CAMDEN AREA CHILD PROTECTION COMMITTEE AND CAMDEN & ISLINGTON HEALTH AUTHORITY

A PART 8 REVIEW AND HOMICIDE ENQUIRY RELATING TO A & F D

MARCH 2002

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Camden Area Child Protection Committee
and
Camden and Islington Health Authority
Part 8 Review and Homicide Inquiry
A - & - F D

CONTENTS

Foreword ... **5**

Executive Summary ... **8**

1.....Introduction ... **8**

1.1. ..Background ... 8

1.2. ..The Terms of Reference ... 10

2.....Summary of Key Points, Conclusions and Recommendations ... **12**

2.1. ..Key Points ... 12

Communication ... 13

Definitions ... 13

Multi-Agency Meetings ... 14

Professional Supervision ... 14

Reluctant and Evasive Service Users ... 14

A Holistic Approach to Psychiatric Assessment ... 14

Accommodation for Homeless People ... 15

2.2. ..Conclusions ... 15

2.3. ..Recommendations ... 17

2.4. ..Recommendations for Central Government ... 17

2.5. ..Recommendations for the Camden Area Child Protection Committee ... 18

2.6. ..Recommendations for the Camden Social Services Department ... 20

2.7. ..Recommendations for the Metropolitan Police ... 21

2.8. ..Recommendations for Barnet, Enfield and Haringey Mental Health NHS Trust ... 21

2.9. ..Recommendations for the Crown Prosecution Service ... 23

2.10..Recommendations for the Camden and Islington Mental Health NHS Trust and Camden Social Services Department (Mental Health Services Delivered in Integrated Teams) ... 24

2.11..Recommendations for Camden Housing Department ... 24

Detailed Findings 25

3.....Period I – August 1995 to November 1996........ 25

3.1. ..Mrs. K C and A........ 25

Mrs. K C makes Contact with the Camden Social Services Department - 17th August 1995 – 13th September 1995........ 25

Initial Work with Mrs. K C and A - 13th September 1995 to 26th October 1995........ 25

A Accommodated in Foster Care - 27th October 1995 to 20th January 1996........ 26

Post Foster Placement Work – 20th January 1996 to 27th July 1996........ 27

A Goes Abroad - 27th July 1996........ 28

Closure of the Case – 17th November 1996........ 29

3.2. ..F D's Early Years........ 30

F D's Past Psychiatric History – 1971 to 1994........ 30

F D Moves to London in July 1994 - Contact with the Primary Care Services........ 31

F D moves to London 1994 – Contact with the Housing Services........ 34

4.....Period II - May 1999 to May 2000........ 37

Concerns about F D May to July 1999........ 37

F D presents himself at a Police Station in Central London - 15th September 1999........ 37

Police Activity in Camden in October 1999........ 39

Police Referral to the Children and Families Team of Camden Social Services Department 14th October 1999........ 39

A Strategy Meeting – 21st October 1999........ 40

A Reconvened Strategy Meeting........ 44

Allocation of the Case in Camden Social Services Department........ 48

Police and the North London Forensic Service Contacts with F D 3rd November and 10th December 1999........ 52

F D visits the Children and Families Team in the Camden Social Services Department 5th November 1999........ 57

Referral of F D to the Adult Mental Health Duty Team – 24th November 1999........ 58

Work Undertaken by the Adult Mental Health Duty Team – 25th November 1999 to 29th November 1999........ 59

Contact Between the Children and Families Team and A's Family 16th November 1999 and 1st December 1999........ 62

F D arrested for Damage at A's School 6th December 1999........ 63

F D Evicted From His Hostel Accommodation – 6th December 1999' 66

A Interviewed Under the Memorandum of Good Practice 10th December 1999 and 4th January 2000 67

F D Charged and Remanded in Custody – 10th December 1999 71

F D Assessed by the Court Diversion Service – 21st December 1999 71

Contact by the Children and Families Team with A's family - 5th and 17th January 2000 77

Police Interview F D while in Custody – January 2000 79

F D's Appearances in Court – January to March 2000 80

F D Released from Custody – 20th March 2000 80

The Crown Prosecution Service and Custody Limits 82

Co-operation between the Police and the Crown Prosecution Service 84

Camden Risk Management Panel 87

The Closing Months of A's Life 89

F D's attack on A – 7th May 2000 90

Appendix 1 - References 91

Appendix 2 – Chronology of Events 92

Foreword

This report which constitutes both a Part 8 Review (constituted under guidance in Part 8 of Working Together to safeguard children 1999), and a Homicide Inquiry, (constituted under HSG (94) 47) has been received by the commissioning Agencies, who are committed to ensuring that the conclusions drawn are used to inform and improve practice across all agencies in order to better safeguard children and strengthen working practices with adults with mental health problems.

In receiving the Report we are clear that what took place was an extremely rare combination of circumstances. We believe that A's death was a tragic event that could not have been predicted nor easily prevented. However good inter-agency practice was in the case, it is probable that nothing could have prevente A's untimely death. We want to extend our sorrow and sympathy to A's family in these circumstances. We accept the recommendations in the Report in full and are committed to implementing those that relate to each of our agencies. We would ask that Central Government consider those recommendations that have implications for the rest of the country and need addressing on a national level.

As is always the case in these matters, we are using the benefit of hindsight in our review and the extensive information gathered through intensive efforts over a period of more than 18 months. It is inevitable therefore that we can see the whole picture in a way that was not open to the individuals involved during the case. This hindsight allows us to learn from what happened and from the conclusions drawn. It does not mean that individuals were at fault for not being able to see the whole picture at the time.

We do believe however, that there are some very important messages for all agencies and for Central Government contained in this report.

We fully accept that there are lessons to be learnt locally. There were things that could have been done that were not, or could have been done better than they were. Of these, the most important are those of communication and the use of multi-agency meetings to share knowledge and understanding. Although no individuals were at fault, some systems were not working effectively to ensure comprehensive inter-agency communication, including the use of multi-disciplinary meetings.

Communication locally was across a particularly wide number of agencies. We are committed need to significantly improving communication locally between agencies working with adults and those working with children, and to improve communication inside agencies between staff involved with adults and those with children. We are committed to doing this.

Similarly, we are committed to ensuing that multi-agency meetings must take place for those matters and situations identified in our own local procedures, particularly for complex situations that arise involving a large number of agencies and people. We will ensure that all agencies give these meetings the priority they need whether statutorily required or not, in a time when pressures on resource can detract from such efforts. This requires us to develop better systems to facilitate this, to address the organisational demands this approach makes and to build into the system models of professional supervision to support such an approach.

We must also accept that locally we need to look collectively at our different professional and practice frameworks together, to create a common set of professional standards in work of this nature.

It is quite clear that there are different systems and processes used to address issues relating to adults within the mental health system who present a risk to others, and those relating to children at risk. Similarly, the criminal justice system and the child protection system operate in different ways. The single most important message within this report is that all agencies are responsible for ensuring that whenever a child is involved in a matter, the child's best interests are addressed and this informs the response to the adult. We accept the need to address this locally, but believe it needs to be considered at a national level if it is to become the norm in practice.

It is also clear that the current child protection system is focused on family based protection. Risks from strangers or from outside the family are currently dealt with differently. The fact of the matter is that the system needs to be extended and amended to address the full range of situations, including the risks posed by strangers, to assist agencies in sharing a common understanding of the issues and a common purpose in the required responses. This would inevitably mean additional resources for agencies that at present do not invest heavily in child protection based practice or understanding. If child protection continues to be seen as the province of a small number of expert professionals, this narrowness of focus will continue. We believe action needs to be taken to ensure all agencies share this responsibility and understanding, and embed it in their normal practice.

The use of definitions to describe our understanding of individuals can obscure and indeed detract from a common understanding and common purpose. In fact, the way in which we define or work with people should not make any difference to the systems and processes we use for working together, or for ensuring that we maintain a shared approach. All agencies need to agree a shared approach to risk assessment and risk management, using agreed definitions of behaviours and what constitutes acceptable and unacceptable risk. The use of a range of definitions to describe and understand FD's behaviour was at best unhelpful, and at worst detracted from a common understanding of the risk he posed to A. We believe that this proposal needs to be supported by national guidance and regulation.

The issue of homelessness and transience and the difficulties of tracking and tracing individuals who move across systems and boundaries is one that did have an impact on this case. Some information was inaccessible to people who would have benefited from it, informing their decisions and actions. This is an issue that again would need national attention if it is to be fully and properly resolved.

These are all lessons from our Inquiry, and they are lessons for local partners and Central Government alike. We have addressed those recommendations that are relevant locally with action plans and deadlines to put right what was wrong and change what needs to be changed for the better

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Executive Summary

1. Introduction

1.1. Background

1.1.1. On the 7th May 2000 a twelve-year-old boy (date of birth 28 August 1987) was attacked in the street and subsequently died of stab wounds. (This boy is referred to throughout this report as A). In March 2001, the man who attacked him (referred to throughout this report as F D) pleaded guilty to his murder and was sentenced to life imprisonment.

1.1.2. There are some unusual features to this case. A was a child being stalked by an adult; this is a rare occurrence and the case was only identified in this way after A's death. Before his death, agencies handled the case as one of possible sexual abuse and paedophilia or harassment of a minor by a stranger. F D was not a stranger to A. The Review Team's study of the case has revealed that F D and A knew each other well. However, F D was not a member of A's family. Neither A's mother nor her partner (referred to as Mr. B L in this report) ever met F D. A feature of this case that has led to difficulties for the various agencies throughout has been the reluctance of A's mother (referred to in this report as Mrs. K C) and F D to engage with the public services.

1.1.3. In 1998 F D changed his surname to that of a well-known early twentieth century occultist. It has become clear during the Review that F D has a long history of contact with psychiatric services. However, views about his diagnosis varied amongst psychiatrists who saw him. Over time the diagnoses given to F D included a type of personality disorder, and a depressive illness, and possibly schizophrenia. There had been repeated attempts at self-harm when F D lived in the North East before his move to London in 1994. Before 1999 there was no recorded evidence of paedophilic activity by F D. There were two recorded instances of violent behaviour towards adults. It is clear with the benefit of hindsight that a more holistic approach to assessment, as opposed to assessment under the Mental Health Act 1983, could have been more useful in assessing the risk F D might have posed to A. It has also become clear that F D has considerable skill in withholding information about himself and he would only reveal himself over an extended period of time such as was not available to those trying to assess him in London between September 1999 and May 2000.

1.1.4. Teams providing services for children and those delivering services for adults have both been engaged in this case. The criminal justice system has also had a major involvement. The Criminal Investigation Department (CID) and the local sector team (LST) of the Metropolitan Police, the North London Forensic Service, the Crown Prosecution Service (CPS), the Court Service and the Prison Service all worked with F D. The criminal justice system and agencies which deliver services for adults are not routinely in communication with agencies that deliver services for children and families. Systems for joint working and protocols for sharing information are not clearly established. The notion of F D posing a child protection threat to A was not seen as central to the work of agencies delivering services to F D, and there was no shared perception of F D as an abuser of children. There was no clinical diagnosis of F D as a paedophile. Even if there had been such a diagnosis, it is hard to envisage a child protection plan based upon such information which would have significantly increased the chances of preventing A's death without seriously limiting his freedom to enjoy the lifestyle of a boy of his age.

1.1.5. Because F D was not a member of A's family the case was handled as extra-familial abuse and dealt with outside the standard child protection procedures. Within the Metropolitan Police the policy is for extra-familial abuse to be investigated by the CID rather than being handled by police child protection teams (PCPT). Because the case was dealt with outside the standard child protection procedures the mechanisms facilitating joint multi-agency working in relation to A as a child in need of protection did not operate, and the police officers in the PCPT, with their knowledge and understanding of abuse and paedophilia, were only marginally involved.

1.1.6. Following A's death, Camden Area Child Protection Committee (ACPC) and the Camden and Islington Health Authority established a Review, to be conducted according to guidance in Part 8 of *Working Together to Safeguard Children (Published 1999. The Department of Health, The Home Office, The Department of Employment and Education)* to 'establish whether there are lessons to be learned from the case about the way in which local professionals and agencies work together to safeguard children' and 'to improve inter-agency working and better safeguard children'.

1.1.7. Running concurrently with the Part 8 Review has been a Homicide Inquiry relating to F D and his care. The role of such an inquiry is spelled out in HSG (94) 47 and in Section 5 of *Building Bridges – A Guide to Arrangements for Inter-agency Working for the Care and Protection of Severely Mentally Ill People (Published 1996 – The Department of Health).* F D had a past psychiatric history of mental health problems

and had been in contact with specialist mental health services between 1971 and 1980 and between 1988 and 1994 and received hospital treatment in the 1970s, 1980s and early 1990s. He was in touch with primary health care services in London from 1994, and he was known to the criminal justice system from 1999.

1.2. The Terms of Reference

The terms of reference for the Review Team were set out as follows,

1.2.1. The Review will examine the adequacy of inter-agency collaboration and the effectiveness of communication with/between agencies in relation to A and F D.

1.2.2. The Review will look at the levels of understanding of roles and responsibilities in the child protection process in those services whose primary users are adults.

1.2.3. The Review will consider if professionals/agencies involved in the case followed local inter-agency child protection procedures.

1.2.4. The Review will consider the suitability of the assessment and care of F D, in the light of his history and assessed needs, and the extent to which they corresponded with statutory obligations, relevant guidance from the Department of Health and the Home Office and local operational policies.

Method of Review

1.2.5. This Review was conducted by Mrs. Rosemary Arkley, an independent social work consultant, who previously worked for the Department of Health in the Social Services Inspectorate, and Dr. Rosalind Ramsay, a consultant psychiatrist with the South London and Maudsley NHS Trust. They met regularly with a Steering Group composed of representatives from the agencies on the Camden Area Child Protection Committee and representatives from the Camden and Islington Health Authority.

1.2.6. Key agencies which worked with Mrs. K C and A and with F D between 1994 and May 2000 undertook a review of their case files. They each produced a chronology of events covering contacts at home and in work places, meetings, appearances in court, details of movements such as change of residence or a journey abroad, and correspondence.

1.2.7. To augment this information the Review Team had discussions with relevant individuals at both management and practitioner level. These discussions were essential because of the complexities of this case and the necessity to acquire a clear

understanding of the inter-actions between the different groups of professionals and also to establish who held what information about A and F D.

1.2.8. A's mother and her partner were invited to meet the Review Team but did not accept the invitation. A meeting took place with A's two older sisters. A decision was made with the Steering Group not to interview F D during the course of the Review.

1.2.9. The Review Team presented a draft report to the Steering Group, which then passed the matter to the Chief Officers of each agency to consider further.

2. Summary of Key Points, Conclusions and Recommendations

2.1. Key Points

This section details key findings and highlights matters which need to be addressed.

Before setting out the key points the Review Team wishes to draw attention to current national policy and local systems for handling the protection of children and the behaviour by adults with mental health needs which may put others at risk. These policies set the context for how this case was handled.

The current national policy and local processes for protecting children focus on the child within the family, and the protectiveness or otherwise of that family. This system is based on an assumption that children are put at risk by their family and that they are made safe by agencies acting protectively towards children in the absence of that safety coming from their parents. This means that the system is not equipped to deal with the risks posed to children by strangers or adults outside the family. The system expects parents to take action to protect children from strangers or adults outside the family.

Current national policy and local processes for reducing the risk of harm which people with mental illness may pose to other people focuses on reaching a psychiatric diagnosis and assessing an individual's mental state. This is done with a view to offering treatment to the individual, which may in certain circumstances be compulsory. In the absence of a recognised psychiatric illness an individual is unlikely to be under the care of the psychiatric services and the identification of possible risk factors by health services in an individual is unlikely.

In some circumstances, for example child abuse, although an inherent risk to others is recognised, the system focuses on the individuals need for treatment, on the way to assess the individuals potential to cause harm and on action to ensure that the individual is made safe. The system does not in the main look at how to contribute to making others, particularly children, safer. Adult mental health services tend not to recognise that if children are involved, the focus must be on making the children safe as well as managing the adult.

The criminal justice system is made up of a number of agencies. These agencies are currently structured in different ways and work to policies which are not always understood by those working in other agencies within the criminal justice system and

agencies outside this system. This diversity leads to a divided rather than co-ordinated approach by the criminal justice system to the handling of risk when there are concerns about the safety of children or the handling of risk posed by adults with mental health needs. This lack of co-ordination is compounded by the absence of well-established links, for example, agreed procedures and regular meetings for sharing information, between the criminal justice system and agencies which work with children and families. The importance of a multi-agency approach which underpins action and decision making in child protection and mental health is not replicated in the systems and policies of the criminal justice system

Communication

2.1.1. Communication between agencies is a recurrent theme in Part 8 Reviews and Homicide Inquiries. This case involved a particularly wide span of agencies including social services, primary and secondary health care including the forensic services, court services, three branches of the police, education, the Crown Prosecution Service, the prison service, the probation service and the housing service. A particular feature of this case is the failure of communication between agencies delivering services for children and families and those working with adults.

2.1.2. The report highlights gaps in communication and recommends procedures to assist communication. Essentially an attitudinal change is required so that professionals in all agencies recognise the importance of multi-agency co-operation which puts the safety of children first. The introduction of new procedures should be supported by multi-agency training events arranged by the ACPC and attended by representatives of all agencies.

Definitions

2.1.3. Various definitions were applied in this case, including extra-familial abuse, harassment of a minor, paedophilia and stalking. The report recommends that Camden ACPC and Camden Multi-Agency Public Protection Panel should develop a risk assessment policy, based on agreed definitions of behaviours and common use of language, research findings, an understanding of risk factors, clinical knowledge, and agreement about what constitutes acceptable and unacceptable risk.

Multi-Agency Meetings

2.1.4. It has been possible to identify five occasions when there was sufficient concern or new information to warrant the setting up of a multi-agency meeting. Such meetings would have provided the opportunity to discuss all the information available, the different perceptions of the case, the likely risks posed by F D, and the vulnerability of A. The report recognises that the social services department and the police are the agencies with primary responsibility for the protection of children but it also emphasizes that other agencies and individuals can and should ask for such meetings when they consider that a child or children are at risk.

Professional Supervision

2.1.5. The report draws attention to the importance of well informed and challenging professional supervision. It must be well-informed in that the supervisor can draw on a body of knowledge about the problem, and challenging in that the supervisor questions assumptions about the way in which a case is being handled. In this case the responsibilities of frontline workers in relation to the protection of a child was a key issue for discussion during supervision. Supervision is essential when frontline workers are dealing with complex cases involving the conflicting interests of different people and difficult interface issues between agencies.

Reluctant and Evasive Service Users

2.1.6. The difficulties which statutory agencies have in engaging evasive and reluctant individuals and families were highlighted by this Review. There is a need for agencies to consider how they can encourage such people to engage with them, and the report identifies a need for guidance for frontline workers on this issue.

A Holistic Approach to Psychiatric Assessment

2.1.7. The advantages of a more holistic approach to mental health are raised in this report, and the approach is commended by the Review Team as offering a comprehensive understanding of the mental health needs of complex and evasive individuals. A longitudinal approach embracing current thinking on paedophilia, obsessive love, stalking etc., could have helped professionals gain a better understanding of this case. This approach recognises the presence of a victim and the possible effect of the patient's behaviour on such a victim. The patient's behaviour is assessed over time rather than in a series of snapshot assessments made at times of crisis.

