Torbay Safeguarding Children Partnership

Child Safeguarding Practice Review

Child 'C80'

Independent Reviewer: Sarah Lawrence
Date Completed: August 2021

Contents

Introduction and Context for the Review

This Child Safeguarding Practice Review was commissioned by Torbay Safeguarding Children Partnership (TSCP) in response to the requirements of statutory guidance issued by HM Government; *"Working Together to Safeguard Children: A guide to inter- agency working to safeguard and promote the welfare of children."* (July 2018) [1].

Summary of the case

On 29th July 2019 at the age of 16 years old, a Torbay looked after child[2], known for the purpose of this review as 'C80', was arrested on suspicion of rape of a 3-year-old. This incident took place at the nursery that C80 worked as an apprentice. Police carried out a detailed review of CCTV footage from the nursery and found evidence of further sexual assaults by C80 towards children within the nursery. A sibling of C80 subsequently disclosed past experience of rape by C80. On 25th October 2019 C80 was charged with 3 counts of rape and 13 of sexual assault by touching. A trial took place in May 2021 and C80 was found guilty of all charges. C80 was given a 14.5-year sentence in July 2021.

The Review

Following the incidents a referral regarding this case was made to Plymouth and Torbay Safeguarding Children Partnership (PTSCP) for consideration of a case review. The National Child Safeguarding Practice Review Panel were notified and PTSCP carried out a rapid review on 28th November 2019. Following this and further debate with the National Panel regarding the type and level of review that should take place, it was agreed that a Local Child Safeguarding Practice review should take place led by the newly created Torbay Safeguarding Children Partnership (TSCP) which replaced the previous joint arrangement with Plymouth.

Working Together 2018 recognises that child protection in England is a complex multi-agency system involving many different organisations and individuals. It states that reflecting on how well the system is working is an important part of the collective effort to improve responses to children and families, including when serious harm or death is experienced, to identify lessons that can be learned at local and national levels. Child Safeguarding Practice Reviews such as this provide a way that this can be achieved.

The intention of this review therefore is to identify learning for local and national systems to prevent future similar harm, and to further safeguard and promote the welfare of children in similar situations to this case. The purpose of this review is not to apportion blame on individuals or organisations or to hold them to account. As Working Together states: "*Reviews should seek to prevent or reduce the risk of recurrence of similar incidents. They are not conducted to hold individuals, organisations or agencies to account, as there are other processes for that purpose,*

[1] See: https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/942454/Working_together_to_safeguard_children_inter_agency_guidance.pdf

[2] Under the Children Act 1989, a child is legally defined as 'looked after' by a local authority if he or she:

- gets accommodation from the local authority for a continuous period of more than 24 hours
- is subject to a care order (to put the child into the care of the local authority)
- is subject to a placement order (to put the child up for adoption).

including through employment law and disciplinary procedures, professional regulation and, in exceptional cases, criminal proceedings".

The circumstances that led to this review are complex and, while of no consolation to the victims and their families, ultimately very rare. Serious sexual harm has been experienced by children that are most vulnerable by their young age. Sexual abuse is immensely traumatic for victims and their families, in this case those who had entrusted their children to the care of a nursery that they put their trust and faith in to nurture and protect them. The right and primary purpose of this review is to identify learning that could potentially prevent similar future abusive situations occurring. In the process of delivering this review, careful consideration has been given throughout to keep to this purpose while at the same time avoiding any unintended consequences that may impact negatively on the outcomes for young people that are care experienced and also victims of past abuse themselves.

Review Themes

This review is based on a number of thematic areas agreed by TSCP. These were drafted reflecting on the range of complex factors and perspectives involved in this case, the concerns and questions raised by parents of children attending the nursery and findings of previously undertaken local reviews of the case. The themes that follow aim to encompass the range of systematic issues involved in this case:

C80's Background and Experiences

- To review multi-agency case record relating to C80 to identify any pre-existing information and learning relevant to this review.
- To consider what information relating to C80 could or should have been shared with his employer from other organisations.
- To identify examples of good practice as appropriate in C80's case history.

Recruitment & Apprenticeship

- To identify if safe recruitment practices were in place and undertaken in the nursery and for an apprenticeship.
- To establish whether the nursery identified or were made aware of any concerns about the employment or work of C80 and if so, the effectiveness of responses.

Supervision & Oversight

- To evaluate the nature and quality of supervision and management oversight provided to all staff in the nursery.
- To establish whether there were particular supervision arrangements for apprentices in the nursery including access to individual children.

Safeguarding Practice

- To establish how matters of concern were identified, recorded, and responded to in the nursery, including CCTV oversight and monitoring.
- Review this response against local and national guidance regarding; whistleblowing, safeguarding policy / procedure, designated safeguarding lead responsibilities and safeguarding training.

Response to Alleged Incident/s

- To evaluate the work that was undertaken following the allegations in this case first coming to attention by local statutory partners and national regulators.
- Establish the quality and timeliness of responses and whether all relevant lines of enquiry were properly and fully pursued

- To understand and evaluate the response of the Day Nursery's Regulator (Ofsted) to being informed of the allegations that centred on the setting.
- To identify and assess the timeliness and effectiveness of the actions Ofsted took following being made aware of the allegations, whether local safeguarding agencies were properly involved and how they impacted upon the safety of children.
- To evaluate the timeliness and effectiveness of information sharing with parents and carers, giving due consideration to any legal constraints that prevent communication.

Local / National Learning

- To identify all points of learning arising from this matter and highlight any implications they have for national and local policy and guidance, strategic or operational management and front-line practice.
- To evaluate the local safeguarding partnership's response to the alleged incident, identify what immediate actions have been taken to identify local learning and how this has been implemented across the partnership.
- To identify any learning in relation to the timeliness of decision making in relation the type of review to be commissioned.

Methodology

This review uses statutory guidance and best practice models for reviews in its methodology. There were limitations to the activities undertaken for this review given it coincided with the Covid-19 pandemic, national lockdown and while varying levels of social distancing guidelines were in place. This meant that there had to be significant adaptations. The review consisted of:

Timeline

A comprehensive multi agency timeline was created covering the time period of review, summary information was also provided for any significant events outside the agreed time period. This document formed the foundation of the review and enabled the reviewer to explore and analyse key events and responses relating to them.

Review Panel

A multi-agency review panel was convened to support and guide the progress of this review as well as to implement any learning as swiftly as possible once identified. The panel comprised:

- Independent Reviewer
- Independent Chair
- Torbay Council Children's Services (incorporating Children's Social Care, Education and Early Years)
- Devon and Cornwall Police
- NHS Devon CCG
- Torbay Safeguarding Children Partnership Business Unit.

Engagement with Practitioners and Organisations involved

The Independent Reviewer sought to engage a wide range of practitioners with direct case involvement with C80 and his family in Torbay. This included practitioners from all safeguarding partner agencies (local authority, police, health) as well as those involved in C80 care, education, apprenticeship, and employment. Ofsted engaged in this review, sending detailed information relating to the case, input to the review timeline and via meetings with the reviewer. This related to their direct involvement as the regulatory authority for childcare providers.

While the process for engagement with practitioners and organisations took a different approach to that which would have been ideal in a 'non covid' situation, the information provided has been of great value to the review process. It was often difficult for those invited to participate given the

circumstances and emotions attached to the case. It is of credit to Torbay as a partnership that all those invited to did participate in an open, transparent, and learning focussed way.

Engagement with Families of Children Attending Nursery

Parents and carers of children that attended the nursery, including parents that were directly impacted as a result of the abuse to their children, were notified of this review by TSCP (via Police). Parents were invited to engage in the review process once the trial was concluded given some were called as witnesses. The reviewer met with 12 parents / carers; this took place online in 8 meetings including meetings with more than one parent present. Parental insights on the case and in particular their perspectives on learning for safeguarding partners in terms of responses to the abuse and support given to them, has been of immense value to the review. Given the extremely difficult circumstances surrounding this case the value of this should not be underestimated. Their insights have informed the analysis in relevant sections of this report.

Engagement with C80 and Family

C80 and family members were notified of the review taking place via their lead social workers. All were invited to contribute following the conclusion of the trial.

C80's eldest two siblings were keen to meet with the reviewer and did so with their foster carer present. Their views and engagement have provided a number of hugely valuable insights into learning that have been included in this report.

The reviewer sought to engage C80 in the course of this review. Initially, the review process and purpose was outlined in writing and discussed with C80 via his key worker, pre-trial. Following the trial, C80's contribution and engagement was sought via his key worker/s again, and a number of options for ways to engage were presented. Unfortunately, engagement was declined by C80.

Similarly C80's mother and aunt were offered opportunities to engage in the process but declined to participate.

Where records of independent advocacy meetings with C80 were apparent and recorded in case files, these are reflected in relevant sections of this report with the aim of reflecting C80's voice in the review.

Document Review

Relevant documentation was provided to the reviewer, this included:

- A comprehensive multi agency timeline based on time period of review
- Local partnership case records and information
- Meeting records
- Local safeguarding policies, procedures, and processes relevant to the time period of review, including within the nursery
- Ofsted early years criteria and procedure e.g. serving welfare and suspension notices relevant to time period
- Communications between TSCP and the National Child Safeguarding Practice Review Panel

Two quality assurance reviews had previously taken place within TSCP and the Local Authority to identify any immediate learning to action from this case. These were carried out by independent people prior to the commissioning of this CSPR, a summary report of one of these has been provided.

Time Period

It was agreed that the review would focus on the period of 1st December 2014, the date that C80 and family move to Torbay, until 17th June 2020, the date that the national panel agreed a local review should take place. The reviewer also requested summary background and contextual information outside of this period in the course of review to analyse as relevant.

Review Context

In person, face to face meetings with the reviewer were not possible because of the Covid 19 pandemic and subsequent restrictions. This meant that those directly impacted and traumatised by the circumstances of this case, including parents of children from the nursery, practitioners and family members had to be approached in less ideal ways. It was also not possible to have 'in person' group meetings with practitioners to discuss practice and learning. Much of the engagement activity was carried out with individuals and remotely due to the pandemic, using secure online meetings, telephone, and email exchanges.

A decision was made by the Review Panel with advice from the Police Senior Investigating Officer, not to approach those that may have been called as witnesses in the criminal trial until it was completed. This was to ensure no interference with evidence. The trial was delayed for a number of reasons including related to the pandemic and this affected the timescale for conclusion of the report.

Reviewer Experience and Independence

Sarah Lawrence is an independent safeguarding and domestic abuse consultant with experience of case reviews concerning children and adults. She has no previous involvement with the case under review or the services involved.

Key Events and Analysis

The table below gives a brief outline of the key events reviewed for this case. An analysis of these events follows.

Summary of Key Events

Year	Key Event
2007	C80 disclosed experience of rape by mother's ex-partner. Alleged perpetrator found not guilty.
2014	C80 family move into Torbay area, children subject to Child Protection Transfer in conference details neglect, maternal mental health, domestic abuse, C80 experience and indicators of past sexual abuse also described. C80 abuse of sibling occurs (disclosed in 2019)
2015	C80 abuse of sibling occurs (disclosed in 2019) C80 and siblings become looked after (first foster care placement) following a police protection order. Initial Health Assessment for C80 takes place Referral for physical and mental health services support C80 alleged to have added bleach to foster carers shampoo and toothpaste bottle, concerns regarding continued influence of mother. Full care order granted. Court psychologist recommendations made Placement change 1; move to second foster care placement.
2016	Therapy started with private therapist with foster carer in attendance Risk management meeting – following disclosure of experiences of abuse and entering other children's rooms. Placement change 2; as result of concerns for carer health, return of male carer to home and C80 behaviour issues Therapy suspended due to placement change Placement change 3; C80 request as a result of allegations against foster carer regarding assault to C80
2017	Missing episode results in mothers arrest / caution under Child Abduction Legislation Series of short missing episodes C80 mother gives birth to fourth child Placement Change 4; move to residential care setting
2018	C80 employed part time in a bar / restaurant C80 finished school, applied, and enrolled in college course "Introducing Caring for Children and Young People Level 2", includes placement at preschool setting A needs assessment takes place following C80 asking for sleepover at a younger girl's house and disclosure of massage being paid for by an older woman College concerned about attendance, attitude and completion of work and commence disciplinary procedures Multiple missing episodes occur Section 47 meeting occurs as a result of concerns relating to behaviours & risk posed to C80 C80 regularly intoxicated, an ambulance is called on one occasion due to him being nonresponsive
2019	C80 leaves college following disciplinary procedures relating to behaviour and attitude to learning Placement supports C80 with applications for work based childcare apprenticeships. C80 attends trial session at a nursery and then becomes employed as an apprentice DBS is completed and returned satisfactorily Apprenticeship commences Missing episodes occur C80 describes a behaviour management concern with a child in nursery IRO concern raised ref lack of allocated social worker and plan 4 references requested by nursery – 1 satisfactorily returned C80 nursery probationary period extended due to incomplete references Further missing episodes occur

	Abuse in nursery reported to nursery and police by victim's family Police investigation commences Ofsted visit nursery and issue 'improvement notice' C80 sibling discloses experiences of rape by C80 at a younger age, to his foster carer Local 'Gold' and 'Silver' command meetings begin to take place Police investigation and review of CCTV reveals further incidents of abuse by C80 in nursery A helpline is set up by partners to coordinate enquiries Rough handling by 2 additional members of staff, with witnesses, identified on CCTV Ofsted & nursery staff review CCTV. Relevant members of staff are suspended Ofsted serve a 'welfare requirement notice' to the nursery Further incidents of sexual abuse by C80 are identified in CCTV footage by Police Ofsted suspend nursery registration C80 arrested for further offences C80 charged with 3 x rape and 13 x sexual assault offences C80 placement change Ofsted interviews with staff raise further concerns regarding safeguarding culture of the setting Independent review of partnership responses takes place National Child Safeguarding Practice Review (CSPR) Panel discuss case Local Rapid Review of case occurs, CSPR agreed Parents raise questions relating to the case via a self-organised parent group Ofsted interview with nursery directors raises further concerns
2020 (to June)	Ofsted notifies the owners of the nursery of their intention to cancel registration Nursery owners resign their resignation National CSPR panel notify of intention to deliver national review of case Support offer to parents is reviewed by partners Police respond to parent group questions C80 pleads not guilty at crown court National CSPR panel notify of a change in decision re national review due to Covid.

Pre Torbay

1. A summary of information was requested from Gloucester Children's Services who had worked with C80's family in his earlier years. This information indicated details of anal rape experienced by C80 shortly after turning 5 years old. This is alleged to have been perpetrated by C80's mothers' ex-partner who was also the father of C80's sibling. Health and Children's services information from this time indicates evidence of physical harm concurrent with C80's experiences of the sexual abuse that is described, the impact of this on C80's health, including bowel incontinence and soiling is also detailed. Following a trial, the alleged perpetrator was found not guilty.

2014

2. C80's family moved to Torbay late in 2014 and within a month, a transfer in Child Protection Conference took place with input from Cornwall (the preceding local authority) children's services department. Records from this conference detail a number of issues of concern including mother's mental health, the children's low school attendance, concerns regarding children's safety in the home and neglect. C80's experience of sexual abuse (while in Gloucestershire) and the health impacts of this were described as part of the handover of information. It was decided that the family should be placed on a Child Protection Plan. Plan review meetings took place over the coming months and the children remained subject to child protection planning with neglect as the primary reason. Records suggest at this time that there was a poor relationship between C80 and his siblings, who reportedly felt threatened and bullied by him. C80's siblings contributed to the review process describing violent assaults by their brother at this time. C80 experiences of soiling are also reported, as are declines in C80's behaviour at school. Bullying of C80 at school is also referenced as a factor. A

referral for Intensive Family Support to address issues was made however there is no evidence of interventions taking place.

3. Advocacy records suggest that C80 was concerned about his home environment and his dissatisfaction with services involvement in his life. C80 also describes his ambition to be a marine biologist at this time.
4. The abuse of C80's sibling, by C80, took place during 2014 and 2015. In a victim statement his sibling describes the impact of this:

   "Whilst I was being abused, I felt nervous and embarrassed as I was being humiliated in the worst possible way by someone I trusted. I felt I had no power or help. I was isolated and alone and felt like I was living in a cage and unable to get out. During the entirety of this time, I lived in a constant state of fear from abuse and rape everyday. I wasn't allowed to go to school or socialise as I was unable to leave the house. I felt scared of [C80] as he had a temper and was violent towards me, both physically and emotionally. I feel let down by the adults and professionals who were in my life during that time.

   My days would consist of waking up in the same bed as [C80]. I would spend the days in a haze and then every single night for years, I would have to endure this abuse by my brother. All of my days were the same, and I would always dread what was to come at the end of the day. My trauma has caused me to block out a lot of memories from this time in my life, but what I do remember vividly is a constant feeling of shame and embarrassment about what was being done to me; this is something I still carry with me today and probably always will. I would consistently have nightmares which led to me waking up, feeling unable to breathe and in a state of anxiety".

5. The abuse was not known or suspected by practitioners or carers involved with the family until 2019, after abuse at the nursery was reported, when it was disclosed by the sibling to his foster carer.

