Surrey Safeguarding Children Board

Serious Case Review Executive Summary

in relation to three children

HH, II & JJ

Arthur Wing

1. Introduction

1.1 A Serious Case Review was completed following the conviction, in late 2015, of the father of HH, II & JJ for a number of charges of serious sexual assaults on one of the children and the possession, distribution and making of indecent images. He will be referred to as Mr A in this Executive Summary.

1.2 Although the Review was completed in 2017, it was determined that it should not be published at that time as there was the possibility of further criminal proceedings. Although that remained the case in March 2019, it was decided that in order to ensure that the learning was taken forward, an Executive Summary should be prepared, sufficiently anonymised to avoid compromising any future criminal proceedings as well as to protect the identity of the children concerned.

2. Arrangements for the Serious Case Review

2.1 The matter was referred to the Local Safeguarding Children Board in the area where the children had been living. In view of the seriousness of the offences committed against the children, the harm caused and the history of multi-agency working with the family, it was decided that a Serious Case Review should be completed. This decision was confirmed in June 2016.

2.2. A Review Panel to be the reference group for the review in order to manage and oversee the conduct of the review and appointed Arthur Wing, an experienced independent reviewer, to lead the review and to write the overview report. The Panel included representatives of the National Probation Service, the relevant Local Authority, including the Children, Schools and Families Services, the Schools and Learning Services and the Youth Support Service, the local Police and the relevant Clinical Commissioning Group. The area's Multi Agency Public Protection Arrangements Team Manager attended the Review Panel and the process was supported by the Safeguarding Children's Board.

2.3 The Review was undertaken in accordance with the Statutory Guidance in Working Together to Safeguard Children 2015, and its purpose was to identify improvements needed and to consolidate good practice in order to prevent similar serious offences and harm. Terms of Reference for the Serious Case Review are detailed in Appendix 1. The children HH, II and JJ and their parents were the main subject of the review and its principal focus was from October 2008 when the children's father was sentenced for earlier offences until August 2015 when he was arrested in connection with the offences that led to the Review. In August 2015, the children were aged six, three and one respectively.

2.4 In total, nine internal management reviews (IMRs), from the agencies which had been involved with the family were considered. The children's mother was interviewed so that she could contribute to the review. In view of their ages, the children, HH, II and JJ were not interviewed. It was not possible to interview the children's father as criminal investigations were continuing with the possibility of further charges.

3. What Happened

3.1 In 2008, Mr A pleaded guilty to the possession of indecent photographs and videos. He was sentenced to 32 weeks imprisonment suspended for 12 months, with a supervision order for 12 months. He was ordered to register as a sex offender for 10 years.

3.2 At the time of his conviction, Mr A and his partner were living in another area and didn't have any children. About six months later their first child (HH) was born and they moved to the area. The police and probation service transferred their responsibilities to their local counter-parts and there were discussions at the Level 2 Multi Agency Public Protection (MAPP) meetings. The family registered with a G.P. and a health visitor became involved. It was agreed at a strategy meeting that Children's Services would assess the family. A Core Assessment was completed and an Initial Child Protection Conference was held. This resulted in HH being made subject to a Child Protection Plan and a Core Group being established.

3.3 Soon afterwards, Mr A's suspended sentence order and contact with the probation service ended. His risk of causing serious harm to children continued to be assessed as Medium. He remained subject to sex offender registration, which was overseen by the Police. Using the police criteria, he was initially considered a High Risk Offender and he was subject to monthly monitoring visits. He cooperated in the installation of monitoring software on his laptop computer.

3.4 An assessment was completed by a social worker and both Mr A and his partner attended educational programmes in relation to the Possession of Indecent Images. It was decided that HH could be taken off the Child Protection Plan and placed on a Child in Need Plan. This Plan continued for a further two months after which there was no further contact with children's services although the police and health visitors remained involved.

