

**Bedfordshire Local Safeguarding Children
Board**

The Executive Summary

of the

Overview Report

into a

**Serious Case Review of the
Circumstances Concerning**

Child J

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1. Introduction

1.1 What is a Serious Case Review?

1.1.1 A Serious Case Review is held when a child has died, sustained a potentially life threatening injury, or been seriously harmed as a result of being subjected to sexual abuse, and the case gives rise to concern about the way in which local professionals and services worked together to safeguard and promote the welfare of children.

1.1.2 A Serious Case Review examines the ways in which the agencies involved with the family and child worked together and individually to support them. The aim of analysing these cases is to learn how services could be improved in the future to reduce the risk of other children suffering in the same way.

1.1.3 The Government provides advice and guidance on how to conduct a Serious Case Review. These are contained in "Working Together to Safeguard Children 2009" which states that:

1.1.4 The purpose of serious case reviews carried out under this guidance is to:

- establish what lessons are to be learnt from the case about the way in which local professionals and organisations work individually and together to safeguard and promote the welfare of children
- identify clearly what those lessons are, both within and between agencies, how and within what timescales they will be acted on, and what is expected to change as a result; and
- improve intra- and inter-agency working and better safeguard and promote the welfare of children.

Serious case reviews are not inquiries into who is culpable for the harm to a child.

1.2 Summary of Circumstances Leading to the Review

1.2.1 In 2009, a man appeared at Crown Court and was convicted of indecently assaulting Child J who was of primary school age. He received a long prison sentence. The man was a Registered Sex Offender and had past convictions for paedophile behaviour as well as being the subject of other paedophile-related police investigations, some of which didn't lead to a prosecution.

1.2.2 For two years prior to the conviction, this man lived in Child J's family home as he was the partner of the child's mother. During much of that period he was a primary carer, had unrestricted access, and was often alone with the child.

1.2.3 Information that this was happening was passed many times to Children's Services and Police by Child J's father, who no longer lived in the family home. Over a 2 -3 year period, agencies took some steps to monitor or restrict the access this paedophile had to Child J but it is now known that he committed serious sexual offences during this time.

1.2.4 No legal order was ever sought by Children's Services to prevent him having access to the child, although there is evidence that some professionals from other agencies were under the mistaken belief that there was some form of enforceable Court Order in place

1.2.5 There was clear evidence that a threshold had been crossed whereby the child was at real risk of suffering significant harm, and therefore a multi-agency Child Protection Conference should have been convened by Children's Services. A request by front line managers for such a conference was refused by those in a more senior position and consequently the case was managed by Children's Services through the Child in Need process rather than as a Child

Protection case. Other agencies failed in their responsibility to challenge the way the case was being handled and suggest alternative methods.

1.2.6 The sexual abuse perpetrated against Child J could have been avoided if basic critical and sceptical thought had been given by professionals to the obvious warning signs, not least the constant pleas from the father of the child to remove the danger from their home.

2. Process of the Review

2.1 Independence

2.1.1 To ensure transparency, and to enhance public and family confidence in the process, The LSCB Chair appointed two independent people to lead the Serious Case Review.

Mr Kevin Harrington, JP, BA, MSc – Independent SCR Panel Chair

2.1.2 Mr Harrington was appointed to chair the Serious Case Review Panel formed to oversee and manage the review process in this case. He was the lead person for ensuring a robust and transparent review was carried out within each relevant agency, and for ensuring that the project management plan was effective.

Mr John Fox, MSc – Independent Overview Report Author

2.1.3 Mr Fox was responsible for drawing together all elements of the individual agency reviews, and for obtaining as much relevant information as possible from family members and significant others who might provide useful learning. He was responsible for analysing the professional practice of professionals and organisations and making recommendations to LSCBs for further action to better safeguard children.

2.1.4 Neither of these Independent People has had any involvement directly nor indirectly with the child or any members of the families concerned or the services delivered by any of the agencies.

