SERIOUS CASE REVIEW EXECUTIVE SUMMARY

In respect of

TB
FORMERLY KNOWN AS TC

CONVICTED OF THE MURDER OF

A FEMALE CHILD AGED 13 YEARS

STRICTLY CONFIDENTIAL

1. The Serious Case Review Process

1.1 Normally, Serious Case Reviews are undertaken by local Safeguarding Children Boards (formerly Area Child Protection Committees) following a child death in which abuse or neglect is suspected to be a factor, and in certain cases when a child sustains life threatening injuries, or experiences serious sexual abuse.

1.2 Chapter 8 of 'Working Together to Safeguard Children' (Department of Health, 1999) places an expectation upon the relevant Safeguarding Children Board, and individual agencies, to formally review their involvement with the child and their family in cases which meet the criterion for a Serious Case Review.

1.3 The purpose of such case reviews is 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;

- Identify clearly what those lessons are, how they will be acted upon, and what is expected to change as a result and as a consequence, and

- To improve inter-agency working and better safeguard children.

(paragraph 8.2)

1.4 On 21 July 2002, a 13 year old child was murdered by TB (formerly known as TC). At the time the murder was committed, it was not seen to be strictly within the terms of reference laid down by the Department of Health 1999 and, therefore, not one around which a Serious Case Review would normally occur. However, following TB's trial, and upon closer inspection of issues related to him and his criminal background, plus the circumstances surrounding his arrival in the household of a woman (Mrs. X) with three children in Lincolnshire, the matter was discussed at an ACPC Case Monitoring Group Meeting in March 2004, when it was felt that the child's death did warrant a Review. Following further enquiries and an inter-agency discussion it was subsequently agreed that a formal Serious Case Review should take place. A recommendation to that effect was subsequently made to the Chair of the then Lincolnshire Area Child Protection Committee and the Review was commissioned.

1.5 In terms of the scope of the Review it was determined that the focus should be on TB and his association with Mrs. X's family. It was agreed that the Review should not address any agency involvement with the family of the child who was murdered, as it was felt that that would not add to the Panel's understanding of why this tragedy happened.

1.6 The agencies asked to contribute to the Serious Case Review were: Lincolnshire Police in consultation with Derbyshire Police; West Lincolnshire Primary Care Trust; Lincolnshire Partnership NHS Trust; Derbyshire Mental Health Services NHS Trust; the National Probation Service – Lincolnshire and Derbyshire Areas; Lincolnshire Education & Cultural Services Directorate and Lincolnshire Social Services Directorate (recently merged under the umbrella of Children's Services); Derbyshire Social Services Directorate; the Prison Service, and Lincoln City Council Housing Department. A representative from CAFCASS contributed to the Review as an independent member of the Panel. The Manager of Lincolnshire Multi-Agency Public Protection Panel was consulted concerning present day Multi-Agency Public Protection Arrangements (MAPPA) relating to 'Risk to Children' (formerly Schedule 1) offenders.

1.7 It was agreed that the Police would advise the murdered child's family about the Review process and during the course of the Review, the Chair kept the child's mother informed of progress.

1.8 It was agreed that the time frame to be examined under the investigative process was from the time of TB's conviction in February 1995 for the offence of indecent assault, until the date of the murder in July 2002. As the Review progressed, however, the time frame in relation to TB's health was broadened to a lifetime approach.

1.9 At the outset of the Review it was not anticipated that TB would be interviewed as part of it, but as the Review progressed, a decision was made to involve him, to which he consented.

1.10 During the course of the Review, the Panel received written and oral submissions from all agencies involved with the case.

2. Summary of the Case

2.1 On 21st July 2002, Lincolnshire Police received a 999 call from a man later identified as TB, claiming to have discovered a body in a park in Lincoln. On arrival at the scene, the Police discovered the body of a 13 year old girl. Still at the scene was the person who called the Police, TB, who gave various explanations to them about his conduct on the day in question. He was arrested on suspicion of the murder and on 12 June 2003 he was convicted and received a sentence of Life imprisonment as a result.