Accommodation for Homeless People

2.1.8. The report highlights the lack of accommodation for homeless people living in London and draws attention to the risks faced by vulnerable people living on the streets. Although the Review Team recognises the resource implications in recommending an expansion of accommodation for homeless people the Review Team wishes to highlight the needs of vulnerable people discharged from custody without accommodation.

2.2. Conclusions

2.2.1. Clearly there are lessons to be learned from how this case was handled. Lessons which if well learned will ensure that services are stronger and better equipped to deal with cases involving risk to children. However, the Review Team wishes to emphasise that it was F D who killed A and not failure on the part of individuals or agencies.

2.2.2. It has to be asked whether the final outcome of this case could have been avoided if communication between the agencies had been better, if all the information gathered by the Review Team over eighteen months had been known to individuals working on the case, if the expertise of child protection specialists had been used more effectively, and if there had been legislation specific to the containment of people with personality disorder.

2.2.3. If there had been multi-agency co-operation it is difficult to envisage an agreed protection plan that could have protected A from F D's sudden attack on a summer evening in a crowded street. A housing transfer for A's family might have been a possibility, but this could have been an unattractive proposal for Mrs. K C who in any event was out of the country during the five months before A's death.

2.2.4. There were no legal grounds for removing A from his family. A was used to a lifestyle with a high level of individual freedom. The desirability of such a lifestyle may be questionable but there is no evidence that A's extended family was neglecting him. There is no evidence that the family were causing or were likely to cause A significant harm. There were no grounds for statutory intervention which would curtail A's freedom and his right to live with his family. The family did not consider that they required intervention by statutory agencies to help them protect A. They saw the solution to the problem as being the removal of F D by the public agencies.

2.2.5. On the basis that future behaviour may be predicated from past behaviour it must be remembered that F D had no significant forensic history and no known history of paedophilia. A risk assessment at the time would have been more likely to suggest possible sexual abuse by F D to A not violence. From the outset the agencies involved in this case identified the possibility of sexual abuse but not physical violence.

2.2.6. With the benefit of hindsight it has become clearer that F D probably had a severe personality disorder. In May 2000 there was no legislation on the statute book which could have been used to remove F D from the community because of his personality disorder. The Review Team thinks that even if the proposed legislation currently under discussion in *Reforming the Mental Health Act Part II High Risk Patients (Published 2000 by The Home Office and The Department of Health)* had been enacted F D would not have met the criteria for removal from the community. He was often difficult and unpleasant but the violence of his final act against A could not have been predicted from his previous behaviour.

2.2.7. It has been possible to piece together the probable deterioration in F D's mental state in the time before A's death and to speculate on how far the assault on A could have been predicted. When last assessed there were no legal grounds for removing F D to psychiatric hospital. Those working on the case were unaware that he had not been seen by his GP for over a year. They did not know that he had not collected medication from his GP, which had previously stabilised his mental state. They did not have a longitudinal view of his problems. During the weeks immediately before the attack F D was out of contact with services and professionals did not know about his mental health at this time. From information about F D's behaviour and demeanour at the time of the murder, and from information gained subsequently in psychiatric interviews, there are indications that his mental health had deteriorated and that he was psychotic on the 7th May 2000.

2.2.8. Even with this information and with the benefit of hindsight the Review Team does not think that F D's final act against A could have been foreseen. Because of the unpredictable nature of this attack the only way in which A could have been protected from the danger posed by F D, and ultimately from murder, was by the removal of F D from society or by the removal of A from his family and a placement where he could have no contact with F D. It is not possible to legislate for all eventualities, and as noted above there were no grounds to restrict the freedom of A or remove F D from society until after the event of 7th May 2000.

2.3. Recommendations

The Review Team is aware that since May 2000 some of the changes recommended below have been under consideration, and in some instances, implemented. We are aware that new policies that are under consideration at Central Government level are relevant to lessons learned from this Review.

For ease of reference, recommendations for local agencies are spelt out for each agency. The Review Team wishes to emphasise that although the recommendations are directed to the agencies covered by the Review, they may also be relevant to other ACPCs and agencies across the country.

Because of the inter-departmental approach to policy making at Central Government level, the recommendations under Section 2.4 are not listed under individual departments.

2.4. Recommendations for Central Government

2.4.1. Relevant Government Departments should consider issuing guidance about the handling of extra familial abuse/paedophilia. It would be helpful if such guidelines could include definitions, advice on criteria and thresholds for intervention, and the roles of the different agencies.

2.4.2. It is recommended that new guidance should state that the police child protection teams should always deal with cases when child sexual abuse has been alleged or is suspected.

2.4.3. Work should be carried out nationally to consider ways of facilitating easy liaison across the new Primary Care Trust boundaries for the purposes of communication and the tracking of patients. (For example, allowing staff in secondary care to identify the GP with whom a patient is registered).

2.4.4. Work should be carried out nationally to develop a system to enable general practitioners to identify those patients who do not attend in accordance with their regular pattern of treatment or medication. Associated guidance should encourage Primary Care Trusts to develop policies about action to be taken when patients are identified by such a system.

2.4.5. Consideration should be given to providing advice for Primary Care Trusts about the models which they should consider when planning services delivered by attached

mental health workers. The advice should emphasise the importance of workers having a clear understanding of the model in use in their area.

2.4.6. There should be a review of the provision of bail hostels and the number of beds available to meet the needs of vulnerable homeless people in the central London area.

2.4.7. Relevant Government Departments should consider establishing multi-disciplinary triage teams in prisons to screen those committed to custody. It is recommended that such teams should also liaise with health services and other agencies about the support required by individuals with mental health needs when they are discharged from custody. Such triage teams should include input from psychiatrists and CPNs with forensic experience and social workers who can facilitate access to social care following discharge.

2.4.8. Relevant Government Departments should consider providing advice about the sharing of relevant health information known to the Prison Medical Service with those working in the court system. For example, when and how the inmate's medical record (IMR) should be shared with those working in court diversion schemes.

2.5. Recommendations for the Camden Area Child Protection Committee

2.5.1. The ACPC should review its policy and procedures about communication between agencies, especially communication between those which provide services to children and those which provide services for adults, including the criminal justice system. Such policies and procedures should emphasise that all agencies, and all individuals working within them, have a responsibility for the protection of children.

2.5.2. The ACPC should request agencies to review their policies concerning the professional supervision provided for staff if there are allegations or suspicions of abuse.

2.5.3. The introduction of any new procedures as a result of this Review should be supported by multi-agency training events organised by the ACPC and attended by representatives of all agencies.

2.5.4. The ACPC should review the take-up of multi-agency child protection training by teams that deliver services for adults, for example, adult mental health teams, forensic teams, housing services, probation teams and the Crown Prosecution Service. This review should be complemented by individual agencies auditing who

has undertaken training, examining the impact of training, and identifying current needs.

2.5.5. The ACPC should review its arrangements for links with schools in the independent sector based in Camden, and should satisfy itself that these schools are aware of their responsibilities concerning the protection of children.

2.5.6. The ACPC should request the individual agencies which receive copies of the Child Protection Procedures to review their internal distribution of these procedures and ensure that they are easily accessible to all frontline workers.

2.5.7. The ACPC should develop links with the newly formed Multi-Agency Public Protection Panel (MAPPP) which covers Camden, and should agree with the MAPPP a risk assessment policy based on agreed definitions of behaviour, common use of language, research findings, an understanding of risk factors, clinical knowledge and agreement about what constitutes acceptable and unacceptable risk. The ACPC and the MAPPP should also agree arrangements for subsequent communication and action.

2.5.8. The ACPC should develop working links with the Camden Area Mental Health Committee and agree criteria and procedures for sharing information.

2.5.9. A senior member of the adult mental health service should be a member of the ACPC.

2.5.10. The ACPC should review their policy and procedures and ensure that they make specific reference to the responsibilities of the Housing Department in relation to child protection.

2.5.11. The ACPC should cover extra familial abuse/paedophilia in its multi-agency training programme. This should be complemented by training within each agency on the roles and responsibilities of individual workers in relation to extra familial abuse/paedophilia.

2.5.12. The ACPC Child Protection Procedures should state that if a strategy meeting is cancelled a decision not to reconvene the meeting must be agreed in writing by the team manager.

2.5.13. The ACPC should address the failure of agencies to attend strategy meetings and child protection conferences and should explore ways of ensuring that attendance is given priority.

2.5.14. The ACPC should establish a working party to examine ways of engaging reluctant and evasive individuals and families with statutory services. The working party should conduct its work with a view to providing guidance for frontline workers.

2.5.15. The ACPC should review its procedures in relation to interviews conducted under the Memorandum of Good Practice.

2.5.16. The ACPC should monitor interviews conducted under the Memorandum of Good Practice and, with the co-operation of the police and the social services department, the ACPC should develop a management system which ensures that the ACPC procedures are followed.

2.6. Recommendations for the Camden Social Services Department

2.6.1. The Camden Social Services Department should review its procedures for recording child protection referrals and for tracking referrals as they are allocated and investigated, and as they are accepted for further work or closed. The social services department needs to establish that there are sufficient checks and balances to ensure that child protection cases cannot be removed from the system without the approval of the team manager.

2.6.2. The Camden Social Services Department Child Protection Procedures should state that the advice of the child protection advisor with regard to specific action, for example the need to reconvene a failed strategy meeting, can only be overruled by written instruction from a more senior manager.

2.6.3. The Camden Social Services Department should introduce procedures which require the involvement of managers in the closure of all cases.

2.6.4. The social services department should provide guidance for its social workers about information which must be gathered and recorded on files to inform decision making; for example, details of family composition, reasons why agreed actions did or did not take place, details of discussions with other agencies.

2.6.5. A system should be introduced in the children and families team which brings up all cases for supervision on a rota basis regardless of whether they are handled by frontline workers or staff with management responsibilities.

2.7. Recommendations for the Metropolitan Police

2.7.1. The Metropolitan Police should develop procedures to ensure communication and co-operation between police child protection teams and other branches of the police force about crimes involving children.

2.7.2. The Metropolitan Police should put into place procedures which ensure that when there is alleged or suspected sexual abuse of a child or children the local police child protection team takes on the investigation.

2.7.3. All police officers in the CID and the local sector teams should receive awareness training with regard to child abuse and neglect. They should also receive training about the child protection system and the procedures to be followed.

2.7.4. The local police child protection teams should take a lead in child protection training, both by ensuring that other branches are aware of training opportunities within and outside the Metropolitan Police, and by delivering training for their colleagues.

2.7.5. Police procedures should make it obligatory for police officers to discuss with the local police child protection team and the local children and families team in the social services department any proposal to give a child a mobile telephone for self-protection. There should be a clear multi-agency plan for the use of every telephone issued.

2.7.6. In keeping with the Glidewell Report, the Metropolitan Police and the Crown Prosecution Service in London should provide joint training for their staff to encourage closer working practices and the sharing of information.

2.7.7. The findings of this Review support those of the Glidewell Report, and it is recommended that the setting up of criminal justice units in London should be carried forward as soon as possible.

2.8. Recommendations for Barnet, Enfield and Haringey Mental Health NHS Trust

2.8.1. The North London Forensic Service should build closer links with relevant ACPCs and ensure that its staff are aware of the ACPC's role, its policies and its procedures for multi-agency working and the responsibility of all agencies and individuals to protect children.

2.8.2. The North London Forensic Service should review the operational policies of the police liaison community psychiatric nurse scheme and the court diversion service and should address the issue of child protection in these policies.

2.8.3. The staff of the North London Forensic Service should receive awareness training about child abuse and neglect. They should also receive training about the child protection system and the procedures to be followed when they become aware that a child might be in need of protection.

2.8.4. The court diversion service should state clearly to other agencies that its role as a court diversion service is to divert individuals from custody and into National Health Service provision as necessary, rather than as a comprehensive assessment service.

2.8.5. The court diversion service should be led by a consultant forensic psychiatrist who is present in court when the team is making assessments.

2.8.6. Before embarking upon an assessment, the court diversion service should have the relevant information about the person they are assessing. They should have sufficient time to read this information before starting their assessment. It is recommended that the North London Forensic Service should list the information they require when making an assessment, and should agree with other agencies protocols and procedures for ensuring that they have the information.

2.8.7. All professionals who work in the court diversion team should receive regular supervision within the context of this multi-disciplinary scheme.

2.8.8. Community psychiatric nurses should be appointed to work with relevant prisons in order to provide an integrated/continuing service for those people who have been seen by the court diversion service. These community psychiatric nurses should have responsibilities to liaise as appropriate with other parts of the National Health Service, and with other agencies such as the children and families team of the social services department, and to consider what support is required when individuals are discharged from custody. This support should include appropriate use of the Care Programme Approach for the person discharged and also support and services for individuals and families affected by the discharge of a particular individual from custody.

2.8.9. There should be regular meetings for representatives of the North London Forensic Service, Camden and Islington Mental Health Services and officers from the relevant

magistrates courts to consider the workings of the court diversion service and any changes or improvements.

2.9. Recommendations for the Crown Prosecution Service

2.9.1. The Crown Prosecution Service should ensure that all prosecutors are aware of the role of the ACPC, the policy and procedures for protecting children and the responsibility of all agencies and individuals to protect children.

2.9.2. All prosecutors should receive awareness training with regard to child abuse and neglect. They should also receive training about the child protection system and the multi-agency procedures to be followed when a child or children may be in need of protection.

2.9.3. The local branches of the Crown Prosecution Service should work with their local ACPC to produce procedures and criteria for identifying sensitive/difficult cases involving children the handling of which requires multi-agency discussion.

2.9.4. The local branches of the Crown Prosecution Service should agree with the local ACPC a fast tracking system and procedures for sharing information as quickly as possible with the police and the social services department about cases which involve children who may be in danger.

2.9.5. The Crown Prosecution Service should explore ways of improving the continuity in the handling of individual cases, and ensuring that other professionals know the name and have access to an allocated prosecutor with whom they can discuss the handling of each case.

2.9.6. In keeping with the Glidewell Report, the Crown Prosecution Service in London and the Metropolitan Police should provide joint training for their staff to encourage closer working practices and the sharing of information.

2.9.7. The findings of this Review support those of the Glidewell Report, and it is recommended that the setting up of criminal justice units in London should be carried forward as soon as possible.

2.10. Recommendations for the Camden and Islington Mental Health NHS Trust and Camden Social Services Department (Mental Health Services Delivered in Integrated Teams)

2.10.1. The trust and the social services department should ensure that all professionals working in the community mental health team are aware of the role of the ACPC, the policies and procedures for the protection of children and their responsibility as members of the team and as individuals to protect children.

2.10.2. All professionals in the Community Mental Health Team should receive awareness training with regard to child abuse and neglect. They should also receive training about the child protection system and the multi-agency procedures to be followed when a child or children may be in need of protection.

2.10.3. The Community Mental Health Team should integrate duty work into the sector mental health teams in order to provide a single point of referral, full discussion of all referrals and assessment by a named worker. This individual would work on the case and follow through from assessment to action plan, including use of the Care Programme Approach.

2.11. Recommendations for Camden Housing Department

2.11.1. The Housing Department should ensure that all their staff are aware of the role of the ACPC, the policies and procedures for the protection of children, and their responsibility as members of the team and as individuals to protect children.

2.11.2. Staff in the Housing Department who have contact with the public should receive awareness training about child abuse, the child protection system and the child protection procedures.

2.11.3. Camden Housing Department should ensure that staff in hostels run by contracted housing associations receive awareness training to alert them to the possibility of abuse and to acquaint them with the work of Camden ACPC and the child protection procedures.

2.11.4. Camden Housing Department should ensure that all contracted housing associations, which run hostels for adults, develop a policy for the safe handling of visits by children to adults who live in their hostels.

Detailed Findings

3. Period I – August 1995 to November 1996

3.1. Mrs. K C and A

Mrs. K C makes Contact with the Camden Social Services Department -
17th August 1995 – 13th September 1995

3.1.1. On the 17th August 1995 Mrs. K C telephoned the children and families team in Camden Social Services Department requesting help with the care of A because of her ill health. At this time A was ten days away from his eighth birthday.

3.1.2. On the 13th September 1995 a report on a home visit identified Mrs. K C, who was separated from her husband, as having difficulties with A. She described him as independent and demanding and lacking in understanding of her problems. The record noted that due to Mrs. K C's reported ill health she had no energy to look after A. Mrs. K C requested a residential school place. A also admitted there were problems but the problems he identified are not recorded.

3.1.3. During the interview Mrs. K C mentioned that she had two daughters, one who was aged 25 years and lived in England. The other daughter resided abroad.

Initial Work with Mrs. K C and A -
13th September 1995 to 26th October 1995

3.1.4. Over the following weeks the social worker from the children and families team in Camden Social Services Department visited Mrs. K C and met with her and A. The contemporaneous records indicate that during this period the social worker met with Mrs. K C and A four times together, twice she met Mrs. K C alone and once she spoke to A alone. She also spoke to Mrs. K C over the telephone. She tried to establish an agreement between A and his mother about the supervision of A.

3.1.5. The social worker also gathered information from the headteacher at A's school. The headteacher noted some unsettled behaviour by A and described him as quite needy, but did not think a referral to the social services department was warranted. The staff at the play centre which A attended identified him as being independent but immature, and said that he did not mix well with other children.

3.1.6. On the 5th October 1995 the social worker and Mrs. K C met an education social worker and discussed the possibility of a boarding school place for A. It was established that A did not meet the criteria for residential schooling. Mrs. K C was disappointed because she preferred a residential school to the alternative option of placement in another family's home.

3.1.7. On the 6th October 1995 the social worker discussed with her supervisor the needs of Mrs. K C and A. The supervisor suggested that a planning meeting of the multi-agency network should be held to consider whether it would be appropriate to accommodate A in order 'to ensure that his healthy development, safety and emotional needs are being met'. It is not clear from the file why a planning meeting was not convened, but the social worker contacted Mrs. K C's general practitioner, the school, the play centre and the education social worker. The social worker saw Mrs. K C alone on the 16th October 1995. Mrs. K C pressed the social worker to accommodate A, stating that, in the context of her poor health, she could not cope with him over half-term. On the 23rd October there was a second meeting with the social worker and Mrs. K C, and then with Mrs. K C and A. The social worker noted that when Mrs. K C wavered in her wish for A to be accommodated, the social worker made it clear that she had powers to protect A if she thought his care was not satisfactory. There was discussion about a 'bridging placement', until a long-term placement could be found, but Mrs. K C did not want A to move twice. It was agreed by the social worker and Mrs. K C that A should remain at home until a more long-term arrangement could be made. Meanwhile, Mrs. K C would take full responsibility for the care of A.

3.1.8. There is no indication on the file that at this time consideration was given to placing A in foster care within his family. Mrs. K C said that she did not have contact with her daughters. The social worker looked specifically for a placement where contact between Mrs. K C and A could be regular and easy. This was seen by Mrs. K C, A and the social worker as an essential part of the plan for A's care and subsequent rehabilitation.

