KINGSTON LSCB
Keeping our children and young people safe
LSCB Richmond upon Thames

BSAB Melissa October 2017

Kingston and Richmond LSCB Learning Summary

This review was undertaken by Bristol Safeguarding Adults' Board (BSAB) and published in October 2017. Melissa, an 18 year old vulnerable young person, was murdered by a vulnerable young man in October 2014.

The Story

Melissa, a young woman with ADHD and autism was murdered by a 19 year old man. BSAB carried out this review using a traditional methodology of requesting individual management reviews from agencies involved. Both young people's families were involved with the review. The review was completed by an independent reviewer and the BSAB Board Manager.

During the criminal trial, it was established that the young man had strangled Melissa with the intention of having sexual intercourse with her dead body. His whereabouts were to have been monitored at all times and he was to have been supervised 2-1. The young man had tried and failed to drag Melissa's apparently lifeless body back to his room at the Care Home. The young people had not known each other prior to living in the Care Home.

Both young adults were placed in the same independent care home by their respective local authorities. Both the young man and Melissa were former Looked After Children (LAC) although their lives had been very different. The young man had lived in residential placements in England since the age of 7, whilst Melissa had spent her childhood living with her family until the 11 months prior to her death.

The young man was known to his local children's services from a young age, due to concerns about unexplained injuries, aggressive and sexualised behaviour. His Local Authority area gained an order to care for him and he went to live in a number of residential placements. He was unable to live in a foster placement due to concerns for sexual violence at the age of 9. At the various residential schools, the young man in his adolescence displayed extreme sexualised and challenging behaviour. At times, units chose to deal with matters themselves instead of reporting them to the Police. This were missed opportunities to involve justice agencies, mental health act and child protection processes in his care. A forensic risk assessment was carried out which identified significant risks – this was not threaded through subsequent work and other risk assessments, particularly regarding his living arrangements.

Melissa lived with her family for most of her childhood years. Due to her special needs tensions grew with her family as she grew older, she was suicidal and at risk of exploitation; child in need instead of child protection processes were used to support her. She moved to the Care Home, with her family expressing reservations. She was initially unhappy there. She and the young man were the youngest people living there.

Key issues identified include national problems in the management of transition from children's to adults' services, lack of risk assessment, and the use of out of area placements.

There was a lack of planning for the young man's care and his home local authority withdrew when he reached 18 years of age. The Care Home carried out a limited risk assessment, despite available information. Similarly, Melissa had no statutory pathway plan prepared when she left Local Authority care.

It was found that neither young person was living in a suitable placement. How potentially dangerous people are cared for and managed is another area of focus, as is ensuring organisations are using professional language which both sides understand when individuals are moving between services. Information sharing is also shown to be vital.

Find the SCR report here:

https://bristolsafeguarding.org/adults/news/melissa-serious-case-review/

LSCB Transitions huddle here with local and national information and procedures:

http://kingstonandrichmondlscb.org.uk/news-resources/policies-and-procedures-87/growing-up-transitions-228.php