



Cambridgeshire and Peterborough Safeguarding Children Board

Learning Report

Case P

May 2018

Learning report

This learning report is to inform practitioners and professionals of the learning from a Serious Case Review (SCR) undertaken by the Peterborough Safeguarding Children Board.

The SCR was undertaken using a practitioner focused methodology. The purpose of an SCR is to illicit learning from a case and this report is to ensure that the learning is available and used effectively to inform and where required to improve practice.

What were the circumstances that led to this SCR?

In November 2015 an 18 year old young person made an allegation of serious sexual assault against a man called RS. The victim stated that this had occurred when they were 14 years of age.

In May 2016 the sibling of the first victim also made a complaint of sexual assault against RS.

The appropriate intelligence checks were not made at the time of the report and had they been it would have been revealed that there was significant evidence and intelligence to suggest that RS presented a risk to young persons as a sex offender. This information would have allowed for more immediate action and earlier intervention.

RS was subsequently arrested and after his arrest another five young people came forward and disclosed that they had also been subjected to serious sexual assaults and offences of rape by RS.

RS was subsequently convicted of numerous serious offences and received a significant period of imprisonment.

Why was the SCR undertaken?

The Peterborough Safeguarding Children Board considered the circumstances and agreed that serious harm had been caused to the young persons and that there were concerns as to how organisations had worked together to protect the young persons.

The review looked at an extended period of time, from 2008 to the time that RS was arrested.

Due to other legal processes there has been a delay in the publication of this review, these processes have not prevented the learning identified from being acted upon and used to improve processes and practice.

What did we know about RS?

RS had a significant offending history including a number of offences of violence. It was clear that the potential risk that RS presented to others, including young persons, had previously been recognised.

RS served a lengthy term of imprisonment and on being released was twice recalled to prison due to the risk that he presented to others.

On release RS was made the subject of Multi Agency Public Protection Arrangements (MAPPA)¹. He moved between areas and there was confusion over the 'ownership' of these arrangements.

He was for a period on bail for a separate serious sexual offence but was ultimately found not guilty of the offence. Due to his moving areas and the fact that he was managed on bail conditions for a period, when the bail conditions ceased to exist not enough consideration was given to how RS could be managed and he effectively 'fell off the radar'.

It is fair to say that over time agencies had concerns regarding his behaviour and association with young persons and children but these concerns did not translate to effective multi-agency management.

RS and his offending

RS befriended a family and by doing so was able to form relationships with two of the children aged 14 and 15 years at the time. The parent trusted RS and considered him to be a friend. There were occasions when RS demonstrated that he was a protective factor in the life of the children, for example protecting them from bullying from other youths, and through this the trust in him was enhanced.

RS also befriended a carer who had responsibility for a 12-year-old and through this relationship was able to gain the trust of the young person and commit offences against them.

Through these relationships RS was able to gain access to his other victims aged between 10 and 14 years of age and over an extended period commit the most serious offences against them.

RS demonstrated that he was adept at not only grooming children but also their parents and carers.

What did the SCR find?

Identification and management of risk – The risk that RS presented was well documented, he had been assessed by various agencies on a number of occasions. The risk in the early stages was dealt with robustly with him being recalled to prison on two occasions, a course of action which is not taken lightly. As time passed this recognition of risk diminished and RS was allowed to fade into the background. If he had continued to be managed within the MAPPA framework this would have allowed agencies to be aware of the risk he presented.

Information sharing and coordinated action – Information, particularly with regard to the risk RS presented was not effectively shared between agencies. It is apparent that agencies had their own concerns regarding RS and his relationship with vulnerable families allowing him access to young persons, but did not act in a coordinated fashion to try to deal with these concerns. There was evidence of warnings being given to families but the right information not being passed to allow them to protect their children. There was also

¹ Multi Agency Public Protection Arrangements (MAPPA) - Multi-agency public protection arrangements are in place to ensure the successful management of violent and sexual offenders.

instances of written agreements being made with families that had no ability to be followed up or enforced.

Decision making – The decision making by agencies was on occasions poor, there was a lack of recognition of previous information which could have better informed decisions to mitigate the risk RS presented. Decisions were taken in isolation without appropriate and available consultation with other agencies.

Community and third party information – In this case there was repeated concerns voiced by members of the community and indeed health professionals. Not enough emphasis was given to these concerns both taken on their own merits and when taken cumulatively.

Recognising the potential signs of sexual abuse – There were occasions when the young persons were spoken to and asked about the relationship they had with RS. When no direct verbal disclosure was made concerns were closed. There were other signs available such as over sexualised behaviour. One child was receiving support through a therapeutic programme and comments were made by them that warranted following up but they were not.

Learning points from the SCR

- There needs to be a better understanding of risk and how that can be managed.
- Agencies need to be able to identify persons who present a risk to children, to be able to flag those persons within their agencies to enable them to be managed in a multi-agency fashion.
- Professionals need to be able to identify potential signs of sexual abuse and be able to act appropriately as a result.
- Decisions need to be made with consideration to all information that is available and relevant. Decisions should be made, where possible, in consultation with other agencies.
- Due regard should be given to community intelligence, in particular where it is received from more than one source.
- Professionals need to be confident in their ability to effectively share information to protect children.
- When offences are reported, the action taken and the priority of that action, should be based on all available information and intelligence.
- Parents and all other carers need to be equipped to identify 'grooming' activity and in particular when a risk is known or perceived.

Recommendations

1. The LSCB should seek reassurance that all staff within contributing organisations feel confident to be able to identify and refer persons who present a significant danger to children, and should review what mechanisms are available to manage such persons, considering both the MAPPa and IOM frameworks.
2. The LSCB should seek reassurance that organisations have a method to effectively flag and monitor persons who are identified as presenting a significant danger to children.
3. The LSCB should review how effective disclosures can be achieved from children and young persons where there is a lack of verbal disclosure, which should include an

emphasis on other factors such as the child demonstrating sexualised behaviour and the emphasis given to community intelligence.

4. The LSCB should seek reassurance that staff are equipped and able to identify signs of grooming and risk indicators of sexual abuse and report it appropriately. This should include staff working closely with children and young persons on therapeutic interventions.
5. The LSCB should review what the offer is to Young People in Peterborough both as offenders and potential victims of sexually harmful behaviour.
6. The LSCB should seek assurance that written agreements with parents are appropriately used and monitored.