

## Care Standards

### The Tribunal Procedure (First-tier Tribunal) (Health, Education and Social Care) Rules 2008

Heard on 14 & 15 March 2018 at Blackpool Magistrates Court, Blackpool

[2018] 3258.EY-SUS

BEFORE  
Mr H Khan (Judge)  
Ms L Bromley (Specialist Member)  
Mr M Cann (Specialist Member)

BETWEEN:

**Little Stars Childcare Morecambe Ltd**

Appellant

-v-

**Ofsted**

Respondent

## DECISION AND REASONS

### **The Appeal**

1. Little Stars Childcare Morecambe Ltd (“the Appellant”) appeals to the Tribunal against Ofsted’s (“the Respondent”) decision dated 5 February 2018 to suspend its registration as a provider of childcare on non-domestic premises at 93 Regent Road, Morecambe LA3 1AF (“the nursery setting”) on the Early Years Register and both parts of the Childcare Register for six weeks to 18 March 2018 pursuant to section 69 of the Childcare Act 2006 ('2006 Act') and the Childcare (Early Years and General Childcare Registers) Common Provisions) Regulations 2008 ('2008 Regulations').

### **Attendance**

2. The Appellant was represented by Mr D Bunting (Counsel). The Appellant's only witness to attend the hearing was Ms Blundell.
3. Mr P Saigal (Solicitor) represented the Respondent. The Respondent's witnesses were Ms Anne Law (Early Years Senior Officer, Northwest Region) and Ms Joanne Wildman (Early Years Regulator Inspector).

4. We also had a statement from Ms Claire Cook, submitted on behalf of the Appellant. Ms Cook was unable to attend due to personal issues. However, Mr Bunting confirmed at the outset of the hearing that he would not be proceeding with the application for her evidence to be heard by telephone. This was on the basis that her evidence was largely agreed.

#### **Restricted reporting order**

5. The Tribunal makes a restricted reporting order under Rule 14(1) (a) and (b) of the 2008 Rules, prohibiting the disclosure or publication of any documents or matter likely to lead members of the public to identify the children or their parents in this case so as to protect their private lives.

#### **Events leading up to the issue of the notice of statutory suspension**

6. The Appellant has been registered with the Respondent since 15 July 2016 and provides a nursery provision for children aged from birth up to 5 years old. It provides a nursery provision from premises known as 93 Regents Road, Morecambe, LA3 1AF (“the nursery setting”). Currently, there are approximately 28 children on the roll.
7. The business is owned by Ms Zoe Blundell. She is a Director in the Appellant Company, its Nominated Individual/Manager and Designated Safeguarding Lead. Her husband Mr Richard Blundell is also a Director of the company but has no direct involvement in the business.
8. Ms Blundell was previously a registered childminder from 2010 to 2017. At her last OFSTED inspection in May 2016, her childminding provision was rated as “Outstanding”. Earlier inspections noted that she had excellent knowledge about the correct safeguarding procedures and action to be taken if she had any concerns about a child in her care.
9. At the preregistration visit on 11 July 2016, Ms Blundell was able to demonstrate a good understanding of safeguarding in order to be considered suitable for registration as a childcare provider. On that basis, the visiting Inspector was able to recommend registration because the plans in place indicated that all of the legal requirements for safeguarding and welfare were met.
10. On 21 December 2016, the Respondent received a notification from Ms Blundell that a 16 month old child SK, who attended the nursery setting, had died at home on 19 December 2017. The child had been to the nursery setting the day before. No issues were reported in respect of Child SK.

11. On 12 January 2018, the Local Authority informed the Respondent that the matter was being referred to the Local Safeguarding Children Board for a serious case review due to suspected neglect in child SK's home life.
12. The Respondent arranged with Ms Blundell to visit the setting on 5 February 2018, to look at the setting's safeguarding procedures and to check if the setting had missed any opportunities to take steps to protect the child. A visit of this nature was normal practice following a serious incident.
13. The Inspector, Ms Joanne Wildman, conducted the visit to the setting on 5 February 2018, found serious safeguarding concerns. She found that the setting had failed to safeguard minded children by not sharing information with relevant agencies. There had been a number of instances of suspected child abuse and neglect, which had been recorded by members of staff on "cause for concern" sheets and other forms but not reported to Children's Social Care (CSC) which placed the children at risk.
14. The Respondent's findings also included little or no management oversight and it was alleged that management were complicit in the recording of concerns as well as a failure to take action by simply signing of those forms and not questioning the information provided.
15. As a consequence of these concerns, a Notice of Statutory Suspension was served on the Appellants nominated individual on 5 February 2018 whilst Ms Wildman was still on site.

