Dudley Safeguarding Children Board

Serious Case Review

Young Person P

Author: Steve Ashley
Lead Reviewer: Mick Brims

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Section One – Introduction

1.1 What this review is about

This serious case review concerns a young person known, for the purpose of this review, as **P**.

Dudley Safeguarding Children Board (DSCB) agreed this case met the criteria laid down in Working Together 2015 for a serious case review to be conducted.

The brief circumstances of this case are as follows; **P** had been adopted at the age of 7 years old, but at 16 years old she left her adoptive parents to live with various friends in informal circumstances. Children's Social Care became involved and attempted to place P in accommodation. In May 2017 **P**'s badly decomposed body was found in the wardrobe of a flat in Dudley. A male was later arrested and charged with her murder. This male was found guilty of her murder and sentenced to serve a minimum of 26 years imprisonment.

1.2 Why this review was conducted

The Independent Chair of the DSCB agreed with a recommendation of the Serious Case Review sub-group that this case should be the subject of a serious case review; under the requirements of the Local Safeguarding Boards Regulations 2006, section 5(1) (e) and (2).

The statutory basis for conducting a serious case review (SCR) and the role and function of a Local Safeguarding Children Board is set out in law by: *The Local Safeguarding Children Board Regulations 2006, Statutory Instrument 2006/90*.

Regulation 5 requires the Local Safeguarding Children Board (LSCB) to undertake a review where –

(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.

Guidance for Local Safeguarding Children Boards (LSCBs) conducting a serious case review (SCR) is contained in Chapter 4 of *Working Together 2015*. This version of Working Together was used when deciding upon the serious case review process, as it was the most current at the time decisions were taken around the review process (published in March 2015).

The purpose of this serious case review is to establish the role of services and their effectiveness in the care of **P**, whether information was fully shared by the professionals involved and child protection procedures were appropriately followed. This process ensures that any deficiencies in services can be identified and lessons learned, to minimise the risk to other children or young people.

1.3 How this review was conducted

1.3.1 The Review Panel

The author of this report was Stephen Ashley who has extensive experience in the compilation of high-level reports into child protection issues, having been a senior police officer for thirty years and worked for Her Majesty's Inspectorate of Constabulary. He has conducted several serious case reviews and is the independent chair of two safeguarding children boards. The lead reviewer was Mick Brims who is a qualified social worker and has extensive experience in children's social care across a number of areas.

The author and lead reviewer are independent of Dudley Safeguarding Children Board in accordance with *Working Together 2015* chapter 4 (10*).*

In addition, a review panel was established. Meetings were held at regular intervals and the panel was consulted about the progress of the review and provided further information where appropriate. The panel included a senior manager from each of the key agencies.

The Dudley Safeguarding Children Board (DSCB) business unit supported the panel.

1.3.2 The Terms of Reference

This SCR has been conducted using a methodology adapted to suit the circumstances of this review and is described in more detail in the next section. The methodology established how well systems have worked, and where they can be improved. It is not a criminal or disciplinary review designed to attach blame to individuals.

This review covers the period from 2014 to P's death. The reviewers also considered **P**'s earlier life where relevant. This period was selected following a Serious Case Review Panel meeting and is of a sufficient range to include all of the engagement that **P** had with agencies in Dudley. Whilst this period was the basis for the review, contextual and relevant information falling outside of this period was also included.

The review was conducted in a way which:

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

Agencies that are involved in child safeguarding are required to follow the statutory guidance laid down by government. The guidance is called *Working Together to Safeguard Children*. It contains all the processes that agencies are required to follow. Working Together has been

through several iterations. This review benchmarks against the statutory guidance contained in *Working Together 2015*[1].

The author took full cognisance of the third annual report of the national panel of independent experts on serious case reviews that was published in November 2016.

1.4 Methodology

The methodology agreed by the Dudley Safeguarding Children Board (DSCB) review panel is based on a model consistent with the requirements of *Working Together 2015*. It ensures that:

- A proportionate approach is taken to the SCR;
- it is independently led;
- professionals who were directly involved with the case are fully engaged with the review process;
- families are invited to contribute.

1.4.1 Chronologies and Management Reports

Agencies were asked to compile a report detailing their contacts with the individual involved in this case, resulting in a combined chronology of events. In addition, each agency was asked to highlight areas of concern and good practice. Where appropriate, an action plan, detailing those areas for improvement, and the work being undertaken to address those issues, was included. All the agencies that were asked for a report provided the information requested. In cases where further clarification was required agencies responded in an open and transparent way.

In some cases, where contact with the subjects was minimal, agencies were only asked to provide a chronology. In addition, interviews with front line staff and managers took place.

1.4.2 Learning Event

A learning event with front line practitioners is an essential part of the process. In the learning event front line staff and managers that had had contact with **P** were brought together for discussions around themes that had been identified from the chronologies and reports. This engagement provided a view of their engagement with **P** that enriched the information provided by agencies and ensured that all the relevant facts were recorded. It was the most effective way of triangulating the evidence and ensuring that an accurate picture of **P** and the traumatic events is provided.

This review seeks to determine **why** events occurred and not just record the facts of **what** happened. The front-line view is invaluable in achieving this.

Whilst the details of discussions that took place were recorded, the comments made by the staff involved were non-attributable and their comments are not quoted directly in this report. For many front-line practitioners, this was the first opportunity for them to discuss with other

[1] ***Working Together to Safeguard Children March 2015*** - https://www.gov.uk/government/.../working-together-to-safeguard-children--2

professionals their engagement with **P** and her family; it was pivotal to the learning from these traumatic events.

1.4.3 Family Engagement

The adoptive parents of **P** were interviewed, and their views are contained in this report.

1.4.4 Parallel investigations

Throughout the period covering this review, a criminal investigation was being conducted by West Midlands Police. This resulted in a male being charged and convicted of the murder of **P**.

1.5 How this report has been structured

Following the introduction, section two provides the story of what happened to **P**. There is a description of **P** and her life and then the detail of what happened to **P** over the agreed timeframe. It provides a synopsis, and tries to paint a picture, of **P**'s world and the circumstances in which she lived during this period. Where an event or issue has proved to be significant, it is highlighted and any pertinent questions are raised at that point. These areas of significance are analysed in greater depth in section three.

Section three analyses the significant issues exposed in section two, and explains **WHAT** happened and **WHY**. From this analysis, the key themes are discussed in section four. Section five contains the key findings. The recommendations in section six have been developed from these findings taking account of the work carried out by agencies since these events occurred.

This report has been written so that it can be read by the public without redaction. As a result, the names of the main subjects are not used and there are no dates that might readily identify **P** or her family.

In this report, the following initials represent the main subjects:

- **P** - the subject of this review
- **MP** – the adoptive mother of **P**
- **FP** – the adoptive father of **P**
- **M1** – the boyfriend of **P**

Section Two – The Story of P

2.1 Introduction

This section sets out the facts in this case. It begins with a picture of **P**. This provides an insight to the type of young person **P** was. The information is provided by **P**'s adoptive parents and school reports. It is an opportunity to understand some of the problems she faced and is the only part of the report based on testimony rather than triangulated facts. It reminds all of us that **P** was a child. She had some problems, but it is important to remember when reading the cold facts, that this was a young person whose life was tragically taken from her.

2.2 What was **P** like?

P had been removed from her parent's care at 4 years old and had been fostered until she was 7 years old. At that point, she was adopted by **MP** and **FP**. The family describe how they went to see her in a school play and as soon as **MP** saw her she felt a deep attachment to her. **P** joined the family who consisted of **MP**, **FP** and their teenage son. **P** quickly assimilated in to family life. It was clear from interviews that **P** was in a loving and stable family unit, in a pleasant environment, and was receiving good quality education. In short, this was what all agencies hope for from the adoption process. A child placed in a stable, loving family.

