Havering LSCB

Serious Case Review

Overview Report and Executive Summary

Abuse of children by a registered childminder

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Introduction

Between June 2015 and June 2016 Havering Safeguarding Children Board conducted a Serious Case Review about two children, both under the age of one, who had been injured at different times by their registered childminder. This report presents the full findings of the review.

The function of the Serious Case Review is to provide a rigorous analysis of the actions and decisions of professionals and to identify ways in which services for other children and their families can be improved.

The report is a comprehensive one which has implications for the local authority, the Metropolitan Police, health services and Ofsted. I am grateful for the cooperation of all of those agencies in working with the board and the independent reviewer in carrying out a very thorough review. I am particularly grateful to the parents of the two injured children who have offered considerable assistance, in very difficult circumstances.

This is a complex Serious Case Review. In order to make the learning from the review as accessible as possible the findings of the overview report are presented in the following way:

- *Part 1 of the report is an Executive Summary - this explains why and how the review was undertaken and provides an overview of the key events and findings.*
- *Part 2 contains the recommendations made for individual agencies, Havering Safeguarding Children Board and national recommendations*
- *Part 3 provides a full explanation of the most important findings of the review. As well as explaining what happened and why it seeks to describe the underlying causes of shortcomings in services*
- *The appendices to the report contain detailed information about the key events and the services that were provided for the families, the views of the parents, further information about how the review was carried out and other background information.*

I hope that by setting out the report in this way it will be possible for readers with different objectives to find the information that they need.

The publication of this report was considerably delayed by the complex criminal investigation into the injuries to the children and the concern of the safeguarding board not to prejudice the criminal trial. In 2016 the board agreed a plan setting out in detail the actions that agencies and the board would take to implement the learning from the review.

Brian Boxall

Independent Chair

Havering Safeguarding Children Board

Abuse of children by a registered childminder

1. EXECUTIVE SUMMARY

1.1. Between June 2015 and June 2016, Havering Safeguarding Children Board (the LSCB) conducted a Serious Case Review (SCR) in relation to the services provided for two infants, referred to in this report as Child A and Child B. On separate occasions both children suffered serious injuries while in the care of their childminder. Before these events both children had been healthy, developing normally and living unremarkable lives.

1.2. The review was carried out under the guidance *Working Together to Safeguard Children 2015*. Its purpose is to undertake a *'rigorous, objective analysis of what happened and why, so that important lessons can be learnt and services improved to reduce the risk of future harm to children'*. The LSCB is required to *'translate the findings from reviews into programmes of action which lead to sustainable improvements and the prevention of death, serious injury or harm to children'.*[1] This document sets out the SCR findings which, in keeping with the statutory guidance, are published in full.

Reasons for conducting the Serious Case Review

1.3. In October 2014 Child A (who was nine months old at the time and had been looked after by the childminder for less than a week) suffered a fractured femur. The local authority, the Metropolitan Police Service, Ofsted and health professionals investigated the injury and the care provided to Child A and concluded or accepted that the injury had been caused accidentally while Child A was attending a playgroup under the supervision of the childminder. As a result the childminder was able to continue working.

1.4. In March 2015 Child B (who was seven months old at the time and had been cared for by the childminder for six weeks) suffered very serious head injuries, as a result of shaking and an impact. Medical staff treating Child B were immediately concerned that these injuries may have been inflicted by an adult carer and steps were taken to provide specialist treatment for Child B and to protect the young children of the childminder. Ofsted, which has responsibility for the registration and inspection of childminders, immediately suspended her and she subsequently resigned as a registered childminder.

1.5. The Family Court subsequently ruled that, on the balance of probabilities, both sets of injuries had been caused by the childminder. The court also found that the childminder had delayed seeking medical care for both children. The Family Court rejected the explanations given by the childminder for the injuries, including those previously accepted by professionals as being plausible in relation to Child A.

[1] Working Together to Safeguard Children (2013), 4.1 and 4.6

1.6. The childminder was later convicted of assaults occasioning grievous bodily harm in relation to both children.[2]

1.7. The case review sub-group of Havering LSCB met on 31 March 2015 to consider the provision of services made for both children and the role of the childminder. It recommended that the circumstances met the criteria for undertaking a SCR because both children had suffered serious harm and there were concerns about the way in which agencies had worked together to safeguard the children. Brian Boxall, the Independent Chair of Havering LSCB, confirmed the decision to hold a SCR on 16 April 2015.

The focus and scope of the Serious Case Review

1.8. In its initial discussions the panel overseeing the review agreed broad terms of reference and specific aspects of service provision for participating agencies to investigate. These are set out in full in Appendix 6. As the review progressed it focused on the following:

- The registration, training and support of the childminder
- The response of the hospital to the presentation of Child A with a fractured femur
- The initial response of police and social care to Child A's injuries
- The role of the Local Authority Designated Officer (LADO) and the effectiveness of the LADO meeting
- Criminal investigation of Child A's injuries
- Social care enquiries following Child A's injuries
- The decisions by Ofsted not to suspend the childminder
- The role of the Havering Early Years Service and the allocation of safeguarding responsibilities within the service
- The role of Ofsted in evaluating the suitability of the childminder to continue to work
- The capacity of the safeguarding system in Havering to recognise and rectify errors
- Professional response to the injuries to Child B

1.9. These topics are addressed in detail in Section 3 of this report. They relate primarily to the provision made by agencies in relation to the childminder and the injuries sustained by Child A. The evaluation in Section 3 of the report includes comment on some aspects of service provision in which there were clear shortcomings, as well as others where procedures were followed correctly, but where the case should trigger wider reflection on current approaches.

[2] Section 20 of the Offences against the Person Act 1861

1.10. Section 3.11 of the report comments more briefly on the practice in relation to Child B. This was found, in the main, to have been good, reflecting the way in which agencies would expect their staff to work.

Agencies involved

1.11. The SCR considered the work of the following agencies:

- Havering Council (Children's Social Care Services and Early Years Service)
- Metropolitan Police Service (the Child Abuse Investigation Team covering the boroughs of Havering and Barking & Dagenham)
- Barking, Havering and Redbridge University Hospitals NHS Trust (Emergency Department Queens Hospital, Department of Paediatrics and Orthopaedic outpatients)
- Ofsted (which registers prospective childminders and inspects the services they provide)

The review has not focused on the GP, primary care or community health services provided to the children prior to their injuries because (as previously noted) both were ordinary children, developing normally. It refers in passing to the role of the health visiting service provided by North East London Foundation Trust.

How the review was undertaken

1.12. Details of the steps taken to carry out the review are set out in Appendix 7. Participating agencies prepared individual management reviews. The independent reviewer took part in interviews with a number of key staff in order to understand the reasons for their decisions and actions and held separate meetings with senior managers in agencies. A large number of original records have been reviewed.

1.13. The parents of Child A and Child B have been kept informed about the progress of the review and have contributed to its findings through interviews with the independent reviewer and the Business Manager of Havering LSCB. The views and concerns of family members are summarised in Appendix 2 and have informed the report at a number of points.

1.14. The childminder and members of her family were not involved in the SCR because of the parallel criminal prosecutions and the risk of prejudice to other legal proceedings.

The remit the Serious Case Review in relation to legal action, and to other investigations and findings

1.15. Given the circumstances, the parents of both Child A and Child B told the SCR that they had reserved the right to initiate a claim to establish whether their child was harmed because the childminder or any of the agencies involved fell short of their legal duties and responsibilities. They agreed to wait until the completion of the SCR and the criminal proceedings before deciding whether to take action over this.

1.16. In keeping with the statutory guidance the purpose of the SCR is:

- to establish the actions taken by agencies involved
- to understand the reasons for the decisions and actions taken by professionals
- to identify strengths and weaknesses in services, both those which affected practice in the individual case, and those which might affect services for children more widely
- to assist the LSCB in reaching a better understanding of any weaknesses and where possible to make specific recommendations about how services can be improved.

1.17. The responsibility of the SCR is to learn from this case in order to propose ways in which services could be improved. It does not apportion blame to specific individuals or agencies as a result of their judgement, decisions or actions. The SCR notes the findings of the Family Court and the criminal proceedings.

Summary of key events and SCR findings

1.18. The following paragraphs are a brief summary of key events and of the SCR findings. Appendix 1 has a detailed narrative of events. Section 3 sets out the findings of the review in full and explains the underlying causes of the shortcomings identified.

Child A's injuries and the response of agencies (October 2014 – January 2015)

1.19. Ofsted registered the childminder in March 2012. In September 2012, in keeping with its normal practice, Ofsted inspected the childminder, visiting her home and seeing her interact with her own children and some of the children that she was childminding at the time. The service she provided was rated as being 'good'.

1.20. On 3 October 2014 the mother of Child A collected her from her childminder. Child A was disturbed that night and unable to move her leg the following day. Her parents took her to a walk in centre from where they were directed to the Emergency Department (ED) of the local general hospital. Hospital staff identified and treated the fractured femur but did not suspect abuse and did not refer Child A to the local authority or the police.

1.21. Child A's parents informed the police directly and uniformed officers visited their home the same day. Based on accounts given originally by the childminder, the police officers formed the impression that the injuries had been caused accidentally by another child in an incident at a playgroup.

1.22. The uniformed police officers referred the circumstances to the police Child Abuse Investigation Team (CAIT) which in turn notified the local authority. Discussions took place between the referrals desk of the CAIT (which manages all new cases referred) and a social care manager working in the multi-agency service hub (MASH) which makes initial decisions about the level of local authority response to the referral.

1.23. They agreed that the local authority would make further enquiries and obtain information from the hospital. The police would await the outcome of these inquiries. As the childminder was a professional person working with children the Local Authority Designated Officer (LADO) was involved. The LADO is an experienced member of staff who has the role of coordinating different aspects of the investigation of allegations involving professionals who work with children.

1.24. Over the next four days, information was obtained from the hospital. This confirmed the serious nature of the injury and led the hospital to recognise that a referral should have been made when Child A was first treated. There were discussions between the LADO and Ofsted. Based on the information provided, Ofsted decided at that point that there was insufficient information to suspend the childminder from her role.

1.25. On 14 October 2014 (seven working days after the initial incident) the LADO chaired a strategy meeting attended by representatives of the local authority (social care) the police (CAIT) and the hospital. Other agencies had been unable to attend because the meeting was rearranged at short notice.

1.26. The consultant paediatrician confirmed that the injury had been caused by a 'significant force' and that based on the medical evidence so far obtained it had occurred between 7 hours and 7 days prior to the hospital attendance. The meeting agreed that the local authority would continue with its Section 47 (child protection) enquiry and the police would review whether there needed to be a criminal investigation. The LADO updated Ofsted and the decision not to suspend the childminder was confirmed.

1.27. Over the following weeks a police officer and a social worker undertook joint enquiries which included visits to the playgroup and interviews with Child A's parents and the childminder. These enquiries were focused on the care provided to Child A by her parents and the childminder and the reported incident at the playgroup. No attention

was focused on the health or development of the childminder's own children.

1.28. The local authority concluded on 14 November 2014 that there was no cause for concern about the care provided for Child A by her parents. The social worker was concerned about discrepancies in the childminder's account about how Child A had been injured, but the local authority did not pursue this. The police decided that it was not possible to prove when and how Child A had been injured, making a criminal prosecution impossible. Police enquiries were closed in December 2014. The LADO strategy meeting was not reconvened so the outcome of these enquiries and the concerns of those involved were not evaluated collectively by the agencies involved.

1.29. While their enquiries were underway, Ofsted relied on the information gathered and communicated by the LADO and the police. At the request of the LADO Ofsted delayed undertaking its own assessment of the care provided by the childminder. On 12 December 2014 an Ofsted inspector visited the childminder to begin its own assessment by checking her records and registers, including the accident records.

1.30. Ofsted took no further action until January 2015 when the mother of Child A phoned Ofsted to bring attention to the lack of action taken about the childminder. Child A's mother was concerned that 1) the police were now taking no action 2) the local authority had assessed the parents' care of Child A but did not seem to have a role in relation to the childminder 3) she believed that Ofsted was the family's 'last hope' of finding out how Child A had been injured.

1.31. An Ofsted inspector visited the childminder on 21 January 2015. Based on the information received by Ofsted from the police and the LADO, reinforced by the concerns of Child A's mother about poor supervision, this visit took as its starting point the assumption that the injuries to Child A had occurred accidentally at the playgroup. It identified a series of concerns about the practice of the childminder in failing 1) to assess potential hazards at the playgroup before taking children there 2) to supervise the children in her care properly and 3) to notify parents of incidents. Ofsted asked the childminder to take action to remedy these concerns in order to remain registered.

1.32. On 3 February 2015 Ofsted posted an account of these findings on the website www.childcare.co.uk (see Appendix 4). This was its normal practice and was designed to enable other parents to take the information into account in deciding whether to use the services of a childminder. On 8 February 2015 the childminder sent Ofsted a written response setting out how she proposed to comply with the requirements of the previous visit.

1.33. The Ofsted inspector was satisfied with the evidence from the letter and her visit. As a result Ofsted updated the website to indicate that

Ofsted had carried out a monitoring visit to the premises to check that the childminder was meeting the actions set and that it was satisfied with the action that the childminder had taken, as a result of which she remained registered with Ofsted.

Contact between the childminder and Child B's parents

1.34. Child B's parents began looking for a childminder in October or November 2014. They did not record the exact dates when they started looking or first made contact with the childminder, so it is not possible to locate their contacts in the chronology of events relating to Child A above. However they are certain that when they were looking for a childminder they had no knowledge of the injury to Child A, the childminder's account of the events described above or the involvement of other professionals during October and November 2014.

1.35. Child B had introductory visits to the childminder during January and February 2015. Child B first attended sessions with the minder on 11 February 2015. Her parents had no concerns about the care that was being provided though on one occasion Child B had a small bruise.

1.36. On 16 March 2015 Child B was seriously injured while in the care of the childminder. Her injuries were immediately recognised as being life threatening and potentially caused by abuse by an adult.

Summary of the evaluation of services provided

1.37. In all of Ofsted's contacts with the childminder during her initial registration and inspection the organisation complied with the requirements of the Early Years Foundation Stage (EYFS) as they applied at that point. No evidence was identified of potential risks posed by the childminder.

1.38. The hospital treated the injuries to Child A correctly but failed to recognise that such a severe injury in a small child was extremely suspicious and should have been referred immediately to the local authority and the police for investigation.

1.39. The police investigation fell below the standard required and expected. Central to this was the failure to challenge or seek further clarification of the timeline given for the injury to Child A. At an early point police officers formed an assumption that the injury had been caused accidentally. This strongly influenced the further steps taken by the police and resulted in the investigation of a very significant and concerning injury being given a low priority. There was no independent evidence to support the childminder's account that Child A had been injured at the playgroup, but the police failed to pursue lines of enquiry which could have defined the timing of the injuries to Child A more precisely.

1.40. The local authority satisfied itself that Child A's parents did not present a risk to her. The social worker was suspicious about the childminder's account but she felt unable to pursue these concerns and there was no management oversight of the social work assessment. No consideration was given to the need to evaluate any risk to the children of the childminder. It was left for the police to determine how the injuries had been caused.

1.41. The LADO did not ensure that the possible risks to Child A from all sources and the risks to the children of the childminder were properly evaluated. No consideration was given to risks to other children being looked after by the childminder. At the end of the investigation the local authority should have brought the professionals together to evaluate critically the outcomes of enquiries by the police and social care.

1.42. Ofsted relied on the information provided by the police and the LADO and then by Child A's mother. It did not challenge the poor quality of the investigations which had been conducted. As a result it undertook its own assessment of the childminder on the basis of a set of false assumptions about how Child A had been injured.

1.43. Section 3 sets out the explains the underlying causes of the shortcomings identified.

Recommendations and action to implement them

1.44. Section 2 of the report sets out the recommendations made by the SCR for the LSCB and for participating agencies. It also summarises recommendations made by individual agencies in their own management reviews.

2. RECOMMENDATIONS

2.1. Multi-agency and partnership recommendations

	Section in the report	Reason for making a recommendation	Intended outcome	Recommendation for member agency or LSCB
1.	Role of the LSCB	The LSCB oversees the implementation of recommendation and challenges agencies to make the changes they have identified as necessary and to show that they are having an impact	The implementation of recommendations will be monitored to ensure that they impact positively on services for children	1. Havering LSCB should monitor the implementation of recommendations made in this report and in the individual management reviews submitted by participating agencies
2.	3.1	The registration and inspection of the childminder by Ofsted complied with the current requirements of the Early Years Foundation Stage (EYFS). Children under the age of one year are known to be more vulnerable than older children but at present the EYFS does not contain any additional requirements for those childminders who propose to look after such children. The current EYFS is heavily focused on educational outcomes which are of least relevance to infants under the age of 12 months.	Government will have an opportunity to consider, alongside others with an interest in improving the quality of childminding, whether the current emphasis and scope of the EYFS adequately reflects the needs of children under the age of 12 months.	2. The Independent Chair of Havering LSCB should make the findings of the SCR known to the Department for Education so that it can consider whether the Early Years Foundation Stage currently offers the best approach to safeguarding the wellbeing of children under the age of 12 months and whether it should be reviewed. Attention should be drawn specifically to the following: the registration and inspection of childminders caring for children under the age of 1 year; whether the current approach to safeguarding is helpful in relation to the registration of childminders; the responsibility to inform the parents of

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		Fundamentally parents have to make their own decisions as to whether a childminder is the right person to look after their child. In this case the official 'endorsement' of registration and the trappings of the childminder's policies and procedures provided parents with a false sense of security.		other children when an allegation has been made against a childminder. (cross reference to recommendation No 15)
3.	3.2	There were shortcomings in the recognition and referral of safeguarding concerns in the hospital Emergency Department (ED) and paediatric services. Wider audit of cases has found concerns about standards of practice in other cases. Nationally it has been shown that safeguarding services are likely to improve in hospital trusts when the work involves all of the divisions that contribute to safeguarding; led at board level and also able to fully involve front line staff in the development of actions and review of progress.	There will be evidence of continual improvement in the recognition and referral of safeguarding concerns in the ED at BHRUT hospitals	3. Havering LSCB should arrange for regular review of progress on the current Barking, Havering and Redbridge University Hospitals NHS Trust safeguarding action plan, including undertaking direct auditing of practice where appropriate. 4. The Chief Executive of BHRUT and the hospital trust board should ensure that senior staff in all hospital divisions are fully engaged in the safeguarding improvement action plan and held to account. 5. The Chief Executive of BHRUT should ensure that front line staff are consulted about and fully engaged in efforts to improve safeguarding practice.

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		The LSCB should seek assurance that this is how the hospital is approaching its improvement work.		
4.	3.3	A culture of very rapid decision making had developed in the Havering multi-agency safeguarding hub MASH which limited the capacity of managers involved to reflect on their decisions and limited discussion and challenge in decision making between police and social care. Strategy discussions had habitually become brief and usually involved only police and social care, even in some complex cases.	Decision making in the MASH will reflect a better balance of speed and thoroughness and provide better scope for reflection and discussion in decision making	6. The LSCB should ensure that it has a good understanding of the nature and quality of strategy discussions and decision making in the MASH and social care assessment teams.
5.	3.4	The LADO function was not effective in this complex case because the officer who took on the LADO responsibility was not experienced in the role and was not well supervised. Some professionals in other agencies had a limited understanding of the LADO role and procedures.	The Havering LADO service will provide a strong and effective contribution to safeguarding arrangements and be properly understood by other professionals working with children	7. Havering LSCB should ensure that the local authority is providing it with a detailed understanding of the quality and effectiveness of the work on the LADO service

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		There was no review or audit of the case when it was handed over to a new member of staff and a new manager. Boundaries and distinctions between LADO meetings and other meetings that form part of the normal child protection arrangements were unclear Additional complications arose from the fact that childminders have no employer who can assist in making decisions about the management of risk		
6.	3.5	There were important shortcomings in the work of the police Child Abuse Investigation Team which arose as a result of the pressure of workload on the team and the lack of specialist experience and training of officers and managers. From 2013 both internally and in discussions at Havering LSCB the impact of workload pressure on performance and quality of the	Senior managers in the Metropolitan Police Service and the LSCB will have mechanisms in place to ensure that they are aware of shortcomings in the quality of work undertaken by the CAIT whether they be due to workload pressures and other sources and will take steps to minimise risks Detectives and supervisors in CAIT teams across the Metropolitan Police Service will have sufficient	8. The chair of Havering LSCB should share the SCR findings with the independent chair of the LSCB in Barking and Dagenham. 9. Both LSCBs should ensure that they offer regular, close scrutiny of the performance of the Child Abuse Investigation Team (CAIT) covering the two boroughs and that the boards are rapidly informed of difficulties the single or multi-agency working of the CAIT (including referral, strategy discussion and investigation).

