Local Child Safeguarding Practice Review

Case A

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Contents

1. *Introduction* **2**

2. *Context* **4**

3. *Key Circumstances and Background* **6**

4. *Views of the Family* **12**

5. *Findings and Recommendations* **12**

6. *Conclusion* **25**

7. *List of Recommendations* **26**

1. Introduction

1.1 In 2023, Mr A pleaded guilty to over 30 sexual offences involving both children and adults. He was given a custodial sentence, made subject to notification requirements and issued with a court-imposed Sexual Harm Prevention Order. His crimes included sexual assault, engaging in sexual activity in the presence of a child, making indecent photographs of a child, voyeurism, exposure and up-skirting.

1.2 Without question, the nature and scale of Mr A's offences are both shocking and deeply disturbing. However, they weren't his first. In 2014, Mr A was found guilty of possessing indecent images of children and given a suspended sentence. At the time, notification requirements were similarly put into place, alongside a five-year Sexual Offences Prevention Order. Mr A participated in an internet sex offender programme, unpaid work and was monitored by a local Jigsaw team[1] from the Metropolitan Police Service (MPS). For the first three years, Mr A was managed under a '*High Risk'* category, although this was subsequently reduced to '*Medium Risk*'.

1.3 Whilst subject to supervision, Mr A became the father of two children. However, there was no record of him telling either the police or the probation service about their births. Furthermore, despite ongoing monitoring and intelligence suggesting that Mr A had a child, it was not until late 2018 that a referral was eventually made to children's social care. By this time, the eldest child was two and a half years old, and the youngest, five months.

1.4 A statutory social work assessment was appropriately triggered by children's social care, although this resulted in no further action and the case was closed. Supervision of Mr A remained with the police until the ending of his notification requirements in 2021.

1.5 The Local Child Safeguarding Practice Review (the review) into this case was commissioned by the City and Hackney Safeguarding Children Partnership (CHSCP). It was triggered to examine how local agencies managed and mitigated the risks posed by Mr A to his children, other family members and the wider public. Terms of Reference were set for the review, with the methodology requiring the following questions to be addressed.

[1] Jigsaw teams are the MPS police teams responsible for the management of sexual and violent offenders living in the community.

- What was the effectiveness of practice and the sufficiency of the arrangements in place to risk assess and manage Mr A as a 'Registered Sex Offender' (RSO)[2].
- What was the effectiveness of multi-agency practice at the point it was established that Mr A had children, including the sufficiency of risk assessment and what was done to help and protect the children at the time.
- What is the sufficiency of the arrangements in place to engage relevant agencies and share information about known child sex offenders, and how do these arrangements either help or hinder the mitigation of risk.
- To what extent do practitioners across all agencies understand the potential risks posed by viewers of child sex abuse material and what is the effectiveness of the collective response to safeguarding children.

1.6 The review was undertaken by the CHSCP's Independent Safeguarding Children Commissioner (Jim Gamble QPM) and its Senior Professional Advisor (Rory McCallum). It makes five findings and five recommendations for improving practice.

1.7 In addition to applying their own professional judgement based on their respective backgrounds and substantial experience, the authors also consulted with Dr Michael Bourke, Ph.D., PLLC to further test their conclusions. Dr Bourke is the former Chief Psychologist of the United States Marshals Service (USMS). In 2008, he joined the USMS to create its Behavioural Analysis Unit, which he headed until 2021. During his career, he has interviewed or evaluated more than 1,000 sex offenders.

1.8 Also of relevance, in December 2023, the Child Safeguarding Practice Review Panel began a national review to examine child sexual abuse within the family environment[3]. Focusing on two key strands, this review will examine the early identification of risks, risk assessment and strategies to mitigate those risks. It will also look at the response to allegations or suspicions of child sexual abuse within the family. Findings from the national review will feed into any local learning captured by this review and as appropriate, will be promoted across the geographic footprint of the CHSCP.

[2] Terminology such as 'registered sex offender' or the 'sex offender register' is often used in place of the notification process for sex offenders. However, there is no centrally held register of all sex offenders in England and Wales.
[3] https://www.gov.uk/government/publications/national-review-into-child-sexual-abuse-within-the-family-environment-terms-of-reference

2. Context

2.1 The legislative, policy and practice frameworks covering the registration and management of sex offenders are complex and nuanced features of the child safeguarding system. They have attracted much debate about their sufficiency due to increasing demand, the changing profile of offending (such as that seen through online-facilitated child sexual abuse), and workforce pressures that have impacted frontline public services over the last decade and more.

2.2 For the purposes of this review, there are several key documents that help place the intervention with Mr A in context. These include, but are not limited to the following:

- Multi-Agency Public Protection Arrangements guidance. Issued in 2014 and last updated in February 2024, this guidance sets out a range of processes in place to assess and manage the risks posed by sexual and violent offenders[4].
- House of Commons Library: Registration and management of sex offenders, Jacqueline Beard, January 2023[5]. This briefing provides a good overview of the various measures in place that enable the police to monitor and manage sex offenders living in the community.
- Authorised Professional Practice on the management of sexual offenders and violent offenders issued by the College of Policing[6].
- Guidance on the risk management of known offenders issued by the London Safeguarding Children Partnership[7].

2.3 More specifically, the following narrative summarises the key arrangements and conditions that were in place for Mr A following his 2014 conviction.

Multi-Agency Protection Panel Arrangements

2.4 Multi-Agency Public Protection Arrangements (MAPPA) are one of the primary mechanisms for managing violent and sexual offenders living in the community. Introduced over 20 years ago in England and Wales, MAPPA provides the primary framework through which the police, probation and prison services can work together with other agencies to manage risk. Through the MAPPA process, eligible offenders are

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[4] Multi-agency public protection arrangements (MAPPA): Guidance, 2014 updated February 2024
[5] House of Commons Library: Registration and management of sex offenders, Jacqueline Beard, January 2023.
[6] Managing sexual offenders and violent offenders, College of Policing
[7] Risk Management of Known Offenders, London CP Procedures, London Safeguarding Children Partnership.

identified, and information is gathered and shared about them across relevant agencies. MAPPA assesses the extent to which offenders pose a risk of serious harm and implements risk management plans to protect the public. It does this through considering four categories of offenders and three levels of management that define how and when resources should be targeted. The four categories of offender are:

- **Category 1 –** 'Registered Sex Offender' - subject to sexual offender notification requirements.
- **Category 2 -** Violent offender or other sexual offender.
- **Category 3 -** Other dangerous offender.
- **Category 4 –** Terrorist or terrorist risk offender.