As **P** moved in to senior school she continued to do well. There were some bullying incidents but **P** became a lively teenager. **P** represented her class as the pupil representative and would always stand up for others and help them talk to teachers when they had a problem. It seemed that she occasionally suffered from low esteem. There was the occasional dispute with teaching staff, but she was generally viewed positively, and one school report described her in the following terms: *"***P** *is a happy and bubbly (sometimes too bubbly!) child",* another described **P** as having: *"a good sense of humour, a wonderful smile and a great giggle"*. **P** also received music tuition for the flute. **P** later became a peer mentor and also contributed to 'Student Voice'. **MP** and **FP** felt this described her well. **MP** and **FP** described her childhood in very positive terms and could talk about family holidays and the good times they had together as a family. Her adoptive brother had a strong relationship with her.

As **P** progressed through her teens issues began to develop at school. Following an incident of alleged sexual assault in 2014 her behaviour became more problematic. The events that followed are detailed in the report. Ultimately, while she had some problems, **P** is described as a loving person, always willing to help others. **FP** described how a stranger might ask her the way to somewhere, she would not just tell them, but physically show them the way. Nothing was too much trouble for her and, whilst she could be naïve, she cared about people.

The focus of this report is on those teenage years to the point of her murder, but we should not lose sight of the fact that this young girl was a kind, loving and entertaining daughter and sister to her adoptive family and a good friend to those around her.

2.3 The background

P had been removed from her birth mother at the age of 4 years old. **P** was then in care and with foster carers until she was seven years old. At this time, she was adopted by **MP** and **FP** through the Children's Services adoption service of a nearby local authority. **MP** and **FP** had decided to adopt an older child and had been through the adoption process in other areas. They decided to adopt **P** as soon as they saw her, and she fitted in very quickly with the family.

The pre-adoption process at this time was a lengthy one but **MP** and **FP** did receive some training and advice, including a week-long course. However, this course talked in general terms about some of the potential issues with adopted children and did not provide individual analysis. It is not clear whether there was more information that could have been provided to the family, post adoption. An analysis of the effects that the neglect that **P** had been exposed to would have been useful for the adoptive family. Guidance around how her early life might impact on **P** would have been invaluable in understanding her behaviour later in life.

Significant Issue One

Adoptive parents should be provided with as much information as possible about the child they have adopted. This should be supported by analysis and support of child safeguarding professionals to advise on how the life of the child might impact on future behaviour. This would allow the voice of the child to be heard and provide adoptive parents with the tools they might need.

MP and **FP** informed the placing Local Authority Children Services that they would not require any further support from them and were satisfied they were able to look after **P** without further support.

2.4 **P**'s Story

2.4.1 Phase one - **P**'s early teenage years

There were a couple of minor reports around **P**'s behaviour when she was 13 years old and some issues with behaviour at school at that time; but these would not be considered significant. **MP** had requested some engagement with Dudley Post-Adoption Support Team and had made enquiries about the *'pupil premium*[2]. **MP** agreed to receive newsletters and information on events for adopted teenagers.

In March 2014 **P** was 14 years old when an incident occurred that seemed to result in a step change in her behaviour. **P** had been out with a friend when she met a boy she knew. **P**'s friend continued home, and **P** went with the boy she knew and two other boys. **P** remembers consuming alcohol but little else. Following a phone call later that day by one of the boys to the ambulance service, **P** was found by the ambulance crew in some woods with her trousers around her ankles; she was insensible. The ambulance took **P** to hospital. She was admitted to the children's ward where she reported that her *"private parts felt a bit sore"*. **P** did not disclose at this point that she believed she had been raped. A referral was made to Dudley Children's Social Care (DCSC) by medical staff. The police state they were informed the following day that **P** had been brought to hospital. Uniformed officers attended the hospital. A specially trained officer from the Rape and Serious Sexual Offences team attended the hospital later.

A medical examination took place, but it is unclear what the status of this medical was and it did not fit the criteria for either a child protection medical or a medical to acquire forensic evidence. The police log reports that clothing was seized and non-specific bruising was photographed. As no disclosure of any sexual offences was made to police officers a forensic medical was not requested. The medical that did take place established that she had not sustained any injuries. No arrests were made, and **P** was not requested to provide an ABE[3] interview. The police took no further action. DCSC wrote to **MP** and **FP** stating that there would be no further engagement by DCSC, but they provided information on support groups that might be able to help if further issues occurred.

[2] **Pupil premium -** additional funding for publicly funded schools in England to raise the attainment of disadvantaged pupils of all abilities and to close the gaps between them and their peers.

[3] **ABE interview -** Achieving Best Evidence in Criminal Proceedings: Guidance for Vulnerable or Intimidated Witnesses, Including Children. The Crown Prosecution Service, 2001.

P was referred to genitourinary medicine (GUM) services and Respect Yourself (sexual health nursing). Following an interview with GUM, **P** expressed her anger at the lack of support and **MP** said that **P** had developed anger issues. Tests took place for pregnancy and STIs and a targeted youth worker was allocated.

The response to this incident by the police, social care and health services was inadequate. The police investigation lacked professionalism and was not thorough. DCSC took no action other than a letter to parents. Health services acknowledged the risks to **P** around sexual health but did not identify any safeguarding issues. There is considerable confusion over the grounds upon which the medical examination took place and whether it had any evidential value.

It later transpired that the boys involved in this case had allegedly videoed their actions on a mobile phone, but this was not reported to the police or education professionals.

P's parents report that her behaviour following this incident continued to deteriorate and become more extreme. This would be interspersed with good behaviour. This was causing significant issues for the family.

P was seen by the school nurse the following month and provided with advice around excessive alcohol misuse. **P** saw a targeted youth worker 3 times over the next 3 months and a member of the Family and Adolescent Support Team (FAST) met her at school 6 further times over the year.

Significant Issue Two

P believed she was the subject of a serious sexual assault in the Spring of 2014. The response by the agencies lacked thoroughness and an understanding of the risks faced by **P**. The lack of action at this stage had a profound effect on **P**'s future behaviour.

In the Spring of 2015 **MP** reported to DCSC that **P** was aggressive, and the family could not cope. This was the second referral to DCSC. It also became apparent that what is believed to be the video footage of the alleged sexual assault incident in 2014 had been passed around the school. This footage has not been seen by the police or education professionals and no reports were made to any agency about its existence. This seems to have been the catalyst for a further deterioration in **P**'s behaviour.

In addition, **P** had been in contact with her birth mother. It seems **P** had been contacted through Facebook and arranged to meet her birth mother. After a few meetings, her birth mother again broke off contact. No one was aware that these meetings were taking place and as such **P** had no support when she was rejected by her birth mother for a second time.

At this time, **P** also disclosed to a support worker that she had been raped 4 months earlier and a third referral was made by Respect Yourself to DCSC. DCSC advised them to contact the police. There is no record of the matter being reported to the police. The referral was closed. It is not known, but assumed, that in fact this report of rape referred to the earlier sexual assault.

These cumulative events saw a further deterioration in **P**'s behaviour and in April she was assaulted by two girls. The police investigated the incident, but **P** did not want further action. The end of year 11 was difficult for **P** whose behaviour had become difficult to manage and the school sent her on study leave early. This followed two temporary exclusions. **P** also knew that if her behaviour did not improve she would not be permitted to attend the end of

year 'Prom'. There were continued concerns about her attendance and it was found difficult to get her to attend final exams. **P** became very uncooperative and had a fixed term exclusion placed on her in May 2015. **P** only attended school thereafter to take her final exams.

MP stated that the school had put in extra resources and identified that **P** was dyslexic. They believed **P** was showing some signs of improvement in her behaviour, but this is not supported by evidence provided by the school.