2015

1. C80 and his siblings were removed from mother's care following an Emergency Protection Order being granted, this was as a result of a visit which found the children padlocked in the home. There were also further multi agency concerns regarding neglect and unsafe home conditions. C80 was placed in foster care with his siblings. C80 is regularly described at this time as in 'low mood' and expressing feelings of anger and anxiety. He continually protested the need for care and expressed a strong feeling that he and his siblings should return home to their mother. Case records reference C80's continued and recurring bowel incontinence.

2. An Initial Health Assessment (IHA) was carried out by a specialist doctor in child health. C80 did not attend all of this assessment, leaving at the start of the appointment. Records from this IHA describe lack of knowledge in terms of C80 past health history. Because C80 was reported to be having issues with soiling and hygiene a referral was made to the Bladder and Bowel service by letter. In this letter, the doctor describes soiling as well as 'long standing difficulties in the past of neglect and adverse home situation', it does not refer to C80's alleged sexual abuse experiences, suggesting this was not known by the doctor. Searches of medical records at this time do not indicate this information was used in the IHA. The letter also suggests that the Bladder and Bowel Service should contact C80 social worker for more details of his experiences. This also indicates a letter had also been written to a worker from the Child and Adolescent Mental Health Service (CAMHS) to enable a joint approach.

3. An appointment was made with the Bladder and Bowel Service. The service describes that at this appointment, also attended by C80's foster carer, they were unable to gain any history of C80's issues and as a result *'advised the foster carer to ask the social worker to contact the clinician for further information'*. It is not clear if any follow up was carried out or attempts to gain this

information were made by the service, by the doctor, or the carer, and C80's referral was subsequently closed two months later. It is the view of panel members and the reviewer that this was not an appropriate course of action, or good practice and should have at least led to written follow up by the health services involved. No further specialist interventions took place in relation to this issue, and the problems continued in the following years as demonstrated in this timeline, until 2018. A later psychologist report (at the time of a Full Care Order being granted) describes this issue and its impact. The report refers to a possibility that C80 *'unconsciously chooses to ignore this area of his body as a post traumatic response to anal penetration'* which leads to *'both the incontinence and his difficulty in accessing treatment'*.

4. At the point of the IHA, a letter was also written to a CAMHS worker seeking advice for C80's foster carer regarding his soiling, alluding to an '*emotional cause'*. The letter states that C80 had already been referred to CAMHS by another route. The referral led to some initial support for C80 and his foster carer, however the intervention was not of a therapeutic nature as the CAMHS practitioner was not clear this was the right time for therapy and indicates that they were also aware that other therapy was in process.

5. In advocacy, C80 presents at this time again as frustrated and angry about being in care, describing a wish for more contact with his mother and a dislike for the placement that he is in.

6. Shortly after this, C80's placement changed following an incident where C80 had placed bleach in the foster carers toiletries, in particular their shampoo bottle. This incident caused injury to the foster carer. The influence of C80's mother in this was discovered after C80's foster carer read messages between C80 and his mother seeming to influence C80 to disrupt the placement. Records therefore linked this incident to continued contact with his mother and highlight concerns about mothers ongoing influence over C80. There is no evidence that this then informed risk assessments or further contact arrangements.

7. A Full Care Order was subsequently granted for C80 and his siblings. A psychologist report produced as part of this process suggested that long term psychological therapy was required for C80 given it was "*quite likely he has a level of PTSD as a result of the sexual abuse he experienced*" and indicating that C80 "*should be assessed for difficulties such as Conduct Disorder".* There is no evidence that this assessment was undertaken. The psychologist in her report also suggested that C80 behaved *"as if he has been in charge of the two younger children*" and that C80 would benefit from *"singleton foster care placement in a family where there might be older children only and with an experienced carer"*.

8. C80 was subsequently separated from his siblings, with supervised contact in place. At the following CLA (Child Looked After) Review it is reported that C80 had settled in well at the placement, and the plan was for C80 to remain there as a long term foster care placement.

9. At this time C80's sibling explained he had thought that their separation was due to knowledge of the abuse C80 had perpetrated against him rather than any other incidents such as bleach in shampoo, or instructions from court. He'd felt at the time that professionals had discovered the abuse, however there is no evidence that this was the case at this time and he recognises that this was not the case describing to the reviewer; *"If I'd been asked, I'd have told them, I thought it was normal. I didn't know how to lie and would have said".*

10. In his victim statement, C80's sibling describes clearly his feelings at this time as:
"Once [C80] and I were separated and placed into foster care, the trepidation I had been suffering for the past years had finally subsided and I felt a level of relief".

11. C80 was reported to have been regularly attending school at this time. School reports many behaviour issues involving C80 throughout the period, described as disruptive and anti-social behaviour, rudeness, bad language, and physical fights with other students. Sanctions were used as a result including periods of isolation and detentions.

12. C80's siblings also moved placement at this time. Both siblings and their foster carer describe a level of physical fighting between siblings at this point, that they explained to the carer had been the way they had also been treated by C80.

2016

13. Therapy was arranged for C80 via Children's Services as a direct result of the psychologist recommendation, and this commenced. C80's experience of sexual abuse was not communicated as part of the referral to the therapist. In engagement with this review, C80's therapist suggested this was unknown until he disclosed his experience within the sessions to the therapist, and to his foster carer. Shortly after this disclosure, the carer raised concerns to Children's Services regarding C80 posing a 'sexual risk' (this is the language recorded in files from the time). Information available to the reviewer indicates that this related to C80 entering other children's bedrooms and removing items. There is no indication in information presented to this review, that any other behaviour was present or that C80 presented a risk of sexual harm at this point.

14. A meeting was held as a result, described in records as a 'Risk Management Meeting'. The meeting concluded that there were unfounded concerns, and no sexual risk was present. Despite this conclusion, the foster carer proceeded to place sensors on all bedroom doors and the term 'sexual risk' remained on C80's case file in relation to this incident.

15. Further analysis of this event has taken place including discussion with practitioners, reflections from partners and a further review of records. It is evident from this that concerns followed on from C80's disclosure of sexual abuse in therapy (with the foster carer present) rather than any indicators being present of harmful sexual behaviour from C80.

16. Approximately 6 months after this event, C80's placement with the same foster carer ended. Information submitted to the review suggests that the sole female carer had developed additional health needs and had put in a request for additional funding to enable the male carer to become a joint carer for C80, this request was refused. At this point the carers had described *"difficult behaviour [by C80] that had not been seen or raised before"* to social workers, including shouting, swearing, and stealing money from another foster child. C80 had also become distressed as a result of being told he was not going to be returning to the care of his mother. Case records from Children's Services suggest that the level of disruptive behaviour reported at this time did not warrant the resources requested for an additional carer. Carers served notice of their intention to end care for C80, shortly after and prior to a permanency panel at which it was expected C80 would have been permanently matched to these carers. It is not clear what support package, if any, was offered at this time to the carers.

17. This placement had offered a level of stability in C80's life and that the sudden placement breakdown that occurred had a detrimental impact on C80's wellbeing. C80 is described as '*tearful and confused*' when being told by a social worker that his placement had ended. Therapy was suspended at this point due to the placement ending, it was not restarted.

18. In advocacy records from this time, C80 is reported to be feeling very low in mood, frustrated and angry, stating he is not interested in talking to anyone. C80 continued to harbour the wish to have more contact with his mother.

19. At C80's next placement, allegations were made by C80 against the carer regarding a physical assault that took place on a holiday abroad. This resulted in a police and a Local Authority Designated Officer (LADO) investigation, and section 47[3] enquiries also commenced. C80, and another foster child, were subsequently moved to new placements. No further action was taken against the carers due to the incident taking place outside UK jurisdiction. Section 47 enquiries also concluded that physical abuse was unsubstantiated.

2017

20. Early on in this year C80 was reported missing by his foster carer. C80 had been taken to school by taxi but never entered school on that day and instead was taken by his mother to a train station where he took a train to stay with his maternal aunt in another county. C80 was found two days later at this address. C80's mother was arrested and cautioned under the Children Act 1989 – abduction of children in care legislation[4]. Two further short episodes of going missing took place at this time, both related to arguments with foster carers about freedoms while on holidays away from the home.

21. C80's placement changed once more and C80 was placed with a residential care setting that provided intensive 1-2-1 support for children. Records from this time do not evidence the rational for this move to a higher level of support, nor is there an assessment of need evident that led to this. Records do indicate however, that this was not a planned move and was considered only once C80's current foster carers had given notice of the previous placement ending. A number of participants in this review suggest this was more based on the need for a placement of some kind rather than C80 having any specific individual care or support needs that warranted this level of support.

22. Throughout this year, C80 again demonstrated his distress at his care arrangements and a wish for increased contact with his mother and siblings. He again reiterated a desire to return to the care of his mother. In advocacy C80 describes feeling settled in the 1-2-1 placement, suggesting some things were better than foster care, however, is concerned about the level of 'rules' in place, lack of freedom and a wish to go out more.

23. Termly Personal Education Plan (PEP) meetings took place for C80. Generally, records of these reflect a positive picture of C80 in terms of attainment and behaviour. C80 was credited with work regarding food technology, and it is referenced that he had won a local award for this. C80 views were fed into initial PEP meetings, indicating that he found school rules more difficult to keep to and that he preferred practical lessons. He later went on to describe how he *'likes nothing about school'*. C80 suggests at this time thoughts about his future career being marine biologist. Later this changes to Chef and then more recently a primary school teacher or career in health and social care.

24. Information in files held by school from this time indicates an increase in negative behaviour episodes. Episodes are described by school as; damage to property, dangerous behaviour, failure to cooperate, disruption in lessons, fighting with other students, kicking, and hitting doors and making inappropriate remarks. Sanctions are carried out for C80 in school including attending the school's behaviour centre. It is evident that school were aware of the links between C80 behaviour escalating and key negative events, such as C80 being told he couldn't return to his mother's care. School representatives participated the PEP meetings, however there is no indication in the information reviewed that the full range of behaviour episodes recorded by school were discussed, noted, or

[3] Section 47 of the Children Act 1989 (reasonable cause to suspect a child is suffering or likely to suffer significant harm)
[4] Section 49 of the Children Act 1989 Abduction of children in care etc.

actioned as part of these meetings and therefore these do not feature in multi-agency plans that may have identified ways to work restoratively with C80 to address his behaviour.

25. At this point, C80 started part time employment at a pub / restaurant near to his placement. This was seen as a positive influence in C80's life at this point.

2018

26. In the early part of this year, C80's mother gave birth to C80's youngest sibling. Case files show that consideration was being given to C80's return to mothers care at this time. C80's mother then advised practitioners that she could not look after C80 due to the new baby. It is not clear how this potential option for C80's care was being assessed, and there is no evidence that describes how information about this situation was communicated to C80 at this time. It is clear from previous indications of reactions to this topic that not being able to return to his mother would have been devastating to C80.

27. Life story work[5] with C80 was discussed, with his Community Care Worker (CCW) during this year, while C80 was 15-16years old. Attempts to carry this out were not commenced until later in the year given C80's preparations for GCSE exams. C80 later refused to engage in any exploration of his Life Story work. The need for this intervention is referenced a number of times from 2015 onwards within the timeline for this review, including alongside referrals for therapy or CAMHS interventions but was never completed. Information suggests that C80 did not want to engage with practitioners at all on this topic, particularly in his adolescent years. At times throughout the timeline of this review it is evident that professionals deemed it was not the right time for this intervention to be carried out, it is unclear when the right time would have been deemed correct to pursue this further with him. NSPCC describes the importance of Life Story Work: *"Children and young people who are in care or adopted may have little understanding of why they don't live with their birth parents, the reason for them entering care and events that took place in their early lives. This can have a negative impact on their emotional wellbeing and self-esteem. Life Story Work aims to help children in care begin to understand and accept their personal history".* Ofsted describes the issue of timeliness in its inspection report of Torbay in 2018, stating; *life story work starts too late in the process for children to learn and understand about their birth family and history".*

28. This experience of lack of life story work was echoed to the reviewer by C80's sibling and their foster carer. Importantly, it was felt by both the sibling and carer that had this been undertaken in a timely way it may have given opportunity for his abuse to have been disclosed to a practitioner much earlier.

29. Information within the timeline for this review suggests there were 5 different social workers allocated to work with C80 in the year 2018/2019. This followed a period of 2 years of relative stability in terms of his lead professional. Some consistency remained in place during this period because of a male Community Care Worker (CCW) that was also engaged in support, providing welfare visits and consistent 'role model' to C80. The CCW describes a positive relationship with C80 up until later in 2018, when the relationship changed following delivery of Return Home Interviews (RHI's) by the CCW. RHI's are a statutory requirement where children go missing from care[6], it is

[6] For more details see statutory guidance page 14
https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/307867/Statutory_Guidance_-_Missing_from_care__3_.pdf

recommended in national guidance that these are delivered independently. The workers perception was that completing multiple RHI's shifted C80's perception of him from providing a supportive role to a more punitive / statutory intervention.

30. The context of services for children in Torbay, including care experienced children, are reflected in findings from Ofsted inspections. It was at this time that an Ofsted inspection revealed deep rooted and long-standing problems across the Children's Service, leading to a second consecutive judgement that the services overall effectiveness was inadequate. Ofsted findings demonstrated serious and widespread concerns, including about child protection. Their report from this time states:

    Children's services in Torbay are inadequate. Some improvements have been made, but not enough, and all judgements from the 2015 Ofsted inspection apart from the adoption judgement are unchanged. The quality of practice ranges across and within services, from areas showing serious weaknesses, such as fostering, to pockets of strong, focused work, such as early help. Overall, the pace of change has been too slow and some recommendations from the previous inspection are not met. Fundamental weaknesses remain in management oversight and supervision and in identification of and response to risk, as well as workforce development and capacity…..

    ….The quality of social work practice is adversely affected by frequent changes of social workers, all of whom are dealing with a range of complex cases. For example, visits to some children do not adhere to recommended timescales….

    ….Too many children in Torbay do not enjoy meaningful and consistent relationships with social workers due to the considerable turnover of staff…..

31. Inspectors subsequently also reported in monitoring visits on 1 February 2019 and 8 May 2019 that while subsequent restorative actions were showing some signs of progress, improvements were fragile, and children were still not considered to be consistently safeguarded. They documented findings of continuing serious weaknesses in management, practice and quality assurance arrangements and expressed concern for the (lack of) pace of change and the debilitating impact of staff turnover which led to social workers having to 'fire fight' rather than use their skills to work intensively and constructively with children.

32. During this year and on turning 16, C80 was eligible to receive the support of a Personal Advisor (PA). There is no evidence that this was offered to C80 until he reached the age of 18 and after the abuse took place. There is also no evidence that any challenge was made regarding the lack of PA at any point during this year by those involved in his care. Statutory guidance[7] states:

    "The PA acts as a focal point for the young person, ensuring that they are provided with the practical and emotional support they need to make a successful transition to adulthood, either directly or through helping the young person to build a positive social network around them. All care leavers should know who their PA is and how to contact them. Throughout their transition to adulthood and independent life, care leavers should be able to rely on consistent support from their PA, who is the designated professional responsible for providing and/or co-ordinating the support that the young

7 https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/683701/Extending_Personal_Adviser_support_to_all_care_leavers_to_age_25.pdf

person needs. This includes taking responsibility for monitoring, reviewing, and implementing the young person's pathway plan".

33. Pathway plans were in place for C80 during this year however there is no evidence to detail how these were being implemented or monitored as part of care planning or within other multi agency arrangements. There is a possibility that the reason for this is linked to the instability and changes of social worker for C80. A challenge was made in terms of the lack of Pathway Plan in 2019, via a Dispute Resolution Procedure from the Independent Reviewing Officer (IRO) to Children's Services however it is unclear what action this resulted in.

34. Part of a PA role, if in place, would have been to "*aid in support and advice on a range of issues relating to leaving care including access to training and employment opportunities"*[8]. A PA could have therefore provided further support to C80 in deciding future career and education plans.

35. C80 was in his final year at school, and he applied to a local college to study "Introducing Caring for Children and Young People Level 2". At this point, a regional careers service became involved in assisting C80 with next steps as a care experience child. Information contained in the timeline for this review from this service suggests that C80 stated he would be interested in employment or university and possibly becoming a Primary School Teacher.

36. Following his application a 'Risk Assessment' meeting was held by the College. The purpose of the assessment meeting was to consider students' needs where necessary because they are care experienced or require further pastoral support. In this meeting C80 was recorded as 'LAC' indicating his care experience was the reason for the meeting rather than any concern about his behaviour and being enrolled on a course of a childcare nature. This is reflected in the actions which relate to ensuring support from College and attending the next PEP meeting for C80. There are some headline discussions regarding C80's course choice and behaviour noted in the meeting records, this does not lead to any further analysis. It is stated that C80 is *"adamant he wants to do the childcare course….He has done really well with food at [school]".* It is noted that *"staff believe he chose a course that may allow him to somehow move home"*. An incident of behaviour issues is raised by the school pastoral lead at this meeting, relating to a chair being thrown across a classroom, linking this to C80 recently being told that he couldn't return to the care of his mother. No concerns are raised at this meeting regarding any risks in terms of his enrolment on the course.

