



Serious Case Review – Child J

Purpose of paper - To provide an overview of the lessons learnt following the Serious Case Review (SCR) in respect of Child J.

Introduction - In October 2009 the Executive Serious case Review Panel (ESCRP) instigated a SCR on the 7th October 2009, the case met the criteria for a SCR. At this time there had not been a SCR in Bedfordshire since 2005.

To ensure transparency, and to enhance public and family confidence in the process, two independent people were appointed to lead the Serious Case Review. Neither of these Independent People had any involvement directly nor indirectly with the child/families concerned or the services delivered by any of the agencies.

Summary of the case - In 2009, a man was convicted of indecently assaulting Child J. He was a Registered Sex Offender, 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.

For two years prior to the conviction, this man lived in Child J's home, the partner of their mother, had unrestricted access, was often alone and a primary carer of Child J,

Concerns about this man 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 he committed serious sexual offences during this time.

A request by Children's Services front line managers for a child protection conference was refused on 2 occasions and the case was managed through Child in Need processes 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.

Lessons learnt from this case.

The invisible child. In this case no professional had asked the question what was a day like in Child J's life. Many SCRs identify that the child becomes 'lost'. The key implication of children not being seen or heard and a lack of understanding of the situation from the child's viewpoint demonstrates that too often practice is not child centred – that the child is not 'kept in mind'. One way of ensuring that this does not happen is for practitioners to have effective supervision and adequate opportunity for reflective practice.

The invisible agency. In this case and others audited by the Safeguarding Children Boards there is clear evidence that for some voluntary agencies their involvement is not acknowledged or aware of. They were not invited to meetings or kept informed of plans or concerns. The implications for these agencies not being inclusively involved and

informed is that information is missing about the child, workers are possibly left vulnerable and duplication of work. To ensure that these agencies are not missed or their involvement dismissed as irrelevant then professionals need to ascertain who is working with the family at that time or recently but also to listen and take seriously the concerns raised by these agencies and their workers, whether paid or voluntary.

Assessment of risk. This 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.

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.

Working with sexual abuse cases. 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.

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

Written agreements. 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.

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.

Child In Need Procedures/Processes. 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.

Listening to the referrer. 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

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

Working with Sex Offenders. 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.

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.

Recording and information sharing. The record keeping by schools about cases which may involve the safeguarding of children needs to be thorough, reliable and consistent in schools across the authority.

Poor communication between agencies and lack of information sharing at crucial points in decision making are highlighted in almost every SCR locally, regionally and nationally.

Safeguarding children. The Crown Prosecution Service to take steps to encourage their staff to be child focused in their decision making and advice to the police.

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.

What Happens Next?

Action plans to address the recommendations are regularly monitored by the ESCRP. The action plans will be reviewed regularly until all of the agreed actions have been completed. In addition to the recommendations contained in the Executive Summary that you can access at (<http://www.bedfordshirelscb.org.uk/publications.php>)

As part of our efforts to embed learning from this SCR into our practice here in Bedford Borough and Central Bedfordshire it is proposed that this is the subject for our **conference** in the spring 2011 will be Sexual Abuse; please make every effort to support this event

Hopefully, most practitioners will never be involved in an SCR and by

acknowledging and acting upon the lessons raised above we will continue to reduce the risk.

For some of you, however, reading this will be a painful reminder of your own involvement in the case. Please do seek support from your manager or supervisor if this is the case for you.