At this point, there seems to have been little consideration by professionals about the cumulative effects of these incidents on **P**. **P** had been removed from her mother at 4 years of age. Following adoption, she had happily moved in to her teens. **P** appears to have suffered a serious sexual assault which had been videoed and she later suffered the public humiliation of that video footage being passed around the school. Her deteriorating behaviour saw a breakdown in the relationship with her adopted family. **P** had met with her birth mother, following a contact through Facebook, but had been rejected again. **P** had disclosed another rape incident (which may have been a reference to the incident in the Spring of 2015) and had been assaulted. Finally, she was excluded from school. This exclusion meant she would not be permitted to attend the end of year 'prom'. **FP** described the effect this had on **P**. He said: *"it was the final straw…..she was totally devastated'.*

At nearly 16 years old **P** was in crisis: the family who had adopted her were struggling to maintain their relationship with her; despite three referrals, her needs had never been fully assessed by DCSC; the police had failed to investigate a potential serious sexual offence committed against her; her peers had been involved in publically humiliating her and she had been assaulted by a further two of them; and, the education system had lost patience with her and, as a result of her behaviour, she was excluded from school. Whilst support had been put in place to try and improve her behaviour, and strategies employed to protect her sexual health, there is little evidence of a child centred plan to provide real safeguarding protective measures and improve her life chances.

Significant Issue Three

Agencies did not effectively conduct assessments or put in place an effective plan to support **P**. Agencies did not use child protection procedures to protect **P**. Agencies showed little understanding of the circumstances **P** found herself in by the time she was 16 years old.

2.4.2 Phase two – **P** leaves home

In July 2016 **P**, by mutual agreement, moved in with her boyfriend **M1**, while his parents were on holiday. This became an extended stay once his parents returned home. During this period, **P** made occasional visits home, but she remained with **M1**'s parents. **P** has remained with her boyfriend **M1** throughout the summer but the relationship with **M1** and his parents broke down and she returned home at the end of August 2016. On returning home relationships in the family remained difficult and on one occasion **P** went missing and was reported to the police. She returned home safe and well. In November **P** reconciled with **M1** and she moved back to his parent's house. However, in December this relationship broke down again and she returned home. After a short period, **MP** made another referral (the 6th referral) to DCSC stating the situation at home had broken down and had become intolerable. In mid-December the case was allocated to a social worker and an assessment began.

P could no longer stay at home and so she requested assistance to find housing. In the third week of December she was allocated a place in a supported living accommodation (referred to as accomodation1) through the 'Young Person's Project'. Accomodation1 is a block of individual flats specifically allocated to young people. **P** had to declare herself homeless in order to be allocated a place. **MP** formally stated that she could no longer live at their home as they would not permit her back in to the house. **MP** states that in fact she only did this to make **P** eligible for accommodation. At the same time, **P** began a course in hairdressing at the local college.

The Christmas period proved to be traumatic for **P**. Not only was she moving in to new accommodation but at one point she was taken to hospital with a head injury, having fallen over while drunk. **P** attended Accident and Emergency reporting several bouts of fainting and was treated for her medical conditions and discharged her home. No referral was made and no safeguarding arrangements considered, she was discharged with no follow up. Staff at Accomodation1 did inform DCSC.

P had a 'support plan' meeting with a support worker in the New Year with a number of personal goals and support needs being agreed. In fact, almost immediately, **P** started staying out at night and not returning to Accomodation1. At these premises, there was a rule that occupants could only stay out for a maximum of 3 nights per week and had to state where they were going. Staff were pro-actively contacting her to establish she was safe and well. It later transpired that **P** was now living, on an ad hoc basis, in a flat with **M1**.

January and February 2017 proved to be a continuation of this chaotic lifestyle for **P**. Social workers were completing an assessment on **P** but in January she was suspended from college for fighting and one evening was returned to Accomodation1 by police officers when she was found wandering the streets drunk. By 24 January 2017 **P** had stated she would not return to Accomodation1. The assessment being undertaken was completed and closed stating that she was now stable and there was no further role for DCSC. It is difficult to understand how this conclusion was drawn. The decision seems to have been based on the fact that she was accommodated at Accomodation1; but it was already apparent that this placement was not going to remain in place. Even though the case was closed an administrative error meant the case remained 'open' on DCSC systems.

Significant Issue Four

Agencies did not appreciate the risk and vulnerability faced by **P**. They failed to assess the risk around 'missing' episodes and did not fully appreciate the level of risk she faced.

By the beginning of February 2017 **P** had been issued with an Abandonment Notice and her placement at Accomodation1ended. This seems to have been a reasonable course of action. They had warned her on numerous occasions and informed DCSC. Places at Accomodation1are restricted, and it was unfair that **P** should take a valuable place when in fact she was residing with her boyfriend. From this point, **P** never returned to settled accommodation and in effect, 'sofa surfed' until the time of her murder. DCSC had been unable to find accommodation **P** could settle in to, and her family had declined to allow her to return home.

In the middle of February 2017, the police were called to a domestic incident at **M1**'s flat. It was a verbal altercation and the police establish **P**'s case was 'open' to DCSC. **M1** wanted her removed from the flat and when **MP** was contacted by a social worker, stated she felt unable to have her at their home. The police removed her from **M1**'s flat and made a referral

(7th referral) to the DCSC Emergency Duty Team (EDT) who, noting the case was still open, requested that an assessment was started and they placed her in bed and breakfast accommodation. Whilst accepting there may have been limited options, it is not best practice to place any child or young person at risk in bed and breakfast accommodation.

The following day **P** refused help with accommodation and returned to **M1**'s flat. DCSC arranged for **P** to be collected by taxi (which is not good practice) and taken to **M1**. Whilst the referral remained open there was no indication of any planned work.

When a child presents as homeless, local authority children services must assess their needs. If the assessment indicates the young person is in need and requires accommodation under section 20 of the Children Act 1989, they are obligated to offer the young person accommodation and become 'looked after'. There should be protocols in place to deal with this. This principle is further endorsed by the *'Southwark Judgment'* guidance.

Significant Issue Five

Whilst some consideration was given to the accommodation needs of **P** no account was taken of statutory section 20 guidance or the associated 'Southwark Judgment'. Homelessness of **P** was a critical factor in this case.

The following day the police were again called to **M1**'s flat with an anonymous call of a domestic dispute taking place. **P** was found alone, and the police reported no concerns.

On 27 March 2016 services again became involved with **P**. This date is significant for **P** and all those involved with her. It is clear at this point that, whatever had happened before, **P** was in crisis and needed support. Police received a call to from **M1** to his flat. **P** claims **M1** had attempted to strangle her and she had punched him. **P** had taken a knife and attempted to self-harm. **P** was taken to Accident and Emergency by ambulance. **P** told paramedics she had felt suicidal since she was raped at 14 years old. After two and a half hours in A and E, **P** discharged herself stating she no longer felt suicidal. A referral was made to DCSC. **MP** was contacted, but stated **P** now lived with her boyfriend. This was the second recorded domestic violence incident and the 8th referral to DCSC.

The next day DCSC decided to re-assess the case and called a strategy discussion. It was agreed that a social worker would visit **MP** within 24 hours and a safety plan would be implemented and this would form part of a section 47 investigation. The same day the police were called to another domestic incident at **M1**'s flat. This was the 3rd domestic violence incident. The matter was recorded as a Common Assault and the police closed the case with the following comment:

"I have reviewed this matter and there is insufficient evidence to proceed…note the vulnerability of the suspect who is a CSE risk and has been safeguarded by being returned to social care. The victim in this matter is totally uncooperative and officers have responded proportionally...no further role for DA and matter can be filed."

MP was contacted by the social worker allocated to the case, but she hung up and **P** was removed and placed with the Churches and Housing Association of Dudley and District (CHADD)[4] for one night.

[4] **CHADD** provides a safety net of supported homes and community based services for people in Dudley who may be experiencing crisis or challenging transitions, homelessness, domestic abuse or may need support with independent living.

Significant Issue Six

There had been 3 domestic abuse incidents involving **P** and yet the issues and risks associated with domestic abuse do not appear to have been fully considered in this case.