37. Records of a PEP meeting that followed this assessment notes good transition work between school and college and discusses C80's plan for college. At this point in time, C80 also attended his Review Health Assessment, and it is reported at this that he is generally well engaged, his wish to study childcare is noted.

38. In the autumn term, C80 was enrolled on to the childcare course. As part of enrolment, college advises that it is a requirement for students to complete a DBS (disclosure and barring service)[9] check to enable their attendance at a childcare placement later in the term. C80 did not complete this within the correct timescales and as a result this was logged as stage 1 of the College

[8] IBID.

[9] The Disclosure and Barring Service helps employers make safer recruitment decisions 8by processing and issuing DBS checks for England, Wales, the Channel Islands and the Isle of Man. DBS also maintains the adults' and children's Barred Lists and makes considered decisions as to whether an individual should be included on one or both of these lists and barred from engaging in regulated activity.

Disciplinary Procedure. During this term a PEP meeting took place. This noted that the DBS had since been completed successfully, with no indications of any concerns coming from the check.

39. In this same PEP meeting, the course tutor suggests C80 is challenged by time management skills and planning. A worker from C80's residential setting contributed to the meeting referencing concerns about C80's recent behaviour and his contact with mother. It is noted in the meeting that there was a discussion about whether childcare was the right course for C80 given his *"love of cooking and his part time work in the hospitality industry"*. The instigation of disciplinary procedures at college was not noted as being discussed at the meeting. No coordinated multi agency action is described to respond to the issues raised in this meeting, and there is no evidence of monitoring actions taken or how this would be communicated to influence C80's plans.

40. Shortly after, C80 and his residential care worker discussed a relationship that C80 had with the younger sister of a college friend. This was first discussed in terms of some friendship issues that had come about as a result of the relationship. C80 told the worker that the girl was 14, at this time C80 had turned 16. C80 later requested to stay overnight at the friend's house. The worker discussed this in detail with C80 explaining issues that may arise with sleeping over, given his girlfriend would be there and her being under the legal age of consent and the impact this could have if there were any concerns. C80 suggested he would be staying with both of the siblings as friends only. As a result of this being raised, a number of detailed conversations took place between the placement worker, C80, his social worker and CCW. A parent of the girl was also contacted, and it was agreed that this sleepover would not take place. The parent later suggested they were happy for C80 to sleepover as long as on the sofa downstairs, it is unclear if any such stays occurred. The consensus of practitioners at the time was that this episode related to C80 struggling to move between childhood and adulthood and to understand the complexity of sleeping over. There is no evidence that any sexual intention was indicated by C80 or suspected at this point.

41. C80 also suggested later, to his residential placement staff, that he had an older female friend, aged 23, that he met at his place of part time employment. He suggested that this female had given him a full body massage that he had paid for. The detail of this was shared with C80's social worker and subsequently followed up with the female friend that had been mentioned. On investigation, it was established that C80 had overheard a conversation regarding massages between the female and an older male member of staff at C80's place of work. Case records indicate this incident, along with the earlier discussions regarding relationships and friendships, was recorded as a 'potential sexual risk'. On exploration of this terminology in case files, it is clear that this refers to risk posed to C80 relating to his suggestions of paying for a massage with the older female, rather than risk he posed to others.

42. Following this, partners continued to be concerned for the safety of C80 given reports of behaviour decline and an increase in episodes of C80 going missing from care and college. C80 behaviour is said to have further declined at this point. He is described to have been vaping, consuming alcohol and being generally reverting to being '*non-compliant*'. C80 is reported at this time to be working long hours at his part time job resulting in him often falling asleep in class, and not attending some classes at college. As a result of this, the college move him to stage 2 of their disciplinary procedures. Within disciplinary meetings C80 is offered alternative options for learning which he is reluctant to engage with.

43. As a result of recent events with C80, a multi-agency strategy meeting then took place to discuss escalation in concerns. In this meeting C80's social contacts, work and attitude to college life are explored in detail. Contacts with, and the influence of his mother are noted within this. C80's potential vulnerability to exploitation by other is noted as this had been flagged following police analysis of missing episodes. His behaviour is described as being linked to transition to adulthood and adolescent development. A number of actions are listed as a result of this meeting to respond to

the concerns, however there is no evidence that these were followed up or that they informed pathway or care plans for C80 beyond this meeting.

44. Shortly after this strategy meeting, C80 started his college placement at a local pre-school setting. This involved attending one day per week for 6 weeks. C80 attended the setting as an induction, presented his DBS and was shown around in his first visit. In subsequent weeks C80's attendance was described as sporadic. When in attendance at the setting, C80 is described as acting like 'a child himself' . The setting advises that on occasion they used similar disciplinary measures to manage C80's behaviour as they would have the young children in the setting, this is described as very unusual. C80's behaviour is said to be of an immature nature rather than anything that would indicate any risk to children at the setting and no concerns of a sexual risk were apparent to the staff. It is not clear if behaviour concerns were feedback to C80's course leader from the setting or how this was assessed as part of his course. The setting leader advised they had at this time, placed responsibility for safe recruitment procedures for students on placement with the college, requesting sight of DBS only as a result.

45. C80's safeguarding file was sent from his school to college approximately 2 months after he enrolled on his course, and after he had begun his placement. School and college advise that this was usual procedure at the time, and that files were transferred only on request. Contributors to the review suggest that improvements to this process have now been made, and that transfer of information where there are safeguarding concerns, students require additional support or have identified needs is much more timely.

46. C80's missing episodes continued throughout this period, with some extending overnight, occasionally taking place following shifts worked at a local pub / restaurant. C80 is noted to have returned to his placement on multiple occasions "*visibly under the influence of alcohol*", advising that he had been out with friends and then had gone to his mother's house. On repeat occasions C80 refused to disclose his whereabouts while he had been missing leading to suspicion about his mother's involvement. Descriptions of these episodes suggest that practitioners were concerned about his mother's influence, specifically in terms of his alcohol use. On one occasion, the placement worker directly contacted C80's mother to warn of consequences of C80 not returning home, resulting in his immediate return. Return interviews regularly took place between C80 and the CCW as described previously, however no evidence suggests how information from these then informed the future planning for C80.

47. College soon moved C80 to stage 3 of their disciplinary procedures for behaviour and attendance. This is the final level of disciplinary. C80 was then absent for further class sessions is reported to not be regularly attending his childcare placement at the preschool setting.

48. Missing episodes continued, again with C80 regularly said to return intoxicated. Staff at the pub C80 worked also reported a noticeable change in behaviour advising placement staff that C80 was not always turning up for shifts at work. On Christmas day of this year C80 is reported was as missing after not returning from his workplace. C80's placement staff were advised by the pub C80 was asked to leave as he had been taking drinks from the bar. C80 had then presented at another residential care setting and been refused entry due to being drunk. C80 was collected by a worker and is described as being heavily intoxicated. An ambulance was called due to him being nonresponsive. C80 recovered once paramedics arrived.

2019

49. The early part of this year commences with further missing episodes and C80's dismissal from his childcare course at college following final disciplinary procedures. C80 did not attend the final disciplinary meeting however it was attended by a care worker from his residential setting. College suggest that they would be in contact C80 to discuss his enrolling in a 'Courses to Careers' course to

enable a lower-level childcare qualification and to complete Maths and English courses. This was refused by C80, stating a preference to begin a work-based apprenticeship. C80 was subsequently withdrawn from college.

50. A CLA review took place shortly after C80 withdrew from college, C80 was not in attendance. A summary of this meeting suggests concern regarding a change in C80's behaviour, use of alcohol and missing episodes alongside the end of his time at college. Concern was raised that C80 may be at risk of CSE as it is unclear who he is spending time with. Despite concerns there is no evidence that actions were agreed including any plans to assess this risk further. It was noted that the Pathway Plan was out of date with a completion date set of one week. An IRO dispute resolution was raised regarding absence of a Pathway Plan however this was not followed up and remained out of date for at least a further 6 months.

51. C80 was provided support with next steps in his career by his placement and the regional careers service supporting with interview preparation and requesting updates on progress. C80 expressed a wish to continue with a career in childcare that was more practical than academic, and an apprenticeship was agreed as the best option.

52. Workers at C80's residential placement assisted him to make speculative approaches to approximately 8 childcare settings in the Torbay area. C80 was subsequently offered two interviews and attended both. C80 expressed a preference to his placement worker for the setting that had a smaller number of children and that was not part of a larger chain. As a result, C80 was invited to attend a trial shift at the smaller setting, and to visit to the nursery to size up a uniform and carry out ID checks. C80 is said to have commenced employment at this nursery 4th March 2019, as evidenced in C80's employment contract.

53. In terms of a suitability assessment for the role, nursery advise that this was delivered via the above trial shift / *'second interview'* that included members of the wider staff team. Nursery advises this review that C80 impressed them at this first interview stage because of his personable approach and experience of caring for his younger siblings. C80 is said to have spoken of his aspiration to become a primary school teacher and his hope that the apprenticeship was a pathway to this. At recruitment stage it was unknown to the setting that C80 was a care experienced child, and this would not have been expected to have been disclosed by C80, as explored in later sections of this report. Nursery expressed to the reviewer that they had held a keenness to employ male members of staff to enable a gender balance and positive role modelling for the children at the nursery. Male applicants were described as rare, and this meant they were pleased when C80 approached the nursery for employment.

54. The nursery safeguarding children policy states that: *"we abide by the requirements of the EYFS[10] and any Ofsted guidance in respect to obtaining references and suitability checks for staff…..to ensure that [those] working in the setting are suitable to do so".*

55. The EYFS statutory guidance details the requirements for providers to check suitability of those present in the setting stating that: *Providers must ensure that people looking after children are suitable to fulfil the requirements of their roles. Providers must have effective systems in place to ensure that practitioners, and any other person who is likely to have regular contact with children*

[10] EYFS: Statutory framework for the early years and foundation stage, see: https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/596629/EYFS_STATUTORY_FRAMEWORK_2017.pdf

*(including those living or working on the premises), are suitable…*and…..*Registered providers other than childminders must obtain an enhanced criminal records check in respect of every person aged 16 and over (including for unsupervised volunteers, and supervised volunteers who provide personal care).* This statutory guidance does not require any further checks in terms of suitability or pre-employment checks, nor does this detail any statutory duty on settings with regards to obtaining references.

56. Local TSCP guidance on Safer Recruitment suggests pre appointment checks and references should be undertaken and an offer of employment should be conditional upon, among other items, *receipt of at least two satisfactory written references, where possible confirmed by telephone*, as well as a satisfactory DBS disclosure.

57. References were requested by nursery from C80's part time employer and his college. The nursery's 'safe recruitment of staff' policy states that *"successful candidate[s] will be offered the position subject to at least two references from previous employment or in the case of a newly qualified student, their tutor and a personal or professional reference. These references will be taken up before employment commences".*

58. A reference was sought from C80's part time role in a pub / restaurant on 8th March 2019, this was returned on 20th March 2019 satisfactorily. Nursery advise that this detailed C80's *"good work ethic and reliability"*. This was positive about C80's suitability for work in a position of trust and with children. Information available to the review suggests a reference from the college was requested on 21st May 2019 via email. This is two months after C80 is said to have commenced employment and is therefore outside of the statement made in the settings safeguarding policy and also is not within the spirit of TSCP's local guidance. The email from the setting to the college states:

    The above-named has recently started an apprenticeship at [X X Nursery] as a Trainee Nursery Practitioner and has given us your details as a referee. We would appreciate your views on his suitability for this position. We would be grateful if you could complete the attached form and return it to within the next week. References are a statutory requirement for working with children and young people, so we really appreciate you taking the time to complete the reference request. If you wish to discuss this request further please contact us on the number below.

59. On 13th June 2019 college responded to the reference request to say that they are *"unable to give a character reference for [C80].. however with [C80's] permission could confirm dates enrolled at the college. If you have any further questions, please do not hesitate to get in touch".* It is not evident that any contact was made between the nursery and the college to follow up on the reasons for this lack of character reference. College representatives have advised the review that they declined to complete a full reference due to C80's immaturity and attitude to learning rather than any risks they had identified or were concerned about in terms of his suitability to work with children.

60. On 15th July 2019, over 4 months after C80 commenced his employment, a reference was requested from C80's secondary school via email. This was responded to on 18th July 2019 with school returning an incomplete reference form and C80's attendance and academic record. Sections on this form relating to C80's suitability to work with children were left blank. The form was signed and dated. According to the school, the reason for this was twofold. Firstly, a key part of the reference form asked them to comment on their willingness to employ / reemploy the candidate, the school representative has indicated being unable to respond to this due to C80 being a student rather than a previous employee. School also advise that the reason much of the remaining form was left unanswered was due to the time that had passed since C80 was a student (having left the previous academic year) as well as their experience of C80's previous behaviour and attitude. They indicate this was not in relation to concerns regarding any kind of sexual risks more a concern based on his behaviour record while in school.

61. School also acknowledged that it had been some time since C80 had left school and that a reference would have been better taken up with C80's further education provider, it was unknown to them that this had been previously attempted.

62. Concerns regarding C80's behaviour and attitude to learning were not communicated by the school or college as referees. Nursery were therefore not made aware of this. In explanation for this to the reviewer, School express concern about giving negative references and how this may be in contravention of data protection legislation including GDPR. It is also not evident, that any follow up took place to explain this gap, and therefore concerns expressed by school to this review were not highlighted to nursery at the time.

63. The reviewer is aware that nursery also attempted to gain a reference, by phone, from the preschool that C80 had attended for placement while in college. A number of missed calls / answer phone messages are reported between the two settings however a direct conversation did not take place and a reference was not completed. Had this contact been successful, the setting indicates a similar reflection as given by college and school, regarding C80's behaviour as well as his immaturity would have been given.

64. C80's probation was extended on 31st May 2019 due to the lack of a satisfactory second reference. Notes from that meeting and nursery records suggest this was the only reason for the extension.

65. C80's apprenticeship training was arranged by the nursery with a private provider that they had previously used. This provider was not part of a Local Authority 'approved' apprenticeship provider list. The apprenticeship involved coursework, testing and tasks as well as a number of visits by an assessor to observe practice and child interaction. C80 reported in a meeting with his assessor that he preferred to be more practical and struggled with coursework. In the time that C80 was employed at the nursery the assessor visited on site on 4 occasions between 23rd March 2019 and 16th July 2019.

66. C80 is recorded as having supervision within the nursery on 3 occasions during his employment, with a probationary meeting also taking place. Nursery policy states that apprentices would be offered supervision every month. Supervision is recorded in C80's personnel file as first taking place on 25th March 2019. Records show a discussion regarding C80 sitting on the floor with legs outstretched, a comment that C80 should `...*say where you are going before leaving the room*', as well as a need to not encourage children to get *'hyped up'*. In further supervision dated 14th June 2019 there is a comment that C80 had' *completed all training*', and that observations and a change of room / age group had been very positive. The third supervision is undated, with little detail of issues discussed or action to be taken.

67. During this time, C80 is alleged to have threatened a member of placement staff before leaving for work one morning. This was reported to C80's social worker at the time, with follow up related to an allegation made by C80 against a member of placement staff rather than this. In a further incident two months later, C80 is reported to have shown threatening behaviour relating to frustration that a game with a higher rating to his age had been taken away. This report indicates use of a shovel to attempt to open doors and break into the placement office and also the smashing of a glass. C80 is reported to have become distressed and emotional following this incident. C80's social worker was informed of this at the time. No records have been presented to this review to suggest follow up , risk assessment or any detail as to how this was responded to.

68. During this period C80 continued to have missing episodes, on one occasion spending time with his maternal uncle at his mother's home. The uncle is said to have been known by services to be an unsafe adult. C80 suggested his uncle was *"off his head on coke"* in a text message that was later

found by staff, to his mother. This information was passed to C80's social worker, subsequent action taken involved discussion with C80's mother to prevent further unsupervised contact. A request was made for C80 to have contact with his maternal aunt which it was suggested would be assessed. Concerns regarding alcohol use continue to be apparent in records from this time.

69. On 9th May 2019, C80 was asked by a placement worker about how he was finding his role in the nursery. In discussion, C80 described that on that day, a child he did not like so much had jumped on him and that he had pushed the child off. The pushing action was demonstrated by C80.
The worker explained consequences of this kind of reaction and C80 was advised he should speak to senior staff at the nursery if he felt overwhelmed or frustrated, as he needed to ask for assistance and 'time out' to get back to positive practices.

70. The issue was discussed with safeguarding leads at the residential placement the next day. It was decided that the nursery should be told C80 was "*struggling with the behaviour management of one child"* and also that the social worker should be contacted. The placement worker then contacted the nursery to discuss behaviour management without mentioning the act of 'pushing' of a child. Nursery advised that behaviour management would be discussed with C80, and support would be put in place. C80's Social work team (via the duty line) were also contacted, they were advised that another conversation would take place with C80 that evening. The placement worker suggested it was possible that C80 may not have 'pushed' the child. The social worker suggested that the nursery should be told the full information once the next conversation with C80 took place, particularly if the conversation identifies that pushing had taken place.