2.2 Individual Management Reviews

2.2.1 The following agencies and organisations contributed to the learning by this Review.

Individual Management Report provided by:
Central Bedfordshire Council Children’s Specialist Services.
Central Bedfordshire Council’s Education Welfare Service on behalf of the schools attended currently and previously by the children in this case.
Bedfordshire Community Health Services
Bedfordshire, Hertfordshire & Essex Police
Northamptonshire Police
Thames Valley Police
Christian Family Care - Manor Farm

Factual Report provided by:
NHS Bedfordshire provided information in respect of the children and adults in this case
Bedfordshire and Luton Partnership Trust (Adult Mental Health services)
Bedford Hospital
Thames Valley Probation (Milton Keynes)

2.2.2 The Independent Overview Report Author carried out in depth interviews with the mother and father of the child as well as other significant adults.

2.3 SCR Panel

2.3.1 A dedicated Serious Case Review Panel of senior managers was set up to assist with the management of the review and to ensure the maximum amount of learning.

2.3.2 Panel membership was as follows:

Independent Chair of Serious Case Review Project Group
Designated Nurse, NHS Bedfordshire
Detective Superintendent, Bedfordshire Police
Head of Quality Assurance Vulnerable Children, Bedford Borough Council
Deputy Director of Children, Families & Learning - Central Bedfordshire Council
Bedfordshire Community Health Services
Assistant Chief Officer Bedfordshire Probation Service
Assistant Director Learning and School Support Central Bedfordshire
Independent Overview Report author (in attendance as required)
Safeguarding Adults Manager, Bedford Borough

3. The lessons learnt from the case

3.01 Child J was sexually abused, at home, by a man who had been the subject of lengthy discussions at multi-agency Child in Need meetings, two independent risk assessments, and management by two police force Sex Offender Management Units. Because of the failure by professionals to identify or act upon the risk he posed, he had the opportunity to carry out this type of abuse every evening when he was alone with the child.

3.02 Too much reliance and faith was placed upon the will or ability of the child's mother to supervise the sex offender and his contact with her child. Professionals asked her to sign unrealistic and unworkable documents in which she had to undertake to supervise all contact, while at the same time she was led to believe that her partner had been assessed by 'experts' and that there was only a low risk of him re-offending. This false assurance led to a situation where there was absolutely no supervision of contact for most of the period relevant to this Review.

3.03 Too much reliance was placed on the findings of an independent risk assessment commissioned by Bedfordshire County Council Children's Services. The Review concludes that this Local Authority made the wrong choice in their commissioning process because the independent psychologist was unqualified and inexperienced for the particular task, and was not regulated by any regulatory body. The effective safeguarding of children from sexual abuse requires that the commissioning of external risk assessments by a Local Authority must adhere to the highest standards of regulation.

3.04 By continuing to manage the case using the Child In Need procedures and meetings, the information exchange lacked rigour and was ineffective, because much of the key information about the sex offender was held by the Police, an agency whose representatives were not present. Even for those agencies which were present, the seniority, training, experience and role of the professionals attending the Child in Need meetings was different in many cases to those who would have attended either a Child Protection Conference or Core Group.

3.05 Professionals without evidenced requisite knowledge, skills and training should not have a central role in assessing, supervising or making key decisions in sexual abuse cases

3.06 Child J's father was not properly listened to and it is essential that safeguarding professionals who come into contact with the public never forget how it feels for people when they are trying to penetrate what to them, is an apparently impervious wall

3.07 Supervision for police officers in cases involving child protection, and in multi agency discussions, needs to be enhanced.

3.08 Sex offenders are often very plausible and effective at 'grooming' both victims, vulnerable parents and carers, as well as professionals. Considerable skill and knowledge and specialist training are required to understand the complexity of sex offender *modus operandi*. Listening to children is important but is insufficient protection if 'grooming' is successfully underway

3.09 Before drawing up written agreements with parents/carers, and professionals, agencies should ensure that there is sufficient evidence that any party to be involved in a 'protective capacity' has been assessed as such. They should also consider whether the proposed agreement will be workable in practice, is clearly expressed, and can be monitored adequately. The legal status and limitations of such agreements should be clearly understood.

