CHILD J - DOMESTIC HOMICIDE REVIEW and SERIOUS CASE REVIEW (combined)

Report into the death of Child J aged 17

Confident and safer communities
SOUTH AND VALE COMMUNITY SAFETY PARTNERSHIP

OSCB
Oxfordshire Safeguarding Children Board

Contents

1. Introduction

1.1 The circumstances that led to undertaking this Review

1.1.1 This Review was commissioned jointly by the Oxfordshire Safeguarding Children Board (OSCB) and the South and Vale Community Safety Partnership, (S&VCSP) following the homicide of a young woman, Child J, who was resident in Oxfordshire at the time of her death. Child J was 17 years old and as such defined as a child for safeguarding purposes. At the time this Review was commissioned Child J's ex-partner, Adult L, had been charged with her murder. Adult L's brother, Child M, had been charged with a related offence. Child M was 17 years old at the time, and therefore also defined as a child.

1.1.2 The Oxfordshire Safeguarding Children Board's Serious Case Review Sub Group concluded that the case had met the criteria for a Serious Case Review (SCR) as identified in Working Together to Safeguard Children 2013[1], in that there was information that:

a) abuse or neglect of a child is known or suspected; and

(b) either — (i) the child has died; or (ii) the child has been seriously harmed and there is cause for concern as to the way in which the authority, their Board partners or other relevant persons have worked together to safeguard the child.

1.1.3 The South and Vale Community Safety Partnership also identified that the circumstances of Child J's death met the criteria for undertaking a Domestic Homicide Review (DHR) under Section 9(3) of the Domestic Violence, Crime and Victims Act 2004, in that the death resulted from violence caused by a person with whom she had been in an intimate personal relationship.

1.1.4 The review takes as its starting point the government definition of domestic abuse as follows:

'*Any incident or pattern of incidents of controlling, coercive or threatening behaviour, violence or abuse between those aged 16 or over who are or have been intimate partners or family members, regardless of gender or sexuality. This can encompass, but is not limited to, the following types of abuse:*

- *Psychological*
- *Physical*
- *Sexual*
- *Financial*
- *Emotional*

Controlling behaviour is: a range of acts designed to make a person subordinate and/or dependent by isolating them from sources of support, exploiting their resources and capacities for personal gain, depriving them of the means needed for independence, resistance and escape and regulating their everyday behaviour.

[1] Working Together: HM Govt 2013 (since replaced by Working Together 2015)

Coercive behaviour is: an act or a pattern of acts of assault, threats, humiliation and intimidation or other abuse that is used to harm, punish, or frighten their victim.'

1.1.5 A decision was therefore made by the Chairs of the Safeguarding Children Board and Community Safety Partnership to convene one Review combining the requirements of both a Domestic Homicide Review and a Serious Case Review.

1.1.6 Separate consideration was given by the OSCB as to whether the criteria for a SCR had also been met in relation to Child M. Whilst it was decided that the circumstances did not meet the criteria for a separate SCR in relation to Child M, the Review was asked to include consideration of his circumstances as a young person who may have experienced harm in his own right.

1.1.7 This combined Review will examine the responses of all the relevant agencies that had contact with Child J, Adult L and Child M. Given some differences in the requirements of the two review processes, the following timeframes were agreed:

SCR: 1st December 2010 to late December 2013

DHR: 1st February 2011 to late December 2013

The starting point in relation to the SCR requirement was the time at which Children's Social Care Services were first involved with Child J on her move to live with her mother in Oxfordshire.

The starting point in relation to the DHR was agreed as this represented the time at which relevant agencies first became aware that Child J was in a relationship with Adult L.

The end point was chosen as this was the date when it was known that Child J had been killed.

However, where there were significant relevant issues that pre-dated this timescale, it was agreed that these should also be considered.

1.1.8 The key purpose in undertaking this joint SCR and DHR is to ensure that lessons are identified following the death of this individual child as a result of domestic violence. Most importantly the purpose is to ensure a full understanding of what has happened in order to identify improvements and contribute to the prevention of future such tragedies.

1.1.9 The methodology and format required of Domestic Homicide Reviews and Serious Case Reviews are different in some ways. This combined Review has been structured so as to balance the requirements of both Reviews. The methodology for doing so is described in full in Appendix C of this report.

1.1.10 In line with the expectations of both SCRs and DHRs full consideration was given by the Review Panel to the involvement and potential contribution of key family members and friends, and also of Adult L and Child M. It was agreed that the Independent Author of the Review would act as the lead for contact with the family. The arrangements for making contact with the family and others are outlined in more detail in Appendix C and their views are included within this report. Child J's mother was asked how she would prefer her daughter to be

referred to in the report and the anonymisation Child J has therefore been used throughout. Child J's family were also given the opportunity to read and comment on the report prior to a final draft being presented to the OSCB and S&VCSP. The family asked for a number of changes, all of which have been included in the final version of the report.

1.1.11 It is the case that there has been considerable public and media interest regarding the death of Child J and that significant information identifying her is already in the public domain. Nevertheless Child J, the perpetrator and all their family members or friends will be anonymised in this report in order to protect other family members.

Individual	Anonymisation	Age at December 2013 (date of death)
Subject of Review	Child J	17
Perpetrator	Adult L	23
Perpetrator's brother	Child M	17

1.2 Parallel processes

1.2.1. A criminal trial relating to Child J's death took place in the summer of 2014, during the timeframe of this Review. Adult L was convicted of the murder of Child J for which he received a sentence of Life Imprisonment with a minimum tariff of 20 years. Child M was charged with related offences not directly involving Child J's death and was also was sentenced to a period of imprisonment in March 2015.

1.2.2. An inquest was initially opened, but was suspended by the Coroner given the criminal proceedings. Following the conclusion of the criminal proceedings the decision was made under S16 of the Coroners Act 1988 that the inquest would not be resumed.

1.2.3. Throughout the time period during which this Review was undertaken, investigations into the actions of a number of police officers by the Independent Police Complaints Commission were taking place. The outcome of the IPCC investigation was that there were failings by Thames Valley Police and that there was a case for a misconduct hearing against 3 police officers and one member of police staff. The misconduct hearings took place in October 2015. Final written warnings were given to two officers and a written warning was given to a third.

1.2.4. The length of time required by the IPCC to complete their investigations had a significant impact on the ability of this Review to be completed within a reasonable timescale. The resulting delay has had an inevitable impact on the family who have been highly distressed at the continuing delay in concluding these processes. It has further resulted in resource implications for this Review and resulted in the Review not achieving a timely completion as is recognised good practice. Given the impact of this delay this Review includes **a multi-**

agency recommendation that agreement is sought with the IPCC as to how this can be better managed in the future.

2. The Circumstances of Child J's Death

2.1. Child J had lived with her mother in Oxfordshire from June 2010, however by the summer of 2013 she was in a relationship with Adult L, living away from home, often missing and with her whereabouts unknown. In November 2013 she presented herself as homeless to Oxfordshire Children's Social Care (CSC) and was placed in supported accommodation. A number of statutory and other agencies had been involved with Child J throughout her time in Oxfordshire. All the agencies were aware that Child J had been in a relationship with Adult L and that she had experienced domestic violence as a result. The relationship with Adult L had ended, but he continued to be both violent and emotionally abusive and controlling towards Child J.

2.2. On Day1, in December 2013[2] Child J told staff at the supported accommodation that she believed she was pregnant and was going out to meet Adult L, who was the father of her unborn child. Staff unsuccessfully attempted to persuade her not to go out and when, shortly after 01.00am, she had not returned to the hostel they contacted police and reported her missing. The missing incident was graded by the police as being of 'medium risk'[3].

2.3. The last known sighting of Child J was on the afternoon of Day1 when she was seen with Adult L on CCTV footage. Whilst it was unknown to anyone other than Adult L, Child J had been killed by him later that day. Adult L strangled Child J and hid her body in the countryside.

2.4. Thames Valley Police were at the time looking for Adult L in relation to an earlier allegation that he had taken indecent photographs of Child J. As a result he was arrested on the morning of Day2 for possessing indecent images of a child. Following interview he was released on bail later that day with conditions not to contact Child J. On Day7 Adult L returned to the place where he had initially hidden Child J's body, removed it and with the help of Child M hid her body elsewhere.

2.5. On Day7 a strategy discussion took place between Thames Valley Police and Children's Social Care. It was agreed that CSC would contact Child J's family for further information about her. The next day, following review of the case as well as further information provided by the supported housing staff that Adult L had told Child J he would '*throw her off a bridge'* if she were pregnant, the missing person investigation was upgraded to high risk.[4] On Day9 Adult L was

[2] The first day that Child J was missing will be referred to as Day1, with subsequent days being numbered consequentially.

[3] Medium risk is defined as: There are identifiable indicators of risk of serious harm. The offender has the potential to cause serious harm but is unlikely to do so unless there is a change in circumstances

[4] High Risk in this context is defined as follows: The risk posed is immediate and there are substantial grounds for believing that the subject is in danger through their own vulnerability: or may have been the victim of a serious crime…"

arrested on suspicion of kidnapping Child J and the following day Child M was also arrested. On Day13 Adult L was charged with the murder of Child J and perverting the course of justice. He was remanded into custody. On Day14 Child M was charged with assisting an offender and also remanded into custody.

2.6. Child J's body was found on Day15. Subsequent post mortem examinations confirmed that Child J had died as a result of strangulation and that she also had a number of other injuries which were not a direct cause of death. It was not possible to confirm conclusively whether Child J was pregnant.

3. Chronology of Key Events

Full chronologies were provided by the agencies identified in Appendix C, including the detail of their involvement with Child J, Adult L and Child M. The resulting combined chronology was extensive and the following section therefore summarises this in narrative form.

3.1 Significant Historical information

3.1.1. Child J was the youngest child of a family who moved to Oxford when she was 5 years old. Child J's parents experienced a number of separations and reconciliations and in 2005 Child J's father moved with all of the children to live in the North West. Child J's father died of a heart attack in 2014 a few days before the trial in relation to his daughter's murder.

3.1.2. Following the parents' divorce there were significant disputes about residence of the two younger children and in 2005 a Residence Order was made in the Family Courts on behalf of their father. Allegations were subsequently made by both Child J's mother and one of Child J's siblings that their father was violent and that he was leaving the children unsupervised. Child J had also experienced problems in school and had been permanently excluded.

3.1.3. In mid-2010 both Child J and one of her siblings returned to Oxford to live with their mother. Child J's mother had serious problems herself, including in her relationship with her current partner which impacted on Child J's stability and on her mother's capacity to meet Child J's emotional needs.

3.1.4. Oxfordshire Children's Social Care (CSC) first became aware of Child J a few months before the starting point for this report, initially because of a notification from the police of an incident of domestic abuse in which Child J's mother's partner had assaulted Child J's mother

3.2 December 2010 to December 2011: Agency involvement with Child J

3.2.1. Child J was at this point living with her mother and attending her local secondary school. Her vulnerability, including a recent suicide attempt and significant difficulties at home, was already known to both health services and

CSC who were at the time involved in preparing a S37[5] report for the Family Court in relation to the ongoing dispute between her parents regarding residence. The Local Authority concluded that Child J was not at risk of significant harm, but was a Child in Need[6]. Child J had recently been referred to CAMHS (Child and Adolescent Mental Health Services) and to Positive Activities for Young People.[7]

3.2.2. A multi-agency meeting took place in December 2010 at the school, attended by: Child J's mother with her own counsellor, the Positive Activities for Young People Worker (PAYP1), Education Support staff, Social Worker (SW1) and a worker from the Family Placement Support Service[8] FPSS1. The focus of the meeting was attempting to help Child J and her mother with all the identified concerns, including accommodation given the mother's recent experience of domestic abuse, and Child J's school attendance and behaviour. The following day the Family Court made a Residence Order in favour of Child J's mother, supported by the Local Authority and her case was transferred to a new Social Worker (SW2).

3.2.3. Within weeks of the Residence Order being made at court it is apparent that there were quite significant difficulties for Child J at home. Child J's mother had reconciled with her partner, but there were also frequent separations. There were evidently tensions between Child J, her mother and her mother's partner. Child J's mother's drug and mental health problems frequently impacted on Child J, leading to arguments and concerns that Child J was often having to take on a support role in relation to her mother rather than having her own needs met.

3.2.4. Child J continued to experience a range of problems at school, with poor attendance and frequent exclusions, which her mother was finding difficult to deal with. A range of support and other measures were put in place by the school, including mentors and a reduced timetable. FPSS1 was to undertake short term work with Child J and her mother on their relationship. Some support services were already in place for Child J's mother, and others, including a place on a 'Living with a Teenager' course, were also provided. Child J began to have regular contact with PAYP1 who frequently went with Child J to meetings with other professionals. PCAMHS[9] Family Support provided 4 counselling sessions for Child J with her mother and her mother's partner. The practitioners involved however considered this was inadequate for Child J's needs. SW2 was regularly involved in liaison with the school, PCAMHS, PAYP1 and other professionals.

[5] A S37 (Children Act 1989) report is undertaken by the Local Authority during any private law proceedings when a question arises about the welfare of the child, and it seems to the court that it might be appropriate for a Care Order or Supervision Order to be made.

[6] A Child in Need under S17 of the Children Act is defined as a child who is 'unlikely to achieve or maintain or to have the opportunity of achieving or maintaining, a reasonable standard of health or development without the provision for him of services by a local authority.'

[7] Positive Activities for Young People (PAYP) was a programme for young people at risk of social exclusion or of being involved in community crime.

[8] The Family Placement Support Service is a service within Oxfordshire County Council for adolescents who are considered to be on the edge of involvement with the Care system.

[9] PCAMHS: Primary Child and Adolescent Mental Health Services

3.2.5. In February 2011 Child J asked to be moved into foster care due to continuing problems in the relationship between her, her mother and her mother's partner. SW2 spent time with Child J and her mother and it was agreed that a meeting at school would be arranged and a referral for an 'On Course' programme would be made. This was a 4 week programme off the school site run by the Local Authority, with the aim of developing resilience, anger management, increasing confidence and self-esteem. The level of distress and tension in the relationship between Child J and her mother was evident from SW2's recordings. There were also difficult discussions about what Child J wanted from professionals as she now said she did not want to go to foster care. Child J told SW2 that she was sick of having to repeat herself about what had happened to her and what was happening now. SW2 concluded that Foster Care would not be considered at this point, but she would continue to work with Child J and her mother on improving their relationship.

3.2.6. In mid-February PAYP1's involvement ended. PAYP1 had worked positively with Child J who had engaged with her well. Child J was adamant that she wanted to continue working with PAYP1. PAYP1 was concerned that Child J needed long term counselling and referred her to Face2Face Youth Counselling Service to be taken up after the PCAMHS work finished. However Child J only attended the introductory meeting with Face2Face and after several unsuccessful attempts to gain her attendance at appointments, her case was closed. PAYP1 offered to seek an exception to her agency's normal practice to allow her to continue working with Child J, but SW2 felt Child J had enough support at the time. At this point there were also suggestions that Child J could be referred to the Young Carer's Project and the Youth Mentoring Service. A multi-agency planning meeting took place where the various support provisions were reviewed, it was agreed that Child J would attend the On Course programme after the Easter holidays and that CSC involvement would be reviewed by SW2 at the next meeting.

3.2.7. The pattern of difficulties at home and school continued over subsequent months, with periods when Child J was missing from both school and home and with crises often dominating both the family and the professionals' time. Child J's frequent absence from school and the limited hours she was able to attend due to behavioural problems, contributed to escalating tensions at home. Child J again asked to go into foster care, on one occasion threatening to kill herself or go missing if this didn't happen. Her mother also talked about Child J going into Care. On two occasions in March 2011 Child J's mother reported her missing to the police, although she subsequently returned. This was reported by the police to CSC. At times Child J's mother's mood was very low and FPSS1, who was very worried about her, made contact with her GP to seek appointments and specialist referrals for her. There continued to be frequent contact between the various professionals. Child J was at times verbally abusive and confrontational with professionals.

3.2.8. SW2 maintained the approach of trying to work with Child J and her mother. However, at the end of March 2011 in the context of her own increasing mental health problems Child J's mother said that she wanted Child J to go into care for a period of respite. Attempts were made to find a short term foster placement for Child J, but when this was unsuccessful SW2 contacted Child J's

sister in County A and arrangements were made for Child J to stay with her for a fortnight during the school holidays. This appeared to be a successful placement with Child J settling well and no identified problems from her sister's perspective.

3.2.9. When she returned to Oxfordshire, Child J began the On Course programme organised by the school, in place of returning to class and her normal timetable. Child J's attendance at this course was almost 100%, her previous attendance at school when she had a reduced timetable having been just under 50%. In June Child J settled well back into school following the course with considerably less exclusions and behavioural problems.

3.2.10. In June Children's Social Care concluded that Child J had made good progress and that their involvement could be ended in August. In July 2011 Child J rang 999 saying that she had been assaulted by her mother, however the attending police officer was satisfied that there was no unlawful assault. Whilst the officer referred this to the Child Abuse Investigation Unit (CAIU) there was no record of a referral being made to Children's Social Care. At a multi-agency (Child in Need) planning meeting two days later it was agreed that Child J and her mother had made excellent progress, that Child J would start a full timetable in the September term and that her case would be closed to both SW2 and FPSS1.

3.2.11. Child J had previously been identified as having Special Educational Needs requiring School Action. This was reassessed as requiring School Action Plus[10] and a comprehensive individual programme was put in place for her resulting in a significant improvement in literacy and comprehension by the beginning of the new school year.

3.2.12. In July 2011 Child J's case was closed to Children's Social Care. There is no known service involvement with Child J over the school holidays.

3.2.13. In autumn 2011 the school were still identifying some concerns regarding Child J's needs within school and the number of exclusions she had had. Child J was provided with mentoring help from two members of staff, the Year 10 support and guidance manager, Ed3, and the Year 10 School Inclusion mentor, Edmentor1, with whom she developed a particularly good relationship. The school arranged for an Educational Psychologist's assessment to help them with their planning and strategies, and wherever possible provided support to both Child J and her mother. Child J's attendance improved to 94% during the school year and she was experienced as more positive about school and her future.

3.3 February 2011 – January 2012: Involvement with Adult L and Child M

3.3.1. At this point Adult L was 20 years old; he was living in supported lodgings and still receiving support from a Leaving Care Personal Advisor (LCPA) from CSC. Adult L was not in education, employment or training and had specialist support

[10] **School Action** is a plan of educational support put in place when there is evidence that a child is not making progress at school and there is a need for action to be taken to meet learning difficulties **School Action Plus** is adopted when adequate support is not being achieved by School Action and there is a need for more specialist help.

as a result. He also had a housing support worker, although this service was coming to an end and Adult L wanted to have his own independent accommodation. Adult L had been banned from a supported accommodation project (run by Stonham part of the Home Group), in which he had previously lived. This was due to various breaches of his tenancy including drug use and violence. Adult L regularly missed appointments with his various workers, was evidently difficult to work with in any planned way and could be aggressive at times. Despite this LCPA persisted in providing the service.

3.3.2. Adult L was also subject to a Community Punishment with a requirement to perform Unpaid Work following a conviction for a Public Order Offence in December 2010, which involved him shouting abuse at his Social Worker in the street. His Community Punishment Order was supervised by Thames Valley Probation Trust and this order required no '*supervisory offender management'* as by its nature it is purely a punishment. The Probation Service had access to previous records from the Youth Offending Service. Adult L was assessed as a medium risk of harm to others. Adult L failed to complete his Community Punishment and was returned to court for breach of his order on 3 occasions. In October 2011 the order was revoked and replaced with a 6 month Community Order with a supervision requirement, although this had not been recommended by the Probation Service. His engagement was superficial and the order expired in April 2012.

3.3.3. Although LCPA recorded signs of Adult L being more settled, there were during this period further incidences which demonstrated aggressive and worrying behaviour. This included an allegation of threats of extreme violence at a takeaway. The police were involved but no further action was taken. There was frequent evidence of demanding behaviour towards professionals and Adult L engaged in a very limited way with any attempt to help him. This was occasionally interspersed with moments of regret for his actions and concern about his behaviour.

3.3.4. There were also incidences of reported domestic abuse towards Adult L's partner at that time and by the summer of 2011 Adult L's landlady was describing deteriorating behaviour and wanted him to move out. LCPA provided advice and support in helping Adult L access independent accommodation and training opportunities. Adult L gained the tenancy of his own accommodation in late 2011. The Housing Association, SOHA, had reservations about the tenancy and sought a support plan from LCPA which was provided.

3.3.5. Adult L had a number of consultations with his GP, often to obtain medical certificates relating to work or Community Punishment. He described himself as '*paranoid and anxious all the time'*. In September the GP referred him to Community Mental Health in relation to personality issues, describing him as '*not objectively anxious or depressed'*. His history of cannabis and cocaine use was also noted. The Community Mental Health assessment took place the following month. He was not diagnosed with any mental illness. He was advised of services which could provide help with reducing substance misuse and anxiety.

3.3.6. There was limited service involvement with Child M during this period. In early 2011, 14 year old Child M assaulted a 12 year old for which he received a Final

Warning from the police. Not long afterwards there was another allegation of abusive anti-social behaviour, but no further action was taken by the police due to insufficient evidence. The school noted a number of exclusions due to Child M's behaviour, including assaults on other pupils.

3.4 February 2012 to February 2013: Child J

3.4.1. In February 2012 ED3 completed a CAF[11], (Common Assessment Framework) and in line with practice forwarded this to the Local Authority Early Intervention Service (EIS) for a positive activities intervention. The EIS worked from a local multi-agency 'Hub'. The focus of the CAF was Child J and her mother's social isolation and parenting needs. It was also recorded that Child J had disclosed at school that she had been sexually assaulted by another child some years ago. This information was not referred to Children's Social Care.

3.4.2. ED3 asked for someone from the Early Intervention Service to attend the Team Around the Child (TAC) meeting that was planned as a result. There was no-one from the EIS available for the meeting but a worker, EIS1 was subsequently allocated to Child J. EIS1 made a number of attempts to contact Child J and eventually met with her at the end of April. Subsequent attempts to engage Child J by EIS1 were largely unsuccessful.

3.4.3. The school had also sought support from Addaction[12], a local drugs service, as Child J and a number of other young people had been found smoking cannabis. Addaction provided a number of group sessions and two individual sessions with Child J before she withdrew. Child J was also now involved with, a local charity which offered detached youth work.