The social worker spoke to **MP** who expressed concern for **P**'s welfare. The social worker managed to find accommodation refuge accommodation out of the borough. A domestic violence risk assessment was conducted, and **P** scored as being at high risk. **P** expressed concern at **M1**'s alcohol consumption and said she felt isolated. The social worker also visited her that day and she said she was depressed, but not suicidal. The following day **P** had left the unit, who reported her as missing to the police as she was suicidal. The police conducted a check at **M1**'s flat and spoke to **P** and reported her to be: *''safe and well".*

On 31 March a joint section 47 investigation visit took place at **M1**'s flat. **P** stated she would be staying there for 4 weeks and then she would move to her brother's flat.

At the beginning of April **P** went to **MP**'s workplace to see her and **MP** had taken her to a dental appointment. **P** told **MP** that she was now staying with friends. **MP** informed the reviewer that at this point her relationship with **P** was improving and she had been with her to buy items to help support her in the new accommodation. As a result, **P** was contacted by the social worker and **P** informed her that she would consider hostel accommodation, but not at the specialist unit. The social worker noted on the file that **P** had again refused accommodation.

On 7 April, the social worker spoke to **P** on the phone and she said she was staying in a flat and she had lost her phone.

On 11 April, a DCSC team manager reviewed the case and decided to close it on the basis **P** was competent to make decisions and was refusing to accept services.

It is unclear whether a discussion ever took place with **P** about a section 20 accommodation offer and what the implications of that might be. Whether **P** was competent or not she was highly vulnerable and had multiple levels of complex need and risk. It is hard to rationalise the decision to close the case at this point.

MP has said that they felt **P** was improving and she was talking of returning home on the Bank Holiday weekend. **MP** said that the family had a meal together and **P** had a bath. **P** left the home and **MP** stated she said she was going to make arrangements to come home, but wanted to be left alone for a while to: *"sort things out".*

On 24 April **MP** was contacted by the social worker to inform her the case was to be closed. **MP** stated she had not been in touch for 2 weeks and the last contact had been a week ago when **P** had sent a text requesting £70 as a deposit for a flat. **MP** was advised to report **P** missing. **MP** did not report **P** missing at this point.

P was not reported missing, but the social worker did make visits to where **P** had been staying on 2 occasions looking for **P**; without success.

On 4 May **P**'s decomposed body was found in a wardrobe in a flat in a hostel for men released from prison (a 'half-way house').

Police evidence shows that **P** had gone to the premises looking for a friend. The friend was not there but she had met another male. The two had walked to another friend of **P** and they purchased cannabis. **P** and the male then walked back to the man's hostel accommodation. At that location, he murdered her. **P** had known the man for no more than 4 to 5 hours at the time of her death.

Section Three – Analysis of Significant Issues

3.1 Introduction

This section looks at the issues highlight in section 2 and provides an analysis of each of those areas.

3.2 Significant Issues

3.2.1 Significant issue one

Adoptive parents should be provided with as much information as possible about the child they have adopted. This should be supported by analysis and support of child safeguarding professionals to advise on how the life of the child might impact on future behaviour. This would allow the voice of the child to be heard and provide adoptive parents with the tools they might need.

When **P** came to attention of DCSC, numerous documents and assessments note that she was adopted at 7 years old after being removed from her mother at 4 years old. There was no evidence of attempts by the local authorities involved to obtain **P**'s early history and pass information and advice to **MP** and **FP.** This information can be accessed from her original home borough as the 'Adoption Agency' or could have been requested by Dudley CSC via an application for information under section 11.53 of Department for Education 'Statutory Guidance on Adoption, 2013. This would have informed professionals and adoptive parents as to the details and impact of the 'neglect' concerns that led to **P** being removed from her biological parents. The information may have provided information highlighting key factors in **P**'s background that could have been used to advise parents about how to deal with the challenging behaviour she exhibited as a teenager.

MP clearly states in early DCSC records that she does not want Post-Adoption Support. It is unclear what approaches, if any, were ever made to the original adopting authority, and if DCSC had access to this information. It was noted at the learning event that there should be a re-consideration of what could be offered to adopters who move into the Dudley area (and support for their children).

Feedback at the learning event indicated that post-adoptive support was 'ad-hoc' and limited and there are limited long-term resources or services to support adoptive parents. Professionals also felt that the adopting authority's CSC should have provided 3-4 years of post-adoptive support and that many professionals had little or no information to say that **P** had been adopted; despite working with her.

P's school for example, were not formally told; her GP was not initially aware. **P** had been provided with a new NHS number and so there was no transfer of records. It is a matter for discussion who should be informed of a child's adoption and there is clearly a balance to be struck. In this case, the school and GP could have been useful in dealing with **P** in an appropriate way and getting the support she needed; if they had known her past. The GP in this case stated that they were aware of 3 other cases at their practice, where adoption cases

had broken down and they had not been made aware the children had been subject to adoption.

3.2.2 Significant issue two

P believed she was the subject of a serious sexual assault in the Spring of 2014. The response by the agencies lacked thoroughness and an understanding of the risks faced by P. The lack of action at this stage had a profound effect on P's future behaviour.

This incident had a profound effect on **P** for the rest of her life. The way this incident was dealt with has raised a number of concerns. The detective inspector at the learning event was concerned at the lack of pro-active action taken by the police at the time the incident was reported and the fact that forensic opportunities were lost and consequently evidence that may have led to arrests was potentially lost. This was a missed opportunity. An ABE interview was not conducted which would have been normal practice. There were further concerns expressed during a subsequent internal review by the police of this incident. Hospital records show that **P** was seen by a paediatrician who had used the body maps from the child protection medical form to record the injuries seen. This caused confusion with some medical staff assuming that a full child protection medical had taken place. Police were consulted by medical staff and there was a discussion about whether a more detailed examination would be required, and whether she should attend a SARC for this. This in itself was a difficult position for professionals since SARC services for young people were not readily available at this time and in practice this would not have been a practical option. That situation has now been resolved. Police records also note the fact that **P** had been at the hospital for 24 hours when they attended, and **P** had eaten. The officers considered there would be little value in a forensic examination.

Hospital notes state the police attended the hospital the day after the incident and **P** had a shower where a police officer was present and **P** said that the female police officer had taken photos. The police log records the fact that photos of **P** were taken by an officer. **P** was seen by a doctor and although it seems some photos were taken, no swabs were acquired for forensic examination. Following the GUM appointment, there was a discussion with police who were unable to attend the ward. A decision was made jointly that **P** could be discharged, and the police would follow up enquires with her at home. There is no record that the police made any 'follow up' enquires.

In addition to this information, police records note that suspected bruising on **P**'s inner thighs was in fact mud and eczema. The police child abuse team were informed about the case and attended the hospital. They made a referral to DCSC who were already aware of the incident. The social worker who spoke with the police stated that she would be sending a letter of support to the family. It is not recorded if this discussion between the police and social worker was considered to be a section 47 investigation. Officers attempted to make contact with **P**'s mother who informed them she had been waiting to speak to them at hospital all that day.

Police records state that **MP** told officers there was nothing forensically they needed to recover that night and that **P** would be going back to school the next day. It seems unusual that the mother of a potential victim should be allowed to make a decision on the value of forensic evidence, rather than trained investigators. The police officer spoke to the nurse attending to **P** who stated that no disclosures regarding a sexual assault had been made by **P**. The child abuse officer spoke to **P** who made no disclosures and the officer gave her advice about drinking alcohol. The matter was then referred to the neighbourhood policing team in order to deal with the alcohol issues, and the case was *'filed'* by the child abuse team supervisor the following day. There was no further police involvement in the case.

