internal managers about some of M's behaviours at work. These had not been discussed further with external managers or taken up with M directly, and there were issues in the recording of them. It was felt that the response to these was confused with assumptions that others were being discriminatory about male workers. The kind of examples were of M not using gloves when changing nappies, and closing toilet doors when with a child. There was also a report of him blowing on a child's body. The examples raised were mainly ambiguous and not necessarily directly indicative of possible abuse intentions, but, as police contributors noted, they were about the breaching of protocols that were about protection and hygiene and should have been acted on on that basis. As noted in the Birmingham SCR and other relevant reports, overall laxity in organisational cultures can mean that abusers are aware that they have more freedom.

As these issues were not raised with external managers by the internal management team, it is not known what response would have ensued, nor what response would have been given if the workers who had expressed concern had gone over the heads of their own managers. Most concerns noted by the managers who knew M, even in hindsight were about perceptions of laziness/scruffiness and it would have been very difficult for the front line workers to have decided to use whistle blowing protocols when they had already been given a view about possible discriminatory attitudes.

In regard to more clear cut issues, police contributors shared information on resources such as Safecall, which enable those worried about situations to use alternative avenues of expressing concern.

Area for consideration

This issue links with the previous discussion on training, boundaries, local cultures and management systems and the recommendations and areas for further consideration noted there. It may be useful for national bodies, in looking at the barriers to disclosure and the sharing of discomfort by children and adults, including professionals, to consider how difficult it is for people to 'whistle blow' even when

they observe behaviours that are fairly clear cut; to take account of power dynamics in these situations; and, of fears of receiving a ‘shoot the messenger’ response.

5.6. Support and liaison mechanisms set up in response to events

The police informed the most senior Council officers about the impending arrest of the offender and a senior liaison group was immediately set up to enable communication, assist with the police enquiries and plan responses for children, parents and other staff. Events unfolded quickly and became public knowledge, attracting the attention of local people and the media around the same time as parents could be given information on what was known and able to be shared at the time. The senior liaison group continued to meet regularly and the Council professionals were trusted by the police and legal systems to the extent of being able to be involved in supporting communication by the Fiscal to affected relatives. The Council also quickly set up a support team and service for staff and relatives, which offered regular and flexible advice and counselling sessions from two professionals at a time, mainly within the nursery setting, but able to use other locations. Efforts were made to contact parents in the other nurseries in which the offender had worked. Written materials on crisis response were also available. The personnel in this team included specialist education resources staff, managers not connected to the nursery, educational psychologists, social work and health professionals. The team itself met weekly to share issues and support each other. Professionals spoken to in both these liaison and support teams commented on the great support given to them by their colleagues in covering their usual work.

Issues that were raised were understandable ones; initial anxiety of parents that their child may have been abused, frustration and anger about the uncertainty of this, concerns about the possible interpretation of their child’s behaviour. For staff, there was great distress about the betrayal of trust and being associated with someone who had behaved in this way. It was noted that there was a low absence rate among the nursery staff following the events and also that despite their distress, most parents expressed positive views about the nursery.

Area for consideration

National bodies and other agencies may wish to consult SLC about the mechanisms of this crisis intervention response should they find themselves in this kind of situation of which they may have little previous experience.

6. Concluding Overview Comments by SCR chair

Whilst most of this review focused on South Lanarkshire Council's Education Resources, the Child Protection Committee considers that most of the learning is relevant to all agencies, voluntary and statutory, providing services for children.

One of the most disturbing aspects of this case was the way in which the perpetrator seems to have set about building up his ability to access children over several years through his career path and the way he created opportunity to abuse children by befriending parents he met through his work: he groomed parents in order to get to children. As the review brings out, this has implications for recruitment on to training courses and into employment, for child protection training, for the alertness of management to the possibility that this could happen and for all involved to be receptive to any concerns raised by parents or colleagues.

Whilst recognising that no systems can completely safeguard against determined and devious individuals, the review makes specific recommendations in respect of recruitment for South Lanarkshire Council and for Scottish Government and advises that these should also be considered by all other agencies providing services for children. This case illustrates the need to be particularly focused on those who work in relatively junior or ancillary roles and who may have less direct one to one contact with children but who could use the opportunity provided by their work setting to make contact with children outwith their employment. This risk is heightened as most of these staff will not have been through the more rigorous professional training and assessment which, for instance, would be the case for social workers, health visitors and teachers.