3.5 Two further children were born to Mr & Mrs A (II and JJ). Children's Services were advised of the pregnancies but on each occasion concluded that, as there had been no significant changes, a further risk assessment was not required and the case was not re-opened. By the time JJ was born the Police assessment was that Mr A was a Medium Risk of sexual offending; this was reduced to Low Risk in 2014 following a modification of the assessment tool – RM2000.

3.6 In August 2015, the police received intelligence that Mr A was using an online chat room that was dedicated to child sexual abuse. Investigations led to his being convicted both in relation to this behaviour and a serious contact offence against one of his children.

3.7 Mr A has since pleaded guilty to the offences of which he was charged and has been sentenced to a substantial period of imprisonment.

4. The Management of the Risk Presented by Mr A and the Protection of HH, II and JJ

4.1 For a short period after HH was born, the probation service managed Mr A and provided 1 to 1 interventions in relation to sex offending. This was coupled with active management by the specialist police officers, combined with attempts to deter him from accessing indecent images on his computer. In March 2010, a specialist voluntary organisation carried out some work with HH's mother. This comprised two 2 hour sessions of the "Inform" programme, which is designed to meet the needs of partners and family members of internet offenders. A brief report was sent to Children's Services following the delivery of the programme.

4.2 In the absence of any authority, or leverage, to compel Mr A to go to a treatment programme, he was referred to the "Inform Plus" programme run by the voluntary organisation which had provided the programme for his wife. It was hoped that this would help him to desist from accessing indecent images. It was concluded that he had ineffective internal controls. It was therefore hoped that the monitoring of his computer, the visits from the police and the health visitor and the agreement that he would not have any part in HH's physical care, combined with the understanding that Mrs A had, would be effective.

4.3 Unfortunately, the monitoring of his laptop proved to be an illusory form of risk management. It is thought likely that Mr A's skills and knowledge of Information Technology will have helped him to thwart the monitoring being attempted. There were a number of occasions when it was known that the monitoring wasn't working, often because he had upgraded the operating system. It is now thought that it only worked effectively for the first year. Additionally, the limitations on his physical contact with HH were not maintained after the end of Children's Services involvement nor were they extended to II and JJ.

4.4 While attention was paid to the risk that Mr A would resume accessing indecent images and that there could be a risk to HH, little focussed attention was paid to the risks to other children, including in his extended family or, to the implications of his stated attraction to 15 year old girls, as noted at the time of his original offence.

4.5 When Mrs A was expecting II and JJ, there was an opportunity to reconsider the protection of the children. It was not taken as it was thought that there was no evidence that anything had changed. This was incorrect. If the original Child Protection and Child in Need Plans had been re-visited, it would have been apparent that the software monitoring and prohibitions on physical contact with HH could no longer be relied on.

4.6 When interviewed, Mrs A gave a clear account of the period under review. Key issues that she shared were that:

- Her understanding of Mr A's offences from 2007 was based on what he had told her about them;
- She had been encouraged to talk with Mr A about what she had learned from the "Inform" sessions she had attended and to speak with him if she had any

concerns about his behaviour. She felt that this may have enabled him to maintain his control over the situation;

- There was no discussion about any need to limit Mr A's contact with other children;
- She was not given any "training" about the risk of child sexual abuse and how to identify the signs of it;
- Once the Child Protection Plan and Child In Need Plan ended in 2010, she felt that given those decisions and that Mr A had attended counselling, probation and a programme, she did not need to worry about his behaviour with the children. It was her understanding that the prohibition on him providing "personal care" for HH had ended in 2010.

5. Analysis

5.1 ***Communication, The Use of Conferences and The Sharing of Information***

Given that HH was not born until after the family had moved to the area the quality of the earlier MAPPA work is of lesser significance. That said, it is concerning that there is little evidence of communication and cooperative working between the police and probation service, other than a message about Mr A's whereabouts over Christmas and two MAPPA screening meetings. At both screening meetings it was agreed that Mr A should be managed at Level 1. It is not known if the fact that Ms B was pregnant was factored into the decision.