This incident was not dealt with correctly and it is difficult to understand what status professionals attached to the complaint. No section 47 investigation was commenced, and an assessment was not conducted; this case was closed to DCSC within a couple of days of receiving the allegation. Previous concerns around bruises were found to be dirt, scratches were found to be eczema. Information available suggests that an internal examination was planned, **P** having complained that her *"private parts were a bit sore".* It is recorded that a medical examination took place, but it is unclear what grounds were used to carry out this medical, which would normally take place following a strategy meeting. It is also unclear whether this medical would have been sufficient as an intimate examination to acquire forensic evidence. There is no indication that it was.

P had been found intoxicated in a wood; she was dishevelled and injured. **P** complained of injuries that must have raised suspicion she may have been raped or assaulted. On the basis that she was referred on to GUM services, and had several presentations thereafter over several months, it is apparent that professionals believed she had engaged in some form of sexual activity.

The conclusion must be that neither the police, health professionals nor DCSC dealt with this as a potential rape incident. Whilst **P** was unable to make specific allegations (because she had been made insensible) there was sufficient evidence available to suggest that professionals should have dealt with this matter as a serious sexual assault. This incident should have been dealt with more professionally by those involved.

This assault incident appears to have haunted **P** going forward; she references it at future junctures, as: *"being raped when 13 or 14"*, and *"having been given horse tranquillisers and raped"* in apparent relation to the same incident, and later said that those professionals involved: *"did not believe me".*

P's interim disclosures, such as the one made to the FAST in March 2015, almost 12 months since the incident in the wood, that she had been *"raped 4 months ago"*, do not appear to have been treated with the gravity that would be expected; DCSC advised the FAST that the FAST worker should explore the allegation further with **P** and then refer to police. No consideration was given by DCSC of referring this potentially new criminal allegation to the police themselves, or holding a strategy discussion to consider a section 47 investigation and an assessment. There was no follow up by DCSC and it was a poor response to this report to advise a support worker to explore a potentially criminal rape allegation with a possible victim. This could have corrupted evidence through inappropriate questioning and it is not good practice to expect a child to tell their story multiple times.

This file was reviewed by the police and DCSC in early January 2017 and the concerns outlined were considered, a decision was made to visit **P** again about the 2014 incident.

P goes on to reference the 2014 rape/assault allegations again, notably during the incident in March 2017 when **P** took a knife to her stomach, after a domestic violence incident with **M1,** and threatened to stab herself. A section 47 investigation commenced after that incident.

On 31 March 2017 police and DCSC finally made a joint visit to **P**. This was in the aftermath of the domestic violence episode where she threatened suicide. This visit took place approximately a week before it is thought **P** was killed. A note of the meeting said: *"***P** *discussed the assault in 2014. She said that she had been given horse tranquilisers, alcohol and raped, she couldn't understand why the police took no action as she believed that they had evidence. (Police Officer) said that he would relook at the file but without some new information further action from the police is unlikely. [***P***] Said that this incident led her to have lots of counselling as she felt depressed."*

P was referred to the FAST who undertook work during 2015. The FAST worker made 12 contacts with the family through the remainder of 2015 to attempt to engage in work with the whole family. At one-point **P**'s mother told the FAST that **P** would be leaving home when she was 16 years old. This is an indication of how the family relationship had deteriorated. The family did not see the FAST worker together during the year. On one occasion the worker missed an appointment through sickness but on other occasions appointments were missed by the family or the family stated they were not available. In August **MP** reported that the family situation was much calmer and in October the FAST engagement ended by mutual consent, as it seemed **P**'s attendance at college had resulted in a more settled position.

The FAST work with **P** covered a number of areas. Initially they undertook the following work:

- Strategies to manage **P**'s anger;
- discussion around feelings towards being adopted;
- engagement in a Wellbeing group.

As the year progressed **P** was allocated a new worker who undertook:

- Further work around anger management;
- work around positive and negative relationships;
- self-esteem;
- sexual health.

The work conducted by FAST was obviously of value and included potential work with the whole family. Much of this work did not take place because appointments were missed.

P herself talked of having been to *"counselling"* and in addition to FAST also had support from the Respect Yourself Team (sexual health nurses who address *"all aspects of sexual health"*), however there does not appear to have been a focus on her at any point as a possible rape survivor and the appropriate support around this. **P** certainly, on at least two occasions, was considered as possible risk of CSE, however not as a survivor of sexual assault/rape. There is, for example, no evidence of a referral ever being made to CAMHS

There were two incidents where rape disclosures were made (although **P** may have been referring to the same incident), and no meaningful investigation took place and these disclosures did not lead to a contact, strategy discussion or assessment (as required) being undertaken. The way in which these incidents were dealt with leads to the conclusion that the police, health professionals and DCSC need to examine local procedures with partner agencies around their response to rape allegations, particularly those made by children and young people.

3.2.3 Significant issue three

Agencies did not effectively conduct assessments or put in place an effective plan to support P. Agencies did not use child protection procedures to protect P. Agencies showed little understanding of the circumstances P found herself in by the time she was 16 years old.

Despite **P**'s complex early history and concerns being raised following the sexual assault in the woods in March 2014, the first assessment completed by DCSC was not until the middle of January 2016; almost 2 years after the sexual assault.

In the interim, there had been a number of events that should have triggered a section 47 investigation and an assessment. Those events were: **P**'s sexual assault case incident did

not receive an assessment nor was it the subject of a section 47 investigation; a subsequent rape allegation disclosed to the FAST and shared with DCSC was not assessed or considered for section 47; aggressive behaviour in the home, which was possibly fuelled by insecurity on the basis **P** disclosed to a support worker that she might have to return to her birth parents; there was suspicion she was inhaling deodorant, was not assessed; information that **P** had found her birth parents on Facebook and then DCSC were informed 2 weeks later that **P** would be leaving the house on her 16th birthday was not assessed; **P** was also not assessed after being physically assaulted at a bus stop – it would appear that this should have been reported to DCSC by **P**'s school.

The first assessment took place after a referral by the Child Exploitation and Online Protection Command (CEOP) when an unknown male was texting **P** and asking to meet up with her and share photo images. This led to a joint section 47 inquiry and a Child and Family Assessment.

The second assessment occurred in the crisis period in December 2016, when **P** was essentially homeless. Her relationship with **M1** had broken down, her mother would not have her home and she moved to Accomodation1. Despite the concerns in **P**'s life, the assessment and section 47 process was due to close just after the New Year. However, a review of the 2014 incident meant that the assessment was to stay open until **P** could be reached to determine if this might result in the case being re-opened.

Even though the task to interview **P** was still outstanding, the second assessment was marked for closure at the end of January. The assessment was closed on the basis that **P** was in stable accommodation at Accomodation1. In fact, staff at Accomodation1had noted two days earlier that **P** had recently been out of placement for 6 days. This did not raise any concern or comment about her being a missing person (misper) for this period. It did not appear that the discussion had occurred with **P** regarding the 2014 allegation (visit completed 29 March 2017). The assessment also notes **P**'s stated decision to leave Accomodation1 to live with **M1**. It had been established at this point that this was again, an abusive relationship. The assessment also notes that **MP** and **P** were willing to accept support services to work on keeping **P** in the home. This work never took place and it seems **MP** facilitated **P** getting accommodation at Accomodation1 directly with the Housing department and DCSC were not involved in this process.

The analysis of **P**'s last assessment in January 2017 is inadequate; despite the assessment being updated with **P**'s intention to leave Accomodation1and return to an abusive relationship, the social worker's analysis proceeds on the basis that **P** will remain in Accomodation1and cites the input of support services there. The analysis also notes the involvement of the CSE co-ordinator. However, it does not make provision for support around domestic abuse or CAMHS support which were required given the issues in **P**'s life to that date.

The team manager's analysis is brief for such a complex case and again proceeds on outdated information. The team manager references **P** being safe in Accomodation1 and attending education. By the end of the assessment in January 2017, **P** was intending to leave Accomodation1 and return to **M1**'s home. This could obviously lead (given the history) to a level of chaos that might suggest that her attendance in College would be in jeopardy when she left Accomodation1. The team manager's analysis does not, for example, consider issues such as whether **P** could be at risk of homelessness and domestic abuse, alongside a difficult relationship with partner and parents and whether this could lead to homelessness and possible need for accommodation support in future. **P** had articulated the fact that she was depressed and had considered self-harming, but mental health issues are not considered.