	Section in the report	Reason for making a recommendation	Intended outcome	Recommendation for member agency or LSCB
		work of the team had been recognised but the steps taken had not been effective	knowledge of specialist aspects of child protection work to be able to play a full role in multi-disciplinary alongside colleagues from other disciplines and be able to understand and challenge their perspectives when required.	10. The boards should ensure that there is regular liaison with senior officers in the Metropolitan Police Service child abuse and exploitation command (SOECA) and that there should be transparency and frankness in the discussions between the two bodies about the performance of the CAIT. 11. The Metropolitan Police Service should take steps to improve the training of officers with supervisory responsibilities in CAITs in more advanced and complex child protection work.
7.	3.6	There were only limited supervisory and management interventions in the local authority work and none at key points in the case history. There was no review or sign off of the social work assessment and closing summary because the manager was away on leave and then sick. Despite its complexity and seriousness the case was never referred to a more senior manager.	The quality of social care supervision provided at all levels in the organisation will be adequate to the tasks being undertaken, particularly in complex and serious cases. First line managers will play a full part and will critically reflect on complex work and challenge staff internally and in other agencies when necessary. Agencies will be aware of the vulnerability that can develop when a staff are acting in interim or	12. Havering LSCB should seek evidence from the local authority that the quality of supervision provided at all levels in the organisation is adequate to the tasks being undertaken, particularly in complex and serious cases. In particular the board should seek assurance that first line managers in all services are playing a full part and are able to critically reflect on complex work and challenge staff internally and in other agencies when necessary 13. Havering LSCB should consider whether

	Section in the report	Reason for making a recommendation	Intended outcome	Recommendation for member agency or LSCB
		The review identified that in a number of instances managers were acting in new roles, fulfilling responsibilities with which they were not familiar or covering for more than one post.	temporary roles or in roles for which they have limited experience	member agencies are sufficiently aware of the vulnerability that can develop when a number of managers are acting in interim or temporary roles or in roles for which they have limited experience. It should satisfy itself that local management arrangements are sufficiently robust.
8.	3.7	During the period when the police, social care and Ofsted were conducting investigations into the injury to Child A and the practice of the childminder, the parents of other children using the childminder and parents of prospective were not informed about the concerns about her conduct. This arose in part from the fact that childminders have no employer who regulate their contact with children during the period when an investigation is underway. The outcome summary posted by Ofsted on public websites complied with the legal	When an investigation is taking place into the practice of a childminder Ofsted and other involved professionals will consider the potential risk to other children placed with the minder and those who are considering using the childminder. (Ofsted cannot decide on its own to inform the parents of other children, but it is best placed to take this into account in discussions in all local authority areas)	14. Ofsted should remind local authorities that when it is investigating a concern, it does not share information about the investigation with parents or the public until it has concluded and then only if the concerns are substantiated. It is therefore for local authorities to determine whether there may be circumstances when this has implications for children attending the setting or for parents who are considering placing their children there. 15. The Independent Chair of Havering LSCB should ask the Department for Education to consider whether it is feasible to make a more permanent change to the regulatory framework to offer better information to other parents and families when the practice of a childminder is under investigation, without unnecessarily jeopardising the childminder's privacy and

	Section in the report	Reason for making a recommendation	Intended outcome	Recommendation for member agency or LSCB
		requirements but was not written in a way which could be understood by prospective users of the childminder or would have alerted them to the nature of the concerns about the childminder's practice.	Summaries of the outcomes of investigations by Ofsted into complaints and concerns about childminders will be written in plain English and convey in practical terms what concerns there have been about the childminder and what steps have been taken to address them.	livelihood. (Cross reference to recommendation No 2) 16. Ofsted should ensure that in future summaries of the outcomes of its investigations into complaints and concerns about childminders will be written in plain English and convey in simple, practical terms what concerns there have been about the childminder and what steps have been taken to address them. Ofsted should work with partners in Early Years Services to ensure that such summaries of concerns are prominent on public websites about childminding services.
9.	3.8	There was no shared understanding among managers in the Havering Early Years Service as to the scope of the role played by the service in safeguarding and the responsibilities of individual managers. This meant that the service was not proactive in following up concerns about the childminder and the decisions	Policies and procedures of the Early Years Service will set out clearly the roles of the service in relation to safeguarding, including when there is a safeguarding concern in an early years setting. The service will monitor the impact of its work when safeguarding concerns arise in any early years setting and report regularly to Havering LSCB.	17. Havering LSCB should assure itself that the Early Years Service is implementing its safeguarding responsibilities fully and effectively

	Section in the report	Reason for making a recommendation	Intended outcome	Recommendation for member agency or LSCB
		reached by other agencies		
10.	3.9	Errors made early in the case history were never recognised or rectified.	Safeguarding arrangements will be resilient and offer (through supervision and challenge to practice) opportunities to identify and rectify errors in practice	18. Havering LSCB should initiate discussion with member agencies about the quality and focus of their supervision, in particular seeking to ensure that supervision provides an overview of the case and does not focus exclusively on current tasks. Audit arrangements for supervision should also not focus solely on procedural compliance.
11.	3.5, 3.6, 3.10	There was insufficient evidence of challenge about the conduct and findings of the investigation into Child A's injuries either within or between agencies. The LSCB has taken steps to promote a culture in which constructive challenge is a normal part of day to day working, but it is unclear how often this happens and how it could be promoted further.	Constructive challenge within and between agencies will be part of the normal culture of day to day work in safeguarding.	19. Havering LSCB should review how far constructive challenge is part of the normal culture of day to day work in safeguarding and consider what further steps it can take to promote this way of working and thinking both within and between agencies

2.2. Recommendations made by individual agencies

2.2.1. In addition to the recommendation made in in the SCR overview report, individual agencies have made recommendations which address more detailed internal policies, procedures and practice. These address the following topics. Havering LSCB will monitor the implementation of these recommendations as well as those arising from the SCR overview report above.

Metropolitan Police Service

- Review of the resources (numbers and level of skills of staff) that are allocated to the investigation of child abuse to the borough of Havering and across London
- Further detailed review of the decisions and actions of officers involved in the investigations in order to determine whether management action is required
- Further work to raise awareness of the need to complete notifications of incidents involving children and young people (MERLIN reports)
- Reminder of the need for officers to refer to current guidance on investigation and in particular the need to escalate concerns to senior officers when there are disagreements about the way in which safeguarding cases are being managed

Havering Council Early Years Service

- The implementation of a comprehensive auditing system in the service to provide information for senior managers about the way in which the Early Years Service is implementing its safeguarding responsibilities

Havering Council Children's Social Care

- Training on the role of the Local Authority Designated Officer in Havering
- Improved supervision arrangements for practitioners so that they receive better feedback on decisions and are able to reflect more regularly on their work
- Equipping managers with better approaches to supervision of staff

Barking, Havering and Redbridge University Hospitals NHS Trust

- Sharing findings of the internal investigations with the parents of both children and with all staff involved

- Review of the level three safeguarding training and additional training and reflection on the case for staff involved
- Revised procedures for the filing and sharing of strategy meeting minutes so that they become part of the patient's hospital record and any actions for hospital staff are acted on
- Implementation of the findings of the wider thematic review of safeguarding cases
- Inclusion of details of the case history and clinical presentation in staff training
- Strengthening the scrutiny given to safeguarding in consultant's annual review and appraisal

Ofsted

- Review of internal policies and procedures to ensure that there is a stronger challenge to agencies (such as the local authority and police) over delays and poor practice in the investigation of allegations
- Giving greater priority to attendance at LADO meetings where there are allegations involving childminders and other services regulated by Ofsted
- Strengthening arrangements for the review of cases where there are allegations against service providers so as to ensure that they take account of all information held by Ofsted

North East London Foundation Trust

- Improved arrangements for obtaining and following up reports from ED on children
- Clarified expectations that staff working with a child need to make contact with the local authority when they are aware that a child protection enquiry is taking place

3. SERIOUS CASE REVIEW FINDINGS

3.1. The registration of the childminder, her training and support

Introduction

3.1.1. This section of the report examines the registration of the childminder in 2012 and the inspection visit made by Ofsted later that year. It also describes the contact between the childminder and Havering Council's Early Years Service during 2012 and 2013. All of these contacts were in keeping with the approach normally adopted by agencies. Although some weaknesses have been identified in the initial registration of the childminder, there is no evidence that they can be linked to any risk to the children in her care.

3.1.2. This section of the report also considers wider aspects of the registration and inspection of childminders.

3.1.3. The role of Ofsted in deciding whether to suspend the childminder and in evaluating her ability to continue as a registered childminder after the injuries to Child A are dealt with in Sections 3.6 and 3.9.

Evidence identified by the SCR

3.1.4. The childminder applied to Ofsted to register in January 2012. She was registered in March 2012. Appendix 3 of this report reproduces in full the section of the management review provided to the SCR by Ofsted which describes the registration process, including background checks, references and a visit to the home conducted by an independent service provider. This shows that Ofsted and the independent contractor complied with the guidance in the Early Years Foundation Stage (EYFS) that existed at that time.[3] No concerns were identified that could have pointed to any risks of serious harm to children.

3.1.5. Ofsted has drawn two points to the attention of the SCR. The first is that the record of the registration visit is not clear whether the

[3] The EYFS is the statutory framework of guidance that regulates early years provision. Department for Education (2014) Statutory framework for the early years foundation stage - setting the standards for learning, development and care for children from birth to five.

This document states that, '*The Early Years Foundation Stage (EYFS) sets the standards that all early years providers must meet to ensure that children learn and develop well and are kept healthy and safe. It promotes teaching and learning to ensure children's 'school readiness' and gives children the broad range of knowledge and skills that provide the right foundation for good future progress through school and life…'.Ofsted and inspectorates of independent schools have regard to the Early Years Foundation Stage (EYFS) in carrying out inspections and report on the quality and standards of provision*.

written policies and procedures of the childminder were seen and assessed or whether they were simply discussed.[4]

3.1.6. In 2012 it was not a requirement to obtain a work reference during registration. This changed in 2014, making employment references part of the registration process. As the childminder claimed to have a long history of employment in childcare, there is a small possibility that a work reference might have identified some concern about her previous conduct, had there been any.

3.1.7. Ofsted made a planned inspection visit to the childminder six months after registration. This graded the childminder as 'good'. Prior to this a visit had been made by the Havering Council Early Years Service in order to assist the childminder in preparing for the inspection. This is again perfectly normal. During the visit the local authority alerted the childminder to a number of voluntary training courses which she said she would attend.

3.1.8. In April 2014 an assistant was added to the childminder's registration. This is common. Both the childminder and Ofsted complied fully with the relevant legal requirements and there is nothing to suggest that this had any relevance to the injuries to the children.

The parents' perspective

3.1.9. In their contribution to the SCR the parents explained their criteria for choosing a childminder. Both wanted a childminder to fit in with their journeys to work and the parents of one of the children needed a childminder who could accommodate shift work. This left both with a very limited choice. This reflects a national concern about the availability of childminders, nationally there was a decline of 10% in the number of childminders between March 2012 and march 2016.[5]

3.1.10. The parents of both children told the review that they were impressed with the childminder's reported lengthy experience

[4] The EYFS in fact states that childminders do not have to have written policies. 'Childminders are not required to have written policies and procedures. However, they must be able to explain their policies and procedures to parents, carers, and others (for example Ofsted inspectors or the childminder agency with which they are registered) and ensure any assistants follow them'. HM Government, (2014) Statutory framework for the early years foundation stage: Setting the standards for learning, development and care for children from birth to five

[5] Ofsted (March 2016) Childcare providers and inspections. Since 31 August 2015, the number of childminders has decreased by 2%, a continuing trend that has seen numbers drop by over 10,000 since 2012. However, the number of places offered by existing childminders has increased by 581 (0.2%) since 31 August 2015, possibly as a result of more childminders taking on assistants. There was a further rapid drop between March 2016 and August 2017. 'Childminder numbers fall by a quarter since 2012', Children and Young People Now 21 November 2017.

working in child care and the fact that she had children of her own. The parents were in addition impressed by how organised the childminder seemed to be and by her records of children's activities and her policies and procedures which seemed to be very 'official'. In fact the childminder had been actively encouraged by the Early Years Service to develop the former and the latter were policies and procedures that are available to download and then adapt by one of a number of childminder support organisations. The fact that they were in place was not necessarily a reflection of the childminder understanding or implementing them.

Wider issues

3.1.11. Registration and inspection of childminders follows the requirements of the EYFS. In this respect childminders are considered as domestic day care settings and are subject to many of the same requirements as preschools and nurseries. The statutory guidance refers to all children in preschool settings, regardless of age and setting, as 'pupils'. The EYFS focuses heavily on children's educational development, which is likely to be least relevant to children under the age of 12 months.

3.1.12. One section of the EYFS deals with safeguarding and welfare. This points to the need for staff to be mindful of signs of neglect and abuse but cannot legislate for a childminder herself hurting a child. Other aspects might be seen as adding unnecessary bureaucracy to normal daily activities without adding to children's safety – for example childminders are required to undertake a 'risk assessment' when taking children on outings.

3.1.13. It is widely recognised that children under the age of one are more vulnerable to serious harm than older children. At present the EYFS makes no distinction in the registration arrangements between childminders who can look after children of different ages, other than prescribing variations in the ratios of adults to children required when children under the age of one are cared for.

3.1.14. The measures that the EYFS can include and inspect are not able to anticipate whether a childminder will have the human qualities that will enable a person to look after someone else's baby – warmth, kindness, patience and the ability to cope with the likely stresses of looking after a small child who has only a limited ability to communicate his or her needs.

Actions member agencies and the LSCB should take

3.1.15. There is no evidence that shortcomings in the childminder's registration or subsequent inspection contributed to the risk to the children.

3.1.16. It is outside the scope of the review to consider whether the Early Years Foundation Stage offers the best framework for safeguarding the welfare of children under the age of one who are being cared for by childminders and regulating the childminders who want to care for them. This case example raises questions about whether that framework adopts the most effective approach. For example: Is its strongly educational focus useful for very young children? Does the current approach to registration of childminders who intend to look after infants adequately identify the qualities that they need? Does the emphasis on 'risk assessment' of outings add anything to the safety and welfare of small children?

3.1.17. Ofsted judges the quality of care provided within the early years framework, but does not set it. Responsibility for the EYFS sits with the government. It is therefore for government to consider whether changes could be made in the EYFS which would lead to improvements in the safety and welfare of infants who are cared for by childminders. The review has made a recommendation on this.

3.2. The response of the local hospital to the presentation of Child A with a fractured femur

Evidence obtained by the SCR

3.2.1. The narrative account of the involvement of the hospital is set out in Sections 17 – 25 of Appendix 1. The Emergency Department (ED) readily identified Child A's fractured femur and it was correctly treated. However nursing and medical staff, including the paediatric consultant in the Emergency Department (ED) and the orthopaedic doctor in training all failed to recognise that in a child who was only just beginning to be mobile, this was a very unusual and serious injury that raised the strong possibility that Child A had been mistreated by an adult carer.[6]

3.2.2. As a result the hospital failed to act on its responsibilities to safeguard Child A, both through its own internal decisions and actions and by not immediately referring information about Child A's to the local authority and the police. There was a delay of five days in making a referral (which should have happened immediately) to the local authority.

[6] Accessible literature is clear on this point. The Cardiff Systematic Reviews publication Core-info – Fractures in Children (2012) NSPCC, describes a '*fractured femur in a child who is not yet walking'* as one of a number of presentations demanding *'careful evaluation to exclude child abuse'*.

3.2.3. Hospital procedures required the use of an injury flowchart. This is designed to assist the questioning of carers, enable factors that pointed to safeguarding concerns to be identified and trigger the involvement of senior staff in decision making. Instead of being used to aid decision making and point professionals to information that needed to be obtained and shared, it was used to validate decisions that had already been made.

3.2.4. The orthopaedic doctor gave advice about the treatment of the injury but did not suggest that an injury of this nature in a child of this age needed to be viewed as a potential safeguarding concern and did not check whether this had been considered. The hospital recognises that this advice should have been given face to face and with sight of the records, rather than over the phone.

3.2.5. Having identified one very serious injury in a barely mobile child, there were grounds to conduct a full skeletal survey. Records do not indicate that any of the doctors involved considered this. There were errors made by the basic grade ED doctor in recording the nature of the fracture in the discharge letter to Child A's GP. The bruising to Child A's shoulders was recorded and measured, but there is no evidence that consideration was given to its significance.

3.2.6. In common with most EDs the hospital has a number of measures in place which should provide a safety net in the event that safeguarding concerns are not recognised during the initial contact. These failed. A senior staff nurse completed the A&E Community Health Visitor & School Nurse Liaison Form but did not identify any safeguarding concerns in relation to the family . Later the case should have been added to the list of cases to be discussed at the weekly psychosocial meeting held on, but this was not done.

3.2.7. These errors occurred at a number of different stages and involved staff at all levels and in different divisions (ED, paediatrics and orthopaedics). They took several days to rectify.

3.2.8. As a result it was left to the family to take the initiative to protect their child. In this case Child A was safeguarded, because the parents had not caused the injury, had sought help and then reported the injury to the police. However in other instances the errors made might have been allowed a child to stay with abusive parents and been at risk of serious harm.

<u>Did the rapid treatment of this injury prevent better assessment of the timing of its occurrence?</u>

3.2.9. The parents of Child A asked the SCR whether the decision to apply a cast immediately to the fracture pre-empted investigations that might have narrowed the timeframe within which injury had occurred and thus hampered work to identify who caused it. The

advice provided to the review is that this is not the case and that an opinion could have been obtained about this by paying careful attention to the history of the child's presentation, signs of pain and other symptoms such as the ability to bear weight at different points over the previous few days. In reaching its findings, the Family Court later relied entirely on this kind of evidence. It was not therefore an error to apply a cast to the injury so quickly.

Why did this vulnerability in services exist?

3.2.10. Staff involved have been interviewed as part of the hospital's own internal review of the case and cannot, either individually or collectively, understand why safeguarding concerns were not identified.

3.2.11. The work context provides no obvious explanation. Records show that the ED was not especially busy that day and that there were sufficient numbers of staff experienced in working with children on duty. The attendance was during the weekend, but there is no evidence that this is significant.

3.2.12. It is a matter of speculation, but taking into account the medical records and reports prepared by the hospital of discussions with staff, one very likely contributory factor is that staff responses were strongly influenced by the manner in which the parents presented.

3.2.13. At the initial triage the parents conveyed the account from the childminder that the injury had been caused accidentally, supported by her accident report form, which may have given it some 'official' status. Records show that the ED paediatrician was confused as to the difference between a childminder, a nursery and a playgroup and did not clarify details of the services or the context in which the injury was said to have occurred. Had he asked for assistance in doing this it might have been more apparent that the account of the injury was not consistent with the explanation given.

3.2.14. The parents had acted entirely correctly in seeking medical assessment as soon as they believed that something was wrong. They were, perfectly naturally, extremely distressed when they were told that Child A had a broken leg and genuinely knew of no possible cause, other than the account they had been given by the childminder.

3.2.15. If it is correct that the combination of a very serious injury and parents who were viewed entirely sympathetically disoriented the staff directly involved, it is also very concerning that 1) the staff involved did not check or test one another's findings and assumptions and 2) a number of hospital staff who had had no

direct contact with the family, and thus could not be influenced by their presentation, were not able to look more objectively at the nature of the injury combined with the age of the child and recognise that it was unexplained and potentially extremely serious.

Wider hospital practice

3.2.16. The SCR has sought to understand whether this individual incident should be taken as being indicative of wider concerns. The hospital has provided the review with information about audits of other safeguarding cases dealt with by the ED where there had been concerns. This identifies six other cases, presented between January 2014 and August 2015, which had been reviewed by the trust's safeguarding team. In these other cases one or more of the following applied:

- Record keeping was poor or incomplete
- Safeguarding policies and procedures were not followed
- Children with concerning injuries were not reviewed by a sufficiently experienced member of staff prior to discharge
- Safeguarding concerns had not been considered or had been prematurely dismissed as a possible explanation for a child's injuries.

3.2.17. This demonstrates that the concerns in these cases were indicative of a wider problem, though it is positive that the hospital safeguarding team had identified the difficulties and brought them to the attention of senior managers and clinicians. This audit work has led to measures being taken in the following areas:

- Closer oversight by the hospital safeguarding team of ED
- Restructured safeguarding supervision and appraisal arrangements for medical staff
- Review of level three training programmes for medical and nursing staff
- Closer auditing of record keeping and the systematic entry of safeguarding alerts into the hospital's electronic system
- A revised trauma pathway for children under the age of two
- Improved induction arrangements for doctors
- More regular senior management scrutiny and discussion of safeguarding practice by hospital managers
- Increased number of paediatric nurses working in the ED.

3.2.18. The hospital has been working on an action plan to coordinate these activities, which is subject to monthly update and review.

Actions member agencies and the LSCB should take

3.2.19. Recognition and referral of safeguarding concerns in the hospital ED and paediatric services are a cornerstone of multi-disciplinary child protection arrangements. The hospital trust has identified and taken steps to address important weaknesses in these services.

3.2.20. The LSCB should set in place arrangements to monitor progress. This should include detailed reporting by the hospital trust and Havering Clinical Commissioning Group (which commissions the hospital's services) to the LSCB but should also involve independent scrutiny by the board itself, for example by including hospital cases in its programme of multi-agency auditing. The SCR has made recommendations in relation to this.

3.2.21. Nationally it has been shown that services are likely to improve in hospital trusts when the work involves all of the divisions that contribute to safeguarding; led at board level and also able to fully involve front line staff in the development of actions and review of progress.[7] The LSCB should seek assurance that this is happening.

3.3. The initial response of police and social care to Child A's injuries

Evidence identified by the SCR

3.3.1. The narrative account of the involvement of police and social care staff at this stage in the case history is set out in Sections 26 - 30 of Appendix 1.