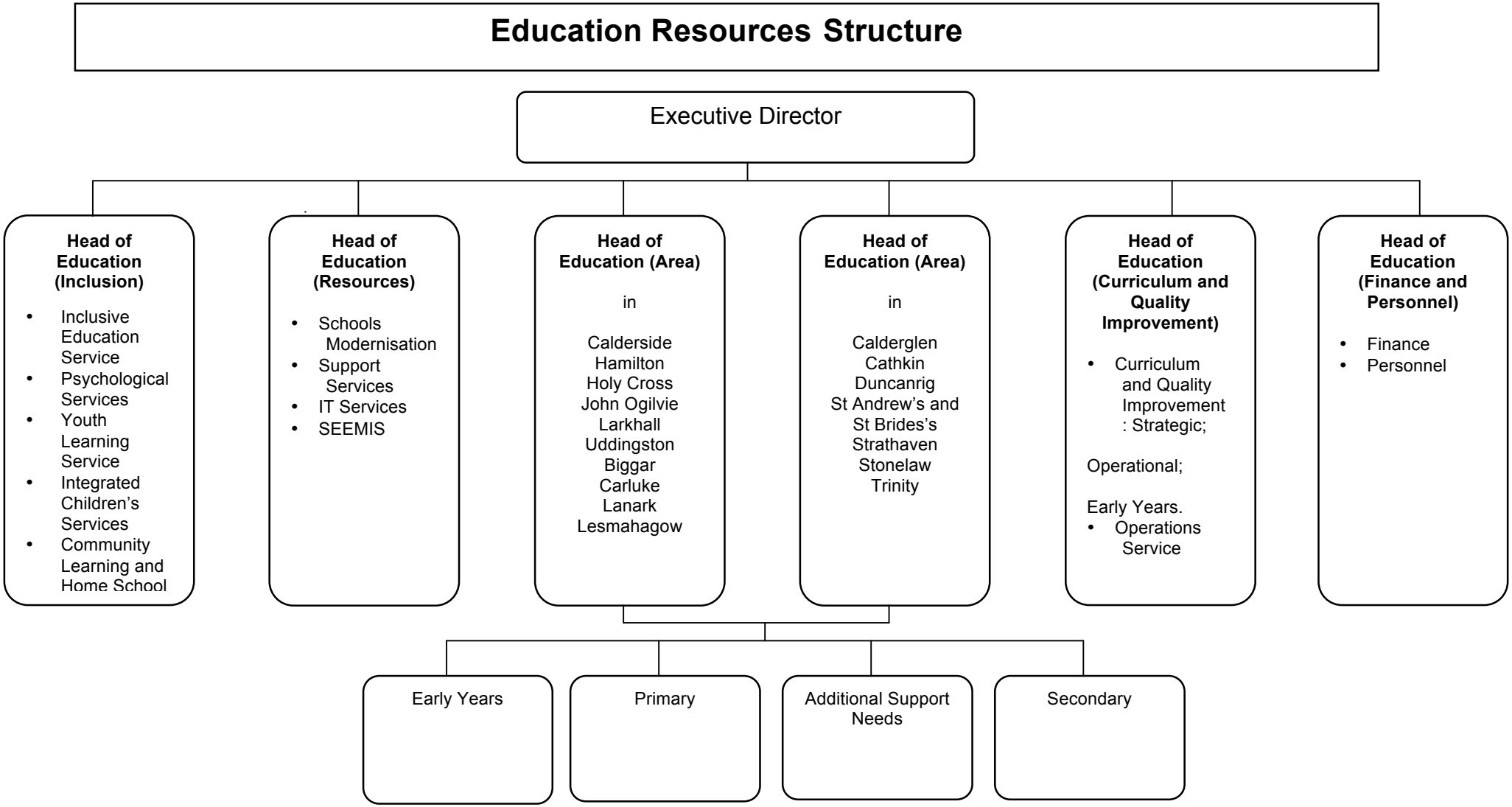
The CPC will take on board the recommendations for training and work with local agencies to ensure that this is followed through in South Lanarkshire and communicated to the wider child protection network.

The review does bring out some positive aspects of the way this case was dealt with from which learning should also be taken. The police operation, using intelligence and technology, which would not have been available even a short time ago, effectively brought this individual to justice before even worse was perpetrated. Though there was inevitable frustration for families involved that some information could be not be released for fear of compromising the prosecution process, it is clear that police, prosecutors and education management worked very closely together to ensure support and counselling was made available as soon and as effectively as possible.

It is distressing that any child should suffer the sort of abuse which occurred in this case and totally unacceptable that this was perpetrated by someone employed in a caring capacity. All who have been involved in this review feel acutely betrayed by the individual concerned. It makes us all determined to take on board the learning from this review and to continue to do our best to improve services for children.