3.010 Sexual abuse is 'significantly harmful' to children and where there is evidence or concern that children may be exposed to sexual abuse, a Strategy Meeting involving ALL relevant agencies must be held and consideration given to holding an Initial Child Protection Conference.

3.011 All agencies and professionals need to be able to recognise 'risks of sexual abuse' and provide constructive challenge to other professionals/agencies if they are unable to recognise it and/or act in response.

3.012 The record keeping by schools about cases which may involve the safeguarding of children needs to be thorough and reliable. Further training or reminders are necessary to ensure that best practice with regard to record-keeping is consistent in schools across the authority.

3.013 Non-specialist, front-line police officers may not be fully aware of the importance and requirements of the safeguarding process as it relates to children. Although a great many demands are placed on the police, there is a need for police forces to renew their adherence to Section 11 Children Act 2004 and the recommendations set out in the Victoria Climbié Report.

3.014 It is essential that police force Child Abuse Investigation Units are made aware of every child abuse related crime being investigated by their non-specialist colleagues. This would allow coordination and the facility to monitor and record interactions with partners. Should deficiencies or blockages occur for whatever reason, Public Protection senior managers can intervene.

3.015 The safeguarding and promotion of the welfare of children is dependant on highly effective sex offender management. The success of this management depends on sufficient resources being deployed in Sex Offender Management Units, and effective and timely communication between agencies and Police Forces.

3.106 The Crown Prosecution Service can have an important role in safeguarding children, and in accordance with Paragraph 3.63 *Working Together to Safeguard Children* (2006) the LSCBs should engage the CPS and take steps to encourage Reviewing Lawyers to be child focused in their decision making and advice to the police.

3.1 What Happens Next?

3.1.1 Recommendations from the Review form the basis of an action plan, which is regularly monitored by the LSCB Chairs to ensure that the recommendations are put into place. The action plan will be reviewed regularly until all of the agreed actions have been completed. In addition to the recommendations contained below, each agency has agreed to implement recommendation which arise from the learning in this case. These will also be monitored by the LSCB Chairs by way of an Action Plan

4. Recommendations for the LSCBs

RECOMMENDATION 1

The LSCBs should ensure that the Child in Need processes in their respective areas are revised to incorporate lessons from this Serious Case Review through challenge to the Children's Trusts, and that appropriate multi-agency involvement is secured in these cases by reinforcing the operational importance and statutory nature of work within this framework.

RECOMMENDATION 2

The LSCB's Inter-Agency Safeguarding Procedures should include a specific system whereby a constituent agency or an operational Children's Services manager, can challenge the decision not to convene a Child Protection Conference. This should specify exactly what managerial level and post should be involved in the multi agency managerial discussions and decision making, and information about any use of this process should be routinely reported as part of the LSCB's management information.

RECOMMENDATION 3

Multi Agency training for managers involved in safeguarding must immediately reinforce the messages from the Victoria

Climbie Inquiry Report about challenging other professionals, and must equip delegates with the confidence to challenge decisions and assessments made by other agencies, and specifically must reinforce the need to challenge a decision not to convene a Child Protection Conference when appropriate.

RECOMMENDATION 4

The LSCBs should conduct a multi agency audit (using senior personnel from the key statutory agencies) of the decision making process and current threshold for convening Child Protection Conferences. A sample of recent decisions to convene a conference, and not to convene a conference, should be examined and a threshold which is acceptable to all agencies should be agreed.

RECOMMENDATION 5

When recording information in case files about the relative risk posed by potential sex offenders, social workers, their managers and staff from other agencies, need to be aware of the importance of using correct terminology. The term 'Risk Assessment' must be reserved for a scientific examination by a qualified person, using a recognised model such as Risk Matrix 2000.