<u>A Accommodated in Foster Care - 27th October 1995 to 20th January 1996</u>

3.1.9. On the 27th October, following Mrs. K C's request the previous day for an urgent placement, A was placed with a foster carer. The reason for placement given on the Camden Children and Families Change Report was 'parent's health problems'. The plan was that A should maintain regular contact with his mother while he was in foster care.

3.1.10. A was in the foster home from the 27th October 1995 until the 20th January 1996. During this time the social worker kept in regular touch with Mrs. K C and A and his foster home. In addition, she arranged for A to attend the same school for the sake of continuity, and she kept in touch with the school. There was regular contact between Mrs. K C and A, and he spent Christmas at home. Transport was arranged when necessary to facilitate contact. Mrs. K C received medical treatment. The social worker offered and arranged practical support for Mrs. K C. She was also in touch with Mrs. K C's general practitioner and on the 30th November 1995 she completed a referral form asking for Mrs. K C to be seen by the community mental health team for assessment. On the 5th December 1995 at a statutory review, the foster placement was considered to be successful. A's routine had stabilised. It was agreed that A would probably return home by February 1996.

Post Foster Placement Work – 20th January 1996 to 27th July 1996

3.1.11. The plan had been that A should return home once Mrs. K C's health needs had received attention and he had settled into a routine. However, his return home on the 20th January 1996 was earlier than planned. It followed a misunderstanding between Mrs. K C and the foster father about A's return from a weekend stay with his mother. At the time there was no rehabilitation plan in place. The social worker regretted the ending of the placement, but she decided not to look for an alternative placement. She noted that with 'a plan and support, Mrs. K C and A can make a success of their situation'. The social worker met with Mrs. K C and A on the 23rd January 1996 and tried to help them live more harmoniously together. In her record of this meeting the social worker noted that she was concerned about the amount of independence Mrs. K C gave to A.

3.1.12. After the termination of the foster home placement there were fourteen recorded home visits when the social worker saw A and/or his mother. Sometimes she saw them together, but there were also planned times when she saw them separately. The social worker also maintained contact with Mrs. K C by telephone. In addition, the social worker was in contact with other agencies which were working with A and his mother. She visited and maintained telephone contact with A's school and the play centre. On two occasions she took A to his former foster home. She worked with A and his mother to clarify what expectations they could have of each other, and to establish an agreed routine for A's supervision.

3.1.13. On the 12th February 1996 the social worker received a letter from the doctor Mrs. K C had been seeing. The letter noted that Mrs. K C had experienced

difficulties, including bereavement and illness, but there was no suggestion that Mrs. K C was unable to look after her child. The doctor wrote that he would be referring Mrs. K C to 'her local community team to see if she can be seen by someone, to be able to understand and to look into the practicalities of her situation'. Mrs. K C was offered an appointment but did not attend.

3.1.14. On the 28th March 1996, during one of the social worker's regular sessions with A and his mother, there was discussion about a mark on A's neck. A declined to talk about it. His mother dismissed the mark, but said that she might have caused it. On this occasion the social worker noted that A behaved differently and was particularly difficult to engage. She was concerned about the mark on A's neck and concluded her notes by saying 'I feel very uneasy'.

3.1.15. On the 16th April 1996 the social worker returned specifically to discuss with Mrs. K C the mark on A's neck. The notes of this meeting are only rough jottings and contain no conclusions about the cause of the mark. They indicate that Mrs. K C was defensive and angry. The notes suggest that there was a discussion about the need for Mrs. K C to inform the children and families team in the social services department about any future marks.

3.1.16. On the 2nd April 1996 the social worker noted that Mrs. K C questioned her ability to help the family. On the 5th June 1996 she noted that Mrs. K C expressed the view that the social worker was achieving nothing. Following this, the social worker drew up a new task centred work plan dated the 23rd June 1996. There was a plan to help Mrs. K C and A with an overnight stay in his former foster home while Mrs. K C was in hospital. The social worker also made a referral to a project working with the effects of chronic illness on families.

A Goes Abroad - 27th July 1996

3.1.17. Mrs. K C and A went abroad on the 27th July 1996 and, although Mrs. K C returned to London after three weeks, she left A behind with the intention of his remaining abroad until at least December 1996. When she saw the social worker on the 21st August 1996 she said that she was thinking of moving abroad permanently. On the 18th September 1996 the social worker attended a meeting at the project working with the effects of chronic illness on families. Mrs. K C had been invited but did not attend. The purpose of the meeting was to discuss what help the family needed. It was agreed that Mrs. K C should be offered treatment in her own right. If A returned the unit would consider family sessions.

3.1.18. On the 20th September 1996 the social worker made telephone contact with A and was re-assured that he was happy, living with relations and attending school. A did not know how long he would remain abroad and whether his mother would join him. On the same day the social worker wrote to Mrs. K C to inform her that she had asked the local Director of Social Services to arrange a home visit to A where he was living abroad. Mrs. K C was not happy that the social worker had contacted her family abroad, and on the 24th September 1996 she made it clear that she did not want any further contact with Camden Social Services Department. Her plans for the future were uncertain and she did not know if she would join A abroad.

Closure of the Case – 17th November 1996

3.1.19. The case was closed on the 17th November 1996 and a background report about Mrs. K C and A was sent by the social worker to the relevant Director of Social Services abroad on 20th November 1996. The letter stated 'I have made contact with A and he appears to have adapted to his new life, attends school and is making friends'.

COMMENT

This was a period of structured work with Mrs. K C and her son. There is no record of an initial written assessment but the social worker's contemporaneous notes indicate that she worked in a structured way. Her objective was to help Mrs. K C to understand A's needs, and at the same time she tried to meet some of Mrs. K C's own needs for personal support and respite. It was appropriate to arrange a placement in a foster home where Mrs. K C could maintain contact with A. When the foster placement came to an end without sufficient time to set up a rehabilitation plan the social worker re-established a structure to her work with the family.

The Review Team considers that the work was properly focussed. There is an undercurrent of concern on the file about A's safety and the adequacy of the supervision his mother provided, but the level of concern was not of the degree required to reach the threshold of significant harm. Although other agencies expressed some concerns about A, there was no child protection referral from any of these agencies and no concerns expressed by neighbours. The Review Team considers that the decision to work on Mrs. K C's parenting skills and to encourage A to follow a routine was appropriate.

Mrs. K C was not happy that the children and families team in Camden Social Services Department was in touch with her family abroad. However, the Review

Team considers that this was a responsible action given the social worker's concern about the care and supervision of A. It was appropriate to close the case after contact with the relevant social services department abroad.

This period of work is relevant to later events, as during this time much information was gathered about the family. Also, at the end of this period Mrs. K C had lost trust in Camden Social Services Department and rejected any further help. This distrust was reflected in her later reluctance in 1999 to become involved with the children and families team of the Camden Social Services Department. From 1996 onwards A's mother did not see Camden Social Services Department as a source of advice or support.

3.2. F D's Early Years

3.2.1. F D was born in 1948 in the North East of England. He changed his name to F D by deed poll in December 1998. The information about F D in this report has been gathered both from contemporaneous records and also from an assessment done after F D attacked A.

3.2.2. F D was a late developer at school. His employment record did not match his apparent intellectual ability. He reported that he worked 'in general clerical positions, the longest period of employment being for less than a year'.

F D's Past Psychiatric History – 1971 to 1994

3.2.3. F D first came to the attention of the local psychiatric services in the North East in 1971. The hospital social worker noted that F D's father said his son was quite ill and causing a great deal of disruption at home. There are references to F D's controlling and manipulative behaviour within the family. Over the next 23 years F D had repeated contact with the local psychiatric services. He was admitted to psychiatric care twelve times. One of these admissions was under Section 26 of the Mental Health Act 1959. This section permitted the compulsory detention of a patient for treatment. Other admissions were very short. During intervening periods F D attended the outpatient department, the day hospital and maintained telephone contact with staff. F D had no contact with psychiatric services between 1981 and 1988.

3.2.4. F D was seen by several different psychiatrists in the North East. The diagnosis varied over time. The medical notes include speculation about a form of

schizophrenia, a depressive illness and a personality disorder. There was an indication that anti-psychotic medication reduced his symptoms. He was described as a difficult and manipulative man who behaved eccentrically and was often lonely and isolated. He made a number of suicide attempts and there were references to the risk of self harm. During this period F D had a limited forensic history. There are notes of two acts of violent behaviour, one in 1974 and the second in 1989. In 1974 the police charged F D with molesting his former girlfriend and in 1989 there is a record of F D being violent towards his neighbours. He regularly found fault with others for what were essentially difficulties of his own making. A recurring theme was his belief that others were engaged in a conspiracy against him. In 1992/1993 there was discussion about whether he might move to sheltered accommodation. F D decided not to move, as he feared that the noise of other residents might disturb him. He remained in his own flat. In the medical notes there were no references to specific risk factors and no references to any relationships with children or any interest in children. There were references to his mystic beliefs and his interest in the occult.

F D Moves to London in July 1994 - Contact with the Primary Care Services

3.2.5. In 1993 a psychiatrist noted that F D was thinking of moving from the North East in order to make a fresh start. F D left the North East precipitately in July 1994 and arrived in London unannounced. He registered with a general practitioner (GP) in central London later that month. At this first appointment with the GP in July 1994 he provided a limited account of his earlier treatment and of his inner psychic world. He told the GP that he suffered from schizophrenia and that he was aware of early warning signs when his illness was returning. In August 1994 the GP requested and received information in the form of discharge summaries and recent clinic letters as well as a letter from F D's consultant in the North East about his anti-psychotic medication. The GP received the primary care records from the previous GP with information going back to childhood. At the first meeting in July 1994 the GP in London suggested a referral to the psychiatric service but F D resisted this proposal.

3.2.6. The GP told the Review Team that at the first interview with his new doctor F D spelled out the rules of the relationship. This amounted to an informal contract. A monthly meeting was agreed and F D came fairly reliably. One day there was a disturbance in reception about a mix-up of appointments, but the GP recalled that F D was generally calm and talkative during consultations. He spoke about 'intrusive imagery' but he did not take anti-psychotic medication all the time. He would ask for it when he needed it.

3.2.7. The GP's notes indicate that between 1995 and 1997, F D was embroiled in litigation with his landlord, he had a dispute with a plastic surgeon about expediting the removal of a cyst on the side of his nose and he engaged in a war of words with the Benefits Agency about not being labelled as a severely disabled person because of earlier mental illness. He wanted to drop the stigma of mental illness by de-registering himself. He said he wanted to work.

3.2.8. In January 1997 F D moved to another hostel in a different part of central London, but he stayed registered with the same general practice. In June 1997 a community psychiatric nurse (CPN) telephoned the GP for information about F D and told him he thought that F D was having a relapse. The GP told the Review Team that he thought the CPN was probably attached to the hostel where F D lived. The GP's notes about this contact are brief and the Review Team could not ascertain whether any action resulted from this telephone discussion. In November 1997 the GP referred F D, at his request, to a specialist neuro-linguistic centre, but he attended only once.

3.2.9. In April 1998 the GP noted that F D was surviving satisfactorily in the community without medication and was not experiencing symptoms. However, in September 1998 the GP noted that, when under the stress of attending a training course, F D was experiencing paranoid thoughts. Personal contact between the GP and F D ceased in September 1998. F D received his last prescription for anti-psychotic medication in September 1998. In April 1999 F D asked for a repeat prescription for other medication but he did not see the GP. He slipped away from contact with the GP after this, although he remained registered with the practice. In December 1998 F D changes his name by deed poll. The GP said he assumed that F D had found another GP nearer to where he lived.

COMMENT

During his years in the North East, F D received regular support from the local psychiatric services. Over the years views about his diagnosis changed. The different diagnoses included a psychotic illness, and a type of personality disorder. At no time during this period was there any record of F D presenting as a paedophile, or of posing any risk to children. The lack of a definitive diagnosis is indicative of the complexity of F D's symptoms as well as his ability to present himself in different ways in order to manipulate those assessing him. With the benefit of hindsight it is possible to see that he continued to operate in this way in 1999 and 2000 making it difficult for those with limited time and information to assess his mental health and carry out a risk assessment.

F D's GP in London told the Review Team that he considered F D to be an interesting patient who responded well to treatment and had some insight into his illness, asking for medication when he needed it. On registration he had made an informal contract with his GP to see him regularly although he refused contact with psychiatric services. This arrangement ensured that F D had regular support and medical oversight from his GP. The GP's referral to the specialist neuro-linguistic centre was a positive step towards trying to get more treatment for F D.

This regular medical support stopped when FD's contact with the practice ended. At the time there was no tracking system to alert the practice to F D's non-attendance and no system to alert the GP to the fact that he had ceased to request anti-psychotic medication. However, even some form of tracking system would not ensure the return of a patient who had drifted away, or was difficult to engage. There was no CPN linked to the practice at the time, but if there had been, she or he could have helped to make contact with F D. There is now a CPN linked to this practice. The GP agreed that a tracking system to alert him and his colleagues to changes in patterns of attendance and requests for medication would be beneficial.

Recommendation 2. 4. 4

There were difficulties in relation to F D's follow-up when he moved to new accommodation within London because he went to an area in which a different NHS Trust organised and managed psychiatric services. The Review Team thinks that work should be carried out nationally to consider ways of facilitating easy liaison across the new Primary Care Trust boundaries for the purposes of communication and the tracking of patients.

Recommendation 2. 4. 3.

The Review Team was advised that local arrangements for follow-up and CPN cover vary. CPNs attached to some practices are expected to maintain links and follow up patients from a particular patch. In other services, community based CPN teams maintain links with a number of practices across a geographical area irrespective of an individual's address. Primary Care Trusts are likely to favour different models. The Review Team wishes to emphasize that whichever model is in use, health professionals working with patients who are living out of the practice's immediate area must be clear about working arrangements and their own responsibilities, and must be aware of arrangements for passing information between Trusts when patients move.

Recommendation 2. 4. 5.

F D moves to London 1994 – Contact with the Housing Services

3.2.10. In 1994 when F D first arrived in London he rented a studio flat. He lost this after the landlord decided to renovate the building. Leading up to his eviction he had an eighteen-month dispute with the landlord. He subsequently moved to bed and breakfast accommodation.

3.2.11. On the 14th January 1997 F D moved to a hostel in central London run by a housing association. He remained there for eighteen months until he was evicted on the 19th July 1998. While he was in the hostel he was often dismissive in his attitude towards others, and had particular problems with staff. He displayed offensive material in his room which included advertisements for prostitutes and images of women being physically abused. Sometimes he walked around the hostel dressed in bin liners and when challenged said he suffered from scabies. The housing association made a referral to the local authority joint homelessness team. This is a dedicated health and social services team working with homeless mentally ill people. The team's records indicate that there was no contact with F D because he left the hostel soon afterwards.

3.2.12. Between July 1998 and May 1999 F D lived in bed-sitter accommodation. On the 17th May 1999 he referred himself to an hostel in the London Borough of Camden. He remained at this hostel until the 6th December 1999 when he was evicted, primarily as a result of threatening behaviour towards staff.

3.2.13. The warden who ran the hostel at the time remembers F D as a man who was completely isolated and aloof. He made no relationships either with other residents or with staff. He refused to co-operate with his key worker, who wished to make a mental health referral on his behalf. Entries in the hostel's day-book and the key worker's notes indicate that F D's behaviour could be frightening and intimidating, and the warden described him as someone who needed help with managing feelings of anger.

3.2.14. The warden recalled that the hostel staff were aware that F D was being investigated by the CID for harassing a minor, and he knew that F D had been seen around children in a local park. The staff at the hostel had contact with the CID and the local police sector team. They did not have contact with the Camden Police Child Protection Team because this team was not involved in investigating this case. It is the policy of the Metropolitan Police that allegations and suspicions of child abuse by a stranger are investigated by the CID rather than by the police child protection team and the social services department. There are records of three occasions when

young people visited the hostel asking for F D. The staff assumed that these children were part of F D's extended family. The warden said that children calling at the hostel to see adult relatives are not unusual. The children asked for F D by name which reinforced the assumption of family links. During the evening of the 15th September 1999, when the police called with a search warrant for F D's room, the hostel staff informed them that two boys had visited earlier in the day. There is a file note which indicates that the police thought that one of the boys was probably A, and said that they would visit him. With the benefit of hindsight the warden of the hostel felt that the hostel staff and the police could have worked more closely together and it would have been useful to have had more information about A. The warden of the hostel acknowledged that staff have difficulties in assessing which of their residents might pose a risk to children.

COMMENT

It is likely that if the police child protection team had been leading in this case, because of their multi-agency approach, they would have worked more closely with the staff at the hostel explaining the risk F D might pose to children, and involving hostel staff in multi-disciplinary meetings.

The Review Team thinks that staff working in hostels, where there is a shifting population of adults, should be recognised as important members of the child protection network. Staff live closely with residents and may gather information about people who may pose a risk to children and who avoid contact with other agencies.

Section 2.1 of the Camden ACPC Child Protection Procedures "Inter-agency Response to Suspected or Alleged Child Abuse and Neglect 1998" lists the constituent members of Camden ACPC and spells out for some of them their role in relation to child protection. The Housing Department is a member of the ACPC but there is no section covering the Housing Department's responsibilities with regard to child protection. The Review Team thinks that this omission should be rectified.

Recommendation 2. 5. 10.

The Housing Department staff have access to information about children who may be at risk and they may also become aware of movements by suspected abusers and paedophiles between different areas. The Housing Department should make sure that all their staff are aware of the role of the ACPC, the policies and procedures for

the protection of children, and their responsibility as members of the team and as individuals to protect children.

Recommendation 2. 11. 1.

The Review Team considers that the Housing Department should ensure that its staff, and those working for contracted housing associations which run hostels for adults, should receive awareness training in child abuse and training in the local child protection procedures.

Recommendation 2. 11. 2.

The Review Team considers that staff working in hostels for adults should receive awareness training in child abuse, paedophilia and stalking to enable them to identify adults passing through the hostel who could pose a risk to children.

Recommendation 2. 11. 3.

It is not unusual for children to visit adults in the hostel where F D was living, but there was no policy about the handling of children's visits. The Review Team thinks that all such hostels should have a policy about the handling of children's visits in order to protect both children and staff.

Recommendation 2. 11.4.

4. Period II - May 1999 to May 2000

Concerns about F D May to July 1999

4.1.1. Some time between the 24th and the 31st May 1999 F D discovered Phoenix Gardens, where he met a number of children including A. On the 31st May 1999 a constable and a sergeant from the CID interviewed F D about his presence there. On the 15th June 1999 the police were alerted by complaints from mothers that F D was loitering near the children in the play area of the park. The police records indicate that they suspected paedophilic activity. The police constable from the local sector team who did this investigation noted at the time 'I believe this is a serious problem'. A check of police records revealed that F D had had a previous name. In December 1998 he had changed his name to that of a well-known twentieth century occultist.

4.1.2. About 5th July 1999 A went abroad and the concern subsided, although F D was still seen around the gardens and asked other children about A's whereabouts. On the 15th August 1999, following a complaint by a mother that F D was frightening the local children, a constable from the local sector team (LST) interviewed F D and gave him a warning.