2.2 As a result of this murder it emerged that TB had a criminal record, including Schedule 1 (C & Y.P. Act 1933) offences committed in 1992, for indecent assault and assault occasioning actual bodily harm on a female under the age of 16 years. He was imprisoned for these (12 months x 12 months running consecutively) and other unrelated offences in 1995. He had served several other terms of imprisonment over the years, the last being for a total of six years from 28.2.1997., for offences of burglary, theft and assault occasioning actual bodily harm. He was released on 20.4.2000., on Non-Parole Licence to Derbyshire Probation Service and was placed in a Probation Hostel. Due to him attacking another Hostel resident, however, his Licence was revoked on 22nd May 2000, and he was returned to Prison forthwith. He remained in Prison until his Licence Expiry Date, being released – no longer subject to any statutory licence supervision – on 20th October 2000. Apart from an enquiry about him from the West Midlands Probation Service to Derbyshire Probation Service immediately following his release, little is known about TB's movements from then until he appeared in Lincolnshire in 2002, living with a woman (Mrs. X) and her three children A, B, and C, in council accommodation in Lincoln. The Review determined that he spent the majority of his time between 2000 and February 2002 in the Derby area.

2.3 According to TB he met Mrs. X via a mobile telephone network in December 2001 and moved in with her and her children in March 2002. The couple subsequently had a child together (child D), who was born on 30.12.2002.

2.4 Mrs. X's daughter – child A – was a school friend of the murdered child.

2.5 TB has suffered from mental ill health from an early age, and has a history of self-harming. Differing diagnoses have been suggested over the years, such as psychotic illness and personality disorder, and he has been in contact with Health Services in Derbyshire, Prison Service Healthcare during his periods of imprisonment, and Lincolnshire, regarding treatment.

3. Main Findings and Recommendations of the Serious Case Review Panel

3.1 In the course of the Review, issues that the Panel specifically addressed were:-

- How TB, a Schedule 1 offender since 1995, with known mental health problems, moved from another area to live with a woman and her children in Lincolnshire without the knowledge of statutory agencies, and went on to commit the murder of a child;

- What plans, if any, were made whilst he was in Prison in relation to accommodating him, treating his mental health problems and supervising him on release;

- What steps did the agencies with whom he came into contact take to share information about him and assess the potential risk he posed to

others – particularly females – as a result of his criminal record and mental health problems.

3.2 The Panel found evidence that TB's mental health problems were apparent from an early age and were specifically identified during the course of his involvement with the Criminal Justice System. Concerns about his 'dangerousness' were articulated by a number of Psychologists and Psychiatrists over the years. He was alternately diagnosed over time as suffering from either 'organic psychosis' or 'dissocial and emotionally unstable personality disorder', and he was accordingly prescribed appropriate medication. In the main, however, the focus of attention in Healthcare professionals' contacts with him tended to be related to diagnosing the nature of his mental ill health and prescribing appropriate medication, rather than formulating an assessment of the risk he may pose to others – particularly females and children/young people - as a result of his offending behaviour history and mental health problems.

3.3 In 2000, TB told a Psychiatrist that he was a registered sex offender, which was not actually the case. Whilst he was a Schedule 1 offender, the Schedule 1 offence occurred prior to the Sex Offender Registration legislation. However, it would appear that his remark about being a sex offender was not pursued by the Psychiatrist, or any other Healthcare professional thereafter, and thus, became lost vital information.

3.4 **I**mportantly, this key information about TB being a Schedule 1 offender should have been communicated between every agency with which he came into contact, from the point at which he became a Schedule 1 offender in 1995, in the interests of the welfare of any females and children with whom he came into contact.

3.5 The Panel found that whilst TB was subject to statutory supervision by the Probation Service – up to his recall to Prison in May 2000 – appropriate measures were taken via multi-agency Risk Strategy Meetings, to manage the risk he was perceived to pose. Once statutory supervision came to an end, however, there was at that time no requirement for the Probation Service to engage in formal planning for his release, or supervision thereafter.