RECOMMENDATION 6

The LSCBs should seek a reassurance from the Chief Constable that Bedfordshire Police is able to meet the standards concerning monitoring sex offenders within the community as recommended by the ACPO/NPIA guidelines '*Protecting the Public, Managing Sexual and Violent Offenders*' (2007). If this is not the case, the BLSCB should ensure the problem is being addressed, and monitor the outcome.

RECOMMENDATION 7

The National Safeguarding Delivery Unit should remind all Directors of Children's Services that the Health Professionals Council is now the appropriate regulatory body for psychologists carrying out Risk Assessments on adult sex offenders, and that an important safeguard for children is that people should not be commissioned for such work unless they submit to regulation.

RECOMMENDATION 8

The LSCBs should seek reassurance from the Directors of Children's Services, by way of a written report, that the current commissioning process in respect of external risk assessors in

child sexual abuse cases is designed to seek contractors with high professional standards and proven skills, and does not lack the integrity expected of a responsible public sector organisation.

RECOMMENDATION 9

The LSCBs need to immediately provide all professionals involved in safeguarding children with guidance in the form of a 'jargon busting' document explaining the risk assessment models in sexual abuse cases and how to interpret them, and this should be backed up by inclusion in multi-agency LSCB training.

RECOMMENDATION 10

The LSCBs should immediately reinforce through their multi agency training programme, the messages about listening to family members contained in the 'Ten Pitfalls' Checklist. To enhance this message they should commission an impactful training material which includes comments by (anonymised) real people about how it felt when they have made referrals to the statutory agencies.

RECOMMENDATION 11

The BLSCB should be concerned about the failure by frontline response officers to properly understand the risks to Child J, and a report should be sought from the Chief Constable outlining what training Bedfordshire's front line police officers receive as regards safeguarding children. Upon receipt, a judgment should be made by the BLSCB about whether extra training is required.

RECOMMENDATION 12

The LSCBs should conduct a multi-agency audit to establish the extent to which written agreements with parents/carers are being used and whether the agreements are adequately contributing to keeping children safe. The audit should consider whether the agreements are workable, clearly expressed, being adequately monitored and whether the limitation of such agreements and their enforceability is understood by all involved.

RECOMMENDATION 13

The LSCB Chairs should seek an early meeting with the Chief Crown Prosecutor in order to devise a strategy whereby in their decision making and advice to the Police, CPS lawyers are encouraged to ensure there is sufficient recognition of the safeguarding needs of child victims of crime.

RECOMMENDATION 14

The LSCBs should seek reassurance from Bedfordshire Police by way of a report from the Chief Constable, that the organisation is fulfilling its safeguarding responsibilities under Section 11 Children Act 2004 and in particular, that the resources and supervisory resilience available for child abuse investigation, is sufficient to comply with BLSCB Procedures and the Victoria Climbié Inquiry Report.

RECOMMENDATION 15

There is evidence that Strategy Discussions under Section 47 Children Act 1989 have been inappropriately held over the telephone rather than this being the exception, that they often lack key agency representation and that they frequently fail to involve managers from each agency. The LSCBs should write to constituent agencies and stress the importance that these meetings/discussions are conducted in accordance with Working Together to Safeguard Children and the recommendations in the Victoria Climbié Inquiry Report. A multi-agency audit should be conducted six months from the publication of this report to monitor compliance.

7.2 Recommendations to Northamptonshire LSCB

RECOMMENDATION 16

The Local Safeguarding Children Board Northamptonshire (LSCBN) should seek assurance from Northamptonshire Police that Force Policy is clear that if a case becomes an intra-familial abuse case during the course of an investigation, the CAIU will be notified and either take it over, or take an active role as advisors and that this policy has been disseminated to all relevant staff.