F D presents himself at a Police Station in Central London - 15th September 1999

4.1.3. On the 15th September 1999 F D walked into a police station in central London and made a statement concerning his relationship with a twelve-year-old boy. He was arrested for indecent assault. When interviewed formally later in the day F D replied "no comment" to all questions and retracted his initial claims. While being dealt with by the police, F D stated that he had a history of mental illness. The custody sergeant asked a police liaison community psychiatric nurse (CPN) from the North London Forensic Service. The CPN reported to the Review Team that he was engaged to ascertain F D's acute mental state. He did not write a report but in a summary prepared on the 3rd November 1999 for the court the CPN encapsulated information relating to the interview of the 15th September 1999. At the interview F D disclosed that "he had been treated in the North East approximately twenty years ago for what he described as 'a breakdown' when he attempted to self harm. He stated that this was due to rejection by a woman and that since this time he had avoided any contact with psychiatric services or formal support networks. Since this time he has had neither employment nor any close relationships, and has led a transient lifestyle, moving from hostel to hostel. He states that he has no friends

other than the young boy he has developed a relationship with". The CPN, when interviewed as part of this Review, said that F D was immediately worrying to him, but did not make a child protection referral to the children and families team in Camden Social Services Department or the PCPT. Camden Police Child Protection Team (PCPT). The police officers who conducted this interview did not make a referral to the children and families team or the PCPT at this time.

4.1.4. On the 15th September 1999 the CID visited A's home address, but his mother refused to allow her son to be interviewed and declined to reconsider this decision. A was abroad at this time. Once F D had withdrawn his statement, and because Mrs. K C would not allow the police to interview her son, there was no criminal evidence against F D and the CID marked the case 'No Further Action'.

COMMENT

The note of the interview on the 15th June 1999 is the first occasion when the suspicion of paedophilia is recorded. It is also the time at which the police became aware of F D's change of name and could have considered the possible significance of such a change. In spite of their concerns the police local sector team did not contact the PCPT or the children and families team in Camden Social Services Department to share this information or discuss the vulnerability of specific children.

On the 15th September 1999 F D came to the attention of the police when he walked into a police station and talked about his relationship with a young boy. Walking into a police station voluntarily for this purpose is unusual behaviour. The CID took the matter seriously setting up a formal interview and arranging for a police liaison CPN to attend to assess F D's mental health. The CPN who assessed F D on the 15th September 1999 did not identify any acute mental illness which required hospitalisation but he did have concerns about F D's general demeanour and his relationship with A. The CID acted appropriately when they visited A's mother to gather information and seek her co-operation.

The Review Team considers that, given the possibility of paedophilia noted by the police in June 1999, the content of F D's statement on the 15th September 1999 and the concern noted by the CPN about the relationship between F D and A there were child protection issues that required consideration. It would have been appropriate for the CID to contact the police child protection team or the children and families team in the social services department to discuss these issues, and it would have been appropriate for the police liaison CPN to have contacted the children and families

team or the police child protection team to share his concerns. As a matter of good practice letters of confirmation should have followed such contact.

Police Activity in Camden in October 1999

4.1.5. Even though the case had been marked 'no further action' the CID continued to have their concerns about this case, and on the 4th, the 7th, and the 8th October 1999 the CID tried to contact Mrs. K C and A at home. They were eventually successful on the 12th October 1999, and they arranged to meet with A and his mother the next day. During this interview A stated that there had been physical contact between F D and him. At this interview Mrs. K C agreed that A should be interviewed in accordance with the Memorandum of Good Practice, and the CID explained to Mrs. K C the course of action that would be followed. Following this discussion the CID contacted the PCPT about the need for an interview according to the Memorandum of Good Practice.

Police Referral to the Children and Families Team of Camden Social Services Department 14th October 1999

4.1.6. On the 14th October 1999 the Camden PCPT contacted the children and families team and made a telephone referral about the worrying relationship between F D and A. This involved physical contact such as wrestling and tickling, and there were swimming trips. The social worker who took this call recorded it on the referral form used by the children and families team. The written account of the telephone conversation mentioned that there had been a delay in making this referral because A did not return to London from abroad until the 13th October 1999. It was also noted on the referral form that while A was away, F D rang A's mother continuously enquiring about A, and eventually she had had the telephone number changed to prevent F D telephoning her. The referral form also notes that F D had a history of mental illness.

4.1.7. In response to this referral the senior practitioner in charge of duty that day made an action plan which included arranging a strategy meeting, completing appropriate child protection forms and completing checks with the school, the school nurse, and the general practitioner. She noted on file that the social worker who had taken the referral had informed her that A was no longer in contact with F D.

4.1.8. On the 14th October 1999 the senior practitioner spoke to the PCPT and arranged a strategy meeting for the 21st October 1999. They agreed that the PCPT would invite

the CID to attend and the senior practitioner would contact the CPN who had met F D in a central London police station on the 15th September 1999.

COMMENT

Camden ACPC Child Protection Procedures are entitled 'Inter-Agency Response to Suspected or Alleged Child Abuse or Neglect'. Paragraph 5.4 states 'that when an allegation of abuse is received a strategy meeting must take place as soon as possible'. The senior practitioner followed this guidance and identified the need for a meeting. In accordance with Section 1 of the procedures, which states that 'a multi-disciplinary approach is essential', the senior practitioner endeavoured to contact the relevant agencies.

A Strategy Meeting – 21st October 1999

4.1.9. On the 19th October 1999, when a social worker in the children and families team contacted Mrs. K C and asked for the name and address of A's new school, Mrs. K C refused to give it, saying that A was now fine, but that F D was a 'sick man'. She had decided to take the matter no further. The calling of a strategy meeting does not depend on the co-operation of parents and the senior practitioner decided to hold one on the 21st October 1999.

4.1.10. With regard to the checks made with other agencies, the senior practitioner recorded that A was unknown to the education social work service. It became clear later that A had moved to a school in the independent sector so the education social work service had no record of his placement. F D was unknown to the adult mental health duty team in the social services department. Mrs. K C's general practitioner was not available until later that day. The file does not record any discussion with the GP at a later time. Although the senior practitioner located the police liaison CPN who had seen F D at the police station in central London on the 15th September 1999, it is not clear from the file whether she spoke to him and invited him to the strategy meeting and whether he expressed his concern about F D to her. A member of staff from the Camden PCPT telephoned to say that the team would be not be represented at the strategy meeting, but that the CID would attend.

4.1.11. In the event no strategy meeting took place. It is not clear whether the meeting was 'cancelled' on the day because of non-attendance, or whether it was cancelled in advance because those who needed to be there had sent apologies before 21st October 1999. In the file held in the children and families team the record states 'Strategy meeting did not take place as CID did not show'. During the Review the

senior practitioner who arranged the meeting said that she remembered clearly that this was what happened. The detective constable from the CID who had handled the case until this point could not attend because he was away on police training. On his return he contacted the children and families team and noted on the police file that the social services department had cancelled the strategy meeting 'for operational reasons'. He had asked a colleague to attend in his place. This colleague told the Review that she thought that the CID and the PCPT would both be present because the CID had information about F D and the PCPT had expertise in child protection. She could not remember why she did not go to the meeting. She remembered that she was busy at the time with work on another case. She was not sure whether she was told by the children and families team of Camden Social Services Department or by the Camden PCPT that the meeting had been cancelled, or whether she sent her apologies because she was busy. This police constable was aware of the importance and seriousness of the meeting and said she would have sent apologies in advance if she was unable to attend. No such apologies have been recorded.

COMMENT

The Review Team considers that the senior practitioner acted appropriately in calling a strategy meeting. This would have been an important strategy meeting, and it was detrimental to the handling of the case that a strategy meeting did not take place at this stage.

There was a failure in communication between the children and families team and the police about who would be attending this meeting. The Review Team has not been able to reconcile the different accounts of why the meeting did not take place. There were no procedures in place to establish speedily why this had happened and whether it was necessary to set a new date for the meeting.

The Review Team considers that a procedure is required to ensure that when a strategy meeting does not take place the team manager is informed. The Review Team thinks that the procedure should state that the team manager must agree in writing the future arrangements for another meeting or agree that it is not necessary to hold such a meeting.

Recommendation 2. 5. 12.

The Review Team was informed that the non-attendance of agencies at the strategy meeting was not unique, and there is a more widespread problem of non-attendance at strategy meetings and child protection conferences. The Review Team thinks that

the ACPC should address the failure of agencies to attend these meetings and explore ways of ensuring that attendance is given priority.

Recommendation 2. 5. 13.

The children and families team file has a note dated the 21st October 1999 stating that the PCPT left a telephone message saying that a representative of the team would not be attending the meeting, but the CID would attend. This cancelled the earlier arrangement of the 14th October 1999 between the police and the children and families team that both the PCPT and the CID would attend. The Review Team consider that the first arrangement was appropriate to the needs of the case, and that any change should have been discussed with the senior practitioner who called the meeting. In the event of continuing inter-agency disagreement there should have been a discussion between the senior practitioner's line manager and the line manager in the PCPT.

The purpose and tasks of the strategy meeting are set out in Section 5 of the Camden ACPC Child Protection Procedures 'Inter-Agency Response to Suspected or Alleged Child Abuse or Neglect'. The meeting would have been to share information and 'to decide what kind of investigation or assessment should take place, the role of each agency and the extent of the joint investigation'.

A meeting should have been held to gather the facts and consider the risk posed by F D and the vulnerability of A. Although F D was relatively new to the area he had aroused considerable concern in the police local sector team and the CID and in the police liaison CPN team, but this concern had not been shared with the children and families team. A strategy meeting would have provided an opportunity for sharing and debating these concerns.

Between August 1995 and November 1996 the children and families team of the social services department had invested time and effort in working with A, and information from this period could usefully have been put alongside Mrs. K C's current ambivalence about co-operating with the investigation.

Holding a strategy meeting at an early stage should have clarified the roles of the social workers and the police officers, and the roles of the different branches of the police force. The lack of understanding between the social workers and the police concerning each other's roles became a problem as this case progressed.

If a meeting had been called to examine the available information it is unlikely that A would have been considered at risk of 'significant harm' but it would have

established a multi-agency approach. Agencies which continued to be involved with F D would have been aware of the child protection aspects of the case, and their responsibility to communicate with the child protection agencies about concerns arising from their contact with F D.

Camden ACPC Child Protection Procedures 'Inter-Agency Response to Suspected or Alleged Child Abuse or Neglect'- Paragraph 5.5 states that 'The police and social services department are always represented at a strategy meeting'. The Social Services Child Protection Procedures are worded slightly differently. The section on strategy meetings states 'A strategy meeting must include the police child protection team and the social services department'. On this occasion the PCPT left the meeting to the CID. It is Metropolitan Police policy that the CID handles incidents of extra familial abuse. Police child protection teams have training which gives them knowledge and understanding of child protection issues. Such expertise is not available in the CID. The Review Team believes that the knowledge and understanding of the PCPT would have complemented the information gathered by the CID. The present arrangement, to which the Metropolitan Police adhere closely, means that cases of extra familial abuse are not handled or scrutinised in the in-depth way accorded to intra-familial abuse; signs and indicators of abuse may not always be recognised. The Review Team has been advised that most, if not all, police forces across the country follow a similar policy in relation to extra-familial abuse.

Before 1999 there were no indications that F D might have paedophilic interests. In June 1999 the CID and the police sector team noted on file suspicions of paedophilia but there is no note that these suspicions were tested against agreed indicators of paedophilia. There is practice and clinical evidence to suggest that people with paedophilic tendencies are devious and skilled in the pursuit of children and the Review Team thinks that both the PCPT and the children and families team should have been involved in evaluating the danger F D posed to A. The Review Team considers that the PCPT should always deal with cases when sexual abuse is alleged or is suspected.

Recommendations 2. 4. 2.
and 2.7.2.

The Review Team has noted gaps in the information assembled about A and his family and about F D. Although the children and families team tried to contact Mrs. K C's general practitioner before the meeting planned for 21st October 1999 they failed to make this contact and there is no note of any subsequent effort to telephone

the general practitioner. The general practitioner had known Mrs. K C for some years and would have had useful information to feed into a strategy meeting.

Recommendation 2. 6. 4.

During the course of the Review A's school was visited and the staff made useful observations about A and his family. If it had been possible to contact the school in October 1999 the staff might have provided information to support the calling of a strategy meeting. It is important that schools in the independent sector should be encouraged to see themselves as part of the child care network and should know how and when to contact the statutory agencies.

Recommendations 2. 5. 5. and 2. 6.4.

Similarly, although the senior practitioner managed to locate the CPN who met F D in a central London police station on the 15th September 1999, there is no file note about her conversation with him. In building up information about an allegation or suspicion of child abuse it is important that records should contain information about the contents of any discussions. The CPN told the Review Team that he was immediately worried about the threat F D might pose to others. Because there is no record of the discussion between the CPN and the senior practitioner, the level of concern he conveyed to her is not known. Such information would have been relevant when considering A's safety, and could have been used by the senior practitioner to support a reconvened strategy meeting.

A Reconvened Strategy Meeting

4.1.12. On the 25th October 1999 the senior practitioner contacted the PCPT to make a date to reconvene the strategy meeting. She was told that the CID was handling the case. Police records show that on the 26th October 1999, on his return from training, the detective constable from the CID with primary responsibility for the case contacted the PCPT and the senior practitioner in the children and families team in Camden Social Services Department and asked for an update on the outcome of the meeting planned for the 21st October 1999. He noted on the police file that the senior practitioner told him that the meeting had been cancelled 'for operational reasons'. He also contacted Mrs. K C on the same day and spoke to her at length about pursuing the investigation. She was resistant to it continuing and two days later confirmed her unwillingness to co-operate. As a result the CID discontinued further investigations because of a lack of evidence, and forwarded a concluding CRIMINT

report to the paedophile unit. Police records note that the PCPT and the children and families team were informed of these events on the 28th October 1999.

4.1.13. The senior practitioner in the children and families team recorded that on the 28th October 1999 she explained to the detective constable that the children and families team would have to continue with their enquiries. There is no record of his response or of any discussion with him about the different roles of the children and families team and the CID. The senior practitioner recorded that, during a discussion with the child protection advisor on the 29th October 1999, the advisor confirmed that this line of action was the correct approach. The advisor agreed that there was a continuing need to speak to Mrs. K C and A, and to reconvene a strategy meeting with the PCPT. A re-convened strategy meeting did not take place. The child protection advisor was not aware of this. Her role was advisory and there was no obligation on the senior practitioner to return to the child protection advisor to discuss the case further. From this point the police and the children and families team systems diverged and relevant information was not shared thoroughly.

4.1.14. It has been difficult for the Review Team to ascertain exactly why there was not a reconvened strategy meeting. The detective constable told the Review that he would have gone to a re-convened strategy meeting if invited, but this did not happen and he was unsure of what procedures he should follow. He had had some training in child protection work and knew that procedures existed but was not sure where to find a copy of them. He said that he found the senior practitioner in the children and families team helpful and that she accepted that the CID could take no further action. The senior practitioner's understanding of the situation is slightly different. She remembers that the CID did not want to come to a re-convened strategy meeting because there was no complaint by Mrs. K C to investigate. The senior practitioner told the Review Team that she was not happy with this situation, but she did not know how to resolve the impasse. There is no note on the file to indicate that she discussed this difficulty with the child protection advisor or the duty team manager. They do not remember any discussion with her at this time.

4.1.15. The child protection advisor is not in the children and families team management line. Although she is consulted about individual cases, she is not in a position to direct social workers' actions. With some serious cases she retains an active interest, but she told the Review Team that she was not involved in further discussion about this case. With regard to resolving any difficulty between the CID and the children and families team about the need to reconvene the strategy meeting, she thinks that she should have been involved. Part of her job is to help social workers negotiate

with other agencies on issues of this kind. She told the Review Team that she would have insisted that the PCPT and the CID attended a reconvened strategy meeting. She observed that officers in the CID often have only a limited understanding of the role of the children and families team with regard to child protection cases, and similarly social workers in the children and families team often lack knowledge about the role and work of the CID. She pointed out that the PCPT and the children and families team have long-standing arrangements for co-operation, and an understanding of each other's roles.

COMMENT

It will become clear as this case unfolds that there were times when, because of specific events or the accumulation of information, there should have been multi-agency meetings to asses the level of risk and to discuss the handling of the case. There should have been such a meeting in October 1999.

The Review Team considers that the strategy meeting should have been reconvened. The concerns about A's safety had not been dealt with satisfactorily. The CID were clearly thinking in terms of paedophilia when they made a referral to the paedophile unit.

The child protection advisor gave clear advice that the meeting should be reconvened, that Mrs. K C should be seen and that the PCPT should be present at the reconvened strategy meeting. The Review Team agrees with this advice. The PCPT have the knowledge and expertise that is required on such occasions. The Review Team considers that it would have been good practice for both the PCPT and the CID to attend the reconvened strategy meeting; the PCPT to focus on the protection of the child and the CID to bring knowledge of F D's recent behaviour and the threat he might pose to children.

The detective constable leading the investigation made it clear to the Review Team that he did not have the expertise in child protection needed to handle this case. He had only limited knowledge about child protection procedures and did not know where to find a copy of them. Police officers in the local sector team expressed a similar lack of understanding about child abuse and only a limited knowledge of child protection procedures. It is a matter of concern to the Review Team that police officers did not know where to find a copy of the ACPC Child Protection Procedures. It is possible that there is a similar problem in other agencies, especially in agencies which work primarily with adults. The Review Team thinks that the ACPC should request all agencies which receive copies of the procedures to review

their internal distribution of these procedures and ensure that they are readily available to frontline workers, and that workers are aware of their relevance in cases involving possible risk to a child.

Recommendation 2. 5. 6

The Review Team is concerned that officers in all branches of the police should have a sound knowledge of child protection procedures, and should be aware of the necessity to share information within the child protection network about children who may be at risk. In order to achieve this level of knowledge and understanding in the CID and the police sector teams the Review Team thinks that the Metropolitan Police should provide child protection training for those working in these branches of the police. This should include awareness training about child abuse and neglect, and training about the child protection system and procedures to be followed.

Recommendation 2. 7. 3.

The local PCPTs have a specialist knowledge of child protection and the Review Team thinks that they should take a lead in child protection training both by making other branches of the police aware of training opportunities and also by delivering training for their colleagues.

Recommendation 2. 7. 4

Having failed to set up a reconvened strategy meeting the senior practitioner should have returned to the child protection advisor and should have taken the problem to her line manager for discussion. Because it was not obligatory for the senior practitioner to take the advice of the child protection advisor the impasse about whether another meeting was required, and about who should attend, was not dealt with and the case slipped out of the child protection system. The Review Team believes that more credence should be given to the views of the child protection advisor and that her opinion should only be overruled by written instruction from a more senior manager.

Recommendation 2. 6. 2.

The next section deals with how the children and families team handled the case. It describes the system for case allocation and case closure which was in place within the children and families team, and how it was possible for this case to drift away from being perceived within the child protection framework.

Allocation of the Case in Camden Social Services Department

4.1.16. The principal officer with line management responsibilities for the children and families team to which this case was referred told the Review Team that at the time it was the practice for all child protection cases to be allocated for investigation. The duty team manager, who worked to the principal officer, told the Review Team that all child protection cases were entered into the 'blue book' and were discussed by the duty team manager, the child protection advisor and the senior practitioners who managed the duty workers. The 'blue book' was used to identify child protection referrals, check that they were allocated and then check that they passed through the stages of the child protection system in accordance with specified timescales until they were signed off. It was the responsibility of the senior practitioner organising duty for the week to make entries in the 'blue book'. At this time the child protection advisor did a monthly check to ensure that cases were progressing in keeping with the procedures.