3.6 When TB was released from Prison in October 2000, there is evidence that the Prison Service sent out information to Healthcare professionals in the community in Derbyshire, upon request, but it has not been possible to determine precisely what that information was. It was clear to the Panel that although all Prison establishments had in place Child Protection Procedures during TB's various imprisonments, which would have identified him as a Schedule 1 offender and monitored that, information about his receipt into, transfer between, and release from some of those Prisons was not always sent to the Probation Service and Social Services. The Panel has been unable to ascertain what, if any, planning took place within the Prison from which TB was finally released in October 2000, when he was discharged without statutory oversight.

3.7 The Review Panel ascertained that following his release from Prison in October 2000, TB registered with a GP in Derbyshire, who referred him to a Consultant Psychiatrist for a routine appointment. He failed to attend that appointment and was discharged from the Clinic. His GP requested another appointment for him, which he kept. The report sent to the GP after that appointment contained information about TB's periods of imprisonment, self-harming, difficulty in controlling his anger, and auditory hallucinations - some of which tell him to hurt people and damage objects - but no mention was made of the Schedule 1 sexual offence, which raises the question as to whether this was known to the Psychiatrist. It was also clear that no risk assessment had been undertaken in relation to TB's behaviour, despite what was clearly known by the Psychiatrist about his background. His medication was changed and he was discharged to the care of his GP. This appointment with the Psychiatrist also presented an opportunity to place TB on the Care Programme Approach to managing his mental health problems, whereby he would have had a degree of support and monitoring from a Community Mental Health Team. This, however, was apparently not considered at this juncture. As a result of lessons learned from TB's contact with Derbyshire Mental Health Services, they have reviewed their risk assessment and formulation training; compiled a contact list for information-sharing purposes between the Trust and other agencies, and formulated their Guidelines for Service Users who do not attend appointments, as a stand-alone policy.

3.8 Another very important factor is that TB changed his name from TC to TB when he came to live in Lincolnshire in 2002. His extensive criminal record was in the name of TC. In his dealings with Healthcare professionals in Lincolnshire he continued to be registered and known as TC, but they were unaware of his Schedule 1 status, whereas he informed Lincolnshire Police and Mrs. X's children's schools that his name was TB, which prevented the revelation of his offending history and Schedule 1 status whilst he was in Lincolnshire.

3.9 In the light of recommendations in the Bichard Inquiry (2004) which reported upon the murders of two children in Soham by a person who was known to the Police in one area but moving between areas and using an alias, national systems are now being established through which individuals who pose a risk to others can be recorded, and their movements traced. At local level also, Multi-Agency Public Protection Arrangement (MAPPA) procedures have evolved considerably since 2000 and the Prison, Probation and Police Services each now have an integral role within MAPPA, in which risk assessments of individuals who are deemed to be dangerous or potentially dangerous, are undertaken within a multi-agency framework, and plans made for their oversight and management. Had the more robust system now in operation been in force in 2000 when TB was finally released from Prison unsupervised, the likelihood is that he would have been made subject to MAPPA and thus been subject to statutory oversight. The Probation Service currently has in place agreed procedures for referral and information-sharing in relation to dangerous and potentially dangerous offenders, and this is monitored by Probation Service Managers. Recently, the Probation Service has evolved

into the new National Offender Management Service (NOMS) and one aspect of the forthcoming arrangements within NOMS involves the photographic identification of offenders. In terms of the Prison Service, all prisoners who have convictions against children are now referred to as 'Risk to Children' and they have a marker on their Prison record denoting them as such. Also, all prisoners now retain the same prisoner number, regardless of how many times they go into Prison.

3.10 TB advised the members of the Review Panel who interviewed him that he had formally changed his name by Deed Poll to TB during his current term of imprisonment. Because TB's alias is now known, both of the names he has used will, in future, be cross-referenced in any Police (or other agency) checks. TB was asked by the Panel members who interviewed him whether he felt that there was anything that might have prevented him from committing the murder and his response was that only his incarceration might have prevented it.