71. The following evening a different placement worker discussed the issue with C80 explaining potential seriousness and impact. C80 reacted angrily and became verbally abusive to the worker, stating he did not know why this would get him into trouble and that he would never hurt a child. C80 stated that he had not actually 'pushed' this particular child but instead that he would sometimes 'like to push' this child. No follow up information is available to suggest any further assessment of this incident, or discussions with nursery or social worker occurred on this matter.

72. On 31st May 2019 C80 discussed his probation review with his placement worker, suggesting that this went well and that he needed to improve one point only which was to gain a second reference, given the nursery had not heard back from his previous college.

73. On 4th June 2019, C80's Independent Reviewing Officer (IRO), raised a concern within the Dispute Resolution Procedure regarding the lack of an allocated social worker, progress of assessments relating to C80's contact with mother and lack of Pathway Plan.

74. On 5th June 2019 during an advocacy appointment, C80 discussed the above concerns in terms of being allocated a social worker, but decided not to raise a complaint. C80's engagement with health assessments and reviews was encouraged and noted to be also out of date. C80 states to his advocate that *"it feels like they've given up on me"*, referring to the local authority.

75. A number of missing and absent episodes occurred at this time. On 10th July 2019, which is the day that the first incident of abuse by C80 is recorded as taking place, C80 is reported as missing given he did not return to his placement after working at the nursery that day. C80's mother is contacted by the placement to check his whereabouts, they are informed that C80 is in mothers home, and he will return. C80 did not return that evening and attended work the next morning, 11th July 2019, the date of a further incident of abuse at the nursery. On collection from work that day, C80 is reported to have been hyperactive having drunk energy drinks. Placement also report concerns about his diet, smoking habit and hygiene. C80 is also reported to have been working at his part time job immediately after his nursery work, often arriving home late at night. It is not clear how these

concerns were raised with children's service or partners involved in his care planning, or what follow up action to resolve these issues was agreed.

76. At this time, C80 is said to have requested a move to more independent placement which was said to be in progress at this time. C80 is said to have been frustrated at the pace of this change in care.

77. On 22nd July 2019, C80 fell ill at work and was collected from work at the nursery early. On this date C80 was advised that he would be moving to the more independent placement. C80 returned to work on 24th July 2019, on this date, 4 incidents of abuse in the nursery by C80 are recorded. C80 also spent his first night at his new placement on this date.

78. A CLA review took place on 25th July, C80 did not attend this meeting. A summary of the review suggests that C80 is more settled however C80 is described as *'not looking after himself'* and again, wanting more contact with his family. It is not clear what actions were agreed as a result of these points.

79. On 28th July 2019, C80 advised his placement worker that he has received a written warning from his part time job following what he describes as *"a few days of sick and haven't been putting enough effort in".*

80. On 29th July 2019 at approximately 4.30pm, a parent of a child attending the nursery telephoned to report an allegation of alleged abuse against their child. This report named C80 as the perpetrator, advising the child had disclosed he had changed the child's clothes that day and put his nipple in her mouth. The parent stated that the word *'nipple'* was used instead of penis in their household.

81. One of the directors of the nursery took the call and asked for this information to be repeated to C80's room leader. Both Designated Safeguarding Leads (DSL)'s, including the co-owner of the nursery were also notified. C80 was suspended in the light of this. At this point he was advised of the details of the allegation, including the detail regarding the use of the word 'nipple'. C80 then returned to his placement and advised them of his suspension.

82. The nursery owners attempted to contact the Local Authority Designated Officer (LADO) for advice on the matter, however the LADO was not available due to the time of day being after working hours. Nursery reported to the reviewer that no other advice was available and that they were not aware of what should happen in this situation, therefore a report to police was not made at this point.

83. At approximately 6pm both parents and a grandparent of the victim attended the nursery to seek further information about what had and would be done. The family were advised that C80 had been suspended. The parents requested sight of the location of the incident and were shown the toilet facilities. Reflections on this meeting suggest there was a level of understandable tension between the nursery owners and the family. There was a sense of disbelief from the owners that this could have happened.

84. A grandparent of the victim then reported the abuse to Police at approximately 7:15pm. This was the first report to the Police. Police subsequently attend C80's previous placement address, not being aware of C80's recent move, followed by attendance at his new placement address, arresting C80 at approximately 10:15pm. C80 was then taken to a Police station where he was assessed by health and mental health practitioners, no concerns were identified. Evidence was gathered from C80 and later from his placement. An 'Appropriate Adult' for interviews was identified from a local service that was independent from the case.

85. Ofsted records suggest they were notified of the allegations made by the nursery director / DSL on 30th July 2019. Ofsted contacted the LADO and were advised that a strategy meeting was to take place. The LADO raised a concern to Ofsted about the settings management of the allegation.

86. On the same day, a multi-agency strategy meeting took place to consider next steps, all safeguarding partners were represented at this meeting. The actions agreed included planning for the victim to attend the Sexual Abuse Referral Centre (SARC[11]) and for an Achieving Best Evidence (ABE) interview to take place with an intermediary.

87. It was also agreed that liaison with the nursery should occur, and that contact should continue with the LADO. Police also requested that C80's mother should be notified of the sexual element to the allegations without full details being disclosed, this was suggested with a view to ceasing any contact between C80 and other children in the family. In addition, it was agreed that a risk assessment and management plan would be undertaken with C80 at his placement.

88. At this meeting the nursery became aware of the full details relating to the issues that were discussed on 9th May 2019, particularly that this had indicated C80 had pushed a child. Nursery were surprised at this detail coming to light, confirming that this information had not been passed to them within conversations that were had at this time.

89. On this date, the nursery sent a communication to parents of children that attended the nursery. This stated the incident involved one person and was believed to be an isolated incident, that this person was arrested and was in police custody. The communication also indicated that '*safeguarding remains our highest priority*', indicating a police log number and that families could contact the Police non-emergency number should they have any concerns. This also asked that families refrain from posting any details of the case on social media or online to prevent any speculation having a detrimental impact on evidence for any potential case.

90. A number of parents advise that they sought further information from nursery regarding this and particularly with regard to the reference to 'safeguarding'. As would be expected, nursery was unable to provide them with any further details given this was a live investigation. Parents expressed to the reviewer that this left them with a difficult dilemma in terms of whether to continue to leave their children in the care of the nursery. Some parents suggested that the 'isolated incident' message was reinforced which led them to feel reassured about the safety of the childcare at the setting.

91. All parents engaged with this review recognised the need for careful management of information and the need to ensure no evidence was contaminated as part of the response. Parents suggested that potential learning on this would be to ensure in future that there was one single point of contact outside of the nursery, perhaps police led would have provided a more appropriate source of information in the very early days of this case coming to light.

92. On 31st July 2020 an Ofsted Early Years Regulatory Inspector (EYRI) liaised with the LADO as described earlier, followed by contact with the nursery. This discussion confirmed action taken by the nursery. They described suitable procedures taken to recruit, support and supervise C80. They also described that as C80 was an apprentice, he was never left unsupervised with children. The EYRI discussed what steps the providers had taken following the allegation and they confirmed that they

[11] https://sarchelp.co.uk/sarcs/what-is-a-sarc/

had refreshed staff's knowledge of safeguarding, they had reviewed their procedures and they had considered increasing CCTV coverage in key areas.

93. The next day the EYRI spoke to the Police lead for the investigation at the time to confirm that a visit to the nursery would not interfere with the police investigation. This was agreed and the EYRI subsequently visited the nursery on 2nd August 2019. Prior to this the EYRI spoke to a lead officer in the Local Authority who confirmed that there were no concerns with the setting. The purpose of this visit is described as not to carry out an inspection, but to enable the EYRI to gain *'a clear picture of how the setting operates, to consider their safeguarding procedures and how these were implemented'* and to *'assess staff awareness of safeguarding and how management support and review'* this. The visit is also described with the purpose of assessing how the setting managed safeguarding issues, incidents and allegations made against staff as well as staff deployment and procedures for monitoring staff practice.

94. The EYRI is described to have observed that staff were deployed effectively and interactions with babies/children and staff were positive. The staff ratios were observed to be high, and this was evidenced to the EYRI within the nursery's attendance records for the day of the incident. The EYRI reviewed the area where the incident occurred and concluded that the bathroom area would be within sight and/or hearing of other staff. The nursery leaders suggested that they were regularly in the rooms with staff and confirmed that they were completely confident that no staff member is ever left on their own with children. In addition, the EYRI was advised that all staff were aware of the nursery policy to never be on their own with children.

95. Staff recruitment, supervision, monitoring of staff practice, safeguarding issues and procedures were also discussed. The EYRI is reported to have viewed evidence of this including a sample of other staff files, evidence of staff suitability, policies and procedures and safeguarding records. The leaders of the nursery indicated that supervision takes place every month for apprentices. The EYRI was unable to see supervision records to test this and analyse the quality of supervision, as this had been removed by the police. There is no evidence to suggest that this file was directly requested from police by the EYRI.

96. The EYRI was advised that C80's probation period had been extended due to incomplete references. The EYRI was aware that C80 had started in employment on 4th March, but it is not clear if dates of reference requests for C80 were checked, possibly due to concern about interfering with the Police investigation. Nursery confirmed to the EYRI that C80 was never left unsupervised with children. In addition it was confirmed that apprentices are not assigned as a key person for individual children and could not undertake intimate care (as this was the responsibility of a key person). Parental contributions to this review suggest that C80 was introduced to them as their child's key worker.

97. The EYRI spoke to other staff during the visit and describes that they displayed a suitable understanding of safeguarding. The EYRI identified some gaps, specifically in terms of responding to the allegation and the details of this being disclosed to C80. In addition nursery leaders had not contacted the Police when the allegation was first made. This resulted in a 'notice to improve' being issued to the nursery to address these issues by 23rd August 2019 to ensure that all staff understood local safeguarding procedures, specifically regarding the management of allegations against staff.

98. Following this visit, the EYRI discussed issues with their line manager, an Early Years Senior Officer (EYSO). This considered the option of bringing forward an inspection of the nursery in the light of the concerns raised. It was noted that the nursery had not received its post registration inspection as this takes place 30 months after registration. The nursery had registered in December 2017 and so was within this timescale. The EYSO confirmed that Ofsted should wait until the police had concluded their investigation prior to conducting a full inspection particularly if this was within the 30-month expected timescale. C80's recruitment and supervision were also discussed. The EYRI was

able to confirm exploration of these issues with the nursery owners, noting that C80's recruitment file had not been viewed due to being in the possession of the police. The EYRI described that the owners had also confirmed C80 was never left unsupervised and had also had probation extended due to the non-return of a reference.

99. According to Ofsted, all actions set as part of the 'notice to improve' were concluded by the setting by 12 August 2019. The EYRI remained in contact with local partners and later attended multi agency partnership meetings.

100. Gold and Silver[12] command meetings that took place between September 2019 and February 2020, led by police with local safeguarding partners and Ofsted involved. The Gold commander *"holds ultimate responsibility for the handling and outcome of the incident and sets the strategy for dealing with it"* whereas Silver *"is responsible for producing the tactical plan following the strategy set out by the Gold Commander".* For this case the Gold and Silver meetings were multi agency including all relevant safeguarding partners.

101. Records from very early Gold and Silver group meetings suggest that partners were content at this point with the plan for the Nursery stay open, stating 'children are safeguarded'. The CCTV review by police at this point had identified further possible incidents involving C80 which were being investigated.

102. C80's sibling advises it was at this point that he disclosed abuse by C80, to his foster carer, that had taken place a number of years previously, stating; *It was only after some time of us being apart- nearly three years after being placed into care -that I finally felt safe and therefore able to speak about the abuse I had suffered.*

103. In response to the disclosure partners discussed and agreed strategies for responding in Silver meetings. This included gathering evidence in relation to the abuse. C80's sibling describes this experience as '*humiliating and degrading'* in his victim statement.

104. Discussions also took place at this time regarding the strategies in place for media and communications, managing the impact of the case and concerns about C80 and sibling's safety. It was agreed that the Silver group should coordinate engagement, and they discussed setting up a helpline. It is referenced that the review of CCTV would continue and there would be a need to agree communications once this had happened. Ofsted were represented at the first Silver Group meeting by the EYSO, requesting contact with local partners for information regarding any other premises or additional staff involvement should this come to light.

105. It was also agreed that a helpline would be set up in MASH (Multi Agency Safeguarding Hub), operating Monday to Friday and that this would be resourced by the partnership. It was also suggested that a script would be drafted to guide the helpline operators, and that they would pass information to relevant organisations when appropriate. Support for parents was suggested via the SARC (sexual assault referral centre) and also the local ISVA (independent sexual violence advisor) service.

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[12] See: https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/736743/critical-incident-management-v12.0ext.pdf

106. It was around this time that C80's siblings and foster carer were made aware of C80's arrest and allegations, despite bail conditions stating no contact with children including siblings, this was not communicated to the carers of the children. Instead, the foster carer reports being advised of this by the Head Teacher at the youngest child's primary school on return for the Autumn Term.

107. On 3rd October 2019, partners were advised that further enquiries and review of the nursery CCTV records by police investigators identified further sexual offences perpetrated by C80 along with other serious concerns within the setting. Both Gold and Silver group were convened to discuss and coordinate relevant action. At the meetings, the footage identified incidents of rough handling of children by two other members of staff. In addition, it is said to have also indicated 'no evidence of supervision of staff'. The LADO advised that no reports of the rough handling incidents had been made to them. Members of the groups were clearly concerned about risks to children being cared for at the setting and that they considered best course of action to address this.

108. Given the concerns, there was a consensus from local partners that nursery registration should be suspended by Ofsted while investigations took place. Multi agency plans to respond to a suspension notice were discussed in both groups including communications to parents and media statements.

109. Ofsted's representatives at the meetings were clear that there was a need to view the footage and then to speak with the nursery owners to seek clarification about the incidents, specifically those involving other staff. This was to identify any action that had already been taken by the nursery to address this, and to allow appropriate action to be taken, prior to any suspension. This was in line with the Early Years Compliance Handbook[13] which sets out Ofsted's approach with providers. Ofsted's representatives indicated that it was their view that the provider had acted appropriately through ought the investigation and that they had no reason to believe this would not continue to be the case. It was agreed that due process should be followed and that Ofsted representatives would travel to the police station to review the relevant CCTV footage as soon as possible and prior to their visit to the nursery.

110. An EYRI from Ofsted later reviewed the CCTV footage and identified that this did raise concerns about the handling of a child, however it was agreed with a Senior Her Majesty's Inspector (HMI) that the information should be shared with the provider to give them the opportunity to identify the staff and take action that was deemed necessary. This was because up to this point the view of Ofsted was that the provider *'took appropriate action when concerns were bought to their attention'*.

111. The next day on 4th October, a further incident relating to another member of staff rough handling a child came to light following police review of CCTV. A decision was made that the nursery owners would view both sets of footage with Ofsted representatives at a police station. The group again discussed likelihood of the suspension of registration, and partners again discussed planning to respond to this.

112. The viewing took place and the members of staff that were responsible for the rough handling as well as those that witnessed it were immediately suspended pending an investigation. Following later discussions within Ofsted it was decided that as the risk relating to the members of staff

[13] See: https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/935665/Early_Years_Compliance_Handbook_161120.pdf

involved in further incidents had been removed, because they had been suspended by the nursery, the risk had therefore been removed and removed the sense of urgency regarding suspension / closure of the setting. Ofsted inspectors visited the setting on the same day, the purpose of this was *'to explore the culture within the setting in terms of safeguarding and staff understanding of behaviour management'*. Inspectors spoke with members of staff that were present discussing safeguarding awareness, whistleblowing procedures and supervision processes. Inspectors viewed the staff files of those that had been recently suspended and observed practice. Ofsted advise that this raised 'no cause for concern' during the visit, but that a case review within Ofsted would take place to review evidence collated so far and agree next steps.

113. On 7th October 2019, local partners convened in a gold group meeting. The decision not to suspend the nursery registration was discussed in detail and there was a consensus across all organisations represented that there were *'lingering concerns and questions'* in relation to reassurances of children's safety at the setting. It was also of concern that the LADO had not yet received a referral from the nursery in relation to the suspended staff. The group discussed what best course of action could be taken and agreed this would be to escalate their collective concerns within Ofsted. The chair agreed to do this on behalf of the group.

114. The EYSO from Ofsted attended part of the gold meeting and advised the group that a case discussion would be taking place later that day. The level of concern regarding the safety of children in the nursery was discussed with the EYSO. Local partners were particularly concerned about the lack of supervision and oversight within the setting, concerns were also raised about the culture of the setting in the light of the incidents viewed on CCTV and how this highlighted a lack of whistleblowing practice and LADO referral. The EYSO reiterated the framework within which they operated and that their visit had not highlighted any additional causes for concern. The EYSO advised that the case discussion would discuss what action was needed and it was agreed that the group would be advised of the outcome. The chair felt the escalation of concerns to regional level within Ofsted should be held off until this point.