2.5 The three levels of management are:

- **Level 1** – Multi-Agency Support
- **Level 2** – Multi-Agency Management
- **Level 3** – Enhanced Multi-Agency Management

2.6 Mr A fell under Category 1 and as with most offenders in this cohort, he was supervised by the police at MAPPA Level 1. This involved officers from Jigsaw undertaking tasks such as home visits and interviews with Mr A to check on his circumstances, updating Mr A's risk assessment using the Active Risk Management System (ARMS)[8] and recording details on the Violent and Sex Offender Register (ViSOR)[9]. As defined on page 42 of the MAPPA guidance, Level 1 management covers the following circumstances:

'…*where the risks posed by the offender can be managed by the lead agency in co-operation with other agencies but without the need for formal multi agency meetings…Offenders will only be managed at Level 1 where the lead agency is confident that their Risk Management Plan (RMP) is sufficiently robust to manage the identified risks, the circumstances of the case do not require the formal multi agency oversight offered by level 2 or 3 meetings and there are no barriers to the implementation of agreed multi-agency actions.'*

[8] The ARMS assessment is a structured, evidence-based tool with five stages: gathering and evaluating information about the offender over the last three months; scoring the presence of risk and protective factors; identifying priorities for action; designing action; and reviewing any changes following action.

[9] ViSOR is a database of records of those subject to notification requirements, those jailed for more than 12 months for violent offences, and those thought to be at risk of offending. It can be accessed and updated by the three Responsible Authority agencies for MAPPA – the police, prison service and probation.

Notification Requirements

2.7 Mr A's 2014 conviction was for an offence listed in Schedule 3 of the Sexual Offence Act 2003. As a 'relevant offender' under the Act, this made him automatically subject to notification requirements. Practically, this meant he was required to tell the police his name, address and certain other personal details. He needed to confirm these within each 12-month period thereafter and advise the police of any subsequent changes to the information provided in his initial notification. Mr A's notification requirements were in place from the point of his conviction until 2021.

Sexual Harm Prevention Orders

2.8 Sexual Harm Prevention Orders (SHPOs) can either be imposed by the court at the time of a conviction or at a later date (through an application from defined statutory agencies such as the police, National Crime Agency or Ministry of Defence). They are issued to prohibit offenders from engaging in particular activity and/or to require them to do certain things. SHPOs are made when an offender presents a risk of sexual harm to the public (or individual members of the public) and an order is necessary to protect against this risk.

2.9 Between 2014 and 2019, Mr A was made the subject of a Sexual Offences Prevention Order (SOPO). Whilst SOPOs have since been replaced by SHPOs, they had the same purpose overall. The SOPO for Mr A mandated the following conditions.

- *Not to undertake any work whether paid or voluntary, which by its nature is likely to bring you (Mr A) into close, regular unsupervised contact with a young person under the age of 16 years.*
- *Not to have any unsupervised contact with any child under 16 years.*

3. Key Circumstances and Background

3.1 Following Mr A's conviction for possessing indecent images of children in 2014, he lived with his parents in another local authority area. Responsibility for overseeing his notification requirements fell to the local MPS Jigsaw team (Jigsaw 1) and there was early involvement by probation.

3.2 In February 2015, after disclosing to his probation officer that he was in a relationship, he was advised to tell his partner about his conviction. Requests for further information about

Mr A's circumstances were sent by probation to the police, but no responses were received and there was no follow up. It remained unknown whether Mr A had acted upon probation's advice.

3.3 A few months later, Mr A told his probation officer that the relationship with his partner had ended. Probation identified the need to contact the police for further information, although once again, this was not pursued. With the completion of Mr A's unpaid work and the sex offender programme, probation's involvement ended in December 2015.

3.4 In May 2016, Mr A's first child was born (Child S). Child S was cared for on the Neonatal Intensive Care Unit (NICU) until being discharged the following month. At the time, health practitioners (including the family's GP) were unaware of Mr A's offending history. He visited the hospital regularly and accessed NICU and maternity services unrestricted.

3.5 In October 2016, as part of an ARMS assessment, Mr A advised Jigsaw 1 that he was having contact with his cousin's three children. This family lived in another part of London although Mr A claimed he did not know their address. Whilst Jigsaw 1 made a record on ViSOR and created a MERLIN[10], it wasn't until February 2017 that the address was confirmed. At this point, the MERLIN was passed to the police in the local area, however, this information wasn't shared with children's social care.

3.6 During the same month, Jigsaw 1 also recorded that Mr A was in a relationship with a new partner (Ms R). At this time, Ms R was living in Hackney. It was recorded she was unaware of Mr A's conviction and whilst Jigsaw 1 identified this should be disclosed, no action was taken to facilitate this or to ensure it happened.

3.7 In November 2016, the UK Border Force informed Jigsaw 1 that Mr A had travelled abroad on a new passport. Neither the journey nor the obtaining of a new passport had been confirmed with the police beforehand. As a result, Mr A was in breach of his notification requirements. He was charged and subsequently sentenced to a 12-month community order to complete unpaid work, pay costs and a victim surcharge. Once again, probation services became involved, and checks were initiated with both the police and children's social care. Probation records indicate there was no response or follow up with the police.