3.3.2. Child A's mother reported the injury to the police on returning from the hospital on Saturday 4 October. Uniformed officers visited the family, took details of the injuries, arranged for consent to access relevant records and photographs and also visited the childminder to take an account from her. The records of the uniformed officers were seen the following day (Sunday) by the Child Abuse Investigation Team (CAIT) detective sergeant who was providing out of hours management cover.

3.3.3. The uniformed officers acted properly in taking details of the injuries and obtaining access to additional information, and then by passing the details to the CAIT and completing a MERLIN notification (which is sent after screening to the local authority). Their initial impression was that the injuries had been caused accidently and noted this in their internal recording and in the MERLIN. Although they were only recording what they had been told, this impression strongly influenced the actions and decisions

[7] White S, Wastell D, Smith S, Hall C, Whitaker E, Debelle G, et al. Improving practice in safeguarding at the interface between hospital services and children's social care: a mixed-methods case study. Health Service Delivery Research 2015;3(4).

of CAIT throughout the remainder of the investigation and was never properly interrogated or challenged.

3.3.4. The CAIT duty sergeant passed the case to the CAIT referral desk (which screens and manages referrals to the CAIT during normal working hours) with advice that there should be a visit to the family the following week. This already appears to have been influenced by the view that the injury was the result of an accident. If not it would have been reasonable to expect CAIT officers to begin enquiries over the weekend, taking statements from the parents as well as making direct contact with the hospital.

3.3.5. The view of the incident as probably being accidental also shaped its initial categorisation as a 'crime related incident', rather than a complaint of possible grievous bodily harm.

3.3.6. Joint discussion of the referral by the local authority and the CAIT began on Monday 6 October with a strategy discussion involving the CAIT detective sergeant who was responsible for the referral desk and the deputy team manager in the Havering MASH, whose role was to determine whether an assessment was required by the local authority.[8] Analysis of this episode is hampered by the fact that the social care records give no explanation for the decisions and the manager involved had no memory of the case.

3.3.7. Initially the social care manager noted the need for a Section 47 enquires and for a strategy meeting involving police, social care and the LADO to be convened. After a brief telephone strategy discussion, police records indicate agreement that the case would initially be followed up by the local authority, who would also contact the hospital to obtain a more detailed account of the injury, sharing this information in due course with the police. This is what happened. The social care manager transferred the case electronically to the children and families assessment service but made no record of the reasons for her decisions. The police played no active role for another seven days.

3.3.8. These were points when the initial view of uniformed officers that this had been an accident should have been subject to more critical analysis, firstly by a police officer with much more knowledge and experience in safeguarding and then by the social care manager. Both should have questioned the explanation being provided for an injury that was evidently serious, highly unusual in such a young child and likely to have been caused by a significant and memorable incident (such as a major fall or a car accident) or by an assault by an adult.

[8] The MASH is described in paragraph 3.3.15

3.3.9. It is also a concern that although there was an implicit consensus that the injury had taken place while Child A was in the care of the childminder, neither agency considered it necessary to make enquiries about the wellbeing of her own children.

Why did this vulnerability in services exist?

3.3.10. The review has identified three factors which influenced the actions and decisions of social care and the police at this stage:

- A lack of time and capacity in the CAIT (this remains a feature of the team's work throughout the case history)
- The existence of a culture of quick decision making in the Havering MASH, based on limited gathering of information and thinking time
- It was uncommon for the local authority to challenge the views put forward by police officers in rapidly conducted strategy discussions about whether inquiries should be conducted jointly or not

3.3.11. It is clear from the interview with the detective sergeant who was responsible for the referral desk that the capacity available was insufficient. This reflected the overall workload of the officer responsible for collaborating with the local authority and making decisions on cases; the level and variability of the number of referrals and the specific capacity and availability of other officers working on the referral desk.

3.3.12. The referral desk for the CAIT covers two London boroughs and according to the officer managing it dealt with between 5 and 16 substantial referrals each day. Symptomatic of this is the fact that she did not record a decision about Child A, who been referred with a serious injury over the weekend, until mid-afternoon.

3.3.13. The officer now clearly recognises that Child A's case should have been investigated by the police as a possible crime of grievous bodily harm, rather than it being left to the local authority to carry out a single agency investigation. Had she had time and capacity to reflect on the circumstances more closely it is very likely that she would have made the correct decision at the time.

3.3.14. Lack of capacity undermined police involvement throughout in the case history and is dealt with further, in Section 3.5.

3.3.15. The local authority has not indicated that a comparable lack of resources had a negative impact on the social care contribution to decision making at this point. However the organisational arrangements for decision making in the MASH are significant. The role of the MASH is to screen large number of referrals in order to determine whether a child and family assessment or Section 47

enquiry is needed. This is a decision about the next steps rather than a full assessment, based on the minimum amount of information that is judged necessary to make a defensible decision. That decision will then be subject to further management oversight by the team or service that begins to work on the case accumulating more information as it does.

3.3.16. Evidence of the lack of wider thinking about the case is that at no point during their discussions did the social care manager and the police sergeant reflect on the possible need for enquiries to be made about the childminder's own children.

3.3.17. The nature of the decision making is highlighted in this case by the fact that, even though this was a serious injury and a very young child, the local authority manager had no memory of the case, even when able to review the notes. In its management review the local authority has drawn attention to the relevance of recent research on decision making in duty systems which shows that the quality of decisions is affected by the very large number that have to be made and the unrelenting nature of the work.[9]

3.3.18. The priority for local authority managers is to complete the task, reducing the likelihood that they will reflect carefully on the history and circumstances in a case, especially if further reflection will not alter the decision made. The risk of doing just enough thinking to get by is inherent in the multi-agency service hub (MASH) form of screening of cases where there is inevitably a trade-off between thoroughness in decision making and efficiency. However there may be measures which can be introduced which will strengthen management and oversight of the most complex cases, such as a face to face handover of such cases.

3.3.19. The local authority had not felt that the quality decision making by the MASH in cases that were allocated for further assessment was a significant problem. As a result there were no arrangements for the audit of cases passed for Section 47 enquiries, whereas other decisions were subject to sampling and audit. This diminished the opportunity for learning and reflection about difficult cases.

Actions member agencies and the LSCB should take

3.3.20. The local authority has made recommendations about the supervision of social care staff as a means of increasing the capacity for reflection and improved decision making.

[9] Elspeth Kirkman and Karen Melrose, (April 2014) Clinical Judgement and Decision-Making in Children's Social Work: An analysis of the 'front door' system, HM Government

3.3.21. The LSCB should be concerned more widely to establish that, within the MASH and in the social care assessment teams the culture of rapid decision making is not adversely affecting the provision being made and that the board is happy that a correct balance between thoroughness and speed is being achieved. It should also take this opportunity to reflect on its understanding of the role of the MASH and in particular the quality of decision making and handover of cases.

3.4. The role of the local authority designated officer (LADO) and the effectiveness of the LADO meeting

Introduction

3.4.1. As the childminder was one of a number of people who might have been responsible for Child A's injury, the local authority designated officer (LADO) played a significant role. The responsibilities of the LADO apply when the behaviour of a person working with children appears to pose a risk of harm to a child. They are listed in the London Child Protection Procedures as follows [10]

i. Receive reports about allegations and be involved in the management and oversight of individual cases;

ii. Provide advice and guidance to employers and voluntary organisations;

iii. Liaise with the police and other agencies;

iv. Monitor the progress of cases to ensure that they are dealt with as quickly as possible consistent with a thorough and fair process;

v. Provide advice and guidance to employers in relation to making referrals to the Disclosure and Barring Service (DBS) and regulatory bodies such as Ofsted, the GMC etc.

3.4.2. Arrangements vary between local authorities but in most there is a dedicated officer who works as the LADO, sometimes with a deputy.

3.4.3. In relation to Child A case almost all of the functions of the LADO were undertaken by an Independent Reviewing Officer, who was acting as the duty LADO on the day of the case referral and who consequently retained responsibility for the case. Review of events has been hampered by the fact that he had no memory of the details of the case or of his involvement and there were gaps in local authority records.

[10] http://www.londoncp.co.uk/chapters/alleg_staff.html

3.4.4. The LADO is required to work with a designated senior manager in each employing agency over complex cases. Additional difficulties arose in this case because a childminder has no employer or line manager. This is also addressed in Section 3.8 which deals with the role of Early Years Services.

Evidence identified by the SCR

3.4.5. The LADO was involved in the investigation in relation to Child A in at the following points:

- Receiving and screening the referral, including discussion with the childminder
- Convening and chairing a strategy meeting
- Liaising with the police and the local authority during the course of their investigations
- Providing updates to Ofsted in order to inform their decisions about whether to suspend the childminder

3.4.6. Attendance at the LADO meeting was poor, largely as a result of decisions over the timing of the meeting. Managers from the Early Years Service were told that their attendance was optional because the LADO believed they had already provided him with relevant information. This neglected the responsibility of the service to continue to liaise with the childminder, to be part of and to own the outcomes of the discussion along with other agencies.

3.4.7. The CAIT procedures specify that a manager is expected to attend, rather than a detective constable as happened in this case. The detective did not question the instruction to attend the meeting, suggesting that this was common practice. Had a more senior member of staff been in attendance the major issue of the meeting (whether or not the police proposed to investigate) could have been resolved without further delay.

3.4.8. Ofsted was informed at short notice of a change in the date of the meeting but has recognised that it should have given priority to attending. In hindsight the organisation's lack of understanding of the case and the missed opportunity to question other professionals had a negative impact on its subsequent work.

3.4.9. The LADO meeting did not fulfil the expected range of functions. There was no preparatory discussion ahead of the meeting between the LADO and managers in the police and social care in order to establish what progress each agency had made and what needed to be resolved and agreed at the meeting. There was no clarity as to whether the focus of the meeting was specifically to consider the implications of the fact that one of the potential pool of perpetrators was a childminder, or whether this meeting was designed to combine the functions of all of the other management

and strategy meetings that might have taken place to plan and oversee the investigation.

3.4.10. The information presented the meeting with a very unpalatable set of options. A barely mobile infant had a very serious but unexplained injury. This had been caused by her parents, her childminder, another person not yet identified, an incident involving another child that had been reported to have taken place at a playgroup or an as yet unidentified but significant accident. The meeting needed to consider what could be done to explore each of these possibilities and to agree how risks to Child A could be minimised while that work was done, an even more difficult task.

3.4.11. In the event neither of the objectives set out in Section 3.4.9 was achieved. The meeting did not for example consider whether there were risks to the childminder's own children or other children she looked after. It did not set out detailed timeframes for any of the actions to be taken by individual agencies or confirm how they would work together in future, which a normal strategy meeting would do. There was no further multi-agency meeting about the case. It is clear from the records that the social worker expected the meeting to be reconvened some weeks later to bring together an overall update (see Appendix 1 section 68) however the LADO did not understand that this was his responsibility.

3.4.12. Following the meeting, the LADO updated Ofsted and gave advice on whether the childminder should be temporarily suspended. It is clear from the records held by Ofsted that the information shared by the LADO tended to minimise the risks, or the likelihood that the childminder had caused the injury, strongly influencing Ofsted's appraisal of the situation. This issue is considered further in Section 3.6.

3.4.13. There was no follow up or review LADO meeting and no meeting to close the case. The duty LADO left his employment in Havering before the case had been concluded; however there was no handover either to the manager who had oversight of the service or to the new interim post holder.

Why did this vulnerability in services exist?

3.4.14. There are a variety of procedural documents designed to set out policy and procedures for dealing with allegations against professionals with children. This includes national guidance, London procedures [11] and specific internal Havering procedures.

[11] http://www.londoncp.co.uk/chapters/alleg_staff.html

3.4.15. There were briefing sessions on the Havering LADO procedures when they were introduced in 2012 but the local authority has identified that more recently they had received only limited circulation and were not widely understood in Havering. However none of these procedures would have catered for all of the detailed problems that needed to be addressed in this case and experience suggests that it would be impossible to draft such procedures. Success relies on having sufficient experience to apply a basic template but to be sufficiently adaptable to cater for the particular difficulties, using the procedures flexibly if required.

3.4.16. The most important factor was therefore that the duty LADO, though an experienced chair of child protection conferences and looked after reviews, had very limited experience of the LADO role. As the preceding paragraphs have made clear the functions of the LADO in a case such as this are both technically and legally complex, as well as being professionally and emotionally challenging.

3.4.17. The local authority has established that the duty LADO had coordinated two other LADO investigations in the previous 12 months. This was not enough to have developed the level of skill and understanding needed to carry out the role effectively in a case such as this. If circumstances made that necessary anyone acting in the role needed time to discuss and reflect carefully on the progress of the case with an experienced and thoughtful colleague.

3.4.18. This was lacking in this case. The local authority has established only two points (currently paragraphs 39 and 69 in Appendix 1) when the duty LADO was given supervisory advice over the case, in both instances on very specific matters. Part way through the investigation responsibility for the LADO line management function changed, without any handover to indicate that this was a complex or concerning case, and that the person who assumed the management function had no capacity to meet regularly with the LADO.

3.4.19. It would be wrong to see the shortcomings in the LADO process in isolation from other aspects of multi-agency working. Regardless of its specific functions the LADO meeting provided an opportunity for agencies to discuss the case history together, critically evaluate the information provided and take shared ownership of the concerning presentation. This did not happen and instead the outcomes of the meeting, and the subsequent actions of the agencies present, suggest that too much reliance was placed on others.

Actions member agencies and the LSCB should take

3.4.20. Since the period under review a permanent member of staff has been recruited to the LADO post and quarterly performance reports are prepared on the LADO role.

3.4.21. The LSCB is expected to receive an annual report on the LADO function. It should ensure in future that the information provided addresses all of the relevant concerns in relation to the LADO function. A self-assessment could include the following:

- How satisfied is the board that the LADO function is being carried out effectively, especially in complex cases?
- Do other professionals understand its functions so that they can work effectively with the LADO? Does the LADO function effectively when dealing with self-employed professionals such as childminders?
- Is the work of the LADO service regularly audited; and are there sufficient staff in the local authority who have the experience and expertise necessary to carry out the LADO functions? Has the LADO service been benchmarked against well-functioning services in other local authority areas?

3.5. The criminal investigation of Child A's injuries

Introduction

3.5.1. Practice in the criminal investigation has been reviewed on the basis of the information that was available at the time to the officers involved. The criteria for a conviction are determined by the ability of the prosecution to prove a case beyond reasonable doubt. The Family Court uses a lower burden of proof and is able to take account of different evidence. The existence of this finding should not be taken as confirmation that there would have been a successful criminal prosecution when Child A's case was considered.[12]

Evidence identified by the SCR

3.5.2. Details of the action taken by the police to investigate Child A's fractured femur are set out in paragraphs 64 – 81 of Appendix 1. This period begins on 24 October 2014, when the CAIT Detective Constable who was responsible for the investigation and a social

[12] Even the fact that the childminder was later convicted of GBH in relation to Child A needs to be treated with caution because by then the jury was considering two cases with obvious similarities.

worker visited the playgroup where it had been said Child A had been injured. It ends on 19 December 2014, when the Detective Sergeant closed the investigation, concluding that there was no evidence to confirm that there had been an assault.

3.5.3. Although this is a period of two months, only a small number of actions were taken:

- The detective carried out an interview with a playgroup leader and made a visit to the building where it was alleged that Child A had been injured.
- The detective and the allocated social worker interviewed the childminder
- The senior paediatrician at the hospital provided a written statement making clear that the injury would have required significant force
- Statements were taken from Child A's parents by a retired police officer on 25 November 2014 (i.e. towards the end of the investigation and after the steps listed above had been taken) and there was phone contact with Child A's mother.

3.5.4. During this time the detective liaised with officers at Ofsted to provide information to assist in its investigation into the quality of care provided by the childminder and whether she ought to be suspended from working. He also worked alongside a social worker. Both the social worker (in her interview for the SCR) and Ofsted (in very detailed contemporaneous records) indicate that the initiative to take these steps came from the social worker and Ofsted and that (in the case of Ofsted) there were numerous unsuccessful attempts to contact the detective before he returned calls.

3.5.5. In addition Child A's parents showed the review notes which confirm that between early October and December they made numerous attempts to contact the CAIT. They describe having a difficult conversation with the detective in mid-October during which they urged the police officer to visit the playgroup as soon as possible, while memories of the reported incident would still be fresh, and before the half term week when the playgroup would be closed. The detective replied that he was unable to do this. He explained to Child A's parents that he could not prioritise the investigation, at one point stating that he was responsible for 18 other investigations.

3.5.6. Child A's mother told the review that while at one level she was grateful that the detective was being honest about his other pressures and priorities, at other times she felt that his attitude was 'belittling'. The account given by Child A's parents suggests

that the care provided for them was below the standard that the police should have offered.

3.5.7. The police investigation concluded that because of the medical opinion that the injury might have occurred over a period of several days it was impossible to tell who had caused it and how it had been caused. It followed that there was no realistic prospect of a prosecution. This outcome was agreed by the CAIT detective sergeant on 19 December 2014. He told the review that he mentioned the outcome to the Detective Inspector in charge of the CAIT but that there was no detailed discussion about it.

3.5.8. The police have recognised that the investigation fell below the standard required and expected. Central to this was the failure to challenge or seek further clarification of the timeline given for the injury to Child A. However as the timeline provided by the hospital could not be narrowed, much more detailed consideration should still have been given to the circumstantial evidence which pointed to the time of Child A's injuries. Everyone involved confirmed she had no injury when taken to the childminder on the morning of 3 October 2014 but showed concerning and unprecedented symptoms on being collected. Even if no prosecution was possible the police should have owned part of the collective responsibility to ensure that the circumstances in which Child A had been injured were understood as well as they could be and that careful consideration was given to her protection and the protection of other children involved.

Management oversight and supervision

3.5.9. There had been little management oversight of the work. The detective sergeant allocated the case to the detective in order for him to attend the LADO strategy meeting on 14 October 2014. There was no full supervisory review of the case at this point, which should have happened if the case was being treated as a possible case of grievous bodily harm.

3.5.10. Following the LADO strategy meeting on 14 October 2014 the sergeant set a limited investigative strategy, indicating that the parents and the childminder should be interviewed. The comments made by the paediatrician at the strategy meeting (indicating that whatever the cause of the injury it would have required 'considerable force' and his clear suggestion that the childminder's account needed to be scrutinised in detail) should have led the police to review the case fully and to pursue a much more active and challenging approach to the investigation.

Why did these shortcomings in the service exist and do they point to a wider vulnerability in services?

3.5.11. The review has identified three reasons for the shortcomings in the investigation.

3.5.12. There was an underlying assumption, first made by the uniformed officers who visited Child A's family, that her injuries had been caused accidentally. Although the reasoning behind this assumption was never explained or fully explored, it shaped the low priority given to the investigation and the mindset of the officer undertaking it. It was never subsequently challenged, despite the fact that none of the evidence gathered provided corroboration.

3.5.13. There was insufficient capacity in the CAIT to give priority to the investigation or to enable officers involved to reflect properly on their actions and decisions. The pressures of workload were undoubtedly real. Whilst a small number of the other cases being investigated might be trivial, malicious or easily resolved, the caseload of all CAIT officers will include vulnerable children who are the alleged victims of serious physical or sexual assaults.

3.5.14. Work pressures have been compounded by recruitment difficulties because whilst the work is viewed as being inherently important and the level of job satisfaction can be very high, work in a CAIT team is experienced as being considerably more arduous and more stressful in terms of personal and professional accountability than in many other detective roles.

3.5.15. Despite his very strong emotional commitment to child abuse investigation, the supervising detective sergeant, who had recently been transferred to the team from another CID role, lacked the experience and specialist knowledge of child protection to recognise the potential gravity of the injury, to understand that the accounts given as to how it had been caused lacked credibility or to challenge the detective to explore other lines of enquiry. During his time in post he had not undertaken specialist training in child abuse investigation or attended any relevant specialist multi-agency training. Bearing in mind the workload of the officers in the CAIT and the complex nature of this and many other investigations he was given too much responsibility with insufficient supervision and support.

3.5.16. Together these factors combined to shape an investigation which lacked curiosity, where officers had concluded at the beginning that the injury had been caused accidentally and where important potential lines of enquiry were not followed up or were pursued after considerable delay or half-heartedly.

3.5.17. The focus of the police investigation was always exclusively on whether there was sufficient evidence to support a criminal investigation. At no point did any of the officers involved consider that they had a wider duty to establish, as best they could, how Child A had been injured and to contribute to discussions with other agencies about the safety of Child A, the safety of the childminder's own children or the suitability of the childminder to continue to act in that role. Nor were they challenged to do so by the local authority social care service, the LADO or Ofsted. This narrow focus on police responsibilities is more likely to occur when officers are overloaded.

3.5.18. In terms of its wider implications the most important of these issues is the noted lack of capacity of the Havering and Barking & Dagenham CAIT team in relation to the rate of referrals, the complexity of the work and the difficulty in attracting and retaining qualified and talented officers. This was also reflected in the pressure on the referral desk described in Section 3.3.