4.1.17. There is no note on A's file of a discussion involving the duty team manager concerning the allocation of this case. It was not noted in the 'blue book'. The child protection advisor told the Review Team that if this case had been entered in the 'blue book' she would have queried why the strategy meeting arranged for the 21st October 1999 did not take place and why it was not reconvened. The duty team manager suggested that the case may not have been added to the 'blue book' because it was a case of extra familial abuse and therefore the standard child protection procedures were not adopted. The child protection advisor told the Review Team that in her opinion the referral should have been entered in the 'blue book' because, although it could be identified as a case of extra-familial abuse and therefore a matter dealt with by the police, there were complicating factors. For example, she felt the family's ability to protect A should have been examined.

4.1.18. The Review Team was told that the 'blue book' system was peculiar to this office, and has since been discontinued in favour of a department wide computer system for logging all referrals and keeping track of their progress.

4.1.19. The Review Team were told that in late 1999 because of pressure of work some low tariff cases, but not child protection cases, were held in 'pending' and these were reviewed each week by the senior practitioner running the duty team for that week. There were two senior practitioners running the duty service at the time. This would normally ensure that all such cases were reviewed over time by both senior practitioners.

4.1.20. The senior practitioner told the review that the file held by the children and families team was designated by her as 'pending' and that she reviewed it every time she was on duty or when demands arose. She recalled that it was handled in pending because it was a low tariff case. She explained her reasons for this categorisation. She explained that the initial referral outlined concerns about the attentions of a male stranger towards an eleven-year-old boy, but the family was not expressing anxiety about A's safety and did not want contact with the social services department or the police. There was no strong message of concern from the police about the ability of the parent to protect A, and other agencies were not expressing worries about A. At the time there were other child protection cases more obviously in need of allocation and investigation. The team was also receiving information about paedophiles in the area, and the senior practitioner said that she considered the case in this context as being of a lower order of concern.

4.1.21. In fact as noted in the previous two sections the case was not immediately held in 'pending'. Initially it had been identified as a child protection referral and a strategy meeting was arranged for the 21st October 1999. When this did not take place it was agreed by the senior practitioner and the child protection advisor that the meeting should be reconvened, but this did not happen.

4.1.22. On the 12th November 1999 the senior practitioner noted on the file a discussion with the PCPT about the fact that the PCPT would be interviewing two boys the following week under the Memorandum of Good Practice. There had been an incident when F D chased the boys down the street. A was not one of these boys. (These interviews took place but there is no indication on police or social services files that they produced any evidence that could be used in a prosecution). After noting this discussion on the file the senior practitioner ended the entry with the words 'Pend until 22nd November 1999'. From this date the case was handled as 'pending' and it was marked up to be brought forward every six to eleven days until Christmas 1999. Over Christmas there was a pending period of thirteen days and a final 'pending' period of thirteen days in January 2000. During these months the senior practitioner and an experienced social work student kept in touch with other agencies and responded to telephone calls. On one occasion the other senior practitioner in the duty team made a note on the file, and gave a directive about the need to seek legal advice before interviewing A under the Memorandum of Good Practice when his mother was not in the county to give her permission for the interview.

4.1.23. The Camden Social Services Department Child Protection Procedures say that 'the duty team manager in the children and families team is responsible for exiting any child protection referral from duty and must record this decision on file'. This case was not fed through the child protection system in accordance with the departmental procedures, although initially there were efforts to make appropriate child protection checks and to convene an initial strategy meeting. When the strategy meeting was not reconvened the case drifted into one of lesser status and the child protection procedures, with their emphasis on multi-agency co-operation, were no longer used. Because there was no entry in the 'blue book' there was no check on the progress of the case as a child protection case, and procedures for maintaining the case in the child protection system or for exiting it were not observed.

4.1.24. The duty team manager told the Review Team that there is a system of professional supervision for social workers in the children and families team. She remembered discussing this case subsequently and she recalled that the senior practitioner was confident that it was progressing well and that the police were handling most of the work. The team manager remembered that during supervision she concentrated on discussing the management responsibilities of the senior practitioner. Managing the duty team was the senior practitioner's primary task and she discussed the management of individual cases with the duty team manager only when the need arose because of current difficulties.

COMMENT

In 1999 there were systems in place which should have ensured that child protection cases were recorded, allocated and investigated. When information about this case was received from the police on the 14th October 1999 it was identified as a child protection case. The systems for record keeping and for allocation of cases were not sufficiently strong to ensure that once the case was identified as a child protection case it was recorded in the 'blue book' and received full discussion within the children and families team and appropriate investigation. When the difficulties about reconvening a strategy meeting were not resolved it was possible for the senior practitioner to move the case into a pending category and handle it outside the child protection system.

The Review Team considers that this case should have been recorded in the 'blue book'. The Review Team believes that if this case had been recorded in the 'blue book' at the time of referral the child protection advisor would have been able to see that it had not been fed through the standard child protection procedures, for example, the strategy meeting which did not take place and was not reconvened.

It has been suggested to the Review Team that this case was not recorded in the 'blue book' because it was seen as extra-familial abuse/paedophilic activity. The Review Team thinks that all child protection referrals to the children and families team, whether they are identified as possible intra-familial or extra-familial abuse, or whether there are suspicions of paedophilic activity, should be recorded as child protection cases at the time of referral. The Review Team thinks that all allegations of sexual abuse against a child or children should be dealt with under the child protection procedures and that the PCPT should conduct the investigation with the social services department.

Recommendations 2. 4. 2. and 2. 7. 2.

Because this was a child protection referral it should have been discussed with the team manager, the child protection advisor and the senior practitioner who managed the duty workers. Maybe, as suggested by the duty team manager, this did not happen because it was a case of extra-familial abuse and it fell through a loophole in the system. The Review Team thinks that given earlier knowledge about the family and doubts about their ability to supervise and protect A this case should have been presented by the senior practitioner for discussion with her colleagues. Such a discussion should have identified areas of current concern and previous concerns about the family. The child protection advisor could have provided expert advice about further exploration of the child protection issues. More information about A and his family might have been collated and the need for closer work with the police, and the involvement of the PCPT would probably have been identified. The Review Team considers that the social services department should review its system for recording referrals and for tracking them through allocation, investigation and further work. The Review Team has been told that a more robust system for tracking child protection referrals is now in place.

Recommendation 2. 6. 1.

It is not possible to know how this case would have progressed if it had been allocated for assessment. The outcome of the assessment might have been closure until subsequent events aroused the concerns of professionals or there might have been some co-ordinated preventative work with the family. It is likely that it would have been easier to achieve a re-convened strategy meeting if there had been an allocated worker for this case.

Time has demonstrated that the senior practitioner needed professional supervision in relation to this case. Social work activity was often reactive to requests by agencies for help rather than being based on a planned approach; indications that a

multi-agency meeting should take place were missed. Challenging and questioning supervision can be particularly beneficial for social workers handling complex cases involving several agencies, and can help case workers question assumptions made by themselves and by other workers in other agencies. The Review Team thinks that a system is required in the children and families team which brings all cases for supervision on a rota basis regardless of whether they are being handled by frontline workers or staff with management responsibilities.

Recommendations 2. 5. 2. and 2.6. 5.

Police and the North London Forensic Service Contacts with F D 3rd November and 10th December 1999

4.1.25. On the 3rd November 1999, F D returned to the police station in central London which he had visited on the 15th September 1999. In the morning he attended to answer his police bail. He was told that there would be no further action concerning the statement he had made at the police station on the 15th September 1999.

4.1.26. In the absence of co-operation by A's mother, senior police officers at the police station visited by F D on the 15th September 1999 decided to follow the route of investigating F D's behaviour in relation to the harassment of mothers caused by him loitering around their children. A police constable from the local sector team re-arrested him during the afternoon of the 3rd November 1999 for harassment.

4.1.27. When he was arrested F D asked if it was because of the note he had left on a roundabout in the park. The police examined this roundabout and found a message from F D to A. The police records note that the message said "I'll always love you A. Please forgive me for everything. I couldn't stand the pain, one day you will know how much you hurt me. How much I need you, I'm sorry goodbye. Welcome back on 2.11.1999. And remember always cheat others before others can cheat you. If they're clever enough, I wasn't and I wouldn't want to be...".

4.1.28. In the morning of the 3rd November 1999 the police liaison CPN who had met F D on the 15th September 1999 met him again by chance outside the police station. There was no formal contact, but the CPN was so concerned about what F D said to him that morning that he passed on this information to the police. This conversation with F D is not recorded specifically in any of the papers submitted to the Review by the forensic service or the police, but the forensic service has confirmed that the report dated 3rd November 1999 encapsulates the information.

4.1.29. In the afternoon of the 3rd November 1999, after F D had been arrested for harassment, the police asked the same CPN to interview F D. In the chronology produced by the North London Forensic Service for this Review there is a note stating that F D refused to see the CPN on the 3rd November 1999. It goes on to say, "alternative appropriate adult arranged through Camden Appropriate Adult Scheme – No formal contact".

4.1.30. In spite of stating that there was "no formal contact" on both occasions, the CPN wrote a contact summary for the attention of the clerk of the court dated 3rd November 1999. He said "I saw this gentleman again today (3/11/99) following his arrest for harassment in a public park, he presents as loud and coherent but has a grandiose and superior demeanour. I am extremely concerned that F D sees himself as a victim, and continues to obsess about the young boy, despite having been arrested following his actions. He refuses to accept that his behaviour is wrong or inappropriate and in fact commented to me that the boy is a coward". F D refused to discuss any further details about his past history, stating merely that "the police don't know the half of it". With regard to F D's mental state the CPN wrote, "F D presents no overt signs of acute mental illness other than some grandiosity and egocentricity. He is extremely resistant to any notion that he requires counselling or treatment for his behaviour". The report concluded with a paragraph expressing the CPN's level of concern about F D. "Due to the serious nature of F D's recent behaviour and the involvement of young children, I believe that he presents a high risk to others until such time as he receives an exhaustive forensic psychiatric assessment. To this end I recommend that he be remanded in custody until Tuesday 9th November when he can be assessed by the court diversion team". F D was not detained in custody and remained in the community. This report was passed to the clerk of the court and the police. It was not copied to any other agency, despite the suggestion that F D could pose a risk to others, including children. The CPN did not make contact with the PCPT or the children and families team in the Camden Social Services Department. When the Review Team met with staff from the forensic service the police liaison CPN team said that they knew of the involvement of the police local sector team in this case and were aware of the police interest in the child protection issues. The police liaison team thought the police would be in contact with the Camden Social Services Department.

4.1.31. On the 10th December 1999 F D went to a police station in west London and "handed himself in". (This incident is dealt with in more detail later). The police asked a police liaison CPN from the North London Forensic Service to see F D. This was a colleague of the CPN who had seen F D in September and November 1999. The

CPN wrote that "F D presented as an articulate and intelligent man, he was of dishevelled appearance, in keeping with his street homeless status over the last five days. F D explained how he had been evicted from his hostel accommodation on Monday, 6th December 1999, following an argument with a worker there, he denied that there was any violence on his part". The report goes on to say that F D "was very adamant that he had no mental health problems and that he is responsible for his actions". The CPN noted his own view that on interview F D "presented with no objective evidence of mental illness, although his demeanour was somewhat grandiose". He noted that F D denied using alcohol or illicit drugs. In conclusion, the CPN agreed with the earlier assessment made by his colleague, the CPN in the police liaison team, and stated his view that "F D's behaviour represents a significant risk to others. In view of F D's disclosure of past psychiatric involvement I feel that he should receive a full forensic psychiatric assessment. To this end I recommend that he be remanded in custody until Tuesday, 14th December 1999 when he can be assessed by the court diversion team". On this occasion F D was remanded in custody. As with the report prepared by the first police liaison CPN on the 3rd November 1999, the second police liaison CPN did not copy the report to the police child protection team or the children and families team in the Camden Social Services Department.

COMMENT

The police pursued the criminal aspects of the case and during their investigations they acquired information which was relevant to the protection of A and this should have been shared with the child protection agencies. For example, the message which F D left on the roundabout was indicative of an inappropriate, and possibly paedophilic, relationship between F D and A.

The police had concerns about the risk that F D posed to others and also about his mental health. They acted appropriately when they asked the police liaison CPN to assess F D's mental state.

On the 3rd November 1999 and the 10th December 1999 the police and the forensic service acquired information about F D which clearly caused them considerable concern. The Review Team thinks they should have passed this on to the PCPT and the children and families team in Camden Social Services Department.

Although the operational policy for the Police Liaison CPN Service sets out the need for CPNs to communicate with other agencies following an assessment it focuses on the needs of the person whom the CPN has assessed. It does not mention child

protection and the need to refer children who may be at risk to the child protection agencies. The Review Team thinks that this policy should be reviewed and the issue of child protection should be addressed in the policy.

Recommendation 2. 8. 2.

The CPN who saw F D on the 15th September 1999 and on the 3rd November 1999 told the Review Team that he was so concerned that he sought supervision about this case. This was an appropriate step to take. However, it did not lead to any formal discussion with, or referral to, the children and families team in the social services department or a referral to the PCPT. The Review Team thinks that a professional supervisor should have helped the CPN to examine the reasons for his concerns about F D. In addition the supervisor should have considered with the CPN his responsibilities towards A as well as F D, and should have encouraged the CPN, as an act of good practice, to contact the child protection agencies.

Recommendation 2. 5. 2.

The North London Forensic Service Police Liaison CPN Team does not have regular clinical meetings where they can discuss specific cases. Given the difficult and complex cases handled by the team the Review Team considers such meetings are essential. Such were the concerns about F D's 'relationship' with a child, and his tendency to withhold information about himself, a discussion should have taken place under the guidance of a consultant forensic psychiatrist.

In their reports the police liaison CPNs made pertinent observations about F D and the threat he might pose if he remained in the community. They dealt with the issue of his mental health, and to some extent the risk he might pose to others in the community, by recommending custody and a full assessment. The police liaison scheme is a court-based service and they rightly conveyed their concerns and recommendations to the police and the clerk of the court in their reports of the 3rd November 1999 and the 10th December 1999. The Review Team thinks that on receipt of the two CPNs' reports the CID should have shared the information with the PCPT and considered with them what action should be taken, for example, a discussion with the social services department and a request for a strategy meeting. However, the Review Team thinks that the police liaison service also had a responsibility to convey their concerns to the children and families team in Camden Social Services Department. The police liaison service was aware of the involvement of the children and families team because they had been consulted when the original strategy meeting was arranged. Given the level of the CPNs' concerns after meeting F D on the 3rd November 1999 and the 10th December 1999 the Review Team thinks that the forensic service should have contacted the children and families team in

Camden Social Services Department to convey the seriousness of their concerns, and they should have confirmed this conversation in writing.

Working Together to Safeguard Children (Published by The Department of Health, The Home Office, The Department of Employment and Education) states in Paragraph 3.39 that "All professionals working in mental health services ...should bear in mind the welfare of children, irrespective of whether they are primarily working with adults or with children and young people". Paragraph 3.41 says "adult mental health services, including forensic services... have a role to play in assessing the risk posed by adult perpetrators...".The Camden ACPC Child Protection Procedures do not mention the forensic service specifically but in section 2.4 of the procedures there is a statement that "All those working in the field of health have a commitment to protect children". The Review Team considers that there is a need for the Barnet, Enfield and Haringey Mental Health NHS Trust which manages the North London Forensic Service, to build closer links with local ACPCs and ensure that staff are aware of the role of ACPCs, the policies and procedures for multi-agency working and the responsibility of all agencies to protect children.

Recommendation 2. 8 .1.

The Review Team thinks that to complement the action of the forensic service Camden ACPC should review its policy and procedures about communication between agencies, and the procedures should make specific reference to communication with the criminal justice system and the forensic service.

Recommendation 2. 5. 1.

The Review Team did not gather detailed information about the multi-agency child protection training available to teams which deliver services to adults. However, practice by those working in these services, including the forensic service, indicates that individuals need training. The Review Team thinks that the Camden ACPC should review the take up of multi-agency training by teams working with adults, and that this review should be complemented by individual agencies auditing who has undertaken training and identifying current needs.

Recommendation 2. 5. 4.

The Review Team considers that a package of training is required to raise the awareness of those working in the forensic service about child abuse and neglect. Such a package should include training about the child protection system and the procedures to be followed when a child may be at risk.

Recommendation 2. 8. 3.

F D visits the Children and Families Team in the Camden Social Services Department 5th November 1999

4.1.32. On the 5th November 1999 F D visited the children and families team at the Camden Social Services Department wishing to talk to someone about A. He spoke to the senior practitioner who was handling this case and a social work student was present. F D said that he wanted to talk to someone about his problems as the victim of A. The senior practitioner noted that F D told her that 'A was manipulative and had led him on'. He said that 'A had taken him for a ride and then dumped him' and he believed that A 'had treated him badly'. In her written observation at the end of the meeting the senior practitioner said that 'F D appeared as having little insight into the concerns that exist with regard to his relationship with A. He was unable to accept that it is not acceptable for a twelve-year-old to have a loving relationship with an adult man'. She explained to him that her priority was A and therefore she could not help him with his problems. She told F D that she would endeavour to find someone with whom he could talk about his problems. On 8th November 1999, the senior practitioner left a message with the adult mental health duty team in the social services department, asking the duty team manager to telephone her. There is no note of a return call. At the time it was standard practice to make referrals to the adult mental health duty team as opposed to the adult mental health sector team.

COMMENT

F D's visit to the Social Services Department on the 5th November 1999 was his only contact with the children and families team. It provided an opportunity for the staff to make some assessment of the risk F D posed to children. A note on the file records F D's attitude towards A and the fact that he saw himself as A's victim. Although there is a note about F D's lack of insight concerning the inappropriateness of his relationship with A, there is no comment on the potential risk his behaviour posed to others. The record of this interview indicates that the senior practitioner missed the opportunity to consider the case more holistically.

The file note states 'that F D was unable to accept that it is unacceptable for a twelve-year-old boy to have a loving relationship with an adult man'. The *ICD-10 Classification of Mental and Behavioural Disorders (Published 1992 by the World Health Organisation)* defines paedophilia [F65.4] as a 'sexual preference for children usually of pre-pubertal or early pubertal age'. At this stage there was no evidence of sexual activity but the new information which F D gave on this occasion

should have alerted the senior practitioner to the need for a more active risk assessment of F D's involvement with A.

On the 29th October 1999 the senior practitioner had agreed with the child protection advisor that a strategy meeting should be reconvened. The information gathered during F D's visit to the children and families team should have raised further concerns about A. The Review Team thinks it would have been appropriate if the senior practitioner had used this information to support a reconvened strategy meeting. She could have invited a representative from the community mental health team and representatives from the PCPT, the CID and the forensic service.

Referral of F D to the Adult Mental Health Duty Team – 24th November 1999

4.1.33. On the 24th November 1999 the social work student in the children and families team wrote to the adult mental health duty team. This letter stated that F D had visited the children and families team on the 5th November 1999. It described his visit to a police station on the 15th September 1999 and referred to his earlier mental health history. It reported that F D felt that he was A's victim and that 'he is confused about this relationship and the controlling influences involved'. The letter concluded by saying that 'Our time was limited with F D and we are exploring the allegations with the young person involved. However, F D did express that he would like to speak to someone. Hence this referral'.

