*Press Release*

**OSCB PUBLISHES JOINT DOMESTIC HOMICIDE REVIEW AND SERIOUS CASE REVIEW INTO MURDER OF CHILD 'J'**

Oxfordshire Safeguarding Children Board (OSCB) has today (24 February 2016) published a joint Domestic Homicide Review (DHR) and Serious Case Review (SCR) into the murder of a 17-year-old girl, referred to as Child 'J,' in December 2013.

The review examines in detail the involvement of all agencies which came into contact with Child 'J' prior to her death as well as the perpetrator, Adult 'L,' and a third person, Child 'M,' who was convicted in relation to the case. The purpose of the review is to identify lessons that can be learned and areas for future work to improve child protection services in Oxfordshire.

"This was a particularly tragic case, linked to the domestic abuse, but also underlying neglect, of a teenage girl and her eventual death at her abuser's hands," said Maggie Blyth, Independent Chair of the OSCB. "I would like to thank the family members and others directly affected both for their valuable contributions, and for their patience during this review process."

The review highlights failures in the case, both in relation to how Child 'J' was protected by Oxfordshire Children's Social Care in the months leading up to her death, and the lack of information shared surrounding the perpetrator, Adult 'L,' by all agencies. Failings have also been identified in relation to Thames Valley Police, when Child 'J' went missing shortly before her murder.

Ms Blyth said: "The review highlights two key findings – the continuing need for services to respond effectively to older children in need of protection; and the importance of understanding the impact of domestic abuse within adolescent relationships."

"However, the review concludes that whatever the actions of agencies, there could be no guarantee that Adult L could have been prevented from killing Child J or any other young woman – either at that time or in the future."

Recommendations for individual agencies have been made as part of the review and these are listed in Annex C of the report. In addition, there are seven multi-agency recommendations for all local organisations with child protection responsibilities.

"The report highlights the importance of all statutory agencies and voluntary organisations, including housing providers, having a clear understanding of the risks facing older children who are the direct victims of domestic abuse within adolescent relationships," said Ms. Blyth.

"There are also recommendations for strengthening agencies' approaches towards young people who pose a serious risk of harm to others, and vital these are acted upon by law enforcement and child protection services," she continued.

"Thames Valley Police, Oxfordshire County Council and other agencies have already put in place changes to address the issues raised in this review and I am committed to doing everything in my power, as independent chair of the Oxfordshire Safeguarding Children Board, to ensure improvements continue to be made."

**Key findings of the report:**

- **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 number 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 (Multi Agency Risk Assessment Conference) 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 point 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 (Multi Agency Risk Assessment Conference) should properly overlap with Child Protection processes
- **Individual workers** particularly, but not only, from the school worked extremely hard to help and support Child J. However, their efforts were not adequately supported by a 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 significantly contributed to the family's trauma

- 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

Ends.

**Notes to Editors:**

**Maggie Blyth is available for EMBARGOED INTERVIEWS from 0930-1100 on Wednesday 24 February 2016 at The Kings Centre, Osney Mead, Oxford, OX2 0ES. Limited parking available for the media on site**

Please contact Rebecca Harrhy or Kay Bishop, Oxfordshire Safeguarding Children Board, for further details and to book a slot (which are limited). Tel: 01865 328994 or 01865 815849, email: Rebecca.Harrhy@Oxfordshire.gov.uk or Kay.Bishop@Oxfordshire.gov.uk

**Background:**

The SCR looks at evidence provided by local agencies from December 2010, when authorities first became involved with Child 'J.' The DHR applies to the last months of Child 'J's' life, beginning in early 2013, when agencies first became aware that she was in a relationship with Adult 'L.'

Individuals and their families are not named in Domestic Homicide and Serious Case Reviews. However, the OSCB is aware that names of individuals to which this case relates are in the public domain.

The independent author of the review is Sian Griffiths, an independent safeguarding specialist and SCR and DHR author.

The review was commissioned jointly by the OSCB and the South and Vale Community Safety Partnership. The OSCB's Serious Case Review Sub Committee concluded that the case met the criteria for a Serious Case Review, as identified in 'Working to Safeguard Children 2013.'

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, under Section 9(3) of the Domestic Violence, Crime and Victims Act 2004.

The full, joint Domestic Homicide Review and Serious Case Review will be available on the

OSCB website from 1100, 24 February 2016, at: http://www.oscb.org.uk/case-reviews/

**OSCB background:** Local Safeguarding Children Boards were established by the Children Act 2004 to help make sure key agencies work together to keep children safe. The Oxfordshire Safeguarding Children Board (OSCB) is the means by which organisations come together at a strategic level to agree on how they will cooperate with one another to safeguard and promote the welfare of children. The OSCB consists of 34 representatives, representing local authorities, the NHS and police, among others.

**OSCB Independent Chair Biography:** Maggie Blyth took up the role of Independent Chair of the Oxfordshire Safeguarding Children Board in May 2014. Maggie has a background in education, initially qualifying as a teacher, but managing services within social care and criminal justice during the 1990s across the Thames Valley and in Inner London. Between 2001 and 2005, she had policy oversight of the youth justice system across England and Wales as Head of Practice for the National Youth Justice Board for England and Wales. Maggie has held held a ministerial appointment as an independent member of the Parole Board for England and Wales, a quasi judicial role with oversight of the decisions to release high risk offenders during the last decade.

**For all OSCB media enquiries, please contact:**

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