### **Legal framework**

16. There was no dispute around the legal framework. The statutory framework for the registration of childminders is provided under the Childcare Act 2006. Section 69(1) of the Act provides for regulations to be made dealing with the suspension of a registered person's registration. The section also provides that the regulations must include a right of appeal to the Tribunal.
17. When deciding whether to suspend a childminder, the test is set out in regulation 9 of The Childcare (Early Years and General Childcare Registers)(Common Provisions) Regulations 2008 ("the 2008 Regulations") as follows:

*"that the Chief Inspector reasonably believes that the continued provision of childcare by the registered person to any child may expose such a child to a risk of harm."*
18. "Harm" is defined in regulation 13 as having the same definition as in section 31(9) of the Children Act 1989:

*"ill-treatment or the impairment of health or development including, for example, impairment suffered from seeing or hearing the ill treatment of another".*

19. The suspension is for a period of six weeks. Suspension may be lifted at any time if the circumstances described in regulation 9 cease to exist. This imposes an ongoing obligation upon the Respondent to monitor whether suspension is necessary.
20. The powers of the Tribunal are that it stands in the shoes of the Chief Inspector and so in relation to regulation 9 the question for the Tribunal is whether at the date of its decision it reasonably believes that the continued provision of child care by the registered person to any child may expose such a child to a risk of harm.
21. The burden of proof is on the Respondent. The standard of proof '*reasonable cause to believe*' falls somewhere between the balance of probability test and '*reasonable cause to suspect*'. The belief is to be judged by whether a reasonable person, assumed to know the law and possessed of the information, would believe that a child might be at risk.

### **Evidence**

22. We took into account all the evidence that was presented in the bundle and what was presented to us at the hearing. We have summarised some of the evidence before us and we wish to make it clear that the following is not intended to be a full record of what we read and heard.
23. Ms Law set out that on 5 February 2018, she received a telephone call from Ms Wildman who was at the nursery setting. A case review was held immediately to discuss the evidence Ms Wildman had found. As part of the process, the Respondent looked at the registration and inspection history, any previous cases where there have been concerns raised and any non-compliance with the legal requirements.
24. Ms Law confirmed that at the review, she was given information that, whilst there was no evidence that the nursery had recorded any concerns about the child SK or her family, there were a high number of safeguarding records for other children. The setting had recorded concerns, injuries and bruising to a number of children over a prolonged period of time. Ms Law was informed that those injuries were not referred to the relevant agencies and were viewed in isolation rather than as a collective concern. Ms Law was of the view that the nursery failed to identify that some of the injuries were classic non-accidental type injuries, or that patterns of abuse were emerging. A particular concern was that the Manager (Ms Blundell) had recently typed up all of the cause for concern sheets "to see if there was any pattern" but failed to identify this even when looking at the concerns together.