COMMENT

Given the nature of F D's problems and the involvement of a child, a referral to the adult mental health sector team with a request for assessment would have been more appropriate than a referral to the adult mental health duty team. However, the procedure at this time was for all referrals to be made to the adult mental health duty team. If the duty workers decided that assessment and longer-term work was required a referral was made to the adult mental health sector team. The Review Team has been advised that the duty team was staffed mainly by social workers, with some involvement by CPNs, and the focus of the work was on resolving immediate problems, whereas the sector team provided a multi-disciplinary assessment service.

A multi-disciplinary assessment of F D would have assisted the children and families team in considering the risk F D posed towards children, and in particular the risk to A, and the need for a protection plan. In addition, an assessment of F D's needs could have resulted in a package of support being offered to him. This would have provided the opportunity to assess whether he met the criteria for allocation of a care

co-ordinator under the Care Programme Approach. A named care co-ordinator could have taken a more active role in trying to engage him with the mental health service. The Review Team has been advised that the referral system is currently changing, with referrals increasingly being made directly to the adult mental health sector team. The Review Team supports this change and recommends its application throughout the Trust.

Recommendation 2. 10 .3.

Later in the report it becomes clear that for seven weeks from March to May 2000, after his discharge from custody, F D was living on the streets and becoming increasingly vulnerable in terms of his mental health. His request for help in November 1999 could have been an opportunity to provide him with a care programme approach management plan with which he might have been persuaded to engage, and this could have allowed some continuity in his management after his release from custody in March 2000.

Work Undertaken by the Adult Mental Health Duty Team – 25th November 1999 to 29th November 1999

4.1.34. On the 25th November 1999 the adult mental health duty worker contacted the hostel where F D lived. The file note of this discussion states that the hostel told the adult mental health duty worker that they knew of F D's involvement with the police, and that the police had asked the hostel 'to contain' F D. However, F D had not told the hostel staff that he might be charged with harassment of a minor. Hostel staff did not mention a child visiting F D but they did share information about F D's bizarre behaviour and his refusal to engage with the mental health worker at the hostel. The adult mental health duty worker heard that on some occasions F D had become very angry but not violent. The adult mental health duty worker also contacted the children and families team in the social services department and was advised of the involvement of the CID and the North London Forensic Service. The senior practitioner in the children and families team gave him the names of the detective constable and the police liaison CPN to contact.

4.1.35. The adult mental health duty worker telephoned the police liaison CPN who had met F D at a police station in London on the 15th September and the 3rd November 1999. The file note made by the adult mental health duty worker states that the CPN identified F D as 'dangerous' but 'definitely not sectionable'. The CPN told him that F D was on bail and due to return to the same police station on the 3rd December 1999, when he might or might not be charged, depending on the evidence available.

If he was charged and brought before the court, the recommendation made on the 3rd November 1999 for referral to the court diversion scheme could be activated.

4.1.36. On the 25th November 1999 the management plan agreed by the police liaison CPN and the duty mental health social worker was to wait until 3rd December 1999 to see what would happen. Following this discussion the adult mental health duty worker marked the file 'No Further Action'. In fact, there was further action; the adult mental health duty worker telephoned the children and families team about the plan to wait until 3rd December 1999 and they agreed it was appropriate. The duty worker also informed the hostel about the plan.

4.1.37. On the 29th November 1999, when F D visited the children and families team to enquire whether arrangements had been made for him to discuss his problems with someone, he was told that he had been referred to the adult mental health duty team. He telephoned the latter immediately to reject any service they might offer.

COMMENT

The Review Team thinks that there should have been a multi-agency meeting at this time. While waiting for F D to return to the police station to answer his police bail on the 3rd December 1999, the adult mental health duty team should have initiated discussion involving the children and families team, the forensic service, the sector mental health team and the staff of the hostel where F D was living.

The referral from the children and families team had asked primarily for someone to talk to F D about his problems, and the terms of the letter probably defined the approach of the adult duty mental health duty worker. However, the letter also indicated concerns about A and said that allegations were being investigated. Subsequent enquiries by the adult mental health duty worker established that the CPN who had met F D considered him to be a risk to others, and the hostel staff described his behaviour as bizarre and they drew attention to his anger. The adult mental health duty worker could have called a multi-agency meeting or could have asked the children and families team to gather together all the professionals with concerns about the relationship between A and F D. Such a meeting would have provided an opportunity to share information across agencies working with adults and those working with children and to evaluate the potential danger F D might pose to A.

A multi-agency meeting before the 3rd December 1999 could have discussed the possibility of a referral to the sector mental health team for assessment, the need to

allocate the case to a specific worker, and the handling of F D's behaviour in the hostel where he lived. A meeting could have considered the need for further action, with regard to A's need for protection, and in relation to F D's mental health needs if F D was not detained in custody on the 3rd December 1999. In fact he was not detained in custody until the 10th December 1999 and was not assessed by the court diversion scheme until 21st December 1999.

The accumulated information that is now available about F D shows that he was a difficult man to engage in discussion about himself. He often gave partial information or he was evasive. On the 5th November 1999 he asked the children and families team for help. On the 29th November 1999 he returned to see if the help had been arranged. He had not heard from the adult mental health duty team or the children and families team during this time. The Review Team thinks that there was an unacceptable delay of nineteen days before the children and families team sent a written referral to the adult mental health duty team. During this time F D was left without the help he had requested and he continued to have access to A. Subsequent events show that he was still preoccupied with A and followed him to school on at least one occasion. If the children and families team had made a referral to the mental health duty team soon after F D's visit then a multi-agency meeting could have been held sooner. However, it must be questioned whether, if F D had been offered help more quickly, and at the time he was actively seeking it, he would have been willing to accept it.

The Review Team thinks that it was important to encourage F D to engage with the statutory services, particularly the adult mental health service. He had mental health needs that required attention and there were child protection issues that needed discussion. F D was evasive and reluctant to engage with the police and social workers on a number of occasions. The Review Team thinks that the ACPC should consider providing guidance for frontline workers who face such resistance when there are suspicions or allegations of child abuse.

Recommendation 2. 5.14.

The handling of this case demonstrates the need for closer working between the children and families team and the adult mental health team and a clearer understanding of each other's roles and responsibilities. The Review Team thinks that the ACPC should develop closer working links with the Area Mental Health

Committee and agree criteria and procedures for sharing information. To encourage this closer working relationship the Review Team thinks that a senior member of the adult mental health service should be a member of the ACPC.

Recommendations 2. 5. 8. and 2. 5. 9.

In support of closer working between the adult mental health team and the children and families team the Review Team thinks that all professionals in the adult mental health team should be made aware of the ACPC policies and procedures for the protection of children and their responsibilities as members of the team, and as individuals to protect children. In addition they should receive awareness training with regard to child abuse and neglect and training about child protection procedures.

Recommendation 2. 10. 2.

Contact Between the Children and Families Team and A's Family 16th November 1999 and 1st December 1999

4.1.38. On the 16th November 1999 the senior practitioner in the children and families team wrote to Mrs. K C saying that the team had received information from the police about the involvement of A with F D. The letter explained that when 'the social services department receive a referral of this nature we are required to make enquiries into the concerns expressed'. The letter went on to say that a home visit would take place on the 24th November 1999. This letter was sent to the wrong address. Another similar letter was despatched to the correct address on the 24th November 1999 addressed to Mrs. K C's partner Mr. B L. This letter made an appointment for a home visit on the 1st December 1999.

4.1.39. On the 1st December 1999 a social worker and the social work student who had done some work on this case visited A at home. At this time Mr. B L and his mother were caring for A. Mrs. K C was abroad looking after her sister who was sick, but there was contact between her and the family in London. The file records that Mrs. K C had left the United Kingdom two weeks earlier. During this interview A told the social workers that F D had recently followed him to school and he was fearful about what F D might do. The file record does not state whether F D followed A on one or more occasions. He said that he had told the headteacher at the school about being followed. A said that he was willing to talk to the police about F D.

4.1.40. Following this meeting the social work student noted on the file that he telephoned A's school and the police constable in the local sector team who knew the family,

but there was no answer to these calls. There is no record on the files that these calls were repeated or that there was any further contact with the school and the local sector team.

4.1.41. The social work student made a further note to telephone the PCPT with the information that A was willing to undergo an interview under the Memorandum of Good Practice. Finally he noted 'in the interim Mr. B L will escort A to and from school'. Arrangements were made for A to be interviewed under the Memorandum of Good Practice on the 10th December 1999.

COMMENT

It is regrettable that the first letter to Mrs. K C went to the wrong address. This mistake caused a delay in the handling of this case.

The information supplied by A on the 1st December 1999 made it clear that he was frightened because F D had stalked him between home and school on at least one occasion. Good practice dictates that contact should have been made with A's school to share information and discuss A's safety and supervision.

Discussion with the local sector team and the local PCPT was equally necessary to alert both the police in Camden, and the police where the school is situated, that an older man was stalking a child. It would have been appropriate to have a multi-agency meeting, with the involvement of the family, to discuss A's supervision and safety, consider the risk to A and the need for a protection plan.

F D arrested for Damage at A's School 6th December 1999

4.1.42. On the 6th December 1999 F D was arrested for criminal damage to the school attended by A. He had daubed messages over the front gates concerning his relationship with A. He appeared in court the next day and was given a conditional discharge.

4.1.43. On the 6th December 1999 the local police where the school is situated completed Form 78 Notification of Children and Young Person Coming To The Notice of the Police, and sent it to the local PCPT who forwarded a copy to the Camden PCPT. A copy reached the children and families team in Camden Social Services Department on the 9th December 1999. Form 78 is used routinely by the police to inform PCPTs and social services departments when they have contact with children and young persons about whom they have concerns. The form detailed what had happened and

also stated that the 'headmaster is very worried about a pupil by the name of A ...'. The fact that the form arrived was noted by the senior practitioner in the children and families team file, but there is no copy on the file. Details of the Form 78 were obtained by the Review Team from the police.

4.1.44. Following the despatch of the Form 78 police activity continued. On the 7th December 1999 a police constable spoke to Mr. B L, Mrs. K C's partner, about the need to ensure that A was safe travelling to and from school. In the police records there is a note that Mr. B L 'was too busy at work to pick A up'. On the 7th December 1999 a Protective Assessment Tasking Form (PAT) was completed and agreed by a detective inspector. This allowed the police to discreetly follow A from his home address to school and home again. By arrangement with his family police officers escorted A to and from school on the 7th, the 8th, and the 9th of December 1999. On the 9th December 1999 a detective chief inspector from the CID agreed an application for a '999 mobile phone' for A. He could receive calls and make outgoing 999 calls. The senior practitioner in the children and families team told the Review Team that she was unaware of the extent of the police work at this time and did not know about the telephone.

4.1.45. The headteacher at the school has changed since A's death, but it was possible to talk to a teacher who remembered A reasonably well. Early in December 1999 the school had become aware that F D was interested in A. Before the incident on the 6th December 1999 A had expressed his fear of a man following him and there had been graffiti daubed on the back gates of the school. The teacher interviewed during the Review said that he had mentioned to the school psychologist that a referral to the local social services department might be appropriate, but a referral to the police was discussed as an alternative. The teacher said that the school expected that the police would pass information on to the social services department as necessary. The involvement of the police and the passing of information to the children and families team in Camden Social Services Department was precipitated by the incident on the 6th December 1999.

4.1.46. The present headteacher of the school spoke warmly of his relationship with the local social services department and mentioned a couple of cases on which there had been collaboration since his arrival. However, neither of these cases involved child protection issues and the headteacher was unaware of the existence of the child protection procedures. He did not know whether any of his staff had had training in child protection. These issues have been brought to the attention of the relevant ACPC. At the time of the previous headteacher's departure a meeting was due to

take place between him and the representative of the local education department who sits on the ACPC. This was cancelled because of the headteacher's departure. The education department intends to set up another meeting to ensure that the new headteacher is aware of the local child protection procedures and the ACPC's training programme.

COMMENT

The incident at the school offered an opportunity for multi-agency collaboration and the Review Team thinks that there should have been a multi-agency meeting of all agencies with concerns about the relationship between A and F D. The request for such a meeting could have been made by the police because of their continuing concerns, or by the children and families team on receipt of the Form 78. This was the time to involve the PCPT, the CID and the police local sector team, in a multi-agency meeting to pull together their different perspectives on the case. Throughout the handling of this case communication between different branches of the police has been unsystematic. There are indications that this may have been because the case was handled as extra-familial abuse, and as a result the PCPT was not involved at appropriate times when their expertise could have been helpful. The Review Team thinks that the Metropolitan Police should develop procedures to ensure communication and co-operation between PCPTs and other branches of the police about crimes involving children.

Recommendation 2. 7. 1.

A multi-agency meeting involving all those who had knowledge of F D and A would have ensured that the concerns felt by the different branches of the police, and the worry recently expressed by the school, would have been shared with the children and families team in Camden Social Services Department, the adult mental health team, police liaison CPN team and the Camden Housing Department. Such a meeting would have encouraged the involvement of the school with other agencies, and it would have given all the agencies an opportunity to make each other aware of their activities and concerns.

At this time the police were working closely with A and his family. The Review Team has been advised that it is very unusual for the police to give a child a mobile phone for self-protection. Although the telephone was authorised by a senior police officer, the PCPT and the children and families team in Camden were not informed and not consulted about whether this was the most effective way to provide protection for a child. The Review Team considers that both the children and families team and the PCPT should have been involved in this decision and any

plans for the subsequent use of the telephone. The Review Team thinks that rather than giving A a mobile telephone for use in emergencies there should have been a multi-agency assessment of the current risk to A and an exploration of the most appropriate way to provide protection for him. The Review Team thinks that if mobile telephones are to be used in this way there should be a thorough discussion involving the PCPT and the children and families team in the social services department.

Recommendation 2. 7. 5.

From different sources the Review Team has put together information about the adult supervision of A during 1999 and early 2000. It has emerged that from mid-November 1999 until A's death his mother was abroad. During this time A was primarily in the care of her partner, Mr. B L, who worked in a restaurant late into the evenings. Mr. B L's mother who was in London from October 1999 until March 2000 helped to care for A. The police records note that Mr. B L was too busy to escort A to and from school. The journey from A's home to his school necessitated him travelling across central London. This is a considerable distance for a twelve-year-old child to undertake alone. Once it was known that F D was following him the question of A's supervision while travelling to school should have been examined. A multi-agency meeting at this time would have enabled the different professionals to discuss the supervision arrangements and A's needs. They could have developed a co-ordinated plan of support to A's family to help them provide him with care and supervision appropriate to the needs of a child his age.

Due to the family's resistance to being involved with the children and families team they may not have wished to participate in any such meeting or been willing to accept an offer of support, but this should not have prevented a multi-agency meeting taking place.

F D Evicted From His Hostel Accommodation – 6th December 1999'

4.1.47. Also on the 6th December 1999, the same day he was arrested for criminal damage at A's school, F D was evicted from the hostel where he was living. This followed an incident of threatening behaviour towards a member of the staff. The children and families team was informed about F D's eviction by the adult mental health duty team, and they in their turn informed the PCPT who agreed to inform the CID.

COMMENT

This paragraph highlights issues about communication between the police and the children and families team. Although the CID and the police local sector team were doing most of the police work on this case the children and families team continued to relate to the PCPT. After the 25th October 1999 there is no note on the children and families team file of any contact with the CID or the police local sector team. The children and families team had some communication with the PCPT about the interviews conducted according to the Memorandum of Good Practice on the 10th December 1999 and the 4th January 2000. The police CRIMINT reports show that after the 28th October 1999 the CID had no contact with the children and families team. The local sector team was in contact with the children and families team on only one occasion. Both the CRIMINT reports and the children and families team file note that on the 6th January 2000 an officer from the local sector team made arrangements for a meeting with the children and families team and A's family later in the month. In fact, as will be shown later, this meeting did not happen.

The Metropolitan Police put in time and energy over this case, but each branch pursued its prescribed tasks, and the activity was fragmented. It has not been possible to identify a senior police officer who took an overview of the case, questioned the activities of different branches and individuals and took a lead in directing activity. Police officers working on the case said that senior staff were supportive in releasing resources for activities such as surveillance etc., but this assistance related to their immediate needs. When asked about supervision of their activity frontline police officers described reporting on their action to more senior staff who provided 'hands on supervision' and practical advice. The Review Team considers that a case involving staff from three branches of the Metropolitan Police, and a number of other agencies required co-ordination and supervision at a senior level. Individual staff carrying out frontline work would have benefited from questioning supervision to help them focus on their specific task and encourage them to relate to colleagues and other agencies as necessary.

Recommendation 2. 5. 2.

<u>A Interviewed Under the Memorandum of Good Practice</u>
<u>10th December 1999 and 4th January 2000</u>

4.1.48. The first interview of A under the Memorandum of Good Practice took place on the 10th December 1999. A further interview took place on the 4th January 2000. During

the Review the police child protection team made the point that it is very unusual to interview a child twice under the Memorandum of Good Practice, but this was done because of the level of concern about F D. Approval for the second interview was given by a detective chief inspector. Both memorandum interviews were conducted by members of the PCPT with social workers. Because of the short notice for the second interview on 4th January 2000 a social worker from another area team within Camden Social Services Department was used. Only social workers who have undergone special training are allowed to do these interviews. A substantial list of trained social workers is maintained. This ensures that there are sufficient social workers to undertake this task on behalf of the borough. Different teams within the borough can use social workers from this list as required.

4.1.49. Following the interview on the 10th December 1999 the note on the children and families team file states that the interview was completed. There are no details about what information was gathered during the interview and no record of a strategy meeting to de-brief staff and plan the future handling of the case. The management review conducted by the Metropolitan Police notes that A spoke of swimming trips to a pool, play fighting and that A said that F D had licked his ear. The police did not think they had sufficient evidence to sustain a charge of indecency.

4.1.50. After the second interview on the 4th January 2000 the social work student working with the senior practitioner on this case made a note on the file that police officers from the PCPT told him nothing new was learned, and A did not say anything that would advance the case being brought by the CPS against F D. His note on the children and families team file gives details of this conversation and describes A's reports of cinema trips, swimming trips, bouts of wrestling with F D and F D licking A's ear.

4.1.51. Appendix 10 of the Camden ACPC Child Protection Procedures 'Inter-agency Response to Suspected or Alleged Child Abuse and Neglect 1988' deals with the interviews under the Memorandum of Good Practice. Paragraph 1.1 states that 'When the child protection team (both social services department and the police) are alerted to either suspicion or disclosure of child sexual abuse...a strategy meeting should be convened'. There is no statement about who should call this meeting. However, in the main procedures at Section 5.4 it states 'that it is the responsibility of the social services department to convene the strategy meeting'. In the Camden Social Services Department's Child Protection Procedures' there is no section which deals specifically with interviews under the Memorandum of Good Practice, but there is a cross-reference to the main ACPC procedures. However, Section 5.17

states that when' a child discloses abuse, or a high suspicion of sexual abuse and this is accompanied by physically alerting signs indicating the probability of abuse...' the investigating agencies (i.e. the police and social services) will arrange a strategy meeting. Section 5.2.8 which deals with medium/low suspicion of sexual abuse with no disclosure says 'social services will initiate a strategy meeting...the police will participate in this meeting, but will only continue to be involved if there is a decision to undertake a joint enquiry'. There is no indication in the management review conducted by the police for this Part 8 Review, or in the social services department file for A and his family, that strategy meetings took place either before the interview on the 10th December 1999 or before the interview on the 4th January 2000.