When Mr A moved to the area, the transfers between police and probation areas worked well. He was discussed at the Level 2 MAPP meeting under Any Other Business on three occasions. Given the decision that he would provisionally be managed at Level 2, Mr A should have been formally discussed at the Level 2 meeting with full papers and minutes, something which would happen today. In the absence of a detailed record, it is not possible to say with certainty whether the risk that Mr A could pose to children other than his own was discussed. However, the notes kept by the agencies who attended do not mention that it was and this will be discussed further below. With the ending of probation service involvement, he was moved to Level 1 – Ordinary Agency Management. The rationale for this decision included that the monitoring software had been installed on Mr A's computer and that Children's Services were now having regular contact with the family.

Soon after the family came to the area, an initial child protection conference was convened. It was held within the timescales laid out in Working Together 2006. This conference, and the subsequent review conferences, focussed on the protection of HH.

It is now known that the children's centres and schools that the family attended were unaware of Mr A's conviction. This meant that they did not have the opportunity to consider the appropriateness of Mr A attending school events and potentially filming them. This is an issue that should have been considered and a clear decision reached.

The GP's practice attended by the family, received copies of the Child Protection Conference minutes. At that time, they were kept separately and no note of the reason for the conference was made on HH's records. Other than through these minutes, there was no record that Mr A was a registered sex offender. Subsequent guidance is that all safeguarding concerns should be recorded in the notes of all children and relevant adults living in the household.

5.2 ***Criminal Justice Interventions with Mr A***

When the probation service prepared the pre-sentence report in 2008, the proposal was that, if he was not imprisoned, Mr A should be made subject to a three year community rehabilitation order with requirements of supervision and to attend a Sex Offenders Programme. The Court instead passed a sentence of imprisonment suspended for one year and added requirements of supervision and to attend a Sex Offenders Programme. Mr A was also made subject to a Disqualification Order for five years to prevent him from working with children and required to register as a sex offender for ten years. It is unfortunate that the prison sentence passed was not suspended for the maximum of two years as this would most likely have given enough time for Mr A to attend the sex offender programme. In the event the requirement was deleted as unworkable. Instead, the probation officers responsible for Mr A carried out some 1 to 1 work with him addressing his offending.

The probation service assessed Mr A using OASys, the Offender Assessment System. This combines static and dynamic factors to generate a risk of non-sexual offending within two years. In this case the risk was assessed to be Low. This was to be expected given that Mr A had no previous convictions. A further assessment was made of the risk of serious harm he presented. This is a professional judgement and he was assessed to present a Medium Risk of Serious Harm to Children[1]. This was a realistic assessment as the next level of Risk of Serious Harm is High[2]. The probation assessment of risk remained unchanged throughout Mr A's period of supervision.

Both the probation service and the Police also used a specialist tool to assess Mr A's level of risk – Risk Matrix 2000 (often referred to as RM2000). The police initially assessed him as High Risk. In October 2010, they reassessed him as Medium Risk. This change would have been due to his increasing age and that he was in a settled relationship. In 2014, using revised guidelines, he was reassessed as Low Risk. At that time, police routinely used the Risk Matrix 2000 level to determine the level of contact with a Registered Sex Offender. It was thus that the level of contact required was reduced to three monthly in July 2010, to six monthly in October 2010 and to annual in 2014. They did however maintain more frequent contacts than the required minimum.

1 The definition of a Medium Risk of Serious Harm is that there are identifiable indicators of risk of serious harm. The offender has the potential to cause harm but is unlikely to do so unless there is a change in circumstances (e.g. failure to take medication, loss of accommodation, relationship breakdown, drug or alcohol misuse).

2 The definition of a High Risk of Serious Harm is that there are identifiable indicators of risk of serious harm. The potential event could happen at any time and the impact would be serious.