3.4.4. In May 2012 a referral was made to the Children and Families Duty Team by the Police CAIU following police attendance at Child J's home when she was found to have self-harmed. The duty Social Worker from the assessment team wrote to Child J's mother advising her to contact PCAMHS and the school.

3.4.5. Two further multi-agency TAC meetings took place during the early summer with the focus on supporting Child J and her mother. The EIS worker did not attend these meetings. Whilst it is not explicit who was the lead professional, this role would have fallen to the school and it is clear that school staff were the driving force and that meetings took place in the school. Further meetings were arranged and then cancelled due to either Child J's absence or her mother's ill health and the TAC approach in effect ended as a result.

3.4.6. At the end of August Child J's mother took Child J to the GP concerned that she was suicidal. Child J described her unhappiness at school, self-harming and use of cannabis. Child J's mother's mental health problems were also noted. Child J did not want to be re-referred to PCAMHS, the GP assessed that she was not at

[11] The Common Assessment Framework (CAF) is a standardised approach used across agencies to conducting an assessment of a child's additional needs and deciding how those needs should be met. The CAF is used when the needs do not meet the thresholds that would trigger child protection processes.

[12] Addaction was commissioned at this time to provide drug services, but is no longer the provider of these services.

immediate risk of intentional suicide, but was at risk of harm by misadventure. The GP planned a review in two weeks, but there is no evidence that this took place.

3.4.7. At the beginning of the new school year, Child J's attendance was again deteriorating and this was linked in part to her taking time off to care for her mother. There appeared to be limited input by the EIS and later in the autumn the school again referred Child J to the Hub for work on her cannabis use. This was referred again to Addaction, but a first meeting in early January 2013 was cancelled by Child J. The school were concerned about Child J's general physical and emotional health and asked for a GP appointment; this took place but was a routine duty appointment with no specific outcome.

3.4.8. In January 2013 Child J's mother left the home after an argument leaving her partner with Child J, resulting in a further confrontation between these two. The police were called by a worker at the Home Group Hostel who was told about the emerging situation by a friend of Child J's and was concerned from what she heard that Child J might be at risk. Police attended Child J's address and took her to the Home Group Hostel to be with her friend who was a resident there. ED3 phoned Children's Social Care, informed the duty team of what had happened, that Child J had recently had to take her mother to hospital following a fit triggered by substance abuse and that Child J now had a boyfriend who was a known drug dealer.

3.4.9. The following day a Social Worker from the duty team was able to contact Child J by phone. Child J would not return to the house while her mother's partner was there and it was decided to undertake an Initial Assessment. There were various discussions including Child J and staff at the school and for the first time it was identified that Child J was now in a relationship with Adult L. Child J spoke about Adult L and said that he had assaulted her, spat at her and taken her mobile phone. Child J said that she was scared of him and did not feel safe living in the area.

3.4.10. Eventually it was agreed that Child J would go temporarily to stay with her sister in County A and she was provided with money for travel. The school were informed and agreed they would send work for her to do, although Child J's mother understands this did not actually happen before she returned to Oxfordshire shortly afterwards.

3.5 February 2012 to February 2013: Adult L and Child M

3.5.1. LCPA1, Adult L's Personal Advisor continued to support him in setting up home and other practical tasks. LCPA1 attempted to work with him and also challenge him on other concerns, such as possession of weapons and his aggressively racist attitudes, but with limited impact. Adult L is described as '*bombarding*' LCPA1 with constant demands when there were specific things he wanted and being aggressively critical if these were not met.

3.5.2. In July 2012 Adult L had received a letter from SOHA the Housing Association about allegations of drug dealing and care of the garden. He spoke about this to LCPA1 who arranged for contact with SOHA's Anti-Social Behaviour (ASB) Officer. Adult L denied he was involved in any drug dealing. On another

occasion Adult L told LCPA1 that an unknown person had come to try to stab him in his home and that there was *"£6000 on his head*". LCPA1 made inquiries with the Police but no information supporting the allegation that there was '*a price on his head'* was found.

3.5.3. Adult L subsequently said he wanted to be rehoused and LCPA1 arranged for a joint home visit with SOHA's ASB officer. When they arrived the police were already at the house, taking drug swabs from Adult L. The different roles and approaches of the professionals involved contributed to a difficult meeting, with Adult L becoming both distressed and abusive. The drug tests were found to be positive for cocaine, heroin and cannabis and SOHA recorded that a 'knife, hatchet and hammer' had been found in the flat. Adult L was served with a possession order by SOHA in August. LCPA1 offered him help and advice as to how to respond and where to access specialist help as well as mediating between Adult L and SOHA.

3.5.4. In August 2012 Adult L's then girlfriend telephoned the police from A&E to report that Adult L had hit her in the face. She described regular violence, a previous attempt to strangle her and threats to kill her if she reported this to the police. Adult L's girlfriend was unwilling to make a statement to the police about the assault due to fear of reprisals but her father, who had also been threatened by Adult L, did give a statement. Adult L was given a Harassment Warning Notice[13] by the police. The Police were called again two weeks after this assault by the young woman's father as Adult L had come to their house. Adult L said that he had come to return her mobile phone. The police informed SOHA that Adult L had breached his Harassment Warning Notice and this information was in turn forwarded to CSC by SOHA. There were further occasions over the following months when Adult L attempted to contact his ex-girlfriend, despite bail conditions that he should not do so.

3.5.5. Later that month Adult L was charged with assault after it was alleged he had stabbed another man. The case was ultimately discontinued by the CPS as the victim withdrew his support and other witnesses were not willing to attend court. LCPA1 also had concerns about whether Adult L was involved in other offending.

3.5.6. LCPA1 continued to support Adult L into the autumn, including attempting to find him alternative accommodation, although he was now 21 years old. As had previously been the case, Adult L's behaviour and unwillingness to follow advice made it difficult to support him effectively. SOHA took legal action to evict Adult L and this took place in March 2013 although Adult L moved out before that date. On the date of the eviction the Police were called to help and a number of weapons, including an imitation gun were found.

3.5.7. As Adult L had reached the age of 21 and was no longer eligible for Leaving Care support, his case was closed after a final meeting with LCPA1 in October 2012. Adult L was clear that he did not want any further support and at the time his case was closed he had no home of his own but was moving between different friends. At the point his case was closed he told LCPA1 that he had a new girlfriend, but gave no details.

[13] A Harassment Warning Notice can be given by the police where it is considered this may be sufficient to stop future harassment.

3.5.8. In January 2013 Police received a report of an intruder at the Home Group Hostel. The intruder was not found, but had been identified by another young person as Adult L. It was believed that he was trying to gain access to a resident in relation to a drug debt. A few days later the police and ambulance were called by Adult L who had received head injuries. Adult L's older brother was subsequently cautioned for the assault.

3.5.9. Child M received a Final Warning programme in summer 2012 for the offence of Actual Bodily Harm committed against another young person a year previously. The programme was delivered by a Police Officer within the Youth Offending Service. An ASSET[14] assessment was undertaken and although the risk assessment has not been recorded, the information available identifies a young person with considerable problems at home who despite some bravado was in fact described as '*timid and worried'*.

3.5.10. A referral was made by the Youth Offending Service (YOS) seconded Police Officer to the Early Interventions Service, seeking support for Child M with anger management as well as positive activities. It also identified a number of problems in the home including the death of his grandfather, domestic abuse and his father's serious illness, all of which were causing Child M difficulties. Three sessions with an early intervention worker were provided including one with a substance misuse worker.

3.6 February 2013 to December 2013: Child J, Adult L and Child M

From this point onwards, Child J was known to be in a relationship with Adult L and therefore their stories are now combined.

3.6.1. Child J stayed with her sister and family in County A for two weeks at the beginning of February 2013. During her stay, CSC closed the case on the presumption that Child J was going to remain with her sister and wrote to Child J's mother and her sister to inform them of the position. Despite having previously intended to undertake an Initial Assessment, the Social Worker (SW3) concluded that there was no need to contact Children's Services in County A, but that there should be a further assessment if Child J returned to live in Oxfordshire.

3.6.2. Edmentor1 from Child J's school contacted Children's Social Care, the day after Child J returned to Oxfordshire and told them that they had not seen Child J, but understood that her mother did not want her to live with her. SW3 eventually made contact by phone with Child J's mother who confirmed that Child J had returned the previous week, but that she wanted her to go back to County A. SW3 then spoke to Child J, who did not want to go back to her sister's. SW3 arranged an appointment to undertake an Initial Assessment.

3.6.3. The following day Child J was taken to hospital by ambulance with her partner (not named) complaining of stomach pains following an attempted overdose 2 days previously. It was noted at the hospital that Child J had probably not intended to die, also that she had self-harmed by cutting. In the early hours of

[14] **ASSET** is an assessment tool used nationally by Youth Offending Teams to assess risk of reoffending, vulnerability and risk of serious harm.

the following morning Child J discharged herself. The hospital contacted the Police to say that she had absconded and shortly afterwards the Police found Child J at home with her mother. Whilst the hospital records refer to involvement with Children's Social Care there is no evidence that either the hospital or the Police informed CSC of this incident, but they were informed by Child J's mother.

3.6.4. The Initial Assessment was allocated to a specialist housing Social Worker from the Children and Families Assessment team, SW4, who met the family and identified the need for a full Core Assessment[15]. The Social Worker made a referral to FPSS, the Family and Placement Support Service (Oxfordshire County Council's service for children at the 'edge of care'). This was for further work to support Child J's mother's parenting although this was not actioned, as Child J's mother and her partner stated they were going to move away. Child J's mother was recorded as having no current support with her mental health issues and a referral was made for her to locally based Community Services for support, although this service was not able to begin work with her until October due to their waiting list. Child J's attendance at school was now very low but she had daily contact with Edmentor1 with whom she would discuss things that she would not talk to other professionals about.

3.6.5. An urgent appointment was also made for Child J with CAMHS and she attended for assessment the following week. The assessment concluded that Child J did not present any diagnosable mental health problems. The recommendation was to ask CSC to call a multi-agency meeting. A care co-ordinator, CAMHS3, was appointed. As CAMHS3 had identified a number of indicators that might place Child J at risk of Child Sexual Exploitation, a referral was made to the specialist CSE team, Kingfisher. The Kingfisher team assessed this referral and concluded that the risks to Child J were due to domestic abuse, not CSE.

3.6.6. Although Child J's mother was planning to move away, Child J stated that she wanted to remain and would not agree to accommodation other than in the immediate locality. The Social Worker completed a Young Person's Housing Assessment and this was sent to South Oxfordshire District Council Housing team during March. SW4 assessed that attempts to sustain Child J's relationship with her mother were likely to be unsuccessful. The tense home situation and Child J's mother's apparently increasing problems, made the need for alternative accommodation urgent. Contact was again made with Child J's sister, who was happy to provide Child J with a home, but commented that Child J had felt isolated there and had wanted to return to Oxfordshire. Child J wanted to have a place at the Home Group supported accommodation, but none was available at the time.

3.6.7. Child J failed to keep her next appointment with CAMHS or with a drugs worker. CAMHS3 agreed with the Consultant Psychiatrist that Child J should be referred to the CAMHS outreach team (OSCA) as this might be a more appropriate approach. The OSCA team undertook two home visits in April, the first

[15] **Section 47** of the Children Act 1989 places a duty on LAs to investigate and make inquiries into the circumstances of children considered to be at risk of 'significant harm' and, to decide what action, if any, it may need to take to safeguard and promote the child's welfare. This is also referred to as a Core Assessment.

unsuccessful as Child J was under the influence of drugs or alcohol but the second visit was successful and they offered a period of OSCA support. However, Child J texted the two OSCA workers after the visit to say that she did not want their involvement. The case was closed to the OSCA team (but remained open to CAMHS) and SW5 informed.

3.6.8. Child J's mother told SW4 that she was worried about Child J's partner, Adult L, who had been '*harassing her'*. She described him as controlling and threatening towards Child J and was worried that he might hurt her. She had stopped Child J from going out of the flat to see him and believed that Child J would not accept accommodation away from the local area because she wanted to remain near him. Child J's mother said she would call the Police if she needed to. Child J said that she was no longer in a relationship with Adult L, but that he was coming to see her '*for a chat and to provide her with cannabis'*. It was recorded that Adult L had a history of involvement with Social Care, aggressive behaviour and drug dealing.

3.6.9. SW4 arranged a joint meeting with Child J and Edmentor1 to assess the risk of domestic abuse using a CAADA-DASH[16] form. This identified a very high level of risk to Child J from Adult L. There was information about a range of highly abusive and concerning behaviour and a history of abuse and violence with previous partners. With Child J's agreement SW4 arranged for a referral to be made to the MARAC[17]. Child J had become dependent on Adult L emotionally and also practically as there were times when she said there was no food in the house and he would bring her something to eat. It was identified that Child J would be unlikely to be able to act on any advice to reduce contact with him.

3.6.10. The DASH form was processed and the case allocated to an Independent Domestic Violence Advisor, IDVA1. IDVA1 arranged to undertake a joint visit to Child J with SW4 a few days later at the end of March. This was cancelled at short notice as IDVA1 had been told by her manager that their service was unable to work with 16 year olds without a MARAC referral. The MARAC meeting was not due for a further two weeks. In the absence of an IDVA, the Oxfordshire Domestic Abuse Service, ODAS, were willing to offer Child J outreach support, although they did not normally work with high risk cases.

3.6.11. A decision was then made by SW4's manager, ATM1,that S47[18] procedures were not appropriate and the case would be transferred from SW4 to SW5 in the Leaving Care team. A Child in Need Planning/ Transfer meeting was held in early April attended by Child J, SW4, SW5, the Consultant Psychiatrist and EIS1. The decision to close the case to CAMHS was explained due to Child J's lack of engagement and the fact that her mental health was not considered a major risk. The opportunity for her to be re-referred in future was left open. EIS1 had had

[16] CAADA-DASH Risk Identification Checklist, is a nationally used tool used to assess the risk of domestic abuse.

[17] **MARAC: (** Multi Agency Risk Assessment Conference.) Multi-agency assessment meeting in relation to serious domestic violence.

[18] **Section 47** of the Children Act 1989 places a duty on LAs to investigate and make inquiries into the circumstances of children considered to be at risk of 'significant harm' and, to decide what action, if any, it may need to take to safeguard and promote the child's welfare. This is also referred to as a Core Assessment.

no contact with Child J and was in the process of withdrawing from involvement with her. EdMentor1 was unable to attend. The Hub Drug Misuse Worker also gave apologies and shortly afterwards closed the case due to Child J's lack of engagement.

3.6.12. An interview with the Home Group supported accommodation was arranged in April 2013. However Child J left the interview because the project required a safety plan, which would have excluded Adult L from the premises.

3.6.13. The MARAC meeting took place on 18th April 2013 and Child J's case was discussed. The recommended action from the meeting was that Child J should be offered advice and support by the IDVA service. This information was forwarded to the GP and representatives from all the key agencies were at the meeting.

3.6.14. At the end of April 2013 Child J's mother called the Police after Child J had rung her in distress; she was with Adult L and was asking her mother if she could come to her. Child J was immediately contacted by the Police on her mobile. She told the Police she was fine and had left without Adult L. She would not tell the Police where she was. Numerous attempts were made to contact her by the Police over the following few days and she was eventually spoken to. The attending Police Officers graded Child J as at '*standard risk*'[19] of domestic abuse from Adult L. They were not aware that she had been subject to a MARAC.

3.6.15. On another occasion Adult L visited the Home Group supported accommodation in an attempt to find Child J and assaulted a female resident who knew her. He also stole the resident's phone. The Police were contacted and attempted to find and arrest Adult L without success. A decision was later made by a Police Sergeant that a welfare check on Child J should take place, given the staff concerns about Adult L. Enquiries were made with Child J's mother who did not know where she was, but then later received a phone call from her. When Adult L was arrested the resident he had assaulted was unwilling to make a statement as she feared repercussions. A safety plan was put in place for the resident. Other residents were also afraid of Adult L.

3.6.16. Child J was also reported missing by SW5 a couple of days later. She had not been in school for nearly two weeks; there had been an argument with her mother who had locked her out of the house. Child J told her mother she was with friends, but would not tell her where. Edmentor1 had received texts and a phone call from Child J, but was very concerned about her safety given what was known about Adult L. The Police graded her as medium risk. Both Adult L and Child J were found by Police later that day at Adult L's cousin's address in Reading. Adult L was arrested for the offences at the hostel and Child J taken to the police station where Police spoke to the Emergency Duty Team. Child J insisted on returning to the cousin's address.

3.6.17. The following evening Edmentor1 was phoned by Child J who sounded distressed and asked to be collected from an address in Reading. Edmentor1 heard a male voice, and the line went dead. Edmentor1 called the Police who went immediately to the address. The occupants initially said that Child J was

[19] Standard risk is defined as: Current evidence does not indicate likelihood of causing serious harm

not there, but she came out visibly distressed, saying she wanted to leave. She was taken to the police station but would not say what had upset her. She denied she was in a relationship with Adult L but refused to go to alternative accommodation and became distressed that she would not be able to go back to the Reading accommodation. Officers eventually returned her there with her mother's agreement. Adult L was not present, but his cousin and partner were.

3.6.18. In June 2013 Child J reported to the police that Adult L had stolen her phone by ripping it out of her clothing while threatening her. She was now at her mother's house and provided a statement to the police when they visited but withdrew her consent the following day. The officers assessed her as at medium risk.

3.6.19. Child J continued to be effectively homeless over the summer, with family and professionals often not knowing where she was. Child J's mother told both Child J and SW5 that she did not want Child J to stay with her while she was with Adult L. Throughout all this time Child J maintained frequent, if irregular, contact with Edmentor1 who in turn kept SW5 informed. On at least one occasion Adult L had deleted all Child J's contacts from her phone. Edmentor1 could often tell by the way Child J responded to her whether Adult L was listening to the calls. Some days later in May, Child J contacted Edmentor1 and said that she wanted to return, but had nowhere to go. She also wanted to come into school for an exam. Edmentor1 encouraged her to keep in touch and agreed she would contact SW5 to see if there was any accommodation available.

3.6.20. In June 2013 Child J contacted Edmentor1 and arranged to meet her. Edmentor1 took her some clothing and was concerned at her weight loss and how dishevelled she looked. After separating from Adult L when Child J reported him to the police, she was now again in a relationship with him. They were sleeping on sofas, with friends and sometimes in doorways. Edmentor1 again offered to help find her accommodation, but Child J refused as she wanted to stay with Adult L. Edmentor1 provided her with some food and Child J promised to stay in touch.

3.6.21. On June 17th 2013 Child J phoned SW5 from a pay phone. She was homeless, had no money and no longer had her mobile phone. SW5 organised for her to go to the social services office in Reading and as there was no accommodation for her locally arranged a travel warrant for her to go to County A. There is no information in SW5's records to demonstrate that he had agreed this course of action in advance with Child J or that he had made contact with Child J's sister, only that he provided her number to Edmentor1 to pass on to Child J. Child J then rang Edmentor1 very distressed, too frightened to go to County A on her own. Edmentor1 contacted the Police concerned for her welfare, but due to an error by the call taker the Police went to the wrong location in an attempt to find her. Child J slept in the block of flats, outside her mother's front door that night and the following day contacted Edmentor1 and met her at the school. Child J could not be persuaded to go to stay at her sister's. Edmentor1 informed SW5 who then informed the Police.

3.6.22. A significant event in relation to Child M also took place in July. Police were called by family members to Child M's home alleging that Child M was threatening his father with a knife. Child M was arrested for affray, but denied

the offence stating that his actions were effectively self-defence as the family dog, of whom he was terrified had been trained to attack him. This was disputed by Child M's father and Child M was bailed to live with another brother pending a decision as to whether he would be charged. The Police made a referral to CSC and forwarded the information to school and community health. Child M was charged with assault, but the case did not proceed to court as neither his father nor another family member were willing to attend.

3.6.23. CSC began an Initial Assessment and then a Core Assessment which was allocated to SW4 as a specialist Housing Social Worker. There was information to support Child M's description of what had happened; that he was experiencing emotional abuse in the home and that his father exerted a high level of control in the family. The focus of CSC's work with Child M was to find him supported accommodation as he could only stay at his brother's for a short period. Child M did not want to be accommodated by the Local Authority under S20. In August Child M was placed on the waiting list for a place at Home Group supported accommodation. Managing his frustrations while he waited and providing other practical help appeared to be the main content of social work contact. His case was transferred to SW5 in the leaving care team at the beginning of December 2013.

3.6.24. Attempts continued over the summer of 2013 to find Child J accommodation and persuade her to accept it. Child J's mother would only allow her to return home if she was not in a relationship with Adult L. Child J would not accept anything that meant separating from Adult L. SW5 organised an assessment for a place at supported accommodation provided by Bournemouth Church Housing Association (BCHA). However his priority was on arranging a placement for Child J with her sister. Child J's sister and family did agree that she could come and stay with them and Child J went to County A in August. They were provided with some financial assistance by CSC.

3.6.25. As SW5 was absent on sick leave, SW5's manager also made contact with the local leaving care service to see whether they would offer support, but this was not agreed. Child J's sister complained to SW5's manager that SW5 had not confirmed with her when Child J was arriving and she only knew that she had arrived when she was contacted by the police to see if she would be meeting her at the station. It is unclear if there was a shared understanding about whether this was to be a temporary or a potentially permanent placement. Nevertheless, SW5 contacted BCHA Supported Housing to tell them to remove Child J from their waiting list as she had moved to her sisters "*hopefully on a permanent basis*". In September her case was closed on the CSC system.

3.6.26. In mid-September 2013 Child J contacted Childline, who arranged for her to speak to Oxfordshire CSC. Child J wanted to return to Oxfordshire but had no money or means to do so following an argument with her sister. There is no information as to whether Child J did speak to Oxfordshire CSC. Child J's sister rang SW5 three days later and informed him that Child J had returned to Reading having left significant phone bills talking to Adult L. She was very concerned that Child J was at risk from Adult L and would still have been willing to provide her with a home. Child J's sister told this Review that Child J had returned to Reading under threats and pressure from Adult L who had come to

collect her. Child J also contacted SW5 in need of money but was told that she was no longer classified as a Child in Need under S17 of the Children's Act and as such not entitled to any funds. Child J spent a few days with her mother but was not allowed to remain as Adult L was being threatening to both Child J and her mother.

3.6.27. On 2nd October 2013 Adult L was named as a suspect following the theft of a suitcase from a train. He was sentenced to a 12 month Community Order with unpaid work for this offence at Reading Magistrates Court on 25th November.