4.1.52. In appendix 10 of the Camden ACPC Child Protection Procedures Section 4.3 is headed 'Further Strategy Meeting'. Under this heading it states 'at the conclusion of the joint interview full consultation should take place between the agencies to ensure proper management of the case'. The police management review and the file held by the children and families team in the social services department do not record either a strategy meeting or a 'full consultation'.

COMMENT

The Review Team can find no recorded evidence that strategy meetings took place before the interviews under the Memorandum of Good Practice. On the 1st December 1999 the social workers from the children and families team had visited A and he said that he was willing to be interviewed. The Review Team considers that on this occasion the senior practitioner in the social services department should have called a pre-memorandum strategy meeting to discuss points set out in Sections 1.2 and 1.3 of Appendix 10 in the Camden ACPC Child Protection Procedures.

On the 4th January 2000 there is a note on the file held by the children and families team which states that the PCPT telephoned 'requesting a memo interview today for A'. This was after a second interview had been authorised by a detective chief inspector. Either the police or the social services department could have called a strategy meeting at this point. However, as the police were wanting to interview A again, the Review Team thinks that the member of the PCPT involved in the interview should have taken responsibility for calling a strategy meeting.

The Review Team has been advised that in Camden strategy meetings are sometimes held as strategy discussions. These discussions take place when there is no need for a formal meeting and may take the form of a telephone conversation between the

police and social services. Sometimes further telephone conversations between these agencies and others who know the child also take place. This approach is in keeping with the guidance in central government advice '*Working Together to Safeguard Children' (Published 1999. The Department of Health, The Home Office, The Department of Education and Employment).* The Review Team thinks that even if there were strategy discussions as opposed to strategy meetings these should have been recorded. However, the Review Team thinks that, given the incident at the school on the 6th December 1999 and the concerns about A's supervision, strategy meetings involving other agencies would have been appropriate.

The Review Team thinks that after the interviews there should have been strategy meetings between the police and social services and relevant agencies working with A and F D to discuss the future handling of the case. The ACPC procedures do not state who should call such meetings.

The interviews under the Memorandum of Good Practice did not produce information which could have been used in a prosecution, but they did add to the information that was accumulating about the relationship between F D and A. They did demonstrate that F D was taking an unusual interest in a young boy and could be grooming him for future sexual abuse/paedophile activity. Such information should have been systematically recorded to contribute to the risk assessment.

Recommendation 2. 6. 4.

The Review Team is concerned that the ACPCs procedures are unclear about the strategy meetings associated with interviews done according to the Memorandum of Good Practice, and the Review Team thinks that these procedures should be clarified. They should spell out in more detail the role of the post interview strategy meetings and state which agency has responsibility for calling these meetings.

Recommendation 2. 5. 15.

The Review Team is concerned that those undertaking the interviews under the Memorandum of Good Practice failed to follow the procedures with regard to strategy meetings. The Review Team thinks that the Camden ACPC should introduce a system which monitors interviews and gathers information about these meetings. With the co-operation of the police and social services department the ACPC should develop a management system which ensures that the procedures are followed.

Recommendation 2. 5. 16.

F D Charged and Remanded in Custody – 10th December 1999

4.1.53. On the 10th December 1999 F D went to a police station in west London and 'handed himself in'. He was charged with harassment under Sections 2 and 4 of the Protection from Harassment Act 1997 and with witness interference under Section 51 of the Criminal Justice and Public Order Act 1994, and was remanded in custody. Subsequently, he was in court on the 11th, 17th, and 21st December 1999. On each occasion the case was adjourned and he was remanded in custody. Such was the importance that the local sector team attached to the case that on each occasion a police constable who had knowledge of the case attended the hearing. Following the first two hearings the police informed A and Mr. B L of the outcome of the hearing. On the 20th December 1999 Mr. B L went to collect his son from abroad leaving A in the care of Mr. B L's mother. On the 21st December 1999 A alone received an update on the court proceedings.

4.1.54. On the 11th December 1999 a probation officer attending court sent written information to another social services department in central London stating that F D was in court. The officer believed that this was the relevant social services department. There is no indication on the file held by the children and families team in Camden Social Services Department that this information was forwarded to Camden.

F D Assessed by the Court Diversion Service – 21st December 1999

4.1.55. On the 21st December 1999 the court diversion service assessed F D. He was interviewed by a specialist registrar in forensic psychiatry, a senior house officer, the CPN from the forensic service who had seen F D on the 10th December 1999, and an approved social worker. The specialist registrar and the CPN signed the report prepared by the court diversion scheme. The interview took place in the custody area of the court. The team had access to the reports prepared by each of the police liaison CPNs on the 3rd November 1999 and the 10th December 1999, but information from the Crown Prosecution Service (CPS) was not available. In the absence of this information, the team had no details of the exact nature of the current charge. The Review Team has been advised by the CPS that a list of charges is prepared daily and this information can be obtained on application to the clerk of the court or the ushers.

4.1.56. With regard to the current charge, F D was unwilling to discuss the alleged offences. The report states that he admitted to writing graffiti which he intended to be read by

the victim. The report continues that "he refused to give any details about the contents of the graffiti. He admits to having had a relationship with the alleged victim, which he described as having 'a certain amount of physical contact'. He also said that the relationship was initiated by the alleged victim. F D said of A "he did all the running but I did not resist".

4.1.57. There were difficulties about the lack of information available to the court diversion scheme. F D was evasive and would supply only a certain amount of information. F D declined to give the name of his current GP and so the court diversion team could not contact him. The court diversion team telephoned a hospital that F D said he had attended in the North East of England. F D stated that his treatment had taken place twenty years earlier. The hospital said his file would have been archived. Even without this archiving policy the information about F D would not have been obtained. In the absence of information normally supplied by the CPS, the court diversion team was unaware that F D had changed his name by deed poll in 1998, and had taken on the name of a twentieth century occultist. They made enquiries under the name of F D which limited the information available to them, and because they were unaware of the change they could not consider the significance of F D's choice of name.

4.1.58. The background section of the report described F D as single, unemployed and homeless since the beginning of December and as having no contact with his family. It also noted that he had lived in London for five years, during which time he had not worked, although previously he had held several general clerical positions. At the time, F D had no address in Camden and was thought to be of no fixed abode.

4.1.59. When asked about his relationships the report states "F D described himself as 'one of life's natural introverts'". He said that he "hadn't met people with whom he wanted to be friends". The report also noted that "he denied any previous friendships or prolonged contact with children", saying that his "paedophile history is zero".

4.1.60. With regard to F D's past psychiatric history, the report noted "F D described how he was 'embroiled into the psychiatric industry in the early 1970s'. He said that this had been due to 'family and environmental problems' that he did not wish to discuss. He said that he 'was the path of least resistance' and 'the most vulnerable' in his family. He went to see his GP who admitted him to hospital under a section of the previous Mental Health Act. The admission lasted for a total of 12 weeks. While in hospital, F D said that he was prescribed 'phenothiazines' (anti-psychotic medication). These gave him 'toxic effects', including 'akithisia and dyskinesia'.

F D displayed an in-depth, technical vocabulary and knowledge relating to psychiatric medication and disorder. He said that he had read a letter from his old medical notes, recording a diagnosis of personality disorder". The report noted that "F D said that he had two further admissions to psychiatric hospitals, both at his own request, the most recent being in the late 1980s for two weeks. He has not been treated on any anti-psychotic/anti-depressant medication, since his initial admission".

4.1.61. When discussing his mental state with the court diversion team F D said that his "current lifestyle made him unhappy, but this did not equate to 'clinical depression', he denied any problems with his sleep or appetite and his concentration appeared good". There was no objective evidence of any mood disturbance or psychotic symptoms. The report ends by saying, "F D does not feel that he has a mental illness and denies that he requires any treatment". The opinion and recommendations section of the report concluded,

- "F D is fit to plead and stand trial.
- There are no formal psychiatric recommendations to make to the court.
- From our assessment and the information that was made available to us, it is likely that F D suffers from a personality disorder, of a dissocial and schizoid type. We have been unable to complete a full risk assessment as we do not have sufficient information regarding the current charges and F D was unwilling to discuss them".

4.1.62. The court diversion scheme co-ordinator told the Review Team that the court diversion scheme functions once a week on a Tuesday and there are on average four referrals a week for psychiatric assessment. In all cases the magistrate must agree that a psychiatric report can be prepared. In about 30% of cases the court diversion scheme co-ordinator has a few days warning of a request for a psychiatric assessment, and he may be able to gather information in advance of the court day. He hears about the remaining 70% on the day the court sits and has from 9:30 a.m. to 10:00 a.m. to gather information. Sometimes people referred for a psychiatric assessment may have used multiple names and this adds to the difficulty in gathering information.

4.1.63. There is no recognised procedure for sharing information between agencies, and some professionals will not provide background material on the grounds of confidentiality. There is one remand prison which sends the inmate's medical record (IMR) with prisoners attending court, but this sharing of information does not happen with other remand prisons. Notes from the Crown Prosecution Service are

usually available, but sometimes they arrive late or go to the wrong court by mistake. Staff in the forensic service have no automatic right to see all the CPS papers. They usually receive a case summary, information about the charges and some information about earlier forensic history.

4.1.64. There are practical limitations to the work of the court diversion service. They conduct their assessment at the court rather than in a clinical setting. However, there is a private room for the use of the court diversion service and this is equipped with a telephone and a fax. People can only be interviewed if they are willing to talk to the team, and even then they may be unco-operative during the interview. Solicitors may block the intervention of the team. The assessment report has to be prepared on the day with the information available. Time for collecting information is often short and it may be impossible to acquire relevant background material or information about charges.

4.1.65. In this case no CPS papers were available to the court diversion team. Members of the team interviewed on 30th October 2000 by the Review Team said that this was atypical and that they usually have access to CPS documents. The court has confirmed that there is a standing request to the CPS to make their files available when cases are seen by the court diversion service. The CPS representative interviewed during the Review could not account for the absence of CPS papers when F D was assessed. The court diversion team interviewed during this Review said that they would welcome a closer working relationship with the CPS and a consistent team of prosecutors with whom they could work regularly. The court diversion team can discuss a case informally with the CPS and they find this helpful, especially if they have a good working relationship with the prosecutor. In association with their assessment, they can discuss the question of risk with the CPS. However, they cannot comment on this issue of risk before the defendant is found guilty. It is for the police to raise the issue of risk, and the magistrate has the responsibility to make a decision about it.

4.1.66. The operational policy of the court diversion scheme states 'Copies of the assessment report will be inserted in the inmate's medical record and faxed to involved agencies and the senior medical officer at the remand prison in question'. The policy focuses on the needs of the person being assessed. It does not mention child protection and the need to refer children who may be at risk to the child protection agencies. In keeping with the policy the court diversion team report was sent to the adult community mental health duty team in Camden and was placed in F D's file. There is no copy on A's file held in the children and families team in

Camden Social Services Department, and no record of a copy of the report being received. In the past, copies of assessment reports have not been retained by the approved social workers attached to the court diversion scheme. This service is provided by the social services department in the borough where the court is situated and in recent months a system which requires the approved social worker team to retain the reports has been introduced.

COMMENT

On the 3rd November 1999 the CPN who saw F D said he should receive 'an exhaustive forensic psychiatric assessment' and recommended that he should be remanded in custody until he could be assessed by the court diversion scheme. This was endorsed by his colleague on the 10th December 1999. The Review Team considers that the court diversion scheme is not equipped to do "exhaustive forensic psychiatric assessments". The scheme was set up to advise the court about who should be diverted from custody into health care with a focus on people with overt psychotic illness who may meet criteria for detention under the Mental Health Act 1983. The Review Team noted that on occasions the court diversion service is seen by other agencies as offering an assessment service. It is important that the court diversion service states clearly to other agencies that its role is to divert individuals from custody and into National Health Service provision as necessary.

Recommendation 2. 8. 4.

It is essential that those who administer the scheme should have sufficient warning of an assessment to enable them to gather relevant information to inform the assessment. The Review Team thinks that the court diversion scheme should not be expected to undertake assessments without basic information, for example, details of the charge against the person whom they are assessing and information from the remand prison. Procedures should be agreed with other agencies, such as the CPS, the Prison Medical Service and other parts of the health service, to ensure that they supply all relevant information to the court diversion scheme.

Recommendations 2. 8. 6.
and 2. 4. 8.

Procedures for sharing relevant information with other agencies after assessments have been completed are essential. Such procedures must emphasise the responsibility of all agencies to pass on information to the child protection agencies about children who may be at risk of significant harm. It is especially important that

procedures should be developed for sharing information across the adult/child interface and between court services and other statutory agencies. The Review Team thinks that the North London Forensic Service should review the operational policy used by the court diversion service and it should address the issue of child protection.

Recommendation 2. 8. 2.

The Review Team discussed with a consultant forensic psychiatrist the significance of an older man stalking a child. He drew on his accumulated knowledge and experience, and said that an adult stalking a child is a rare event. The Review Team believes that a consultant led court diversion service would be more effective.

Recommendation 2. 8. 5.

Such a consultant could inform professional group discussion and provide supervision, and encourage members of the court diversion scheme to examine and learn from individual cases. The Review Team considers that regular professional supervision and group discussion within this multi-disciplinary scheme is important and should be available to all professional staff. Such supervision could help frontline workers manage complex cases involving child protection issues.

**Recommendation 2. 8. 7.
and 2.5.2.**

A consultant leading the team could also have an oversight of the working of the scheme and consider with staff ways of improving the service. For example, the team could agree a list of information they require when making an assessment, and they could examine ways of working more closely and effectively with other agencies.

Recommendation 2. 8. 9.

No formal psychiatric recommendations were made to the court. This implied that there were no grounds for invoking the Mental Health Act 1983 in order to transfer F D to hospital. However, given the difficulty in assessing F D, and the limitations of the available information, the Review Team thinks that the court diversion team should have recommended a further assessment while he was in custody. The Review Team would like to see CPNs appointed to work in relevant prisons to provide a continuing service for those assessed by the court diversion service.

Recommendation 2. 8. 8.

The court diversion scheme thought it most likely that F D was suffering from a personality disorder; a similar diagnosis had been made previously. The Department of Health and the Home Office are considering new legislation for the management of high risk patients and those with severe personality disorders. However, although there were concerns about the risks that F D posed to A, he had a limited forensic history and the Review Team does not think that he would have met the criteria set out in the White Paper – *Reforming the Mental Health Act – High Risk Patients*. The first case history in the White Paper describes a woman who has an extensive forensic history, including fire setting, convictions for theft and arson, and assaults on staff during detention. Her most recent offence has resulted in the death of her victim and she is a compulsive self-harmer and emotionally unstable. She is a danger to herself and others and is unwilling to engage in dialogue to get to the root of her personal situation and behaviour. This example describes a woman with a wide range of very serious problems, which are clearly of a different degree to those manifested by F D before his act of violence against A.

Contact by the Children and Families Team with A's family - 5th and 17th January 2000

4.1.67. On the 5th January 2000 the children and families team wrote to Mrs. K C asking her to come to a meeting at the office on 17th January 2000. This request was a follow-up to a visit made by a social worker and a social work student to A's home on the 1st December 1999 when they met Mr. B L, his mother and A. During the December visit Mrs. K C was absent from the discussion because she was abroad. The letter in January said that social workers would like to discuss with Mrs. K C the present situation and see whether the social services department could offer her any support. The children and families team were not aware that she was still abroad in January. Both the police and the children and families team had limited information about A's supervision and care and were not always well informed about who was living with him in England. It is now known that Mrs. K C had been abroad since November 1999.

4.1.68. On the 6th January 2000 a police constable from the local sector team, who had been in touch regularly with Mr. B L and A, was invited to attend the meeting on the 17th January 2000. Between the 6th January 2000 and the proposed meeting of the 17th January 2000 the police interviewed F D and acquired information that should have been fed into the meeting of the 17th January 2000.This is covered in the next section.

4.1.69. On the 17th January 2000 Mrs. K C did not keep the appointment and the social work student made a telephone call from the children and families team to A's home. A said that his mother was abroad and he did not know when she would return. A message was left with A asking Mr. B L to ring the children and families team to arrange a meeting about 'further support'. With the agreement of the senior practitioner the case was placed in 'pending' on 17th January 2000 while awaiting a message from Mr. B L. When he had not contacted the children and families team by the 3rd February 2000, the senior practitioner closed the case and marked it "No further action required. Family will contact if they require support". The police officer who was to have attended the meeting on the 17th January 2000 remembers that he was told by Mr. B L that it had been cancelled by the social services department. There is no record of any subsequent discussion between the police and the children and families team. When the case was closed there was no case summary and no assessment of the current situation.

COMMENT

It is not known whether Mr. B L ever received the message of the 17th January 2000 and the Review Team thinks that such a message should not have been left with a twelve-year-old boy. The Review Team thinks that the initiative should not have been left with the family given Mrs. K C's unwillingness to work with the Camden Social Services Department. From 1996 onwards Mrs. K C did not see the department as a source of support. In October 1999 she did not wish to co-operate with police officers and social workers who contacted her about F D's involvement with A. It was important for A's safety to engage his mother and her partner in dialogue about the risks he might be facing. Working with reluctant and evasive family members when there are child protection concerns is a problem for frontline workers. The Review Team thinks that the ACPC should consider producing guidance for workers facing such resistance.

Recommendation 2. 5. 14.

The closure of the case following no contact with the family was precipitate. Procedures which required a closing summary and assessment of the case, and the involvement of the line manager in the decision about closure, could have halted the closure of this case. The Review Team believes that the social services department should introduce procedures involving the line manager in the closure of cases.

Recommendation 2. 6. 3.

Police Interview F D while in Custody – January 2000

4.1.70. On the 11th January 2000 the CID had seven interview sessions with F D while he was in custody and heard his version of his relationship with A. In these interviews he described how he was lonely and isolated before he met A, and how he attached great significance to this friendship. F D described an intense and distorted relationship in which he gave presents and treats to A expecting friendship in return. Such behaviour is indicative of paedophilic grooming of a child. Over time A rejected these advances and F D began to see himself as the victim and began to feel angry with A. The interviews illustrated F D's lack of understanding of a child's emotional needs, the urgency of his own need for friendship and affection and his growing ambivalence towards A. The CID officers informed the local sector team officers about the contents of these interviews, but this information was not shared with the children and families team or the PCPT and was not discussed with the family.

4.1.71. The warden at the hostel where F D was resident until the 6th December 1999 told the Review Team that some weeks after F D's eviction the police telephoned and asked him if F D had left any papers in his room. F D had told the police he had left behind a piece of paper about his stalking activities with regard to A. In fact, the hostel staff found the paper hidden behind a fire extinguisher outside F D's bedroom. It gave details of times and dates when F D had followed A, when they had met, details of bus routes and details of Mrs. K C's movements and her absences. When it was discovered, the police did not share this information with the children and families team in the social services department, the police child protection team or the family.

