Two Serious Case Reviews from Leeds: 'A system clouded by secrecy and fear'?

March 2013

Published in *Argument & Critique*.

By Professor Terry Thomas, Visiting Professor in Criminal Justice Studies at Leeds Metropolitan University. t.thomas@leedsmet.ac.uk

Biography

Terry Thomas has been a Visiting Professor of Criminal Justice Studies at Leeds Metropolitan University since his retirement as Professor in August 201 he is the author of 'Criminal Records' (2007) Palgrave Macmillan and 'The Registration and Monitoring of Sex Offenders' (2011) Routledge. He spent 12 years as a local authority social worker and senior social worker.

Keywords

Serious Case Reviews; Secrecy; Child death inquiries; Public accountability; transparency.

Two Serious Case Reviews from Leeds: 'A system clouded by secrecy and fear'?

Abstract

Two recent Serious Case Reviews on the sexual assault and death of a child in Leeds at the hands of a man already on the sex offender register have concluded that the death 'may have been prevented had the agencies…worked more effectively within the mechanisms available'. Of particular concern is the lack of openness about these two Reviews as only a summary of one of them has been made available to the public. The present Coalition government believes more openness will result in more public trust in the agencies charged with better public and child protection.

Introduction

The sexual assault and murder of a fifteen year old child in Leeds in 2007 caused a good deal of concern in the city. The man responsible has been convicted and sentenced to life imprisonment; he was already known to the police and other agencies because he was on the sex offender register.

Two Serious Case Review (SCR) reports have been written following the offence to establish whether the agencies involved could have better protected the victim of this crime. Neither of these reports will be published. The Leeds public are only allowed to read an Executive Summary of one of them written for the Leeds Local Safeguarding Children Board. This summary was published in March 2012 and concluded that the murder 'may have been prevented had the agencies…worked more effectively within the mechanisms available' (LSCB 2012)

This paper considers the details of what we know of this child's death and the activities of the agencies involved from the SCR Executive Summary that has been published and the criminal court hearing. The arguments for *full* publication of both reports and the arguments made by the Leeds Local Safeguarding Children Board against publication are also examined.

Writing about a SCR written in Doncaster, Michael Gove Secretary of State for Education has recently stated his view that:

> 'The policy of publishing SCRs is intended to explain the many difficult decisions that have to be taken on a daily basis when working with vulnerable children… We want an open, confident, self-regulating system where professionals are continually asking how they can improve rather than a system clouded by secrecy and fear. Where there is clear evidence of failure or incompetence, individuals and organisations need to be held to account. Where there are successes, these should be celebrated and shared' (Department for Education, 2012).

The paper explores the themes of accountability and transparency in relation to SCR's. How accountable are public services to the public, when the public are not allowed to know the full details of Serious Case Reviews? Is secrecy appropriate or necessary? In addressing these questions, the paper provides supporting evidence to challenge the system that Gove has described as one 'clouded by secrecy and fear (Department for Education, 2012).

The Case

Zuzzana Zommer was aged 15 when she was sexually assaulted and murdered in her own home in Harehills, Leeds on1st October 2007. Her parents had been out for the day and returned to find her body in a state of undress and with her throat cut ('Teenager murdered: a piercing scream and grim discovery' *Yorkshire Evening Post* 2 October 2007). The parents called the West Yorkshire Police who promptly arrested them both on suspicion of having committed the crime and took them into police custody. Within eight hours the parents had been released and a new suspect had been arrested. ('Quiz goes on over stab girl' *Yorkshire Evening Post* 3 October 2007).

The new suspect was 39 year old Michael Clark who lived in the same street as the Zommer family. Clark had a long history of sexual offending and consequent custodial sentences and was a registered sex offender. He had left HM Prison Hull on 17 November 2006 after serving a custodial sentence; throughout the final months of his sentence Clark had stated his intention to live in Leeds (his home address was Scunthorpe) because of the better employment opportunities. He was sentenced to life imprisonment for the murder of Zuzzana Zommer at Sheffield Crown Court 8th May 2008 and ordered to serve 35 years before he could apply for parole.