3.6.28. Child J was again effectively homeless and appeared to be with Adult L. On one occasion she presented at the Hub, '*hungry and distressed'.* At this point she told staff she was staying in Reading with Adult L's cousin. The worker from the Hub contacted SW5, but was told that the case was closed and that Child J should be told to return to her sister in County A and was not homeless. On another occasion Child J contacted Childline, and arrangements were again made to organise a three way call with Oxfordshire CSC which she did not take up.

3.6.29. A Case Closure summary was signed off by SW5 and his manager on 11th October. The summary refers to Child J having moved to her sister's and being happy to remain there, although this was clearly no longer the case.

3.6.30. In October there was a multi-agency meeting at Home Group supported accommodation in relation to Child M's application for a place. Child M agreed to the project's requirement that Adult L would not be allowed access. Towards the end of November Child M was informed that he was at the head of the waiting list for Home Group supported accommodation.

3.6.31. On 22nd October Adult L was arrested following a serious assault at a train station on another young person, who was known to him. He was given police bail.

3.6.32. At the beginning of November Child J presented as homeless to the Looked After Children Team in Oxford and was accommodated in bed and breakfast overnight on an emergency basis. A request was made for accommodation at BCHA's Supported Housing who asked for an updated risk assessment.

3.7 November 2013 to December 2013

3.7.1. In early November Child J was assessed at BCHA's Supported Housing and provided with a place. The project recorded that they were waiting for an up to date risk assessment from her social worker.

3.7.2. Child J was allocated a support worker, BCHA1 who met with her the following day. Child J told her that she had been in an abusive relationship with Adult L for 18 months but that it had now ended. However, Adult L was still controlling her behaviour and had indecent images of her on his phone which he was threatening to post online. Child J continued to talk about Adult L's violence while she was at the hostel, including particularly disturbing violence committed against previous partners. The support worker put together a risk management plan including:

- Police to be called if Adult L attended or made threats to Child J
- Police to be contacted if Child J did not return to OFF within 24 hours
- Staff to seek advice from Domestic Violence team and specialist CSE team (Kingfisher)
- Staff to alert SW5 to concerns.

3.7.3. Two days later Child J returned to the hostel in the evening and told BCHA1 that she had had an argument with Adult L over talking to another male resident and that he had thrown her room key into a river. The risk management plan was updated by the manager, BCHAMgr who noted the importance of ensuring they received evidence of action taken by SW5 in response to their concerns. The following day the Police visited having had a call from Child J's mother concerned about her daughter. Both the Police officers and staff spoke to Child J who assured them she was just tired. Her mother contacted the Police again later that day after Child J texted her saying that she wanted to die. Police contacted Child J on her phone; she refused to tell them where she was but agreed to meet later at BCHA. Officers attended as arranged and again she assured them that she was just tired.

3.7.4. A joint meeting took place a few days later with Child J, SW5, BCHA1 and another support worker BCHA6. SW5 spoke in detail about the history of domestic abuse. It was agreed that BCHA would contact the local 'Step Out' programme to refer her for support for Child J regarding domestic abuse and that staff at BCHA would undertake work with Child J on the 'cycle of abuse'.

3.7.5. Three days later another resident raised concerns about Child J as she had not been out of her room. Child J described highly controlling behaviour by Adult L including:

- Not allowing her to see her family
- Not allowing her to leave her room, even to go to the toilet, or use the shower, which she had to do at his grandmother's.
- Not to speak to anyone at BCHA

She also told them that she believed he was getting information from other residents about her and talked about his previous violence, including strangling her. Child J said that she knew he had a new girlfriend. The risk management record was updated.

3.7.6. Within another couple of days Child J reported to BCHA staff that Adult L had taken her phone and said that if she reported him to the police he would post indecent images of her on Facebook. Staff offered to call the police on her behalf but Child J told them not to worry as it was now over. Staff phoned SW5 to inform him and also left a message at the Step Out team asking for support for Child J. The Step Out team however, was not a specialist Domestic Abuse service.

3.7.7. At the end of November, BCHA staff contacted Police with Child J's agreement and reported that following the ending of their relationship the previous week Adult L had threatened to publish indecent images of Child J on social media. Child J provided a statement to the Police regarding the indecent images and

the Police informed her that they would arrest him. The attending officer graded her risk of harm as 'standard' on the basis that living at BCHA was a protective factor. On the same day Adult L was reported by the parent of a young person he was now in a relationship with following threatening behaviour to the young woman and her family. No further action was taken by the attending officers.

3.7.8. The Police attempted to locate Adult L for the offence of possessing indecent images over several days and finally succeeded in doing so on the day after Child J was reported as missing, when we now know that she was already dead. Adult L was then bailed by the Police pending forensic analysis of his phone. The officers concerned were not aware that Child J was reported missing at the time this decision was made.

3.7.9. Also at the end of November Child J's mother's support worker contacted the police on her behalf to report threats made by Adult L to the mother and her partner. A Neighbourhood Police Community support officer phoned Child J's mother to arrange to meet her and was also told that Child J's mother believed that Adult L had killed her cat. Contradictory information has been provided to this review about why this meeting did not go ahead, but it is evident it did not. Child J had told her mother she was now pregnant with Adult L's child.

3.7.10. At the beginning of December Child J told staff that she had taken a pregnancy test which was positive, she believed Adult L was the father. Child J had told Adult L and he had '*become nasty'.* A staff member also heard Child J on the phone to Adult L, saying *'what do you mean you are going to throw me off a bridge, I'm pregnant'.* Later that day (Day 1) Child J left the hostel to meet Adult L. Staff attempted to persuade her not to meet him, but she assured them she would be meeting him in a public place and then left. A handover note was left for the late shift staff at the hostel instructing them to call the police if Child J had not returned by curfew at 10:00pm.

3.7.11. Shortly after midnight on Day 2 staff at BCHA contacted police to report Child J missing. They stated that she should have returned at 11.30 and that they believed she was with Adult L who was understood to be angry and threatening as a result of her pregnancy. Two Police Officers were allocated and sent to BCHA. They assessed Child J as a '*medium risk'* and attempts began to locate her, predominantly by checking potential addresses and speaking to Adult L. There were gaps in the way that information was recorded by the two officers and no discussion with a supervisor took place, neither was any contact made with CSC. As a result the direct threat to harm made by Adult L was not properly highlighted and was in effect lost for the next few days. First thing in the morning BCHA staff also informed SW5 that Child J had been reported to the police as missing. SW5 is reported to have made a dismissive remark in relation to the seriousness of this.

3.7.12. On Day 7 a strategy discussion took place between Police Child Protection Referral Manager 17[20], SW5 and the Social Work Team Manager (SWMgr1). It was agreed that CSC would contact Child J's family for further information.

[20] For consistency, Police officers and staff are referred to using the anonymisations used within the IPCC report

Later the same day a support worker from the supported accommodation, BCHA3, spoke to the police and provided further significant information about Adult L's behaviour including the level of control exerted over Child J and abusive behaviour towards previous girlfriends. BCHA3 stated that she believed something serious had happened to Child J and that Adult L could have killed her. This information was forwarded to Detective Inspector 34 who reviewed the missing file and stated that he was concerned about Child J's welfare. Detective Inspector 35 also reviewed the investigation and requested that outstanding actions be followed up quickly.

3.7.13. The Local Police Area Commander (18) who was increasingly concerned about Child J's disappearance raised her risk to high the following morning and required further immediate actions to be taken as a result. The following day (Day 9) a Silver Command Structure was set up in line with Force Policy for a High Risk missing person investigation. Later that day Adult L was arrested on suspicion of kidnapping Child J, but was subsequently released. Adult L was arrested again on Day 10 and charged with the murder of Child J on Day 13. Child M was also arrested for assisting an offender and both were remanded into custody.

3.7.14. Child J's body was found on Day 15.

4 Contribution of Child J's Family and Friend

4.1 Child J's mother and maternal grandfather

4.1.1. Child J's mother and maternal grandfather met with the Chair and Author of this review in December 2014. Child J's mother's partner was also present as was the mother's support worker from a voluntary sector organisation. The following is a brief summary of their contributions and concerns as described to the Review and will be considered in the context of the other available information from the agencies involved later in the Review.

4.1.2. Child J's mother and maternal grandfather shared information about Child J's early life and spoke in particular about the period when she moved to live with her mother up until the time of her death. Both expressed a number of significant concerns about the way in which some of the services had worked with Child J and her mother. They feel very strongly that she was failed by the agencies that they believe should have protected her.

4.1.3. Her mother said that although there were some problems, Child J initially settled with her reasonably well after moving from her father, who she explained she had left following domestic abuse. Child J's mother referred to having her own problems as a result of her own experiences and their impact on her ability to manage Child J's behaviour. She described the situation deteriorating particularly after Child J met Adult L. Adult L became increasingly emotionally and physically abusive towards Child J, and was also threatening towards Child J's mother and her partner. Child J's mother described Adult L as being well known in the community for his aggression and his abuse of previous

girlfriends. Child J's mother felt that eventually Child J chose Adult L over her family.

4.1.4. Child J's mother said she felt '*completely let down'* by social services and the police. She said that even though Child J could be an awkward child, she would engage with people she liked if they talked to her like an adult which was particularly true of the school learning mentor. Child J's mother also felt strongly that staff at BCHA's Supported Housing should not have allowed Child J to go to meet Adult L on the night she died.

4.1.5. Child J's mother made a formal complaint to the IPCC about Thames Valley Police given the strength of her concerns. These concerns related to: a lack of a police response when she contacted them about threats made by Adult L and the risks he posed to Child J; failing to take action when she identified Adult L following a serious assault on another young man; not taking proper action despite knowing how dangerous Adult L was; failing to charge Adult L when he assaulted Child J; and failing to take action when she had reason to believe Adult L killed the family cat.

4.1.6. Child J's mother was also particularly unhappy about the service provided by the Social Worker responsible for Child J's case from April 2013 (SW5). She has grave reservations about this Social Worker, who she felt did not listen to her and did not support her and Child J. On one occasion she stated that SW5 made a decision to send Child J to her sister in County A without speaking to any of the family about it. He also did not contact her for several days after Child J went missing in December 2013. Child J's mother told the Review she had made a complaint about this to the Local Authority. Overall, she felt that she was not listened to and her concerns about the risk from Adult L were never properly dealt with by the agencies concerned.

4.1.7. Despite these concerns, Child J's mother nevertheless highly praised the Police Major Crime Unit and also the school learning mentor (Edmentor1), who she said had been really good at keeping in touch with Child J.

4.1.8. We discussed whether there were other things that could have made a difference, for example whether something such as Clare's Law[21], which was not in place at the time, could have been helped. Child J's mother felt that this while useful for some people, might not have made a difference for Child J, because '*the more she was told not to see him, the more she wanted (to be with him).'*

4.2 Child J's sister (S)

4.2.1. Child J's sister (S) also spent time with the Chair and Author of this review and spoke with warmth and great sadness about Child J. S had herself worked in a children's home which had given her a particular insight into the difficulties young people can experience.

4.2.2. S described Child J as having been quite badly hurt by the separation of their parents, who were both '*in a bad way'* after they separated. Child J was

[21] 'Clare's Law' : The Domestic Advice Disclosure Scheme which allows members of the public to ask for information about whether someone they/or a family member is in a relationship with.

younger than S by several years and so this had a particular impact on her. Child J would come to stay with S at times, because their mother had her own problems and needed some respite. S spoke warmly of their relationship and of Child J's affection for her nieces and nephews. S never experienced any difficulties with her sister's behaviour, describing her as helpful around the house and with the children. Child J had no friends near her sister's so she wondered if this might have affected how she behaved. She said that she could be a bit stroppy sometimes, but nothing out of the ordinary for her age. Child J could be quite quirky and funny and the two sisters enjoyed '*messing around, doing things like horrendous makeovers'*.

4.2.3. Child J's sister was shocked at the change in Child J when she started going out with Adult L. She had matured suddenly and talked about things that were unusual for her age. Child J told her sister that she loved Adult L but also about the '*horrendous*' things he did to her. She was not willing to leave him. S's husband got on well with Child J and he talked to her a lot about her relationship with Adult L. S found it increasingly hard to hear about Adult L, she wanted to tell Child J to cut all ties with him, but this made no difference as Child J wanted Adult L more than her family. Child J's sister did not think that anyone could have stopped Child J seeing Adult L. "*I don't think anything would have helped as she loved him and nothing would have changed her mind….she told my husband that she knew one day Adult L would kill her…nothing that could have been done apart from keeping her hostage."*

4.2.4. Nevertheless, S also felt that Child J had been let down by services, particularly by the Social Worker, SW5, and by the Police and the criminal justice system. S said that SW5 had been helpful when Child J had first been coming to stay with her for respite. SW5 had provided some money for food, but in the last few months he seemed to have become '*fed up'* with giving her money and stopped being helpful. When Child J stayed with her in the summer of 2013 SW5 had sent some money for bedding and clothes but made it clear it was a favour and not something he had to do. He implied to S that he was '*sick of trying to sort her out'* and she found his attitude very frustrating. On one occasion he had arranged for Child J to come to stay with her without discussing it with her first. She only knew that Child J was meant to be arriving because she got a phone call from the Police asking if she had arrived. S felt that she would have really struggled to cope without her experience of working with young people.

4.2.5. S said that the school learning mentor, Edmentor1, had been in touch all the time. '*Whenever Child J was in trouble she went to Edmentor1, because she was very available and supportive'.* S was clear that Edmentor1 had *'gone above and beyond'* what was required of her.

4.2.6. S pointed to the fact that Adult L was well known to the Police, that he had been on bail for serious violent offences and had a history of violence towards his girlfriends. On one occasion Adult L had brought Child J to stay with S because he was expecting to be sent to prison and did not want Child J to be in Oxford if he was not there. S's husband went to find him at the station, and there was a big row and he took Adult L's backpack off him. S said that the Police came to the house, but only seemed to be interested in returning the backpack to Adult L, not about their concerns for Child J, nor that Adult L was stealing suitcases

from trains. '*If he had been arrested, then it might have stopped her from seeing him'.*

4.3 Child J's friend

4.3.1. One of Child J's friends also met with the Author of this report and was able to give a very valuable view from her perspective. She described Child J as **'***Amazing - funniest female ever. Tomboy, gobby, took no rubbish, wouldn't do anything to hurt anyone. She was a problem solver, wouldn't want to cause any trouble. You would want her as a friend* **'.**

4.3.2. Child J's friend had direct experience of Adult L and Child M, both of whom she knew. Adult L had come to a hostel run by the Home Group where the friend was living, trying to find Child J. Her friend described being punched in the stomach by Adult L who also held a knife to her throat. The Police were called, but in the end, the case was not pursued. Child J's friend said: '*I didn't want to stand next to him in court unless I was sure he would go down'.*

4.3.3. Child J's friend felt really strongly that because BCHA's Supported Housing staff knew that Adult L had threatened to throw Child J off a bridge, they should have called the police as soon as Child J told them she was going to meet him. She also asked *'why did he never go down for anything? Why was he always on bail, the police always letting him go? He should have been put behind bars for the assault on me – he was always on the run, always something".* Like Child J's family, her friend did also have positive experiences of particular professionals, especially Edmentor1 and one of the workers at the Home Group Hostel who she described as straightforward and the only one who Adult L would back down from.

5 Contributions from Adult L and Child M.

5.1 Adult L

5.1.1. Adult L was sentenced to life imprisonment for the murder of Child J. After his sentence he agreed to speak to the author of this report, who visited him in prison. His contribution to this report, whilst by its very nature will be distressing, even distasteful to Child J's family, nevertheless has provided important material which contributes to our understanding of his perception of events and the services' responses to those events.

5.1.2. Adult L is aware that his comments are likely to be viewed with some scepticism by many readers given his actions before and after Child J's death. He was initially resistant to talking about his own upbringing as he did not want to suggest that he was making excuses for his behaviour. In response to a question about what could have prevented Child J's death, he stated '*it could have been prevented by me.*' The information he has provided about himself and his background was therefore in response to direct questions by the author

of this review for the purpose of contributing to the better protection of others in the future.

5.1.3. Adult L talked about a highly damaging experience of family life and, in his view, an equally negative experience of being a looked after child, which evidently affected his attitude to professionals, such as social workers. Adult L described a residential care system which appeared to him to have no interest in him or what had happened to him and described himself as '*growing up angry'*. Adult L said that almost anything would have been better than living in a children's home. "*Children's homes were meant to be my salvation, but it was a fight (with the other boys) from the first day, felt like a punishment, not a salvation*". He was critical of what he felt was a lack of interest from professionals in him and said that the only way to get a social worker to come to visit him was to be abusive to another worker. Adult L remembered going to a Foster placement '*I couldn't wait'*, but he felt he was treated like an outsider and the placement only lasted 2 weeks. Asked what professionals could have done differently when he was in care and he said '*they could have spoken to me'*. He was particularly angry with the leaving care service which he describes as '*designed for you to fail*.' '*They want you off their books, it's all about money'.*

5.1.4. For Adult L a crucial point was when he lost his flat and became homeless. He described his and Child J's chaotic existence, stealing for food and money, and his willingness to do '*really bad things'* to get by. He could see no purpose in his Probation supervision, which just required him to sign in and there was no-one else he could imagine going to for help.

5.1.5. As far as his relationship with Child J was concerned, Adult L frankly admitted that he was violent and possessive. He could not imagine how anyone could have helped him or stopped his behaviour at the time. In trying to explain why he was always violent in relationships he said that he had never felt he was in control of anything in his life, perhaps relationships were something where he could be in control. Adult L fundamentally felt that the only thing that could have stopped his behaviour was himself.

5.1.6. Adult L described the Major Crime Unit who investigated Child J's murder as having done a good job. In particular he spoke of the impact of being shown pictures of Child J during the Police interviews and feels this is something that should always be done with suspects. Whilst Adult L still denies that he intended to kill Child J, a denial which was accepted by the trial judge, he did not question the legitimacy of the sentence he had received.

5.2 Child M

5.2.1. Child M, who is now an adult, met with the author towards the end of the Review after he had been released from prison. Child M found it difficult to talk about some aspects of what had happened and repeatedly spoke of Child J's death as a truly terrible thing which he wished he could do something to change. He expressed considerable anger with his brother for having involved him in what happened after Child J died and spoke of Adult L having control

over him. '*I was tricked into doing the worst thing possible…she didn't deserve it…..Adult L has damaged so many people*".

5.2.2. Child M knew Child J and spoke very positively about her. He was not able to contribute any specific information with regard to her death as he was not involved until after this had happened. He also stated that he did not know that Child J had been in a relationship with his brother, who he believed had a different girlfriend.

5.2.3. Child M confirmed information, much of which is known to this Review from other sources, about his own experience of childhood which had been very difficult. He had to leave home when he was 16 after a serious argument with his father, but says that he had just assumed his life was normal. When asked whether the different services could have done different things to help him, his only comment was that he felt he was judged, wrongly, by his brother's reputation. He did not remember much about the involvement of Children's Services, but did feel that he was not treated fairly by the Home Group, who were unwilling to give him accommodation because of what they knew about his brother. He remembered that he was helped by the Hub however. His attitude was that he did not ask for or expect help, he just got on with things.

5.2.4. Child M is aware that many people still believe that he knew that he was willingly helping his brother to conceal Child J's body, even though he was not convicted of this offence. He spoke with apparent disgust about domestic abuse and violence against women and described himself as having very different attitudes about this to his brother. The most important thing that Child M said might help prevent a death like this again was that children should learn useful things about real life at school, not just academic things. He felt that the best thing would be to have sessions in school about relationships, to teach both boys and girls what is right and wrong and what proper relationships should be like.

5.3 Adult L and Child M's family

The parents of Adult L and Child M were also informed of the Review and offered the opportunity to contribute by meeting with the Author. However they did not wish to do so. A member of the family simply stated that they "*knew who was responsible; it was the Police because they should have arrested (him) sooner"*.

6. Analysis and appraisal of agencies' practice

6.1 Introduction

6.1.1. The first four Key Lines of Enquiry (KLEs) as identified in the Terms of Reference will provide the structure for this analysis, with the last three KLEs being integrated within the analysis as relevant. Each of the sections will identify the resulting learning and identify multi-agency recommendations.

6.1.2. The key lines of enquiry are as follows:

i. What actions were taken to safeguard Child J and how well agencies worked on their own and together.
ii. Identification and assessment of risk posed by Adult L and how well agencies worked on their own and together.
iii. Identification and assessment of the risk and needs of Child M and how well agencies worked on their own and together.
iv. Effectiveness of multi-agency support provided to Child J to minimise risk posed by the perpetrator
v. Policies and Procedures
vi. Co-operation and engagement of the services with the parents and Child J
vii. The extent to which equalities issues were addressed

6.1.3. The analysis will include appraisal of the quality and effectiveness of practice provided to Child J and her family at the key points during the 3 year period under consideration. As far as is possible, in order to avoid hindsight bias, the appraisal will be based on what agencies and individuals could have known or be reasonably expected to know at the time. It will judge practice against the practice standards in place at the time and take into account the context in which that practice took place.

6.1.4. Detailed analysis of each agency's individual practice has been provided within the Individual Management Reviews and also within the external report undertaken by the Independent Police Complaints Commission. These reviews comprise of several hundred pages and the contents will be referred to selectively and in summary form here. Where there is learning identified by individual agencies this will not be repeated here other than where it has particular significance individually or as part of the multi-agency learning. A total of 65 recommendations for individual agency action have been made and these are included in Appendix C. The actions arising out of these recommendations will be subject to oversight and review by S&VCSP and the OSCB as appropriate.

6.2 What actions were taken to safeguard Child J and how well agencies worked on their own and together.

6.2.1. This section will focus on the safeguarding of Child J prior to the point in early 2013 at which it became apparent that she was at risk from Adult L.

6.2.2. Child J was the youngest child of a white British family who moved to Oxford when she was 5 years old. Child J was not known by any of the agencies to have any active religious faith and did not, as far as is known, have any mental or physical health needs. Child J was assessed in school as having special educational needs (SENs), primarily in relation to Behavioural, Emotional and Social Difficulties but with some moderate learning difficulties.

Initial Involvement of Children's Services

6.2.3. The request in late 2010 by the Family Court for a S37 report[22] from Oxford CSC following the mother's application for residence, and the accompanying Core Assessment[23], was the first occasion that CSC was required to fully assess Child J and her needs. Whilst this episode is outside the timeline for this Review it was a significant point in CSC's assessment of Child J and could be considered to have set in train an approach to her safeguarding which was never fundamentally reappraised. That approach was to focus on maintaining Child J at home with her mother.