115. Suspension of the settings registration was considered at Ofsted's (single agency) case review meeting. Suspension of registration thresholds are explained in the Early Years Compliance handbook as:

"We suspend registration generally or only in relation to particular premises when we reasonably believe that the continued provision of childcare by the registered person to any child may expose such a child to a risk of harm."

"We suspend to allow time for an assessment into the grounds that give rise to our belief that a child may be exposed to a risk of harm, or for any necessary steps to be taken to eliminate or reduce the risk of harm.

116. In their case review meeting on 7th October 2019, Ofsted representatives decided that as the provider had taken steps to eliminate or reduce risk of harm by suspending staff involved on all occasions, the threshold of suspension was not met. A Welfare Requirement Notice (WRN)[14] was

[14] A WRN sets out the actions that a provider must take by a certain date to meet one or more requirements of the 'Statutory framework for the early years foundation stage'

agreed because of the identified issues in relation to behaviour management in the setting. This required the provider to meet relevant requirements that are set out in the EYFS statutory framework. Following this, it was agreed that a WRN monitoring visit would take place and that Ofsted would continue to liaise with the LADO and police should any further information come to light during the investigations for this case.

117. The local partners met again later the same week for a further gold meeting. They heard from the EYSO regarding the WRN being served, including what action would be specified within the notice. This addressed concerns relating to supervision and monitoring of staff practice, children's behaviour management and physical interventions and staff roles and responsibilities. The EYSO advised they would re visit the setting following the deadline for the requirements to be met. In the same meeting there were discussions about supporting the setting with reduced staffing following suspension as well as with appropriate levels of information about the investigation.

118. A multi-agency silver meeting took place later that month, on 24th October 2019. At this meeting partners and Ofsted were informed that the police review of 250 hours of CCTV footage had identified further incidents of sexual abuse by C80 within the nursery. Meeting notes from this suggests police had *"significant concerns with the extended period of time [C80] was unsupervised and this is when the incidents occurred"* This, along with other (non-sexual) concerns relating to other members of staff use of, or witnessing of, physical interventions was the trigger, Ofsted advise, that bought further in to question the adequacy of safeguarding arrangements and evidence of concerns regarding the safeguarding culture at the setting. The threshold for suspension of registration is described as being met at this point, and following a case review meeting within Ofsted, it was decided to suspend the nursery registration on this date. In line with Ofsted procedures, parents of children attending the nursery were notified of the suspension.

119. C80 was arrested on 25th October 2019 and was later formally charged with 3 x rape offences and 13 x sexual assault offences. He was released on conditional bail with the trial date was initially set as 23rd November 2020. Risks to C80 safety were considered in silver meetings throughout this period and on 31st October 2019, C80 placement was changed due to concerns regarding risks. C80 is reported to have been *"emotional and upset*" on hearing the news of this planned move.

120. A gold group meeting took place on 29th October 2019. Ofsted's EYSO advised they were expecting an appeal by the provider and felt information should be shared with the owners regarding the information that had come to light regarding additional offences and that had led to their suspension. It was agreed that this could be shared.

121. At the same meeting communications with and support for nursery parents and those directly impacted was confirmed. The group expressed concern for the welfare of the families and also that all nursery parents should be engaged with regarding recent developments. The group heard that plans had been put in place via the silver group, for police and social workers to engage with parents and carers – prioritising victims and their families first, with all parents of children at the nursery following. Follow up welfare visits were also discussed.

122. On 5th November 2019, a police communication to parents of children impacted by the case described that a system of email notification had been set up to deliver important news on the case. In addition parents were made aware of press coverage that day that would likely be covered

in news. Parents advise that the news had broken at this point, in particular because of an interview a director of the nursery with a national newspaper, followed by a filmed press statement by a police lead. Parents received further updates on the police investigation and progress beyond this. For example on 20th November 2019, 21st January and 22nd April 2020 advising progress around charges and what may be published in the press. Communications also requested that parents do not engage in social media activity in relation to the case as this may undermine the court processes. The purpose of these communications was clearly stated in emails, for example: *"Our position is and will remain that wherever possible, we will tell you, as the parents of children who attended the Nursery, before news reaches the media".*

123. The communications also aimed to provide reassurance to families regarding concerns they may have about abuse of their child, advising; "*Police have made personal contact with those parents of children on whom the above charges are based. If you have not been contacted, please take reassurance that the fact remains we have not uncovered evidence that would raise concern for your child".*

124. A further silver meeting on 12th November took place, multi-agency actions to coordinate responses were again discussed and agreed. The group were updated that the helpline had been busy the previous week and that this should continue to be offered. Ofsted's representative advised that the setting was planning to appeal their suspension at a tribunal however the providers had notified that they no longer intended to continue with their appeal on 11th November. Ofsted and partners were not aware of the reasons for this. Ofsted also advised they'd been notified of a parent forum that had been set up with circa 40 parent members and a lead parent involved, it was agreed that relevant information could be shared with partners to ensure a coordinated response. Ofsted also detailed arrangements to interview nursery staff and next steps in terms of their investigations.

125. Ofsted Inspectors carried out interviews with nursery staff between 12th November 2019 and 3rd December 2019 as part of their evaluation of the providers suitability and ability to meet the requirements of the EYFS. The findings of this indicated concerns to Ofsted regarding practice in the setting beyond those identified in earlier visits to the nursery. Ofsted have summarised their findings from the meetings to this review and this is explained as follows:

- Staff talked of concerns with C80's behaviour related to his *'tendency to get children over excited'*, and winding children up for example throwing them in the air. Concerns were raised related to the time he spent in the nursery 'sleep room'.
- They were aware that senior staff had taken the behaviour related concerns to the provider. The response was that C80 had always be with a senior or qualified member of staff and couldn't be left alone with children in a room, *"as noise levels would become too high*".
- Staff advised inspectors that on occasions when C80 was working with only one other member of staff, that they would send him to change children or take them to the bathroom rather than leave him with a group of children because of the concerns about his behaviour. Ofsted have advised that this contradicted what they had been told by the nursery owners that apprentices were never left unsupervised.
- The Inspectors were advised that the owners gave a list of concerns that had been raised about C80's practice to the leader of the room in the nursery that C80 was working in. These were to be discussed with C80 during a supervision meeting.
- Staff interviewed indicated that this was a reason C80's probation was extended - however records show the reason was as Ofsted were advised by the nursery, relating to the incomplete references that were awaited.
- Staff also confirmed to inspectors that, when the bathroom door was in place, children did use the cubicle behind the door suggesting they were out of sight.

- Staff demonstrated a general awareness of safeguarding issues, but not all had a strong understanding of particular issues such as grooming. They spoke about whistleblowing procedures, but evidence showed they did not implement this in practice.
- Staff were able to demonstrate an understanding of appropriate behaviour management strategies, but not all were aware of suitable procedures regarding managing the use of physical intervention.
- Staff described two incidents where children had been left unsupervised, Ofsted advise they did not have records of these.
- Staff describe some occasions where observations of staff practice took place and feedback was given, Ofsted found little evidence to support effective monitoring of practice.
- Some staff had a poor understanding of whistleblowing. A member of staff had observed poor practice of a colleague who lifted a child just by hands/arms, confirming that she had not realised at time she should have reported this.
- Other staff had also observed/heard a staff member shouting at a child. Discussions with staff suggested that the directors also had concerns about this staff member shouting however there was no evidence of action being taken and no records had been kept on the staff member's supervision files.
- Staff spoke of checks being taken up for their appointment, some saying if DBS was not back, they were identified by not wearing uniform, but might be left unsupervised at times. Some staff felt the induction they received was helpful and it had included completing safeguarding training. However, until the recent dismissal of other staff, they had received no refresher training.
- Staff in baby room appeared to be organised and well supported by their senior member of staff.
- After staff were dismissed due to the rough handling identified on CCTV, Ofsted advise that the directors had confirmed they would contribute personally to ensure safe staffing levels and that they would work alongside staff much more, so they had a better understanding of day-to-day practice. Staff confirmed that the directors did this for a few days after which they returned to being back in office for the majority of their time.

126. Following these meetings, a case review took place within Ofsted, and it was agreed that the suspension of the registration should be extended by six weeks while considerations were ongoing. This was communicated to nursery owners and parents of children attending. Ofsted's representatives continued to liaise with Police and relevant partners via the silver group meetings to share information about this and gain updates as relevant.

127. Parents of nursery children had continued to engage (via a representative) with Ofsted and questions that had been raised were fed into the multi-agency silver meetings in November and December 2019. It was agreed that local partners should be involved in answering their questions and a police lead was identified to take this forward via the silver group, who would liaise with the lead of the parent group.

128. During October 2019, the local partners begin to discuss a number of partnership learning review mechanisms. Communications on this were also taking place with involvement of the National Child Safeguarding Practice Review Panel. Torbay Council had forwarded a serious incident notification to the relevant national bodies on 23rd September 2019. This triggered a review of the case at a National Panel meeting on 29th October 2019. A decision not to instigate a national review was made at this meeting and communicated to the local safeguarding partners in Torbay. The panel advised there was a need for a rapid review to take place by TSCP. This rapid review took place on 28th November 2019 where it was agreed that this case met the threshold for a local CSPR. The rapid review was also considered by the Nation Panel which took a decision to reverse their previous advise that a National review was not required. However, the complexities caused by the

Government response to the Covid-19 pandemic meant that the National review was set aside in favour of a local learning review.

129. In the meantime, a brief review was underway, entitled 'Independent Review of the Response of the Torbay Safeguarding Partnership' to check responses were in line with good practice and expectations. This review was commissioned by the DfE appointed Children's Commissioner under the terms of Torbay's statutory notice. It was intended that this review would assure the commissioner that the safeguarding activity and the actions taken by partners were robust. this review was presented to Torbay's improvement Board that was attended by DfE and all relevant partners. In addition it was made available to the Gold commander. Subsequently an independent consultant reviewed the recent file records and verbally feedback his findings to the commissioner.

130. On 16th December 2019, Ofsted met with the directors of the nursery to follow up their lines of enquiry. Ofsted have shared their analysis of this meeting for this review and a summary is below.
    - Directors denied that anything like this could have happened in their setting.
    - They were not aware of the majority of the concerns raised from the CCTV footage and accounts given by staff in interviews.
    - Accurate records were not kept relating to all incidents nor had notifications been made to Ofsted of significant incidents, including where a child had been left alone in the garden unsupervised.
    - Directors did not recognise the weaknesses in safeguarding practice within the setting including confidence in use of physical interventions or following whistleblowing procedures.
    - They were not aware of the EYFS requirement to ensure staff under 17 were not left unsupervised with children.
    - One director shared information they had been told about, regarding knowledge of C80's behaviour in the past.

131. Following the meeting, Ofsted representatives liaised with police and the LADO regarding the information shared by one of the settings directors, and also to gain further clarity on matters that impacted on their investigation. This included the use of CCTV in evidence when assessing the suitability of registration of the nursery.

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132. Once this was confirmed, a case review took place within Ofsted on 7th January 2020 to review evidence gathered and identify next steps. It was decided that given evidence of significant and wide-ranging breaches of the EYFS and responses to these by the provider, that Ofsted would proceed to cancel the registration of the nursery. The significant concerns were explained to the nursery owner along with the decision to cancel their registration. The provider was also notified that the documentation would be drafted and sent as soon as ready, and that this may take a few days. The following day, on the 8th of January 2020 the provider emailed Ofsted to advise they wished to resign their registration. Ofsted advise that it would not have been possible for the provider to resign their registration once formal notice had been served.

133. At this time partners were aware of a number of questions raised by parents of children at the nursery relating to the case and circumstances of C80's employment. At a silver meeting on 10th January 2020 police representatives advised that they were leading on attempts to answer as many of the parent queries as possible within the parameters of the current investigation, and that some may need answering by Ofsted or other parties. Police leads fed back progress to group and advised that parent engagement with responses to the questions had taken place in April 2020. There were some gaps in answers to these questions where local partners could not respond as indicated above.

134. At this time, parents had raised questions about the support that could be provided to them and their children in relation to this incident. This was discussed by partners in the same silver group, specifically to ensure that support services that families had been referred to were appropriate and meeting the parents identified needs. Services currently offered were discussed in detail with representatives from the SARC and a local sexual violence advocacy service in attendance. They gave an overview of the services that they could provide and relevant referral routes in and out of their provision where relevant, for example due to the age of the children or specific needs. It was apparent that at this point, four families had accessed SARC support in relation to this case and that two had had contact with the sexual violence advocacy service.

135. Records of the partnership silver meetings that followed indicate that those directly affected or identified as potential victims were offered support via SARC or had been referred there, however not all took up this offer. This was an area of focus for the partnership at this time specifically as it was apparent that wider support needs of parents and children may not have been met via this route. Partners considered options available to parents and a letter was sent to parents TSCP giving the options for support that were available on 23rd April 2020. This included signposting to Victim Support, Health Visitors and GP's. This also gave more detail about specialist services that could be offered by the SARC and a local ISVA service where this was appropriate for parents.

136. On 3rd February, the National Child Safeguarding Practice Review Panel wrote again to Torbay partners suggesting that on detailed review of case information, they felt there would be significant opportunity for national learning and advised they would be delivering national single case review. Torbay partners responded to request further detail of the reasons for this. A set of preliminary terms of reference for the review were drafted.

137. On 2nd June 2020 C80 attended a virtual crown court hearing and pleaded not guilty to all charges.

138. On 17th June 2020 a change of decision from the National Panel was communicated to Torbay, given Covid restrictions, Torbay agreed to undertake local CSPR incorporating previously agreed TOR.

Learning Summary

C80's Background and Experiences

139. On review, it is clear that C80 experienced a chaotic and traumatic childhood. C80's experienced serious adverse childhood experiences (ACE's) including sexual abuse, neglect, domestic abuse, adult mental health and substance use in his early life. The impact of this is evident in the behaviour demonstrated in his childhood and adolescence. C80's trauma was compounded by the instability caused by multiple placement breakdowns, regular changes of carer and lead worker during the period of this review.

140. C80's experience of trauma is not uncommon for a care experienced child. Neither is the expressed behaviour that was clearly demonstrated as a result of this. As the National Institute for Health and Care Excellence (NICE) states*; "The rates of emotional, behavioural and mental health difficulties are 4 to 5 times higher amongst looked-after children and young people than the wider population".*

141. It is, however, uncommon for those experiencing this go on to abuse or commit crime. Research and evidence suggest that most looked after children are not involved in offending behaviour with 94%

of children in care in England not proceeding to commit crimes[15]. For those who do offend, it is likely that their behaviour results from a complex interaction between; their experiences in care, involvement with different professional systems, individual characteristics and resilience, and the familial and environmental risk factors that led to their entry into care (Schofield et al 2014).

Learning Point: Care experienced children are more likely to experience emotional and behavioural difficulties. Almost all care experienced children do not engage in any offending behaviour, let alone sexually motivated offending and there is no evidence to suggest that being care experienced as a child leads inevitably to offending. It is not therefore deemed evidential or appropriate that a child or adult should be mandated to share their care experience or that of the ACE's that led to their care, with employers.

142. C80 experienced much instability in his life as a looked after child, the impact of this can be seen in his own words through advocacy and input to his looked after child reviews. This is also evident in the key events described in the timeline for this review, and in conversations with practitioners from all partner agencies. At points during the period of review, C80 identified he did not have a social worker and on one occasion he described that the person that was his social worker, lived in a distant place. C80 described his frustration with this in the information provided to this review. Local Authority representatives have advised the reviewer that plans have been implemented since this time to improve placement suitability assessments as well as to increase stability of allocated social worker for looked after children. These plans as well as those to improve recruitment and retention of social workers are being implemented and monitored by the local children's services improvement board.

143. This case demonstrates the need for further development of a trauma informed and restorative approach to addressing the care and support needs of care experienced children. In C80's case it is particularly evident that responses to his behaviour and attitude to learning in education settings (pre and post 16) were not trauma informed and there is no evidence that the sanctions used, such as disciplinary measures, were influenced by a restorative approach. This meant they had minimal impact on improving his educational or behaviour outcomes. Similarly the volume of care placement changes experienced by C80 demonstrates there could have been a lack of understanding by carers regarding his childhood experiences and/or a limited understanding about how to care for a child with the level of behaviour and support needs that C80 demonstrated. This could also indicate a lack of appropriate suitability assessment each time that C80 was placed with carers. A number of these placement breakdowns related to behaviour issues and in one case, C80's own experience of sexual abuse as a child, indicating a possible lack of knowledge of his history and also limited understanding of the impact of such adverse experiences and how to respond.

144. It is evident in the records considered as part of this review that C80's mother had negative influence on C80's behaviour throughout this period, however consideration of this does not seem evident in the arrangements made for contact or in later care planning. Examples of mother's negative influence in this case include:
    - disruption of C80's placements (e.g. C80 adding bleach to his carers toiletries).
    - escalation of C80's negative behaviour post contact with his mother
    - mothers central role in a number of missing episodes, including C80 returning under influence of alcohol

[15] "In Care, Out of Trouble" Lord Laming, 2016.