RECOMMENDATION 17

The Local Safeguarding Children Board Northamptonshire (LSCBN) should be concerned about the failure by Northamptonshire Police CIU Officers to properly understand the risks to a vulnerable child victim of crime. LSCBN should seek a report from the Chief Constable of Northamptonshire Police on the training that front line police officers receive on safeguarding children and the action being taken to address any shortfall in this. Upon receipt the LSCBN should consider this as part of the needs assessment contributing to the LSCBN Training Strategy

Appendix A

Terms of Reference Bedfordshire LSCB Serious Case Review Child J

1. Decision to hold Serious Case Review

1.1 The decision to hold a Serious Case Review (SCR) was made by Laura Eades Independent Chair Bedfordshire Local Safeguarding Children Board (LSCB) following a recommendation from the Bedfordshire Executive Serious Case Review Panel (ESCRP) and a discussion with the Government Office (GO) East Safeguarding Advisor. Completion of the Review will be on the 8th April 2010.

1.2 From April 2009 Bedfordshire County Council ceased to exist and 2 new Unitary Authorities, Bedford Borough Council and Central Bedfordshire Council were established, as a result of Local Government reorganisation. Central Bedfordshire Council Specialist Children's Services are now responsible for services previously provided by Bedfordshire County Council Children's Social Care, in their local authority area.

1.3 This case involves the sexual abuse of Child J. The reasons for holding an SCR in this case, are drawn from Working Together 2006 as follows;

There was clear evidence of a risk of significant harm to a child that was

- not recognised by organisations or individuals in contact with the child or perpetrator or
- not shared with others or
- not acted on appropriately

The concerns of one or more agency or professional may not have been taken sufficiently seriously, or acted on appropriately, by another agency

It appears that the thresholds for accessing child protection services may have been too high at this time.

There are concerns that staff from a number of agencies did not take adequate account of

- The ways in which those involved in the sexual abuse of children can successfully manipulate professionals to support their "grooming" of victims
- The impact of domestic abuse, both recent and historical
- The different approaches to risk assessment used across agencies, and the differing meanings attached by agencies to those assessments

There appears to have been an unrealistic view across agencies of a vulnerable mother's ability to protect her children in the circumstances of the case.

There may have been different multi agency views on risk of harm in relation to sexual offenders and a focus on the mother rather than the offending male.

This case is now in the public domain. It is essential that Bedfordshire LSCB responds proactively to the legitimate public interests in relation to the protection of children from child sex abuse.

1.4 In addition to the above Bedfordshire LSCB has already identified that numbers of children subject to child protection plans under the category of sexual abuse are below the national average in the area. The LSCB has explored reasons for this, concluding that the identification of risk was an issue as was knowledge and expertise where there concerns in respect of sexual abuse. A previous SCR in Bedfordshire identified an undue confidence in

the ability of a mother to protect her child.

2. Key Issues:

Individual Management Review (IMR) authors need to ensure that they address the following key issues specific to this case but also consider the guidance in Working Together 2006 (pages 175 -176).

2.1 Thresholds for the identification of risk of sexual abuse

- 2.1.1** The case raises concerns about the relative thresholds used by the statutory agencies for the identification of children at risk of child sexual abuse. IMR and Overview authors will need to comment on the application of any thresholds for the identification of risk to children from child sexual abuse and to consider whether this was appropriate considering the circumstances of the case and the information that was available.
- 2.1.2** IMR and Overview authors should specifically consider how risk was assessed, on what basis, how decisions were made about what should happen next, what action was taken by each agency and what the outcomes were. If there were differences of opinion about approach, how were these handled?
- 2.1.3** IMR authors will need to consider in detail, how their agency responded to the information available to it across the period to be covered by the review.

2.2 Knowledge and expertise regarding child sexual abuse

- 2.2.1** IMR and Overview authors should review the level of knowledge and expertise in relation to child sexual abuse that existed within and between agencies. Was staff appropriately prepared and competent to deal with this case? If expert opinion and advice was sought, how was that expert opinion secured, who had sight of that opinion and what did that opinion contribute to the management of the case and the decisions made? Were the decisions appropriate based on what was known at the time? Were there any challenges to the approach and if so by whom and what was the response?