3.5.19. Havering Safeguarding Children Board discussed these difficulties and the risks arising from them at all of its meetings between November 2013 and May 2014 and again in March and July 2015. The concerns identified have included the increase in child abuse referrals and investigations, shortage of officers to be involved in joint investigations and attending child protection conferences, reported inappropriate use of police powers of protection (Section 46 Children Act 1989) when no proper investigation had been undertaken. The picture is made more complex because of the need to balance the allocation of resources between the two boroughs.

3.5.20. In June 2014 the chair of Havering LSCB wrote to the Commissioner of the Metropolitan Police formally raising the concerns. This was followed by meetings between senior managers in the local authorities and the police. Subsequently responsibility to monitor difficulties was passed back to local managers who were expected to report problems to more senior staff and to the LSCB.

3.5.21. The police state that concerns about capacity are kept under constant review but acknowledge that this is taking place within an overall framework of funding cuts. It has told the SCR that during 2014-15 SOECA (the sexual offences and child abuse command) was given an increase in resources which will allow for a substantial increase in the establishment of detectives. The Havering LSCB minutes of July 2015 note that the CAIT has four additional officers to assist with increased demand. The police management review prepared for the SCR recommends that the SOECA command should continue to keep the level of demand and capacity so that staff ratios are maximised and risk is reduced.

3.5.22. The information provided to the review also suggests that there is a need to address the training and knowledge base of CAIT officers. All of the officers who contributed to the SCR had undertaken detective training but none showed the capacity to grapple effectively with more complex aspects of child protection, such as for example talking constructively with the doctors involved about the timeline of the injury or other forms of evidence that might have been relevant. The CAIT did not cooperate with Ofsted to the degree that it should.

Actions member agencies and the LSCB should take

3.5.23. From 2013 onwards the LSCB had identified and begun to seek to address the concerns about the lack of capacity in the CAIT. This involved local managers in the local authority and the CAIT, as well as those in more senior positions.

3.5.24. The LSCB needs assurance as to how effectively the CAIT is now functioning. This should be the subject of close, regular scrutiny by the safeguarding boards in both local authority areas. The boards need to ensure that they are rapidly informed of difficulties the single or multi-agency working of the CAIT. In turn the board should confirm that its concerns will in future be considered in a timely way by the child abuse and exploitation command (SOECA) and that there should be transparency and frankness in the accountability between the two bodies.

3.5.25. The review is concerned about the lack of training in more advanced and complex child protection work in the CAIT. Metropolitan Police Service SOECA command should consider how, given the demands and complexity of current child protection work, it is ensuring that detectives and supervisors obtain sufficient knowledge of multi-disciplinary child protection work to be able to work competently alongside colleagues from other disciplines and to be able to understand and challenge when required their perspectives.

3.6. Social care enquiries following Child A's injuries

Evidence identified by the SCR

3.6.1. The initial local authority social care screening and decision making in relation to Child B are described in Section 3.3. The role of the LADO and the LADO meeting were dealt with in Section 3.4

3.6.2. Responsibility for the social care assessment of Child A was allocated to a social worker on 7 October 2014. The social worker visited the family of Child A, immediately after the LADO strategy meeting on 14 October 2014. She felt reassured by the account

given by the parents and by their attitude. She could find no cause for concern about their care of Child A. She noted concerns about discrepancies between what the childminder had recorded in her accident form and the account she had given the LADO and the Havering Early Years Service about the incident.

3.6.3. On 27 October 2014 the social worker visited the playgroup and the childminder with the detective. Prior to this she had spoken to the Early Years Service in order to understand more about how the playgroup should operate. After the visit the social worker wrote to the LADO setting out the discrepancies in the childminder's account. She told this review that having met her she felt uneasy about the childminder but did not record or discuss this instinctive reaction. She was uncertain as to whether the childminder had attended the playgroup and also noted her concern that a number of children might have accessed it without signing in.

3.6.4. In a phone conversation with Child A's mother on 20 October 2014 the social worker said that she expected there to be a further meeting involving her manager, the LADO and the police to review and plan the investigation. This was a sensible expectation, but no such meeting was held. The LADO told her on 4 November 2014 that he did not believe that a meeting was needed until the investigations were complete. In the event no further meeting was convened.

3.6.5. On 14 November 2014 the allocated social worker emailed the duty LADO to inform him of the outcome of her assessment. It focused on the care of Child A by her parents and recommended that there should be no further action by the local authority. The following day she forwarded her completed assessment to her manager. He was off sick and then on leave. As a result there is no evidence of any management oversight or reflection on the proposed outcome of the assessment. No explanation has been given as to what arrangement was meant to be in place to cover the manager's absence.

3.6.6. There was no further communication between the social worker and the LADO or management oversight. The social worker prepared a closing summary which was submitted on the electronic recording system on 15 December 2014. A copy of the social work assessment was sent after considerable delay to the parents in February 2015.

<u>Why did this vulnerability in services exist?</u>

3.6.7. The first scrutiny given by the deputy team manager in the assessment team correctly highlighted the seriousness of the injury and the need for an investigation.

3.6.8. However for the reasons set out in Section 3.4 the LADO meeting failed to provide a strategy for pursuing all of the areas of potential risk. No separate child protection strategy meeting was held to do this.

3.6.9. The social worker's only task as she understood it was to assess any risk to Child A from her parents. She quickly formed the view that they posed no risk of future harm. She completed an assessment and closing summary. The template documents directed her to gather information from the parents about their general parenting capacity, which was never doubted.

3.6.10. No consideration was given to the need to evaluate any risk to the children of the childminder. It was left for the police to determine how the injuries had been caused. For the reasons described (Section 3.5) this focused only on whether there was sufficient evidence to prove the case in the criminal court.

3.6.11. After initially identifying this as a concerning case the deputy team manager provided no further management oversight. There was no review or sign off of the assessment and closing summary because the manager was away on leave and then sick. Despite its complexity at no point was the case referred to a more senior manager. The social worker instinctively felt that there were concerns about the childminder but did not feel that she could challenge the LADO's decisions or bring the case to the attention of a more senior manager.

3.6.12. With the exception of the social worker, standards of record keeping among social care staff were poor, with important decisions and actions not being noted by number of managers and the LADO. This may have made it harder for anyone to obtain an overview of the case history.

3.6.13. Reviewing the involvement of staff and managers as a whole there is a pattern of a number of members of staff acting in new, interim roles or covering the work of more than one person:

- The deputy team manager in the MASH told the SCR that she did not have significant experience in child protection work
- The deputy team manager in the assessment team had been appointed as an interim in September 2014 when the previous post holder was on sick leave. He had substantial experience of child protection work; however he had no experience of the role of the LADO. This may well explain the lack of recognition of the need for an investigation in relation to the children of the childminder and the lack of an overall strategy for the investigation.
- The reviewing officer who was acting as the duty LADO had only very limited experience in the LADO role

- The service manager who had been responsible for the LADO service and the wider safeguarding and standards unit left the council when her post was deleted in October 2014. During the period under review another manager was effectively covering two roles and was unable to offer the LADO regular supervision or oversight.

3.6.14. Taken together this pattern made it less likely that the complexity in this case was recognised and that no one raised concerns about whether the intervention in the case was addressing the fundamental questions: how had Child A been so seriously injured and were there risks to other children.

3.6.15. The role of first line supervisors (the deputy team managers in this case) is particularly critical in providing space for staff to reflect on their work, identifying cases that are problematic and identifying cases that need to be brought to the attention of senior managers. The experience in this case suggests that the authority needs to strengthen the capacity of first line managers to carry out these functions consistently.

Actions member agencies and the LSCB should take

3.6.16. The local authority has made recommendations as to how supervision of front line staff will be improved. The LSCB should consider how it will monitor their implementation and impact.

3.6.17. The local authority should bring forward proposals to strengthen the deputy team manager role. It should also consider what further steps it can take to enable staff to challenge colleagues in their own and other agencies in a constructive way

3.6.18. The board should consider whether agencies are sufficiently aware of the vulnerability that can develop when a number of staff are acting in interim or temporary roles or in roles for which they have limited experience. The board should consider how member agencies can monitor and report on this.

3.7. Decisions made by Ofsted about whether to suspend the childminder and other decisions about the safety of other service users

Ofsted's legal powers

3.7.1. If there are serious concerns about the care being provided by a childminder (including allegations that a childminder has harmed a child) Ofsted is required to consider whether the childminder should be suspended. Ofsted may do this when it reasonably

believes that the continued provision of childcare by the registered person to a child may expose the child to a risk of harm.[13]

3.7.2. Ofsted told the SCR that it is required to judge whether 'a reasonable person, judging a situation in the light of the law and the information concerned, would believe that a child might be at risk'. Ofsted understands this to be a lower burden of proof than the balance of probabilities test used in the family court. Reports provided to the SCR state that 'suspension is normally used to allow time for an investigation into the grounds that give rise to the 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. Suspension lasts for a period of six weeks initially, but can be extended for a further period of six weeks.'[14]

3.7.3. Childcare providers (including childminders) may appeal to an independent tribunal against suspension or variation in the terms of their registration.

Evidence identified by the SCR

Consideration of the suspension of the childminder

3.7.4. Ofsted twice formally considered whether to suspend the childminder. These episodes are described in the following paragraphs. There was a further opportunity to revisit the decisions made which was not taken (when minutes of the LADO meeting were received by Ofsted). This is dealt with from paragraph 3.7.15 onwards.

3.7.5. On 10 October 2014 the Havering LADO phoned to inform Ofsted of the information received directly from the childminder on the first working day after Child A was injured by the Havering Early Years Service and the LADO. This was that a child had broken her leg, possibly as a result of an accident that had occurred at a playgroup. Ofsted would be invited to a strategy meeting the following week when further information would be provided by the hospital, police and social care. The case was discussed with a senior regulatory officer who decided that the information provided so far did not warrant suspension. Responsibility for the case was passed from the Ofsted call centre to the regional team for follow up through attendance at the meeting. Given the information presented the decision not to suspend at that point was correct.

3.7.6. The LADO strategy meeting was held on 14 October 2014, but because it was rescheduled at short notice Ofsted staff (who would

[13] The Childcare (Early Years and General Childcare Registers) (Common Provisions) Regulations 2008

[14] Excerpts from the management review prepared by Ofsted for the SCR

normally attend a meeting in these circumstances) and some others did not attend. Ofsted has recognised that it was an error not to prioritise attendance, as a result of which no one in the organisation had any first hand working knowledge of the circumstances or was able to test the accounts and decisions of other professionals. Its absence side-lined Ofsted from the coordination of the investigation.

3.7.7. On 16 October 2014 an Ofsted inspector rang the Havering LADO for an update. The LADO provided a summary of the information shared at the meeting and the decisions that had been reached, recorded in detail by Ofsted. Key points were:

- Medical opinion was that the injury was 7 hours – 7 days old when seen at the hospital
- The LADO said that he 'doubted the police would take the matter further as there was no evidence of a crime'. Confirmation of this was awaited
- The LADO found it difficult to say if there was a risk to other children as a number of people had been with the child during the suggested timeframe including the childminder, parents, possibly grandparents and the toddler group
- There was no suggestion that the injury was non-accidental, it was a clear break, there was no bruising and there were a few marks that were explained by the toddler group attendance
- Ofsted confirmed that the childminder had been registered in March 2012 and that there had been no previous reported concerns about her
- The LADO stated that Ofsted must not investigate until the police had decided on further action and that he would get back with any further information and a date for the next strategy meeting.

3.7.8. The regulatory officer said that she would discuss the information with a more senior member of staff and that a decision would be made about whether to suspend the childminder's registration. There is no recording of this discussion and neither party could recall it; however telephone records confirm that the two members of staff had a lengthy phone conversation shortly after the call from Havering. Again it was decided not to suspend the childminder's registration. On this occasion no reasons were recorded.

3.7.9. During the second conversation the Ofsted inspector asked the LADO the age of the child, indicating that this had not been part of the discussion on 10 October 2014. This is of concern because the age of the child could have been a critical factor in determining likelihood that an injury might have happened accidentally.

3.7.10. Nor was any information asked for or provided in either conversation about the ages of other children cared for by the childminder (another factor affecting risk). No agency had obtained this information, which is itself a concern.

3.7.11. Given the information presented by the LADO and the way in which he is said to have interpreted the outcome of the LADO strategy meeting, Ofsted's decision not to suspend the childminder is again understandable. However there are a number of important issues arising from this that agencies need to address.

3.7.12. If the Ofsted record is accurate (and there is no reason to doubt this) the LADO had presented an incomplete and partial view of the discussion at the meeting. For example, it is not clear, from the record of the meeting that the police were unlikely to take the matter further (unless this was 'understood' but not recorded). The medical opinion about the timeframe about the injury was reported accurately but the doctor's statement that the injury was unusual and must have been caused by the use of 'considerable force' was not conveyed. Nor was there any report of the doctor's suggestion that the childminder's account needed detailed scrutiny as part of an investigation into the circumstances surrounding the injury. The minutes of the meeting also point to discrepancies in the childminder's accounts and highlight questions as to whether a child could have caused the injury, which were not discussed.

3.7.13. If these issues had been comprehensively presented it is possible that Ofsted would have been much more cautious in its decision. Even if it had still decided not to suspend the childminder, it may have done more to encourage other agencies to complete their investigation quickly and it is likely to have pressed for the anticipated follow up meeting.

3.7.14. It is of concern that neither of the decisions made by Ofsted were recorded properly, despite this being a clear requirement in its procedures. At this point the case was being managed in a duty system, so it was vital that other members of the organisation who might need to deal with it were able to see what decisions had been made and why. Lack of recording also makes it impossible for Ofsted to explain and account for its decisions to other agencies and to independent tribunals.

3.7.15. On 17 October 2014 the LADO sent Ofsted the minutes of the strategy meeting. These were saved in a shared folder by a duty worker. At Ofsted's request they had also been sent to the senior officer, but they were not seen or read by this member of staff who left her post two weeks later. Ofsted told the review that there was a problem with its email system on the date in question so she may not have received them.

3.7.16. Receipt of the strategy meeting minutes provided an opportunity for Ofsted staff to review its decision in the light of the information set out in Section 3.7.10 above. It is a concern that the minutes were not reviewed, especially as no one from Ofsted had attended the meeting. Nor were they taken into account when Ofsted reviewed the case again on 19 November 2014. By this time further information had been received underlining the discrepancies in the childminder's account. At that point Ofsted decided to await the outcome of the police inquiries, believed to be imminent, before commencing its own investigation.

Wider considerations

3.7.17. The SCR has considered the process for suspending a childminder more widely. In this case, given the way in which information was presented to Ofsted, the decisions made can be understood and were defensible. The judgement of the review is that, given the views of the local authority and the police, and the subsequent lack of police activity, a decision to suspend the childminder is very unlikely to have been upheld if the childminder had appealed to a tribunal.

3.7.18. There are particular difficulties in relation to the suspension of a childminder that do not apply to other professionals working with children. The national LADO policy and the London child protection procedures (referred to above at various points in Section 3.4 and designed to apply to all staff working with children) describe suspension as 'a neutral act'. For a childminder suspension cannot be a neutral act because it immediately removes the childminder's livelihood and risks substantial damage to her personal and professional reputation which would be very difficult to restore. It is therefore vitally important that information that might require the suspension of a childminder should be fully and objectively collated by the LADO and presented to Ofsted.

3.7.19. A further difficulty is created by the fact that a childminder has no employer who can propose an alternative to suspension that would protect service users (such as restricting a person's duties or providing closer supervision). In other instances the employer or their representative (a chief executive, head teacher or nursery owner for example) will consider the potential risk to other service users. In relation to a childminder neither Ofsted (which is the regulator) nor the Early Years Service (which has a more loosely defined support role discussed in Section 3.8) can serve this function. Risk to other minded children must be considered by the local authority and the LADO as part of their function. Discussions in the SCR have indicated that this is not clear in current

procedures and that the implications of this were not grasped by those who were involved in the management of this case.

Why did vulnerabilities in services exist?

The need for an active stance over the investigation

3.7.20. All of the significant delays in the investigation were caused by other agencies, as were the problems Ofsted experienced contacting colleagues and delays in responding to messages. However Ofsted has recognised that on a number of occasions it was too passive in the face of these difficulties. Ofsted needs to help its staff improve their performance not least because it recognises that this is a problem that the organisation often faces. It has agreed to draw up an escalation policy so that staff bring concerns about barriers to effective working to the attention of more senior staff, both within Ofsted and in other agencies.

3.7.21. Ofsted has recognised that it disadvantaged its work by not prioritising attendance at the LADO strategy meeting and has agreed to issue instructions to address this.

3.7.22. Ofsted has reflected on the fact that between 10 October and 19 November 2014 the case was managed on its London duty system, rather than being allocated to an individual inspector. Advantages have been identified (there was always someone available to deal with the case, whereas a single worker might have been away from the office for days at a time attending a tribunal) as well as disadvantages (no one person had ownership or oversight making it less likely that drift in the work would be identified and challenged). These are the sorts of tensions that any duty system has to manage so it would be wrong to make a specific recommendation in relation to this.

3.7.23. The work was also disadvantaged by the fact that during this period the key decisions were made by three different senior regulatory officers. Although they may have individually made correct decisions, the involvement of three managers reduced the likelihood of challenge to other agencies. This could have been much more easily avoided by allocating responsibility for oversight of the case to one manager, even if it could not have been allocated to one regulatory inspector.

3.7.24. Ofsted has told the SCR that all of the staff and managers involved were 'extremely skilled and experienced' had received specialist training in conducting and managing investigations (NVQ level 7 Advanced Professional Qualification in Investigative Practice). It is not clear whether this had in fact prepared the staff and managers concerned to exercise the level of curiosity and challenge that is necessary in a case such as this. Nor is it clear whether it gave

managers sufficient knowledge of safeguarding to understand how unusual and serious Child A's injury was. Ofsted should review the content of this training so as to ensure that it takes full account of the issues that should have been addressed in this case. Supplementary training should be developed if required.

The timing of the Ofsted investigation and decisions about the safety of service users

3.7.25. Agencies were addressing the concerns about the care of Child A during October and November 2014; the same point at which the parents of Child B were looking for a childminder. Child B's parents had no knowledge that there had been concerns about the care that she was providing. Nor we assume did the other parents who were using the childminder when Child A was injured. No consideration was given to this by the LADO and it was not discussed at the strategy meeting or with Ofsted. Ofsted agreed to delay its own investigation until the police investigation was over. There was no arrangement whereby those who are seeking a childminder can be alerted to the fact that an investigation is taking place and (as has been noted) there is no employer who can give consideration to this. It is easy to envisage circumstances in which this would place other children at risk.

3.7.26. This is an anomaly that should be addressed, though it may be legally and practically complex to find a way of safeguarding other children without jeopardising the reputation and livelihood of the childminder. Options might include:

- setting much shorter timescales for completion of investigations by the police and Ofsted
- placing the childminder under a duty to inform other service users and those who are looking for a childminder that an investigation is taking place
- taking an informed, individual decision as part of the LADO or strategy meeting in each case

3.7.27. Ofsted has told the SCR that the legal framework governing the sharing of information prevents it from sharing information with the parents of other children who are using or considering using

the services of a child minder.[15] The relevant regulations are extremely complex as they address the overlap of numerous other Acts of Parliament and guidance. The SCR has therefore not considered in detail how this might be addressed.

3.7.28. Ofsted has in turn suggested that responsibility should fall to the local authority Early Years Service, which has a duty to provide information about childcare. Local authority Early Years Services are unlikely to accept that this is legitimate as their duty is a general one which does not extend to warning individual parents about individual childminders. It would be an appropriate role for an employer, but the local authority is not the childminder's employer.

3.7.29. Until a solution can be found, LADO meetings which are considering allegations against a childminder must make clear decisions on whether parents of other children who are using a childminder need to be informed about a concern or allegation. As Ofsted will attend such meetings in a number of local authority areas, Ofsted should ensure that its own staff always consider this and raise it in LADO meetings.

Actions member agencies and the LSCB should take

3.7.30. Ofsted has recommendations on its own practice addressing the following areas:

- A written internal and external escalation policy, including consideration of requesting multi-agency meetings.
- Giving priority to attendance at strategy meetings
- Strengthening guidance and the pro-forma used for conducting case reviews to make clear the expectation that the review must consider all new information received since the last review or since the case began, whichever is the later
- Challenging instructions not to initiate its own investigation until other agencies' enquiries are over

3.7.31. In addition the review should make recommendations to other agencies to ensure that information passed to Ofsted provides a full and objective account of the concerns in a case

3.7.32. Ofsted should be asked to consider how safeguards for other service users and those who are seeking a childminder should be

[15] Specifically Statutory Instrument 2007 No 722, The Childcare (Supply and Disclosure of Information) (England) Regulations 2007. Statutory Instruments are a form of legislation which allow the provisions of an Act of Parliament to be subsequently brought into force or altered without Parliament having to pass a new Act.

addressed during the time that an investigation is taking place, including the options referred to above.

3.8. The role of the Havering Early Years Service and safeguarding responsibilities within the service

The role of the Early Years Service in relation to childminding services

3.8.1. Havering's Early Years Service has a number of roles relevant to childminding identified by the SCR. These are

- to provide information to parents and prospective parents about services (including childminding) and the details of individual childminders whose provision has been graded as either 'good' or 'outstanding' by Ofsted on the local Family Information Services website.
- to offer information, advice and training to childminders in the local authority area.[16]
- first aid and safeguarding training are provided free of charge to childminders, the former now being a pre-condition for registration
- to provide support to a childminder in the event of an allegation being made against them
- to help services comply with safeguarding responsibilities, both generally and in individual cases.