3.11 The Panel established that when TB was referred to Lincolnshire Partnership Trust Mental Health Service, the GP referral contained information that he was living with a partner and her children, which he confirmed to Healthcare personnel. However, his Schedule 1 status was not known to his Lincolnshire GP nor to Lincolnshire Mental Health Service personnel. Just prior to committing the murder, after deliberately self-harming following an argument with Mrs. X, TB was placed on the Care Programme Approach at Standard Level to assist him in managing his mental health problems, but he committed the murder before the Community Mental Health Team in Lincolnshire could engage with him. Despite TB advising Healthcare professionals that he and Mrs. X were having arguments, and given that he was diagnosed as having a personality disorder, no apparent connection was made with the potential risk for violence within the X family household, or the consideration of potential indicators/risk factors associated with child abuse or neglect. The Panel established that it was the case in 2002 that Adult Mental Health personnel in Lincolnshire did not, as a matter of course, assess parenting capacity or the risks to children within a family when the presenting Service User was a parent. As a result of this Review, the Lincolnshire Partnership Trust is currently in the process of implementing a Child Protection Policy that makes it clear that this should be done. In addition, the Trust is increasing access to appropriate child protection training for its various staff groups.

3.12 TB had contact with the schools in Lincolnshire where Mrs. X's children A and B were pupils and he was known to school staff in both as Mr. B. It was thought that he attended a meeting with Mrs. X at child A's school on one occasion, as a result of reported difficulties that child A was experiencing because of being bullied, but his identity and relationship to Mrs. X and child A were not clarified at that meeting. As a result of the findings from this Review, the LEA has issued instructions to schools to record fully all contacts with families, other agencies and/or significant incidents involving children, which should be dated and signed, and clearly state who the contact was between. An instruction has also been issued indicating that staff holding meetings in school should ensure that the identities of all attendees are

confirmed, and that Minutes of any such meetings be made. A further directive is about to be issued to schools and education staff regarding record keeping, with some good practice guidelines.

3.13 On one occasion whilst he was resident in Lincolnshire, TB was specifically interviewed by a Police Officer in relation to spreading alarming information to parents at child B's school about some potential harm that he had heard about that could befall the children. Worried parents reported this to the Head, who in turn, contacted the Community Police Officer, who saw TB with the Head and warned him about spreading this worrying information. He told the Police Officer that his name was TB, and because the Police Officer was unaware that TB was a Schedule 1 offender, and had no information from his contact with TB to suggest that he was a Schedule 1 offender, he merely logged the incident locally and did not make any further local or national checks. Even if he had, because TB was operating under that name, it is unlikely that his criminal record would have come to light, as it is recorded under his other name of TC. TB was spoken to a second time by Police in Lincolnshire in July 2002 when they were called to Mrs. X's house as a result of a disturbance there being caused by her brother, whom TB was restraining when the Police arrived. He was asked who he was, but no checks were carried out on that occasion, because he was spoken to as a witness to the disturbance.

3.14 During the course of this Review, Lincolnshire County Council's former Social Services Directorate and the Education & Cultural Services Directorate were combined within one Children's Services Directorate. What was formerly known as 'Social Services' is now Children's Social Care. The only contact Children's Social Care had with the X family during the time that TB was said to be a member of the household, was in April 2002, via a telephone conversation between a Duty Social Worker and Mrs. X regarding a referral to Children's Social Care from child A's school concerning child A having some difficulties. Mrs. X's response to the telephone enquiry from the Social Worker about the difficulties was to decline assistance, indicating that the difficulties had been resolved. If contact with the X family had been pursued at this time, it may have come to light that TB was in the household, but as Children's Social Care personnel were not aware of his presence in the X household, the Panel concurred with the view that the assessment and decision made by the Duty Social Worker at that time not to pursue matters, appears to have been reached in an informed and professional way.

3.15 The ability of dangerous/potentially dangerous offenders to move between statutory agency boundaries without the prompt transfer of relevant information is of major concern to the Panel. Indeed, this very issue was remarked upon by TB who told the members of the Panel who interviewed him that if a Schedule 1 offender wants to disappear – he can. The Police feel that the tracking and monitoring of potentially dangerous offenders should always include risk assessment, and that such people should preferably be subject to a national registration system similar to that which exists for the registration of sex offenders.

3.16 Due to the passage of time since the commencement of the Panel's investigation in 2004, there have been changes in legislation relating to children/child protection; Multi-Agency Public Protection Arrangements (MAPPA); the tracking of Schedule 1 (now known as 'Risk to Children') individuals, and implementation of recommendations from the Laming Inquiry 2003 (Victoria Climbie) and Bichard Inquiry 2004 (Soham murders). As a result, there have been consequential improvements in policies and procedures in each of the agencies which had dealings with TB.