145. C80 regularly demonstrated his frustration regarding being separated from his mother through his behaviour and also in advocacy and other discussions with practitioners. C80 was determined to be reunited with his mother and siblings throughout his childhood and adolescence which clearly impacted on his progress and recovery from trauma. There were at times mentions of plans to review contact arrangements however no action is evident to adjust these or consider contact further. In addition concerns raised by C80's foster carers regarding contact between siblings were not fully assessed or responded to.

> Learning Point: The impact of trauma and adverse childhood experiences is evident in the timeline for this case. A trauma informed approach was not in place in Torbay, this is now beginning to form in Torbay led by the Local Authority. Given the role of partners in care experienced children's lives, this could be further developed within wider the partnership. A trauma informed / restorative approach can also be considered in terms of behaviour management and disciplinary approaches in education settings (pre and post 16).

146. C80's own experience of sexual abuse at the age of 5 was discussed at his transfer in child protection conference in 2014; where details of the physical and emotional impact of this were given. Sexual abuse was then not explicitly stated in the future work or interventions with C80. This was not communicated to a number of C80's carers

147. This is evident given one foster carer concerns that are recorded as unfounded 'sexual risk' in 2016 following C80's disclosure of sexual abuse. This demonstrates that it was unlikely that the foster carer was aware of C80's specific adverse childhood experiences of abuse prior to therapy being undertaken and also highlights a potential issue with placement suitability assessment at that time. The feeling that there was a need expressed by the carer for sensors on doors reinforces this.

148. C80's sexual abuse history was not apparent in crucial assessments and planning by partners after the transfer in conference, including in terms of initial and review health assessments, onward specialist health referral to bladder and bowel services (linked to physical consequences of the abuse) or in referral for mental health and therapeutic interventions.

149. This led to very little direct intervention to respond to C80's complex and specific physical and emotional needs that were linked to his experience of sexual abuse. Why this was not communicated is possibly linked to the lack of transfer of key information between practitioners / services for example when carrying out the Initial Health Assessment for C80, which led to limited information being passed to specialist onward health intervention referrals. A further explanation given to the review is that the alleged perpetrator of C80's abuse had been found not guilty and this could have impacted on practitioner's confidence to refer to and respond appropriately to the abuse. Another explanation relates to the fact that the serious neglect of C80 and his siblings was the primary reason for protection, which was then the issue that was communicated in future multi agency plans and assessments.

Learning Points: C80's experience of sexual abuse, and the responses to this, are relevant factors in this review.

Partners should ensure that a child's experience of sexual abuse forms an integral part of care plans and assessments even where this is not the primary reason for protection or intervention. Referrals for specialist support as a result of abuse should be explicit about the reasons for this so that appropriate interventions can be delivered. Protocols within Health services should be reviewed in the light of this review, to ensure sufficient guidance to practitioners where care experienced children are referred for specialist support.

Experiences of sexual abuse can contribute to a child displaying harmful sexual behaviour; however this is not a definite outcome by any means. It is therefore not deemed necessary or appropriate that an adult or child's experience of sexual abuse, or other ACEs should be shared with employers.

150. Therapy was indicated as a necessary intervention for C80 by the doctor carrying out the IHA and a Clinical Psychologist at FCO stage. Therapy was commissioned and C80 was said to have been engaging well. This was interrupted by a placement change at what is described by the therapist as a crucial point and was never restarted indicating that therapy was not an ongoing feature in C80's care plans. In addition, the Clinical Psychologist carrying out the assessment at FCO stage recommended further assessment of C80 for difficulties such as Conduct Disorder. There is no evidence that this subsequently happened. C80 is often described as in low mood, 'blocking things out' and refusing to engage in work that would have looked at his traumatic experiences including his life story work. Had these further assessments been done, and therapy or life story interventions been successfully delivered it is possible that this could have had a more positive and lasting impact on C80's emotional well-being and future life.

151. In addition, C80's sibling has expressed a view that exploration of his 'life story' may have been an opportunity in which he would have disclosed his experience of abuse by C80 much earlier than was the case.

Learning Points: Where commissioned, therapy should form part of ongoing care planning to ensure continuity, particularly when placements are disrupted. Where further assessments are recommended for looked after children in family court processes, this should be followed up and monitored as part of multi-agency care planning. Life story work with all children in care should be mandatory and undertaken in a timely way.

152. Of the records presented to this review that related to the time period prior to 2019, there are none that indicate C80 demonstrated any obvious indicators of harmful sexual behaviour, either to practitioners or carers, until the abuse reported. Practitioners involved in this case and contributing to the review described shock regarding this tragic outcome. The review panel communicated to the reviewer that this in itself could denote a need for further learning on this topic, given the abuse that was perpetrated by C80 both in the nursery and to his sibling.

153. The abuse of C80's sibling was disclosed once the allegations of abuse in the nursery had come to light, 5 years after the abuse took place. There are no indications that this was known or suspected by practitioners previously to this point in time. There are many complex reasons why a child in the siblings' position will not have been able to disclose their experience of abuse any earlier including shame, embarrassment and fear of being believed. This is demonstrated in the Governments Tackling Child Sexual Abuse Strategy (2021), which gives some insight in to the barriers that exist for children (and later adults) in coming forward about their experiences of sexual abuse, the most

common being that children feel they will not be believed. The report also highlights that boys are less likely to report sexual abuse than girls.

154. In his victim impact statement, C80's sibling describes his own reasons for disclosure as follows: "*It was only after some time of us being apart- nearly three years after being placed into care -that I finally felt safe and therefore able to speak about the abuse I had suffered*"

155. Clearly, professionals working with children have a responsibility to raise concerns and identify children who are at-risk of, or experiencing, sexual abuse. However, this can be difficult. In 2015, the Children's Commissioner for England reported that just one in eight children who are sexually abused are identified by professionals. There is concern that professionals do not have a good enough understanding of the signs of child sexual abuse and lack the confidence and skills to talk about it[16]. The crucial role practitioners play in identifying abuse is best demonstrated in the clear and impactful words C80's sibling stated to the reviewer:

"If I'd been asked, I'd have told them [about the sexual abuse], I thought it was normal. I didn't know how to lie and would have said".

156. Abusive behaviour is often hidden from plain sight and may not visible until a disclosure from a victim is made, as was the case in this situation. It is crucial therefore that practitioners and carers of children are confident in recognising harmful sexual behaviour and distinguishing between 'normal' age-appropriate behaviours and those of concern. Research tells us that around half of young people who have displayed harmful sexual behaviour have experienced sexual abuse themselves[17]. In the light of this case, it is crucial that the practitioners working with children and young people in Torbay fully understand the context and indicators of Harmful Sexual Behaviour.

157. As reported earlier the terms 'sexual risk' and 'potential sexual risk' are recorded in C80's case history in 2016 and 2018. On review, neither seems to have been recorded as such for an evidenced or substantiated reason, the latter event may have referred to risks posed to (rather than from) C80. While a strategy meeting took place, there is no evidence of specific assessment or consideration of how practitioners could robustly identify if this related to 'normal' age-appropriate relationships/friendships, or if this was behaviour which causes concern - and was not therefore considered in future multi agency work or planning.

158. There are a range of frameworks and checklists to locate children and young people's sexual behaviours at various levels of seriousness or concern that could be utilised in such circumstances. TSCP itself has an agreed Harmful Sexual Behaviour procedure[18] and Brook has an online sexual behaviour 'traffic light' tool[19] for professionals which distinguishes between three levels (green, amber, red) of sexual behaviour in children and young people.

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16 https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/973236/Tackling_Child_Sexual_Abuse_Strategy_2021.pdf

17 https://www.stopitnow.org.uk/concerned-about-a-child-or-young-persons-sexual-behaviour/preventing-harmful-sexual-behaviour/

18 https://www.proceduresonline.com/swcpp/torbay/p_sexually_harm_behav.html

19 https://www.brook.org.uk/training/wider-professional-training/sexual-behaviours-traffic-light-tool/

159. The TSCP procedure also explains that; *"there are no diagnostic indicators in personal or family functioning that indicate a pre-disposition towards sexual offending, although the following characteristics have been found in the background of some young people who sexually offend:*

- *Attachment disorders - poor nurturing and parental guidance.*
- *Domestic violence and abuse.*
- *Previous sexual victimisation - a younger age at the onset of the abuse is more likely to lead to sexualised behaviour.*
- *Social rejection and loneliness.*
- *Poor empathy skills.*

Many of these factors exist alongside typical family environments where other forms of abuse are present".

> Learning Point: Abusive behaviour is often hidden from plain sight and may not be visible until a disclosure is made. It is crucial that practitioners across TSCP, as well as carers, are confident to identify and respond to sexual abuse indicators and to differentiate between 'normal' age-appropriate behaviour and that of concern or risk, so that this informs their planning and work with children.

160. C80 experienced multiple missing episodes during the period that this review covers. These increased in frequency in the period leading up to the abuse perpetrated by C80. At times, the episodes seem to have been linked to disruption in C80's life or to be linked to contact with his mother.

161. Partnership information in relation to missing incidents was well shared, for example with C80's education providers (pre and post 16) so that concerns could be raised should he not attend college. There is however limited evidence of coordinated activity to respond meaningfully once this point had passed and to identify strategies to prevent future episodes. A strategy meeting took place in late 2018 which included discussion about the growing number of missing episodes. Actions were agreed here however there is no evidence of how these actions were implemented or how they influenced future plans or work with C80 by any of the partners that were present. Return Home Interviews (RHI's) were at this time being delivered by C80's social worker or the family support worker from the local authority, rather than an independent practitioner. This was not concurrent with expectations set out in national guidance. It has been reported to this review that this had a negative impact on C80's relationship with one of his closest positive influences (male support worker) as it changed the relationship from a supportive to a more punitive one. There is no evidence of how findings from RHI's influenced future actions or care / pathway plans with C80 and his carers.

162. Child Sexual Exploitation (CSE) risks to C80 are recorded in case records around the time of the increase in missing episodes, largely due to this increase and some concerns as to who C80 was spending time with. There is no evidence that an agreed partnership risk assessment took place at any point relating to CSE risk and this therefore did not inform future planning for C80. The reviewer has been advised that the Local Authority has since developed approaches to missing children, including:
    - return home interviews are provided by an independent person, and that findings inform assessments of risk, care, and planning
    - where risk of child sexual exploitation is identified and recorded, relevant assessment takes place to identify risk and inform future planning.

163. C80 was not offered a personal advisor until July 2020 (age 18), a year after the abuse perpetrated by C80 was reported. This is clearly outside of legal duties of the local authority[20]. At this time there were also multiple changes to the social worker for C80 and at one point he was left 'unallocated' in this period. C80 is reported to have said at this point to his advocate that it had felt *"as if everyone has given up on me".*

    Torbay Council's website states that a Personal Advisor is offered at the age of 16 and supports care leavers with the following:

    - practical help (e.g. helping secure a tenancy, paying for certain things in your home
    - emotional support (e.g. being there when you need us, keeping your motivation up)
    - advice and information (e.g. helping you go through your housing options, choosing the right course and college).

164. Where Pathway Plans do exist for C80's 'care leaver' period in the time covered by this review, they are incomplete, do not include input from C80 and do not show actions or demonstrate how these were monitored and progress evaluated.

165. As corporate parent for C80 the local authority did not meet its statutory duties at this time. It is not possible to predict whether C80 would have taken up the offer of a Personal Advisor at age 16 as he had by this point often found it difficult to engage or trust practitioners following the long period of instability he had experienced. Residential placement worker/s seem to have stepped in to provide parts of this role and coordinated many of the activities that would have been expected of a PA, for example assisting C80 with his search for work after ceasing college.

166. Virtual school involvement with post 16-year-old care experienced children in Torbay at this time was also limited, contributors to the review suggest that this was reactive, stepping in if any issues were highlighted as part of post 16 Personal Education Plan (PEP) meetings or concerns raised by education providers. It is said that this related to the level of resources and time within the virtual school team. A PEP took place shortly after C80 started college highlighting concerns about his progress and submission of work. Concerns were raised at this meeting regarding his attitude and behaviour in the care setting at this meeting, and also if the childcare course was the right one for him. There is no indication of follow up on this latter point. C80 very rarely engaged in his PEP's, and it is not obvious how actions that were agreed for him to progress were communicated with him, monitored, or followed up by partners. No further PEP records are available for C80, there is no evidence that these took place for C80 once he had been subjected to college disciplinary procedures in the months that followed.

167. A regional careers service also provided some support regarding C80's options, specifically once he had been dismissed from his college course and was deemed to have been Not in Employment, Education or Training (NEET). They had been notified of this by C80's carer and met with C80 to assist with preparation for interviews. No further contact is apparent in terms of recording C80's success with interviews or employment in the next two months. Had C80 been offered, and engaged with, a Personal Advisor a coordinated level of support for C80 could well have been in place including further careers advice. This may in turn have influenced his preparation for independence and decisions regarding his future options for career and employment. This is not

[20] Section 3 of the Children and Social Work Act 2017 requires Local Authorities to provide personal advisors to care leavers from the age of 16 up until they reach the age of 25

however to suggest this would have been an intervention that would have altered C80's choice of employment or indeed had any influence on his perpetrating abusive behaviour.

168. In contributing to this review, practitioners gave some context of what was happening at this time, particularly in terms of the challenges faced by Torbay, and indeed, all Councils in recruiting and retaining social work staff. This clearly impacted directly on Torbay's ability to deliver consistent social work services to C80, and to deliver expected roles and plans to assist in his next steps as a care leaver.

169. At points in 2018 the lack of pathway planning is noted by partners – for example in CLA (Child Looked After) review. There is, however, limited evidence of how or when this was followed up or concerns escalated, and the situation and quality of plans remained the same. It is not clear if partners were aware of potential escalation routes beyond the IRO dispute resolution procedure which took place but resulted in little action. This was instigated but unsuccessful. Use of the TSCP "Escalation Policy[21]" does not seem to have occurred indicating a lack of awareness of this as a route to achieve a more positive outcome in this situation.

170. The Local authority has advised that improvement plans are currently being implemented that have altered or will positively influence practice in this area, specifically as a result of improvements to:
    - Sufficiency strategy for looked after children
    - Support for post 16 looked after children, specifically relating to the quality of pathway planning, actions and follow up
    - Personal advisor allocation as set out in the Child and Social Work Act
    - IRO dispute resolution procedure and appropriate escalation points / routes
    - Role of the virtual school is clarified in terms of post 16 education employment and training

> Learning Point: Personal Advisors and Pathway Plans form the foundation of post 16 support for care experienced children. This is essential and a statutory requirement for the Local Authority as corporate parent. Virtual school coordinate PEP plans for those in post 16 education, this is particularly important where there are concerns or a care experienced student enters disciplinary procedures. Partners can ensure that this support is in place and effective and where there are gaps, consider linking to the IRO to utilise the dispute procedure and / or
> refer to TSCP's Escalation Policy to assist in supporting and challenging to ensure the needs of the child are met.

171. C80's student file, which contained essential information about his care experience, family history, school behaviour and safeguarding issues, was passed to his college two months after his enrolment in a childcare course, and some six months after the college held a 'risk assessment' meeting (held for all vulnerable students) relating to his application to attend the college and this course. This meeting is discussed later.

172. In addition, it would be pertinent to review the timing of such information exchange between schools and post 16 education or training provider to ensure that the full range of information is considered when assessing student's suitability for their chosen courses.

[21] https://www.proceduresonline.com/swcpp/torbay/p_escalation.html

173. The file transfer coincided with the onset of college disciplinary procedures being launched (for reasons related to his behaviour and lack of motivation for study). GDPR and poor relationships between settings has been referenced to this review as a barrier at that time to the automatic transfer of files for students. School representatives describe improvements to this process since the period of the review with better relationships with some but not all post 16 education settings and training providers in the Torbay area. Work on this does continue, with suggestions that this approach mirrors transition for looked after children between primary and secondary education.

> Learning Point: It is essential that there is a timely transfer of information regarding vulnerable students between pre and post 16 education and training providers. This is to ensure that relevant suitability / risk assessments are fully informed and that an appropriate level support is in place for the student.

174. Following C80's disclosure that he was struggling to manage behaviour of one child at the nursery, it is clear that full details of this should have been shared with the nursery. Specifically, the suggestion from C80 that he had used a physical intervention and 'pushed' a child. This crucial detail of this event was not given to the nursery. The reason this was not shared is said to have been because C80 had subsequently denied he had actually pushed the child and stated he'd sometimes felt that is *what he might do*. Nevertheless, this detail, even his intention that he might carry out such physical intervention, could have been shared to enable the nursery to be fully informed to decide about the correct course of action at that time. It was good practice that the Local Authority social work duty team were consulted about this matter and that the detail was shared initially. There is no evidence to suggest however that there was any follow up on this matter by the care provider or C80's social worker at the time, to ensure that C80 was being supported with the behaviour management issues that this raised.