The Zommer family had only been in England a matter of months having come here from Poland in search of work; Mr Zommer was an IT software engineer and his wife a physiotherapist. Zuzzana had a nine year old brother. The family returned to Poland within days of the murder.

Serious Case Reviews

There are two different kinds of Serious Case Reviews applicable in the circumstances surrounding the murder of Zuzzana Zommer. The first is that produced by the West Yorkshire Multi Agency Public Protection Arrangements (MAPPA) and the second by the Leeds Local Safeguarding Children Boards (Leeds LSCB).

Other possible relevant reviews

The police have their own internal Police Internal Management Review (PIMR) report covering further serious offending by any registered sex offender and others managed by the MAPPA (MoJ *et al,* 2009: para.29.2.1). These reports are marked 'Restricted' and are exempt from the Freedom of Information Act (MoJ *et al,* 2009: para.29.5). It is of note, however, that the new 2012 version of the MAPPA Guidance omits any reference to PIMRs (MoJ *et al,* 2012). The probation service could also conduct their own reviews under Probation Circular 22/2008 though this is not applicable in this case because the offender was not under probation supervision of any kind

Multi Agency Public Protection Arrangements (MAPPA) Serious Case Reviews

Multi Agency Public Protection Arrangements (MAPPA) were introduced by the Criminal Justice and Courts Services Act 2000 to facilitate joint working between agencies having oversight of registered sex offenders and other people considered 'dangerous' within a given geographic area (see Bryan and Doyle 2003; MoJ *et al* 2012).

In 2009 guidance was given to MAPPAs that Serious Case Reviews should be carried out when an offender managed by MAPPA at levels two or three commits a serious further offence. The guidance states that it is 'essential' that the 'activities of the agencies involved is scrutinised and this must be a transparent process' (MoJ *et al* 2009: para.28.1); it also states that 'the [SCR] report must not be widely distributed or published' (MoJ *et al* 2009: para.28.14). A summary of the report known as the Overview Report should be shared with the victim/family but not with the public; it should be marked 'Restricted' (MoJ *et al* 2009: para.28.15).

This guidance was updated in 2012. In general terms the new guidance tells us that one of the criteria for a review is that it is 'in the public interest' (MoJ *et al* 2012a: para.20.5) unless it is case listed in Probation Instruction 10/2011. All Probation Instructions (PI) are available on a Ministry of Justice web site but PI 10/2011 is omitted for some reason (MoJ *et al*, 2012b).

The advice about the report being marked 'Restricted' remains (MoJ *et al,* 2012a: para.20.18) as does the advice that 'the report must not be widely distributed or published' (MoJ *et al,* 2012a: 20.21). Guidance on giving information to the victims or their families becomes more specific with on-going liaison with the family encouraged throughout the process of the report writing (MoJ *et al*, 2012a: para.20.10). On completion, however, the new guidance states that the family should only be given verbal feedback on its' contents and 'a copy of the MAPPA SCR should **not** be provided' to them (MoJ *et al*, 2012a: 20.24, author's emphasis).

The SCR in the Zommer case has therefore not been published. It is unclear whether the Zommer family in Poland have had the findings given to them. In reply to a parliamentary question the Secretary of State for Justice confirmed that 'no summary has been prepared for publication, but the SMB [Strategic Management Board of the MAPPA] is prepared and has offered to share the findings of the review with the family of Zuzanna Zommer' (Hansard HC Debates 21 July 2009 Col. 1401W).
.

Local Safeguarding Children Boards (LSCB): **Serious Case Reviews**

Serious Case Reviews on child deaths were original known as 'Part 8 Reviews' when introduced by the Children Act 1989. 'Part 8' was that section of the relevant guidance at the time. The idea was to learn immediate lessons when a child's death in a given geographic area was non-accidental and possibly preventable had the child protection agencies provided a more effective service.