6.2.4. Although the Social Worker undertook all the relevant enquiries the assessment was insufficiently robust and has been recognised as such by CSC. It did not adequately establish the extent of the continuing damaging nature of the adult relationship or the other adult problems and their impact on Child J. There were unresolved concerns about Child J's fathers care of her and Child J had stated that she wanted to live with her mother. Placement with either parent therefore presented concerns. The solution was to make a Residence Order in favour of Child J's mother alongside a Child in Need plan. That the Residence Order was made by the Court appears in itself to have contributed to a mindset which then precluded reconsidering whether this was the right approach. Instead, the court decision was '*viewed as the ultimate authority under which CSC must now work to provide support to the family'*.

6.2.5. The Social Worker's team manager has accepted that, with hindsight, greater thought should have been given to considering whether Child J's mother had demonstrated an ability to care for her long term, even whether the threshold for Care proceedings may have been reached. The team manager describes a combination of significant difficulties at the time, including that she herself was relatively new in post, a post which carried a massive workload, the social worker was not strong at risk assessment or court work, the prevailing situation which was that it was '*almost impossible'* to find care placements for adolescents, and a culture that young people's interests were best served in their families. However this approach was not based on a good quality risk assessment and the resulting effectiveness of support plans was therefore compromised.

6.2.6. As a result CSC has identified a range of learning points for practice and the team manager has contributed constructively to the review. This team manager now felt confident that there has been a '*cultural shift'* in the department's approach to thresholds with young people. A new placement strategy for Looked After Children has been developed including the investment of additional resources for young people. This includes the development of residential units within the county; an increase of fostering placements for hard

[22] A S37 (Children Act 1989) report is undertaken by the Local Authority during any private law proceedings when a question arises about the welfare of the child, and it seems to the court that it might be appropriate for a Care Order or Supervision Order to be made.

[23] Core Assessment: Section 47 of the Children Act 1989 places a duty on LAs to investigate and make inquiries into the circumstances of children considered to be at risk of 'significant harm' and, to decide what action, if any, it may need to take to safeguard and promote the child's welfare.

to place young people and the recommissioning of all supported housing provision for this age group.

6.2.7. There were occasions when new information provided by other agencies should also have contributed to proper review of Child J's situation, but did not appear to have done so. One particular example is a referral by the Police to CSC in May 2012 after Child J had repeatedly cut herself. The referrals noted that Child J did this '*because she has witnessed her mother doing the same thing when she is upset'*. A duty social worker wrote to Child J's mother suggesting that she speak to school and PCAMHS, but it would appear did not have any discussion with either Child J or her mother. Given the historical information about Child J's vulnerabilities that was available, this should have triggered direct contact with the family and further enquiries with other agencies and as such has been acknowledged as a poor decision by CSC. It has not been possible to identify an explanation for the limited nature of the assessment at this point.

6.2.8. In reality due to the complex difficulties within this family, improvements were only short term and the placement of Child J with her mother was never stable nor able to meet her needs. There is little information about contact between Child J and her father after she moved to her mother's and no apparent involvement of him by services in Oxford. This meant that another opportunity to understand what was happening in the family was not made use of. Despite the Child in Need plan and the specialist services that were put in place, the risks to Child J were never systematically analysed. Child J's mother and her partner were never really challenged about the care they provided, how they would be able prioritise Child J's emotional needs or to keep her safe. Child J's mother's mental health was at times at crisis point. Child J frequently went missing from home and school, was herself self-harming and within a matter of months both Child J and her mother were asking for her to be accommodated by CSC.

6.2.9. When Child J's mother told professionals that she did not want Child J living with her the response was to consider options for a period of respite. Efforts were made to support Child J's mother and it is evident from records that social work staff were very concerned about Child J's mother and liaised with GP and mental health services to arrange the respite. However, the focus remained on attempting to support and maintain the family situation, in the absence of any real evidence that this could be achieved and without recognising the level of emotional neglect that Child J was in fact experiencing. When alternative options, such as a fostering placement, were explored, these were always short term. A short stay was arranged for Child J with her sister out of county which appears to have been successful from many perspectives. Child J's sister did not experience the same problems as her mother did; the positive relationship with her sister's family had a noticeable effect on Child J's behaviour which was apparent in school.

6.2.10. The reality was that over the following years there were repeated occasions when Child J was told she could not return home. What should have become apparent as time went on was that this reflected the nature of Child J's mother's relationship with her daughter rather than being a short term dip that could be

resolved by a period of respite. It has now been recognised by CSC in reviewing their involvement that what was needed for a sustainable long term plan and greater statutory involvement to support Child J, but that this was not the routine practice approach at the time. Expected practice now as described to the Review would, for example not simply be to provide Child J's sister with some financial support during the placement but to formally accommodate Child J with her sister under S20 of the Children Act[24]. Such an approach would have meant more structured support would be offered to Child J's sister. Even if this could only be on a short term basis, on her return Child J would have then been subject to statutory reviews and therefore more oversight and accountability would have stayed with CSC.

6.2.11. What is apparent is that the appropriate response would have been not to close the case, but to work with Child J at least as a Child in Need, possibly even as a child at risk of significant harm. CSC have acknowledged this and made relevant individual agency recommendations as a result (Appendix C). This Review has also sought and received specific evidence to support the assertion, as described previously, that there has already been a change in culture and approach towards the safeguarding of young people. Evidence has, for example, been provided of increased numbers of children and young people being made subject to Child Protection (CP) plans. Between 2011 and 2014, the figures rose by 50%, with continuing increases since 2014. The greatest increase has been with older girls experiencing high levels of risk, who are being made subject to a CP plan in recognition of the risks both in and outside the home to this group of young people. An annual safeguarding review undertaken by CSC also identifies that they are now doubling their capacity to provide support to young people viewed as being at high risk or 'at the edge of care'.

6.2.12. The approach to working with adolescents is a crucial area of learning for this report and features throughout Child J's experience and must be recognised across the services as such. Consideration was given to making a recommendation to the Board to review the approach to working with this age group in Oxfordshire. However given the evidence provided about the work now being undertaken by Oxfordshire CSC this Review does not include a separate recommendation regarding the thresholds for safeguarding in relation to young people.

The multi-agency approach

6.2.13. The next Social Worker allocated to Child J attempted to achieve a positive resolution for the family by working with other agencies. There is evidence of constructive practice by both the Social Worker and others, for example the CAMHS worker and the Social Worker who helped support Child J to manage her behaviour in school. A range of services were drawn on, from parenting sessions for Child J's mother to referrals to PCAMHS, the adolescent mental health service, for Child J herself. Whilst these were both in themselves

[24] **Section 20 of the Children Act:** provision for a child in need to be accommodated by the Local Authority with the consent of the parents or others with parental responsibility.

perfectly logical referrals to make, in reality these services struggled to really engage Child J or significantly impact on her mother's capacity to care for her over time. It would also appear that the numbers of services that Child J and her family were being referred also had the effect of deterring rather than encouraging Child J's involvement, with 2 or 3 appointments on some days.

6.2.14. It is very clear to this Review that staff from Child J's school consistently provided a crucial resource for Child J and that their practice not only met, but often exceeded required standards. The school was leading a project for a group of local schools to identify pupils with additional needs and their commitment to such pupils is apparent in their approach to Child J. Child J was understood from her arrival in the school as vulnerable and was described as their '*most challenging pupil*'. Despite this there is clear evidence that the school adopted a well-planned and structured approach to working with her, including involvement of the Educational Psychologist who worked to build on Child J's strengths. Child J was routinely discussed at school-based multi-agency meetings and internal meetings in order to consider what further supports could be provided.

6.2.15. There is evidence of good working relationships between the school and other services and the school's approach was to work with both Child J and her mother's needs. What is particularly apparent is that from the outset there were individual professionals whose role was to work with Child J, who began to develop lasting relationships with her and that she would seek them out for help and advice. There were continued attempts to support her and maximise her access to education, based on a strong underpinning approach of wanting to help empower her and a high value placed on maintaining communication with her. The effectiveness of the school's approach is evidenced in Child J's significantly improved attendance in year 10.

6.2.16. The involvement of mental health services during this time highlights a recurring issue about the capacity of mental health services working with young people with complex emotional and behavioural problems, yet who do not meet the thresholds for which those services are commissioned. During this period Child J, her mother and mother's partner were offered 4 sessions with a PCAMHS family support worker, which they took up. The worker felt that the family were making progress, but that 4 sessions was not enough for Child J. As a result Child J was referred to yet another service, a youth counselling service, with whom she did not engage beyond the first meeting. The issue of what mental health services are available for young people will be returned to later in this analysis and is subject to a **Multi-Agency Recommendation.**

6.2.17. A recurring feature of the response to Child J, which was already becoming apparent in this initial period, were difficulties that agencies frequently seemed to experience in engaging with Child J. It has been widely recognised in recent years, not least as a result of developing knowledge regarding Child Sexual Exploitation, that professionals and agencies can struggle to work effectively with adolescents or to understand their behaviour. The difficulty agencies experienced in engaging and working with Child J as she grew into adolescence is a repeating feature of this review.

6.2.18. A critical issue for learning, which provides an example of the way in which services sometimes struggle to work positively with adolescents, was a tendency for professional judgements about what was best for Child J to take precedence over her own views. Child J had developed a good relationship with PAYP1 whose role was focussed on working with young people. However a decision was made by the Social Worker that this service should not be extended after the planned 12 week period of involvement, in order for Child J to concentrate on accessing counselling with the youth counselling service. Child J had previously told PAYP1, who had been encouraging Child J to attend the counselling, that she only wanted to speak to her. The professional view appeared to value the option of specialist expertise over the quality of the relationship with an existing professional. Although PAYP1 did ask to continue working with Child J this was not agreed. The reason as recorded by PAYP1 was to: '*avoid her dependency on me thinking that I will always be there for her.*' Child J subsequently expressed distress at the ending of this relationship and specifically asked for '*my old worker back'*. It is also the case that she only attended one session with the youth counselling service who subsequently closed the case.

6.2.19. Whilst there is a legitimate issue of managing professional relationships in a way that does not result in an unhealthy dependence with no positive long term outcomes, there is no evidence that this was the case here. Child J was a vulnerable young person who, it was known, had felt rejected within her family and who could be challenging in her relationships with professionals. She had been working with PAYP1 for just 3 months and had already shared her frustration at having to keep telling her story to different professionals. For Child J to commit to the sort of specialist interventions that she no doubt would have benefitted from, first she needed to establish trusting relationships.

6.2.20. Research tells us that young people place considerable importance on : '*having one consistent person with whom they can build a relationship of trust and then work with'* [25] and that "*frequent changes in key professionals can be devastating and mitigate against attempts to engage or support them in a meaningful way*" No explanation was given to Child J as to why PAYP1 was no longer working with her and there is evidence that she experienced the withdrawal of this positive adult relationship as a further rejection: "*I am sorry for whatever I did to you, just hope you can forgive me"*. [26]

6.2.21. The quality of professional relationships with any service user is of crucial importance, but we know that this is particularly the case with adolescents. The failure to recognise the significance of this and to seek a solution within the multi-agency partnership represented a wasted opportunity to better engage and support Child J. This is an issue which will be returned to in Section 6.5 and is subject to a **Multi-Agency Recommendation.**

6.2.22. There was also evidence across the services that Child J was often viewed by professionals as a difficult young person and as a result this meant that she was not always recognised as a child who needed safeguarding. This is a

[25] Rees et al (2011:117)
[26] DfE (2014:6)

familiar theme across services and within Serious Case Reviews.[27] Thames Valley Police have identified one particular example when the police attended following allegation and counter allegation between Child J, her mother and stepfather. One of the attending officers record describes her as '*unruly teenager with an attitude*'' and it is apparent that Child J's behaviour was often contradictory and difficult. Whilst there is no criticism of the Police Officers' response to the incident itself, what was clearly absent was a recognition of the need to look beyond the presenting behaviour and to recognise that Child J at 14 years old is not simply a difficult teenager, but a vulnerable child who might need safeguarding. With hindsight and the benefit of more recent training, one of the Police Officers concerned has subsequently acknowledged that they should have made a child protection referral, but given the passage of time, could not be sure why they had not done so.

6.2.23. After Child J's positive stay with her sister in early 2011, services were reassured by the improvement in her behaviour and by June 2011 a decision was made by CSC to close her case. This decision has been described by CSC as being within accepted standards of practice at that time, identifying that this was not an issue of weak practice by individual workers, but part of the prevailing service culture and the organisational approach. In fact, it was at least a rather over optimistic view of whether the apparent improvements between Child J and her mother had been maintained for an adequate enough period to reassure that they might be sustained in the long term. What also does not appear to have been known to CSC is that in July Child J had made an allegation of assault against her mother, although her description of the event was certainly contradictory. Although the Police Officer reported this to the Child Abuse Investigation Unit it does not appear to have been referred to CSC by the Police. This incident is a classic example of how an event, which in itself may appear minor, could have provided important information if passed on to another agency. We cannot know whether any different action would have been taken by CSC if they had been aware of this allegation. Nevertheless, it might have suggested that the home situation was not as positive as CSC at the time believed and at least would have offered a challenge to the plan to close the case.

6.2.24. The problems within the family were again identified as causing concern in February 2012, when the school initiated a CAF. However what should have been an integrated multi-agency approach struggled to be effective due in part to failings in the way the Early Intervention Service (the 'Hub') responded to the initial referral from the school. The CAF should have been quality assured on receipt at the Hub by the manager, but this was missed. The CAF's main focus had been a request for positive activities for Child J from the Hub, but also included information about Child J having disclosed historic sexual abuse. No checks were made by the Hub with Children's Social Care about previous contact and staff have reported that making checks with other agencies was not common practice at that time. The allegation of historic abuse was never reported to Children's Social Care and therefore never investigated. Support workers attempts to engage with Child J, a total of 28 such attempts, were ineffective and the support staff were not able to attend some of the TAC (Team

[27] OFSTED (2011:4)

Around the Child) meetings. It is evident that school felt frustrated with the lack of involvement of staff from the Hub and that the concept of the TAC never really got off the ground.

6.2.25. The Early Intervention Service, which is part of Children's Services, has accepted that both on this occasion and on another occasion in relation to Child M, they did not achieve the standards required of them. This has highlighted some underlying vulnerabilities in that service, including; problems with the quality assurance system which would have required a manager to review referrals coming in; a tendency to take initial referrals on face value; not making relevant enquiries with other agencies, including Children's Social Care; and not making positive efforts to co-ordinate the work of other agencies. As a result Children's Services has undertaken work on the quality assessment process and reviewed systems for accepting referrals and allocating a worker. A new recording system has been in place from early 2014 which allows Early Intervention workers to check if a family is known to CSC. CSC has also made a single agency recommendation for an audit of practice and safeguarding in the EIS which the OSCB will be required to monitor in due course.

6.2.26. Again during this period there was independent evidence of considerable tension between Child J and her mother and concerns about Child J's self-harming and the situation at home. The school were concerned that Child J was acting as a carer for her mother which was impacting on her attendance and sought help by contacting her GP and the Hub, ultimately with limited impact for Child J. The school '*sought help from any external agency which they thought would address her complex needs'.* There is no doubt that the school worked extremely hard throughout to respond to and manage Child J's needs, what however, they did not do when their attempts to involve Children's Services had limited success, was to escalate their concerns.

6.2.27. In summary, Child J was recognised from the age of 14 as being a vulnerable young person with additional needs. A range of services were provided and for a period she was worked with as a Child in Need. However, there was inadequate recognition as to the degree of emotional harm she experienced over an extended period of time and that she needed not simply to be supported, but to be safeguarded.

6.3 Identification and assessment of risk posed by Adult L and how well agencies worked on their own and together.

Adult L's early development and experience of being a Looked After Child

6.3.1. An examination of Adult L's background is fundamental to this Review. Without a better understanding of how Adult L reached the point he did, then the contribution that the Review may make regarding future prevention will inevitably be limited.

6.3.2. Adult L is a young white British man, one of a group of siblings from a family living in Oxfordshire. CSC had involvement with Adult L periodically from the age of 7 and at 13 years old he became looked after by the Local Authority under S20 of the Children Act. This followed allegations that he had been

physically abused by his father. Following his move into care his father refused to have any contact with him and also forbade other family members from seeing him. During the last two years of his education, he had a Statement of Special Educational Needs. Adult L's own description of his childhood is disturbing, including physical abuse, highly rejecting behaviour and neglect from an early age.

6.3.3. Adult L was described in CSC records as a very challenging boy, who was unable to settle in a placement and who was moved frequently. The placement breakdowns were frequently as a result of aggressive and threatening behaviour as well as possession of weapons. Adult L consistently talked of having experienced violence by his father from a very young age and also of other violence within the home. At his trial the Judge referred to the '*clear emotional damage done to you as a child*'.

6.3.4. There is also considerable information in CSC records about emotional damage including expressions of suicidal impulses and highly concerning behaviour which meant that it was extremely difficult to find a placement for him that could be sustained. As a result, Adult L was assessed by a Consultant Psychiatrist at the age of 14. This assessment concluded there was no evidence of mental illness but that Adult L was '*chronically at risk of impulsive and angry behaviour'*. A further report referred to "*controlling interactions which are characteristic of disorganised attachment insecurity… threatening self-harm in order to achieve a goal or exert control over a frightening situation"*. Adult L was offered a referral to CAMHS to help him manage his behaviour, but never engaged with that service and based on what is known now, he would not in fact have met the threshold for access to that service at that time. Adult L's childhood experiences and needs could also have benefitted from specialist behavioural or mental health services in line with the multi-agency recommendation referred to in the previous section.

6.3.5. Adult L's own description of how he experienced his life is revealing and is particularly concerning regarding the picture he paints of how he experienced being a Looked After Child. It is important to note that Adult L's memory differs sometimes from the written records in important ways and that the professional analysis of the problems he describes is also at times very different. However, Adult L's unremittingly negative description of being in care (as described in Section 5) provides a sharp insight into what influenced him during his adolescence, his view of himself and the impact on his relationship with the professionals he encountered in later years. Whilst his view is evidently a partial one it is nevertheless crucial in understanding what contributed to his attitudes and behaviour as he moved into adulthood.

6.3.6. Adult L made no attempt to suggest that he was an easy child to work with or to care for. Whatever the reality of his later behaviour, his description of himself is one of a very damaged child in a system that seemed unable to reach him, and where there was no-one with whom he could make a positive relationship. The outcome of this was that his anger and frustration towards services created an insurmountable barrier with those individuals, not least his Leaving Care PAs, who attempted to work constructively with him.

6.3.7. When he was 16 years old Adult L removed himself from care, although he continued to receive extensive support both from Children's Social Care, as required with legislation, as well as from other agencies. Adult L's behaviour throughout the time he was known to Children's Social Care gave cause for concern. From everyone's description he was an angry, difficult young person. Adult L himself would say that he was '*feral'*. He openly spoke about carrying weapons, significant drug use and criminal behaviour. He described smoking cannabis consistently since he was about 11 years old, and believes that the extent of his drug use contributed to a sense of '*paranoia*' about the world and the people around him.

6.3.8. One of Adult L's criticisms of Children's Services and the Looked After system is what he felt was a failure to provide him suitable independent accommodation after leaving residential care. He describes having a nice flat at one period but having to leave this to move into hostel accommodation, for what it seems likely may have been financial reasons such as access to benefits. Whatever the reasons, the loss of this flat clearly added to his sense of injustice and further alienated him from those who were trying to work with him. His behaviour towards the LC Personal Advisors was often demanding and threatening with one worker having to be withdrawn after he made threats. In the words of one of the LCPAs: *'how much more of this do I have to take before we withdraw - Adult L is very challenging and the abuse is a huge barrier for me when trying to support him'.* In fact it would appear that Leaving Care staff and in particular his last LCPA, worked extremely hard to try to provide him with accommodation and support him to keep it in the face of extremely difficult, sometimes threatening behaviour.

6.3.9. What is of concern is the way in which individual workers find themselves trying to fill the gap in support and resources that often exists when a young person leaves care. Particularly when that young person responds with anger or abuse at attempts to help them. It is concerning that there is no evidence of a response from senior management to the LCPA's question identified above, although there was support at a team level. The LCPA who worked with Adult L for the last two years, did so almost entirely alone and could never have been expected to meet all his needs and demands.

6.3.10. Adult L was involved with the Youth Offending Service for several periods between the ages of 13 and 18, prior to the scope of the Review. There are limitations to the evidence available in that Youth Justice Board guidance requires the YOS to review and '*weed out*' personalised data after a period of time, meaning that copies of some documents, including assessments are no longer available. Adult L had a number of criminal convictions, including violence or threats of violence, some of these towards professionals working with him. There was concerning information about Adult L's use of violence; carrying weapons; substance abuse and supply; aggressively racist attitudes and domestic violence in relation to previous partners.

6.3.11. There is very little evidence that a multi-agency approach was adopted in the work with Adult L. Other than an attempt by his Personal Advisor to set up a professionals' planning meeting in late 2010, there was no planned multi-agency approach. Attempts to link him with other services were generally

unsuccessful either because he did not engage or because of his behaviour towards professionals. Adult L was referred by his GP to the adult mental health team in 2011, but he was assessed as not meeting the criteria for services. The outcome was that his Personal Advisor effectively worked with him alone.

6.3.12. There is no information to suggest that there was any contact between the Leaving Care team and the Probation Service, during the period when Adult L was being seen by both agencies in 2012. This is of concern given the nature of his offending and the difficulties both agencies experienced in working with him. Good practice would have been to have shared relevant information and possibly to have undertaken some joint work. The lack of contact between the two agencies meant that Probation were not aware of the significant information about him held by Children's Services. Given that the Probation Service has a role and expertise in working with offenders this was a lost opportunity to establish a more holistic approach to managing his behaviour with Children's Services.

6.3.13. All young people need a sense of stability, basic economic security and adequate personal and family resources to become secure, independent adults. By definition, this can be extremely difficult for many young care leavers to achieve. It has long been recognised that this is an area for improvement in the Care system nationally '*the most vulnerable young people are falling between the gaps in our complicated and over stretched support systems.*[28] This continuing problem is not one that can be entirely resolved at a local level. Policies at a national level, for example relating to housing provision, are fundamentally important in contributing to the support for young people leaving care. Nevertheless, what the experience of working with Adult L so clearly highlights is the crucial role played by statutory and other agencies in working directly with young people who present with difficult or damaging behaviour as they move into adulthood. In particular, what this Review has identified is a need to better equip and support practitioners who work with young people, often though not always young men, whose anger and behaviour raises cause for serious concern. This is subject to a **multi-agency recommendation**.