175. There is a possibility that in this case the LADO may have been consulted for advice. The LADO and other contributors to the review have advised that local settings were at this time, aware of the role and support offered in this kind of scenario. Given subsequent events related to this nursery and more serious issues that required reporting to the LADO it is not obvious if nursery procedures would have led to this. It is also very unlikely that any formal LADO investigation would have been progressed whoever had contacted them, as a result given the circumstances of the disclosure. It is, however, the view of the LADO that had this information been shared with them, it would be most likely that this would have led to proactive contact with his lead worker / IRO in terms of coordinating support for C80 for example, and the nursery on the issue.

176. Feedback in wider practitioner meetings for this review indicated a lack of clarity regarding application of allegations management procedure for under 18's including looked after child working or volunteering in position of trust. The LADO in Torbay has indicated to the reviewer that they have action underway with early years settings and others in relation to awareness that the relevant procedure applies where staff, apprentices or volunteers are under 18.

> Learning Point: While information about C80 struggling to manage the behaviour of a child was shared with his employer, a crucial detail regarding his alleged use of physical intervention (or intention to use this) was not. This should have been shared by those responsible for C80's care to enable informed assessments and decisions to be made. Where a child under 18 discloses issues relating to a position of trust that they hold, whether as an employee, apprentice, or volunteer this should follow the same procedure as for an adult.

Recruitment & Apprenticeship

177. Safe recruitment is central to the safeguarding of children and young people. All organisations which employ staff or volunteers to work with children and young people have a duty to safeguard and

promote their welfare. This includes ensuring that the organisation adopts safe recruitment and selection procedures which prevent unsuitable persons from gaining access to children[22].

178. The EYFS Statutory Framework suggests that all providers should ensure staff are 'suitable', this seems to be broadly based around processes relating to DBS. There is no further detail to guide carers or settings on other essential safety and suitability checks, for example references. In comparison, the statutory guidance for schools and colleges, KCSIE (Keeping Children Safe In Education[23]) describes safe recruitment requirements in detail and gives very clear guidance regarding pre appointment checks, including references that are required for any individual working in or visiting schools. The EYFS suggests that childcare providers may "find it helpful to refer to this [KCSIE] guidance" but there is currently no statutory duty for them to meet the requirements within it. Ofsted's Early Years Compliance Handbook as a result describes only DBS processes in relation to safe recruitment, although the regulator states clearly that it can act where it feels the welfare of children is not safeguarded.

179. Given the vulnerability of the babies and young children that are within early years settings, it is not clear why less specific safe recruitment statutory guidance is currently in place in EYFS compared to KCSIE.

180. Suitability to work with children could also be examined more closely where students wish to study childcare, in particular where they include placements in settings or a pathway through qualification to roles in childcare settings. This would be equitable to the requirements to study for a teaching qualification. While the college C80 attended did hold a 'risk assessment' meeting, this happens only for students with additional or complex needs rather than specifically for those studying to work with children. The meeting did cover some aspects of 'suitability' of C80 to attend this course and did not identify any issues that deemed him to be unsuitable.

181. Representatives of the college advised the reviewer that a letter is now sent to previous education settings for all students enrolling to study childcare, to ask about suitability.

> Learning Point: There is no statutory guidance regarding the level of suitability assessment required for students attending placements as part of childcare studies. This differs from expectations for trainee teachers, as KCSIE applies.
>
> Post 16 education and training providers offering childcare courses, especially those that involve placements, should carry out pre-enrolment checks, references, and suitability assessment procedures in the light of this review. Particularly to ensure that these are as robust and thorough as those within higher education courses offering teaching qualifications.

182. Information submitted to this review suggests that the nursery was not adhering to it's safeguarding policy in terms of ensuring that two satisfactory references as part of pre-employment checks for C80 were in place, prior to his start date and work with children. The DBS was carried out within 12 days of start date and one reference (from C80's part time job) was received 16 days after start. Evidence held in C80's personnel file and gained from school and college suggests requests for a second references were taken up some time after C80 commenced employment, at 2 months (college) and 4 months (school) after his start date.

[22] https://www.proceduresonline.com/swcpp/torbay/g_safe_rec.html
[23] https://www.gov.uk/government/publications/keeping-children-safe-in-education--2

183. The nursery owners recalled to the reviewer that C80 was acting as a work experience student, wearing different clothes to staff to distinguish that fact, during a period in which a DBS was awaited. His contract of employment states a start date of 4th March 2019, subject to satisfactory DBS checks being returned. Delays to start dates are not evidenced in the case of lack of references however C80's probation had been extended for this reason. Staff from the nursery spoke to Ofsted (post suspension of registration) regarding the issue of checks being taken up for their appointment, stating that if their DBS was not back before they started work, they were also identified by not wearing uniform. Nursery explain that this would indicate that they were not yet employed and were working as work experience. It is not clear if these non-uniformed staff would then be included in the nursery ratios. It is also unclear if this was known to Ofsted prior to the suspension of the nursery registration.

184. It is important to try to understand the context for why setting may allow staff to commence employment prior to satisfactory pre-employment checks and references being gained. In the course of the review it has been suggested that this may be linked to a need to swiftly recruit and employ staff due to high turnover of staff and recruitment and retention issues in the sector. In this case, the nursery has indicated a particular keenness to recruit male members of staff given the relative rarity of male applicants, this could have also impacted on decisions made in this case.

185. Having consulted with all three potential referees as part of this review it is apparent that there were no concerns or indicators visible to them of the sexual risk that C80 posed, and this would not have been identified in any of the references had they been completed. All three did describe C80's behaviour and attitude to work and learning very negatively, albeit with hindsight given the events that have since occurred. Separately they suggested that had they completed the full reference or been contacted by the employer by phone, they would have not recommended him for employment for this role.

186. The reasons for not communicating this proactively to the nursery are mixed. In conversation with one of the potential referees, it is apparent that they considered the reference document format unsuitable for education referees. The representative at the school also advised that they are also concerned about the legalities of providing a negative reference, there were concerns that they could be challenged. They also reflected that on the very few previous occasions where a reference for a student had not been fully completed, they would have had proactive contact or a phone call following up on this from the employer, and that this didn't happen in this case. School was not aware that a failed attempt for a complete reference had been made to the college prior to the request to them. The college also shared a view that they had expected follow up from the nursery to ask further questions, and this would have been in line with TSCP guidance on the matter. The setting that provided a placement to C80 and was contacted for a reference seems to have not been followed up because of missed calls and answerphone messages.

> Learning Point: Pre employment suitability checks, including successful references, are an essential part of safe recruitment practice in all settings working with children. TSCP guidance gives the local framework for this. There is no legal reason for information that may be of safeguarding concern to not be shared by referees with potential employers. Referees should proactively communicate all concerns to employers relating to a prospective employee.

> Learning Point: The EYFS does not provide a detailed statutory framework for safe recruitment (beyond DBS) that guides settings on this topic and enables HMIs in Ofsted to hold them to account. Keeping Children Safe in Education does offer this for schools and colleges, and therefore Ofsted, but it is not mandatory for childcare settings to follow this.

187. C80s apprenticeship was arranged by the nursery with a training provider they had previously used. In a recent safeguarding visit to the training provider, Ofsted found insufficient progress in relation to safeguarding and the report from this visit demonstrates poor quality safeguarding practices there. There is no evidence that suggests the training provider quality assured the safe recruitment or suitability assessment carried out by the nursery prior to commencing work with C80.

188. It is evident that the apprenticeship training provider was aware of C80's care experience given their invitation to a CLA meeting in the period of C80's apprenticeship. It is not clear if additional bursaries were accessed for C80 as a result by the provider or if this could have instigated additional support. There was no system for arranging apprenticeships for looked after children in Torbay at that time and given the lack of personal advisor and pathway planning, the local authority and partners involved in C80's care did not have oversight of the apprenticeship arrangements that were taking place. Local Authority apprenticeship leads have advised the reviewer that they can offer a role for coordinating and oversight of arrangements for apprenticeships for care experienced children and care leavers which would ensure providers are of a good quality.

Supervision and Oversight

189. Throughout the entire time of his employment at the nursery, C80 was aged 16 years old. The EYFS framework states; "*Only those aged 17 or over may be included in ratios (and staff under 17 should be supervised at all times)"*[24]. This indicates that C80 should not have been included in staff ratios at the setting.

190. In initial visits to the nursery by Ofsted the owners of the nursery presented very positively that this had always been the case. The owners were adamant that this abuse could not have happened in the setting because C80 was always supervised. They describe to the review that C80 was always in 'sight or sound' of a supervisor and that they always ensured staffing levels were above the recommended numbers.

191. CCTV footage collated for the police investigation is said to indicate that C80 was seen to be left unsupervised on a number of occasions for periods of time that enabled the abuse to occur, for example Police suggest a period of 39 minutes in relation to one incident, where C80 was effectively left unsupervised. C80 was taking children to the toilet unsupervised, demonstrated by the location of the rape that was committed. While the often-hidden nature of sexual abuse is a possible explanation for the discrepancy in accounts and evidence, it is difficult to comprehend how this could have happened had he been in sight or sound of other staff while taking children to the toilet. In the course of meetings with parents of children that attended the nursery for this review, the reviewer was frequently told that nursery owners had assured parents that children would not be taken to the toilet by individual members of staff as detailed in their policies and this had reassured parents enough to choose this as a setting they would want to use.

192. This is compounded by the information staff of the nursery later reported in meetings with Ofsted inspectors. Here they suggest that they had been told by setting leaders C80 could not be left unsupervised. This was thought to be linked concerns of immaturity and behaviour, rather than any safeguarding risks, and it is possible also to the issue raised by his placement. Staff indicated that because of deployment issues it was not possible for him to be constantly supervised. Staff indicate he would often be asked take children to the toilet or to change individually rather than be left with

[24] The guidance goes on to state that Staff that work in 'early education' as apprentices (aged 16 or over) can be included but only if the provider deems they are *'competent and responsible'*.

a bigger group of children to manage. This is not to say C80 would have been 'out of sight and sound' on each occasion that he did so. However it seems possible that the level of supervision and oversight at the nursery did allow the opportunity for C80 to abuse children.

> Learning Point: In order to ensure children are safeguarded it is vital that settings adhere to the guidance set out in EYFS regarding supervision of 16-year-olds, and their inclusion in staff ratios. Staff in settings should be confident to report situations internally and then to escalate this, where these requirements are breached. The terms 'competent and responsible' are open to local interpretation and could be further clarified in EYFS guidance.

193. Ofsted detail that while investigating nursery practice as part of their registration suspension, some observations of staff practice were apparent with feedback given in the setting but there was limited evidence of how the setting were monitoring practice as a result, to measure how well improvements were made.

EYFS Statutory Guidance states: "Providers must put appropriate arrangements in place for the supervision of staff who have contact with children and families. Effective supervision provides support, coaching and training for the practitioner and promotes the interests of children. Supervision should foster a culture of mutual support, teamwork and continuous improvement, which encourages the confidential discussion of sensitive issues".

194. The nursery supervision policy states, "*supervision meetings are be carried out every month for apprentices"* and that *"supervision is carried out by the line manager"*. Monthly supervision is not recorded each month for C80. Evidence from Ofsted records suggests that the nursery owner/s completed supervision for senior staff and senior staff completed supervision for all other staff. Ofsted were told by staff that C80's room leader had been given a list of concerns that had been raised about his practice, specifically regarding his behaviour by the owners. These concerns influenced the choices made about how to deploy C80 as stated earlier and were to be discussed with C80 during a supervision meeting. On review of supervision notes, there is very little noted in meetings to demonstrate that this happened, and to then track progress C80 may have made relating to concerns raised.

195. It is evident that the nursery owners ensured all staff read and understood their policies and procedures, and that this formed part of their induction. Staff, including apprentices such as C80, had to sign to confirm they had read these. There is no evidence that leaders at the nursery then 'tested' application of this knowledge through observation and their oversight of practice.

> Learning point: Safeguarding children should be a formal part of supervision and observation of practice. Application of key safeguarding policy and procedures in practice, for example the use of physical intervention and whistleblowing, should be measured as part of this. Managers / owners of settings should ensure 'leadership by example' in terms of linking observation, supervision, and tracking practice improvement. The EYFS could be expanded in the light of learning from this review, to give further clarity to settings and Ofsted on these expectations.

Safeguarding Practice

196. The EYFS states: "*Providers must have and implement a policy, and procedures, to safeguard children. These should be in line with the guidance and procedures of the relevant Local Safeguarding Children Board (LSCB). The safeguarding policy and procedures must include an explanation of the action to be taken when there are safeguarding concerns about a child and in the event of an allegation being made against a member of staff and cover the use of mobile phones and cameras in*

the setting". The nursery adhered to this requirement and policy regarding key safeguarding issues relevant to this review detail all the right and proper principles and procedures to follow.

197. The application of these in practice is however not always evident in the information gathered. Meetings held by Ofsted inspectors with nursery staff suggest that there were gaps in some significant areas, for example Ofsted state that staff were not confident in managing the use of physical intervention or following whistleblowing procedures.

198. Staff also seem to have had a poor understanding of whistleblowing and were not aware of or implementing the duty to report physical interventions or behaviour concerns even where this was witnessed, as demonstrated by the evidence found on CCTV. Contributors to the review suggest that when issues had been flagged there was very limited follow up which led them to no longer feel confident that their concerns would be acted upon. A further explanation given to the reviewer by parents and other contributions to the review is that there were some strong friendships within the staff group which could have affected the likelihood of reporting incidents because of a fear of losing social networks. In any event, there is no evidence of staff having knowledge of wider local procedures[25] in terms of whistleblowing or of the possibility of reporting concerns to the LADO or Ofsted. There also seems to have been no awareness of national helpline run by the NSPCC that is available to all. This is despite the Designated Safeguarding Lead (DSL)'s regularly engaging in Safeguarding Forum meetings held by the Local Authority, indicating a lack of communication of issues learned at that forum to staff. In addition, staff reflected that they felt the induction they received was helpful and it had included completing safeguarding training. However, until the recent dismissal of other staff, they had received no refresher training.

Learning Point: Policies alone do not safeguard children; it is crucial that these form a part of a whole setting approach to safeguarding. Settings should ensure that the principles and processes that policies reference are implemented every day in practice and through regular training, awareness raising and monitoring of practice.

Learning Point: Staff in the nursery were not confident about whistleblowing procedures. It is this vital for children's and adult's safety that staff feel safe and listened to and that action is taken when appropriate when they raise concerns about practice/s in their setting. There is a national Whistleblowing Advice Line available that offers free advice and support to professionals with concerns about how child protection issues are being handled in their own or another organisation.

199. The setting had two DSL's rather than the statutorily mandated one. This role is said by EYFS to be responsible for; *"liaison with local statutory children's services agencies, and with the LSCB. They must provide support, advice, and guidance to any other staff on an ongoing basis, and on any specific safeguarding issue as required. The lead practitioner must attend a child protection training course that enables them to identify, understand and respond appropriately to signs of possible abuse and neglect".* The settings safeguarding policy describes the correct process for reporting concerns to the DSL, for them reporting to the correct statutory authorities, and the recording procedures within the setting.

200. CCTV was in use at the setting, footage from this provided essential evidence for the investigation and criminal trial of C80. At the time of the first report of abuse the setting discussed the angles

[25] For example TSCP Whistleblowing Procedure: https://www.proceduresonline.com/swcpp/torbay/p_whistleblowing.html

covered by the CCTV with investigating police officers and agreed that there were some areas, including the toilets, that were not covered by the cameras. The nursery had a clear CCTV policy in place, stating the details of the purpose and process for the use of this. The lack of cameras in the toilets and changing areas is said in the policy to have been deliberate in order to protect the dignity of children. This lack of coverage would have provided further opportunity for the abuse to happen.

201. The EYFS does not detail any statutory framework in relation to the use of CCTV in early years settings, simply stating that if CCTV is in use it should be covered by a policy. CCTV use therefore does not form part of the Ofsted inspection framework handbook. The setting policy states, *"CCTV is monitored centrally from the nursery office",* and that CCTV footage may be used for training purposes "*including staff supervisions"*. As with other policies referred to in this report, it is not clear how this was evident in practice. Evidence of multiple episodes of abuse committed by C80, and later others physical interventions was found on the CCTV footage by police investigators, however this was not seen as part of routine monitoring by the owners of the setting. In addition there is no evidence to suggest that footage was used to address concerns regarding C80's behaviour in supervision as the policy suggests it could be.

> Learning Point: There is no reference in EYFS statutory guidance relating to the use of CCTV in settings, simply a requirement that there is a setting policy regarding their use. This should be considered in the light of this review, particularly to ensure it does not replace in person observation and to encourage proactive use of this to monitor practice where improvements have been

202. A nursery policy states that "No…. intimate care routines take place behind closed doors". It is the view of a number of parents that engaged in this review that the toilet facilities were not appropriately laid out for a childcare setting and that these provided a further opportunity for the abuse to take place. This is because at the time of the rape incident the toilets were contained within a room that had a closable door. This door opened in a direction that partially blocked sight of some of the room. This door was later removed by the owners. The EYFS does not indicate any guidance on visibility of toilet areas, it only states that "*Providers must ensure there is an adequate number of toilets and hand basins available. Except in childminding settings, there should usually be separate toilet facilities for adults".* Parents also questioned how the set-up of toilets is considered in Ofsted inspections of settings, it is clear that the layout in terms of safeguarding is not considered however Ofsted have advised that inspectors may discuss how settings ensure the privacy and dignity of children for example where there are no doors.