The unspoken aim was to avoid the numerous public enquiries that had been entered into on child deaths over the 1970s and 1980s and to keep the reviews 'in house'. Parton notes 45 public inquiries between 1973 and 1989 but only 14 between 1990 and 1999:

> That is not to say that the problems in the 1980's had gone away, as a reading of Part 8 reviews indicates, the same problems were evident concerning the failure to 'spot the signs' and the inadequacies of communication and coordination. It did mean, however, that the issues were much less in the public domain
> (Parton, 2006: 40).

A study into Part Eight reviews carried out at Liverpool John Moores University stated that 'it has become the norm to keep Part Eight reviews unpublished'. Where reports had been made public, it had been the result of considerable pressure from relatives, the community, media and presiding judges (Corby, Doig, & Roberts, 2001:73, 185) .

'Part Eight Reviews' were renamed as Serious Case Reviews by the Children Act 2004 which created Local Safeguarding Children Boards (LSCB's). The subsequent Local Safeguarding Children Boards Regulations 2006 no. 90 Regulation 5 requires LSCBs to undertake reviews of serious cases.

Guidance on Serious Case Reviews is currently outlined in the 2010 version of *Working Together* (HM Government 2010: chapter eight) and SCR's must be undertaken when a child dies (including death by suspected suicide), and abuse or neglect is known or suspected to be a factor in the death. The full LSCB SCR reports are known as Overview Reports and they are accompanied by an Executive Summary, not to be confused with the MAPPA SCR's where the *summary* is called the Overview Report.

Originally LSCB Overview Reports were not published but the Executive Summary was. The public were to get a glimpse of what had happened amongst their local public services but that was all. The guidance was quite clear that 'SCRs are not inquiries into how a child died …or who is culpable' (HM Government, 2010: para.

8.6). The Overview Reports were to be kept in-house just for the professionals and practitioners. The writers of the Executive Summary had to decide what was revealed and what was to be kept secret.

This position changed when the new Coalition Government confirmed in June 2010 its commitment to ensuring all SCR Overview Reports, suitably anonymised and with identifying details removed, would in future be published. The more open regime of publication started from 10 June 2010. Now the public could read everything. The letter from the Under Secretary of State for Children and Families Tim Loughton making this announcement stated that the greater 'publication…is reasonable and in the greater public interest', and will:

> Restore public confidence and improve transparency in the child protection system, and to ensure that the context in which the events occurred is properly understood so relevant lessons are learnt and applied as widely as possible (Loughton, 2010).

The Leeds Child K case - Executive Summary

Perhaps one of the most poignant observations to be made is that the Leeds LSCB has always referred to Zuzanna Zommer as Child K despite everyone else, including the media, using her real name from the criminal court proceedings. The local media have never talked about Child K. That the Executive Summary still uses the alienated and alienating language of Child K, is in itself, evidence of agencies lost in the clouds of unnecessary secrecy and fear.

Overall, the Leeds Executive Summary published in March 2012 is a disappointing 24 page document that concludes that Zuzanna's murder 'may have been prevented had the agencies (according to their role and level of responsibility) charged with protecting the public from high risk offenders worked more effectively within the mechanisms available' (LSCB, 2012: 17).

The Summary gives only the briefest of outlines of what happened and what agencies did to try and prevent Clark committing more offences. The inadequate planning for Clark's move from Humberside to West Yorkshire including the decision by the Humberside authorities to only tell West Yorkshire the day before he arrived, even though they had known of his pending move for months, is covered. The Executive Summary itself is confused though about when Clark actually went on the register. The Summary says that he went on the register in 1998 (LSCB, 2012: para.3.2) and later says he went on the register in 2004 (LSCB, 2012: para.3.4).