Understanding the risk posed by Adult L

6.3.14. Risk assessment is a complex and difficult area of practice, however, what is most clear from research[29] is that statistically one of the best predictors of violent behaviour is previous behaviour. Given Adult L's history within the care system and within the criminal justice system, there was a considerable body of information about him. This information was enough to raise concerns about his potential for future harm to others and this did appear to be the case for many of the professionals. However, a number of factors hampered professional ability to produce a comprehensive assessment of the extent of the risk Adult L posed:

[28] Action for children 2015
[29] Munro, E (2008: 58-75)

- Adult L's extensive Social Care records did not include a comprehensive chronology creating difficulties for a practitioner attempting to track his history.
- The focus of risk assessments undertaken in the context of domestic abuse were victim based, rather than offender based.
- During the last crucial months, no individual agency was responsible for supervising or assessing Adult L.

6.3.15. Throughout Adult L's contact with agencies there is frequent reference to violence and threatening behaviour. The Youth Offending Service referred to a propensity to violence which was frequently *'unprovoked and disproportionate'* and further recorded that he wanted to *'hurt others as he was hurting'*. There was a range of information held by different agencies, including the Police and Children's Social Care about Adult L's history of violence and highly controlling behaviour towards 3 previous girlfriends. In 2008 Adult L had received a harassment warning after threatening to stab his 16 year old pregnant girlfriend in the stomach. On another occasion he had threatened to share compromising pictures of an ex-girlfriend with others. Some of the information known at the time, as well as information which emerged during his trial in 2013, was of a particularly disturbing nature and demonstrated a pattern that was to be repeated with Child J. Not all of the information however was available to all services at the time.

6.3.16. Despite the availability of information about his background, CSC had no up to date risk assessment, either single or multi-agency, for Adult L on their files. Risk assessments that did exist were either out of date or missing important information. CSC's involvement with Adult L had ended before he became involved with Child J and therefore CSC had no statutory role in managing or assessing him at the time of Child J's death. After the end of CSC's involvement with him, there is no evidence that other agencies contacted CSC to seek information. Nevertheless, the lack of a full chronology and up to date risk assessment represented a gap in information which might legitimately have been accessed subsequently about any serious risk Adult L might pose whether to Child J or to someone else. This is subject to a single agency recommendation by CSC. What is also apparent is that there is a difficulty for Leaving Care Personal Advisors in balancing their main role as advocate for the young person and at the same time assessing and manage any risk. The CSC IMR has as a result identified the need to consider how these two aspects of the work should best be managed.

6.3.17. A familiar feature of multi-agency working is the difficulty that can arise in sharing personal information across agencies. Housing support workers involved with Adult L were unaware of historical information about his behaviour and potential risk. The reasons for this are not explicit but it is likely they are linked with the difference in roles between agencies and therefore what information is able to be shared, or what information it is believed by agencies should be shared. These difficulties are increased when young people move into adulthood and therefore the legislative and data protection requirements for agencies have different thresholds.

6.3.18. The Probation Service's first involvement with Adult L began in late 2010 when they were required to undertake a Pre-Sentence Report for the magistrates court in relation to a Public Order offence. Probation accessed what information was available from the Youth Offending Service which provided background history, including evidence of physical abuse when he was young and his own capacity for violence. An ASSET, the assessment tool used by the YOS was also available, but had not been completed adequately and failed to identify all the risks posed by Adult L, which it is understood, were recorded in other internal documents. The Probation Service assessed that Adult L was a medium risk of harm to anyone with whom he was in conflict, which was in itself a reasonable judgement based on the information available to that service at that point.

6.3.19. The Probation Service was aware that a Leaving Care worker was allocated to Adult L and did not identify any particular social or individual factors that might be linked with future offending, therefore no supervision was recommended to the court. The Court had specified that the sentence should be one of punishment and as a result a Community Order with a requirement to perform unpaid work was proposed. Good practice would have been to discuss the involvement of the Leaving Care worker prior to making a recommendation. That this did not take place has to be understood in the context of the court's direction that they were considering a sentence focussed purely on punishment. As a result there was no supervisory aspect to the Probation Service's involvement with Adult L. Given the comparatively minor nature of his offence and the expectation of courts in such cases for Pre-sentence reports and sentencing to be completed on the same day, the Probation Recommendation was in line with national judicial sentencing guidelines and expected practice.

6.3.20. Adult L was subsequently resentenced by the court for breach of the original order and at that point the Court made a supervision requirement, despite this not being proposed by the Probation Service. Adult L was assessed as a Tier 1 offender. Tier 1 supervision is mainly limited to restricting liberty by having to report as instructed, which in Adult L's case would have meant reporting only about 8 times. He did not engage well with the order, which he described to this Review as a waste of time, but it was completed in April 2012.

6.3.21. It is evident that there were some fundamental flaws in the approach to Adult L's supervision, including lack of a more detailed assessment; further checks regarding child protection or domestic abuse and the absence of a risk management plan. A significant factor appears to be that these weaknesses arose as a result of the requirement to meet '*speedy summary justice'* targets at the point of sentencing leading to a narrow approach to assessment and the management of offenders. Whilst it is difficult to judge whether the sentencing outcome would have been different given a more comprehensive assessment at this stage, the absence of a full assessment prevented a proper analysis of any risks he might pose. Irrespective of the quality of the assessment of Adult L at this point, it is however unlikely that he would have met the criteria for management as a high risk offender through the MAPPA system, which will be considered further below.

6.3.22. In January 2013 CSC and the school first became aware that Child J and Adult L were in a relationship when she disclosed he had assaulted her. There is no evidence that this assault led to any enquiries by the duty Social Worker into Adult L's background and this is covered further in section 6.5. However two months later SW4 did respond appropriately to concerns raised by Child J's mother about Adult L's behaviour. SW4 completed a DASH Risk Assessment Checklist which provided a detailed risk of Adult L's violence and the level of coercive control he was using against Child J. The information included some particularly concerning information about Adult L including sexual violence to other girlfriends, strangling and the killing of pets. From this point onward there was a collated body of material about Adult L that could be accessed or shared with other agencies as part of any multi-agency work to protect Child J.

6.3.23. The GP had also become aware in early 2013 that Child J was experiencing domestic abuse from her boyfriend. In a consultation with the GP which is well recorded and detailed, the boyfriend, who is not identified is described as "*abusive – spat in her face, gripped her arms etc."*. The GP made a referral to CAMHS as a result, with the focus on providing help and support to Child J. What did not take place at this point was a referral for direct help from a specialist domestic abuse service. Whilst from what we know now, this is unlikely to have been taken up at that time by Child J, good practice would always to be to offer such services and as such reinforce a clear message to a victim about the potential for support.

6.3.24. With the benefit of hindsight and the opportunity to undertake the sort of comprehensive assessment that is open to a formal Review, it is possible to identify other indicators that Adult L was frequently involved in violent incidents. Examples include frequent attendances at A&E, often with hand injuries typically indicative of punching. However, such injuries are extremely common, with estimates of between 20 and 30 young people attending A&E every week with hand injuries thought to relate to punching. It is only therefore with hindsight that we could view this as an indicator that Adult L was high risk, or that staff and A&E should have identified him as such.

6.3.25. The quality of individual Police risk assessments concerning Child J will be discussed in the following section. However a broader concern about the Police's role in managing the risk has been raised within this Review and is something that the family feel particularly strongly about. The Police had considerable information about Adult L in the form of criminal convictions, harassment notices and other allegations which did not ultimately result in convictions. Child J's family has posed the question as to why the Police did not appear to identify him as a high risk or take action to ensure that he was remanded in custody at key points, despite occasions when they specifically raised concerns about his abusive and threatening behaviour to them. As the individual events have been dealt with by the IPCC, it is the underlying issue of the Police's role in identifying potentially dangerous individuals that will be discussed here.

6.3.26. Where sexual or violent offenders have been identified as posing a risk of serious harm to others, they are subject to review and management through the

MAPPA (Multi-Agency Public Protection Arrangements) procedures[30]. These procedures require the local criminal justice agencies and other relevant bodies to work together in partnership in dealing with such offenders. The identification criteria for MAPPA are as follows:

1. Registered sexual offender.

2. Violent or other sexual offender who has been sentenced to 12 months or more custody for a Schedule 15 offence under the Criminal Justice Act 2003 and is transferred to hospital under s.47/49 MHA 1983, or is detained in hospital under s.37 with or without a restriction order under s.41.

3. Other dangerous offender – has been cautioned for or convicted of an offence which indicates that he or she is capable of causing serious harm AND which requires multi-agency management. This might not be for an offence under Sch.15 of the Criminal Justice Act 2003[31].

Adult L did not therefore meet the criteria identified in these three categories.

6.3.27. An alternative option would have been that Adult L could have been considered to be classified as a Potentially Dangerous Person (PDP). The definition of a PDP is:

- A person who is not eligible for management under MAPPA but whose behaviour gives reasonable grounds for believing that there is a present likelihood of them committing an offence or offences that will cause serious harm.

- Serious harm is defined as life threatening and/or traumatic, from which recovery, whether, physical or psychological, can be expected to be difficult or impossible.

6.3.28. A key principle of the definition is that there must be immediate present likelihood of serious harm; it is not intended to cover a general possibility of harm, however concerning that might be. The thresholds are therefore very high and as such, Adult L would not have met the criteria.

6.3.29. A particular feature of Adult L's actions is the frequency with which he was implicated in various offences, some of them of quite a serious nature, but which never resulted in charges, or proceeded to court. Frequently this was because the victims of these offences were unwilling to make statements, or like Child J's friend, unable to face Adult L in the court setting. There is an obvious implication here that people felt intimidated either directly by Adult L or because of a reputation which both he and others who knew him have identified. Whatever the reason, the reality is that despite what is known about Adult L now, he had never actually been convicted of an offence resulting in a sentence of imprisonment, or which would place him in the statutory categories of 'risk of serious harm' as defined above. With hindsight what this meant was that Adult L was never really held to task for his abusive and violent behaviour.

[30] Criminal Justice Act (2003)
[31] MAPPA Guidance 2012 p35

6.3.30. Considerable thought has therefore been given within this review about whether Adult L should have been formally identified as a serious risk and therefore a comprehensive risk assessment undertaken and a risk management plan put in place. The current legislation has been developed in order to balance the protection of the public with the need to keep surveillance and restriction of liberties of people who have not been convicted of serious violent crime to a minimum. Given that there are well established legal parameters for identifying potentially dangerous persons, it is unrealistic to conclude on the basis of one event, however serious, that the established parameters should be reviewed to reduce the thresholds. What this highlights is a difficult gap in the ability of agencies to work with individuals about whom there are legitimate concerns, but who do not meet the criteria for statutory involvement as outlined here.

6.3.31. Current possibilities for proportionate multi-agency review of individuals who present such concerns in Oxfordshire would be either through the Complex Case Panel where the individual was known to Children's Services or the Joint Agency Tasking And Co-ordination (JATAC) group. This (and other similar groups around the county) is a working group of the South and Vale Community Safety partnership and is designed to tackle complex problems in a multi-agency partnership. These two routes offer some means to put in place a multi-agency approach regarding individuals of concern. However, it is the recommendation of this Review that a more comprehensive and strategic approach is required to ensure that there is a well understood, effective multi-agency response across the different partnerships. Such a response will need to consider the full complexity of working with this group of individuals from the legal implications, to the organisational practicalities and the capacity of and support for individual workers. This is subject to a **Multi-Agency Recommendation**

6.4 Identification and assessment of the risk and needs of Child M and how well agencies worked on their own and together.

6.4.1. Child M pleaded guilty to perverting the course of justice but was found not guilty of knowingly preventing Child J's lawful burial. Whilst his actions clearly contributed to the family's distress, none of the information that was available to the agencies at the time or since would have suggested that he was likely to become involved in such a serious incident. Information available both to the criminal trial and this Review does identify that Child M was at times frightened of his brother. The level of analysis of Child M's role is designed to be proportionate to his actual involvement in the events surrounding Child J's death.

6.4.2. Child M is the younger brother of Adult L and as such significant information about Adult L's family circumstances will also have been of relevance to Child M. Information from Children's Social Care describes Child M as having been victimised by his father, and that his relationships with Adult L and some other members of his family were '*significantly characterised by fear'*. It has acknowledged in relation to Adult L that there was no assessment of the family as a whole when Adult L was taken into the care of the Local Authority in 2005. It is apparent that this was a family who did not always respond positively to professionals and from the information provided by both Adult L and Child M

that there were significant problems within the family. As a result any risks or needs with regard to Child M were not identified at that time. Whilst this pre-dates the time period for detailed examination within this Review it is evident, and has clearly been accepted by CSC, that a S47 assessment should have been undertaken in relation to Child M.

6.4.3. Child M was referred by the Youth Offending Service to the Early Intervention Service, based at the Hub in May 2013 which provided an opportunity to undertake a more holistic assessment of him linking his offending and his family and social situation. The assessment undertaken by the Youth Offending Service had identified a number of vulnerabilities and problems within his family life which could reasonably have been expected to trigger a CAF. However the EIS did not access this assessment, despite the fact that the Hub worker had previously worked in Youth Offending and therefore could have been expected to know that such an assessment existed.

6.4.4. The Early Intervention Service has acknowledged that a CAF would have been appropriate at this time and that this should have been initiated. No checks were made with CSC and therefore the systems in the EIS were operating in parallel to those in CSC. This was the same gap in practice that has already been identified in relation to Child J and as such confirmed that this was a repeating problem and therefore contributed to the Single Agency recommendation by CSC as already noted. What has also been identified is the lack of any clear plan of work with Child M at this point, poor records and a lack of any review of whether work had been effective at the point of closure. This again is subject to a single agency recommendation by CSC.

6.4.5. The contact between the police and Child M has also been scrutinised in detail. A number of weaknesses in practice or systems have been identified as a result, although these could not reasonably be linked to the eventual outcome for Child J. However, what has been acknowledged is that too often Police Officers' consideration of him as a child was poor. When Child M was arrested allegedly for threatening his father in August 2013, a referral was made to CSC. Child M described a very different explanation for his behaviour including some disturbing information about the situation at home.

6.4.6. On receiving the referral from TVP the focus of intervention was on finding Child M accommodation and his case was therefore allocated to a Specialist Housing worker, rather than to an Assessment team Social Worker for a S47 Child Protection enquiry. A Core Assessment was undertaken but the case was ultimately transferred to the Leaving Care Team with the purpose of work being purely Child M's housing needs. This approach again mirrors the approach taken with Child J during the latter part of 2013 in focussing on the specific issue of housing rather than assessing wider needs.

6.4.7. Nevertheless what is also apparent from the records is that work with Child M by CSC and others was more able to engage with him and work with him constructively. He is described, for example by the GP as being willing to share his problems and seek help and there is no information during the final weeks suggesting that he was involved in any way with his brother's relationship or behaviour towards Child J.

6.5 Effectiveness of multi-agency support provided to Child J to minimise risk posed by the perpetrator

6.5.1. **Introduction**: This section will briefly summarise the contribution of the key services involved with Child J from early 2013 when agencies were becoming aware that she was in a relationship with Adult L. This will then contribute to an analysis of the way agencies worked together and identify some common themes that have arisen.

6.5.2. It is understood that Adult L and Child J began a relationship sometime in 2012 although it was in 2013 that this became apparent to professionals. Child J's family were surprised and increasingly concerned about the relationship, the degree of abuse Child J was experiencing and for Child J's mother there were concerns about Adult L's threatening attitude towards herself and her partner. Some time prior to her death, Child J is believed to have ended the relationship and Adult L was involved in another relationship. Despite this, he continued to be abusive and controlling towards her.

The contribution of CSC

6.5.3. The interventions of CSC's work with Child J during 2013 appeared to repeat many of the patterns that had existed during the involvement the previous year. Intervention at this point was inevitably more difficult for a number of reasons including:

- Child J was now 16 years old, and therefore more determined and more able to make her own decisions.
- The passage of a further year with the continuing difficulties at home and Child J's responses to these, which would have made her problems more entrenched.
- The level of control Adult L was able to sustain over Child J and the highly damaging nature of this relationship.

6.5.4. Social Care's response on the first occasion when Child J was known to have been assaulted by Adult L in early 2013 was not of a good standard. The duty social worker advised Child J to contact the police herself. Advising any victim of domestic abuse to report this herself rather than ensuring that she had some support to do so, would not have been good practice. Given that the victim was a 16 year old girl, legally a child, this was unacceptable. Child J should have been offered support to report the offence. In fact there is no evidence that the allegations were ever reported to the Police, who had initially been involved in relation to the dispute between Child J and her mother. This event had taken place in the context of a significant dispute between Child J and her mother and the records described Child J being '*mischievous*' and was not in fact homeless as a result of the argument.

6.5.5. It is recorded that an Initial Assessment would be undertaken, but arrangements were then made by the family, with the encouragement of the Social Worker, for Child J to go to her sister's in County A. There is no further information to suggest that consideration was given to the significance of the assault on Child J by her boyfriend, whether she might be at future risk, or what

support her sister might require. It was not considered necessary to alert the local children's services and the case was closed. It is not evident that Initial Assessment was in fact completed at this point.

6.5.6. This episode suggests that there was a lack of understanding of the potential seriousness of Child J becoming involved with a violent older boyfriend. From the records it is difficult to tell whether her disclosure was taken seriously.

6.5.7. The response from CSC that followed a couple of months later after Child J had taken another overdose was of a much higher standard. The social worker (SW4) allocated to undertake the assessment liaised well with the school and identified the concerns about domestic abuse. It is evident from the information within the CAADA DASH Risk Identification Checklist (DASH RIC) that she had spoken to Child J in detail and had been able to obtain a lot of significant personal information from her. The result of this risk assessment was that Child J was referred to the MARAC, which was in itself the appropriate step to take at this point.

6.5.8. On this occasion there was explicit discussion with the team manager as to whether there should be a full S47 assessment[32], but the decision was taken to work with her under Child in Need. At this time the team manager believed that given Child J's age and in the context of a MARAC about to take place little would be achieved by initiating a Child Protection planning process. She took the view that this would not be normal practice when there was domestic violence in a peer relationship. A similar approach has also recently been identified in SCRs in relation to CSE, in that abuse of young people outside of their family tended to be identified as a police matter rather than a child protection issue. Since Child J's experience, there is now a clear recognition that whilst MARAC has a proper role in relation to domestic abuse, it is not in itself an alternative to Child Protection. At this point Child J should have been made subject to a Strategy Meeting and a Child Protection Plan considered.

6.5.9. The outcome of the assessment was therefore to work with Child J as a Child in Need again and as such this required a change of social worker as SW4 was part of the Assessment team. SW4 is recorded as having made considerable efforts to support Child J at the meeting, which demonstrates that she was focussed on empowering Child J's involvement. Whilst the structures within CSC meant that a change of Social Worker was routine, what this highlights again is a lack of flexibility in considering what might be the best way to respond to an individual child's needs. Frequent changes of allocated social workers and other professionals undermines, rather than supports working relationships with families, and particularly with young people who place high importance on having a professional worker they can trust, and who sticks with them[33]. Child J's subsequent relationship with her next Social Worker never appears to have developed constructively and whatever else may have

[32] **Section 47** of the Children Act 1989 places a duty on LAs to investigate and make inquiries into the circumstances of children considered to be at risk of 'significant harm' and, to decide what action, if any, it may need to take to safeguard and promote the child's welfare. This is also referred to as a Core Assessment.

[33] Pearce, J (2009:65)

contributed to this it is reasonable to suppose that facing Child J with another change of worker did nothing to help.

6.5.10. Throughout the remaining months of CSC's contact with Child J the focus was primarily on managing the fact that she was homeless rather than the domestic abuse or her safeguarding needs. SW5 was a specialist housing worker within the Leaving Care Team and in the words of the CSC IMR a more holistic view of her needs had been '*largely lost'*. It is recorded that '*Child J decided that she wished to maintain a negative relationship with her boyfriend, Adult L',* demonstrating a lack of understanding of the nature of that relationship, her vulnerability, the impact of coercive control and her status as a child who might be at risk of significant harm. Decisions regarding placements were made without consultation with the family or Child J and appeared to be purely pragmatic attempts to house Child J rather than full assessments of what would best support and protect her.

6.5.11. When SW5 referred Child J to the Kingfisher Team, there was a very clear response from that team's manager that the risk related to domestic abuse and not CSE, stating *'this child is clearly at risk of significant harm from Adult L*' and suggesting that a referral be made to the Complex Case Panel to discuss a safety plan. Neither SW5 nor the team manager (an agency manager who no longer works for the authority) followed up this suggestion. Although there were several more reports of domestic abuse over the following months, these did not trigger a review of the intervention with Child J, nor whether there was cause for re-referral to MARAC or a strategy meeting. Information from various sources including records, information from the family and other professionals, identifies that SW5 was frustrated with Child J's responses and sought to close the case quickly. Her case was duly closed in the autumn of 2013 on the basis of her non-engagement, combined with a judgement that she was not homeless as she had the option to live with her sister. This despite the fact that she was clearly not doing so and was living rough.

6.5.12. A similarly narrow approach was again taken when Child J presented as homeless just a month later. Whilst a placement was found for her at BCHA's Supported Housing, no updated risk assessment was completed and there is no evidence that there was any reappraisal by the Social Worker or challenge by his managers about the approach to risk management or Child J's wider needs. During the period when Child J was reported missing, there was also a poor level of response from CSC in the first few days, with very little evidence of contact with the family. There was a lack of urgency from the Social Worker who saw this episode as nothing unusual, demonstrated by the fact that no strategy discussion took place until Day 7 when SW5 made contact with the police, and no full strategy meeting for a further 5 days.

6.5.13. Child J's mother had told the Review that she had made a complaint to the Local Authority about SW5, however, extensive searches have not found any information about such a complaint. Nevertheless, there has been open acknowledgement from CSC to this Review that the social work practice with Child J during these months fell below acceptable standards and that there was a responsibility for this both with the individual social worker and the organisation more widely. Without the opportunity to speak to SW5 directly it is

difficult to entirely understand why he took the approach he did. His practice had not caused concerns previously, as is confirmed by BCHA's Supported Housing who had previously found him to be very supportive and with a positive attitude to young people. It was subsequently identified that there were significant problems within the management of the team relating to sickness absence and other employment difficulties with a consequent impact on management capacity to fully oversee the work of the team. It was also the case that SW5 was himself experiencing health problems that were not fully understood at the time but it is now known had an impact on his work. Management actions were taken as a result including a referral to the Health and Care Professions Council (HCPC), the registration body for social workers. SW5 no longer works for the authority.