3.8.2. This part of the report focuses on the last two of these roles.

Evidence identified by the SCR

3.8.3. After she was registered as a childminder the Early Years Service made visits to assist her in understanding her responsibilities and to help in preparing for inspection visits by Ofsted. More detail is set out in Appendix 1 (paragraphs 7 - 11). This was normal practice and there is no indication that it was significant in relation to the injuries to the children.

3.8.4. On the first working day after Child A was injured, the childminder phoned the Early Years Service to report the fact that the parents believed that their child had fractured her leg while in her care. The service identified this as very concerning, directed the childminder to speak to the LADO while at the same time recording the details in full and sharing information with the LADO and the

[16] The duty is to offer the service to childminders graded as 'inadequate' or 'requiring improvement' but Havering offers access to training to all childminders. The service can only be provided if the childminder choses to take up the offer and cannot be imposed, even if an Ofsted inspection indicates that it is needed.

MASH (social care screening service). Subsequently the service arranged to be represented at the LADO strategy meeting, though this did not happen because of confusion about the dates. The LADO also downplayed the need for the service to attend, which was an error.

3.8.5. Subsequently the LADO asked the service to make a visit to the childminder to offer her support. This was done promptly. At that point the police and social care investigation had not begun so the visit correctly focused on the childminder's work in general. Later the service provided information to the allocated social worker to assist in her understanding of childminding and playgroups.

3.8.6. The only significant gap identified in the Early Years Service provision was that it did not monitor the outcome of the enquiries being made by social care, the LADO and the police. Whilst it was not the role of the service to lead any of these enquiries, it should have been concerned to monitor and understand the outcome in such a serious case. Had it been proactive in doing so, there would have been an opportunity to challenge weaknesses in the work.

3.8.7. This did not happen because during 2014 there had been a substantial restructuring of the service, triggered by the need to make substantial financial savings. As a result there was no clarity as to which manager had the safeguarding lead in the service and so should have maintained some oversight of this case. There may also have been no understanding among some staff and managers that the role of the service in relation to individual cases was not just to pass on referrals and share information (which is what occurred) but also to monitor and challenge other professionals over safeguarding concerns.

<u>Actions member agencies and the LSCB should take</u>

3.8.8. As a result of the review the Early Years Service has recognised the need for clarity about its remit in relation to safeguarding and about the responsibilities of individual officers. In future the service will monitor the impact of its work when safeguarding concerns arise in any early years setting. The LSCB should consider how best it can audit the safeguarding work undertaken by the Early Years Service.

3.9. The role of Ofsted in determining whether the childminder complied with the requirements of the Early Years Foundation Stage

Background

3.9.1. This section of the report considers the responsibility of Ofsted in interpreting and acting on the outcome of the investigations undertaken by the police, health professionals and the local authority. Ofsted's responsibilities are

- To determine whether the childminder's practice complies with EYFS
- To judge what improvements are necessary and whether the childminder has made them
- To provide a public account of the areas of concern and action taken by the childminder to address them through a statement on the Ofsted website and linked local authority websites that give information about childminders.

3.9.2. The key events are set out in paragraphs 82-97 of Appendix 1. Appendix 4 sets out the information that was posted on the Ofsted website in February and March 2015 and Ofsted's description of the guidance that it follows when formulating summaries of concerns and the action taken.

3.9.3. The evaluation of practice presents some difficulties because Ofsted's intervention with the childminder was based on its understanding of the outcomes of investigations by police and local authority and by the concerns raised directly with it by the mother of Child A. This was that on Friday 3 October two incidents had happened to Child A at a playgroup, during which Child A's leg had been broken by another child and that these showed that the childminder had failed to supervise the children in her care sufficiently, had failed to undertake a risk assessment prior to the trip to the playgroup and had failed to notify Child A's parent of the incident in line with the arrangements that she had made with the childminder.

3.9.4. This is an account of events that the Family Court has now determined was entirely false because there is no evidence that the children were taken to the playgroup or that these incidents took place. Because of the childminder's false account Ofsted was left with the task of ensuring that something that had never happened (because something worse had happened) was not repeated. The evaluation therefore has to separate 1) the question of whether Ofsted was sufficiently critical of the outcome of the investigations undertaken by other agencies 2) the actions of Ofsted based on what it believed had happened and 3) wider matters.

Evidence identified by the SCR

3.9.5. On 12 December 2014 an Ofsted inspector made a visit to the childminder. At that point the police investigation had ended but had not been formally concluded and the childminder had not been told the outcome. However the police officer had told Ofsted that he could not establish how the injury had been caused. The Ofsted inspector explored the childminder's account and asked how it had been that two incidents had happened causing such a serious injury to a small child. Her account was that on both occasions she had been 'putting the children's coats on'.

3.9.6. No further action was taken by Ofsted until January 2015 when it was triggered by contact from the childminder. Had this not happened it is not clear when Ofsted would have acted.

3.9.7. On 2 January 2015 Child A's mother phoned Ofsted and gave an account to the call centre of her concerns. She too based her this on the childminder's explanation. As a result she believed that the childminder had not been supervising Child A properly. Child A's mother had received no information about the lack of evidence that the children had ever been taken to the playgroup. Ofsted connected its records on this call to the previous records.

3.9.8. When Child A's mother subsequently called Ofsted she was told that no information about its actions could be shared and the mother would have to rely on the information that would at some point be added to the website. Whilst it is clear that Ofsted's first duty is to the wider public there is no good reason, particularly given the seriousness of the injury to Child A, that Ofsted should not have kept her mother directly informed about its further actions.

3.9.9. These contacts were unnecessarily bureaucratic. This was because, despite the serious nature of her contact with Ofsted, Child A's mother was only ever able to phone a call centre and had no named contact or direct line number. Child B's mother told the SCR that she had had a similar experience, even though her child had been very seriously harmed. Ofsted recognises that this was not helpful and in future in similar circumstances it would seek to offer a more personal service.

3.9.10. Ofsted then had contacts with the police and the LADO which confirmed that there was no objection to Ofsted beginning its own investigation. No further information about the events of 3 October 2014 was provided because neither the police nor the local authority claimed to fully understand the cause of Child A's injuries. Ofsted's further actions are therefore likely to have been based on 1) the accounts given in October and November by the

LADO and the police 2) the account of concerns given by the mother of Child A.

3.9.11. Ofsted has told the SCR that it did not accept the childminder's account as the basis for its further regulatory visits. However the evidence is that at some level everyone accepted this account and there is no evidence that Ofsted subjected it to any critical scrutiny. The minutes of the LADO meeting of 14 October were not reviewed, so the Ofsted inspector was not mindful of the discrepancies that had been identified in the accounts of the childminder. Ofsted made no request for a formal meeting to conclude the investigation and did not comment on the (unusual) absence of such a meeting.

Visits to evaluate the childminder's practice

3.9.12. An Ofsted inspector made two visits to the childminder. During the first she saw the premises, saw one minded child and one of the childminder's own children and inspected her paperwork. As a result the inspector formed the view that 1) the childminder would need in future to ensure that she had taken all reasonable steps to ensure that children were not exposed to risk and that she ought to have carried out a 'risk assessment' before attending the playgroup for the first time 2) she should have supervised Child A more closely and 3) she should have communicated more effectively with her parents, in line with her agreement with them. These judgements were set out in a standard template letter.

3.9.13. The childminder said that she accepted these findings, presumably on the basis that they were a great deal more palatable than the truth of what had actually happened. She could also see how complying with the requirements would mean that she could continue to work as a childminder.

3.9.14. On 3 February 2015 Ofsted posted an account of these concerns on the website www.childcare.co.uk . This is set out in full as Appendix 4.

3.9.15. On 12 February 2015 the childminder sent Ofsted a written response setting out how she proposed to comply with the requirements of the previous visit using the template letter sent by Ofsted.

3.9.16. An unannounced visit, which lasted 45 minutes, was made on 5 March 2015 to monitor her compliance. The Ofsted inspector said

that she was satisfied with the evidence from the letter and her visit and posted an update on the website saying this.[17]

3.9.17. The investigations and assessments carried out by the police and social care were unsatisfactory. Many of the weaknesses identified in sections 3.3 – 3.6 of this report were apparent at the time. Ofsted is clear that it is the role of social care and the police to establish what has happened. However Ofsted should be convinced that the investigation has been conducted in a professional and thorough way. In this instance it is apparent that there was no critical reflection within Ofsted on the outcome of the investigations carried out by other agencies. The senior regulatory officers in Ofsted believe that this was unusual and that a culture of critically reflecting on investigation outcomes does exist within Ofsted. The organisation will need to monitor this aspect of practice in future.

3.9.18. Having made its own inspection visit and found shortcomings in the childminder's practice, it is not clear how the improvements required of the childminder might be demonstrated, other than by her agreeing in writing that she would improve her record keeping and risk assessment. This concern about its own approach had been identified by Ofsted over the visit made on 9 December 2014 where it is noted that the inspector stated that 'good knowledge and practice in safeguarding were demonstrated' (by the childminder), though the evidence to support this was limited.

3.9.19. To a degree this may be a difficulty inherent in the regulation of childminders where the practice of the childminder cannot only be observed very briefly. But more could have been done. For example no thought appears to have been given to speaking face to face to the mother of Child A or to the parents of other children who were using the childminder. Given the very serious nature of the injury to Child A, the lack of clarity about its cause and the inconclusive outcome of the investigation, there was a strong case for doing so in this case. Ofsted says that often the parents of children are spoken to during regulatory visits.

Information to publicise the concerns and the action taken following the visit

3.9.20. Ofsted has told the SCR how the information posted publicly on the childcare.co.uk website is checked by its legal department and that the organisation has to find the correct balance between being specific enough to indicate the nature of the problem to give parents who might wish to employ the childminder some idea what

[17] In normal circumstances this would have stayed on the website for a further five years, but in the event the childminder resigned after the injuries to Child B so all material relating to her were removed.

had happened while at the same time not running the risk of identifying the children concerned.

3.9.21. It is difficult to see how the information posted about this episode (Appendix 4) would help another parent to understand what had happened on 3 October 2014, what concerns this reflected in the childminder's practice or what the childminder had done to improve subsequently. Instead of presenting in simple and concrete terms what the childminder was believed to have done or not done (as for example in Section 3.9.3 above) the childminder's shortcomings are couched in terms of the aspects of the Early Years Foundation Stage standards that Ofsted believed she had not complied with. This renders the information posted on the website of little use to the general public.

3.9.22. More widely it is not clear what likelihood there is that parents who are using or considering using a childminder would actually access this information, as it was not the practice of any agency involved to signpost it.

Actions member agencies and the LSCB should take

3.9.23. Practice in this case was consistent with Ofsted's normal approach and not the result of individual failings. It is therefore recommended that Ofsted should review the way in which it responds to police and social care investigations, the investigation of childminder practice and the posting of information on its website. This should ensure that:

- There is proper scrutiny and challenge of how an investigation has been conducted (comparable to the challenge that all professionals involved in safeguarding are expected to offer)
- Scrutiny of the childminder's practice is proportionate to the seriousness of the incident and will if necessary include consulting other parents who use the childminder
- Public statements of outcomes are written up in an accessible way, using plain English and not relying on the professional jargon in which the EYFS is written

3.9.24. Section 3.7 has set out the arguments in favour of some information being posted at an earlier point, or setting out an expectation that the childminder tells all those involved that an investigation is taking place.

3.9.25. Ofsted and local authority Early Years Partnerships and other agencies with an interest in childminding need to provide much clearer signposting of any documented concerns about childminders.

3.10. The capacity of the safeguarding system to recognise and rectify errors before they become significant and dangerous

Introduction

3.10.1. Any complex system designed to deal with risk must be resilient. A key feature of resilient and safe systems is their capacity to recover from errors. To do this they have mechanisms that enable errors, mistakes and unwarranted departure from procedures to be spotted and rectified before they become potentially dangerous.[18]

3.10.2. Most of the errors made in the professional response to the injuries to Child A were rooted in assumptions made and actions taken early on in the case history that were never revisited or re-evaluated. In order to have a greater chance of identifying and rectifying such errors it is critical that staff and managers are able to step back from their focus on immediate tasks in order to take an overview of the case history and critically evaluate steps previously taken.

3.10.3. It is much more difficult to achieve this when staff are under pressure or working in unfamiliar and new roles. Agencies need to make create the conditions in which individuals (especially managers) can be more curious. Agencies also need to create conditions in which constructive challenge between professionals is the norm, both within and between agencies.

Evidence identified by the SCR

3.10.4. Section 3.2 has shown how the reassuring presentation of Child A's parents at the hospital Emergency Department (ED) contributed to the failure to recognise that Child A had suffered a serious and unexplained injury and to a substantial delay in making a child protection referral.

3.10.5. Section 3.3 demonstrated how police officers concluded during their initial contacts with the family the injury had been accidental. This untested assumption was adopted by all of the police officers who worked on the case and never properly challenged.

3.10.6. In combination these two sets of errors set the tone for the way in which the case was subsequently understood and managed.

3.10.7. There was an opportunity to remedy this and recognise the potential seriousness of the case when the MASH social care deputy team manager and the police CAIT referral desk sergeant discussed the referral. But that discussion was a very brief one and

[18] E Hollnagel, D Woods, N Leveson (eds) (2006) Resilience Engineering – Concepts and Precepts, Ashgate; E Hollnagel, J Braithwaite, R Wears (eds) (2013) Resilient Health Care, Ashgate

the role expected of the MASH manager was only to move the case on to the correct team and assign the right level of urgency (which was done correctly), rather than to challenge the police thinking (which should have happened). This was the first of a number of points when procedures and established practice favoured swift decision making at the expense of a thorough review.

3.10.8. The LADO meeting (Section 3.4) was the only time that representatives from the main agencies involved met together to discuss the case. It failed to carry out its proper function because key people were missing and it failed to address important aspects of the case, such as the safety of the childminder's own children and the risks to other children using the childminder. The notes of the meeting show that there was some limited challenge to the assumption that the injuries had been caused accidentally, but this did not feature strongly in the summary and decisions of the meeting. The clear view that 'considerable force' had been applied to cause the injuries was noted but never subsequently pursued.

3.10.9. In a case of this seriousness and complexity there should have been a reconvened multi-agency meeting to review progress and conclude the case. Only one worker asked for this to happen but she did not feel able to challenge the decisions of more experienced members of staff.

3.10.10. Only limited steps were taken by the police (Section 3.5) over a protracted period of time. The social care enquiries (Section 3.6) raised doubts about the validity of the explanations provided by the childminder, but neither the LADO nor a social care manager provided the supervisory input to explore these doubts, challenge the police approach or call for the multi-agency meeting to be reconvened to consider the case again.

3.10.11. When Ofsted reviewed the quality of the care provided by the childminder it accepted without any detailed scrutiny the outcomes of the investigation by police and social care. It offered no challenge to the failure to reconvene a multi-agency meeting over the case.

3.10.12. The difficulties experienced at an early stage left the system vulnerable to further errors. The gap between the actions taken and what was needed in a case in which a small child had been seriously injured widened, rather than narrowed, over time

Why did this vulnerability in services exist?

3.10.13. At a number of points, opportunities to identify the previous shortcomings and errors existed, but they were missed and further errors were made. The recurring reasons were:

- Arrangements for management oversight failed in police and social care
- The culture of supervision in all agencies involved focused on immediate practical tasks and did not value review looking back over the whole case
- Multi-agency face to face discussion of the case was very limited
- There was no culture of challenge within or between agencies, or at best challenge was weak and 'implied' rather than frank and open

3.10.14. Behind these shortcomings lie patterns of service delivery in which some staff were under considerable work pressure, working in new or unfamiliar roles for which they were not properly equipped, coping with additional responsibilities brought on by organisational change, covering the work of colleagues or in some instances a combination of more than one of these.

Actions member agencies and the LSCB should take

3.10.15. In such circumstances senior staff need to ensure that sufficient value is placed on mechanisms which can review the progress of the case as a whole in order to increase the likelihood that they will identify cases where a number of elements of practice are 'going wrong' and be able to rectify them

3.10.16. It is not easy to turn this finding into one concrete proposal since it will take different forms in different agencies. A number of the proposals already made in individual agency management reviews will assist but there is also value in the LSCB considering in detail whether agencies have arrangements in place that ensure that supervision provides an overview of the case and does not focus exclusively on current tasks. Audit arrangements should also not focus solely on procedural compliance.

3.11. Professional response to the injuries to Child B

Evidence identified by the SCR

3.11.1. In contrast to the difficulties described in relation to Child A, the SCR is satisfied that, with a small number of exceptions, the presentation of Child B in collapse and with some concerning signs of possible head injury were dealt with effectively.

3.11.2. Her injuries were immediately recognised as being very serious and she received intensive medical treatment both at the local district hospital and on transfer to a tertiary centre. However the review has identified concerns that whilst the London Ambulance

Service identified the severity of Child B's collapse, staff did not consider whether it might be indicative of a safeguarding concern.

3.11.3. There is also a concern that two doctors were aware of discussions with the childminder about Child B being shaken (she said in order to rouse her after collapsing) but did not recognise that this might be relevant to the police inquiries. As a result there was a delay of some days in reporting this to the police. This concern should be addressed under the actions being taken by the hospital described in Section 3.2 above.

3.11.4. Social care and police report no concerns about the work undertaken in their agencies. In contrast to the work on Child A, in relation to Child B the LADO arrangements worked well.

3.11.5. Child B's parents views are set out more fully in Appendix 2. They report being severely shocked by the severity of the injuries to their daughter and the realisation that the injuries had occurred while she was in the care of her childminder. They were largely very positive about the work undertaken by professionals who they said were direct and unambiguous about the difficulties that their daughter was facing, which was what they needed at the time. Professionals also gave them space and time to focus on their daughter while agencies got on efficiently with work to investigate what had happened to her.

Appendices

Appendix 1	Narrative of professional involvement	
Appendix 2	Views of family members	
Appendix 3	Registration of the childminder – account from Ofsted	
Appendix 4	Information made public about the outcome of Ofsted's investigation of the childminder	
Appendix 5	Principles from statutory guidance informing the Serious Case Review method	
Appendix 6	Terms of reference and lines of enquiry	
Appendix 7	How the review was undertaken	
Appendix 8	SCR review panel members and report authors	
Appendix 9	References	

Appendix 1

NARRATIVE OF PROFESSIONAL INVOVLEMENT WITH THE CHILDMINDER AND THE CHILDREN'S FAMILIES

This narrative is based on professional records, interviews with staff members and managers, management reports provided by agencies and interviews with the parents of the injured children.

Registration, support, training and inspection of the childminder

1. The childminder applied to Ofsted for registration in January 2012. Ofsted's role is to determine whether the applicant meets the requirements of the Early Years Foundation Stage (see Footnote 3 page 21) through a series of checks and references, followed by a visit to the childminder's home. The visit is carried out by one of two private providers contracted by Ofsted to undertake this work.

2. Ofsted has given the SCR full details of the checks and references normally made and their application in relation to the childminder. These are set out in Appendix 3. The steps taken to register the childminder were in line with the normal arrangements. This did not highlight anything which, even with the benefit of hindsight, would have been of concern.

3. The childminder gave an employment history which described her substantial work experience in nurseries and day care, stating that she had worked as the deputy manager of a nursery. Her reported history was one which would have presented her in a positive light. In line with the framework that applied at the time, it was not checked and no reference was taken up from her previous employer.

4. The parents of both injured children told the SCR that they found the childminder's reported work experience reassuring, along with the fact that she had her own children.

5. Ofsted's practice has changed since 2012 because the guidance governing childminder registration was updated in late 2012 to include a reference from the applicant's last employer.

6. The childminder registration was completed in March 2012, the only specific condition that applied to the registration related to the use of her garden by minded children (because a fence was broken). Once the fence was repaired this condition was removed.

7. In August 2012 an Education Officer from the Early Years Quality Assurance Team of Havering Council made a routine support visit to the childminder. This was to assist the childminder to prepare for the normal Ofsted inspection visit, scheduled for September 2012, six months after registration. She confirmed that the childminder had

completed her paediatric first aid course (required of childminders) and noted that the childminder said that she was attending other training programmes.

8. The Education Officer suggested that the childminder should produce a journal for each child in her care, capturing information about the activities they had undertaken and their development. She provided information about the London Child Protection Procedures and the role of the Local Authority Designated Officer (LADO)[19] so that the childminder was aware of the action needed if any allegation were to be made against her. A further support visit was made in mid-2013.

9. The scheduled Ofsted inspection of the childminder took place in late September 2012. Present at the inspection were the childminder's own children (both under 5 at that point) and a minded 12 month old child. The inspection judged the childminder to be 'good' under the Early Years Foundation Stage framework. The inspection concluded that the childminder '*demonstrated good knowledge and understanding of child protection and keeping children safe and secure whilst in her care, both at home and when out on trips, and of the steps to follow if an allegation was made towards her or a member of her family'*.

10. In mid-2014 the childminder arranged for an assistant to be employed as part of her business. She approached the local authority and Ofsted for advice over this and complied with the relevant regulations and guidance. There is no indication that this is of any significance in relation to the injuries to the children.