2.3. Assessments under Section 47 and Section 17, Children Act, 1989

- 2.3.1** IMR and Overview authors should consider whether;
 - i. The context of the case, its designation as a Child in Need (S.17 Children Act 1989) case, rather than a child protection case (S.47 Children Act 1989), affected the way in which information was held and shared by agencies – if so how and why? Was available information used to actively inform the child protection process?
 - ii. Should the case have been managed under S47 (Children Act 1989)? Why or why not? Why didn't it meet the threshold?
 - iii. Were there opportunities for a holistic multi agency assessment of the needs of and risk to these children? At what points? How has the current assessment under the child protection process added to the understanding of the impact of their family life on the children?
 - iv. How effectively were the protective factors assessed in this case? Did this assessment take into account all relevant factors and were there any contingency arrangements should family circumstances change? If not, why not?

2.4 The role of universal services

- 2.4.1** IMR and Overview authors to consider what role universal services played in this case? Were the expectations of agencies to safeguard and promote the welfare of children who may be at risk of harm from child sexual abuse clearly understood within the agencies and was this a shared understanding between agencies? Do current procedures and protocols support good practice in this area of work?

2.5 Perceptions of the parents

- 2.5.1** IMR authors should consider if there is relevant background information concerning the background of any of the key adults involved and to summarise this and comment on the impact on the case.
- 2.5.2** IMR and Overview authors to consider how the concerns of Child J's father were received and responded to and what were the reasons for this?

3. Time Period over which events should be reviewed

- 3.1** The review will cover a period of some 4 years from the first involvement of Bedfordshire County Council Children's Social Care until an initial child protection conference held in 2009.
- 3.2** IMR authors will be asked to consider whether there is any relevant and significant background information on the key adults under consideration.

4. Organisations to be involved in this SCR

- 4.1** All organisations listed below are to provide either an IMR or background information to the SCR.

Individual Management Report provided by;	Background information provided by;
Central Bedfordshire Council Children's Specialist Services.	NHS Bedfordshire
Central Bedfordshire Council's Education Welfare Service	Bedfordshire and Luton Partnership Trust (Adult Mental Health services)
Bedfordshire Community Health Services	Bedford Hospital
Bedfordshire, Hertfordshire & Essex Police	Thames Valley Probation (Milton Keynes)
Northamptonshire Police	
Thames Valley Police	
Christian Family Care	

- 4.2** The Individual Management Review (IMR) Author must be of sufficient seniority to be able to work at all levels within their agency. The IMR Author must be fair in the way that the views of staff are represented. The IMR Author should be familiar with current child protection practice and is expected to produce an independent and objective report within prescribed timescales in accordance with national guidance.
- 4.3** The IMR Author will have had no significant involvement in the case under review and should not be the direct line manager of their agency representative on the Executive Serious Case Review Panel.
- 4.4** The LSCB Business Manager and chair of the Serious Case Review Project Group (SCRPG) will make contact and be the link with Christian Family Care and provide support

in producing an IMR.

- 4.5** A number of other LSCB's have been contacted and advised of the SCR. The Independent SCRPG Chair will manage the relationships with these agencies.
- 4.6** In the case of Bedfordshire LSCB Members the Chief Executives of the key agencies have been advised of the Review and of their responsibilities in relation to the review. At the request of the Independent SCRPG Chair, the LSCB Chair will take up any issues of non compliance.
- 4.7** The SCRPG will specifically oversee this SCR and report back to the ESCRPG as per statutory requirement.
- 4.9** The SCRPG for this review will be as follows;

