Executive Summary

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

Oxfordshire Safeguarding Children Board

1. Introduction

1.1. A joint Domestic Homicide Review (DHR) and Serious Case Review (SCR) was commissioned by the South and Vale Community Safety Partnership, (S&VCSP) and the Oxfordshire Safeguarding Children Board (OSCB) following the murder 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.

1.2. The purpose in undertaking this joint Review was to examine the actions of agencies and to ensure that lessons would be identified following the death of this individual child as a result of domestic violence. Most importantly the purpose was to ensure a full understanding of what has happened in order to identify improvements and contribute to the prevention of future such tragedies.

1.3. The Home Office was informed of the decision to undertake a joint Review in March 2014. The expectation for both a DHR and an SCR, is that wherever possible the Review will be completed within 6 months of the decision to undertake it. In this case it was evident that an extended timescale would be required because of the complexity of the Review and the investigation of police practice being undertaken by the Independent Police Complaints Commission (IPCC), which prevented Thames Valley Police (TVP) from completing their individual agency analysis. As a result it was not possible to finalise this Review until December 2015. Family members were kept informed through this process and have approved the final version of the Review.

1.4. The content and findings of this Review were strictly confidential during the Review process. Information provided was only available to 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.

1.5. The completed report has been sent to the following agencies and relevant Chief Executives:

- 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

The report has also been sent to each of the individual agencies who contributed to the review.

2. The Review Process

2.1. This Executive Summary outlines the process undertaken by South and Vale Community Safety Partnership, in reviewing the murder of Child J in December 2013.

2.2. The perpetrator, Adult L was convicted of the murder of Child J in the summer of 2014 and received a sentence of Life Imprisonment with a minimum tariff of 20 years. Adult L's brother, (Child M), was also convicted of related offences not directly involving Child J's death and was sentenced to a period of imprisonment in March 2015.

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

2.4. The Review Panel first met in March 2014 and then on a total of 10 occasions. The Review was chaired by an Independent Social Work Consultant, Fiona Johnson and authored by an Independent Social Work Consultant, Sian Griffiths. Both the Independent Chair and Author were independent of the case and all the agencies involved.

2.5. DHRs and SCRs both focus on establishing the learning that arises out of an individual case but there are some differences in methodology. In order to meet the requirements of both types of review the broad structure and framework established within the DHR statutory guidance was adopted, but this was combined with the principles defined in the statutory guidance for SCRs.

2.6. All potentially relevant statutory and voluntary agencies were contacted and asked to provide information as to whether they had previous contact with Child J and with Adult L and Child M. Individual Management Reviews (IMRs) and full chronologies were commissioned from the agencies which had relevant contact. The purpose of the IMR is for each agency, using the Terms of Reference provided, to consider its practice critically and in detail; to identify whether there should be changes in policy or practice and make recommendations. IMRs were provided as requested from 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

2.7. The following 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

Information was also provided by a Local Safeguarding Children Board about contact between Child J and local services in another part of the country. This was of a very limited nature.

2.8. Given some differences in the requirements of the two review processes, the following timeframes were agreed for detailed consideration:

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, all agencies were required to consider any other significant relevant contact with the subjects that pre-dated this timescale.

2.9. Other relevant documents, such as post mortem reports, were provided to the Overview Author as requested.

2.10. 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 of Child J, and also of Adult L and Child M. The mother, maternal grandfather and sister of Child J all met with the Independent Author of the Review. They each offered helpful contributions to this Review and were also provided with an opportunity to read and comment on the contents before the Review was finalised. A friend of Child J also contributed to the Review. The Independent Author also met with both Adult L and Child M.

3. Concise Summary of Events.

3.1. Child J had lived at different times with each of her parents who were separated, but 2½ years before her death she moved to live with her mother in Oxfordshire. Child J's mother had quite serious problems of her own and Children's Social Care became involved with the family for two periods of time, alongside several other agencies who also attempted to provide help and support, but with limited long term success. Child J became more and more unsettled, her needs were not being met at home, she was missing school and it is apparent that she was very vulnerable. Many professionals and agencies, were finding it hard to help her.