Whilst the assessment overall contained a lot of pertinent information, for instance around **P** and her life, the conclusions and analysis do not appear to reflect **P**'s stated intention to move

out of Accomodation1 into a situation which would likely have led to very different risks and needs for **P** than those stated.

The poor assessment and a lack of understanding about the serious risks faced by **P** resulted in an inadequate service for her.

Despite all the apparent issues, closure was the recommendation. Despite the history of domestic abuse and **P**'s stated intent to return to this relationship, the assessment does not plan for either longer-term work by DCSC or specialist involvement of domestic abuse services.

It appears from subsequent records that whilst **P** remained in crisis the DCSC closure administration did not take place. **P** continued to be an open case yet was outside any longer-term planning framework to meet her needs, as the aim was to close the case. As such, from records it seems that the assessing social worker was essentially left in limbo and remained allocated to this case until **P**'s death. However, DCSC had no strategy or plan for **P** to complete longer-term work and stabilise and support her. A Child in Need (CIN) plan for example, would have meant a likely transfer to a new social worker, who would have called a CIN Review within 10 days of the assessment being completed and the case being transferred. This would have pulled all agencies together to formulate a plan to meet **P**'s needs; this opportunity was missed.

As **P** slipped in to crisis she was unable to return home. **MP** states that should would come home for occasional visits and meals but not on a permanent basis. **P** would then be placed for a night (sometimes inappropriately in bed and breakfast accommodation) and would leave accommodation to go elsewhere. The second Child and Family Assessment was signed off on 26 January 2017 with an outcome that **P** was safe in accommodation and there was no further role for DCSC (despite regularly being absent from Accomodation1 and stating her intention to leave).

Case records suggest that the allocated social worker continued to try and engage with **P**. However, by February/March 2017 there is a sense that **P** was slipping away; she was in occasional contact with her mother; was living with her abusive partner and sometimes staying with friends. **P** does not appear to have had access to benefits (records are silent on this) and was, it seems, forced to survive through occasional support from her mother or friends. **P** stated that **M1**broke her phone in a domestic abuse incident and as such the abusive partner, stated that he was now the point of contact for **P**. **P** was essentially missing at this time, yet no multi-agency strategy meeting took place to address this.

From 26 January 2017 to her death in April 2017 **P**'s case was open; ostensibly without a long-term engagement plan. Even the section 47 investigation commenced on 28/29 March 2017 and concluded on 20 April 2017 had an outcome that concerns were substantiated, but that **P** was not at risk of ongoing significant harm. It is possible that **P** was deceased by that time.

The continued decisions to close assessments and enquiries without longer-term planning, and at times without clear support plans from partner agencies, is likely to have contributed to missed opportunities for the professional network to come together to review **P**'s circumstances and devise a plan to engage her and attempt to meet her substantial needs.

3.2.4 Significant issue four

As early as Summer 2016 P was in effect missing. It is clear from disclosures by MP in late 2016 that Agencies did not appreciate the risk and vulnerability faced by P. They

failed to assess the risk around 'missing' episodes and did not fully appreciate the level of risk she faced.

P had moved out of the family home in the Summer of 2016 and stayed with the parents of **M1** for some time; then moved back to her home; then back to the home of **M1**'s parents for a further 8 weeks. **P** then moved back into the home for a brief, tumultuous period in December 2016 before she was assisted to find accommodation in Accomodation1; a supported accommodation project. It is arguable that **P** may have been 'missing' at times during these earlier periods, however she was not reported as such.

From mid-December 2016 onward, **P**'s instances of being missing accelerate rapidly. **P** is soon noted by Accomodation1to be missing from the accommodation for more than the 3 contractually permissible nights a week. There are very few records of **P** being formally reported missing – and at no point is she considered as a high risk misper. If **P** had been considered as missing this may have led to professionals coming together to consider **P**'s circumstances. West Midlands CP Procedures state:

"If a child goes missing for a significant length of time or repeatedly the risks increase and should be reviewed through a missing strategy or intervention meeting.

Local guidance will specify the trigger points, pathways and escalation processes for multi-agency meetings however as a minimum expectation any child missing for 72 hours (from home or care) should have a multi-agency meeting to review the risk and plan for their safe recovery.

Other criteria to call a multi-agency meeting might include:

- *A child who has gone missing three times in a 90-day period.*
- *Any case where the risks involved in even a single future missing episode are very high.*
- *Cases where it has been identified that immediate action is necessary to ensure the wellbeing of the person.*
- *One individual having between four and six missing episodes in one year.*

Consideration should be given to alerting the Director of Children's Services, especially in the event that the child is looked after".

Information gathered in this review process has not indicated that at any time **P** was classified as missing until after her death. No evidence of misper strategy meetings or any record that DCSC were concerned about **P** being a repeat or high risk misper. The impression given is that DCSC simply accepted that **P** was residing with her partner or, towards the end, that she was 'sofa-surfing'. This was despite the fact that **P** was visited in various types of accommodation including **M1**'s home and the home of another couple. It is entirely likely that **P** wanted to remain where she was, however there is no evidence that DCSC took this to be a serious, high risk missing situation and it is unclear what knowledge senior management had of this 17 year old child who was: homeless; presenting with mental health issues; living in accommodation with an abusive partner; with limited other options or resources; and she had left education.

Dudley put in place new guidance in December 2017[5]. This new process involves a multi-agency approach, where each high risk missing person's cases are examined in depth and

[5] *"**CHILDREN AND YOUNG PEOPLE MISSING FROM HOME AND CARE -** This guidance outlines risks to consider and steps to take when children are absent or missing" -*

action plans are signed off by a senior manager. This should ensure that in future cases similar to **P**'s would be more closely monitored and action plans scrutinised.

3.3.5 Significant issue five

Whilst some consideration was given to the accommodation needs of P no account was taken of statutory section 20 guidance or the associated 'Southwark Judgment'. Homelessness of P was a critical factor in this case.

The information provided to this review has been analysed, including the assessment that was completed in January 2017 and the subsequent section 47 inquiry commenced on the 29 March 2017, and there is no evidence of **P** being offered accommodation on the premise that she become a Child Looked After (CLA) as per 'Southwark Judgment' principles, or having the implications of this action explained to her. The January 2017 assessment states that the parents privately facilitated their daughter acquiring accommodation in Accomodation1. This was done through direct communication with Dudley Housing, meaning that DCSC may not have had the opportunity to offer section 20 accommodation at that time. The assessment is marked for closure on the premise that **P** is safe in accommodation and it is only towards the end of the assessment that **P** states she is going back to her previously abusive boyfriend.

From the information provided, there does not appear to be any evidence of Southwark Judgment considerations being included in the assessment completed in January 2017 – ie. an assessment of whether **P** is in need of support and accommodation under section 20 of the Children Act 1989. Accommodation issues were discussed with **P** on several occasions, but the social worker either did not consider, or did not record, whether **P** did need support and/or accommodation under section 20. The implications and potential benefits of becoming a CLA do not appear to have been explained to **P** and there is no record of whether she wanted to become a CLA. Whilst accommodating **P** was always going to be difficult DCSC did not formalise the process around offering accommodation to **P** under section 20 following a considered assessment of need, as they should have done.

West Midlands Safeguarding Procedures notes the following –

"Homeless 16 and 17 year olds

When a 16–17-year-old presents as homeless, local authority children's services must assess their needs as for any other child. Where this assessment indicates that the young person is in need and requires accommodation under Section 20 of the Children Act 1989, they will usually become looked after. Each local authority should have a joint protocol with their relevant housing department on the care pathway for children 16 and 17 who present as homeless.