11. On 3 October 2014 the childminder approached the Early Years Service to seek advice about the number and ages of children that she could childmind under the regulations and guidance. Although this is the day on which Child A was injured by the childminder, nothing points to this contact as being significant.

Family A – finding a childminder

12. Child A was born in late 2013. GP and other health records show no concern about any aspect of her health and development. Family A told the SCR that they began planning what kind of child care to arrange in April 2014. They preferred a childminder to a nursery on balance, thinking their daughter would be happier in a 'home from home' environment. Their family circumstances meant that the location of the minder was a key consideration, together with the fact that not all childminders offer places for babies. At the back of their minds was the idea that a childminder would offer some flexibility of

[19] See section 3.4

care at times outside the working day and, if relationships developed positively, become part of their child's network. Child A's mother identified the childminder through the HM Government www.childcare.co.uk website.

13. The parents noted the childminder had a 'good' inspection report (as described in paragraph 9 above). The mother told the SCR that she visited the childminder's home and that the parents were impressed that the childminder reported having 14 years of child care experience, 7 years of experience childminding and that she had children of her own. In April 2014 the parents paid a deposit which was the equivalent of six weeks payment to secure a place in October 2014. Child A attended five taster sessions in September 2014, which her parents felt had gone well, two of which were free. Child A started her normal attendance at the childminder on 1 October 2014.

Injuries to Child A on 3 October 2014

14. Child A was injured at some point this day, though the childminder has not provided a plausible account of how the injuries occurred. When the child's mother collected her after work, the childminder told her about an incident that she said had happened that morning during their visit to a playgroup. Child A was sleeping, when collected, then upset when she woke, both of which her mother says were unusual. When her mother brought her home, she ate unusually little and had a very unsettled night.

15. Before she left the childminder, Child A's mother was shown and asked to sign an accident form, describing the reported event at the playgroup. She says that at that point she was too upset to read it carefully or take in the details.

16. During the evening Child A's movement was unusually restricted (i.e. she was unable or unwilling to crawl in circumstances when she would normally have done so). The parents say that they were angry because they felt that the childminder must not have been supervising Child A properly. They contacted the childminder who confirmed that Child A had been fine earlier in the day.

Initial identification and treatment of the injuries to Child A

17. On the morning of the 4 October 2014 Child A still could not move her leg so her parents took her to a local polyclinic (drop in GP and primary care centre). The parents say that they were seen after a wait of two hours and told to take Child A to the local district hospital Emergency Department (ED).

18. The family were seen at the ED reception and triaged (screened on the basis of how urgent the concern appeared to be) before being seen by a junior ED doctor and a Paediatric Consultant, who in turn took advice from an orthopaedic doctor. During the triage the parents say that they showed the nurse the yellow accident report form that the childminder had given the mother the previous evening.

19. The parents repeated the account provided by the childminder, i.e. that an older child at the playgroup had grabbed Child A on the shoulders but that Child A had crawled away afterwards. X-rays revealed that Child A had a supracondylar transverse fracture of the femur, just above her knee.

> Explanatory note
>
> This type of fracture is most typically found in the humerus (elbow) in active and mobile children. It is frequently observed to have occurred when a child has fallen and landed with some force on the outstretched limb which is instinctively used to break the fall. Supracondylar fracture of the humerus in older children is normally found to be an accidental injury.[20]
>
> There are considerable differences in the extent of the displacement in the bones that can be caused by such a break. In Child A's case, because of her age and the relative softness of her bones, the break in the bone was easily treated.

20. Treatment was straightforward, by applying a small cast, and the initial plan was to offer an outpatient follow up appointment. The bruises on Child A's right shoulder were reported by the parents and noted but not photographed.

21. The parents were, by their own account, distraught when the fracture was identified. They sent text messages to the childminder at a number of points during the morning, letting her know how serious the injury was. The parents asked hospital staff more than once what should happen now and what they should do. After discussion with different members of hospital staff they decided that they should notify the police about the incident. These discussions and their decision are referred to in the medical records.

22. The ED summary record notes the history and treatment given. It identified that there were 'no safeguarding concerns' because of the consistent story given by the parents, their obvious concern and upset,

[20] Cardiff Child Protection Systematic Reviews (op cit)

their caring attitude to and interaction with their baby, their action in seeking treatment and the fact that the hospital information systems showed no marker indicating that the child had a history of involvement with social care.

23. The hospital records include an injury flowchart. This is an algorithm designed to aid decision making which should be completed for all children attending the ED with an injury. Its function is to help staff identify when they are dealing with a 'high suspicion injury' that should be discussed with a senior doctor in paediatrics. This was completed by the junior doctor on the advice of the paediatric consultant and recorded that Child A had 'no unexplained injuries'.

24. At the request of the consultant paediatrician a senior staff nurse completed a notification form. This form would be shared with the liaison health visitor who would in turn pass the information to the community child health service as a means of notifying the family health visitor. This is the normal practice for any child attending the ED. The nurse had had no direct involvement with the care of Child A other than discussing the liaison form with the parent. No consideration was given to completing a Havering multi-agency referral form (for social care) until several days later, or contacting the social care out of hours emergency duty team.

25. There would have been an early opportunity to review the management of Child A at the hospital's multi-disciplinary psycho-social meeting on 7 October 2014; however Child A's name was not added to the agenda for that meeting, despite the nature of her injury and her age.

<u>Involvement of the Metropolitan Police Service (MPS) on 4 October 2014</u>

26. On returning home Child A's mother phoned the police to report that the previous day her daughter had suffered a broken leg while in the care of her childminder. Uniformed officers came to the family home and took the mother's account. This was that there had been two episodes at the playgroup, once when an older child had grabbed Child A by the shoulders and a second a few moments later when the same child pulled her backwards causing her to fall. The officers said this would be reported to the specialist service that investigated child protection concerns (Child Abuse Investigation Team (CAIT)). The officers photographed the injuries to Child A's shoulders, gained permission to access Child A's medical records and gave the parents a crime reference number so they could follow up what was happening.

27. The officers then visited the childminder at her home and took an account from her.

28. The following morning the police records were reviewed by the detective sergeant providing the out of hours duty cover for the CAIT. Her decision was that a visit was required by CAIT officers the following week. The police officers created a notification (referred to in the Metropolitan Police as a MERLIN) to share the information with the local authority. This was sent to the multi-agency safeguarding hub which screens possible referrals to social care.

29. Within police recording systems the episode was categorised as a crime related incident (i.e. an incident which would normally be classified as a crime but because of the specific circumstances is categorised in another way). Later this classification was corrected by administrative staff to a crime of possible Grievous Bodily Harm. These were both administrative actions, neither of which was significant in itself. However the first is indicative that from the outset the episode was viewed as being an accident. The reclassification did not lead police officers in the CAIT to view the circumstances differently.

30. The MERLIN set out the accounts given by the parents and the childminder and concludes that the injury appears to have been the result of an accident, though no reasons are given for this conclusion. The MERLIN records details of Child A and her family, but no details of the childminder's own children or family. There is no separate notification about the childminder's children, suggesting that no one thought that they could be at risk.

Actions taken to initiate child protection enquiries on Monday 6 October 2014

31. On the morning of Monday 6 October 2014 the childminder contacted the Havering Early Years Service by phone to report the incident, indicating that she knew that she would also need to notify the LADO. The childminder stated that she had already contacted Ofsted to report the incident and been told that 'as the incident did not happen on her premises … it was not a notifiable event'. Ofsted has found no record of this reported call. Ofsted cannot be certain whether a call was made or not because the call would have been routed through its national call centre and it cannot be certain that every call is logged. This account of the reported call to Ofsted was reiterated later to and by other professionals and at no point was the content questioned or discussed. The childminder also stated that she had been in contact with a solicitor (identified through the Professional Association for Child Care and Early Years – PACEY, to which it is believed she belonged).

32. The childminder then contacted the duty Havering LADO to reiterate her account. On that morning the responsibilities of the duty LADO were being undertaken by an Independent Reviewing Officer (whose

normal role was to chair looked after children's reviews and child protection conferences). He made no record of the conversation with the childminder, but it is clear that a discussion took place because he subsequently referred to the call in meetings and discussions.

33. Later that afternoon a strategy discussion took place between the detective sergeant on the MPS CAIT referrals desk and a social work manager in the Havering MASH (see section 3.3 footnote 6). Both agencies had received the MERLIN and it was part of normal working arrangements to hold a discussion to determine how to proceed.

34. Details of the discussion were only placed on the police record. The agreed outcome was that there would be a single agency investigation by the local authority. Two further decisions were noted. The local authority would contact the hospital to confirm the exact details of the injury. The episode needed to be reported to the LADO as an allegation against a professional working with children. There are no details of how these decisions were reached though they are consistent with the view held by the police that the injuries were accidental. In social care the case was then allocated electronically for an assessment (under Section 47 of the Children Act 1989) to be undertaken by a social worker in the children and families assessment team.

Actions between Tuesday 7 and Tuesday 14 October 2014

35. On 7 October 2014 the case was transferred to the Havering assessment team where the deputy team manager allocated it to a social worker, setting out a series of actions for her to take. He noted that a strategy meeting was required which should be attended by the LADO because the allegation related to a professional working with children. His records indicate a high level of concern about the seriousness of the injury. He had a conversation with the Service Manager (responsible for the LADO service) about the need to obtain the medical assessment of the injury. The Service Manager recorded this discussion but the deputy team manager did not. The social worker had contacts with the police (who indicated that they would take no action until the medical evidence was received) and the hospital, which confirmed that Child A was due to be seen the following day at the fracture clinic. The named doctor (the paediatrician with lead responsibility for safeguarding would be receiving a review of the records and reports). This had been the result of an intervention by the liaison health visitor (whose role was to communicate with the health visitor who was in touch with the family) who had seen the ED record summary and been very concerned about the injury.

36. Child A's mother has a note that she phoned the MPS that day and was put through to the CAIT. The officer she spoke to could give no update on any investigation, which the mother says she found upsetting. The following days Child A's mother contacted her health visitor who arranged to visit in order to provide reassurance about the injury.

37. On 8 October 2014 the fracture clinic appointment confirmed that Child A's bone density was normal, ruling out a bone disorder as an explanation for the fracture. Senior medical staff exchanged views at this point and noted that the injury could in theory have been caused by an accident but that the childminder's account needed to be carefully assessed. Subsequently this opinion was conveyed to the local authority along with a recognition that the hospital had erred in not referring the case immediately from the ED the previous weekend.

38. On 9 October 2014 Child A's mother has a record that she again phoned the police in order to try to establish what action the police and social care were going to be taking. On this occasion the same police officer directed her to the local authority. This led to a conversation with the deputy team manager who explained that social care was waiting for further information from the hospital.

39. The same day there was discussion within the local authority between the Service Manager (responsible for the LADO Service) and the duty LADO. The duty LADO was asked to convene a strategy meeting involving the referrer (Early Years), the allocated social worker, the police, Ofsted and MASH and to obtain a medical report for the meeting to consider. He was also asked to contact Ofsted and request that the childminder be suspended from looking after children until the investigation had clarified the concerns. The discussion with Ofsted took place the following day.

40. On Friday 10 October 2014, the duty LADO called Ofsted and spoke to a regulatory professional.[21] He provided a lengthy account based on the information received from the childminder and the account of subsequent professional contacts. This included reference to the reported conversation that the childminder said that she had had with Ofsted. Further phone calls confirmed that a strategy meeting would be held, to which Ofsted would be invited and that a medical report and update on police action were awaited. Information provided to Ofsted was discussed with a more senior member of staff whose view

[21] This is a member of staff whose role is to receive calls which relate to concerns about the regulation or conduct of childminders from the call centre call handler.

was that there were no grounds for suspending the childminder at that point.[22]

41. The case was passed for 'urgent regional action' i.e. for the attention of the London regional team which dealt with allegations against childminders and early years providers. It was subsequently handled on the duty system of the London region until 18 November 2014, when it was allocated to an individual member of staff for follow up.

42. The local authority received the written report from the hospital named doctor, which stated that 'it would have required considerable force to cause such a fracture'.

43. On 13 October 2014 the case was allocated to an experienced detective constable in the CAIT. He told this review that at that stage his task was 'to attend the LADO meeting' rather than to undertake an investigation. This is consistent with the actions taken so far by police officers which were based on the assumption that Child A's injury had been caused in an accident.

The LADO strategy meeting - Tuesday 14 October 2014

44. The proposed arrangements for the LADO meeting were changed in the days before the meeting in order to accommodate the availability of the duty LADO to chair it. As a result of changes or uncertainty about the date a number of professionals were unable to attend and their agencies were not represented.

45. The following professionals attended: Duty LADO; Detective Constable (CAIT); Deputy Team Manager, social care assessment team; Named Doctor from the hospital (a senior paediatrician), together with the Paediatric Liaison Nurse and a Paediatric Nurse who had seen Child A (who was attending on behalf of the ED Paediatric Consultant). The minutes suggest that of the hospital staff only the doctor actively contributed to the discussion.

46. The following gave apologies or were unable to attend:
    - Early Years Inclusion Manager - the LADO had been ambivalent about whether anyone from Havering's Early Years Service needed to attend because it had no further information to add, and the change in dates had caused some confusion
    - Ofsted – was unable to attend because of the late notice of a change in date)

[22] This member of staff was a Ofsted Early Years regulatory managers for the London region, Early Childhood Senior Officer. The person's role is to oversee investigations into complaints and standards of care

- the allocated social worker - she was updated straight after the meeting in order to make a visit to Child A's family.

47. The meeting was given details of the report provided by the childminder, first to the Early Years Service and then to the LADO. It noted the nature of the injury and that there had been no previous allegation against the childminder. As with previous records, the notes of the LADO meeting identify the childminder but do not include details of her children, or other family members.

48. The meeting considered the reports of events, noting that there were discrepancies between the report made by the childminder to the Early Years Service (which refer to only one incident at the playgroup) and the reports given to the police during their visit to the parents and to other professionals (which refer to two separate incidents involving Child A and the same, older child).

49. The hospital confirmed the nature of the fracture and that 'considerable force' would have been required to cause it. Asked by the CAIT representative whether it was possible that the injury had been caused by a 3 or 4 year old child, the named doctor said that it would require a detailed review of the alleged incident and the circumstances in which it was said to have occurred in order to judge whether that was possible. He reiterated that the bones of even a small child are strong and would require considerable force to break. The view of the named doctor was that the injury had occurred between 7 hours and 7 days before the x-ray and there needed to be an investigation of the circumstances to try to ascertain what had actually happened. He suggested identifying a list of all the carers over this time period, finding out how Child A had been transported to the playgroup and identifying any witnesses to the reported event at the play group.

50. The police officer told the meeting that he would need to consult with his supervisor in order to determine whether there should be a criminal investigation (so that the next steps would be planned and conducted jointly by the CAIT and social care). If not social care would proceed with a single-agency Section 47 investigation. It was noted that social care would speak to Child A's mother, the childminder and 'people at the toddlers' group' and find out who else was supporting the family.

51. The duty LADO reminded the meeting that there was a duty of care towards the professional involved and that he would talk to the Early Years Service in order to arrange advice and support for the childminder. He noted that he would speak to Ofsted to provide an update.

52. Minutes of the meeting were prepared and sent on 17 October 2014 to those present and also those who had given apologies. At the hospital the notes of the meeting remained as an attachment to the emails and were not added to Child A's medical record. The LADO meeting notes became part of Ofsted's record, where they were placed in a shared folder with papers on the allegation. The minutes were also addressed to the Early Childhood Senior Officer in person, but because of what Ofsted describes as a technical problem with its email system that day, she may not have been received them. This officer left her post on 6 November 2014. The notes of the LADO meeting were not referred to in subsequent discussions within Ofsted; these relied on further updates and copies of emails sent to Ofsted by the LADO and later on phone calls made to Ofsted by Child A's mother.

53. Shortly after the LADO meeting the social worker made her visit to Child A's family. The parents reiterated their account, which was consistent with the information that they had previously provided. The social worker obtained information about the family for her assessment and outlined the steps that she thought would be taken, which included a visit to the playgroup. She later reported having no concerns about the behaviour or presentation of the parents at all and felt that they had done everything that would have been expected of them.

54. The social worker did however feel concerned about the apparent discrepancy between the account that the childminder had set out in the accident form (which referred to two episodes, during one of which Child A was said to have been pulled backwards) and the phone report given to the LADO which referred only to one incident. The social worker felt it was odd that there should be this error because the details should have been fresh in the childminder's memory and, if there was any doubt, the childminder could easily have referred to her own incident log. The social worker sent an email pointing this out to the duty LADO. He added this to the LADO record but did not respond. He later forwarded the social worker's detailed email to Ofsted.

Steps taken to pursue the investigation 16 – 27 October 2014

55. On 16 October 2014 the duty LADO contacted Ofsted to provide an update and gave details to an Early Childhood Regulatory Inspector.[23] The Ofsted records contain the fuller account. In it the LADO explained the medical view about the timeline within which the injury would have occurred. He said that a decision was awaited from the police as to

[23] This is a job title. The person's role is to undertake enquiries when there are concerns or complaints about childminders and other early years providers.

whether there would be an investigation. It was difficult to know if there was a risk from the childminder because of the number of people who might have been in contact with the child during the period when the injury might have happened, and that there was no suggestion that the injuries were non-accidental. The LADO asked Ofsted not to undertake its own investigation until the police had decided how to proceed.

56. The Ofsted staff member had a lengthy phone conversation with a more senior member of staff as a result of which it was concluded that at that point there was no new information which would justify suspending the childminder. This was confirmed in a phone call to the childminder who was told that she was free to continue working.

57. The duty LADO also contacted staff in the Havering Early Years Service to provide an update and to ask the service to support the childminder. The service was also contacted by the allocated social worker seeking background information about the policies and procedures that should have applied to the playgroup (for example whether they should have registered details of children attending) so that she would know what questions to ask of the playgroup when she visited.

58. On 18 October 2014 the detective constable agreed an investigative strategy with his supervisor. He was to liaise with the social worker and take statements from the childminder and the parents.

59. On 20 October 2014 a member of the Early Years Service visited the childminder. They talked about the children she was minding and her approach to her role. They did not discuss the reported incident or incidents with Child A as it was not the role of the service to conduct the investigation.

60. Child A's mother has a record that she spoke to the allocated social worker on 20 October 2014. She noted that the social worker said that the next step would be a meeting involving the LADO, the police and social care.

61. On 22 October 2014 the social worker gave Child A's mother the name of the police officer who would be dealing with the case. She noted speaking to the detective constable that day and remembers that he explained the reasons why there had been no progress in the investigation. These were that he had been on leave and that he had 18 other investigations to progress, a number of which had taken priority over Child A.

62. On 22 October 2014 a different regulatory inspector from Ofsted contacted the police for an update. The CAIT confirmed that the investigation was still being undertaken and identified the officer

responsible. This was the first of four attempted contacts initiated by Ofsted over the following three weeks. The first conversation between Ofsted and the officer responsible for the investigation took place on 19 November 2014 at which point it was stated that no firm update was available as interviews with witnesses remained to be undertaken.

63. On 24 October 2014 Child A's mother phoned the officer again urging him to visit the playgroup before it closed for the half term week. He responded that he could not do that, but that he was going to devote a day to the case the following week. He told Child A's mother that she should not make a visit to the playgroup herself.

64. On 27 October 2014 the social worker and the detective made joint visits to the playgroup and to the childminder. The social worker told the review that she had been chasing the CAIT to make this visit; the mother of Child A told the SCR that she had also phoned both police and social care to see what was happening.

65. The playgroup leader said that she had no recollection of the reported incident at all. She had checked with other volunteers, none of whom remembered the incident or the childminder. After the visit the social worker asked the Early Years Service for a copy of the childminder's original incident form, which she had seen referred to but not read herself at that point.

66. This noted that there had been two incidents which had taken place either ten or twenty minutes apart. The time that was said to have elapsed between the two reported incidents had been altered by the childminder. It noted that Child A had been so distraught that she had refused to be put down for 20 minutes and that the child who had hurt her had kept behaving in the same way towards other children. The social worker told the Serious Case Review that she felt uneasy about a number of aspects of the presentation of the childminder. She did not record or air her concerns at the time; she did however highlight the discrepancies in the childminder's accounts in an email to the LADO, which was in turn forwarded to Ofsted.

Conclusion of the police and social care enquiries

67. On 31 October 2014 the Service Manager (who had overall responsibility for the LADO service and had always undertaken a large proportion of the LADO work) left Havering. This is the officer who had initially been consulted about this case (see paragraph 35 above). The local authority re-designated her role and did not replace her. Day to day responsibility for the LADO service fell to another manager. At the same time arrangements were being made to recruit an interim LADO who started work on 3 November 2014.

68. On 4 November 2014 the social worker contacted the duty LADO (who had chaired the meeting on 14 October 2014) confirming that there was a continuing police investigation and asking when a review LADO meeting would take place. He replied that unless significant new information emerged there didn't need to be a review strategy meeting; however the meeting should be reconvened at the end of the investigation. He said that he understood that further witnesses from the playgroup needed to be spoken to.

69. The same day the duty LADO spoke to the social care manager who was now responsible for the service. She advised him that background checks were needed on the childminder and her family and that he should reply to the email previously received from the social worker about the playgroup.