> Learning Point: There is a need for clarification regarding the layout / design of toilet facilities in nursery settings. National guidance (and settings policies) should address the need for balance between safeguarding children from harm and ensuring their dignity - both in terms of CCTV coverage where this in use, and in ensuring the design and layout of toilets prevents the opportunity for abuse.

Response to incidents

203. At the point that the parents of the victim of abuse reported to the nursery it is evident that there was confusion in the setting about how to respond to the allegation. The police did not immediately receive a report from the nursery, instead they attempted to seek advice from the LADO, who was not available at that time. C80 was told details of the allegation in the process of suspending him from the nursery. This included details about the language used by the child (the term 'nipple' was used by the family instead of penis), which could have affected evidence gathering. A family member of the child later reported the abuse to the police and C80 was arrested This created a delay in arrest of C80 and a potential that crucial evidence could have been lost.

204. This approach within the setting is possibly due to the rare, unthinkable, and shocking nature of such abuse. Sadly abuse in a nursery setting has happened before and could happen again, consideration

could be given to ensure settings have 'critical incident' procedures that are used in such cases. It is evident that there was a feeling of disbelief and a sense that "this could not have happened here" from the nursery owners from this point on. Parents reflected to the reviewer was that it felt as if nursery owners were suggesting it was impossible, because of CCTV, supervision, and staffing levels. This was also the view of the owners when communicating with partners and crucially Ofsted inspectors in their early visits to the setting when they attended shortly after the incident. Tragically this was not the case. It is clear that many perpetrators of abuse, whatever their motivation, will seek out opportunities to abuse regardless of how well guarded non abusive individuals or organisations feel they are against this.

Learning Point: Childcare settings should view safeguarding through a lens of '*it could happen here*' in the light of this review.
There is a crucial period for evidence gathering when sexual abuse is suspected. Consideration should be given to developing critical incident procedures within settings to respond to such cases in future.

205. An independent review into how local safeguarding partners responded to this case was reported in 2019. This stated that, *"based squarely on evidence collected, that Torbay's response as a safeguarding partnership to safeguarding issues at the [nursery] was outstanding"*. Two recommendations were made as a result of this review that are included in the recommendations section of this report. The Terms of Reference for this subsequent CSPR has led the reviewer to undertake a more in-depth analysis of the response from partners, identified learning is summarised below.

206. It is thankfully extremely rare that safeguarding partners would need to respond to a case as complex and difficult as this. It is evident that as the circumstances of the abuse unfolded, local partners worked together to share information and respond appropriately, echoing the positive findings of the earlier review. Given the rarity of the events there are some learning points that have arisen that can be actioned should similar cases come to light in future in Torbay or other local authority areas.

207. Parents of children that attended the nursery and contributed to the review provide helpful suggestions for learning from the response to this incident. There were mixed comments made about communication throughout this process. On the whole, communication from Police in later stages (from Autumn 2019 onwards) was seen as positive. All parents reflected positively how well police and the Crown Prosecution Service (CPS) had enabled the outcome via criminal proceedings. There was however a general feeling by parents that they were 'left in the dark' in the immediate days / weeks after the first reporting of concerns. Parents that were not directly involved in the initial reports knew that something major had happened but had no information about the nature of the allegations or how it impacted on their child's care. One parent described a connected group of parents that they felt 'knew everything' while there were others that new very little.

208. Clearly the level of appropriate communication was influenced by a need to ensure protection of evidence as part of the investigation, this was acknowledged and understood by parents. It is also evident that police were reviewing 250 hours of CCTV footage and it was not until later in the process that the details of the abuse that was carried out were uncovered, while this was not known by parents at the time, it does provide an explanation for this. There was much speculation and hearsay in the community about the abuse at this time, which is not uncommon in a case of this nature. The lack of factual information given to parents seems to have fuelled this further.

209. Early communications to parents of children attending nursery regarding this case were sent by the owners of the nursery. The earliest communication was sent by email and suggested that '*all safeguarding process are in place'*, it was an '*isolated incident'* and advised against discussing on social media. The mention of safeguarding highlighted the nature of allegations and subsequently

this caused anxiety. When enquiries were made about this to the nursery, parents were told they couldn't be given any further details and therefore felt that they were being asked to make their own decisions about continuing to send their child in to their care. It was difficult therefore for parents to make informed decisions about their children's future care arrangements in these early days given limited information that came from the provider.

210. Later in the investigation, communications were organised via the Police investigation team. Feedback from parents indicates these were viewed more positively given the factual information that was then sent from a more neutral position.

211. Communication with the carers of C80's siblings was also an issue, with the main carer discovering the details of allegations and arrest of C80 once the children had returned from school. This meant there had been no preparation work with the siblings in terms of what may happen once they returned to school. One of the siblings attended primary school opposite the nursery site and, given the area their school was based, many of both siblings fellow students and teachers had links to the case. The reviewer is aware also that there were bail conditions restricting C80's access and contact with siblings at this point, which the foster carer was not aware of and feels rightly that this should have been included in the multi-agency response in these earlier stages.

212. Parents input to this review demonstrated an ongoing need for practical and emotional support related to theirs and their children's wellbeing. The level of need varied for individuals according to their level of involvement in the case, including those directly impacted by abuse, those unable to identify if their children were victims and more generally for those who felt a level of anxiety related to their association with the nursery.

> Learning Points: Where police investigations relate to abuse within a childcare or similar setting, communications to parents and carers should be delivered by a member of the safeguarding partnership, rather than through an interested party or witness.
>
> A single point of contact should be established from the outset for this type of investigation specifically for proactive contact with concerned parents and carers in situations such as this, that signposts to appropriate support services. In line with the recommendations from an earlier independent review, this should be overseen by a lead senior officer.

213. It is evident in the information passed to this review that support needs were discussed in detail and actioned within the partnership silver and gold command groups and the local SARC was suggested as the key supporting specialist service. This came relatively late in the process and there was some mixed understanding about what could be offered by local specialist services which added further delay. Therefore this did not translate as support to parents in a way that met their needs at that time.

214. The evidence considered for this review clearly explains the actions of Ofsted as regulator of the nursery setting once the allegations of abuse had come to light. Inspectors use the Ofsted Early Years Compliance Handbook, which is in turn, based on the EYFS statutory guidance. Following thorough review of the actions of the regulator it is clear that all statutory guidance and handbook thresholds were applied appropriately in this case.

215. However, local partners have expressed a sense of frustration with the time taken between notification of concerns to suspension of the registration of the setting. This was rightly centred around concerns for the safety of the remaining children in the care of the nursery. As identified earlier in the report, it was the view of the that the owners of the nursery that the abuse 'couldn't have happened' in their setting. This positivity was communicated to an Ofsted EYRI in their initial visit, and this was tested to the level expected by their handbook. The setting adhered to all

requests made and were able to demonstrate the improvements made to specific actions that were agreed, for example in terms of inviting in the LADO. They responded to concerns regarding additional staff by suspending and investigating them promptly which in the Ofsted inspectors and senior officers view had removed the risk. All of this added to the positivity felt by Ofsted that the setting was reacting and responding appropriately. It is for these reasons that the setting was viewed optimistically by inspectors up to the point that the registration was suspended. An Ofsted representative contributing to this review reflected also that settings can and do challenge decisions relating to suspension of registration legally through tribunal. This means that inspectors are required to adhere to the framework that determines this should happen.

> Learning Point: Regulators and inspectors can adopt an 'it could happen here' approach when visiting settings following safeguarding incidents or concerns being raised.

216. In visits to the nursery, the EYRI spoke at length the owners of the nursery, observed practice, viewed a number of staff files, and met with practitioners. Practitioners did not disclose anything of concern, and observations of practice did also not raise any further concerns. C80's personnel file was not available at the nursery at any point, as it had been taken by police as evidence. The file was not requested by the EYRI as they had been concerned that this would have interfered with the police investigation. Viewing the file may have highlighted issues with the timing and details of reference requests, which may have led to further probing and questioning.

> Learning Point: Criminal investigations and evidence gathered as part of this, are not a barrier to seeking essential information that is required by regulators, this should be clarified and reinforced to inspectors.

217. Once concerns were raised regarding further staff members at the setting, regarding physical interventions, others witnessing this and the lack of awareness of this by owners, local partners explicitly raised concerns about the safeguarding culture and practice in the setting to Ofsted representatives. Ofsted Inspectors that had viewed CCTV footage and subsequently visited the nursery to explore the culture of the setting are noted to also have carried these concerns. The visit at this time focussed on observations and staff discussions, these gave no cause for further concern. Ofsted have identified that the time spent at the setting was limited (as Inspectors had also spent time reviewing CCTV nearby) which could have impacted on their ability to carry out their investigations. The suspended members of staff were not approached by Ofsted at this time, which could have provided vital information to enable Inspectors to probe further. Members of staff were much more open and descriptive about the culture of the setting once its registration had been suspended.

> Learning Point: Appropriate time is needed in such serious cases to ensure full investigations can take place to inform decision making by regulators. Past employees may offer a more open and descriptive view of settings where there are concerns about safeguarding practices.

218. It is clear that Ofsted Inspectors were required to follow the due processes relating to their own guidance, and this, at times was in conflict with local partner expectations and concerns regarding children in the setting. Partners regularly challenged and questioned decisions made by Ofsted inspectors through their attendance at gold and silver command meetings, and on most occasions partners presented as concerned but satisfied with next agreed courses of action. It is not clear if Ofsted representatives were invited to every part of every meeting or if they were able to attend all of the sessions, perhaps due to their own limited resources. It is clear that at key points in this case there was a continued level of dissatisfaction from some of the local partners. Escalation of concerns to a more senior / regional level within Ofsted was considered at times, although not actioned or completed. Ofsted representatives held internal case discussions at appropriate stages in the management of this case, these were single agency. Consideration of a including a lead partner (in

these cases the police SIO), particularly where there is remaining concern about the thresholds and actions being taken may enable a stronger sense of working together to safeguard children.

> Learning Point: In order for children to be fully safeguarded in responses to such complex cases, local partnerships and regulators need to work together, sharing appropriate levels of information to inform their work and aid in decision making. Where concerns are raised and responses deemed unsatisfactory to achieve this, escalation of these concerns, between appropriate senior leaders, should occur.

219. The National Child Safeguarding Practice Review Panel and TSCP leads had communicated regularly regarding the type and level of review to undertake at points within the period of this review. It is evident that there was a change in direction communicated by the National Panel over the course of that period in terms of the type of review that was being suggested. The eventual decision that this should be a local review was due to practicalities related to the onset of the Covid 19 pandemic. Torbay partners had undertaken other activities to quality assure responses including an independent review of partner responses to the allegations and a local Rapid Review. The latter took place later than the statutory timescales that are detailed in Working Together 2018. This, and the need for a Serious Incident Notification was prompted by the National Panel in one of their communications to TSCP. Local leads asked for clarification on regarding thresholds for these and both then took place. The reasons for this delay were linked to interpretation of statutory guidance and criteria for notification / review, but are also explained by partners as potentially due to a change in local partnership arrangements from a regional safeguarding children partnership to one more local to Torbay.

> Learning Point: The combined learning from previous reviews has been included in this CSPR and is presented as part of this report. Decision making related to the nature and type of review required by the National Panel and TSCP caused some delay in the commencement and completion of this CSPR.

Good practice in C80's case history.

220. Safeguarding Partnerships can learn as much from good practice as it can from practice requiring improvement. In the course of this review examples of positive practice have been demonstrated, including the following:

- There were timely multi agency interventions to protect C80 and his siblings once in Torbay area. Therapeutic work was commissioned and was making good progress prior to it ceasing.
- C80's voice was represented well at times, because of the contacts he had with the advocacy service, and this was fed in regularly. A male CCW from children's services provided consistency and role modelling for C80 at a time when there was high turnover of social workers.
- There is evidence of shared multi agency knowledge regarding C80's missing episodes, particularly relating to C80's mother's role in these.
- Safeguarding work by the Local Authority with early years providers is regularly evident including termly Designated Safeguarding Lead (DSL) meetings, training, and self-assessment safeguarding audits. LADO work has developed well with early years settings to build relationships and awareness.
- An open and engaged partnership approach to safeguarding has been demonstrated in the engagement in this review, demonstrated by panel and also by the positive input of practitioners to the process. There is clear evidence of improvements in leadership and practice in Torbay since this time.
- Partners coordinated responses to the incident well while protecting evidence, through regular and well attended gold and silver command meetings.

Recommendations

The following recommendations are made in the light of the learning from this review. Unless otherwise stated, these recommendations are for the Safeguarding Partners as TSCP:

1. Develop a partnership wide restorative / trauma informed approach in systems for care experience children, specifically:
   - Education (pre and post 16) relating to behaviour / disciplinary approaches
   - Placements and suitability assessments
   - Working with hostile and coercive parents
   - Language used and recording concerns
2. Raise awareness of the impact and indicators of child sexual abuse with practitioners and carers of care experienced children.
3. Seek assurance of partners responses to sexual abuse particularly the communication of a child's experience in referrals, plans and assessments.
4. Ensure timely delivery of Life Story Work with care experienced children, and that where therapy is commissioned for a care experienced child that:
   - It is completed when there is placement disruption
   - Recommended assessments take place
   - Progress of this informs care planning
5. Consider ways to improve the confidence of local practitioners in distinguishing between 'normal' age-appropriate relationships and behaviour that may cause concern.
6. Ensure that consideration is given to implement best practice tools for assessment (incl. Brook Traffic Light Tool) within TSCP's current review of HSB policy / procedures.
7. Seek assurance of the implementation of improvements to the post 16 offer to care experienced children – specifically personal advisor provision, pathway planning and virtual school.
8. Request assurance of quality and timeliness of handover of safeguarding information between secondary and post 16 education providers.
9. Seek assurance that robust commissioning processes are in place for independent residential care providers and that this includes requirements of the placing LA to meet needs of child in standard operating procedures as well as use of the TSCP Allegations Management Procedure.
10. Ensure all practitioners, including early years and childcare settings, understand how to respond to concerns relating to under 18's / apprentices working in positions of trust, and the role of the LADO.
11. Ensure 'out of hours' access to LADO related advice and support
12. The Department for Education (DfE) should provide statutory guidance for post 16 education providers relating to safer recruitment procedures for students enrolling on childcare courses.
13. Ensure all early years and childcare settings aware of TSCP Safe Recruitment procedures specifically in relation to standards relating to seeking pre-employment references
14. Seek assurance from schools and colleges to ensure there is proactive contact with employers when references are refused or sent incomplete as a student is deemed as not suitable for work in a position of trust with children or other vulnerable people.
15. Provide clarity to education settings and other partners regarding GDPR and what can be included in references relating to students
16. DfE should review the EYFS framework in the light of this review, specifically in terms of:
    a. Providing statutory guidance on safe recruitment requirements and pre-employment checks to mirror expectations in KCSIE for schools and colleges

b. Defining further what is meant by 'competent and responsible' in terms of those under 17 working in early years settings
c. Clarity of use and purpose of CCTV in early years settings
d. Identifying safeguarding concerns relating to the layout and design of toilets and areas used for intimate care.

17. Early years settings and childcare providers should reflect on the learning points highlighted in this review, evaluating their safeguarding practice, and setting culture, through a lens of *'it could happen here'*
18. Raise awareness of whistleblowing procedures and the national Whistleblowing Advice Line specifically targeting frontline, early years practitioners.
19. Consider ways develop safeguarding assurance work with EY settings, such as 'deep dive' audit work and practitioner involvement to address themes from this review and adherence to safeguarding related elements of the EYFS guidance, specifically regarding:
    - Inclusion of under 17's in staff: children's ratios
    - Supervision of under 17's
    - Safeguarding within supervision and observation of practice
    - Staff feedback and monitoring of practice (including CCTV)
    - Record keeping where physical intervention used / process for informing parents
    - Whistleblowing practices including record keeping and Ofsted notification where statutory criteria met.
20. Develop a framework for responding to complex and high-profile safeguarding issues that includes from the outset.
    - assigning a single officer to take a 'helicopter or balcony' view of the process
    - providing a single point of contact for parents / stakeholders
    - ensuring communication is sent from an independent organisation
    - Sending proactive, coordinated communication that reaches all stakeholders
    - Providing specialist support to those affected.
21. Ensure practitioners and leaders are aware of and utilise TSCP escalation policy, and that this and other escalation routes are used as necessary to safeguard children
22. Ofsted should use the lessons learnt from the independent review to influence regulatory policy and practice, and to brief inspectors inresponding to serious incidents and/or allegations in regulated settings.
23. Ofsted and the National Police Chiefs' Council should develop a joint protocol to support working together when responding to serious incidents in regulated settings, including:
    - Opportunities for joint work within parameters of investigation
    - Contact points for both parties
    - Information sharing to enable full consideration of thresholds for interventions
    - Participation in local multi agency meetings
    - Escalation routes for local partners within Ofsted.