25. Ms Law had taken the decision to suspend the nursery. She believed that the continued provision of childcare by the Appellant to any child may expose such a child to a risk of harm. In reaching her decision, she reviewed the provider's history. She was concerned that the Nominated Individual/Manager was previously an "outstanding" childminder and had attended relevant safeguarding training in the past but failed to apply her training in practice. She was also informed that the majority of staff at the setting had attended Level 2 Designated Person for Safeguarding Training.
26. Furthermore, Ms Law was concerned that the Manager and the Deputy Manager, Ms Claire Cook were a party to the written recorded information and the failure to take action to safeguard children. Ms Law was not assured that any person in a leadership and management role at the nursery was capable of taking action to safeguard the children. In her view, there was no leader or manager, at present, capable of taking action to safeguard children in the nursery setting.
27. On 16 February 2018, she held a further case review with Ms Wildman and considered all the updated information. Ms Wildman informed her of the actions taken and the proposals of the Appellant in order to facilitate the lifting of the suspension. These included what the Appellant would do to ensure that the children were safe and that there would not be any repeat occurrences of the failures that led to the suspension. Ms Law reviewed the actions and proposals and found them to be very similar to those which were proposed at registration. Ms Law made the decision to refuse to lift the suspension for reasons including that the management arrangements would be inappropriate to safeguard children in the nursery.
28. There was a further review on 20 February 2018 and once again, Ms Law considered all the information, including the action plan. The action plan detailed the measures that the Appellant would take to safeguard children. In her view, Ms Law found that the action plan submitted by the Appellant on 18 February 2018 very similar to those which were proposed at registration. Ms Law was not reassured that, if faced with similar circumstances, the Appellant would safeguard children effectively and be able to take the appropriate action to maintain their safety and welfare.
29. Ms Law confirmed that she had reviewed the information provided by the Appellant to date but considered that the continued provision of childcare by the Appellant to any child may expose such a child to a risk of harm.
30. Ms Law did not have any confidence in the Appellant's ability to protect children. The Appellant had told the Respondent at registration what steps they would take to safeguard children. However, the Appellant failed to implement these and the lack of action left the children open to

abuse and neglect for a prolonged period of time. The failings were not in respect to one child or limited to one staff member but were widespread and systematic across the whole staff team. Ms Law was not prepared to put children at risk of harm in order for the Appellant to practice their safeguarding skills for a second time.

31. Ms Law had considered the proposal for the staff to have further training. However, she did not believe that the training undertaken by the staff team recently was "*embedded and sustainable*" as stated in the appeal. Ms Blundell, Ms Cook and five other members of staff had completed Level 2 Safeguarding Training for nominated officers prior to the suspension. Ms Law failed to see how completing the nominated safeguarding training course again could embed the learning and make it sustainable. She had considered the existing policies and proposals. There were no major concerns in relation to them. The concern was in relation to following the safeguarding procedures, which staff at the setting had not done.
32. Ms Law did not have any confidence in the leadership and management to enable this to happen. She had reviewed the handwritten document concerns and noted that a number were signed off by Ms Blundell herself, including one where the child disclosed that his father had hit him. This concern was not reported to any relevant agency or advice sought.
33. Ms Law accepted that although the necessary investigations had been completed, she did not consider that the necessary steps had been taken to eliminate or reduce the risk of harm. Ms Law set out that the Respondent needed reassurance that there was appropriate oversight, such as through a mentor, that safeguarding was taken seriously and procedures were being followed. Ms Law confirmed that a Notice of Intention to cancel the registration had been served on 2 March 2018.
34. Ms Wildman set out that the case was allocated to her on 18 January 2018. The Respondent had not considered that an urgent visit was required. On 31 January 2018, she spoke with Ms Blundell by telephone. On 5 February 2018, she visited the setting. During the course of the investigation visit, she was shown a "chronology of significant events" and there were concerns in relation to children WG, SP, LP, HP and RH. In summary, the nature of the concerns indicate neglect, non-accidental injuries including small circular burn marks to feet and bruises concealed by a false tan.
35. Ms Wildman was worried as some of the concerns were so significant that they may have justified a CSC investigation. However, because the Appellant had failed to raise the concerns with the relevant agencies, in her view, children had been left at risk of harm and potential evidence had been lost.