The accommodation provided must be suitable, risk assessed and meet the full range of the young person's needs. The sustainability of the placement must be considered. Young people who have run away and are at risk of homelessness may be placed in supported accommodation, with the provision of specialist support. For example, a specialist service might be provided for those who have been sexually exploited, or at risk of sexual exploitation. ***Bed and Breakfast accommodation is never a suitable placement for a child under 18."***

It is therefore concerning that, knowing **P** was about to leave Accomodation1, to return to an abusive relationship, the child and family assessment (CAFA) in January 2017 does not make

http://www.proceduresonline.com/dudley/childcare/user_controlled_lcms_area/uploaded_files/MISSING%20FROM%20CARE%20PROCEDURES.pdf

provision for either extending the assessment beyond usual timescales or a consideration of whether section 20 accommodation and support was something she would be assessed as needing. It appears to have been completely overlooked.

Even after a domestic abuse incident on 19/20 February 2017, when a visit was completed to **P**, after the social worker placed her in temporary accommodation overnight, no evidence of discussion or suggestion of ongoing section 20 support took place.

It is possible that **P** may not have accepted support under section 20 if Dudley felt that she was assessed as requiring this. However, if this was offered and accepted, the CLA process would have been triggered, again bringing professionals together to address **P**'s circumstances and to start making plans to meet her health, emotional, educational and safety needs going forward.

3.3.6 Significant issue six

There had been 3 domestic abuse issues involving P and yet the issues and risks associated with domestic abuse do not appear to have been fully considered in this case.

Information suggests that there were at least 3 domestic abuse incidents in **P**'s life in the 2 months prior to her death and it is an enduring narrative of this case that since at least mid 2016, **P** appears to have been in (and out) of a domestically abusive relationship with **M1** although reports were made to the police predominantly by **M1**. **P** reports on different occasions that this has involved physical assault to the face and body. It should also be noted that **P** assaulted **M1** on a number of occasions.

Whilst specialist refuges were utilised at times to provide accommodation, it seems that it was not possible to engage **P** around these domestic abuse issues; there are examples on file of the social worker visiting **P** at the home of her abuser to talk to both young people. It is important to note that, at that time, it may not have been possible to locate **P** anywhere else or that **P** may have been reluctant to meet social workers outside of **M1**'s home.

As with the missing behaviour, the impression from records is that this abusive relationship appeared to become simply part of **P**'s experience.

The domestic abuse incident on 29 March 2017 is extremely serious in terms of **P**'s threats to self-harm with a knife and between adults would be seen as a high risk domestic abuse situation. This incident did lead to a section 47 investigation, however, by this time **P** had been in this relationship with for some time, suggesting that any violence between the couple may have been entrenched.

It seems that incidents that would have triggered a multi-agency response in adults was almost completely overlooked in this case. Whilst there were clearly times when **P** was violent towards **M1** it was clear that there was domestic abuse taking place in this relationship and it was not appropriately dealt with by professionals.

Section Four – Key Themes

4.1 The sharing of post adoption information and the provision of post adoption support

In the discussion with **FP** and **MP** it was clear that the adoption process had been a difficult experience. **P** was adopted through another local authority adoption services. The couple went on a standard, week long, course which they found useful. They did inform the local authority that they would not require further support.

Dudley Post Adoption Service team should have obtained the information about **P** and contacted **MP** and **FP**. Dudley and the adopting local authority should have agreed who would be responsible for post adoption support. This would have ensured that **MP** and **FP** would be clear who to go to for support if they needed it.

There is a difficult balance to be struck. It is ideal that a child settles with their new family and is assimilated in to family life, and if this works then agencies should not interfere unnecessarily. However, the process is likely to be more difficult in the case of an older child who may have unresolved issues from their earlier life. **P** settled well until she entered her teens. This is always a potentially difficult time as young people begin to explore their boundaries. There is no evidence that **MP** or **FP** were seeking support until **P**'s behaviour became intolerable. At this point, there was no clarity provided to the family about what support was available. **MP** says that the family were offered some form of counselling, but this did not take place because appointments were missed or the family were unable to attend.

In March 2018 Dudley Metropolitan Borough Council joined with Wolverhampton City Council, Sandwell Metropolitan Borough Council and Walsall Council and launched a new joint service to deal with adoption and adoption support services. This replaces the systems that were previously in place.

The new organisation is called *adoption@heart*. Their role is to match children to adoptive parents, support them through the process and provide post adoption support.

The organisation state on their website[6]:

"The support you and your family need or want to access will change over time and will be different for all families. In recognition of this adoption@heart have established a multidisciplinary adoption support team comprising of a Clinical Psychologist, Play Therapists, Social Workers and Family Support Workers all of whom have experience of supporting adoptive families.

The team have developed a range of services which families can dip in and out of at different stages of their journey including the following:

- *Newsletter*
- *Support with Contact*
- *Social Activities*
- *Stay & Play*
- *Training Workshops*
- *Support Groups*
- *Advice & Counselling"*

[6] https://www.adoptionheart.org.uk/support

The ambition to provide these services provides a clear pathway for adoptive parents and adopted children. This organisation was not in place at the time of **P**'s adoption.

In addition to the support that is now being offered there needs to be consideration of the effect that social media is having on adopted children. It would be expected that adoptive parents will consider when and how they are going to explain to their adopted child who their birth parents are. This should be a thoughtful process and needs to be dealt with sympathetically. **P** discovered her birth mother's location through Facebook. As a result, her first meeting with her birth mother since her adoption was uncontrolled and she did not get any support because no one knew they were meeting. It has been suggested that the adoption service should maintain contact with adoptive parents on an annual basis and this might provide an opportunity to advise on how to deal with this situation.

4.2 The quality of assessments and application of child protection procedures

This review has established that the assessments that did take place were inadequate. Child protection procedures were not followed in terms of strategy meetings and section 47 investigations. This resulted in a lack of support for **P**.

It is difficult to understand why these procedures were not more closely followed. It is possible that DCSC felt the adoptive parents should do more and the fact that **P** was approaching adulthood was a potential factor.

Child protection procedures are laid out in statute. Whilst most procedures are subject to statutory guidance they should not be considered as a 'take it or leave it' option. If professionals chose to work outside the system they must clearly justify, and document, why they have done so.

Whilst considerable work is taking place in Dudley to improve children's services the DSCB needs to ensure that all those involved in the child safeguarding process are aware of, and following, statutory guidance.

In this case, a social worker did try to arrange accommodation and did make efforts to trace her in her final days. The social worker also asked **MP** to report her missing. However, professionals from agencies failed to formalise their actions through the statutory guidance which was not used appropriately, and as a result they were unable to understand **P** and the risks she faced and they failed to intervene when **P** was in crisis.

4.3 Understanding domestic abuse in teenage children

This and other recent cases in Dudley have involved teenagers engaging in domestic violence. Agencies have developed a complex strategic approach to domestic abuse. Many agencies have developed processes to ensure that when a person reports domestic abuse they are able to deal with perpetrators and support victims effectively.

These efforts have concentrated on adult victims. This, and another recent serious case review, have highlighted the need to extend services and a positive approach to teenage victims. This forms part of a bigger picture for teenagers around on line abuse and sexting.

There are new processes in place in Dudley including the use of Young Persons Independent Domestic Violence Advisors (IDVA). This is an excellent initiative that should provide a positive addition to current services.

The DSCB need to assure themselves that these issues are understood, and agencies processes reflect these concerns.

4.4 Processes relating to the investigation of sexual offences

P believes that she was subject to a serious sexual assault when she was 14 years old and stated she had been raped to support workers sometime after. It has never been established if she was referring to the first incident when she said she had been raped. On the first occasion when she was 14 years old she had been taken to hospital. Neither health, DCSC nor the police followed correct processes. **P** should have been dealt with more professionally when she arrived at the hospital, in terms of dealing with a potential victim of crime, and this incident should have been treated as a serious sexual assault. Whilst the facilities for forensic examination and victim support were not readily available at that time, it seems that this incident was not dealt with effectively and some basic forensic recovery work and evidence gathering did not take place. **P** does not appear to have made any form of witness statement.