The role of the Police

6.5.14. As previously noted the IPCC has undertaken an investigation into the actions taken by Thames Valley Police. Between this report and a very detailed, self-critical IMR, each episode of contact with Child J and her family has been examined in detail. Two aspects of the police practice will be considered here. Firstly, risk assessments and the Police response to welfare concerns, secondly the response to the report of Child J going missing in December 2013. In both aspects there is a mixed picture with some positive practice and some considerably less so.

6.5.15. The IMR has identified that there were several occasions when officers did not identify that there was a risk to Child J. This was often the case when the primary reason for Police involvement was a missing person report or where another agency, or family member had raised a concern about Child J's welfare. Dealing with young people who go missing can be a frustrating experience for Police officers. Officers may regularly encounter young people who repeatedly go missing, but where it is not immediately evident that they have suffered harm, and who may be abusive to the officers who are trying to help them or be unable for various reasons to accept help. The risk in these situations is that what is seen is the '*unruly teenager with an attitude'* rather than the vulnerabilities and risks that lead to this behaviour. The Oxfordshire SCR regarding child sexual exploitation[34] drew attention to a very similar issue:

'*The need to bring an investigative mindset to missing person reports – The objective is not just to locate the person but to also understand why they have gone missing'*

As a result TVP has put in place a variety of actions including extensive training and improvements to their missing persons documentation and have made a further recommendation within this review to support this as a continuing priority.

6.5.16. Risk assessments regarding the risk of domestic abuse from Adult L to Child J were also undertaken as required on a number of occasions during 2013.

[34] Serious Case Review into Child Sexual Exploitation in Oxfordshire: from the experiences of Children A, B, C, D, E, and F

Where risk was identified officers consistently used the assessment form (Dom5)[35] as required. The form is based on the Domestic Abuse risk assessment form designed by ACPO, which pre-dated the CAADA-DASH RIC form. What is noticeable from reviewing all the different occasions on which risk assessments were undertaken is the variation between medium and high risk. There are a number of reasons for this:

- What historical information was available to the officer
- Different professional judgements
- Individual officer's awareness of significance of risk factors

6.5.17. What has also been highlighted is the degree to which risk assessments undertaken by the attending officers were subsequently changed by the Domestic Abuse Risk Assessors, sometimes increasing, sometimes decreasing the level of seriousness. The examples included times when this seemed justified, other times when it did not. Risk assessment of this nature is not an exact science and some variation is to be expected. However TVP need to satisfy themselves that these variations are within a reasonable range. This is absolutely crucial as it is the risk assessment grading which determines the police response and the level of resources given to an individual case. TVP have therefore appropriately made a recommendation to undertake an exercise to review the practice of domestic abuse risk assessors. This has already been put into action.

6.5.18. The Police IMR and the Independent Police Complaints Commission Report have also analysed in detail the actions of TVP following the final report that Child J was missing in December 2013. This Review will not attempt to repeat these comprehensive investigations, but will summarise the main points linked to future learning. The two officers who initially attended at the BCHA are both subject to internal disciplinary procedures as a result of the IPCC investigation.

6.5.19. Even without the advantage of hindsight, it is clear that the initial response to the report that Child J was missing lacked any sense of urgency. We now know that Adult L had murdered Child J by the time she was reported missing. The Police's actions from this point would therefore never have been able to prevent her death. What could have been minimised however, was the distress caused to her family because of the length of time it subsequently took to locate her and to charge Adult L. Whatever the outcome in Child J's case, it must nevertheless be recognised that a more urgent robust response could in other circumstances lead to the prevention of a homicide.

6.5.20. The attending officers (PCs 90 and 91) had been told about the threat made by Adult L to Child J to '*throw her off a bridge*' and yet this crucial piece of information was not properly identified during the subsequent days and was not reported to their supervisor. It was 6 days before the information about the threat was identified within the investigation. The recording by the officers referred to there being '*some suggestion*' that Child J was going to meet Adult L, despite it being clear from the original contact with the police by BCHA that

[35] Dom5: form created and used by Thames Valley Police in Oxfordshire instead of the CAADA DASH form

she was definitely going to meet him and had been threatened by him. The threat made by Adult L was not considered to be immediate or high risk. The officers' recording was poor and the internal missing persons form was not shared with the supervising sergeant as was required. For the first few days that she was missing it appears that she was thought to be 'sofa surfing' with her boyfriend with no particular reference to domestic violence. During those days there was no effective review of the actions taken or the risk assessment.

6.5.21. There was also no contact with CSC during the first few days or understanding that Child J was a Child in Need. This was in part because of poor information gathering by the police from BCHA at the outset, however a routine check should have been made with CSC due to Child J's age. As a result it was several days before a strategy discussion took place, again, failing to meet required policy standards. Once Child J was identified as high risk, the liaison with CSC appears to have been '*regular and comprehensive'*.

6.5.22. It was not until day 5 that a Critical Incident Inspector reviewed the actions, noted a lack of previous reviews and arranged for a Police Constable (PC33) to be dedicated to updating the record. This constable then undertook a thorough and detailed review, including visiting BCHA, viewing CCTV and speaking to Child J's mother. He identified gaps in the process taken so far and highlighted the need for the Risk Assessment to be upgraded. Nevertheless it was then a further 3 days before the decision was taken to upgrade the risk level to High risk. At this point a clear command structure was established and the remainder of the investigation was of a high standard.

6.5.23. There appear to be a number of reasons for the quality of the initial police response to Child J''s being reported missing. At the outset the initial call handler wrongly recorded the call as being in relation to '*fear for personal welfare'* rather than a *missing person* report. Although this was quite quickly corrected by the supervising sergeant, the result was that the risk assessment which should be completed at the outset of a missing person investigation was not in fact completed by the initial call handler. This was not identified by subsequent officers until the involvement of PC33. There is repeated evidence that supervisors and senior officers who had a responsibility to review progress of the missing person investigation were juggling high numbers of other missing reports, some which were identified as high risk, which in the early stages Child J was not. PCs 90 & 91 explained that they had been unable to find a sergeant in order to pass on the initial form as both sergeants were involved in dealing with a serious assault. Whilst they should have rectified this as soon as possible, it does identify the competing demands on supervising officers.

6.5.24. The absence of reviews by the duty inspectors during the first five days highlights a worrying weakness in the Police management of missing person investigations. There seems little doubt that resources were a significant factor. Several of the inspectors described extremely busy shifts, with one day being described as '*a horrendous day with 5 medium risk missing persons, 3 missing persons to be assessed, 2 high risk missing persons from outside the force area, a further missing person with Child Sexual Exploitation concerns and a complaint'.* The proper review of a missing person file is said to take at least 4

hours of uninterrupted work, time which a duty inspector is unlikely to be able to set aside. This same inspector felt that an unreasonable expectation was placed on duty inspectors and there needed to be an increase in this resource across the county.

6.5.25. The level of resources allocated to each missing person enquiry is determined by the level of risk. Whilst this is a defensible approach, the clear lesson from Child J's experience is that in adopting this approach it is crucial for there to also be a very strong system of risk assessment and review in place. TVP has since provided clear guidance as to what is expected of an inspector's review and also confirmed that delegation of the task, as was eventually the case here, is a proper way of managing resources.

6.5.26. PC33's practice in undertaking a comprehensive and considered review of the information and then rectifying the shortfalls met the good standards expected. That he was able to do so appears to have been partly because he was specifically given the time to dedicate himself to the task, but also it appears to have been a feature of the individual officer's qualities and approach to his task. He was also initially unaware of the threat made by Adult L, but nevertheless was concerned that the missing person grading was '*at the high end of medium, possibly even high'* and asked that it be reviewed by a Detective Inspector.

6.5.27. Although it is apparent that there have been some shortfalls in the quality of individual officers' standards of practice, what is of greater concern are the wider resource issues in relation to missing persons' investigations. The police IMR has made a number of recommendations in response. However, given the continuing pressure on police resources it remains a concern for this Review that Police resources will continue to be stretched in this way and risk creating a system that is not always as safe as we would wish it to be.

6.5.28. What is undoubtedly the case is that the overall impact of the actions taken prior to the involvement of Major Crime Unit, has been very damaging for Child J's family's confidence in the police.

The role of BCHA

6.5.29. BCHA's Supported Housing played a brief but significant role in Child J's life. BCHA was at this time commissioned by the local authority to provide housing related support and supported accommodation for young people between the ages of 16 and 24 with high support needs, in partnership with other agencies. Their involvement with Child J during this period of just one month, has highlighted both some important strengths, but also some weaknesses in the service.

6.5.30. As has previously been noted, the information provided to BCHA by the Social Worker was inadequate. The risk assessment that was available was out of date and provided limited information about her relationship with Adult L and the risks he posed. Much of their knowledge about the risks of domestic abuse when she first arrived was provided by Child J herself. They did receive further information from SW5 at a joint meeting the week after Child J moved in to

BCHA, including that she had been subject to a MARAC referral but '*had refused to engage in any support offered.'*

6.5.31. It is evident that staff were very frustrated at the lack of information that was provided by CSC and did ask for it on subsequent occasions. However, it is also the case that when this was ineffective there seemed to be no system or culture to raise the concerns at a higher level. When a young person with complex problems is accommodated by a resource such as this, it is a reasonable expectation that they receive full information from the referring professional. Whatever the failings of the Social Worker in not offering this information in a timely way, there was still a responsibility for BCHA to actively follow this up, particularly given the concerns regarding the risks posed by Adult L. That this did not happen may in part have been as a result of having had a previously positive relationship with SW5, making it more difficult to escalate their concerns. Staff have acknowledged that they did not want to '*go over the social worker's head and damage relationships*'. The team manager has recognised with hindsight that she should have escalated the concerns to CSC and the need for proper escalation procedures is a recommendation within the BCHA IMR.

6.5.32. What is apparent is that in the comparatively short time she lived at BCHA Child J build up good relationships with members of staff, particularly it seems female staff and made considerable disclosures to them, often of quite a disturbing and personal nature. She spoke to them in detail about Adult L's continuing controlling behaviour while she was living at BCHA. This demonstrates that staff had the skills and time to engage well with Child J and that she was able to trust them. What was more difficult for the staff in the absence of any substantial knowledge or experience of domestic abuse, was finding ways to help support Child J. As was the case with other agencies, they did not always recognise that what they were being told was a child safeguarding concern which required a referral to CSC, or know where they could get help. Their main focus of support was CSC and what has become apparent is that the project did not have established links with specialist resources in the community who may have been able to provide wider help and support both to staff and to Child J

6.5.33. That BCHA did not report Child J as missing immediately on leaving the project is felt by her mother and her friend to be a significant failing. When Child J left the project to meet with Adult L, it is evident that staff were worried and attempted to persuade her not to do so, but without success. Although they were uncomfortable they felt that Child J was taking appropriate actions to stay safe, such as meeting him in a public place. They also took into account that she had met him many times previously and had always returned to the project. Staff have also since reported having had a mistaken belief that police would not take action until someone had been missing for 24 hours. For these reasons staff did not consider that they should seek advice from a manager or contact the police urgently, but instead waited to see if Child J returned that night. What this evidences is the level of support workers' understanding of the risk factors in relation to domestic abuse. Given that Adult L had made an explicit threat to Child J's life, staff with greater experience and understanding

of domestic abuse might have been expected to recognise that this was a situation of high risk. In the absence of any knowledge of risk assessment in relation to domestic abuse, their decision-making becomes more understandable.

6.5.34. BCHA has now recognised that staff in the unit had limited training or knowledge of domestic abuse, for example none of the staff were trained in CAADA-DASH assessments and there was a lack of understanding of the role of MARAC and the IDVAs. With hindsight the manager does not believe they were equipped to manage the level of risk Child J faced. Had they been aware of the level of risk the manager now questions whether they were the right resource and whether Child J should actually have been in a refuge. Given what is known about Adult L's control over Child J it however seems unlikely that she would have been able to go to a refuge, even if there had been a space available at the time.

6.5.35. Whether or not a more suitable place could have been found for Child J, it is inevitable that the group of young people being placed in a resource like BCHA's supported housing unit will be experiencing a range of problems not all of which are fully understood when they arrive. Staff therefore need to be equipped with adequate basic knowledge about Domestic Abuse or other safeguarding issues so that they know where they can seek help if they need it. This has been properly recognised by BCHA who have arranged for relevant training, including for the manager to attend training provided by CAADA (now known as SafeLives). The BCHA manager has also now been trained as the designated MARAC officer and 2 young people have since been referred.

6.5.36. These events have also raised some questions about the quality of handovers between different shifts and recording of concerns. Staff during the day are described in the IMR as being extremely concerned about Child J's safety, yet this level of concern does not appear to have been communicated fully to the later shift. The night staff did not immediately contact the police when Child J did not return. This was partly due to involvement with another young person causing concern, but also because staff did not view it as unusual that Child J was late returning. Another point at which there may be evidence for some gaps in recording was identified by PC33, who visited the hostel as part of his enquiries and fed back that different members of staff had different information. It has also been identified that although individual disclosures made to staff were recorded in various places they were not always recorded on BCHA's serious incident database which is required in order to ensure that such incidents are brought to the notice of a senior manager. **BCHA is therefore advised by this SCR** to review the effectiveness and quality of its recording systems within its residential projects.

The role of the school

6.5.37. Despite the continued difficulties with Child J's attendance, the school continued to work actively to support her, both collectively with regular weekly briefing meetings but also in their individual roles. Staff at the school worked hard to maintain contact with Child J and they were clearly the most consistent and trusted professionals in her life at this time. Child J's previously improved

attendance was now deteriorating again as her situation outside school got progressively worse and her basic needs for housing, shelter, food and security were increasingly pressing. Edmentor1 acted as a link between Child J and other agencies, particularly the police and CSC, although Edmentor1 never actually met the Social Worker. Child J would contact Edmentor1 at points of crisis, frequently outside normal working hours, '*often hungry and tired, with no clear place to live'*. Edmentor1 always responded to Child J, offering emotional support, providing food and clothing. This role placed enormous pressure on Edmentor1 personally, but she continued to make herself available *'how could I not respond?*'

6.5.38. The school also attempted to work with Child J directly in relation to the risks posed by Adult L and the potential for continuing domestic abuse. The school was aware that other pupils were afraid of Adult L and worked to try to empower her to make good choices and help her believe that her life could be different. Again, these are approaches that are known to be valued and more likely to have a positive outcome for young people. Edmentor1 contributed directly to the Risk Assessment undertaken by CSC leading to the MARAC. Edmentor1 was clearly aware of the degree of control being held by Adult L. She was conscious of how difficult it was for Child J to speak privately to her and was able to distinguish occasions when Adult L appeared to be in the background and therefore affecting what Child J was able to say to her.

6.5.39. Both Child J's family and her friend when interviewed as part of this Review spoke very highly about Edmentor1's involvement with Child J. Child J's mother said that Edmentor1 spoke to Child J like an adult and tried to work with her to get her away from Adult L. She said that she was really good at keeping in touch with Child J, even when Adult L was making this difficult, taking her phone or cutting up her SIM cards. Child J's friend described Edmentor1 as being very skilled at getting the young people to talk without making them uncomfortable, they would open up while she got them doing interesting or fun things '*she was young, enthusiastic and not boring…good at distracting you… drawing you in without you realising it and then you would tell her things.'*

6.5.40. There is no doubt that Edmentor1 felt frustrated at the lack of adequate help from other agencies, particularly Social Care, but felt unable to do anything about it. It is evident that the school worked tirelessly to support and empower Child J, to link her with the right resources and to liaise with the social worker, and that they had a very good understanding of her needs and the risks to her. However, what did not take place was an escalation of the school's concerns to more senior levels within CSC. Escalation of concerns was identified in the recent Oxford SCR (A-F, 2015) and subject to a recommendation in that Review and is currently subject to action as a result. Therefore no further recommendation is included in this Review.

The role of CAMHS

6.5.41. CAMHS became involved with Child J for the second time in early 2013 after a referral from the GP, Child J having taken an overdose. Practitioners in CAMHS followed agency and national standards and practice in their contact with Child J. In the absence of any evidence of acute mental illness she was

referred to the CAMHS outreach team, OSCA. However, this did not lead to longer term involvement as Child J said that she did not want the service and the assessment of the team having met her on two occasions was that she did not meet the criteria for work with the team.

'She does not present any diagnosable mental health problems except trauma and she is at risk of developing mental health problems later in her life if the underlying issues are not addressed at this point in time.'

6.5.42. CAMHS undertakes its work based on strict commissioning and assessment criteria which Child J did not meet. Whilst the assessment concluded that she experienced trauma as a result of her life experiences, this did not reach the level of intensity or frequency to meet the clinical definition of Post-Traumatic Stress Disorder. The team had agreed that they would be willing to work with Child J despite her not meeting the formal criteria, if she was willing to commit to that work. What their assessment also clearly acknowledges is that Child J was at long term risk of developing mental health problems in adulthood. This reflects a short term approach to commissioning services that is well understood and recognised at a national level:

'The focus of investment in CAMHS should be on early intervention – providing timely support to children and young people before mental health problems become entrenched and increase in severity, and preventing, wherever possible, the need for admission to inpatient services.'[36]

6.5.43. This should not be perceived as a problem created by or unique to Oxfordshire, or a problem that can easily be solved given the resources currently available. The long term policy approach can only be properly solved at a national policy level and this has recently been the subject of a Government task force which published its report in March 2015[37]. However, what this Review, in common with many other SCRs, highlights is the lack of suitable specialist services for young people with complex problems which do not meet current criteria for mental health services. A **Multi-Agency Recommendation** is therefore made by this Review.

How the multi-agency approach worked

6.5.44. It is apparent that whilst agencies did work together in relation to Child J Adult L and Child M, this was predominantly in smaller groups or in response to individual crises rather than by bringing together all those involved in order to agree a shared approach to risk management and achieve a sustainable long term plan.

6.5.45. In relation to the specific risks to Child J of domestic abuse from Adult L, the key opportunity to achieve a full multi-agency approach was through the CAADA-DASH risk assessment form undertaken by SW4 which identified Child J as high risk and therefore triggered the MARAC (Multi-agency risk assessment conference) in the spring of 2013.

[36] Health Select Committee 2014

[37] https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/414024/Childrens_Mental_Health.pdf

6.5.46. The completed risk form was sent as required to the IDVA team[38] on 26th March, and arrangements were also made for it to be listed at the next MARAC meeting. A planned joint visit to Child J with SW4 and one of the IDVAs was cancelled at short notice by the IDVA manager because staff in the IDVA team had not yet received training in working with young people, and she believed it needed to be discussed first at the MARAC. Prior to April 2013 Government guidance had not included 16 and 17 year olds either in its definition of Domestic Abuse nor the related statutory guidance and as such this age group were not able to access the IDVA service nor be subject to MARAC. Child J was the first young person to be referred to the MARAC after the change to legislation. Whilst this change in government policy had been announced in 2012, the guidance on IDVA practice with under 18s were not published until April 2013 after Child J was referred.

6.5.47. Cancelling the joint meeting with Child J prior to the MARAC left Child J without an option for specialist domestic abuse support appropriate to the risk level for a period of nearly three weeks, when the service standard is to seek to arrange contact within two working days, given that these are by definition potentially high risk cases. At the point of referral Child J did not meet the IDVA service's remit but this was only by a matter of days. It is the case that Home Office guidance had stated that services intending to work with this age group should have the right training and skills. However given that the date for a change in the definition and therefore the likelihood of receiving referrals was well known, and the fact that the young person's Social Worker was working alongside the IDVA, this decision was disappointing. The IDVA service has recognised that the decision was questionable, particularly in cancelling a meeting at short notice with a young person who was known to be disengaged from services, and when this would have provided the opportunity to seek her views before the MARAC meeting. The service does however believe that this was a unique set of circumstances and has found no other evidence of such a delay in responding to a referral.

6.5.48. The purpose of the MARAC meeting is to identify victims of domestic violence and abuse who are at high risk, to pool information, agree immediate coordinated safety plans and respond rapidly. A referral is made by any agency to the MARAC which is a meeting, not an agency in its own right. In Child J's case this was done appropriately by the Social Worker at the time. The MARAC is made up of nominated representatives from all key agencies and will consider several referrals during a meeting and each will be given 15 minutes for consideration.

6.5.49. The outcome of the MARAC meeting was that the IDVA service would meet with Child J*, 'stress to her that she should report any future DA incidents to the police and ensure that she understands how important it is for the future'.* The IDVA service stated that the note of the meeting did not represent the breadth of the discussion, nor did it limit their involvement. However, as an action plan it appears limited. Over the next few weeks the IDVA attempted on several occasions to make contact with Child J, including through her mother, social worker and Edmentor1, but without success. During some of this period Child J

[38] The IDVA team is provided by Reducing the Risk of Domestic Abuse

was effectively missing. The IDVA service closed the case in June as there had been no information about any further incidents of abuse, but with the knowledge that statutory services were involved with Child J and could be expected to inform them if she required their services in the future. The IDVA Service Manager has now accessed the required training for working with young people and the service has in the last year worked directly with 10 young people, comprising 5% of the referrals it has received.

6.5.50. The response from MARAC highlights the limitations of the process in that there is nothing to suggest a multi-agency plan was identified either regarding Child J's vulnerability nor Adult L's level of danger. What was missing was a recognition that Child J was a child and in need of safeguarding, not an adult who was fully able to make her own decisions. At the time there was a view within CSC that Child Protection processes were not necessary if a MARAC was taking place as this could provide the appropriate risk assessment forum. However, the MARAC failed to engage with Child J and she was never re-referred even when there were further incidences of abuse. It has now been explicitly stated by CSC, and recognised by the other agencies involved, that MARAC and the IDVA service cannot be relied upon to replace the quality of assessment of a Child Protection Conference, or the level of statutory authority that may be required in order to protect a young person and hold professionals to account.