[10] The 'Merlin' IT application has recently been replaced with a new system in the MPS. It was used to record the details of those vulnerable people aged 17 and under via a Pre-Assessment Check (PAC) and for details of vulnerable adults aged 18 or over via an Adult Come to Notice (ACN). MERLIN was also used for the recording and investigation of Sudden Deaths, Unidentified Persons/bodies and other found persons. Reports were recorded on Merlin to enable safeguarding teams to assess any risks or harm to individual children based on the report and any further relevant information. These reports were often shared with partner agencies to ensure a multi-agency approach could be taken to safeguarding.

Checks with the local Multi-Agency Safeguarding Hub (MASH) identified '*no safeguarding concerns*'.

3.8 In October 2017, during a home visit completed by Jigsaw 1, Mr A confirmed that he was staying at Ms R's address three times a week. There was no action taken to explore this further.

3.9 In March 2018, during a home visit by Jigsaw 1, family members commented that Mr A had '*dropped his daughter off the night before and left'*. A ViSOR entry was created that included these details, although no further enquiries were made. Mr A wasn't interviewed, no consideration was given to whether he was in breach of the SOPO, and no MERLIN was created to engage children's social care.

3.10 In July 2018, Mr A's second child was born (Child T). Like their sibling, Child T was also admitted to NICU and as before, health practitioners remained unaware of Mr A's status. During follow up visits by midwives, Mr A was seen at Ms R's address on at least two occasions with the children.

3.11 In August 2018, children's social care received a referral from a local children's centre reporting that Mr A had '*slapped*' Child S. No checks were made with other agencies and no further action was taken by children's social care who were satisfied that the practitioner who saw the incident had addressed it with the parents.

3.12 In October 2018, Mr A confirmed with Jigsaw 1 that he was spending most of his time at Ms R's address in Hackney. He was advised to register this as his home address and to attend the police station to make this amendment. Whilst recorded on ViSOR (as an 'additional address'), Mr A did not confirm this as his substantive residence for another two years. Over this period, there was no visit to the property by the police to assess its suitability and confirm who was living there. The same month, Child S started at a nursery, attending for three days per week. The nursery had no knowledge about Mr A and his conviction for possessing indecent images of children.

3.13 In November 2018, Mr A failed to attend the police station and complete his annual notification. He claimed that he wasn't aware of the appointment, although agreed to a voluntary interview at which an ARMS assessment was completed. He was subsequently charged and found guilty of failing to comply with his notification requirements. He was fined and ordered to pay costs and a victim surcharge.

3.14 Later that month, Ms R was contacted directly by Jigsaw 1 to confirm what Mr A had told her about his offending. Ms R stated that Mr A had said he was on the sex offender's register and that he would be for five years. Significantly, he had not told her why. At this meeting, Ms R disclosed that she had two children with Mr A.

3.15 Mr A was subsequently contacted by Jigsaw 1 and admitted that he was the father of the children. He was reported as being upset about the police finding out and that he was concerned he would get into trouble. Mr A was advised a MERLIN report would be created and this would be shared with children's social care. He was also told that as a '*formal disclosure*' had yet to be authorised, he had 24 hours in which to tell Ms R the details about his conviction.

3.16 During a later interview with Mr A, he confirmed to Jigsaw 1 that he had made a full disclosure to Ms R. He also confirmed he had been staying at Ms R's address for two to three nights each week. Mr A initially reiterated a position that he was too scared to say anything to the police, although contradicting himself, he also said he didn't think this was necessary. This was because he believed Jigsaw 1 already knew about the children (following a family member telling them in March 2018). He also said he had told them about his eldest child during an ARMS assessment in 2016. Despite these events suggesting a breach of notification requirements, there were no sanctions and the risk level recorded for Mr A remained at '*Medium*'.

3.17 On receipt of the MERLIN, children's social care triggered a statutory social work assessment and whilst contact was made with a range of agencies, most had no knowledge about Mr A's offending history. This included the GP, other health practitioners and the local Children's Centre.

3.18 With regards to the assessment itself, this was led by a qualified social worker. However, professionals who held specialist knowledge about child sexual abuse and child sex offenders were neither consulted nor engaged. There was no direct work with the children by children's social care and no activity was undertaken with Ms R about safety planning and how to mitigate risk (although the Health Visitor had shown initiative and initiated this themselves – talking with Ms R about strategies to reduce risk and sharing the NSPCC's *'Talk Pants'* video[11] with Ms R).

3.19 The assessment recorded that Mr A had '*strategies*' should he become concerned about his behaviour, but no further information was recorded as to what these were and what

[11] Talk Pants - NSPCC

'behavioural concerns' he would be looking to identify. Ms R was noted as being in shock and upset that Mr A had not told her about his offending. However, she also believed he had changed. She trusted him and had no concerns about him being with the children.

3.20 In January 2019, children's social care closed the case. Whilst a closure summary was sent to some agencies, not all received this. Details about the restrictions in place for Mr A (such as the SOPO conditions) weren't included. The letter stated:

'Jigsaw made the referral as a matter of course, but they have not raised any concern in regard to Mr A and are not concerned for his family. The parents engaged well with our assessment and have been open and honest with each other and appropriate family members. During the assessment no parenting or safeguarding concerns have been raised, or any on-going work have been identified'.

3.21 Whilst providing a degree of reassurance to partners, there remained ambiguity. For example, around this time, Ms R told the Health Visitor that Mr A's convictions were because he had purchased a second-hand computer with images already on it. This was untrue.

3.22 Furthermore, remaining uncertain about Mr A's status and what this meant for their setting, the nursery manager made direct contact with Jigsaw 1 to find out more. On being advised of the SOPO conditions, the manager wrote to both parents to place restrictions on Mr A accessing the site. Later that year, Mr A was observed dropping off and collecting his children unaccompanied. The manager spoke to Mr A, reminding him of the nursery's expectations. Mr A did not attend at any point afterwards. Child T started at this setting in September 2019.

3.23 In November 2019, Mr A gained employment in a local supermarket. This could have been in breach of the SOPO as the role may have brought him into close, regular and unsupervised contact with children under the age of 16. However, there was no risk assessment undertaken by Jigsaw 1 or any action taken in this regard. ViSOR records also showed two previous periods of similar employment in 2016 and 2017. Again, there was no evidence of any action being taken. In December 2019, Mr A's SOPO expired.