The monitoring of Mr A's computer became a key aspect of the risk management plan. There were however regular problems with the application of the monitoring software. This has emerged as a particular concern during this review as Mr A's apparent willingness to cooperate was seen as very positive in the context of child protection. As part of this review, the police have reviewed the effectiveness of this monitoring and have concluded that it only worked properly for the first ten months. The investigation into his offences in 2015 revealed that he had downloaded a substantial number of images, most likely over a number of years.

5.3 **Assessments of, and Interventions with, the family**

A Child Protection Plan was put in place through the Child Protection Conferences together with an agreement limiting Mr A's physical contact with HH. The decision to place HH on a Child Protection Plan was appropriate. A risk assessment was carried out by Children's Services. It was considered well-constructed and well-argued by staff at the voluntary organisation when they read it prior to working with Mr A. This was when he undertook their "Inform Plus" programme. Although this was voluntary, it was an expectation of the Child Protection Conference. It was not however a treatment programme and, at the end of it, it was not felt that he was insightful. He was relying on external controls rather than internal ones.

Once the plan had been completed and actions were in place to protect HH and to manage the risk of Mr A reoffending, it was reasonable that the decision to take HH off the Child Protection Plan was made. However, although a Core Assessment was carried out and a Child in Need Plan was put in place for a short time, no clear contingency plan seems to have been made. The decision to reduce, and then end, Children's Services involvement with the family at this time was, in itself, a reasonable and justifiable decision but there was no commitment to revisit the case in the future. Instead, Mrs A's increased understanding was relied on, combined with Mr A's acceptance of the external controls of computer monitoring, visits from the police and limitations on his physical contact with HH.

As noted in paragraph 4.1 above, Mrs A undertook the "Inform" programme in 2010. The report from the voluntary organisation was that Mrs A was clear about the nature of Mr A's offending although she did not want to contemplate the detail. The social worker's assessment was that she understood the concept of grooming, both in relation to herself and to HH. However, in the voluntary organisation's IMR it is commented that processing the feelings and impact of what Mr A did, when he, was after all, in a relationship with her, can take years and require professional engagement and support.

In reflecting on the information she received, Mrs A commented that she had been encouraged to share her learning from her work on the "Inform" programme with Mr A and to speak with him if she had any concerns. She felt this had contributed to his ability to control her and the situation. Mrs A also felt that it could have been helpful if she had understood what to look for in terms of child sexual abuse.

There were subsequent opportunities to initiate new assessments, particularly when Mrs A was pregnant. These were missed as it was considered that nothing had

changed. While these decisions were made by Children's Services, they were not challenged by the police or health visitors.

It is also a concern that none of the agencies appear to have considered fully whether Mr A was a risk to children outside his immediate family, albeit that Mrs A had been clear with the social worker that she would always supervise any contact with children who visited the home.

5.4 ***The use of professional judgement & expert knowledge in relation to sexual offending to inform decision making***

Before commenting on the level of expert knowledge used in the management of this case, it is important to recognise the level of knowledge both of internet offending and of the crossover between non-contact and/or internet offending and contact offending both now and in 2008 when Mr A was convicted. Given that the first conviction in the UK for an internet offence was in 1997, the amount of validated research available in 2008 was very limited. While the situation is better now, it is still difficult to identify conclusive evidence. It is instead necessary to be aware of the potential both for reconviction for further internet related offences and for the offender to move on to contact offences.

The early assessments and management of this case were partially informed by expert knowledge. The probation officer correctly proposed the use of a sex offenders programme and, if this had been possible, it is hoped that Mr A would have attended a programme designed specifically for internet sex offenders. The decision in 2009 to seek a specialist assessment was essentially a sound one. The one that was actually carried out was seen to be well-constructed and well-argued.

The management of risk depended significantly on Mrs A's ability to protect her children and on the effectiveness of the computer monitoring software. It is clear that the prohibition on Mr A having physical contact with HH was allowed to lapse and there was no process by which this was challenged once Children's Services had closed the case. The assumption that the monitoring software was effective was not shared by the police officers involved but the combination of the lack of authority to insist on it and the lack of inter-agency discussions about the family and risk meant that it was never subsequently addressed by the different agencies together.