The Summary is also less than clear on the police activities. It fails to explain the reasons the police gave for initially arresting the parents but whatever those reasons were it 'raised questions' for the report writer (LSCB,2012: para.4.18). It is also unclear who exactly arrested the parents – the West Yorkshire Police local officers in Harehills or officers of the 'Homicide and Major Enquiry Team' or officers of the Child and Public Protection Unit (CPPU). All three were involved in the case at one time and we are told that communications between them were not good.

The police Family Liaison Officers are said in the Summary Report 'to be commended for their sensitive and compassionate response to the family which acted to secure the family's cooperation and confidence in West Yorkshire Police' (LSCB, 2012: Finding 13) when we know the family went home 'within days' of having been arrested (LSCB, 2012: para.3.11) and later when contacted by the FLO they refused to cooperate with the SCR investigation (LSCB, 2012: para.1.7).

We are told that Clark was 'charged with threatening behaviour and criminal damage' whilst he was in Leeds and on the register (LSCB, 2012: para.3.7) but this was not reported to the police officers responsible for his registration. There is also no indication in the Summary as to whether the Crown Prosecution Service was consulted on this charge (and if they were why is there no reference to them in the Summary as another involved agency) or any explanation as to why the case did not go to court where hopefully the full picture would have been revealed.

There are other errors and misunderstandings in the Summary Report. The Home Office and the Ministry of Justice are muddled up (LSCB, 2012: pp23-4). A MAPPA 'emergency' meeting took a month to organise (LSCB, 2012: para.4.15) but the Summary fails to say why. We are told a Teaching Assistant's actions were 'not compliant with good practice or guidance' (LSCB, 2012: Finding14) and then later told that what appear to be those same actions 'demonstrated a level of outstanding practice' (LSCB, 2012: Finding 17). The high degree of error and lack of clarity, demonstrate exactly why these documents need to be in the public domain where they can be subjected to proper scrutiny.

The Leeds Response to Full Publication

The Leeds Local Safeguarding Children Board steadfastly refuses to publish the full Overview Report despite the changes implemented from 10 June 2010 requiring SCR Overview Reports to be published in full. Their argument is simply that this SCR began and was carried out under the *earlier* guidance and therefore full publication is not required; the Under Secretary of State's letter would support them in that (Loughton, 2010). They add that:

> There are surviving family members who do not expect or want publication and to do so would provide further unwelcome attention and an invasion of privacy, thus heaping additional trauma onto that already experienced
>
> (personal communication with the chair of the Leeds LSCB 14 March 2012).

This despite the comment in the published Summary that 'very little is known of Child K's family history' and the fact that the family went home to Poland within days of the murder and later refused to assist with the SCR; had the SCR started post-10 June 2010 the family would have had no say in the matter. The Leeds LSCB also state that the safeguarding of confidentiality by blocking out parts of the report would be too expensive and 'the cost of adequate redaction would be an unacceptable use of public money' (personal communication with the chair of the Leeds LSCB 14 March 2012) again missing the point that they will have to do this in the event of any future SCRs.

More significantly they state that:

> All parties contributed to this SCR in the understanding that information they shared would be confidential and to publish the SCR now would seem to represent a breach of that trust (personal communication with the chair of the Leeds LSCB 14 March 2012).

This is surely to confuse 'confidentiality' with 'secrecy'. Confidentiality has traditionally applied to personal information about the service users and not to the professionals and practitioners. The activities of the professionals and practitioners do not constitute personal information about them and their *private* lives and the SCR was presumably just asking how they performed their *public* roles. This is a way of allowing the agency workers – 'all parties' - to hide behind the arras of confidentiality that is there to protect members of the public and in many ways it is nothing new. It also suggests that under the new regime of full publication, parties contributing to SCRs will be less than forthcoming.