COMMENT

The Review Team thinks that there should have been a multi-agency meeting after the CID interviewed FD in custody. Although the information acquired by the CID while interviewing F D in custody did not provide evidence to support the prosecution which the police wished to pursue in order to detain F D in custody. It did provide information about the relationship between F D and A and was indicative of future risk to A if F D was released.

The information that the CID acquired while interviewing F D in custody should have been shared with the PCPT and the children and families team both of which had the knowledge and expertise to interpret what F D said and to identify the risk to A. Either the children and families team or the PCPT should, on receipt of this

information, have asked for a multi-agency meeting to be convened as soon as possible.

The Review Team believes that a multi-agency meeting at this time should have been convened. It could have brought together the children and families team, the different branches of the police, the adult mental health duty team, F D's general practitioner, staff from the forensic service who had worked with F D, staff from the hostel where F D had lived and representatives from A's school. Such a meeting would have brought together professionals who had been pursuing specific tasks in relation to A or F D and had not known all the facts of the case. It would have provided an opportunity to establish the facts and assess the current situation, including the care and protection of A during his mother's absence. The relevant professionals could have made plans for future collaboration between all the agencies involved in different aspects of the case.

F D's Appearances in Court – January to March 2000

4.1.72. F D was in court on the 5th and the 18th January 2000, and the 1st and the 8th February, and the 6th March 2000, and on each occasion he was remanded in custody. On each occasion a police officer from the local sector team who knew the case was in court and the outcome was fed back to Mr. B L and/or A. This frequency of attendance in the court by the police is exceptional. The Review Team was told that it reflected the concern felt by the police about F D, and their wish to ensure that the Crown Prosecution Service understood the serious nature of the case.

F D Released from Custody – 20th March 2000

4.1.73. On the 20th March 2000 the Magistrates Court released F D from custody. It did so because the custody limits for his detention were not extended. The reason why the custody time limit was not extended is dealt with in Paragraph 4.1.77 to 4.1.81 The Court set five bail conditions,

(i) Not to attend the address where A lived

(ii) Not to contact A directly or indirectly

(iii) Not to attend Phoenix Gardens

(iv) Not to attend the school

(v) To attend a specific police station each day between 14:00 and 16:00

When F D was discharged from custody the police officer from the local sector team told Mr. B L and A about the outcome of the court hearing but this information was not passed to the children and families team or the PCPT.

4.1.74. When F D was discharged from custody he had nowhere to live. At the time of his release the court asked that he could be accommodated in a bail hostel. There are five bail hostels in Inner London. Beds are allocated to those who pose the greatest risk and those on orders or those with specific bail conditions. F D did not qualify for a bed using these criteria. The chronology prepared by the Inner London Probation Service noted 'No hostel placements available. At this time, demand exceeding resources'. A probation officer provided him with a list of shelters for the homeless and the address of an advice centre. The Review Team has been unable to ascertain whether he made an application to a shelter. Between 20th March 2000 and 31st March 2000 he called at the probation office on a few occasions to ask about the bail hostel place. The probation service chronology notes that he became increasingly disgruntled as the days passed, as he felt it was his right to be given accommodation.

4.1.75. Subsequently F D made two appearances at the court on the 27th March and 3rd April 2000 in relation to the charges against him.

4.1.76. He was arrested for theft from two supermarkets on the 21st April 2000 and again on the 1st May 2000. On the second occasion he returned to the court in which he had appeared in late 1999 and early 2000. In spite of these contacts, little is known about his whereabouts and his style of life from the 20th March 2000 onwards. From the 20th March 2000 until the date of the attack there was no known contact between F D and A and no recorded sightings by the police of F D. From the information that is now available it seems likely that F D was living an isolated and rough existence, and his mental health was probably deteriorating.

COMMENT

F D's discharge from custody meant that he found himself back on the streets and he was free to search for A. The Review Team thinks that there should have been a multi-agency meeting when F D was discharged from custody. The police could have asked for such a meeting.

The Review Team has been told that such is the pressure of numbers discharged from custody that only those with the most serious problems, and those who are identified as being a serious risk to others, have planned exits including a referral to agencies which can support them. F D was not in this category and in addition his precipitate release pre-empted any plans being made for him. The Review Team thinks that multi-disciplinary triage teams should be established in prisons to screen those committed to custody, and to liaise with the NHS and other agencies concerning support required by individuals.

Recommendation 2. 4. 7.

No plans had been made for his accommodation or for contact with agencies which might have offered him help and support, for example, there was no referral to the adult or forensic mental health service and no contact made with his general practitioner. It is possible that he would have continued to reject assistance from the mental health service, but if it had been possible to find him accommodation, monitoring his mental health would have been more feasible. If he had had somewhere to live he would have been saved from the difficulties of street life and its effect on his mental state. In addition it would have been possible for the police to monitor his movements in relation to A and other children. F D was often resistant to accepting help from public services but, as indicated in the probation service chronology, he would have welcomed an offer of accommodation.

The lack of accommodation in London for people like F D is of serious concern to the Review Team. Living on the streets probably increased F D's vulnerability and the deterioration in his mental health. This deterioration increased the risk he posed to others.

Recommendation 2. 4. 6.

The Crown Prosecution Service and Custody Limits

4.1.77. On the 20th March 2000 F D had to be discharged from custody because the custody limit for the offences with which he had been charged had expired and the court could not grant an extension to the custody time limits. F D had been in custody for 100 days and the custody time limit for the offences with which he had been charged was 70 days. The custody time limit should have run out on the 21st February 2000, but on the 8th February 2000 the Crown Prosecution Service (CPS) had requested and were granted an extension until the 6th March 2000. On the 6th March 2000, when the CPS told the court that they were not ready to proceed, the defence did not object to the adjournment, but the court warned the CPS that they would be in

difficulties if they applied for an extension on the next occasion (20th March 2000) when F D would be in court.

4.1.78. After the hearing on the 6th March 2000 the CPS sent a standard letter dated the 9th March 2000 to the chief clerk at the magistrates court and to the solicitor acting for the defence, giving notice that the Crown would apply on the 20th March 2000 to extend the custody limit. The Review Team has seen copies of these letters. The Review Team has been told by the CPS that this case was reviewed on the 16th March 2000 by a lawyer. In addition, the CPS told the Review Team that the same officer who sent the letters on the 9th March 2000 also endorsed the file for the lawyer dealing with the case on the 20th March 2000 concerning the need to apply for an extension to the custody time limits if the case was not committed. Another endorsement written by a different officer to the lawyer explained that an adjournment would be required on the 20th March 2000.

4.1.79. On the 20th March the CPS were still not ready to proceed. Although they said that there had been some earlier delays in sharing information between themselves, the police and the defence, they reported to the court that they had received all relevant papers from the police on the 15th March 2000. The CPS told the Review Team that they informed the court that the case had not been prepared because of a lack of staff and a very heavy caseload. The Review Team has seen a copy of the court records which refer to the delay caused by the loss of an audiotape. The defence invited the court to discharge F D for lack of prosecution. The court did not grant an extension to the custody time limit. However, the magistrate ruled that it would not be in the interest of justice for the case to be discharged and granted a further adjournment to the 27th March 2000.

4.1.80. The Review Team has received independent legal advice about The Prosecution of Offences Act 1985. Under this legislation a defendant must be released from custody by operation of law unless the prosecution can obtain an extension of the custody time limit (which in this case had been extended on previous occasions) under Section 22(3) of this Act. This section states that the court can grant an extension only if it satisfied

(a) that there is good and sufficient cause for doing so, and
(b) that the prosecution has acted with all due expedition

The Review Team has seen copies of the court records which note that on the 20th March 2000 the CPS advocate stated that the CPS were "in difficulty demonstrating that they had acted with 'due diligence'". The Review Team has received legal advice

that the Divisional Court has explicitly stated that staff shortages and sickness within the prosecuting authority do not excuse a failure to act with 'due diligence and expedition'. The Review Team has been advised that once the CPS acknowledged that they were in difficulty demonstrating that the prosecution had acted with due diligence the magistrate had in law no discretion to extend the custody time limits and therefore had to release F D on bail. The prosecution sought to have conditions attached to F D's bail. The court granted these and the defendant was released. (For conditions see Paragraph 4.1.73).

4.1.81. The Review Team has received further independent legal advice that Section 22(8) of the Prosecution of Offences Act 1985 provides for an appeal by the prosecution to the Crown Court against a refusal by the Magistrates Court to extend the custody time limit. Rules of Court provide that the appeal must be commenced before the custody time limit expires. However, in this case there had been no refusal by the Magistrates Court against which the CPS could appeal. The CPS had lodged with the court the standard form giving notice of an intention to appeal to the court for an extension to the custody time limits, but this form is not in itself an application to appeal. The Review Team has received copies of the contemporaneous court records and there is no note of an appeal being made.

COMMENT

In view of the warning given by the magistrate on the 6th March 2000 and the concerns of the police and other services, including the forensic service, about the danger F D might pose to A and other children, the Review Team thinks that the CPS should have prepared thoroughly for the court hearing on the 20th March 2000. The CPS should have considered the implication of the warning from the magistrate on the 6th March 2000 that the CPS would be in difficulties if they applied for an extension to the custody limits on the 20th March 2000. The discharge of F D from custody was detrimental to him and placed A at risk of F D's renewed attention.

Co-operation between the Police and the Crown Prosecution Service

4.1.82. The Review Team was told by the CPS that on occasions the police and the CPS meet to discuss difficult cases. Although the CPS agreed with the Review Team that this was a sensitive case, there was no formal review to discuss and plan the handling of the case. On 12th January 2000 a police officer from the local sector team, who attended regularly when F D was in court, tried to meet with the CPS to discuss the case. This meeting did not take place because the prosecutor was on sick

leave. An urgent message was left with the CPS requesting contact. The CPS told the Review Team that a lawyer gave informal advice to the police on this case on or about 13th January 2000 and followed it with further advice later. The CPS told the Review Team that on the 18th January 2000 they had a meeting with the defence counsel and the police to discuss the case. The police officer from the local sector team who was working on this case recalled attending court on this date with material for the defence and videotapes for the CPS. He discussed with the prosecutor the charges to be brought against F D. The police drew the Review Team's attention to the difficulty of working with a number of prosecutors on a single case. This happens because prosecutors carry a range of cases and they may be called to deal with different cases in different courts at the same time.

4.1.83. There was no fast tracking system between the CPS and the police to ensure that all information relating to a child about whom the police were concerned, and about an adult who was thought to pose a risk to children, was passed quickly to those who needed to know. Because the police constables from the local sector team were in court on the 20th March 2000, they were able to advise both Mr. B L and A that F D was free. Also, the bail conditions were put on the Police National Computer. The local sector police officers were conscientious in maintaining contact with A and his family, but they did not alert either the children and families team or the PCPT to the changed circumstances. The family did not turn to the children and families team when they heard that F D had been released from prison.

4.1.84. F D was in court on the 27th March 2000, and again on the 3rd April 2000. On the first occasion all bail conditions except (ii) and (iv) (see Paragraph 4.1.73) were dropped, but the police officers who were in regular contact with the family were unaware of this because they were not in court. They told the Review that they heard of these changes only after A's death. The variation in the bail conditions meant that F D was no longer to report every day to a specific police station. The police officers to whom F D reported daily must have been aware of the changes to the bail conditions, but this information was not passed to their colleagues working most closely with the family. On the 3rd April 2000 the CPS dropped all charges against F D, except harassment under Section 2 of the Protection from Harassment Act 1997. The police officers from the local sector team told the Review Team that they were unaware of this change.

COMMENT

The Review Team found that the working relationship between the CPS and the police was poor; regular and good quality communication did not take place.

Different members of the CPS gave the Review Team conflicting messages about the existence of formal arrangements and procedures to ensure good communication. The Review Team found no evidence that procedures for sharing information and joint decision-making had been followed.

The CPS operates in the context of the criminal justice system and has little direct contact with children and families teams in social services departments. Information about sensitive cases, when there are indications that a child could be at risk of harm, is shared between the police and the CPS. The Review Team thinks that the CPS should ensure that all prosecutors are aware of the ACPC and its procedures and of the responsibility of all agencies and individuals for the protection of children.

Recommendation 2. 9. 1.

The Review Team thinks that in order to ensure a satisfactory understanding of the child protection system the CPS should provide training for all prosecutors about the multi-disciplinary child protection system and awareness training about child abuse and neglect.

Recommendation 2. 9. 2.

A fast tracking system and procedures are needed for sharing information as quickly as possible about such sensitive cases, especially when they involve individuals who may be a risk to children or children who may be at risk of harm. These procedures should ensure that agencies with specific responsibilities for child protection, the social services department and the police, are kept informed and involved in the handling of cases which involve possible risk and harm to children.

Recommendation 2. 9. 4.

Criteria and procedures for calling case conferences and case reviews of particularly difficult and sensitive cases involving children are required. These procedures should include directives which make it obligatory to include those with an understanding of child abuse in such discussions, for example, members of the PCPT and the relevant social services department.

Recommendation 2. 9. 3.

The handling of this case was hampered by the change over of prosecutors which was exacerbated by an extended period of sick leave by one prosecutor. Whilst recognising the difficulties of manning a number of courts the Review Team thinks

that the CPS should explore ways of improving the continuity in the handling of individual cases.

Recommendation 2. 9. 5.

The Review Team is aware of the Glidewell Report published in 1998 and the work that is currently being undertaken to ensure close working between the police and the CPS. The Glidewell Report recommended the introduction of criminal justice units (CJU). These are a new type of CPS/police administrative unit that prepares cases for the magistrates' courts. The objective of the CJU is to improve the quality of service, maximise efficiency and eliminate duplication within the prosecution process. The Glidewell Report recommends joint training for prosecutors and police officers. In view of the information gathered during this Review the Review Team endorses the need for this joint training.

Recommendations 2. 9. 6.
and 2. 7. 6.

The Review Team has been told that at present there are no CJUs in London, but there are plans for one to be based at a police station in central London. The Review Team has seen papers that indicate that this project should lead to closer co-operation between the CPS and police officers working in the London Boroughs where this case was handled.

The Review Team wishes to encourage the development of this project as soon as possible in order to improve the working relationship between the police and the CPS for the benefit of the people to whom they deliver services. In addition, the Review Team emphasizes the importance of CJUs establishing good lines of communication with other agencies. This case has demonstrated the need for CJUs to set up good working relationships with other agencies, especially those which have responsibility for the protection of children.

Recommendations 2. 7. 7.
and 2. 9. 7.

Camden Risk Management Panel

4.1.85. On the 5th April 2000 the Camden Risk Management Panel met and it was noted that F D had been discharged from custody. His name had first arisen at the panel on the 26th November 1999, when discussion of his activities was deferred until the next meeting, which took place on 5th January. By this time F D was in prison and discussion was deferred again until his release. On the 5th April 2000 F D's name was raised by the probation service. The police were asked to make enquiries and

the sex offenders officer was asked to find out why F D was granted bail. There was no further discussion about F D at this meeting.

4.1.86. During this Review, the police officer who chairs the panel explained that the primary purpose of the panel is to discuss in a multi-agency forum the management of registered sex offenders living in the community. A secondary purpose is to raise awareness about particular individuals who are thought to pose a risk to others. F D was in this second category. The chairman of the panel said that F D would be given low priority for attention by the panel. He had not committed any violent acts, and harassment is a low tariff offence in the context of crime in Camden. Indefinite monitoring would not be possible with available resources.

4.1.87. Under the Criminal Justice and Court Services Act 2000, which was implemented on the 1st April 2001, multi-agency public protection panels (MAPPP) are being established to replace risk management panels. They will have a wider remit than the risk management panels and a wider multi-agency representation. It is intended that MAPPPs will work with, and be complementary to the child protection system, and will be a forum for the sharing of information about adults who may be a risk to children.

COMMENT

The Review Team welcomes this development and co-operation between the MAPPP and the ACPC. The Review Team wishes to emphasize the importance of all relevant agencies being represented on the MAPPP.

The earlier sections of this report give details of the need for better communication between those providing services for adults and those providing services for children. The Review Team thinks that the ACPC should review its policy and procedures about communication between agencies working with children and those working with adults, including the criminal justice system. The review of procedures could provide an opportunity for the ACPC and the MAPPP to work together to develop complementary procedures.

Recommendation 2. 5. 1.

It is important that staff should understand the reason for procedures and the introduction of new ACPC procedures should be supported by multi-agency training events arranged by the ACPC and attended by representatives of all agencies.

Recommendation 2. 5. 3.

This case has demonstrated the need for professionals in all agencies to have a clear understanding of different forms of child abuse and a common language for discussing their suspicions and concerns. At different times the case has been identified as extra-familial abuse, paedophilia, harassment of a minor and stalking. Sometimes professionals have described their suspicions and concerns in terms of 'risk' without specifying the nature of such risks, or the indicators by which they can be identified. The Review Team thinks that the ACPC and the MAPPP should build up working links and develop a joint risk assessment policy based upon an agreed definitions of behaviour, common use of language, research findings, an understanding of risk factors, clinical knowledge, and what constitutes acceptable and unacceptable risk. The ACPC and MAPPP should agree procedures for sharing information and subsequent action.

Recommendation 2. 5. 7.

The ACPC already has a multi-agency training programme and the Review Team has been told that this does not cover extra-familial abuse and paedophilia. The Review Team thinks that this omission should be rectified and that this is another area in which the ACPC and the MAPPP could work together. The Review Team thinks that that such training should be complemented by training in each agency on the role and responsibilities of individual workers in relation to extra-familial abuse and paedophilia.

Recommendation 2. 5. 11

The Review Team considers that it would be of assistance to both ACPCs and MAPPPs if relevant central government departments would consider issuing guidance about the handling of extra-familial abuse and paedophilia, including advice on criteria and thresholds for intervention and the roles of different agencies.

Recommendation 2. 4. 1.

The Closing Months of A's Life

4.1.88. Between 20th April 2000 and 25th April 2000, A, Mr. B L and his fifteen year-old son were abroad visiting Mrs. K C. Mrs. K C had been abroad since November 1999,

and remained there when A, Mr. B L and his son left. From this time onwards A was in the adult care of Mr. B L, Mr. B L's mother having left the country in March, and Mr. B L's son was his companion.

4.1.89. On the evening of 7th May 2000 F D attacked the two boys when they were out shopping. Both boys were given treatment at the site and A was found to be dead on arrival at hospital.

F D's attack on A – 7th May 2000

4.1.90. F D had probably lived a lonely existence since his discharge from custody on the 20th March 2000. Although little had been seen of him after discharge, there is evidence to suggest that he had been following A and Mr. B L's son earlier in the day on the 7th May 2000. The police recorded that F D told them ' I did not try to kill the older one, he attacked me and I defended myself'. He was also keen to emphasise to the police that this was the first attack he had ever made on anyone. From information that has become available since May 2000 it seems likely that, during his period of isolation, F D had been increasingly preoccupied with A and the child's rejection of him. On the day of the assault he had been following A and had a knife with him. He had not received any anti-psychotic medication since September 1998. It is likely that between March and May 2000, F D's mental health deteriorated and he was psychotic at the time of the attack.