3.24 In early 2020, Child S was referred to Community Paediatrics and was later referred for an autism assessment. However, given no information about the family's situation was shared, Child S remained on the waiting list. Ordinarily, children who have been involved

with children's social care would have information proactively shared to facilitate a rapid assessment. It remains unclear why this did not happen.

3.25 In March 2020, Mr A was visited by Jigsaw 1. He confirmed he was still working and that whilst he was staying with Ms R three days a week, he stated that he had not moved in. Around this time, Ms R saw her GP. She reported feeling depressed, triggered by a breakdown of her relationship with Mr A. Significantly, when talking about his offences, Ms R recounted the story of Mr A buying a laptop which contained the indecent material.

3.26 The same month, the country went into lockdown and Covid-19 restrictions were implemented. Both children were offered places at the children's centre, although the family turned this down. Despite contact being maintained by the centre and further offers to attend, the children did not return.

3.27 In September 2020, Child S began primary school, with their younger sibling starting at the school's nursery. Mr A was observed to drop the children off at school and collect them, as well as attend events arranged by the school, such as parents' evenings. However, no information had been shared with the school about Mr A's offending by either the children's centre or via any other source. Whilst the children's centre had procedures in place and a clear understanding about the need for this to happen, the challenges created by Covid-19 meant this was missed.

3.28 In November 2020, Ms R was pregnant and booked for maternity care at a different hospital to that used for her other children. At the initial appointment, Ms R explained that she was separating from her partner. She did not explain why, and it was recorded that Mr A was providing care for the two other children. The hospital recorded that Ms R spoke about children's social care contacting her due to Mr A '*possibly being on the sex offenders register*'. She once again explained this by way of Mr A purchasing a second-hand laptop. She further explained that Mr A was arrested, and the charges were dropped – with him being removed from the register once his purchase of the laptop had been proven. Again, this was untrue.

3.29 Despite policy, the family GP wasn't contacted by hospital staff to establish further details about the family and to enquire about any possible safeguarding concerns. Furthermore, no information was shared by the hospital where Child S and Child T had been born. This meant that no practitioners in this new setting had any oversight on Mr A's history of sexual offending and the family context (beyond what they were told by Ms R). As before, Mr A was allowed on the postnatal ward without restrictions.

3.30 Also in November 2020, Mr A confirmed his change of address as being in Hackney. Responsibility for his monitoring was transferred to the local Jigsaw team (Jigsaw 2).

3.31 Mr A's third child was born in June 2021.

3.32 In July 2022, Mr A was arrested for further sexual offences. The multi-agency practice that followed was child-focused, authoritative and effective in securing both the protection of the children and prosecution of Mr A.

4. Views of the Family

4.1 As part of the review, Ms R was invited to participate and provide her reflections of the multi-agency practice involving her family. Whilst this was declined, agency records seen by the review provide a level of insight into her perceptions at the time.

5. Findings and Recommendations

5.1 For individuals known to have committed child sex offences, they will always present a risk to children. What this looks like will vary from offender to offender and can change over time, but there will never be no risk at all. As highlighted by Lussier et al. 2023[12], *'One underlying assumption about risk is that there is always some risk of sexual reoffending – the risk cannot be null given that offenders have committed at least one sexual offense in the past and past behaviors are the best predictor of future behaviors. While criminal justice policymakers sometimes suggest that ensuring the absence of risk is one of their goals when dealing with convicted offenders, such an objective is simply unrealistic given that the risk is not null for the general population (e.g., Malamuth, 1981[13]; Marshall, 1997[14])'.*

5.2 Accepting this fact must be the starting point for everyone working with children, their families and offenders themselves. It reflects an unambiguous safeguarding first approach and there should be no practice within our system that dilutes this position. Time served in prison, sex offender courses, dynamic assessment and monitoring all have the potential to reduce an individual's relapse into criminal behaviour. However,

[12] Lussier, P., Chouinard Thivierge, S., Fréchette, J., & Proulx, J. (2023). Sex Offender Recidivism: Some Lessons Learned From Over 70 Years of Research. Criminal Justice Review.
[13] Malamuth N. M. (1981). Rape proclivity among males. Journal of Social Issues, 37(4), 138–157.
[14] Marshall P. (1997). *The prevalence of convictions for sexual offending in England and Wales: Research findings*, No. 55. Home Office Research and Statistics Directorate.

what they can't do is change the fantasies of those with a deviant sexual interest in children or predict with absolute certainty who will go on to re-offend. It is factors such as these that make the management of child sex offenders so complex and why the paramountcy of child protection must always steer the decision making and actions of practitioners.

5.3 Beyond this complexity, we also know there continues to be a growth in activity[15] and that resource pressures on public services remain. Combined, these circumstances have created somewhat of a '*perfect storm*' that is placing immense strain on those agencies responsible for this work, particularly the police. As highlighted in the independent review by Mick Creedon QPM[16], because of this environment the system needs to work differently. We agree.

5.4 However, whilst accepting there are no easy answers, we don't believe that system change should correlate with a system doing less. Many would see this as counter-intuitive, and yet solutions continue to be promoted that focus on a reduction in activity to cope with demand. This has largely, but not exclusively, focused on those perceived as being '*low risk'* offenders and/or '*viewers*' of indecent images.

5.5 As far back as 2017, the former child protection lead for the National Police Chief's Council raised concerns about the volume of offending and that the police had reached '*saturation point*' in terms of its capacity to respond[17]. He argued there was a need to look at alternatives to custodial sentences, including prevention and rehabilitation, although the monitoring of offenders would continue. More recently, the report by Mick Creedon QPM recommended changing the monitoring regime itself by introducing discretion, reducing timescales and allowing for more flexibility in decision making.

5.6 All these points can be seen as an understandable response to the demand / resource conundrum that the police are facing. That said, it is hard to see how any of them will make children safer, particularly when considering the exponential increase in sex offences, the spikes in online offending / exploitation seen during the pandemic and the rapidly emerging advances in Artificial Intelligence. Doing less won't address the fundamental challenges in this space. What is perhaps more likely is that additional fault-lines will appear in the form of harm.