It is also noted that the voluntary organisation which had provided the "Inform Plus" programme were not involved in any discussions after Mr A had completed it in 2010. They had suggested some work with HH on self-protection once he was older and they might have brought another perspective to discussions.

When the family were twice re-referred to children's services when Mrs A was pregnant, the decisions not to re-assess the case were based on a view that nothing had changed. In some ways, this was correct as Mr A was still cooperating with police officers and had not been re-arrested. However, there were now more stressors on the family (particularly given II's health problems), Mr A was much more involved with the children and the monitoring software was providing no reassurance at all.

As indicated earlier, there was a lack of professional curiosity about the range of risks that Mr A might present – e.g. using his technical, including audio-visual skills, to produce and distribute images of children.

It is also of note that he talked about travelling abroad in connection with his work. It is recognised that there were no grounds to prevent him from doing so but there is no evidence that consideration was given to the possibility of him offending when abroad. His probation officer had recorded in the pre-sentence report that he was aroused by images of fifteen year old girls, which was another aspect that could have been considered.

6. Key Issues and Findings

6.1 It is recognised in this review that Mr A's conviction in 2008 was for the possession of indecent images and that he had not committed any contact offences. In reviewing the case, it is clear that this was the context in which he was seen and managed. While Mr A's physical contact with HH was limited by a signed agreement, there is no other reference to concern that he might commit a contact offence against his, or other, children. Mrs A has said that she was not given training in identifying the signs of child sexual abuse. There was also no discussion about the possibility that he would himself take photographs of his, or other, children, for his own gratification or to sell or share with others. The need to think more broadly about non-contact sex offenders is addressed in paragraph 6.3 below.

6.2 *Findings in relation to the management of risk presented by Mr A*

6.2.1 The management of risk in relation to internet non-contact sex offenders needs to be in relation to the likelihood of a repetition of the offences, the impact this can have on the children who are the subject of the indecent images and the potential risks, both sexual and emotional, to any children with whom they have contact.

6.2.2 Before HH was born, the management of risk was through a combination of police enforcement of the sex offender registration and probation management and intervention. The intervention was originally a precursor to the sex offender programme planned.

6.2.3 Subsequently, there was a period of about five months when probation service managed Mr A and provided interventions in relation to sex offending. This was coupled with active management by the specialist police officers combined with the attempts to deter him from accessing indecent images on his computer. In the absence of any authority, or leverage, to compel Mr A to go to a treatment programme, he was referred to the Inform Plus programme. It was hoped that this would help him to desist from accessing indecent images. It was concluded that he had ineffective internal controls. It was therefore hoped that the monitoring of his computer and the visits from the police and the health visitor and the agreement that he would not have any part in HH's physical care, combined with the understanding that Mrs A had, would be effective.

6.2.4 Unfortunately the monitoring of his computer proved to be an illusory form of risk management, as demonstrated by the evidence in relation to his new offending. Additionally, the limitations on his physical contact with HH were not maintained nor were they extended to II and JJ.

6.2.5 While attention was paid to the risk that Mr A would resume accessing indecent images and that there could be a risk to HH, little focussed attention was paid to the risks to other children, including in his extended family or, the implications of his stated attraction to 15 year old girls.

6.2.6 It can be said that the MAPP meetings held had a useful function, although if it was decided that Mr A should be managed at Level 2, then this should have happened. It is also problematic that as he was discussed under Any Other Business, no proper record was kept. It is understood that this would not happen under current procedures.

6.3 ***Findings in relation to the Protection of H, II and JJ***

6.3.1 When the family moved to the area, appropriate actions were taken to assess the risks to HH and then to manage them. Child Protection Procedures and Conferences were appropriately used.