6.5.51. A multi-agency working group was established in January 2015 in order to identify the care pathway, assessment tools and other services necessary to support 11-18 year olds who are the direct victims of domestic abuse. A domestic abuse pathway for young people has now been agreed and is being rolled out across the agencies. This pathway includes the requirement to take advice about whether a strategy meeting and S47 enquiry are required. A new strategic lead has very recently been appointed by the council in order to contribute to the development of an effective multi-agency approach. Given that several of these developments are still at an early stage a **Multi-Agency Recommendation** is made by this Review jointly to the OSCB and the Oxfordshire Safer Communities Partnership[39] to reinforce the importance of ensuring positive progress in this area of work.

6.5.52. A further important area for learning and improvement that has been highlighted is the way in which information shared in the MARAC meeting is communicated to front line professionals. Several of the organisations involved with Child J were not aware that she had been subject to a MARAC:

- CAMHS: staff were unaware the MARAC process. Information might not have changed their decision about eligibility for services, but would have helped them better understand her vulnerability (this is subject to a recommendation by Oxford Health).
- Thames Valley Police: information was recorded on the MARAC database which is only accessible to the MARAC co-ordinators and some staff within the Domestic Abuse Investigation Units. Therefore, officers dealing with

[39] The Oxfordshire Safer Communities Partnership provides strategic oversight and direction for preventing crime and anti-social behaviour across the four district-led Community Safety Partnerships.

subsequent domestic abuse incidents involving Child J and Adult L would not have been aware of the fact that Child J had previously been graded as 'high' risk and had been the subject of a MARAC(this is subject to a recommendation by TVP).

As it has become apparent that there were gaps for a number of agencies in their capacity to share information from the MARAC with frontline professionals, this is also subject to a **Multi-agency recommendation**.

6.5.53. In order to provide the best possible approach to working with both Child J and Adult L a strong, effective multi-agency plan was required, with clarity about the responsibilities of different agencies, a means to effectively share information across agencies and a lead professional. It would appear that given the risk of significant harm to Child J this would best have been achieved by the use of existing statutory child protection processes.

6.6 Summary of Key Findings

This review has identified a wide range of learning across the various agencies both individually and in partnership. The following issues have been identified as the key findings which have contributed to the final recommendations for the Review:

The **assessment and response to Child J's needs by different organisations** was not based on an understanding of the level of difficulties she faced and was variable in quality. Proper consideration was not given to how best to maintain support for Child J over the long term, including whether she should have been subject to Child Protection procedures. This reflects the challenges faced by professionals in working with adolescents.

Child J's **needs and vulnerabilities as an adolescent** were at times poorly understood, and agencies were often unable to help her access their services. The numbers of professionals involved with her was sometimes actively unhelpful and there was inadequate thought given to her relationship with key professionals and how this could be developed, or how those key professionals could be better supported.

Too often Child J was viewed as a difficult young person and not recognised as a **child in need of safeguarding.**

Professionals and agencies did not always fully understand **the serious nature of the risks to Child J** or were too quick to be reassured that she would be able to protect herself from those risks. A MARAC did take place and support was offered, but this did not result in Child J actually accessing that support.

The **significance of domestic abuse in young people's peer relationships**, the features of that abuse and the level of risk that can exist, is a key learning for this Review. Processes for supporting 16-18 year old victims of domestic abuse were still very new in line with national developments at the time that Child J was murdered. This included a lack of clarity about the way in which processes such as MARAC should properly overlap with Child Protection processes.

Individual workers, particularly, but not only, from the school and the CSC Leaving Care Team worked extremely hard to help and support both Child J and Adult L when he was still receiving services. However, their efforts were not fully supported by an adequate, planned, multi-agency approach.

The **response of the key agencies on the last occasion that Child J went missing was fundamentally flawed** and lacked a sense of urgency. The police response, which was also investigated by the IPCC, failed to recognise the seriousness of the threat made to Child J by Adult L and was therefore not responded to as a high risk. This delay significantly contributed to the family's distress.

Considerable information was known across the agencies about **the risks posed by Adult L**, but there was no system to support a proper multi agency assessment or plan of intervention with him.

7. Concluding Remarks

7.1. Two issues have during this review run as threads throughout the responses of agencies at an individual, organisational and multi-agency level. The first is the **effectiveness of work with adolescents**. The second, more specifically is the level of understanding and **response to adolescents who are experiencing domestic abuse in peer relationships.**

7.2. The quality and impact of **services provided to adolescents** has been a feature of many SCRs[40] nationally and was also identified within the recent Oxfordshire SCR regarding child sexual exploitation. What is apparent from Child J's experience is that there were a range of barriers as a result of her age that came between her and the provision of a fully effective multi-agency service. There are a wide number of examples throughout the information received by this review including:

- Services, such as mental health services, working to a model of intervention, which teenagers find difficult to sustain.
- Individual practitioners and services not viewing Child J as a child who needed protecting.
- Practitioners' difficulty in understanding or responding constructively to Child J's sometimes contradictory or '*unruly*' behaviour.
- Professionals struggling to find the balance between protecting Child J as a child and respecting her development as an autonomous young person, including working with her consent and maintaining her engagement.
- Professionals not having the skills, or the organisational support to work flexibly with young people.
- Lack of consistency or an identified key lead professional
- Limited access to safe placements or accommodation for young people at risk

7.3. A clear message has been given to authorities and services nationally that the approach to working with adolescents demands improvements and requires

[40] OFSTED 2011

strategic oversight. The OSCB has confirmed that it prioritises the need for such change and in particular recognises that the nature of safeguarding for young people has changed and will continue to change.

7.4. Secondly, Child J's experience has highlighted some particular gaps in knowledge, practice and provision of services in relation to the impact of **domestic violence within young people's peer relationships**. Some of the learning about domestic violence applies irrespective of the age of the victim, for example the need for improved awareness of the significance of coercive control, the high risks associated with particular behaviour such as previous failed strangulation, and the continuing risks post separation. However, there are other aspects that are particularly important when working with young people.

7.5. The prevalence and potentially serious nature of peer domestic abuse with young people has only comparatively recently begun to be understood and acknowledged within research and national policy. This needs to be understood as the background context when judging the practice in Child J's case. In particular there is now considerable research to identify that the risks of domestic abuse in relation to young people can be particularly serious.

7.6. Research conducted by the NSPCC[41] has identified features which are directly relevant both to Child J's experience and to what we have learnt about the response of agencies, including:

- Three quarters of girls report having experienced emotional abuse and a quarter having experienced physical violence.
- Experiencing family violence is significantly associated with partner violence for girls.
- An older boyfriend (i.e. at least 2 years older) represents an increased risk of domestic abuse for girls. The risks for these girls are considered particularly worrying with 75% experiencing physical or sexual violence and 80% reporting emotional abuse.
- Very few young people speak to an adult, even fewer to a professional about their experience of DA If a girl did talk to a professional it was most likely to be a learning mentor.
- The violence does not stop when a relationship ends and in many cases the level of violence increased. Ending a relationship does not necessarily protect a young person.
- The degree to which coercive control features, particularly in relation to the use of social media.

7.7. Too often it seems that professionals and agencies did not recognise the serious nature of the risks to Child J or were too quick to be reassured that she would be able to protect herself from those risks. Child J in fact required proactive intervention to protect her from Adult L and consistent, non-judgemental support across the agencies.

7.8. Although not within the time period established for this review, the role of early intervention with families and young people once again needs highlighting.

[41] Barter et al: NSPCC 2009

Whilst the outcome for Child J, Adult L and Child M and the effect it had on their lives and behaviour was dramatically different, from the perspective of agencies there are some similar lessons to be identified in relation to the services provided at much earlier stages in their lives.

7.9. Both families were known for considerable periods to the statutory agencies including police and social care. All three of the subjects of this review were in their different ways very damaged by some of their earlier experiences. Child J became increasingly vulnerable, whereas Adult L became increasingly dangerous. The importance of early intervention is well known and given the passage of time and consequent change in agency practice, it is not the view of this Review that a recommendation in this regard is justified. However, there is a stark lesson to agencies here about the long term damage that can be caused to children in the absence of proactive services during their early years.

"*Childhood is short. It is the foundation of our self-esteem and sets the tone for most of our adult life. Children and young people need to feel loved, secure and safe. They should push boundaries knowing that someone will catch them when they make a mistake. They should know that there are people in their lives who will never give up on them."*[42]

7.10. This Review has also identified considerable learning about **the risks posed by Adult L**, risks which highlight the need to develop more effective responses to in order to minimise the chance of future tragedies such as that of Child J. Identifying whether an individual event such as this could have been prevented is highly problematic, as to do so assumes that we can accurately predict the future outcomes of an extremely complex range of actions, not just of the professionals and agencies, but also of individuals receiving those services. There is no doubt that there was enough information to alert agencies to the risks that Adult L posed and to Child J's vulnerability. Whilst it would be unrealistic to suggest that the murder of Child J could have been predicted, all the evidence pointed towards the likelihood that Child J would experience further abuse, including the possibility of serious emotional or physical harm.

7.11. It is evident throughout this Review that at times mistakes were made by services and that the long term approaches taken to protect Child J were, whilst often well intended, were ultimately ineffective. There were times when it is possible that alternative responses or strategies might have made a difference, both in providing Child J with better support to help protect her from harm and in fully identifying and responding to the level of risk posed by Adult L. The reality was however, that Adult L was able to maintain control over Child J from an early stage of their relationship and had created a bond with her that would have been extremely difficult for any individual or outside organisation to break. Whatever the actions of agencies, there could be no guarantee that either at that particular time, or at some date in the future, Adult L's actions would not have led to the death or serious injury of Child J, or another young woman.

[42] A4C (2014:1)

8: Recommendations

A large number of recommendations for individual agencies have been made as part of this review and these can be found in Appendix C.

The identified **multi-agency recommendations** relevant to either or both the OSCB and the OxSCP are grouped below to reflect the three key areas of learning within this Review. One additional recommendation regarding the process of DHRs and SCRs is also included.

Where it has been evidenced that appropriate action is already being taken in relation to identified learning, no related recommendation has been produced by the Review.

A: Working effectively with young people

Multi-Agency Recommendation 1: The OSCB to request that the importance of young people's relationships with professionals is built into the multi-agency work currently being undertaken on vulnerable adolescents. The learning should be used to identify how best practice can be developed more widely across the multi-agency partnership.

Multi-Agency Recommendation 2: The OSCB to seek assurance from the relevant health and children's services commissioning agencies that suitable services are available for young people with complex emotional and behavioural problems who do not meet current CAMHS thresholds.

B: Young people and domestic abuse

Multi-Agency Recommendation 3: The Oxfordshire Safer Communities Partnership & Community Safety Partnerships and OSCB to work with the strategic lead on domestic abuse to ensure an effective unified approach to working with young people who are victims and/or perpetrators of domestic abuse.

Multi-Agency Recommendation 4: The Oxfordshire Safer Communities Partnership & Community Safety Partnerships and OSCB seek assurance that all agencies have in place systems for ensuring information regarding referral to MARAC is shared with all relevant frontline professionals.

Multi-Agency Recommendation 5: The OSCB to seek assurance that the programme provided by schools in Oxfordshire covers healthy relationships in the context of domestic abuse.

C: Working with young people who pose a risk to others

Multi-Agency Recommendation 6: The Oxfordshire Safer Communities Partnership & Community Safety Partnerships and OSCB to review current multi-agency approaches for young people who present serious risks in the community, but do not meet the criteria for MAPPA and are not subject to court orders. Consideration to be given to:

i) Clarifying and promoting the most appropriate structures for managing both the risks and needs of the young person concerned.

ii) Maximising good interagency communication.

ii) Ensuring that staff are properly supported and that adequate management oversight and supervision arrangements are in place.

D: Additional learning

Multi-Agency Recommendation 7: That South and Vale Community Safety Partnership and the OSCB recommend to the Home Office and the Department for Education that a Memorandum of Understanding is agreed with the IPCC regarding the production of DHRs, SCRs and IPCC investigations.

Appendix A: Acronyms

ASB	Anti-Social Behaviour
BCHA	Bournemouth Church Housing Association
CAADA DASH	Co-ordinated Action Against Domestic Abuse – Domestic Abuse Stalking and Honour based violence
CAF	Common Assessment Framework
CAIU	Child Abuse Investigation Unit (Police)
CAMHS	Child and Adolescent Mental Health Services
CSC	Children's Social Care
CP	Child Protection
S&VCSP	South and Vale Community Safety Partnership
DHR	Domestic Homicide Review
EIS	Early Intervention Service
IDVA	Independent Domestic Violence Advisor
IMR	Individual Management Review
IPCC	Independent Police Complaints Commission.
MARAC	Multi-Agency Risk Assessment Conference
MAPPA	Multi-Agency Public Protection Arrangements
OSCB	Oxfordshire Safeguarding Children board
OXSCP	Oxfordshire Safer Communities Partnership
PCAMHS	Primary Child and Adolescent Mental Health Services
SCR	Serious Case Review
TAC	Team Around the Child
YOS	Youth Offending Service

Appendix B: Professional Identifiers

AGENCY AND JOB TITLE	CODE
Bournemouth Church Housing Association	
Support worker	BCHA 1
Referrals coordinator	BCHA 2
Manager	BCHA Mgr
Support worker	BCHA 3
Night Support worker	BCHA 4
Support worker	BCHA 5
Support worker	BCHA 6
Children's Social Care	
Social Worker	SW1
Social Worker	SW2
Social Worker (assessment team)	SW3
Social Worker (Housing specialist, C&F Assessment team)	SW4
Social Worker	SW5
Social Work Manager	SWMgr1
Family Placement Support Service (FPSS)	FPSS1
Leaving Care Personal Advisor	LCPA
Early Intervention Service	EIS1
Education Services	
Head of House, School	Ed1
Support and Attendance Officer	Ed2
School Inclusion mentor	Edmentor1
School inclusion officer	Edmentor3
Year 10 support and guidance manager	Ed3
Integrated Youth Support Services	
PAYP linkworker	PAYP1
Oxford Health NHS Foundation Trust	
School Nurse	SchoolNurse1
School Nurse	SchoolNurse2
Senior Mental Health practitioner/CPA Care co-ordinator	CAMHS3
CAMHS	CAHMS1
CAMHS	CAMHS2
Consultant psychiatrist CAMHS	ConsPsych
CAMHS	CAMHS4
CAMHS	CAMHS5
CAMHS	CAMHS6
CAMHS	CAMHS7
Reducing The Risk Of Domestic Violence - IDVA	
IDVA	IDVA1

Appendix C: Process and Methodology for the Review

1 Timescale for undertaking this Review.

1.1. The decision to undertake a combined review was made on 8th January 2014. As is required, on 21st January 2014 the Department of Education was informed that the SCR was being commissioned as part of a joint review. On 21st March 2014, the Home Office was similarly informed, the delay resulting from the need for a formal agreement between the OSCB and South and Vale Community Safety Partnership (S&VCSP).

1.2. The expectation for both a DHR and SCR, is that wherever possible the Review will be completed within 6 months of the decision to undertake it. It was evident to the OSCB and S&VCSP from the outset that it could be difficult to achieve this timescale due primarily to criminal and other investigations. It was therefore recognised that the timescale for this Review would need to be extended. A timescale was therefore put in place with a view to completion by November 2014. The Chairs of S&VCSP and the OSCB both informed the relevant government departments as required in the summer of 2014.

1.3. Although significant progress was made by the agencies involved in collating and analysing the necessary information required for this Overview Report, there were continuing delays as a result of an investigation by the IPCC (Independent Police Complaints Commission). The Review was initially informed that the IPCC investigation was likely to be completed by August 2014. The IPCC were however unable to meet this date or to provide a definite timetable for completion. Thames Valley Police were unable to complete their IMR until the IPCC investigation was finalised, and a planned meeting with relevant practitioners had to be delayed until early 2015 as some of the police officers concerned were still subject to the IPCC investigation. The Chairs of the S&VCSP and the OSCB both wrote to the IPCC stating their concerns at the resulting delay.

1.4. In March 2015, the panel were informed that the IPCC report should be completed by the end of April 2015. Given the central role of Thames Valley Police it was the clear view of the panel that this Review could not be completed without a full IMR from the police. At the March 2015 Panel meeting it was therefore agreed that the SCR/DHR could not progress any further and a recommendation was made to the Chairs of the SCB and the CSP that the Review process would need to be put on hold until the IPCC report had been received.

1.5. The IPCC investigation was completed and their report forwarded in May 2015 to both Thames Valley Police and the author of this report. A new timetable was produced, which had to take into account the capacity of Thames Valley Police to complete their IMR and the availability of the author of this review. As a result this review was completed in October 2015 and received by a Joint Meeting of the South and Vale Community Safety Partnership and the Oxfordshire Safeguarding Children Board in December 2015. The final report was approved by the Home Office at its DHR Quality Assurance Group on 27 January 2016.

2 Confidentiality

2.1. The content and findings of this Review were strictly confidential during the Review process. Information provided was only available to the identified participating officers and professionals and their line managers until the Overview Report was approved for publication by the Home Office Quality Assurance Group and the OSCB. The Home Office Quality Assurance Group letter of approval is attached at Appendix E.

3 Dissemination of the Report

3.1 On final completion the report will be sent to the following bodies:

- South and Vale Community Safety Partnership
- Chief Executive of South Oxfordshire and Vale of White Horse District Councils
- Chief Executive Oxford City Council
- Chief Executive Officer Oxfordshire County Council
- Oxfordshire Domestic Abuse Strategy Group
- Oxfordshire Safeguarding Children Board
- Oxfordshire Safer Communities Partnership

3.2 The following agencies will also receive copies of this report:

- Bournemouth Church Housing Association
- Home Group (Housing)
- National Probation Service
- Oxfordshire County Council Children's Social Care and Early Intervention Services (CSC)
- Oxford Health NHS Foundation Trust
- Oxfordshire Clinical Commissioning Group (GPs)
- Oxford University Hospitals NHS Foundation Trust
- Reducing the Risk of Domestic Violence (IDVA service)
- Schools and Special Educational Needs
- South Oxfordshire District Council Housing (SODC)
- South Oxfordshire Housing Association (SOHA)
- Thames Valley Police
- Young Addaction Oxfordshire

4 Purpose and Terms of Reference for the Review

4.1. The purpose of the Domestic Homicide Review is to:

a) establish what lessons are to be learned from the death of JP regarding the way in which local professionals and organisations work individually and together to safeguard victims;
b) identify clearly what those lessons are both within and between agencies, how and within what timescales they will be acted on, and what is expected to change as a result;

c) apply these lessons to service responses including changes to policies and procedures as appropriate; and
d) prevent domestic violence and abuse homicide and improve service responses for all domestic violence and abuse victims and their children through improved intra and inter-agency working.

4.2. The purpose of the Serious Case Review is outlined in Working Together as follows:

> *Reviews are not ends in themselves. The purpose of these reviews is to identify improvements which are needed and to consolidate good practice. LSCBs and their partner organisations should translate the findings from reviews into programmes of action which lead to sustainable improvements and the prevention of death, serious injury or harm to children.* (Working Together 2013, p66)

4.3. The guidance further requires reviews to consider: "*what happened in a case, and why, and what action will be taken*".

4.4. It is not the role of either a DHR or a SCR to act as an inquiry into how the victim died, or who is culpable. These are matters for the Criminal and Coroners courts. Neither is it the Review's role to initiate disciplinary or other employment procedures, as these remain the responsibility of the employing organisation.

4.5. Detailed Terms **of Reference** were established and these are included below.

5 Methodology

5.1. Whilst the underlying purpose and significant aspects of the approaches taken by DHRs and SCRs have much in common, there are some differences and these have been accommodated within this joint review. The DHR statutory guidance requires a specific methodology, including the provision of Individual Management Reviews by each agency involved. Previous statutory guidance in relation to SCRs took a similar approach, however since 2013 there is no longer a requirement to use a specific model or to commission Individual Management Reviews. Instead, the guidance requires that case reviews should be conducted in a way which:

- recognises the complex circumstances in which professionals work together to safeguard children;
- seeks to understand precisely who did what and the underlying reasons that led individuals and organisations to act as they did;
- seeks to understand practice from the viewpoint of the individuals and organisations involved at the time rather than using hindsight;
- is transparent about the way data is collected and analysed; and
- makes use of relevant research and case evidence to inform the findings.

The SCR guidance allows the use of any learning model which is consistent with the principles in this guidance, including the systems methodology recommended by Professor Munro[43].

5.2. In order to meet the requirements of both models, this Review has used the broad structure and framework established within DHR statutory guidance, but in doing so has drawn on the principles of a systems approach to case reviews as developed by Professor Munro and SCIE[44]. A 'systems approach' to learning recognises the limitations inherent in simply identifying what may have gone wrong and who might be 'to blame'. Instead it seeks to identify which factors in the work environment support good practice, and which create unsafe conditions in which poor practice is more likely. The purpose being to move beyond the individual case to a greater understanding of safeguarding practice more widely.

5.3. The Review was chaired by Fiona Johnson, an Independent Social Work Consultant, who is also the Independent Chair of the OSCB Case Review and Governance Group. The Review was authored by Sian Griffiths, an Independent Social Work Consultant who has significant experience in undertaking Serious Case Reviews and is an Accredited SCIE Learning Together Reviewer[45]. Sian Griffiths has experience of working with domestic abuse both in practice and in the context of undertaking SCRs where domestic abuse has regularly been a factor. Both the Chair and the Author are independent of the case and of all the agencies involved.

5.4. A Review Panel consisting of the Chair, Overview Author and Senior representatives or Safeguarding Leads of the following agencies was established:

Agency/Organisation	**Role**
	Independent Chair
	Independent Overview Author
A2 Dominion	Services Manager
Oxford City Council	Domestic & Sexual Abuse Co-ordinator
Oxfordshire Clinical Commissioning Group	Designated Nurse Safeguarding
Oxfordshire County Council (Children's Social Care)	Safeguarding Manager
Oxfordshire County Council (Children's Social Care)	Social Care Manager
Oxfordshire County Council	Head of Law and Governance
Oxfordshire County Council	Children with SEN Manager
Oxfordshire County Council	Joint Commissioning Manager DAAT
South Oxfordshire and Vale	Strategic Director

[43] Working Together (2013:67)
[44] SCIE: Social Care Institute for Excellence

of White Horse District Councils	
Thames Valley Police	Detective Chief Inspector, Oxfordshire Protecting Vulnerable People Unit
Thames Valley Probation	Senior Probation Officer Public Protection Unit

5.5. The OSCB Business Officer and Administrative Officer also contributed to Review Team meetings.

5.6. The Review Panel met on 10 occasions.

5.7. All relevant voluntary sector and statutory agencies were contacted at the outset to check for any involvement with Child J, Adult L or Child M.