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[15] The most recent data published by government on Multi-Agency Public Protection Arrangements (MAPPA) (2022/23)[15] shows a 51% increase in the MAPPA population since 2013. This comprised 91,040 offenders, with 68,357 being Category 1 sex offenders.

[16] Independent review into the police-led management of registered sex offenders in the community, Mick Creedon QPM, April 2023.

[17] Letter from Chair of the Home Affairs Select Committee to the NPCC Lead on Child Protection, February 2017.

5.7 Research continues to emphasise caution in this context. In her book *Predators*[18], Anna Salter cites Gene Abel's seminal work back in the late 1980s, when he examined undetected crimes among so-called '*low risk*' offenders and found a stunning amount of abuse that remained in the shadows. She writes, "*Despite these astounding figures, most of the offenses had never been detected.*" Studies by DeLisi et al. (2016)[19] and Drury et al. (2020)[20] illustrate the same about this so-called '*dark figure of sexual offending'*.

5.8 Based on the lessons from this review, contemporary research and established practice in other countries, we believe there are opportunities to do things differently. Working smarter, not harder so to speak - harnessing the insights of local practitioners to help improve the monitoring of offenders, mitigate risk and increase protection. This can only happen with improved information sharing.

5.9 Indeed, whilst acknowledging the need to protect an offender's rights to privacy and liberty, ensuring that practitioners share information is an obvious way to manage risk. This is one of the fundamentals of safeguarding, reinforced in MAPPA guidance and yet in the case of Mr A, such practice was distinctly absent. So too was an approach that erred on the side of caution. This latter point is key given what we know about some offenders and the way they operate.

5.10 For example, many are masters of manipulation and deceit, experts in grooming and highly proficient in conditioning the adults around them. When apprehended, they minimise their offending, self-justify and blame others. It is this cocktail of characteristics that means features such as professional curiosity, healthy scepticism and effective information sharing should be at the bedrock of both the system and front-line practice when engaging sex offenders.

What was the effectiveness of practice and the sufficiency of the arrangements in place to risk assess and manage Mr A as a 'Registered Sex Offender'.

Finding 1: The management of Mr A via the Level 1 MAPPA arrangements was insufficiently robust in terms of professional curiosity, rigour and authority. Ineffective investigation resulted in missed opportunities to identify risk and intervention lacked any clear focus on the paramountcy of the child.

[18] Salter, A.C (2003), Predators: Pedophiles, Rapists, and Other Sex Offenders

19 DeLisi, M., Caropreso, D. E., Drury, A. J., Elbert, M. J., Evans, J. L., Heinrichs, T., & Tahja, K. M. (2016). The dark figure of sexual offending: New evidence from federal sex offenders. Journal of Criminal Psychology, 6(1), 3–15.

[20] Drury et al. (2020). The dark figure of sexual offending: A replication and extension. *Behavioral Sciences and the Law, 38*(6), 559-570.

5.11 Over the period of Mr A's supervision, there were several missed opportunities to share information, identify risk and protect children from potential harm. For example, during probation's first engagement with Mr A, there were episodes when inter-agency communication with and by probation was poor. There was also a lack of curiosity by some of its staff into Mr A's circumstances and probation's overall approach to risk management was largely ineffective.

5.12 This was seen through the insufficient efforts of probation to establish the identity of Mr A's partner, clarify their circumstances and determine whether they had any children. With Mr A reporting he was in a new relationship; probation should have been considering the obvious hypothesis that children may be present (either at the time or at some point in the future). This should have resulted in action to obtain information from other agencies, alongside an updated risk assessment. Neither happened.

5.13 Acknowledging this contact was nearly a decade ago, the review understands that practice has since improved, with there now being greater emphasis on joint working, home visits, risk assessment and information sharing. Probation and Jigsaw staff in Hackney are also co-located which has been reported to assist in better collaboration locally.

5.14 With regards to the police oversight of Mr A, practice by Jigsaw 1 was characterised by poor administration of the SOPO, an absence of basic investigation, deviation from policy and the incorrect use of the ViSOR system. These issues are likely to have contributed to Mr A's children not being identified earlier, risk to other children being missed and deficits in the overall approach to risk management.

5.15 For example, as part of the ARMS assessment undertaken in 2016, Jigsaw 1 became aware that Mr A was having contact with his cousin's children. Whilst a MERLIN report was sent to the police in the local MASH (*MASH police*), this was some four months delayed. The MASH police refused to take responsibility for the case or share the details with children's social care.

5.16 This was fundamentally wrong. The rationale for this decision was that it was neither the responsibility of the MASH police nor that of children's social care to disclose Mr A's status to the parents. As a result, the case was simply passed back to Jigsaw 1 who took no further action.

5.17 The reasons why the police did what they did remains unknown, although there are several hypotheses. The delay by Jigsaw 1 in sending the MERLIN could have been due

to issues such as capacity, poor supervision, or officers not properly recognising risk (and the need for a timely response). The inaction of the MASH police could have been caused by the same factors. Whilst uncertainty remains, given that Mr A was being managed as a 'high risk' offender at the time, the lack of rigour by the police was a significant error. Whatever the reasons, practitioners lost sight of the children and the paramountcy of child protection.

5.18 Then, as now, the response should have been relatively straightforward, with the information that Mr A was having contact with children triggering a Section 47 enquiry under the Children Act 1989[21]. A strategy discussion is likely to have followed where multi-agency decisions about disclosure (in line with page 55 of the MAPPA guidance[22]), investigation and who was responsible for what could have been made. As it was, no action was taken at all. It is reasonable to assume that Mr A continued to visit his cousin without the family being told of his conviction.

Recommendation 1: In all cases where known child sex offenders are having contact with children, the MPS (specifically MASH police officers (or equivalent)) should ensure that referrals are always made to children's social care.