Kevin Harrington	Independent Chair of Serious Case Review Project Group
John Fox	Independent Overview Report author (in attendance)
Designated Nurse	NHS Bedfordshire
Detective Superintendent	Bedfordshire Police
Head of Quality Assurance Vulnerable Children	Bedford Borough Council
Deputy Director of Children, Families & Learning	Central Bedfordshire Council
	Bedfordshire Community Health Services
Assistant Chief Officer	Bedfordshire Probation Service
Assistant Director Learning and School Support	Central Bedfordshire Council
Safeguarding Adults Manager	Bedford Borough
LSCB Business Manager	Central Bedfordshire Council
LSCB Administrator	Central Bedfordshire Council

5. Involvement of Family Members

The independent Overview Author will take the lead responsibility for facilitating the involvement of the parents of Child J in this Serious Case Review.

6. Other Parallel reviews (e.g. homicide or suicide reviews)

- 6.1** NHS Bedfordshire has registered a Serious Untoward Incident in relation to the circumstances of this case. There will not be a separate investigation and the Serious Untoward Incident will be completed in parallel with the completion of the SCR.

7. Involvement of organisations in other LSCB areas

- 7.1** The relevant LSCB's have been formally advised of the review by the LSCB Office through a letter to the Chair and Business Manager and asked to consult their members regarding any other agency involvement and to have oversight of and respond to the IMR's recommendations and action plans prepared for this review.
- 7.2** The individual agencies concerned in other LSCB areas have also been written to.
- 7.3** The subsequent Overview Report and action plan will be shared with any LSCB where a member agency has contributed to the review in order that the action plans can

be monitored and any relevant learning for the local area be disseminated.

- 7.4 The other LSCB's will be invited to participate in the development of the overview report action plan and in the evaluation feedback from Ofsted.

8 Coroner's Inquiries/Criminal Investigations

There are no coroner's enquiries and the criminal investigation has been completed.

9 How should the serious case review process fit in with the processes for other types of reviews e.g. for homicide, mental health or prisons?

There are no additional review processes planned for this case

10 Who will make the link with relevant interests outside the main statutory organisations e.g. independent professionals, independent schools, and voluntary organisations?

The LSCB Business Manager will provide support to the voluntary organisation, Christian Family Care supported by the SCRPG Chair

10 Media Coverage/Enquiries

The LSCB Business Manager will develop a media and communications strategy according to the Bedfordshire LSCB procedures and will keep the LSCB Chair and Central Bedfordshire Council Director of Children, Family and Learning regularly updated. Enquiries will be dealt with by a single communications contact, likely to be Central Bedfordshire Council who will respond in line with the agreed strategy. If there is any conflict of interest for the LSCB, the LSCB Chair will access an independent press officer.

11 Legal Advice

There is no aspect of the review at this stage requiring legal advice although this is available from the LSCB legal advisor if needed. There are no issues regarding the disclosure of information from the criminal proceedings which are complete.

12 Commissioning of an Independent Author and Panel Chair

This is the first SCR that Bedfordshire LSCB has commissioned under the new arrangements for evaluation. The Board wishes to ensure that the Review is conducted in a way which will set the standard for all future work in this area and which will allow the maximum opportunity for embedding a culture of critical enquiry. The Board has decided to commission an independent overview report author and an independent SCRPG chair. This will ensure that the role of the LSCB in addressing any learning arising from previous SCR's, audits etc and in addressing the issues that arise in this case are also robustly identified.

John Fox has been identified as the overview report author because of his expertise in relation to the assessment of risk from a Police perspective. He is completely independent of the Board and its member agencies.

Kevin Harrington has been identified as the Independent SCRPG chair due to his involvement in conducting recent SCR's which have been positively evaluated. His role

will be to ensure that there is full and complete understanding of roles and responsibilities by agencies in relation to the SCR including compliance with time scales and quality assurance arrangements.

Guidance will be provided to the Chair and Overview Report author as to their respective roles.

13 Liaison with Ofsted and GO

The LSCB Chair and Business Manager will liaise with the GO East over progress should any extensions to timescales prove necessary.