36. Ms Wildman was concerned that there had been a systematic failure at the setting in safeguarding children because she had observed that safeguarding concerns in respect of multiple children had been documented but ignored. In her view, the failures could not be linked solely to an individual member of staff, but in fact involved the entire staff and management team. Ms Wildman felt the case was so serious that she made an urgent telephone call to Ms Law while she was still at the setting and an urgent case review was held.
37. Ms Wildman stated that Ms Blundell informed her that she had been absent for a large period between April and September 2017 and therefore had not been aware of some of the concerns. However, 13 of the recorded incidents across chronologies were signed off by Ms Blundell and 34 of the recorded incidents were dated before April 2017 and after September 2017 when Ms Blundell was working at the nursery setting. Miss Wildman was also concerned that the Deputy Manager was failing in her duty to safeguard and protect children the risk of harm.
38. Ms Wildman described that the Respondent had been sent a “mock OFSTED report” authored by the Poppins Family Consultancy dated 30 January 2018 (prepared just a few days prior to the suspension). The report concluded that “*safeguarding was sound. The staff are aware of their responsibilities and supporting children to be safe*”. However, her visit of 5 February 2018 indicated that this was not the case. Ms Wildman considered that there was a lack of awareness around any safeguarding issues prior to the service of the suspension notice.
39. On 18 February 2018, Ms Wildman received two emails from Ms Blundell. In the first email, Ms Blundell acknowledged weaknesses and in the second she attached a raft of new and revised policies and procedures and an action plan. The action plan identified a long list of weaknesses and failures in safeguarding and the action she had taken and intended to take to remedy them. However, many of the promised actions in Ms Blundell action plans were in fact the same as that she has proposed at registration. These had not been implemented.
40. On 19 February 2018, Ms Wildman attended a professional strategy meeting. The meeting was chaired by the Local Authority Designated Officer (LADO) and was also attended by representatives from the police. The police advised her at that the meeting that as a result of the delay by the nursery in reporting the concerns in relation to the children, evidence had been lost. Ms Wildman confirmed that in total, of the five children whose chronologies had been sent to CSC by the Respondent, four had reached the threshold for a social work assessment. Ms Wildman confirmed that she did not have any confidence in Ms Blundell’s leadership and management responsibilities.

41. Ms Blundell confirmed that she assisted and provided advice to members of staff when a safeguarding concern was raised. As part of her role, she also attended the Common Assessment Framework (CAF) and the Team around the Family (TAF) meetings when required. It was her responsibility and that of the Deputy Manager to check and file documents completed by members of staff as well as to input data into electronic system at the nursery, relating to children, in order to ensure both paper and digital records were up-to-date.
42. Prior to having its registration suspended, Ms Blundell confirmed that the Appellant employed eight members of staff. However, due to the suspension, all members of staff had terminated their employment. She was currently actively recruiting for these roles to ensure she has new staff in place in the event the suspension was lifted.
43. Ms Blundell confirmed that the staff were expected to read and understand and adhere to policies and procedures relevant to their role and the safe running of the setting, as well as ensuring that good standards of safety, hygiene and cleanliness were maintained at all times.
44. She had employed a Deputy Manager, Ms Claire Cook who also worked on the nursery floor as a Nursery Practitioner. In addition to the nursery practitioner responsibilities, the Deputy Manager was required to manage and monitor members of staff, act as a safeguarding lead and the designated health and safety officer.
45. The nursery cared for 28 children but there are no more than 12 children on site at any one time. The children's ages range from six months to four years old.
46. Ms Blundell confirmed that she thought it would best practice to report the death of SK to the Respondent. Ms Blundell explained that the procedure for raising a safeguarding concern previously for all staff included completing a cause for concern form and this would then be submitted to the office. The administrative employee would input information contained within the form onto the nursery's electronic system. Once information was uploaded to the system, it was Ms Blundell's and the Deputy Managers responsibility to review the relevant child's chronology on the electronic system. Ms Blundell confirmed that there was no formal process for reviewing these and they would be reviewed as and when they were uploaded to the system.
47. Ms Blundell discovered a problem with inputting information on the nursery' electronic system in the week prior to the Respondent's visit. She noticed that the system had not recorded a safeguarding entry. Ms Blundell considered that the failure of the IT system had a significant impact on oversight of the safeguarding concerns. In future she would store such records in both paper and digital format.