70. Neither party was later able to recall this discussion. However on 12 November 2014 the duty LADO did discuss progress with the social worker. The social worker highlighted her concerns about the discrepancies in the accounts given by the childminder (adding that the childminder had told the social worker that Child A had in fact only cried for a couple of minutes). It was noted that the playgroup leader said that she had had no knowledge of the childminder until she was contacted by her after the day that Child A had been injured. This contact took the form of a request from the childminder asking to make sure that she would be able to attend the group on 10 October 2014, stating that she had already attended a session on the day that Child A had been injured.

71. Noting that the investigation was continuing the social worker said that she would be speaking to the police officer the following day. However there is no record in either agency to indicate that they discussed the case again.

72. On 6 November 2014 Child A's plaster was removed and it was noted that the bone had healed well, needing no further immediate intervention.

73. The same day Child A's mother spoke to the detective sergeant who was supervising the detective. He reassured her that the playgroup had been visited and that an officer would take statements from the parents soon. They had a similar conversation when she phoned the CAIT again on 13 November 2014.

74. On 12 November 2014 a different regulatory inspector from Ofsted rang the police to establish what action if any they were taking and whether the childminder was suspected of having caused the injuries. She was advised that the detective would be returning to work the following day. Having explained her frustration at the numerous

attempts to get through to the detective, she was put through to a detective sergeant (not his supervisor) who is recorded as having said that it was not entirely clear from the file what was happening but he could see that the child had sustained a significant injury. Acknowledging the urgency from Ofsted's perspective, the sergeant agreed to speak to the detective the following day to instruct him to call Ofsted with an update.

75. On 14 November 2014 the allocated social worker emailed the duty LADO to inform him of the outcome of her assessment. It recommended that there should be no further action by the local authority. The following day she forwarded her completed assessment to her manager. He was off sick and then on leave. As a result there is no evidence of any management scrutiny of the assessment. There was no further communication between the social worker and the LADO or management oversight. The social worker prepared a closing summary which was added to the electronic recording system on 15 December 2014.

76. On 18 November 2014 Ofsted allocated the case to a different regulatory inspector, who subsequently retained responsibility for it. The inspector immediately sought updates from the local authority and the police. Following a brief discussion the duty LADO forwarded to Ofsted the lengthy email sent to him recently by the Havering social worker. This set out details of her visit and discussions, as well as her concerns about some of the discrepancies in the childminder's account. This was summarised in the Ofsted record. A senior officer decided that a case review would be held later that day to reconsider the possibility of suspending the childminder following the information received.

77. Before the meeting the detective phoned Ofsted to summarise the progress with his investigation. He had further interviews to conduct and until these were complete, he could not offer any indication of the outcome or further police action. In his mind some doubt existed as to whether the childminder had ever been at the nursery, and if that was the case she would need to explain what exactly had happened. However the Ofsted note states that he went on to say that he felt that Child A's fractured femur had happened as a result of 'a genuine accident' that (according to the paediatrician) could have happened at any point during a period of 7 days.

78. These views informed the Ofsted case review that was held on 19 November 2014. This was chaired by a different senior officer as the previous officer had left her post. The review also noted that Ofsted had no history of concerns and the childminder's practice had been judged at the last inspection to be 'good'. Ofsted had been advised by

the LADO to await the conclusion of the police investigation before visiting the childminder. The conclusions were that Ofsted needed further information from the police and LADO and then to visit the childminder as soon as possible, but risk of harm from the childminder was not demonstrated, so suspension was not appropriate.

79. Immediately after the meeting the Ofsted notified a colleague of the detective that they were aware the childminder had continued to practice since October 2014 without any contact from Ofsted to assess whether she was meeting the statutory requirements for registration. The inspector asked for confirmation that she could visit the childminder, not to discuss the injury at this stage but to establish whether the childminder was meeting the Early Years Foundation Stage requirements more generally.

80. The parents of Child A say that on 25 November 2014 a retired police officer working with the CAIT visited them at home and took a statement. It was consistent with the accounts that they had given throughout.

81. This was the last contact that the family had with the CAIT until about two weeks later when the detective phoned them to say that the police would not be able to pursue a criminal case because there was too large a period of time when the injury might have occurred, making it impossible to prove a case against the childminder. On 19 December 2014, the detective sergeant who was supervising the detective closed the police investigation noting that, 'there is no evidence of an assault or even a GBH and this injury is un-accounted for'.

Ofsted contacts with the childminder - 12 December 2014

82. After making an unsuccessful attempt on 24 November 2014, the Ofsted inspector visited the childminder by appointment on 12 December.

83. By then the Ofsted inspector had heard from the detective that he could not determine how the injury had been caused or who had caused it and that he would be recommending to his supervisor that the police should take no further action. He noted that there was agreement that Child A had been well when dropped off at the childminder in the morning but behaving unusually when she had been collected that evening. It was accepted that the injury must have been caused by 'a significant blow, whether or not accidental'. He voiced no concern about the proposed Ofsted visit.

84. The Ofsted visit lasted 75 minutes, during which the inspector met the childminder, two minded children and her son. The inspector explained she was there to ensure the childminder was meeting the Early Years

Foundation Stage requirements and she was not going to discuss the details of the injuries to Child A because they were still the subject of a police investigation. The inspector checked records and registers, including the accident records. The childminder's accident records were reported to be thorough, with diagrams and times and dates and included the two reported accidents involving Child A on 3 October 2014.

85. The inspector's report states that the childminder demonstrated good knowledge and practice in safeguarding, though Ofsted has told this review that there is little evidence cited to show what this meant in practice. The childminder reportedly stated that until the police had visited her on the Saturday after the accident she thought the parents were making enquiries rather than allegations. She had therefore contacted the LADO on morning of Monday 6 October 2014. The childminder stated that the children are always within sight and sound of her. The inspector questioned why two such serious incidents had happened to a child. The childminder stated she was with the child but putting on the other children's coats and it had happened in a split second both times.

86. The report of the visit states that the childminder was very upset and concerned regarding her registration. The inspector explained her role and said that she would visit again once the police investigation was complete. The childminder expressed surprise at the lack of support from the local authority and lack of updates on the progress of the case from the police. She was encouraged to contact the police for the information she wanted.

87. There was then a break over the Christmas period when no action was taken by agencies.

<u>Renewed contact with the childminder and the mother of Child A – January 2015</u>

88. In the New Year the parents of Child A and the childminder separately took the initiative. On 2 January 2015 the mother of Child A phoned Ofsted (and spoke to the call centre) in order to explain her concerns about the events of 3 and 4 October 2014. She told the Serious Case Review that her reasons for doing this were that 1) the police were now taking no action 2) the local authority had assessed her care but did not seem to have a role in taking any action over the childminder 3) she believed that Ofsted was the family's 'last hope'. The parents say that they had thought about what had happened a lot over Christmas, trying to understand how Child A could possibly have been injured. They felt that the childminder had not been made to give a proper account of what had happened. They had come to the view that

Child A had either fallen off a changing table or that another child had stamped on her or kicked her: either explanation meant that the childminder was not supervising her daughter properly.

89. Child A's mother told the call centre that she believed that the fracture had happened at the playgroup but that this showed that the childminder had not been supervising her daughter properly. She described her contacts with the childminder and other professionals. Child A's mother said that she felt that she had never been given a full account of what had happened and asked if Ofsted could assist with some form of mediation between her and the childminder. She was also taking the childminder to the small claims court (over her refusal to repay their deposit). She believed that the social worker had never visited the playgroup. After the call Ofsted cross referenced the details of the case to the information previously received from the local authority and the police.

90. On 6 January 2015 the childminder called the LADO and spoke to the member of staff who had been appointed in November 2014 (paragraph 67 above). She stated that she had not had an update on the outcome of the enquiries. He contacted the detective and was told that there would be no further action by the police because it was not possible to be certain who had caused the injury or how it had happened. The LADO asked the detective to update social care, Ofsted and the childminder. He spoke directly to the childminder to inform her. He also wrote to these agencies seeking any comment before closing the LADO papers on the case. There was no response from social care. The LADO papers were closed with the comment that there was 'no blame associated' with the incident. The LADO also updated the Havering Early Years Service to remind it of the continuing need to offer support to the childminder if required.

91. On 12 January 2015 there was contact between the police and Ofsted during which details of the outcome of the enquiry were shared. On 15 January 2015 the allocated Ofsted inspector phoned the original duty LADO, who told her that he no longer worked for Havering. Later the current LADO informed the inspector that there would be no further action from social care and that he was happy for Ofsted to assume the lead in the investigation. The inspector arranged to visit the childminder on 21 January 2015.

<u>Action by Ofsted to evaluate the quality of care being provided by the childminder in January 2015</u>

92. The visit lasted for an hour during which time the inspector saw the childminder, one minded child and one of her own children. The visit included a discussion of the reported episode at the playgroup, based

on the account given by the mother of Child A and previous records provided to Ofsted. It was agreed that three actions would be set for the childminder to improve her practice under the headings (which are linked to the EYFS) of 'meeting children's needs'; 'completing risk assessments' and 'adhering to agreements made with parents'.

93. The detailed records set out the following concerns, based on the information that had been provided to Ofsted by the mother and by the LADO: 1) the childminder would need in future to ensure that she had taken all reasonable steps to ensure that children were not exposed to risk and that she ought to have carried out a 'risk assessment' when attending the playgroup for the first time 2) she should have supervised Child A more closely at the playgroup and 3) she should have communicated more effectively with her parents, in line with the agreement that she had made with them when she became Child A's childminder. The childminder felt that the incident had been a minor one, which she did not necessarily need to report to the parents immediately. When it was examined the childminder's written agreement stated that she would contact the parents immediately there was any incident. The childminder admitted that the agreement was a standard one provided by a childminder organisation which she had not read closely.

94. On 3 February 2015 Ofsted posted an account of these concerns on the website www.childcare.co.uk . The material posted on the website is set out in full as Appendix 4 of this report.

95. On 5 February 2015 the mother of Child A phoned Ofsted asking for an update on the investigation. The Ofsted inspector explained that she could not discuss the case or her actions or views with the mother but that a summary of the outcome would be on the Ofsted website.

96. On 8 February 2015 the childminder sent Ofsted a written response setting out how she proposed to comply with the requirements of the previous visit. For example, if in future she planned to take minded children to a new activity such as a playgroup, she would visit it ahead of time. Ofsted made an unannounced visit, which lasted 45 minutes, on 5 March 2015 to monitor her compliance.

97. The Ofsted inspector said that she was satisfied with the evidence from the letter and her visit. She told the childminder she would update the outcome summary on the Ofsted website and close the investigation. The update to the website stated that Ofsted had 'carried out a monitoring visit to the premises to check that the childminder was meeting the actions set. We are satisfied that the childminder has done so and no further action was required. The childminder remains registered with Ofsted'.

Contact between the childminder and Child B's parents

98. Child B's parents began looking for a childminder in October or November 2014. Understandably they did not record the exact dates when they started looking or first made contact with the childminder, so it is not possible to locate their contacts in the chronology of events relating to Child A above.

99. However they are certain that they had no knowledge of the concerns about Child A, the childminder's account of the events described above or the involvement of other professionals during October and November 2014 when they were looking for a childminder. Key for them was the availability of childcare that would suit the parents' working hours and the location. The childminder they chose was the only one they could find who offered this.

100. Child B had introductory visits to the childminder during January and February 2015. The parents' diaries show that the first introductory visit was on Monday 16 January, prior to the visit by the Ofsted inspector described above (section 92).

101. Child B's mother recalled seeing one positive reference about the childminder on the www.childcare.co.uk website at the beginning of their search. She did not recheck the website closer to the time when she returned to work. She therefore had not seen the summary of the concerns written by Ofsted on 3 February 2015 (referred to in paragraph 94 above).

102. The parents were impressed by the childminder's offer to be flexible and also by the apparently well organised paperwork, setting out her policies and procedures, which seemed to present a very professional approach. This is in fact standard paperwork that any childminder who is linked with the PACEY organisation might reproduce and customise to describe their own circumstances.

103. Child B first attended sessions with the minder on 11 February 2015. Her parents had no concerns about the care that was being provided for Child B. On one occasion (they did not record the date) they noted that Child B had a small bruise on her leg, to which they did not attach any particular significance. The childminder said that this had probably occurred when the child had been using a toy that enabled her to 'sit and stand' (a baby bouncer some kind of) and they thought no more of it.

104. On 16 March 2015 Child B was seriously injured while in the care of the childminder.

Appendix 2

VIEWS OF THE PARENTS

Introduction

1. This section of the report summarises the views of the parents of Child A and Child B, provided in meetings with the independent lead reviewer and the Havering LSCB Business Manager. These interviews took place prior to the criminal trial and parents only had information about the role of professionals in relation to their own child. Factual information from the parents that the review has relied on is also contained in the narrative (Appendix 1). The parents experience of looking for and choosing the childminder are described in Section 3.2.

Child A's parents

2. Child A's parents were disappointed and concerned that the hospital had not identified the possible safeguarding concerns about Child A when she attended and that the initiative had come from them. '*The hospital should have contacted an expert to obtain an opinion regarding the cause. If this had happened a timeline for the injury may have been given*'. Child A's parents were glad that the hospital had allowed them to take her home, '*but it could have been that they had caused the injury, which would have left a child in a dangerous position'. The staff at the hospital were not at all curious regarding how the injury had been sustained. None of the staff looked at the marks on Child A's shoulders during the hospital visit or recorded details of them….*

   The hospital provided for Child A's physical needs but not her need for protection and safeguarding. The hospital did not consider the possible risk to children by the child minder.

3. The parents were glad that the social worker visited because it meant that the investigation was moving on. They had not had any report back from the social worker about the visit to the playgroup, so she had assumed that she had not made the visit. The assessment undertaken by the social worker was accurate enough but because it focused on their parenting ability (Child A's parents) it did not contribute to their understanding of why it had happened. They understood and did not mind that the social worker was obliged to undertake the assessment: *'it was a procedure and the Social worker was doing a job and ticking boxes'*.

4. The parents did not really understand who was leading the investigation. Initially they assumed that it was the social worker who was leading, but it was not. This was not communicated well.

5. Child A's mother was disappointed by the police investigation because it took so long for the police officer to visit the playgroup, which was an obvious step to take. She understood that the '*that the police had competing priorities and that (her daughter) was not the priority for the detective, and she understood that'.*

6. Child A's mother had had very frank conversations with the police officer leading the investigation, which at one level she appreciated. She understood that the case might not be a priority in the police 'pecking order'.

7. Child A's mother noted that the detective had the ability to make her feel stupid when speaking with him; to make her feel as though she did not know what she was talking about; and the ability to 'knock her down'. She felt more lenient towards the police because they could not pursue a prosecution if the medical evidence was not there. She noted that she did hassle the detective but understood that funding cuts and limited staff, impacted on the service given.

8. Child A's mother was not clear whether those still using the childminder to care for their children were aware of the nature of the concerns. She felt that Ofsted's report was insufficient; the report was OK but did not result in a change to CM's 'good' grading: Ofsted refused to discuss the episode any further and told her that the information was 'there is the report'.

9. Child A's mother wondered 'If I had not called to complain would Ofsted have done an inspection?' She felt that Ofsted should had conducted a much more thorough investigation given this was an unexplained injury. They let it slip through the net and did not take it seriously.

10. She had not seen Ofsted officers but if they had come to see me 'I could have explained what had happened and shown them the letters I had received from the child minder (which concern the repayment of deposits) that they would have found interesting.

<u>Child B's parents</u>

11. Child B's parents had only very minimal contact with professionals until after their child had been seriously injured. Child B's parents told the review that the service provided by the local hospital was excellent and all the staff were very supportive.

12. Child B was transferred to the intensive care unit at the specialist children's hospital and the family went with her. The medical care there was excellent. They were not contacted by any agency over the weekend, which was appropriate because all of the family's energy and focus was on their child, who was very sick.

13. Child B's parents told the review that all contact made by agencies was sensitive to the family's needs, clear and concise. All agencies kept the family in the loop and no one was overbearing. All agencies, especially police, were straight to the point, which was best for the family. Although the whole situation as traumatic and unbearable, staff were sympathetic and understanding. Professionals were direct and unambiguous about the difficulties that their daughter was facing, which was what they needed at the time. Professionals also gave them space and time to focus on their daughter while agencies got on efficiently with work to investigate what had happened to her.

14. Child B's mother contacted OFSTED following receipt of a letter to advise that the childminder had been suspended, giving details of the lead Ofsted investigator for the case. The letter asked the family to call if they wanted to discuss. She did so but was put through to a call centre and despite being very upset during the call, was not put through to the investigating officer, who never returned the call. No further update was provided regarding the suspension of the childminder The family believed that a call / conversation may have helped them to understand what was going on.

Appendix 3

Registration of the childminder – account from Ofsted

The following information was provided by Ofsted to the SCR as part of its individual management review

I. Please describe the process of registration and areas covered in visits made to prospective childminders.

At the time this childminder applied for registration in January 2012, Ofsted policy and practice were as laid out in the Registration and Suitability handbook which was effective from September 2010 (this was succeeded by a revised version effective from September 2012, and most recently from December 2015).[24] This section of the report therefore describes the practice extant under the 2010 guidance followed by the main changes made in the 2012 version.

Following receipt of an application to become a childminder for children under eight years of age, Ofsted carried out a number of checks on the applicant, every person living or working on the childminding premises aged 16 and over, and every person caring for children (for example, a childminding assistant). We also sought references from two referees named by the applicant.

The checks carried out on each of these people were:

- A 'known to Ofsted' check to identify whether the person was previously known to Ofsted in any childcare associated capacity. Where the person was known, we reviewed our information to identify whether there were any previous causes for concern.
- An enhanced Criminal Records Bureau (CRB, now DBS) check to find out about whether the person was on any barred list, or had any criminal convictions, cautions, reprimands or warnings that would give cause for concern about them working with children, or living on the premises where childminding was taking place.
- Where an applicant had lived outside the United Kingdom in the past five years, we usually required additional checks such as a certificate of good conduct to ascertain whether there were any causes for concern about them in the other country or countries in which they had lived.
- A check with the local authority children's services department to see if they were known in connection with care orders or other information that might bring into

[24] https://www.gov.uk/government/publications/become-a-registered-early-years-or-childcare-provider-in-england

doubt their suitability to work or be in regular contact with children. This also enabled us to determine whether a person was disqualified from registration.

- A health check on the childminder applicant and, where we had any cause to be concerned about their health, any assistant or co-worker.
- Any other checks we judged necessary in order to determine whether a person was suitable.

The applications team requested and received the response to the checks, and where these gave no major cause for concern, passed the case to the relevant Inspection Service Provider (ISP) to schedule a registration visit, and made sure the ISP inspector had all relevant information arising from the checks and application form. All routine early years registration and inspection visits are carried out by one of two contractors for Ofsted, known as Inspection Service Providers, or ISPs.

The registration visit normally happened when all checks were complete but could take place earlier where Ofsted decided it should. In the small proportion of cases where significant concerns arose from the application or checks, the case was allocated to an Ofsted Early Childhood Regulatory Inspector (ECRI) who investigated, conducted the registration visit and decided whether the childminder was deemed suitable, and registered, or unsuitable and refused registration.

Whichever inspector conducted the registration visit, its purpose was to assess the applicant's suitability and their ability to meet the requirements of the Early Years Foundation Stage (EYFS). During the visit the inspector interviewed the applicant and was instructed to ask a full range of questions to assess their suitability, and to probe fully with further questioning any areas where the applicant was less secure in meeting the requirements.

Where the inspector identified any cause for concern, they had to discuss it in full with the applicant and record details of the discussion in their evidence. The inspector was instructed to ensure that the questions they asked would draw out enough information to allow proper consideration of suitability. The inspector's evidence had to give a judgement of 'met' or 'not met' for the following areas of the EYFS:

- Learning and development
- Safeguarding and promoting welfare
- Suitable people
- Suitable premises, environment and equipment
- Organisation
- Documentation.

At the end of the registration visit the inspector had to review all the evidence and the information provided by Ofsted relating to checks, and recommend either that the applicant was suitable for registration, or that they were unsuitable and should be refused registration.

The inspector's visit report and recommendation was sent back to a decision-maker in the Ofsted applications team who reviewed the application, all checks, the inspector's evidence report, their recommendation and any other information, and made the overall decision of whether or not to grant registration.

The main differences to the Registration Handbook in the 2012 revision relate to regulatory changes to the Early Years Foundation Stage (EYFS) that came into power on 1 September 2012. One of these was the new requirement for childminder applicants to have completed their local authority approved training course and a paediatric first aid course before they could be eligible for registration (previously they were allowed six months after registration to attend this training). Post 1 September 2012, the inspector conducting the registration visit has to see documentary evidence that the applicant has attended local authority approved childminder training and proof of a first aid qualification. In addition, to increase the robustness of registration practice, all our early years inspectors (including ISP inspectors) were thoroughly trained at that time to be more probing in their questioning and ensure the process was very thorough. The regulatory staff who make most of the final registration decisions also since then very carefully quality assure all the evidence to check for thoroughness of assessment.

