city & hackney safeguarding children board

CHSCB Response

Serious Case Review concerning the sexual abuse of children in a foster home

December 2015

1. Introduction

1.1 In July 2013, the Independent Chair of the City and Hackney Safeguarding Children Board (CHSCB), Jim Gamble QPM, decided to initiate a Serious Case Review (SCR) into the sexual abuse of a number of children by two men. One was an approved foster carer, the other a member of his family. The abuse of foster children is known to have taken place between 1999 and 2008.

1.2 The Chair's decision to undertake the SCR was made in line with Regulation 5 of the *Local Safeguarding Children Board Regulations 2006* and consistent with the statutory guidance set out in *Working Together to Safeguard Children (2013)* (since revised in 2015). Its overall purpose has been to look at what happened in this case and why, to identify learning and to make recommendations for either improvement or the consolidation of good practice.

1.3 The SCR's specific focus has been on providing a rigorous analysis of the actions and decisions of professionals in order to explain how the man concerned and his wife were approved as foster carers, whether concerns were identified when the abuse was happening and why it was not recognised. These were all questions that the young people who were victims of the abuse told the review were of great importance to them.

1.4 The SCR has also focused on identifying ways in which professionals who work with vulnerable children, and the agencies that employ them, can make it more difficult for those who seek to abuse children to gain positions of trust and make the care of looked after children safer.

1.5 It should be noted that the SCR has been unusually challenging because it has been required to consider the provision made to a number of children over a period of years. It has also been challenging because of the CHSCB's inability to publish the final report due to parallel criminal investigations.

1.6 Regardless, these challenges have neither diluted nor detracted from the importance or relevance of the review's conclusions, with the CHSCB actively coordinating the monitoring and implementation of required actions.

1.7 At the end of the criminal trial, tribute was paid to the courage of the survivors. The CHSCB would similarly like to take this opportunity to thank them for their bravery and the important contribution that both they and their families have made to this review.

1.8 The findings and associated recommendations of the SCR have been accepted in their entirety by the CHSCB.

2. Allegation of possession of child abuse images

2.1 The SCR recommended that the MPS should consider what further action it can take to determine why the allegation made in 1999 that the foster carer possessed images of child abuse was not investigated properly. In response, the Specialist Crime Review Group, on behalf of the Metropolitan Police Service (MPS), is currently investigating the circumstances surrounding the handling of the original intelligence and the findings will be reported back to the CHSCB.

2.2 The SCR also recommended that the MPS should provide assurance that it consistently investigates allegations of the possession, creation and distribution of child abuse images and that it works effectively with local authorities and other partners to safeguard children in such cases. The MPS has confirmed to the CHSCB that a comprehensive investigative response is initiated in response to all such similar circumstances and it is confident that similar information received would now be acted upon. Through the formation of the Sexual Offences Exploitation and Child Abuse Command (SOECA) in June 2013, a dedicated response to allegations of child abuse is now in place, co-ordinating any actions required across departments under one single command.

3. Disclosure of 'soft intelligence' under the Police Act 1997

3.1 The SCR recommended that the MPS should undertake a dip sample audit of cases in which it has not disclosed 'soft intelligence' as part of CRB / DBS checks in the last five years. It further recommended that the MPS should consider the introduction of independent scrutiny of decisions not to disclose soft intelligence. In response, the MPS has introduced a system whereby character enquiries with soft intelligence are sent each month to SOECA Command for risk assessment and consideration of disclosure to local authorities. This allows specialist child protection police staff to assess intelligence held on individuals and judge relevance for disclosure. This work is ongoing alongside an agreed process for the sampling of cases.

3.2 The CHSCB has requested the MPS evidence that the decision-making process regarding soft intelligence is robust, quality assured and accurate and this will form part of the ongoing monitoring of the SCR action plan by the CHSCB.

3.3 The SCR also recommended that the MPS should review its current policy and practice in relation to the disclosure of 'soft intelligence' in order to determine whether a different interpretation of the law, associated case law and guidance should be applied. The SCR also recommended that the Association of Chief Police Officers (ACPO) should establish from other police services whether the approach taken by the MPS to the disclosure of 'soft intelligence' in the course of DBS disclosure has been taken more widely and if so determine what further action is necessary. Subject to this wider enquiry, a recommendation was made for ACPO to consider whether it is necessary to ask the Home Office to review its current guidance on the disclosure of soft intelligence. ACPO has been replaced by the National Police Chiefs' Council (NPCC) with the findings of this SCR being escalated to the Chief Officer lead for DBS matters in the Police.

3.4 The CHSCB has requested the MPS provide a formal report detailing the outcome any action by the Chief Officer lead to ensure that policy and procedure relating to disclosure of soft intelligence does not expose children and young people to risk.

4. General Practitioner (GP) contracting of counselling services

4.1 The SCR recommended that NHS England should ensure that in the future, GP contracts for counselling services include appropriate reference to safeguarding procedures for children and vulnerable adults so that allegations made by vulnerable patients are reported to those with the power to investigate them.

4.2 NHS England has confirmed they have undertaken action to ensure that GPs include appropriate reference to safeguarding procedures for children and vulnerable adults within their contracts. This specifies that allegations made by patients must be reported to the relevant statutory agencies.

4.3 To reinforce this recommendation, NHS England and The City and Hackney Clinical Commissioning Group (CCG) have communicated to all GPs through the Primary Care newsletter in April 2015 and sent letters directly to all GPs in June 2015. The CCG has also specifically uploaded information for counsellors onto the health intranet highlighting the importance of following local safeguarding procedures.

5. Role of City and Hackney Safeguarding Children Board

5.1 The SCR recommended that the CHSCB should monitor the actions taken by Hackney Council in response to the independent review of its fostering services. Hackney

Children and Young People's Services (CYPS) has provided regular updates to the CHSCB on the progress made in ensuring that all staff working with Looked After Children (LAC) and their carers, including those in placement commissioning and support services such as fostering, are aware of and equipped to respond to the specific vulnerabilities of LAC.

5.2 Hackney CYPS has demonstrated that they have implemented learning from this review across their service. In particular, additional training opportunities have been made available across CYPS to heighten awareness on the dynamics of the impact of sexual abuse, including understanding sexualised behaviour and the behaviours of those who seek to sexually abuse children. There has been work undertaken with Hackney's fostering service and the Fostering Panel to ensure that assessments and reviews of foster carers are thorough, robust and appropriately challenging, giving consideration to information being sought from a wide range of sources.

5.3 The SCR recommended that the CHSCB should monitor the effectiveness of the work undertaken by agencies to safeguard and promote the welfare of LAC and challenge them when the outcomes are not in line with the aspirations of the CHSCB, the local authority and the corporate parenting strategy.

5.4 The CHSCB multi-agency performance dataset has been reviewed and appropriate amendments made to improve oversight on LAC arrangements as part of ongoing quality assurance work by the CHSCB. This, alongside a focus on LAC as part of its other functions ensures ongoing attention is applied to this particularly vulnerable group of children and young people. The CHSCB sets out its wider assessment on the effectiveness of safeguarding and the promotion of child welfare concerning LAC through its cycle of annual reporting. Annual reports are published and available on the CHSCB website.

5.5 The SCR recommended that the CHSCB should monitor the implementation of the recommendations made by member agencies in their individual management reviews.

5.6 The CHSCB maintains ongoing oversight of all recommendations made by member agencies, regularly scrutinising actions and their related impact on improving safeguarding arrangements for children and young people.