Recommendation 2: Both the MPS and the London Safeguarding Children Partnership should review their guidance on the risk management of known offenders and as required, strengthen the clarity on triggering a Section 47 enquiry when known child sex offenders are believed to be in contact with children.

Recommendation 3: The MPS should consider the sufficiency of its arrangements covering the disclosure of an offender's details to third parties. Where necessary, guidance should be updated to specify who is responsible for making third-party disclosures and who is expected to attend relevant multi-agency meetings where disclosures might need to be considered (such as strategy discussions). The MPS should seek reassurance that its processes neither delay nor inhibit its duty to protect children from potential harm.

[21] See London Child Protection Procedures – Threshold: Continuum of Need Matrix, Sexual Abuse / Sexual Activity, Level 4, Page 4
[22] https://www.gov.uk/government/publications/multi-agency-public-protection-arrangements-mappa-guidance

5.19 An absence of basic investigation by Jigsaw 1 also led to an ineffective approach to risk management. This can be seen during several events:

- The failure to engage Ms R in October 2016 when it first became known she was Mr A's partner.
- The lack of any follow up with Ms R to confirm she was aware of Mr A's status (after Mr A was investigated for two breaches of his SOPO in November 2016).
- The lack of action in October 2017 and October 2018 when Mr A confirmed he was staying at Ms R's address.
- The absence of any enquiries in March 2018 after a family member stated Mr A had a child.
- The failure to complete an annual ARMS assessment in 2017, 2018 and 2020 and not conducting an extra ARMS assessment in November 2017 due to there being a significant change to Mr A's circumstances (when he was confirmed as having children).

5.20 All these incidents were missed opportunities that could have revealed the existence of the children to Jigsaw 1 and ensured their safeguarding. The precise reasons why MPS policy was not followed and why practice reflected such a distinct lack of curiosity are also unclear. They may relate to one or a combination of factors relating to inexperience, workforce pressures, or a view that less scrutiny was required due to Mr A's risk status changing to '*Medium*' in 2017.

5.21 What we do know, however, is that none of these omissions were identified or rectified at the time, raising clear questions about the sufficiency of both managerial oversight and the effectiveness of the systems in place to monitor practice. Both these issues were identified as areas for improvement in the police effectiveness, efficiency and legitimacy (PEEL) assessment of the MPS in 2021/22[23]. This found:

'There is no clear, standardised approach for collating, recording and scrutinising the number of outstanding offender visits or outstanding risk assessments. So the force can't assure itself that Jigsaw teams are effectively managing demand.'

'…the recording of activity and decisions about the management of offenders is inconsistent. The force should make sure supervisor reviews provide detailed case direction and set actions.'

[23] Metropolitan PEEL Assessments 2021/22, HMICFRS

5.22 The Central Jigsaw team of the MPS reported its confidence to the review about the response to this PEEL assessment, having provided additional training and operational learning tools/data to help supervisors manage its cohort of offenders.

5.23 The MPS has also developed a range of single agency actions in response to this review. These focus on raising awareness about the circumstances of Case A, alongside processes for ongoing auditing, scrutiny and the testing of practice.

What was the effectiveness of multi-agency practice at the point it was established that Mr A had children, including the sufficiency of risk assessment and what was done to help and protect the children at the time.

Finding 2: Practitioners in children's social care were too optimistic when engaging the family. There was little evidence of thoroughness, reflection or an understanding about the risks posed by child sex offenders, and too much emphasis was placed on the police assessment of risk. Opportunities were missed to bring the partnership together to develop clear safety planning and to ensure that everyone was sighted on this family's circumstances.

Finding 3: There was evidence of good practice by the health visitor and nursery manager. Both showed initiative through the health visitor working directly with Ms R on strategies for safety and the nursery manager seeking out further information.

5.24 After Child S and Child T were identified in 2018, Jigsaw 1 recognised the need to make a referral to children's social care. In line with procedure, this was appropriately actioned and whilst the referral was accepted, the practice that followed was largely insufficient.

5.25 Intervention over this period was characterised by over-optimism and a lack of rigour. The assessment by children's social care was weak, as was the help and protection afforded to the children. Activity was also limited, comprising conversations with Jigsaw 1, checks with some of the involved agencies, one visit to Ms R (and the children) and one visit to Mr A. At no point was there any multi-agency meeting, discussion or forum that brought together the partnership to discuss the potential risk posed by Mr A and the need for ongoing safety planning.

5.26 Somewhat surprisingly, the referral itself didn't initiate action under Section 47 of the Children Act 1989. The circumstances of Mr A's offending and the way in which the children were discovered clearly justified the local authority having '*reasonable cause to*

suspect a child was suffering or likely to suffer significant harm'. And yet, the intervention triggered was that under Section 17 of the Children Act 1989 - for children in need. Practically, this meant that an early opportunity for a formal, structured approach to multi-agency information sharing and planning was missed (by way of a strategy discussion).

5.27 The assessment by children's social care was also significantly influenced by the perception of risk held by Jigsaw 1. This reflected a broad position that despite Mr A's convictions, there were no concerns for the children. Whilst it would not be unreasonable for a social worker to consider these views, there were clear contradictions that weren't challenged. Ultimately, this led to risk being misunderstood and minimised.

5.28 For example, both Jigsaw 1 and children's social care concluded that Mr A had been '*working well*' with them, however, he had concealed the births of his children and breached both his notification requirements and the SOPO. This basic lack of honesty should have raised more concerns about his trustworthiness and there should have been a much stronger hypothesis about disguised compliance.

5.29 Furthermore, there was a sense that the parents' perspectives were being given '*privileged status*' and taken as fact throughout the assessment. There was a distinct absence of critical thinking and little by way of '*respectful uncertainty*'. Indeed, despite the conclusion that the '*parents engaged well*' and had been *'open and honest with each other and appropriate family members',* eight days before the assessment closed, Ms R was giving an incorrect version about Mr A's offending to the health visitor (i.e. that he had purchased a second-hand lap-top).