Whilst in hospital **P** was subject of a medical examination as would be expected. This seems to have been conducted outside of usual child protection procedures and its status is unclear. The body map that was drawn was reviewed by a paediatrician, but again it is unclear why this was required if she had been properly examined in the first place. Before any forensic examination could take place, **P** took a shower supervised by a police officer, who also took some photos. This is remarkable and against any possible procedure that should take place when a serious sexual assault is being considered. Whilst professionals do not appear to have treated this incident as a potential sexual assault they did refer **P** to GUM services, so there must have been some assumption she had engaged in sexual activity.

P stated she had been raped 12 months after this incident in the woods and said the offence had occurred 3 to 4 months previously (so 8 months after the original incident). It may be that she was referring to the original incident but no report was made to the police and the matter was not investigated. DCSC suggested that a support service should report the matter to the police. This report was not treated seriously.

Whilst these incidents occurred in 2014/15 it is of great concern that such serious offences, committed against a child were not treated with the degree of professionalism **P** deserved. Police procedures required that this matter should have been referred to a detective inspector which did not happen.

4.5 Dealing with the homelessness of 16 and 17-year olds

P was homeless. Statutory guidance was not always followed when dealing with her. There seems to have been no consideration of the '*Southwark Judgment'* and its implications. **P** should have been offered the opportunity to be returned to being a Child Looked After. This had implications for the local authority but could have provided the stability **P** needed.

The housing issues in this case are a cause for concern and the DSCB needs to assure itself that the resources and support for homeless 16 and 17 year olds is in place and front line professionals understand their responsibilities in this area.

4.6 The voice of the child

Throughout the course of this review there have been numerous examples where the voice of **P** was not listened to. In fact, it would be more pertinent to say that many professionals failed to understand **P** and the needs she had.

The first clear example of this came when **P** suffered a sexual assault or rape when she was 14 years old. The matter was poorly dealt with by the professionals involved and this made **P** resentful. **P** talks about the case to many professionals over the subsequent 3 years, but at no point was she was ever signposted to any form of support specifically aimed at victims of sexual assault and it appears this was never considered. No professional ever offered an explanation or apology. It is difficult to imagine that an adult being taken to hospital in an insensible condition, half-dressed and complaining of pain in her vaginal area, would effectively have their concerns dismissed. This incident had a profound effect on **P** as she moved through her teens. This was compounded by the fact that a mobile phone video of the incident was shown at **P**'s school which, whilst it was not apparently reported to authorities, would have been common knowledge at school.

When **P**'s behaviour deteriorated at school she was given support. However, there does not appear to have been any account taken of the fact that she was adopted, or the effect the sexual assault had had on her. When **P** is excluded and told she cannot attend the prom she was devastated. Whilst educators have a duty to all their pupils, it does not seem teachers were aware of the effect this 'ban' would have on her. It is not possible to say this was a disproportionate response by the school to her behaviour. They had followed well laid down procedures and **P**'s behaviour was unacceptable. None the less **P** felt she had been badly treated and felt ostracised.

When **P** moved in with **M1**', there are three specific incidents of domestic abuse. No action is taken. **P** was 'sofa surfing' and needed accommodation and support. Limited attempts to place her failed but at no point is there an offer to make her a Child Looked After and the implications of this explained to her.

P was at times a difficult teenager and her behaviour could be unacceptable. However, professionals were too often quick to see these faults without taking time to understand **P** or the issues she had. It is difficult not to reach the conclusion that professionals saw **P** as a problem but did not listen to her anxieties. There appears to be no consideration that she was rejected by her birth mother as a small child and then again by her when she was 15. The relationship with her adopted family had deteriorated, she had been raped but no action was taken and she was in a relationship which was at times violent.

There must have come a point in **P**'s life when it must have seemed the world was against her. The combined effect of: the rejection by her birth mother; the breakdown of the relationship with her adoptive family; the rape/sexual assault and consequent showing of a phone video; the contact with her birth mother on Facebook followed by a second rejection; numerous incidents of domestic abuse; no accommodation; and a lack of support must have resulted in a feeling of victimisation and inevitable failure.

Professionals did not spend enough time listening to **P** or trying to understand what caused her behavioural problems. The cumulative effect of all these incidents on her, almost certainly led her to undertake high risk behaviour and to become angry and frustrated with those she thought should help her.

Section Five – Key Findings

The key findings of this review are:

P had a difficult start to her life and was adopted at 7 years old. **P** had a close and loving relationship with her adoptive parents until her early teens. In her early teens her behaviour deteriorated following an incident in which she believed was sexually assaulted. Repeated

behavioural problems resulted in her being excluded from school. At 16 years old **P** had left home and was 'sofa surfing' until at 17 years old she was murdered by a man she had met only hours before her death.

P's murder did not occur because of any actions, or lack of them, by agencies. **P** was brutally murdered by a man with a history of violence who, within hours of meeting her, took advantage of **P**'s generous nature and killed her in the bedsit of the hostel he was living in. It was a motiveless and senseless crime that robbed a young teenager of her life.

Agencies in Dudley must reflect on a number of areas in which their performance did not meet the standard expected. In particular:

- The failure by the police to properly investigate the sexual assault that **P** believed she was subjected to at 14 years old;
- the lack of assessment of the risks faced by **P**;
- the failure to instigate statutory child protection measures;
- the failure to follow statutory guidance when **P** became homeless and missing;
- the lack of understanding of domestic violence issues between teenagers;
- a failure to listen to the voice of the child.

These issues need to be addressed by agencies in Dudley as a matter of urgency.

P was killed a man she met by chance. P almost certainly died within a few hours of meeting him. Agencies were not responsible for P's death, but they should have done more to protect her and mitigate against the high-risk behaviours she was exhibiting.

Section Six – Recommendations

6.1 Recommendation one

Dudley Safeguarding Children Board should assure itself that new post adoption services in the local authority area are able to adequately meet the needs of parents and children. These services must be able to resource support plans to ensure children remain with their new families, in a loving and secure environment. There needs to be consideration on providing advice to adoptive parents on how to deal with circumstances when a child discovers the identity and location of birth parents through social media and dealing with adolescent behaviours.

6.2 Recommendation two

Dudley Safeguarding Children Board should consider holding a learning event for front line professionals, to review and discuss the learning from this and other recent cases. The event should focus on statutory child protection procedures, risk analysis and leadership in respect of the oversight of cases.

6.3 Recommendation three

Dudley Safeguarding Children Board should consider a review of the way in which children who are involved in domestically abusive relationships are assessed, in terms of risk of harm and the provision of support, including the role of the Young Persons Independent Domestic Violence Advocate. The Board needs to assure itself that the Domestic Abuse, Stalking and

Honour Based Violence (DASH) risk assessment is being used appropriately when domestic abuse is occurring between young people.

6.4 Recommendation four

Dudley Safeguarding Children Board should ensure that resources and support for homeless 16 and 17 year olds is adequate and that professionals understand their responsibilities to these children, particularly with regards to the Southwark Judgment.

6.5 Recommendation five

Dudley Safeguarding Children Board should seek assurance from partners that local procedures and support for children reporting sexual offences is robust and properly resourced. In particular, the way in which evidence is gathered and child protection medicals are undertaken. The Board might consider using a review of the 2014 sexual assault to assure itself the issues raised have been dealt with.

6.6 Recommendation six

Dudley Safeguarding Children Board should seek assurance from partners that the procedures for reporting children missing is adequate and front line staff understand their responsibilities to take pro-active and appropriate action.

6.7 Recommendation seven

When conducting section 11 and section 175 audits Dudley Safeguarding Children Board should ensure that the 'voice of the child' forms an element of the analysis of those audits.