3.2. In February 2013 it became known that Child J was in a relationship with Adult L. Adult L had been very damaged by his own childhood and adolescence, and had also been known to various agencies including Children's Services. He had a very worrying history of violence and threatening behaviour towards strangers, peers, professionals, and previous girlfriends. From early in the relationship with Child J his behaviour was controlling and both emotionally and physically abusive. Those close to Child J, including her elder sister and a mentor from school were unable to persuade Child J to leave the relationship. Her situation was subject to a referral to the MARAC (Multi Agency Risk Assessment Conference) a multi-agency victim-focussed meeting where information is shared on the highest risk cases of domestic abuse. However, Child J did not take up the support

offered as a result of the MARAC. In the last few months when she was with Adult L she was frequently homeless and her situation was increasingly worrying. A few weeks before her death she was however found a place by Children's Social Care in a supported housing unit for young people.

3.3. Child J spoke to the supported housing staff about the extreme level of control that Adult L had over her, but could not be persuaded to stop seeing him. When she discovered she was pregnant she arranged to meet Adult L who had threatened to kill her on being told of the pregnancy and indeed did so later that night. Child J was reported to the police as missing, although it is now known that by the time the police were informed she had already been murdered. It was several days before the seriousness of the risk to her was properly recognised and she became classified as being at high risk by the Police. Her body was ultimately found where it had been hidden 2 weeks after she had first gone missing.

4 Key issues arising from the Review

4.1. The history of Child J and the response of agencies to her and to Adult L, is a complex one which has resulted in recognition of considerable areas of learning across the agencies. Two issues have run as threads throughout the responses of agencies. 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.

4.2. The Review has also identified considerable learning about the risks presented by Adult L. 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.

4.3. There are therefore 3 significant, repeating themes identified within the Review as requiring attention from both individual agencies and the multi-agency partnerships :

- **Working effectively with young people**
- **Young People and Domestic Abuse**
- **Working with young people who pose a risk to others.**

4.4. It is evident throughout this Review that at the time mistakes were made by services and that the long term approaches taken to protect Child J 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.

4.5. The key issues of learning arising from the Review included:

4.6. 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.

4.7. 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.

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

4.9. 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.

4.10. 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.

4.11. **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.

4.12. 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.

4.13. 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.

5. Conclusion and recommendations

5.1. Many agencies were involved with Child J, Adult L and Child M over a long period of time. Whilst there was evidence of some very good practice, there were also times when practice fell seriously short of expected standards. This has been recognised by the relevant agencies and changes made.

5.2. In considering whether more could have been done to prevent Child J's death, it has to be acknowledged that Child J was highly vulnerable by the time she met Adult L and he was able to establish significant control over her from a very early stage in their relationship. Attempts were made to encourage her to separate safely from him but this proved extremely difficult and both family and professionals who did try were left painfully aware of the risks she was facing but unable to persuade her to end contact with him.

5.3. It is evident that mistakes were made by services and different options and strategies could have been considered over the long term. The approaches taken, whilst often well intended and pursued with commitment by individuals, were ultimately ineffective in protecting Child J from harm or in fully understanding and responding to the level of risk posed by Adult L. It is also the case that different actions could have been taken in the immediate hours before Child J was murdered, but this sadly would not have been a guarantee that either then 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.

5.4. As a result of the review, a total of 65 recommendations have been made by the individual agencies in relation to their practice.

5.5. The Review has also identified 6 **multi-agency recommendations** which are relevant to either or both the OxSCP and the OSCB and are grouped below to reflect the three overarching areas of learning within this Review. One additional recommendation regarding the process of DHRs and SCRs is also included.

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 Child and Adolescent Mental Health Services (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 front line 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.

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