Appendices

1. Summary of SLC Education service structure



Information for Organisation Chart

All establishments have access to support from a range services depending on the matter being discussed:

Head of Education (Area)

- Line management of establishments within Learning Communities
- Wider management issues such as personnel/budget/IT
- Parental enquiries as appropriate
- Liaison with elected members

Curriculum and Quality Improvement Service

- Support for the curriculum
- Establishment improvement planning
- Quality assurance
- Support for inspection
- Parental enquiries as appropriate

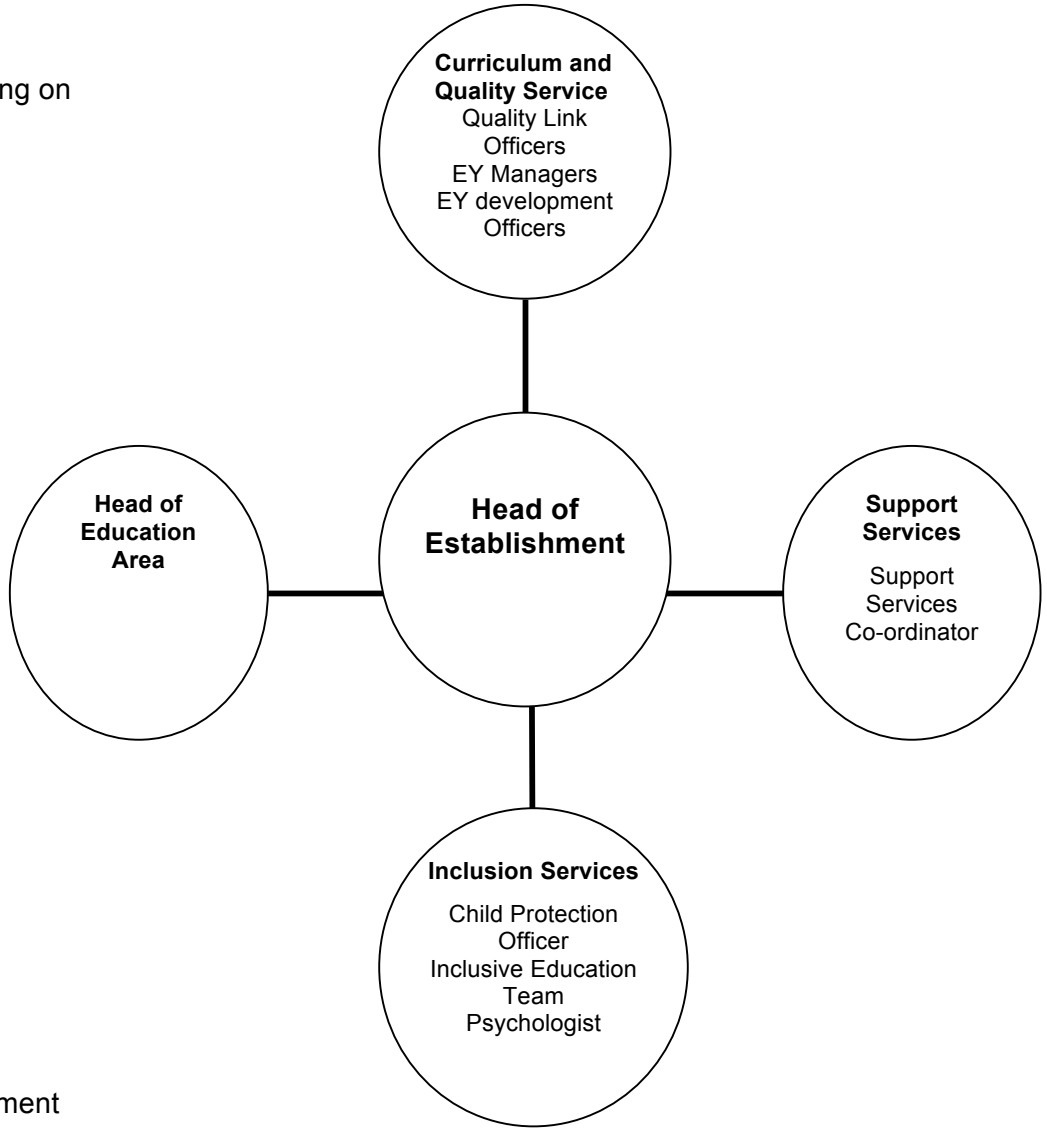
Inclusion Services

- Child protection
- All aspects of additional support needs planning
- Parental enquiries as appropriate
-

Support Services

- Risk management
- Day to day management of Support Staff
- Property matters
- Support for finance and procurement
- Parental enquiries as appropriate

Heads of establishment with a concern are encouraged to speak to their line manager or the appropriate officer. If in doubt, the head of establishment should seek advice from any head of education or manager who will advise them of the appropriate route to progress the matter.