4. Lessons Learned from this Review

4.1 TB's Schedule 1 status – now known as 'Risk to Children' – should not have been lost sight of. It should have been communicated and followed through by all agencies with whom he came into contact and who knew about it, since 1995.

4.2 It is imperative that the Police, Probation and Prison Services, and where relevant, Healthcare professionals, liaise closely regarding risk assessment and planning for the management of offenders, especially prior to the release from Prison of offenders who have mental health problems and who potentially pose a risk to females and children.

4.3 Information regarding TB's Schedule 1 status, his offending history and his mental health problems that was communicated to Healthcare professionals prior to him coming to Lincolnshire should have triggered the need for assessment and management of the potential risk he posed to females and children.

4.4 Information-sharing between Healthcare professionals, and with other agencies, needs to be improved to ensure that vital information is not lost.

4.5 In terms of his mental health problems prior to coming to Lincolnshire, more serious consideration could have been given to placing TB on a Care Programme Approach much earlier than was the case, which could have afforded a degree of monitoring of his whereabouts.

4.6 When meetings are convened in schools, it is important to identify and record all attendees.

4.7 When the Police attend incidents involving males who are spreading alarming information about what could happen to children who attend school, wider ranging and more rigorous enquiries should be made about them, and the views of school staff should be sought in the process.

4.8 TB was the third man to have a Schedule 1 offence who moved into Mrs. X's household. Given that Mrs. X's former husband is also a Schedule 1 offender, and whilst he was in Prison it came to the attention of Children's Social Care that she was accommodating another man who had committed offences against children – before she knew TB and he became a member of

her household – arguably, more rigorous checks should be carried out by Social Workers when referrals are made relating to such families.

4.9 The fact that TB changed his name when he came into Lincolnshire (except in relation to GP registration) is indicative of a wider national problem of offenders who change their names and cross geographical boundaries, and this needs to be addressed at national as well as local level.

4.10 **W**hilst it is recognised that it will always be difficult to guarantee fail-safe solutions to the issues that have been highlighted in this Review, at national as well as at local level, nevertheless, it is reassuring that some progress has been made since 2002 in the areas of public and child protection, by the introduction of the more robust risk assessment, tracking and monitoring of dangerous and potentially dangerous offenders via MAPPA, and a change in the legislation regarding Schedule 1 (Risk to Children) offenders who are now considered in relation to the ongoing risk they may pose, as opposed to merely being defined by their offending history. However, as in some notable cases nationally in recent years, and in the case examined in this Review, when people use different names, move across geographical boundaries, and carry out offences under those different names, the ability of agencies to monitor and track such individuals can be seriously called into question. As a Review Panel, whilst we support the new initiatives which have been introduced to date, we nevertheless recommend that the DfES brings the issues we have outlined to the attention of the Home Office, and Ministers who are responsible for the public protection agenda, as a matter of urgency.

In conclusion, the unusual length of time that it has taken for this Review to be completed has been occasioned by a number of factors. Firstly, it proved necessary to make wide-ranging enquiries and seek information from agencies in Derbyshire as well as Lincolnshire, and Prison establishments, in addition to engaging in communication with, and carrying out a visit to interview TB in Prison. Secondly, part way through the Review, concerns were raised regarding the welfare of the X family, and some enquiries were pursued in relation to that, resulting in a decision to document the concerns of the Panel in that regard for Children's Services in the area where Mrs. X and her children are currently resident. Thirdly, due to some extenuating personal circumstances of the Chair, the Review was not able to be proceeded with for several months during 2005.

Finally, the Panel recognises that whilst the long-awaited publication of the findings of this Review may be welcomed by the family of the child whose young life was so tragically cut short, it may also resurrect distressing memories for them, for which we apologise. The Panel nevertheless offers the family sincere sympathy on their loss, and hope that the findings of this Review and the improvements that have occurred since 2002, in the areas of risk assessment, risk management, and the monitoring of dangerous and potentially dangerous offenders, does offer them some reassurance that more robust measures are now in place to try and avoid another such tragedy.

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