5.8. Individual Management Reviews (IMRs) and chronologies were commissioned from the agencies which had relevant contact with Child J, Adult L or Child M. The purpose of the IMR is for each agency, using the Terms of Reference to consider its practice critically and in detail; to identify whether there should be changes in policy or practice and how these will be made. IMRs were provided as requested by the following agencies:

- Bournemouth Church Housing Association
- Home Group (housing)
- National Probation Service
- Oxfordshire County Council Children's Social Care and Early Intervention Services (CSC)
- Oxford Health NHS Foundation Trust
- Oxfordshire Clinical Commissioning Group (GPs)
- Oxford University Hospitals NHS Foundation Trust
- Reducing the Risk of Domestic Violence (IDVA service)
- Schools and Special Educational Needs
- South Oxfordshire District Council Housing (SODC)
- South Oxfordshire Housing Association (SOHA)
- Thames Valley Police
- Young Addaction Oxfordshire

5.9. The following agencies provided chronologies and a shorter factual report in recognition of the limited nature of their involvement with the subjects of the Review:

- CAFCASS
- ChildLine (chronology only)
- Oxfordshire County Council, Drugs and Alcohol Commissioning
- Oxfordshire Youth Offending Service
- Oxfordshire County Council Legal Services

5.10. Inquiries were also made with another Safeguarding Children Board in a different area of the country (County A) who confirmed that Child J had been known to 3 agencies in that area. This consisted of very brief contact with

Children's Services, a GP and Hospital which was detailed by the Safeguarding Board Manager. The Review panel agreed that given the level of involvement of these agencies, no further information was necessary.

5.11. In order to increase the Review's understanding of the actual experience of the practitioners involved and minimise the use of hindsight, IMR authors were specifically asked to explore with individuals not only what actions they took but the context in which those actions were taken. Additionally, a meeting involving both Review Panel members and the key practitioners took place during the Review process, in order to further maximise practitioner contribution to the report.

5.12. As well as the individual agency chronologies and IMRs, the Overview Author was provided with other documents as requested, including the Post Mortem reports and the minutes of a MARAC meeting.

6 Involvement of Child J's Family and Friends.

6.1. Given that at the outset of this Review, criminal proceedings were still outstanding, the Chair of the Review sought the advice of Thames Valley Police's Senior Investigating Officer regarding meeting with family or friends. Clear advice was given that any meetings prior to the completion of the criminal trials could potentially compromise the proceedings. As a result it was not possible to discuss the Terms of Reference for this report with the key family members as is the normal practice in relation to DHRs.

6.2. The Independent Chair of the Review wrote to the family of Child J and the family of Adult L and Child M in March 2014 to inform them that the Review was taking place and to explain that they would be contacted at a later date to seek any contributions they wished to make. The family were given information about the organisation AAFDA (Advocacy After Fatal Domestic Abuse), which provides support and advice to families in these circumstances.

6.3. Following the criminal trial in relation to Adult L, further advice was sought from the Senior Investigating Officer regarding contact with family and friends. Advice was given that there was no bar to contact with the immediate family of Child J, Adult L or Child M, but that in the light of the retrial of Child M, contact with Child M, Adult L and certain friends of Child J who might be called as witnesses, could compromise the retrial.

6.4. Contact was therefore made with Child J's mother who agreed to meet with the Independent Author and Independent Chair of the Review. This meeting took place in December 2014, with Child J's maternal grandfather, Child J's mother's partner, and the mother's support worker from locally based Community Services also present. The contributions made by Child J's mother and grandfather have proved very valuable to this Review and are included as a summary in Section 3, but also included where relevant in the main body of this report.

6.5. Sadly, Child J's father died unexpectedly days before the start of the criminal trial, so it was not possible as had been intended to provide him with the opportunity to contribute to this review or provide his perspective.

6.6. Contact was also made with the elder sister of Child J, who also agreed to meet with the Independent Author and Chair in December 2014. Child J's sister also provided the Review with valuable insights into their experience of services and concerns about Child J. Her contributions are also summarised in Section 3 and included throughout this report.

6.7. Given Child J's age and the importance of peer friendships to her, attempts were made to speak to a number of her friends as identified by her mother and professionals. Considerable efforts were made to contact a total of 6 young people through those professionals who had a positive relationship with them, through social media and in writing. A flexible approach was taken to the place and timings of meetings, including offering the option of meeting with some of the young people together. Although some of the young people initially responded positively to the idea, in the end only one young person met with the Author of this Review. Her comments are also summarised in Section 3

6.8. In line with the DHR requirements Child J's mother, maternal grandfather and sister have had the opportunity to read and comment on the full draft of the Overview Report and their views have been taken into account. A month prior to presentation of the report of report at the Board, the Author and OSCB Board Manager met with Child J's mother and grandfather and the author met with Child J's sister to share the review and discuss its contact and consider any amendments that family members wished to make. All the amendments suggested were subsequently included in the final draft.

7. Involvement of Adult L, Child M and their family

7.1. As is customary with a Domestic Homicide Review, contact was also made with the perpetrator, Adult L, his brother, Child M as well as their parents in order to achieve a greater understanding of the role played by agencies in working with them and any resulting impact on protecting Child J.

7.2. Advice was sought from the Police Senior Investigating officer who again confirmed that any meetings prior to the completion of the criminal trials could potentially compromise the proceedings. As a result of this advice arrangements were made to meet with Adult L in early 2015 following his sentence to life imprisonment, and to meet Child M later in the year after he had been released on custody.

7.3. Contact was made with the parents of Adult L and Child M who indicated they did not want involvement with the review.

7.4. Both Adult L and Child M agreed to meet the Author of this Review and their contributions can be found in section 5 of the report.

8. Terms of Reference

1. What actions were taken to safeguard Child J and how well agencies worked on their own and together, where relevant

- Were relevant enquiries made, in the light of parental requests and professional referrals?
- How well were her vulnerabilities identified e.g. domestic abuse, difficult home life, unstable accommodation, substance misuse?
- What were the relevant points or opportunities for assessment, including any undertaken for early intervention, and decision making, in this case?
- Were assessments clear, accurate and comprehensive?
- Do decisions appear to have been reached in a timely, informed and professional way?
- Were problems identified in completing assessments, if so what were they and were they resolved?
- Were appropriate services provided?
- Were there any issues in communication, information sharing, decision-making or service delivery, between those with responsibilities inside and outside of the county?
- How well was action taken to reduce risk?
- Where interventions were successful with good outcomes why did they work?
- If there were problems or difficulties what were the causes? And what did you do to mitigate the problem?

2. Identification and assessment of risk posed by Adult L and how well agencies worked on their own and together, where relevant

- How well were the risks identified and understood?
- What were the relevant points for assessment of the risk he posed?
- Were assessments of risk clear, accurate and comprehensive?
- Do decisions appear to have been reached in a timely, informed and professional way?
- Were problems identified in completing the assessments, if so what were they and were they resolved?
- Were appropriate services provided?
- Were there any issues in communication, information sharing, decision-making or service delivery, between those with responsibilities?

- How well was action taken to reduce risk?
- Where interventions were successful, why did they work?
- If there were problems or difficulties what were the causes? And what did you do to mitigate the problem**?**

3. Identification and assessment of the risk and needs of Child M and how well agencies worked on their own and together, where relevant

- How well were his vulnerabilities identified e.g. difficult home life, unstable accommodation?
- What were the relevant points or opportunities for assessment, including any undertaken for early intervention, and decision making in this case?
- Were assessments clear, accurate and comprehensive?
- Do decisions appear to have been reached in a timely, informed and professional way?
- Were problems identified in completing the assessment, if so what were they and were they resolved?
- Were appropriate services provided?
- Were there any issues in communication, information sharing, decision-making or service delivery, between those with responsibilities?
- How well was action taken to reduce risk?
- Where interventions were successful with successful outcomes, why did they work; if there were problems or difficulties what were the causes?

4. Effectiveness of multi-agency support provided to Child J to minimise risk posed by the perpetrator

- Was Child J subject to a Multi-agency Risk Assessment Conference (MARAC) or a child protection plan? If not, should she have been?
- Was there a role for Multi Agency Public Protection Arrangements (MAPPA) and the Domestic Violence Perpetrator Programme (DVPP)? Please explain your agency's understanding of these processes
- Did Child J have any contact with a domestic violence and abuse organisation or helpline?
- Where these interventions were successful, why did they work; if there were problems or difficulties what were the causes?

5. Policies and procedures

- What local single agency and inter-agency procedures and professional standards were in place?

- Were they followed and were they effective?
- If they were not followed why not?

6. Co-operation and engagement of the services with the parents and child

- How did professionals understand Child J's behaviour, wishes and feelings and support her **as an adolescent**?
- How did professionals understand Child J's behaviour and support her as a **young victim of domestic abuse**?
- How well was the contact managed between Child J and the perpetrator and his family?
- How well did professionals engage with her family?
- How well did professionals engage with Adult L and understand his behaviour as a **perpetrator of domestic abuse**?
- How well did professionals engage with Child M?

7. The extent to which equalities issues were addressed

Were practitioners were sensitive to the needs of the child and the family in their work, for example, whether the:

- racial /cultural /linguistic /religious
- gender (Equality Act 2010)
- needs of the children and parents

were taken into consideration alongside any issues pertaining to disability, gender or sexual orientation.

In doing this consideration should be given to identifying good practice and why this was achieved and where there was not sensitivity to the needs of the children why this was the case and what would have made a difference.

In addition the review will:

1. Provide an anonymised multi-agency overview report in accordance with the SCR and DHR guidance including a clear multi-agency action plan that addresses any areas highlighted for change or improvement.
2. Make recommendations for multi-agency practice.
3. Put in place a process for publication of the report and ensure that all findings are communicated to ensure public confidence in the safeguarding arrangements for children and young people in Oxfordshire.
4. Establish a clear action plan for individual agency implementation

5. Put in place a process for monitoring the implementation of the individual and multi-agency actions identified.

Appendix D: Individual Agency Recommendations

Bournemouth Church Housing Association

1: Educate front line staff on the risk factors around domestic abuse and how to refer concerns to appropriate agencies within Oxford

2: Educate front line staff on the risk factors and signs of domestic abuse

3: Refresher training / briefing to front line staff regarding internal safe guarding procedures

4: Reflect the Government's guidance which extends the definition that domestic abuse can apply to 16 and 17 year olds.

5: Implement a Missing Young Person protocol

6: Where there are concerns about an external agency workers conduct or profession working relationship, this should be escalated formally

7: Raise awareness on online child exploitation

8: Implement a more robust Multi agency approach to managing risk

9: All BCHA managers working within Young People's Services to include outside of Oxford Area) to attend domestic Abuse Training

Home Group (housing)

No Recommendations have been made for the Home Group.

National Probation Service

1. To ensure that Court Induction processes clearly inform Courts staff of the routes and contacts for obtaining information pertaining to risk assessments for Oral Reports.
2. To monitor any issues in respect of any delays or difficulties in obtaining checks and feed these back immediately to the Head Of Public Protection/Safeguarding for the South West South Central Division
3. To continue to review learning from SFOs and SCRs within the quarterly Public Protection Development Group.

4. To maintain links with sentencers to keep the tensions noted above on the agenda and raise with the SWSC Leads for Courts and Public Protection

Oxfordshire County Council Children's Social Care and Early Intervention Services (CSC)

Theme 1- Safeguarding adolescents

CSC should:

- Undertake a countywide audit of safeguarding practice focussing on s37 reports, thresholds for child in need, child protection and entry into care, threshold for case closures, ensuring these are consistently applied within all teams in respect of vulnerable adolescents.
- Countywide training for staff on domestic abuse: understanding the issues for 16 and 17yr olds and using MARAC and CP procedures appropriately; understanding the dynamics of violent and controlling relationships.
- Undertake a management review of the roles and locations of specialist housing workers (Southwark) to ensure young people's safeguarding needs are addressed as well as their need for accommodation.

EIS should:

- Undertake an audit of practice and safeguarding focussing on quality of referral, assessment, planning, review and impact on outcomes.

Theme 2- Managing Young People who present serious risk to others

CEF should:

- Ensure practitioners have prompt access to updated risk information on dangerous young people and adults. Significant event chronologies and multi-agency risk assessment and management plans should be consistently updated in order to provide this.
- Consider how practitioners in YOS can participate in plans for dangerous young people for whom CEF has a statutory responsibility e.g. they are LAC, care-leavers, subject to CP plans, even when they are not formally subject to criminal disposals.
- CSC should develop practice guidance for social workers and personal advisors on managing their responsibility to provide services to dangerous/offensive young people.

Theme 3 - Child's voice and advocacy

CSC should ensure:

- Children and young people who request to become LAC and who are refused should be offered an advocate so their views can be represented in decision-making
- Staff and managers are aware of Viva, the CEF advocacy service and how to access it.

Theme 4- Service Re-Design

Detailed consideration needs to be given by CEF to **c**reating a multi-agency, co-located Leaving Care service for 18-25 year olds.

Oxford Health NHS Foundation Trust

1. A Strategic and operational review of domestic violence pathways within all Oxford Health NHS Foundation Trust services is completed. To include information sharing systems; a consistent documentation strategy and training strategy for staff.
2. Review of Oxford Health NHS Foundation Trust MARAC guidance for Named Nurse and information sharing protocols for MARAC cases- in line with the strategic and operational review of domestic violence pathway.
3. There needs to be further clarity about the service provision for young people who are excluded or not attending school, to ensure the school nursing service has the capacity to outreach to these vulnerable young people in partnership with other services.
4. There needs to be communication with adult mental health services to ensure that the assessment questions and documents whether there is contact with children or young people both in and out of the home environment.

Oxfordshire Clinical Commissioning Group (GPs)

1. A new protocol to govern the transfer of at risk records from one Practice to another must be devised.
2. A review of the way at risk information is held in the patient record so that it fully complies with the latest guidance.
3. A review of the way registration questionaires are processed to try and act on certain significant unexpected data contained there.
4. Advice to appraisers to discuss safeguarding specifically at appraisal

Oxford University Hospitals NHS Foundation Trust

1. To have routine access to the list of LAC to enable the Trust to enter a flag on Trust hospital electronic patient records. This is being discussed with colleagues in children's social care to ascertain the feasibility of sharing this information.
2. To discuss with legal services whether it is possible for hospital staff to automatically inform police of any incidences of young people under the age of 18 being victims of assault.
3. To assure that the process of recording whether any 16 or 17 year old attending ED is unaccompanied or, if accompanied to identify the person accompanying by name and relationship, is robust.

4. To develop a formal policy for assessment and actions when a young person aged 16 or 17 years absconds from ED prior to full assessment/treatment.

Reducing the Risk of Domestic Violence (IDVA service)

1. Reducing the Risk trustees and staff should draw on national and CAADA guidelines and good practice research in work with young people in abusive relationships, as and when available, and incorporate these within their practice and procedures.

2. Reducing the Risk should ensure that staff have appropriate specialised training in work with young people in an abusive relationship once training is available.

3. Reducing the Risk should ensure improved record keeping in particular of work prior to MARAC referral and associated activation of the IDVA casework software.

4. Reducing the Risk should work proactively in partnership with child social care and ensure immediate liaison following a referral.

5. Reducing the Risk should remind all designated MARAC officers of processes for simultaneous referral to IDVA and MARAC.

6. Reducing the risk should continue to develop a partnership model of support in line with CAADA MARAC recommendations and ensure clear communication with partners.

7. In circumstances where there may be reason not to follow Reducing the Risk practice guidelines Reducing the Risk will ensure a robust process of decision making.

8. Reducing the risk staff and trustees will contribute to the OSCB children's domestic abuse strategy group young people's pathway work.

Schools and Special Educational Needs

1. a) To improve the monitoring of reduced timetables both at local authority and school levels.

   b) To ensure that any use of a reduced timetable is part of a holistic plan to re-engage a young person into full-time education.

2. To ensure that the critical information schools hold about the most vulnerable children and young people, particular where they are living with domestic violence, substance misuse and mental health issues, is used for planning.

3. To disseminate guidance for settings/schools, colleges and professionals and parents on identifying and supporting children and young people with social, emotional and mental health difficulties as a graduated response to special educational needs, in line with the Children and Families Act 2014.

4. To remind schools about LA guidance relating to sharing personal information and the use of social networks.

South Oxfordshire District Council Housing (SODC)

No Recommendations have been made for South Oxfordshire District Council.

South Oxfordshire Housing Association (SOHA)

No Recommendations have been made for South Oxfordshire Housing Association

Thames Valley Police

Recommendation 1 - Thames Valley Police to revise their Domestic Abuse Standard Operating Procedure to ensure that *referrals* as opposed to *notifications* are made to Children's Social care following domestic abuse incidents were either party is a child. The *referral* should then prompt a strategy discussion between police and CSC to consider the requirement for a joint investigation.

Recommendation 2 – Thames Valley Police MARAC Coordinators to update the Record Management System (Niche) in relation to MARAC referrals from other agencies. This will include the reasons for referral into MARAC and an indication as to risk level.

Recommendation 3 – Thames Valley Police to devise an innovative and effective way of delivering the message to front line officers of the importance of identifying and responding to offences, vulnerability and safeguarding issues when dealing with potentially vulnerable people. This is to include the vital role of supervision.

Recommendation 4 – Thames Valley Police to carry out an audit in six months' time to assess whether the new Niche RMS system is correctly creating a record for **every** missing person report. The quarterly held performance meeting (chaired by the Deputy Chief Constable) in relation to Child Sexual Exploitation and Missing People will monitor this.

Recommendation 5 - Thames Valley Police to ensure that all front line staff abide by their duty to record and investigate any disclosures of serious crime, e.g. rape, serious assault, made by a victim in any circumstance. This should include an input to Supervisors.

Recommendation 6 – Thames Valley Police to consider and implement options in relation to who should conduct research (secondary investigation) for Missing Person Investigations. An options paper should be completed addressing the viability of the following:

- Responsibility remaining with the attending officer
- Missing Person Co-ordinator
- Information Research Bureau

Recommendation 7 – Thames Valley Police to provide anonymised DOM5 forms from this review to domestic abuse risk assessors throughout Thames Valley Police and ask them to complete risk assessments and grade the victims. The results will indicate whether staff are competent risk assessors.

Recommendation 8 – Thames Valley Police to provide role/rank based training and reference materials to Sergeants and Inspectors providing guidance on how best to use Niche Record Management System (whiteboard) to carry out their reviewing responsibilities for Missing Person Investigations in relation to:

- Risk assessment approval/amendment
- Action management
- Closure
- Inspector reviews

Recommendation 9 – Thames Valley Police to raise awareness amongst front line staff in relation to the potential serious impact of emotional blackmail incidents involving the threat of publicly circulating intimate images of people.

Recommendation 10 – Thames Valley Police to issue guidance to all staff in relation to the investigation of incidents involving the exchange of indecent images between children (under 18) via mobile phones and other such devices; referred to as 'sexting'.

Recommendation 11 – Thames Valley Police to task Local Police Areas with considering local partnership working groups as somewhere to refer offenders who fall below the threshold for MAPPA but whose offending behaviour and level of risk nonetheless are of concern.

Recommendation 12 – Thames Valley Police to review how the local Daily Management Meetings are recorded and retained.

Recommendation 13 – Thames Valley Police's Crime Strategy Unit to review and determine how rolling arrest attempts should be recorded, including any specific instructions such as searching for evidence, rationale for arrest resourcing decisions and results of any arrests attempts. These are decisions relating to an investigation and must be recorded in the Niche Occurrence or a related Command and Control log, and not solely within handovers between supervisors.

Recommendation 14 - Thames Valley Police to put in place an archive system for storage of handover documents between shift supervisors.

Recommendation 15 - Thames Valley Police to put in place an archive system for storage of minutes from daily management meetings.

Recommendation 16 - Thames Valley Police to carry out dip sampling of missing person records to ensure that adequate reporting standards are being met.

Recommendation 17 - Thames Valley Police to carry out a review of property currently stored at Abingdon Police Station and a review of local management practices.

Recommendation 18 – Thames Valley Police to issue further practical guidance to clarify the use of 'investigator summaries' and the frequency of reviews (to include Detective Inspector reviews) in NICHE RMS when managing missing person investigations.

Recommendation 19 – Thames Valley Police Protecting Vulnerable Strategy Unit to conduct research into other police force areas' approaches in relation to the role of Missing Person Co-ordinator and/or a dedicated Missing Persons Investigation Unit. This could be used as a basis for Thames Valley Police to review their own approach to this role

Recommendation 20 – Thames Valley Police to issue guidance to CR&ED staff asking them to actively consider whether any early contact with a victim would put them at risk from the perpetrator and to refer any concerns to a supervisor before making contact.

Young Addaction Oxfordshire

1. Addaction to implement a training session in relation to recording the time of intervention within case notes with worker in Young Addaction Oxfordshire.
2. Addaction will explore creative options for re-engaging young people who don't want to engage or who drop.

Appendix E: Letter from Home Office dated 05.02.16

Home Office

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Kay Bishop
Business Manager for Oxfordshire Safeguarding Children Board
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5 February 2016

Dear Ms Bishop,

Thank you for submitting the joint Domestic Homicide Review/Serious Case Review report for Oxfordshire to the Home Office Quality Assurance Panel. The report was considered at the Quality Assurance Panel meeting on 27 January 2016.

The QA Panel would like to thank you for conducting this review and for providing them with the final report. The Panel found this to be a competent, probing review with good representation of different agency inputs and family contribution. The report demonstrates a good understanding of domestic abuse which has resulted in lessons learned that are evidenced in the analysis.

There were some aspects of the report which the Panel felt could be revised which you may wish to consider before you publish the final report:

- The Panel felt that the report may benefit from capturing all the findings under a summary heading so that they are more easily identifiable;
- The Panel suggested paragraph 6.3.26 may need reframing as it does not accurately reflect how MAPPA operates;
- The Panel recommended publication but given the considerable detail in the report about the family, friend, perpetrator and the perpetrator's brother, suggested the commissioning area should reassure itself that it is safe and reasonable to do so.

The Panel does not need to see another version of the report, but I would be grateful if you could include our letter as an appendix to the report.

I would be grateful if you could email us at DHREnquiries@homeoffice.gsi.gov.uk and provide us with the URL to the report when it is published.

The QA Panel felt it would be helpful to routinely sight Police and Crime Commissioners on DHRs in their local area. I am, accordingly, copying this letter to the PCC for information.

Yours sincerely

Christian Papaleontiou
Chair of the Home Office DHR Quality Assurance Panel

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