6.3.2 Given HH's age, it was inevitable that the protection plan centred on managing Mr A's behaviour, together with encouragement to Mrs A to take HH to a toddler group. Referring HH to a Stay Safe programme was however recommended by the voluntary organisation. It is aimed at primary school children but no action was taken about it.

6.3.3 When Mrs A was expecting II and JJ, there was an opportunity to reconsider the protection of the children. It was not taken as it was thought that there was no evidence that anything had changed. This was not correct. If the original Child Protection and Child in Need Plans had been re-visited, it would have been apparent that the software monitoring and prohibitions on physical contact with HH could no longer be relied on.

6.4 ***The Difficulty of Managing Offenders who have accessed Indecent Images***

6.4.1 This review has highlighted the lack of certainty in the assessment of those who access indecent images of children. Reducing the risk of their reoffending in a similar way is a key task for criminal justice agencies given the harm the production of such images causes. While the statistical and research evidence suggests that only a proportion of them go on to commit contact offences against children, one can never be sure which of these offenders will do so. It is therefore important that agencies dealing with such offenders are as well-equipped as possible to manage these risks. The numbers of them are however large and increasing which means that the resources available need to be prioritised.

6.4.2 It is therefore necessary that the agencies, involved in assessing and managing such offenders and safeguarding children, work together to identify the best ways of allocating appropriate resources and of assessing and managing the risks. A cornerstone of any approach must be the ability to make assessments and review them periodically. This case has illustrated the danger of relying on earlier assessments without reviewing them with all the agencies involved.

6.4.3 It has also highlighted the confusion that can prevail over the meaning of risk assessments. Even though it is considered that the Kent Internet Risk Assessment Tool (KIRAT) and the new Active Risk Management System (ARMS) are an advance on Risk Matrix 2000, there remains a problem if agencies do not understand what they and other assessment tools measure and to what level of certainty. In this case, a discrepancy between the police's Risk Matrix 2000 assessment of High Risk and the probation service's OASys assessments that Mr A presented a Medium Risk of Harm to children and a Low Risk of Reoffending, were noted and contrasted. It is not clear that the fact that the OASys risk of Reoffending assessment was of his likelihood of committing a non-sexual offence was understood.

6.4.4 It is also most important for agencies to identify what changes in an offender or his situation might lead to that offender being assessed as presenting a greater risk of carrying out the harmful behaviour. These factors can then be monitored.

6.4.5 Recent developments in safeguarding and, in particular, the introduction of the Multi Agency Safeguarding Hub have strengthened the arrangements for dealing with referrals such as those made when Mrs A was pregnant with II and JJ. It is understood that now a similar referral would trigger a Child and Family Assessment and consideration would be given to holding a Section 47 Strategy meeting involving children's services, police and health. Additionally, "Signs of Safety", a strengths based practice model, is now being used to develop and improve practice with families.

6.4.6 It is encouraging to learn that the software now used to monitor internet usage is considered more effective than the previous software. It is though most important that an undue reliance is not placed on the use of such technology when many internet offenders are highly skilled at circumventing such controls.

6.4.7 What is just as important is that all professionals involved in a case are aware of the potential risks and are encouraged and supported in ensuring that a proper and

proportionate assessment is made when they have concerns. Such assessments then need to be followed by approaches that combine support for the offenders to change and desist with placing boundaries and controls around them and protecting children considered to be at risk from them. Programmes are available for such offenders and are most often provided as part of a prison sentence or community order. Sex offender notification requirements and sexual harm prevention orders are important as controls. It is not however realistic or justifiable to impose a policy banning all such offenders from contact with children. To do so is also likely to be harmful to the children of the majority of those offenders who would not have gone on to commit contact offences. Although there may have been publicity in relation to court proceedings, care has to be taken to manage any disclosures about them, e.g. to schools, and to ensure that any detrimental impact is justifiable and proportionate.

6.4.8 Staff must therefore be trained and supported in understanding the issues, in carrying out assessments and in working with offenders and their families over, potentially, a long period. Resources need to be identified to provide the required interventions and controls. Managers need sufficient knowledge and understanding to prioritise the use of such resources.