II. How was the registration process carried out in relation to the childminder?

The process of registering this childminder followed the procedure described above under the 2010 Registration Handbook. She applied for registration on 17 January 2012 and checks were then carried out on her and her husband, who was the only other member of the household aged over 16. They were both subject to enhanced Criminal Records Bureau checks that came back clear on 14 March 2012 for her, 22 March 2012 for him. They were both subject to checks with Havering Children's Services that each came back clear on 26 January 2012. The childminder was subject to a health check with her general practitioner that was returned clear on 13 March 2012. We sought and received two references for the childminder, one on 26 January 2012 and the other on 13 March 2012. Both were considered acceptable.

An ISP inspector carried out a registration visit on 5 March 2012. The inspector found all six requirements, i.e. Learning and development, Safeguarding, Suitable people, Suitable Premises, Organisation and Documentation to be met. In response to the question 'How will you deal with suspected child abuse or neglect?' the childminder said she would keep children safe at all times, free from danger and record any

concerns or incidents. She appropriately described signs that might indicate abuse (child withdrawn, gaunt, distant, hungrier or thirstier, change in behaviour, bruising in areas there shouldn't be, marks). She said she would go to social services and also report to Ofsted regarding any concerns. She had comprehensive written policies and procedures, including what would happen if an allegation was made against her or a member of her family. In reply to 'How will you manage children's behaviour?' she had a written policy and said she would work closely with parents to ensure consistency and encourage positive behaviour strategies. She also described activities she would conduct with children, including taking them to toddler and other groups. However, there were shortcomings in the report in that it did not indicate the evidence source, therefore it is not known whether written policies and procedures were seen and assessed by (the inspector).

There is no qualification requirement for childminding other than paediatric first aid, but the applicant had a BTEC NVQ Level 3 in Early Years Childcare and Education, a current Child Protection and Advanced Child Protection First aid certificate and had completed an impressive variety of other relevant training courses. She also had extensive experience of child care, having worked at a number of nurseries over a 12 year period, being a deputy manager at the time of leaving to have her own children. References were not sought from her previous employer and as described above, practice has recently changed to ensure this happens.

Overall the visit led the inspector to recommend the applicant as suitable for registration as a childminder. The registration information was then considered by a member of the Ofsted applications team and she became registered as a childminder on 22 March 2012.

III. How are judgements made about the suitability of prospective childminders to care for small infants? Are there additional requirements for those who wish to care for under 1s?

Registered childminders have autonomy over which children of which ages (within the ratios prescribed by the EYFS) they choose to mind, and once registered they are authorised to care for children of any age. Therefore the registration and inspection processes are carried out on the assumption that all childminders must be suitable to care for children of all ages and the care of small infants is an integral part of the registration process, rather than a separate element.

IV. How are judgements made about a childminder's understanding of safeguarding and child protection? Please provide any background information that you have to indicate whether this approach is generally reliable. This might for example include information about serious incidents involving children under the age of one placed with childminders

Three of the EYFS requirements are: child protection; suitable people; and safety and suitability of premises, environment and equipment, all of which contain significant elements of safeguarding and/or child protection. The inspector at registration and at inspection must gather information to enable them to judge whether these requirements are met.

Within 'Child Protection' there are requirements to be able to identify, understand and respond appropriately to signs of possible abuse and neglect, to have and implement a safeguarding policy and procedures, and to be alert to any issues for concern in the child's life at home or elsewhere. Registered providers must inform Ofsted of any allegations of serious harm or abuse by any person living, working, or looking after children at the premises. Within 'Suitable People' requirements are that the childminder, and any other person likely to have regular contact with children (including those living or working on the premises), are suitable, and providers must not allow people whose suitability has not been checked, including through a criminal records check, to have unsupervised contact with children being cared for. 'Safety and suitability of premises, environment and equipment' requirements include complying with requirements of health and safety legislation, ensuring the safety of children, use of reasonable force to prevent children from injuring themselves or others, ensuring all reasonable steps are taken to ensure children in their care are not exposed to risks and able to demonstrate how they are managing risks, keep children safe while on outings.

Ofsted's Registration and suitability handbook sets clear requirements for checking at the registration visit that an applicant is able to meet the requirements of the Statutory Framework for the Early Years Foundation Stage, including those relating to safeguarding and welfare. This guidance makes it clear that if an applicant does not show sufficient understanding of these requirements during the interview, the inspector should recommend refusing registration. The inspector's evidence is also reviewed alongside all other information that Ofsted has about the applicant, including evidence from checks carried out, before a final decision is made to register or refuse. This allows Ofsted to build up a complete picture of the suitability of the person to provide early years and childcare provision before registration is granted. The Registration and suitability handbook was strengthened in September 2012 to make clearer for inspectors and applicants the expectations placed on them by the Ofsted registration process.

There is evidence to illustrate that this has had an impact on both registration decisions and on the quality of provision delivered after registration. For example, our Annual Report for 2012-13 records that we received 2,100 fewer applications to register as a childminder than in the previous year, and that there was a higher 'drop-out' rate during the registration process, as providers became aware of the high expectations needed to be accepted for registration. There was also a four percentage

point increase in the proportion of applicants whose registration was refused. Those who did complete the registration process were more likely to perform well in their first inspection than those registered before the changes were made. After September 2012, 79 percent of childminders were judged as good or better, whilst prior to the introduction of these tougher arrangements, only 73 percent were judged as such.

Appendix 4

Summary of the concerns about the childminder

Published by Ofsted on www.childcare.co.uk

The following material was published on the Ofsted website on 3 February 2015

On 6 October 2014 a notification was received from the childminder which informed us of an injury sustained by a minded child. This notification means that the childminder met their legal responsibility as set out in the Early Years Foundation Stage welfare requirements to notify Ofsted particulars of any significant event which is likely to affect the suitability of the early years provider or any person who cares for, or is in regular contact with, children on the premises to look after children. On the 10 October 2014 we received a notification from an outside agency that raised concerns about an injury sustained by a minded child. In addition on 02 January 2015 we received information in the form of concerns regarding notification of accidents and risk assessment.

We investigated these concerns to see whether the setting was meeting the Early Years Foundation Stage welfare requirements relating to, 'Key person', 'Staff: Child ratios', 'Health', 'Information and records' and 'Safety and suitability of premises, environment and equipment'. We liaised with outside agencies while they conducted their own investigations. We do not investigate to prove or disprove a complaint but we use the information to check if the childcare provider is meeting all legal requirements. We carried out an unannounced visit to the premises and found that partnerships with parents were not secure as parents understanding of the accident procedure did not correspond with the childminder's written policy. Consequently parents were not provided with information regarding the care of their child as agreed. In addition risk assessments completed prior and during an outing were not sufficiently robust.

Following our investigation, we issued a notice to improve that asks the provider to: ensure arrangements meet the needs of all children and their safety with regard to adequate supervision to ensure children's needs are met (The Early Years Foundation Stage – Staff: child ratios); ensure all reasonable steps are taken in order that children are not exposed to risks, to demonstrate how risk is managed and determine where it is helpful to make some written risk assessments in relation to specific issues, to inform childminding assistants and to demonstrate how risk is managed if asked by parents and/or carers or inspectors (The Early Years Foundation Stage – Risk assessment); ensure that as the key person to children that any arrangements agreed with parents regarding the care of the child is implemented effectively in order to ensure that every child's care is tailored to meet their individual needs (in accordance with paragraph 1.10), offer a settled relationship for the child and build a relationship with their parents (The Early Years Foundation Stage – Key Person). We will monitor the provider to ensure they meet this action. The provider remains registered with Ofsted.

In March 2015 the website summary was updated with the following paragraph

'*We carried out a monitoring visit to the premises to check that the childminder was meeting the actions set. We are satisfied that the childminder has done so and no further action was required. The childminder remains registered with Ofsted'.*

Explanation of Ofsted policy on the writing of public summaries of the outcomes of its investigations - extract from Ofsted management review prepared for the Serious Case Review

Ofsted inspectors write outcome summaries following inspections or investigations that include looking into concerns relating to potential non-compliance with the requirements for registration. We publish outcome summaries on the provider section of the Ofsted website on gov.uk. Complaint summaries remain on the website for five years.

We only write and publish outcome summaries where we or the provider needed to take action to put something right. Where we carry out an inspection or an investigation visit and we find nothing wrong, we do not publish an outcome summary.

Outcome summaries include concise details of the information received, the potential non-compliance, what we found as a result and what we did in response. They do not include information about other non-compliance issues that arise during the inspection or investigation.

When deciding on the level of detail that ought to be included in the outcome summary, inspectors must use their professional judgement. They should have particular regard to the requirements of the Data Protection Act 1998 and any rights of children and their families and the provider and their families, as well as the requirements of the Human Rights Act 1998 and the European Convention on Human Rights.[25, 26]

This means that inspectors must not include sensitive child protection concerns or detail that may inadvertently lead to the identification of a particular child in the outcome summary. This includes reference to incidents so unique to a case that children could be easily identified.

A complaint or compliance outcome summary should include these sections:

- summary of the information and the potential non-compliance
- what we did in response
- what we found as a result
- other matters (if applicable)
- action taken.

The summary should include:

- the nature of the information we have received and where it came from, for example 'a concern' or 'notification from a provider'
- the nature of the concerns. It is not enough just to say that they suggested a person may be in breach of requirements - it should be clear to the reader what the concern is about. If the concern is so specific that it may identify individuals or the complainant, then the summary should detail the nature of the legal requirement
- the regulatory breach/general welfare requirements requiring investigation and the specific legal requirements to which it relates.

Ofsted's policy on writing complaint summaries is at:
https://www.gov.uk/government/publications/ofsted-writing-complaint-and-compliance-action-summaries

[25] Data Protection Act 1998: www.legislation.gov.uk/ukpga/1998/29/contents.
[26] Human Rights Act 1998: www.legislation.gov.uk/ukpga/1998/42/contents.

Appendix 5

Principles from statutory guidance informing the Serious Case Review method

The approach taken to reviews should be proportionate according to the scale and level of complexity of the issues being examined.

Reviews of serious cases should be led by individuals who are independent of the case under review and of the organisations whose actions are being reviewed

Professionals must be involved fully in reviews and invited to contribute their perspectives without fear of being blamed for actions they took in good faith.

In addition Serious Case Reviews should:

- Recognise the complex circumstances in which professionals work together to safeguard children.
- Seek to understand precisely who did what and the underlying reasons that led individuals and organisations to act as they did.
- Seek to understand practice from the viewpoint of the individuals and organisations involved at the time rather than using hindsight.
- Be transparent about the way data is collected and analysed.
- Make use of relevant research and case evidence to inform the findings.

Working Together to Safeguard Children 2015 (Sections 4.9 and 4.10)

Appendix 6

Terms of Reference and details of areas to be considered by the review

1. TERMS OF REFERENCE APPLYING TO ALL AGENCIES

I. How did practice in the case comply with expected professional and clinical standards?

II. Identify practice which met or exceeded professional standards, or where staff undertook effective work in difficult circumstances.

III. How did practice in the case comply with the agency's Policies procedures? If procedures were followed, but it did not result in the right outcome, why does the agency think this is the case?

IV. Please comment on the factors (including service user, personal, team and organisational) that have influenced practice and decision making in this case. This should include any specific circumstances, such as events that occurred out of normal office hours.

V. Did professionals identify this as a potentially complex set of circumstances? Please provide reasoning

VI. Was appropriate expertise (clinical, investigative, management and senior management) brought to bear during the course of the investigations and was the case brought to supervision? Did accountability for the decisions made sit at the correct level in the organisation?

VII. Were professionals involved sufficiently clear about the responsibilities of agencies in relation to possible criminal proceedings; action to safeguard children from harm; action in relation to the suitability / safety of professionals working with children? How well understood was the role of the LADO?

VIII. How effective was your agency participating within multi-agency meetings at scrutinising information, considering anomalies, challenging decisions, identifying risk, raising concerns and challenging outcomes?

IX. Are there elements which were weak or missing in the environment needed to enable staff (this might for example include policies, procedures or training?)

X. Identify any potential vulnerability or limitations in current safeguarding arrangements highlighted by the case

XI. Please identify opportunities for learning and service improvement (i.e. doing things differently). The fact that an agency may identify things that can be done better does not in itself imply any criticism of the way in which they were done which may reflect a legitimate interpretation of existing policies and procedures

TERMS OF REFERENCE APPLYING TO INDVIDUAL AGENCIES

2. OFSTED

INITIAL REGISTRATION PROCESS

I. Please describe the process of registration and areas covered in visits made to prospective childminders

II. How was the registration process carried out in relation to the childminder? Please provide information as to the skill and experience of those involved in the registration of this childminder

III. How are judgements made about the suitability of prospective childminders to care for small infants? Are there additional requirements for those who wish to care for under 1s?

IV. How are judgements made about a childminder's understanding of safeguarding and child protection? Please provide any background information that you have to indicate whether this approach is generally reliable. This might for example include information about serious incidents involving children under the age of one placed with childminders

FOLLOW UP INSPECTION AND REVIEW

VII. How is an assistant childminder added to a registration and what judgements are made in relation to that person's suitability and understanding of safeguarding and child protection?

VIII. Are childminders required to report concerns about the practice of other childminders?

OFSTED INVOLVEMENT POST INJURIES TO HS

IX. What information did Ofsted receive during the period when injuries and concerns were being investigated by police, social care and the LADO? Is this in keeping with your expectations as to how arrangements should function?

X. How does Ofsted track the progress of an investigation (by police, LADO, social care) and what standards does it set for relevant staff in relation to this? Were these applied in this case?

XI. How does Ofsted make interim decisions about whether to restrict the activity of a childminder or suspend the childminder pending the outcome of an investigation? What threshold is used and was it properly applied in this case?

XII. How was Ofsted informed of the outcome of the investigations into the injuries? How was the outcome of the investigative process then considered in Ofsted and what evaluation was there of it? What steps if any did Ofsted take in order to establish whether satisfactory investigations had taken place?

XIII. How and why did Ofsted focus on the account that the injury had been caused at the playgroup? Did this offer sufficient critical evaluation of this explanation and the process that had been used to verify the account?

XIV. How does Ofsted make final decisions about whether to restrict the activity of a childminder or suspend the childminder pending the outcome of an investigation? What threshold is used and was it properly applied in this case?

XV. How was the complaint outcome summary that was posted on the Ofsted website formulated?

XVI. How are those who may wish to employ a childminder made aware of the advice on the Ofsted website? What role does Ofsted play in bringing this information to the attention of parents?

XVII. Are childminders expected to bring information on the Ofsted website to the attention of parents seeking a childminder?

XVIII. How was Ofsted satisfied that the childminder continued to meet the requirements of the Early Years Foundation Stage after the investigation?

XIX. Are there any other matters that the organisation should bring to the attention of the SCR panel in order for it to fully understand the services provided?

3. LOCAL AUTHORITY LONDON BOROUGH OF HAVERING EARLY YEARS SERVICES

I. What is the role of early years services in relation to childminding and how was it implemented in this case?

II. Did the early years service contribute in the correct way to the investigation into the injuries to HS? Was it involved in decision making in relation to the outcome of the investigation?

III. How are those who may wish to employ a childminder expected to know about the advice on the Ofsted website? What role do the council and partner agencies play in bringing this information to the attention of parents?

IV. Are there any other matters that the organisation should bring to the attention of the SCR panel in order for it to fully understand the services provided?

4. HOSPITAL

I. What safeguarding procedures were in place at the hospital A&E department?

II. What is the safeguarding assessment tool? How was it employed?

III. Please describe the clinical (i.e. medical, nursing and social) assessment and management of the injuries? How were the injuries understood and evaluated and was this in keeping with expectations of good clinical paediatric practice? Did this meet expected professional standards? If not how could it have been improved?

IV. Could steps have been taken to narrow the original timeframe (up to 7 days) within which the injury was said to have taken place?

V. How were judgements made about the potential safeguarding risks? Did this meet expected professional standards? If not how could it have been improved?

VI. Given the gravity of the injury, how was the potential risk from the parents evaluated?

VII. How was information shared with other agencies and at what points in the process? Did this meet expected professional standards? If not how could it have been improved?

VIII. Are there any other matters that the organisation should bring to the attention of the SCR panel in order for it to fully understand the services provided?

5. POLICE CHILD ABUSE INVESTIGATION TEAM (CAIT) AND BOROUGH COMMAND (UNIFORMED) STAFF

I. How was the strategy to investigate the injuries to HS arrived at, including all steps taken to preserve and gather evidence?

II. What consideration was given to steps taken to safeguard and protect HS and other children?

III. How were timescales set for steps to be taken? Were the timescales consistent with the safety of the child? Were they met?

IV. What dialogue and information sharing occurred with other agencies, including the local authority, health care professionals and the local authority designated officer (LADO).

V. How were decisions as to whether this was a single or multi-agency investigation arrived at?

VI. How effective were the arrangements for risk assessment and management in the CAIT? Was the MPS SOECA risk management took used as it was intended and if not why?

VII. How was the evidence that the childminder might not have been at the playgroup on the day in question evaluated?

VIII. Were all possible lines of enquiry and sources of evidence explored by the police? If not, why was that?

IX. Could steps have been taken to narrow the original timeframe (up to 7 days) within which the injury was said to have taken place?

X. Was a coherent time-line of events drawn together to enable agencies to identify discrepancies in the accounts given and consider the full range of possible explanations for these injuries?

XI. Are there any other matters that the organisation should bring to the attention of the SCR panel in order for it to fully understand the services provided?

6. SOCIAL CARE

I. How was the strategy to investigate the injuries to HS arrived at, including steps taken to protect HS and other children?

II. How were timescales set for steps to be taken? Were the timescales consistent with the safety of the child and were they met?

III. What dialogue and information sharing occurred with other agencies, including the police, health care professionals and the local authority designated officer (LADO).

IV. How effective were the arrangements for risk assessment and management in the local authority?

V. How was the evidence that the childminder might not have been at the playgroup on the day in question evaluated?

VI. Could steps have been taken to narrow the original timeframe (up to 7 days) within which the injury was said to have taken place?

VII. Did the local authority adopt the correct standard of proof in evaluating the injuries?

VIII. Was a coherent time-line of events drawn together to enable agencies to identify discrepancies in the accounts given and consider the full range of possible explanations for these injuries?

IX. Are there any other matters that the organisation should bring to the attention of the SCR panel in order for it to fully understand the services provided?

7. Local Authority Designated Officer (LADO)

I. Was the referral to the LADO made at the right point and in the right way?

II. How timely and effective was the response of the LADO

III. Was there clarity in the investigative strategy developed between the LADO, police, social care and other agencies? If not why was that? What impact did this have?

IV. Please comment on the effectiveness of the LADO process in instigating appropriate investigations, in collaboration with other agencies with investigative responsibilities, keeping those processes under review, convening review meetings and bringing those processes to a conclusion where clear out comes had been identified

V. How was the evidence that the childminder might not have been at the playgroup on the day in question evaluated?

VI. What other cases was the LADO dealing with at the time? i.e. numbers, type of cases and their relative seriousness

VII. How are LADO decisions on complex cases supervised and signed off?

VIII. Could steps have been taken to narrow the original timeframe (up to 7 days) within which the injury was said to have taken place?

IX. Did the LADO adopt the correct standard of proof in evaluating the injuries?

X. Was a coherent time-line of events drawn together to enable agencies to identify discrepancies in the accounts given and consider the full range of possible explanations for these injuries?

Appendix 7

How the review was undertaken

1. The LSCB compiled a chronology of key events based on the written and electronic agency records.
2. The parents of the injured children were informed about the review bu letter and in person
3. Participating agencies were asked to prepare individual management reviews following the terms of reference set out in Appendix 6. These were written by senior staff with safeguarding expertise who had not been involved in the provision of services to the family. They were authorised by a senior manager with authority to submit and act on the findings of the report by the agency.
4. Reports were prepared based on agency records and interviews with the professionals most involved. The independent reviewer participated in interviews with a number of professionals who had been identified as playing key roles
5. Management reviews were scrutinised by the independent reviewer who met authors and senior managers to discuss the individual review documents
6. Additional documents and reports were provided for the review, including copies of internal reviews already conducted
7. SCR panel (Appendix 8) scrutinised individual management reports
8. Further meetings were held with agency representatives
9. The parents of the injured children were interviewed by the independent reviewer and the LSCB Business Manager
10. A draft review and narrative were prepared by the independent reviewer and discussed by the SCR panel
11. Final versions of documents were prepared.
12. These were reviewed with the parents of Child A and Child B prior to publication

Appendix 8

SCR REVIEW PANEL MEMBERSHIP

Independent members	
Mark Ansell	Consultant in Public Health Havering
Keith Ibbetson	Independent Lead Reviewer
Business Manager	Havering LSCB
Agency	**Designation**
Ofsted	Principal Officer for Safeguarding
Metropolitan Police Review Team	Detective Superintendent
	Detective Sergeant
Barking Havering and Redbridge University Hospitals NHS Trust	Deputy Director of Nursing
Havering Clinical Commissioning Group	Designated Nurse for Safeguarding
Havering Council	Assistant Director Learning and Achievement
	Assistant Director Children's Social Care
	Principal Social Worker
London Ambulance Service	
NELFT	Integrated Care Director
Authors of agency reviews	
Ofsted	Principal Officer, Safeguarding and Regulation
Metropolitan Police Service	Members of the Serious Crime Review Group
Barking Havering and Redbridge University Hospitals NHS Trust	Named Nurse Safeguarding Children
Havering Council Learning and Achievement	Independent author with expertise in safeguarding
Havering Council Social care	Independent author with expertise in safeguarding

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