5.30 In respect of the attempts by children's social care to fully understand the risks, these are considered by the review to have been largely superficial. The over-reliance placed upon Jigsaw 1's assessment gave false reassurance, and this was translated into there being little to no risk at all. This can be seen in the detail of the closure summary sent by children's social care that stated, *'no parenting or safeguarding concerns have been raised, or any on-going work have* [sic] *been identified'.*

5.31 Additionally, there were no attempts to seek either internal or external support from specialists in this field of work. This is likely to have been more cautious in its conclusions, confirming that risk couldn't be discounted and that a long-term safety plan would be required for the children. As it was, the position adopted by children's social care reflected a simplistic view that Mr A had '*only looked at images*' and that this '*had not gone any*

further'. There was a belief that as he had received a conviction, this in itself would act as some form of deterrent to further offending.

5.32 There were no attempts to work directly with the children, although some good practice was seen by the Health Visitor who took the initiative to share resources with Ms R and talk directly about how risk could be mitigated.

5.33 At the point it was decided to close the case, engagement with the wider partnership was also ineffective. No safety plan had been developed by children's social care (and hence couldn't be shared) and the details communicated in the closure summary were too ambiguous. This made no reference to Mr A's notification requirements and the fact that SOPO conditions were still in place. It provided a degree of false reassurance about risk and left most agencies unsighted on the specific issues of concern. Only one practitioner (the nursery manager) appeared to query this summary and attempted to seek out more information. This was good practice.

5.34 The absence of detail in the closure summary is also likely to have resulted in risk being missed. For example, after the case was closed, Ms R continued to tell professionals that Mr A was convicted as he had purchased a second-hand lap top with images on it. On no occasion was this challenged or escalated as an issue of concern back to children's social care and/or Jigsaw 1. Given the details of Mr A's offending had been disclosed in full to Ms R, this false account / minimisation would have been sufficient to re-assess her protective capacity.

5.35 Since these events, children's social care has taken significant steps to strengthen its practice in response to child sexual abuse. Alongside identifying dedicated practice leads to develop expertise and be available for consultation, practitioners have access to much clearer guidance and there are defined processes in place such as the following:

- To ensure leadership focus, service managers are informed about any disclosures of child sexual abuse.
- Multi-agency strategy meetings under Section 47 of the Children Act 1989 are convened to discuss risk, develop safety plans and determine the approach to investigation.
- There is an expectation that a safety plan is co-produced with the protective care giver, recorded on the case management system and shared with the family and professionals.

5.36 Importantly, there is defined guidance covering how to issue instructions for specialist risk assessments. This includes the following narrative about how Jigsaw risk assessments should be considered.

'*Risk judgement offered by the Jigsaw team engaged with convicted sexual offenders - This judgement of risk is given based on a number of factors present or absent at a specific point in time. This risk judgement should always be reviewed in light of changing context (e.g. living circumstances for the alleged perpetrator), which could cause the assessed risk level to either increase or decrease. We should not base our decisions about child safety on this risk judgement alone.*'[24]

5.37 Revised guidance is also much more explicit about the need for direct work with children and how to engage them and protective carers. There are clear examples about the practical work that can be undertaken. Given these developments and the progress made since the triggering of this review, no recommendations are made.

What is the sufficiency of the arrangements in place to engage relevant agencies and share information about known child sex offenders, and how do these arrangements either help or hinder the mitigation of risk.

Finding 4: Practitioners responsible for Level 1 MAPPA cases are potential single points of failure. The absence of the need for formal multi-agency meetings, the reliance on professional judgement and the operational pressures on both the police and probation, means it is sensible to consider widening the cohort of practitioners who are automatically alerted to RSOs (i.e. beyond those agencies with access to ViSOR). Whilst not advocating for unfettered information sharing, engaging key partners could help with monitoring and the identification of risk.

5.38 What is perhaps most striking about this case, is that despite MAPPA guidance referring to Level 1 management as a category for '*multi-agency support*', there was little to no evidence of partnership working whatsoever until the referral was made to children's social care in late 2018. Prior to this event, there were no obvious attempts to engage others and responsibility for Mr A's supervision was almost entirely retained by the police. This meant that Jigsaw 1 became a single point of failure.

[24] Working with the Risk of Intra-Familial Child Sexual Abuse, CHSCP, Para 7.2, page 14

5.39 From a safeguarding perspective, the importance of a multi-agency approach to practice and effective information sharing are well recognised and do not need to be rehearsed. However, despite safeguarding being an overarching objective of MAPPA, support from the wider partnership doesn't appear to have been considered as necessary.

5.40 It is likely that Jigsaw 1 didn't see a need to do this because it believed there was identified risk, and disclosure of Mr A's status to others would have been seen as disproportionate. As far as Jigsaw 1 was aware, Mr A had no children, was having no unsupervised contact with children and was engaged through a risk management plan. That said, Jigsaw 1 was fully aware that Mr A was in a relationship and that becoming a father at some point would have been a real possibility. It is in circumstances such as these - where there is a clear potential for risk as opposed to one being clearly identified - that there is scope for improvement.

5.41 Indeed, had other agencies known about Mr A's status, then it is highly likely that one of them would have made the referral to children's social care before the police. This is simply because they knew about the children beforehand. As opposed to the infrequent contact via the Jigsaw team, there was routine engagement with Mr A as part of health appointments and his participation in his children's early years / nursery arrangements.

5.42 Whilst we recognise the sensitivities of information sharing in this area, our view is that the current system is far from adequate. The right to individual liberty and the need to mitigate the risk of harm from vigilantism or mistaken identity is acknowledged, but any system that places an over-reliance on one agency to monitor potential risk and/or the honesty of convicted offenders is likely to be exploited.

5.43 Indeed, had the system operated to a process that ensured the details about Mr A were shared with a wider cohort of agencies then this could have been the catalyst for earlier intervention. Specifically, the review believes that had Mr A's GP known about his offending, this is likely to have created an immediate line of sight (through Mr A's health record) to the other practitioners that were engaged with the family (such as the midwives, health visitors and others who subsequently supported the family).