Conclusions

The Coalition government have moved SCRs towards more openness and transparency in order to improve public trust and confidence in public agencies. There is now even talk of changing the very format of SCR's. In his letter regarding the Doncaster case Michael Gove Secretary of State for Education has said:

> The redacted SCR overview report published today does not meet my expectations. It is an example of how the current model of SCRs is failing. It documents everything that happened but with insufficient analysis of why and what could have been done differently. In the future we want SCRs to focus on why professionals acted the way they did, and what was getting in the way of them taking the right action at the right time.
>
> Today's SCR report puts a good deal more information into the public domain on the `J' children case and it is right to publish it. However, I am not satisfied with the position we have reached. In particular, I want to be confident that all the necessary lessons and improvements have been identified. (Department for Education, 2012)

The Munro report had also expressed reservations. Professor Munro recommended that LSCBs adopt 'systems' methodology in conducting SCRs in order to move beyond identifying what happened to explain why it happened (Munro Report, Recommendation 9; see also Corby, 2003).

Meanwhile questions remain about what the SCR really found in the Zuzzana Zommer case, not to mention questions about the Leeds LSCB arguably clinging to technicalities to avoid publishing the full child protection Overview Summary, something they will have to do in future and can avoid this time only by an accident of timing. In terms of building up trust with the local community Leeds have not done themselves any favours.

Finally questions remain about why it has taken the Leeds LSCB so long to publish the child protections SCR; the murder took place in October 2007. We know from the summary that Ofsted sent a first attempt back to them because they had failed to comply with statutory guidance on writing SCRs. In Aril 2009 they started all over again and eventually the Executive Summary of the SCR report was published in March 2012 – almost four and a half years later. Again such delays do not foster trust with the local community.

References

Bryan T and Doyle P (2003) Developing Multi-Agency Public Protection Arrangements, in Matravers, A. *ed* 2003 *Sex Offenders in the Community: managing and reducing the risks*, Cullompton, Willan Publishing.

Corby, B. Doig, A. & Roberts, V. (2001) *Public Inquiries Into Residential Abuse of Children,* London, Jessica Kingsley Publishers.

Corby, B. (2003) Towards a new means of inquiry into child abuse cases *Journal of Social Welfare and Family Law*, 25(3): 229-241.

Department for Education (2012) *Letter from the Education Secretary on the publication of the Edlington SCR,* Press Release, 29 March.

HM Government (2010) *Working Together to Safeguard Children: a guide to inter-agency working to safeguard and promote the welfare of children*, Department for Children, Schools and Families, March.

Leeds LSCB, Local Safeguarding Children Boards (2012) *Executive Summary of Serious Case Review in respect of Child K*, 6 March.
http://www.leedslscb.org.uk/professionals/executivesummaries/Child%20K/Child-K-executivesummary.shtml

Loughton, T. (2010) *Publication of SCR Overview Reports* the Under Secretary of State for Children and Families open letter to Directors of Children's Services and chairs of LSCB 10 June.
http://www.education.gov.uk/munroreview/downloads/LettertoLSCBsreReviewandSCRs10June2010.pdf

Matravers, A. *ed* (2003) *Sex Offenders in the Community: managing and reducing the risks*, Cullompton, Willan Publishing.

Ministry of Justice, National Probation Service, HM Prison Service and Association of Chief Police Officers (2009) *MAPPA Guidance 2009 Version 3*, National Offender Management Service, Public Protection Unit, London.

Ministry of Justice, National Probation Service, HM Prison Service and Association of Chief Police Officers (2012a) *MAPPA Guidance 2012 Version 4*, National Offender Management Service, Offender Management Group and Public Protection Unit, London.

Ministry of Justice, National Probation Service (2012b) *Probation Instructions*. http://www.justice.gov.uk/offenders/probation/probation-instructions

Munro, E. (2011) *Review of Child Protection: Final Report – A child Centred System*, Known as 'the Munro Report', May, London, Cm 8062 TSO.

Parton, N. (2006) *Safeguarding Childhood: early intervention and surveillance in a late modern society,* Palgrave, London.