48. She acknowledged that there was confusion among staff and management as to who the safeguarding lead was at the nursery. The Deputy Manager felt it was Ms Blundell whilst Ms Blundell considered it was the Deputy Manager. Ms Blundell accepted that there was a communication issue in this respect and would ensure this was not the case in the future.
49. Ms Blundell confirmed that she had been away from the nursery intermittently for five months between April and August 2017, due to personal issues. However, she was available by telephone and email. She accepted that her physical absence from the nursery setting caused difficulties and that it was not "*an ideal situation*".
50. Ms Blundell confirmed that she was present during some of the incidents referred to in the response and had signed some of the forms. She thought that the issue relating to the IT system had affected her ability to see the bigger picture on an individual child. She accepted that the IT failure should have been picked up sooner.
51. Ms Blundell accepted that there were a number of incidents that should have been referred to CSC and there was a failing on the part of the nursery and on her part in this regard. This included referring various children (including RH, SP and LP) to children services in respect of various injuries including bruising and burn marks. She accepted that there had been "weaknesses" and "failings". She did not lead by example and accepted that there was an inclination to believe the parents over the children.
52. Ms Blundell set out that the Appellant had taken steps to ensure that the above issues were thoroughly looked into and addressed. She did not think that she tried to minimise the concerns and not accept personal responsibility. She accepted the seriousness of the matter and this was demonstrated by the time she had spent making improvements and taking steps to address those issues.
53. She obtained a report from the Health and Safety Consultant, Mr Martin Shenton. Mr Shenton recommended safeguarding training for staff including Ms Blundell. Following recommendations made by Mr Shenton, staff were trained on safeguarding. This took place on 9 February 2018.
54. She spoke of recruiting additional managers at the nursery. She intended to remain as a Registered Manager until a new manager is in place. The new manager would report to her and she would remain the Designated Safeguarding Lead. She would continue to attend the setting to ensure that the policies and procedures are being followed by staff and management.

55. She acknowledged that the setting could not open for a number of weeks. This was due to the fact that there were no staff at present save for her. There was no Manager or Deputy Manager. She had placed adverts and was waiting for the outcome of this hearing before proceeding with them. She had also made enquiries with regard to the possibility of shadowing a manager of an “*outstanding nursery*” but had not had a response to date.

### **The Tribunal’s conclusions with reasons**

56. We reminded ourselves of the lower threshold for confirming the suspension and reminded ourselves that at this stage we are not finding facts.

57. The matter was somewhat urgent as the Tribunal had to hear and communicate its decision prior to the end of the suspension on 18 March 2018. We communicated a brief summary of our decision on 16<sup>th</sup> March 2018.

58. We found both of the Respondent’s witnesses to be knowledgeable and clear in their evidence. Both presented their reasons for taking the decision to suspend with clear reference to the evidence. Ms Wildman, who had first hand operational knowledge of the setting very fairly recognised the efforts the Appellant had made and made it clear that there was no effort to deliberately deceive on the part of the Appellant

59. We found that Ms Blundell was very frank and honest about her failings and those of the setting in general in relation to safeguarding which resulted in the Notice of Suspension. Ms Blundell also demonstrated a good knowledge of safeguarding in response to answers to various questions during the hearing.

60. We concluded that we were satisfied that the continued provision of childcare by the Appellant to any child *may* expose such a child to a risk of harm. Our reasons for doing so are set out below.

61. We also acknowledge that Ms Blundell has in the past, had an outstanding rating as a childminder and that from the period from April to August 2017, her personal circumstances meant that she was intermittently at the setting. We sympathise with her personal circumstances from April to August 2017. However, we note that she was present at the setting from September 2017 until the suspension was imposed on the 5 February 2018. This included signing off causes for concern forms and playing an active part in the management of the setting.

62. We took into account the admission by the Appellant that safeguarding was “*inadequate*” prior to 5 February 2018. Ms Blundell accepted that there had been “*weaknesses*” and “*failings*” which resulted in the Appellant taking its eye off safeguarding matters. She accepted that

the Appellant should have contacted CSC in respect of a number of children including RH and LP & SP and should not have accepted parental assurances about the injuries with which they presented. She accepted that the effect of this was that the relevant agencies did not have the full picture and that there was a possibility that decisions were taken by those agencies based on a lack of information.