5.44 Whilst recognising there will be different viewpoints about the ethics of automatic information sharing in this context, it is seen by the review as a simple and practical solution to close a gap. We think this should be explored in more depth, with lessons being drawn from the containment model operating in the United States of America. As part of these arrangements, there is good evidence to show that agencies have to not only

work together, but they make offenders sign consent forms confirming details of inter-agency information sharing. Polygraph examiners are also engaged, and practitioners are actively encouraged to share concerns with anyone else. This facilitates a 'pooling' of observations, more vigilance and accountability, and less chance that something will be dismissed or fall through the cracks.

5.45 The review accepts that there can never be unfettered communication about an offender's status, and that the appropriate conditions will always need to be met. That said, we know that RSOs will always present a risk in one form or another and we also know that good information sharing is one of the most effective ways to mitigate risk. In this sense, much as section 327 of the Criminal Justice Act 2003 references a presumption of 'disclosure' to members of the public[25], we believe such a presumption should exist for the sharing of information about RSOs to specified agencies.

Recommendation 4: As part of its national review into Child Sexual Abuse in the family, the Child Safeguarding Practice Review should form a view on the potential for the secure and routine information sharing of Level 1 MAPPA Offenders with other key agencies, particularly General Practitioners.

To what extent do practitioners across all agencies understand the potential risks posed by viewers of child sexual abuse material and what was the effectiveness of the collective response to safeguard children.

Finding 5: Practitioners need to be mindful of the range of research findings about viewers of indecent images of children. Overreliance on messages about low recidivism rates or offending trajectory can lead to superficial conclusions, risk being misinterpreted and false reassurance. In all circumstances, individualised assessments are required that engage those with sufficient expertise in this field of work.

5.46 In the case of Mr A, practice was characterised by risk being misinterpreted and minimised, with 'light touch reassurance' resulting in missed opportunities. Beyond the issues already identified by the review, there are broader questions about whether practitioners are sufficiently alive to the risks posed by sex offenders (particularly viewers of indecent images of children) and whether there is sufficient guidance in place to help them. The answers to these questions are perhaps best reflected in the ongoing uncertainties and different perspectives that exist in this area. Indeed, there is a reason

[25] https://www.legislation.gov.uk/ukpga/2003/44/section/327A/2018-05-25

that calls for further research continue to be made and a strong argument that both the evidence base and guidance needs strengthening.

5.47 That said, some of this work has already been undertaken and there is now substantial guidance for practitioners available from the Centre of Expertise on Child Sexual Abuse. However, whilst positive, the review remains concerned about the broader narrative promoted about 'internet offenders' and its influence on practice.

5.48 Put simply, headlines that emphasise low rates of recidivism, contact offenders being more likely to transition to internet offences (than the other way around) and internet offenders who reoffend tending to do so by way of committing further internet offences, can all suggest that risk is less of an issue. The unintended consequence here is that these headlines can 'over-influence' practice, with assumptions being made that an internet offender equals less risk and hence there is less need for monitoring and less need to be worried about future harm.

5.49 Without wanting to oversimplify the complexity of this issue or question the efficacy of some of the available research, we know that some people just don't get caught and that most child sexual abuse does not come to the attention of authorities. In this sense, relying upon recidivism rates and/or the honesty of an offender are weak foundations upon which practice should be predicated. For example, recidivism rates are not the same as re-offending rates, they are re-conviction rates. A contemporary study by Dr Michael Bourke (nearing completion), indicates that less than 1% of all offences result in a criminal conviction.

5.50 Furthermore, as described by Anne Salter, "*Offender self-reports have dubious validity, especially when the offender's self-interest is at stake. The only rule for deception in sex offenders I have ever found is this: If it is in the offender's best interests to lie, and if he can do it and not get caught, he will lie.*" The same conclusions were drawn in the 2009 Butner study[26] and by Dr Michael Bourke and colleagues in 2015[27]. This latter piece of research involved 127 people under investigation who agreed to take part in a polygraph test whilst being investigated for internet offences. Prior to the polygraph, 4.7% of the suspects admitted contact offences against a child. During the polygraph examinations, there were disclosures about contact abuse of a child from 52.8% of the suspects.

[26] Bourke, M. L., & Hernandez, A. E. (2009). The "Butner Study" redux: a report of the incidence of hands-on child victimization by child pornography offenders. *Journal of Family Violence, 24*(3), 183–191.
[27] Bourke, M. L., Fragomeli, L., Detar, P. J., Sullivan, M. A., Meyle, E., & Riordan, M. (2014). The use of tactical polygraph with sex offenders. Journal of Sexual Aggression, 21(3), 354–367.

5.51 In the context of the above, there are strong arguments that a much more 'risk averse' response is required. Supporting other recommendations made by the review, there is a logical lesson to be drawn about raising awareness and continuing to develop practitioner understanding within the CHSCP's footprint.

Recommendation 5: The CHSCP should commission context specific training on child sex offenders and include this as part of its annual programme open to all practitioners within the City and Hackney.

6. Conclusion

6.1 Too often safeguarding practitioners differentiate the risk between offenders who target children. This is done on the basis of whether they have committed offences related to downloading images or those involving physical contact with children. Indeed, the presumption is that those who view images are less of a risk and that only some of them, a few, will go on to commit contact offences.

6.2 Offending, however, does not take place in a linear fashion, whereby an offender views an image and over a period of time is drawn to contact offending. Often the offender has already committed contact offences, but still accesses and uses indecent images of children for sexual stimulation or at times as an alternative, when they have no access to a vulnerable child.

6.3 Whilst others may argue academic perspectives from one point or another, the fact remains that viewing is by default considered a lower-level risk and is mirrored in how the system responds to them. For example, according to the National Crime Agency, 80% of those convicted of viewing indecent images of children do not receive a custodial sentence. This feeds into the myth that those who view are less likely to cause harm. In the opinion of the review, such presumptions undermine a safeguarding first approach. Risk assessments and plans to 'contain' known offenders must begin and end by giving the benefit of the doubt to the child not the predator.

7. List of Recommendations

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