2. Summary of issues addressed in relation to the Terms of Reference

- *What lessons can be drawn from reflecting on the management arrangements within the nursery and externally? Are there lessons to be learned about how parents are involved when there are concerns about their children and is there an organisational understanding that sometimes the concerns may relate to issues in the nursery and not in the home?*

Addressed in 5.3

- *How can system wide capacity for managing risk in individual establishments be strengthened? Possibly considering:*
  - *Council policies and procedures including any lessons from the way the individual was recruited* ***Addressed in 5.1***
  - *Specialist or senior officer support for the work of establishments* ***Addressed in 5.3***
  - *The role of the Performance Development Review process and associated professional development programmes in informing and strengthening practice standards; the nature and frequency of training, to ensure staff actively engage* ***Addressed in 5.2***
  - *Whether more needs to be done to facilitate staff and managers being able to raise concerns about colleagues and these being followed up.* ***Addressed in 5.5***
- *What further assurances might be needed for the parents/carers and families involved at the time? Is there a case for temporary closure of a nursery in these circumstances?* ***Addressed in 5.6/the decision to keep the nursery open was taken by the Council in consultation with the police investigators, and enabled continuing routine for families and a hub for support and enquiry activities.***
- *What further engagement might we require with parents/carers in relation to their knowledge of child protection through public information from the CPC and other sources?* ***The awareness of some parents of public messaging would seem to reinforce the value of further information, including reassurance on how and with whom to raise concerns.***
- *Could clues have been picked up from the knowledge of agencies in relation to individual children or practice at the nursery or from concerns*

raised by parents about their children's behaviour? ***Did not emerge as an issue***

- *How can we continue to improve support for parents, carers and families who have suffered a trauma?* ***Addressed in 5.6***
- *How well did services and agencies work together in response to this case and what lessons can we learn from this experience?* ***Addressed in 5.6***
- *How can we further build public and parental confidence in the early years sector?* ***Addressed in recommendations***
- *Can advice to employees regarding personal and/or non-service-related contacts with families be strengthened?* ***Addressed in 5.4***

3.References

HMIE.gov.uk.

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NCERCC, 'Selecting the Best Staff' Recruitment toolkit, 2006
Safer Recruitment 2007Sciswis.com [Care Inspectorate website]

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Scottish Executive, Interim Guidnace for CPCs on Conduction a Significant Case Review, 2007

4.**Extracts from NSPCC Inform [www.nspcc/inform.co.uk] summaries of recent comparable reviews**

August 2013 - **Birmingham - Case No.2010-11/3**

Serious sexual assault of a toddler, Subject Child, by an early years student and staff member, the Perpetrator, at a nursery in Birmingham in 2010. Knowledge of the incident came to light following an accusation by a 13-year-old girl of online grooming in January 2011. Examination of the Perpetrator's computer revealed a number of child abuse images, including videos of the assault against Subject Child. Issues identified include: recruitment and screening procedures; staff supervision; organisational safeguarding practices and policies; management and team culture; inspection and complaints procedures; and early identification on online sex offenders by police.

Recommendations include: effective recruitment processes that explore motivation and value base; balancing physical environments in nursery settings between a respect for privacy and reducing opportunities to abuse; rigorous inspections of early years settings that examine the implementation of safeguarding policies and procedures; and effective communication across the three relevant arms of the Local Authority: Early Years, Local Authority Designated Officer and Children's Social Care.

Nurseries, child sexual abuse, staff supervision, organisational safeguarding procedures

December 2013 - **East Sussex - Child G**

Abduction of a 15-year-old girl in 2012, by her teacher, Mr K. Child G was involved in a sexual relationship with Mr K, which began around her 15th birthday. Mr K was found guilty of abduction and admitted a number of charges of sexual activity with a child under 16-years; he received a custodial sentence of 5-and-a-half-years. Identifies serious concerns relating to school's actions, including: failure to identify the abuse and exploitation of Child G; fixed thinking; failure to hear concerns raised by students; failure to involve Child G's mother; insufficient recognition of Mr K's inappropriate use of Twitter to communicate with Child G; and serious concerns with the ways in which information was recorded, stored, retrieved and provided for the review.

Identifies procedural failings in police handling of allegations relating to inappropriate images of Mr K on Child G's phone.
Makes various interagency and single agency recommendations covering: East Sussex Local Safeguarding Children Board, children's services, school and police services.
Grooming, social media, fixed thinking

If you need this information in another language or format, please contact us to discuss how we can best meet your needs.

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