63. Ms Blundell accepted that there was confusion in relation to who was the safe guarding lead. Both Ms Blundell and Ms Cook (Deputy Manager) were not clear and both thought it was the other. This also created confusion amongst staff. There should have been a clear communication of this issue for staff and Ms Blundell accepted that.
64. Ms Blundell accepted that she was too trusting of staff and should have checked up on what they were doing. Ms Blundell should have ensured that they completed all the relevant documentation and followed the policies and procedures. She accepted that she did not lead by example, both by failing to record information and by accepting the parents' version of what had occurred. She now accepted that it was not her job to investigate any safeguarding concerns.
65. We also acknowledge that Ms Blundell has put forward a plan of the action that she will take to ensure that the mistakes of the past do not occur again.
66. However, we acknowledge that whilst the Appellant had undertaken extensive training across the previous staff membership, focusing upon the need for robust safeguarding and actions, we agreed with the Respondent that the issue wasn't one of training but one of applying that training in practice. The previous staff (who have now all left) had the relevant training (including Level 1 & 2 Designated Safeguarding Training). This was according to Ms Blundell and accepted by the Respondent to be more than the required level. Nevertheless, taking Ms Blundell's admissions, multiple staff (including Ms Blundell) failed to deal with safeguarding matters in the appropriate way.
67. The allegations relate to multiple children across a period of time when Ms Blundell was and was not present. The concerns also relate to documentation that she has completed. We had no reason to doubt Ms Wildman's evidence that the Police have confirmed that as a result of the safeguarding concerns not being passed to other agencies, evidence may have been lost. Out of the five referrals to the CSC, four are now proceeding with a social care assessment.
68. Ms Blundell accepts that the setting cannot reopen until she has recruited, inducted and trained new staff. This would take a few weeks. We noted that Ms Blundell admitted that safeguarding was "inadequate" as at the 5 February 2018 when she had a full complement of trained staff (level 1 and level 2). We could not see how the risk of harm had reduced on the basis of the position at the

hearing whereby she had no staff, although she had placed adverts in the press advertising for such roles. The position at the hearing was worse than it was on 5 February 2018.

69. Even if we accepted that there were appropriately trained staff, we agreed with the Respondent that the issue was also one of ensuring that there was appropriate oversight to make sure that any new staff and Ms Blundell were complying with their own policies. Ms Blundell accepted that she had failed in this regard.
70. The concerns around safeguarding are serious. They should have been picked up earlier. The problems with the IT system should have also been picked up earlier. We were not persuaded that there were appropriate safeguards in place to ensure that the safeguarding concerns which led to the decision to serve the suspension notice had been dealt with or the risks mitigated.
71. We could not be assured that the arrangements in place would reassure us that the admitted failings around safeguarding would be addressed. Ms Law suggested that there needed to be clear oversight arrangements (such as through the use of an approved mentor) to ensure that there was a strict compliance with the safeguarding policies and procedures. We agreed that, given the admitted failings, there needed to be a robust arrangement for the management and oversight of safeguarding concerns. As Ms Blundell recognised, safeguarding is a serious issue and one that should be a priority for every individual.
72. We remind ourselves that the power to suspend the Appellant's registration is intended as a short term measure. We acknowledge that the Respondent had completed its investigations but, in our view, we agreed with the Respondent that the Appellant had not taken the necessary steps to eliminate or reduce the risk of harm for the reasons set out above.
73. In reaching our decision, we also took into account a range of factors including the Ms Blundell's personal circumstances and the parents who use the services. However, in our view, the nature of the allegations and admissions led us to conclude that at this point, the action taken is both proportionate and necessary.
74. We reminded ourselves that, although there were only a few days remaining of the current suspension as at the date of our decision, the suspension may be lifted at any time if the circumstances described in regulation 9 cease to exist. This imposes an ongoing obligation upon the Respondent to monitor whether the suspension is necessary. Mr Saigal assured us that this was the case.
75. We conclude therefore that the continued provision of childcare by the Appellant to any child may expose such a child to a risk of harm.

76. We are aware that the Respondent has commenced cancellation proceedings and we make no observation on the merits or otherwise of that process. That, assuming it gets that far, carries with it a separate right of appeal.

**Decision**

77. The decision to suspend the Appellant's registration is confirmed and the appeal is dismissed.

**Mr H Khan (Judge)  
Ms L Bromley (Specialist Member)  
Mr M Cann (Specialist Member)**

**First-tier Tribunal (Health Education and Social Care)**

**Date Issued: 20 March 2018**