7. Conclusions and Lessons Identified by Agencies

7.1 It is clear that the management of Mr A and support given to the children's mother in 2009 and 2010 were appropriate, other than the inability to get Mr A to attend a sex offenders programme. The use of monitoring software and an agreement limiting his physical contact with HH were good practice, although both were relatively short-lived and should have been kept going. The risk assessment completed appears to have been satisfactory and proportionate to the assessed risks. MAPP meetings and Child Protection Conferences were used to coordinate assessments, planning and the implementation of plans.

7.2 The use of the specialist voluntary organisation to deliver the "Inform" and "Inform Plus" was good. It would however have been helpful if the staff involved had been consulted subsequently.

7.3 The decision by Children's Services to end contact with the family in late 2010 was understandable as the work planned had been completed. What was missing was a plan for how ongoing risks could be reassessed and the recognition of the importance of doing this periodically and particularly when new children entered the family. There was also no plan to consider providing a Stay Safe programme for HH.

7.4 When interviewed, Mrs A was invited to share her advice for mothers when a member of their family has a conviction for accessing indecent images of children. It was:

- "Look out for secretive nature/behaviour." – *He had taken his laptop everywhere with him. The only time he hadn't was one particular holiday.*
- "Be wary if he knows so much about computers and downloading."
- "Look at the way your children are with him." *She commented that HH had never liked Mr A – there was no bond between them.*

7.5 There is a need to review the approach to families in which a member has committed offences of this type. The review will need to:

- Consider the number of such families
- Identify how to distinguish which cases need independent specialist assessments and those which can be dealt with using internal assessors from the various agencies involved
- Address the controls, both voluntary and enforceable, that can be sought in terms of contact with children within and outside the family, e.g. through schools and churches and when they are justifiable
- Identify interventions that can provide treatment, education and information for offenders and family members including children
- Develop approaches to monitoring and re-assessing such cases over long periods of time.

7.6 To support the implementation of the approach, it will be important for staff in the relevant agencies to have an up-to-date understanding of the issues and risks as well as of the meaning of assessments and their terminology. It is recognised that this can be confusing to non-experts.

8. Recommendations

8.1 The following recommendations made:

1. The Safeguarding Children's Board should work with other bodies so that a review of the approach to families in which a member has committed offences in relation to on-line indecent images of children is undertaken.
2. The Safeguarding Children's Board and its partners should ensure that relevant professional staff have sufficient skills and knowledge to work with those who access indecent images of children on-line and their families in furtherance of the above approach and to integrate this work into strengths based practice with them.
3. The Safeguarding Children's Board Strategic Case Review Group should receive and review reports from agencies in relation to internal Action Plans developed as part of this Review.

Appendix 1

Terms of Reference of the Serious Case Review regarding HH, II and JJ

To take into account the particular circumstances of this case, the SCR should consider:

i. Whether, and the extent to which, agencies were or should have been, aware of Mr A's offending and whether this knowledge was responded to adequately in accordance with that agency's child protection and safeguarding policies and procedures and established good practice.

ii. Whether the agencies involved with Mr A's management worked together and did all they reasonably could to manage effectively the risk of re-offending in the community, including whether sufficient interventions were offered in relation to sexual offending

iii. Whether relevant multi- and inter-agency arrangements (including the child protection and MAPP arrangements) were effectively applied in the management of Mr A and the protection of potential victims

In addition, consideration should be given to:

iv. The adequacy of the transfer to the area (Police to Police, Probation to Probation, Children's Services to Children's Services and on an interagency basis)

v. The adequacy of risk assessment & decision making particularly when reducing risk levels, reducing monitoring both within the agency and when a joint or multi-agency decision

vi. The use of professional judgement & expert knowledge in relation to sexual offending to inform decision making

vii. The extent to which the children's mother was informed of and understood the risks that Mr A posed to the children