

Melissa's family's contribution

The views and opinions expressed in this statement are those of the Family and do not necessarily reflect the view of the Bristol Safeguarding Adult Board

Melissa's last eleven months ending with her brutal murder have been traumatic and heart-breaking for the whole of Melissa's family, her friends and teachers. It has raised many questions with the family that need answers. The Serious Case Review is not about who is responsible for her murder, that fact has been answered in a court of law. It is not even about the finger pointing between agencies and blaming each other for what they have and haven't done - that is what the police and inquest are for. It is about ensuring, in Melissa's name, that this sad tragic day and the events leading up to it are examined so this cannot happen again to another family. The agencies concerned need to be looking inward at themselves critically firstly to find and rectify all faults but they also need to listen to families and look for ways to improve their services to prevent any similar disaster befalling any other family. If they don't improve the smaller things, how can they hope to improve the bigger things and prevent this from happening again?

We feel we have been treated with contempt and arrogance before and after Melissa's death by the local social services, with no thought about the stress and trauma the family had been put through. Both Melissa's mum and I have suffered serious health problems and there is no sign of the behaviour of the local authority getting better. It feels as if the local authority already know the outcome of the serious case review and inquest and feel that they have no questions to answer or mistakes to rectify. I hope this is not the case.

What we find distressing is that in the last 11 months of Melissa's life while under her home authority social services, Melissa had so many changes to her that were totally out of character. These changes affected her personality at the most crucial time of her teenage life, her relationships with family and friends suffered, and had she lived, would have affected her future employment. What we are also extremely concerned about is how Melissa's 'capacity' was used as a weapon against us at each hurdle without the proper checks, measures and safeguards put in place. This ultimately led to a young lad in the same care home as her being able to walk into Melissa's room while she slept and strangle her.

We recognise that the young adult that murdered Melissa was let down by all the services. He should never had been put in the position where he could carry out his fantasy but knowing how services moved Melissa from home to home, how the authorities removed all of Melissa's boundaries, allowed her to get a police caution and a criminal record, and encouraged her fantasy, we are not at all surprised that this could happen. There are far too many mistakes being made by all services around the country for this to be just an isolated case. Children and young adults at the most crucial time of their lives are being let down. Focusing just on the murder will not prevent this mistake happening again. I hope that Melissa's death will be a turning point in how the services treat families of autistic young adults, young adults with mental health issues and that Melissa's death is used to change attitudes of all services and that they help families to cope before there is a breakdown of trust.

We do not want Melissa's short life to have been for nothing.

Melissa's journey

I am Melissa's dad and I want to provide some background on my daughter's life prior to entering Care Home 1. After Melissa's death, my wife Karen also sadly passed away

from breast cancer but it is important that her voice is heard, as well as mine. We owe this to our beautiful daughter Melissa. The Serious Case Review's draft report describes Melissa as having a 'troubled relationship with her family', which is very misleading without giving the context of Melissa's upbringing.

We were always hard working professional people that paid their taxes, who raised two children, both of whom were on the autistic spectrum and had their own particular complex set of needs. Our youngest child Melissa was diagnosed with a learning disability, ADHD and autism early in her life. She struggled with speech from a young age and was given 35 hours a week learning support at school. Karen had to fight at every opportunity to arrange this support and obtain a diagnosis. Melissa always found school difficult as a result of her condition. She was not able to make friends in her peer group and she suffered bullying at her first two schools. When she did learn to speak, it was through talking to the teachers, support workers, parents etc. Therefore, she could come across as quite grown up at times, and was able to hide her underlying disability. But unfortunately, she lacked the maturity of her actual age and was missing certain social skills that are learnt in the playground.

After primary school, we were determined to send Melissa to a mainstream school after seeing the lack of progress that our son had made at the local area special needs school. She was entitled to the disability allowance so we found a school with a specialist autism unit. The Council refused to extend the transport allowance to cover Melissa's transport fees, as the school was marginally outside the designated area. We saw this as a slight on us for not opting to send her to the local special needs school. We nevertheless sent Melissa to our preferred school, at considerable cost to ourselves, because as good parents we considered it was the best option for her.

As Melissa grew older, her condition developed, which meant that Karen and I were constantly having to evolve as parents. She was a lovely, friendly, cooperative girl most of the time but from her teenage years there were occasions when her behaviour, due to her autism, could be challenging. She would sometimes refuse to go to school or say hurtful things or shocking things to her peer group to try make conversation. For the most part we were able to cope, as we knew she did not fully understand what she was saying. However there were several incidents that, for various reasons, led to social services being involved. Although we had contact with social services on many occasions, they never really offered us any individual support as a family. They would impose periods of separation between us, where Melissa would be sent away to live with her grandparents. We would be interviewed and supervised by social workers, which felt to me and Karen as though we were being judged as parents. Their 'help' was always framed as criticism and blame rather than as assistance for us to cope with the challenges of raising two young adults with autism. We were full time carers as well as loving parents.

The incidents that social services were responding to were invariably related to Melissa's conditions. It never felt as though social services appreciated this. We were repeatedly made to feel like failing parents rather than parents of two disabled children who were struggling to cope with their individual disabilities. Over this time a carer's assessment was never carried out with the family. Social services' intervention in Melissa's life was also unhelpful in other ways. Their approach was always prescriptive rather than cooperative and they did not consult us in relation to Melissa's needs. This meant that they had no understanding of the effect that their interventions were having on her and importantly her relationship with her family. By her early teens, Melissa also developed an obsession with the fictional story of Tracey Beaker who lived happily in a care home with other children. This was partly driven by her autism but was also inspired by the fact that she had always struggled to make friends in her own peer group. Whenever social services

became involved, her social worker (which changed each time) would talk to Melissa about going into care, without really explaining to her what this actually meant. This encouraged Melissa to further develop this fantasy of care as being the answer to all her problems. Over time, this became more of a problem as it would inform Melissa's actions. She learnt that if she said shocking things, she could capture the attention of social workers and other professionals.

Despite the involvement of social services, we managed well with Melissa for most of her teens and she continued to live in the family home. We tried to encourage a sense of independence in her, by giving her certain controlled freedoms, such as sleep overs with her friend or going to Thorpe Park on her own with her brother. Karen had arranged for her to have two jobs in the local area to show her she could lead a normal life and build up her confidence. She always engaged and tried her best. She had expressed an interest at school in helping other people like her when she grew up and was studying a GCSE in Health and Social Care. All of this hard work achieved by Melissa was undone over an 11 month period prior to her entering Care Home 1.

It was around the time that Melissa was turning 17 when things started to go badly wrong. She was admitted to hospital following a short spell at her first foster home, which had been imposed by social services following another incident. At the hospital she was given medication for the first time, and became ill. She was then sent by the psychiatrists at the hospital to a unit in another local authority for teenagers with mental health issues. It is now clear that this was completely the wrong place for her. She was an autistic girl who did not understand her condition and really wanted to fit in with children her own age. Placing her in a setting with other young people who struggled with self-harm was always going to be dangerous for her. Had we been informed of the risks before sending her there, we could have said something about how this might affect her but no one warned us at the time. Melissa took an overdose of paracetamol during a weekend trip back from the unit, something that was completely out of character. This was not something we were prepared for, we were terrified and blamed ourselves for failing to keep her safe. It was incredibly distressing for our son, who struggles with difficulties of his own.

Over the period of about a year while Melissa was 17, she was moved between various care homes and other institutions, returning to the family home only intermittently, mainly on weekends. At each place there would be problems: she would run away, she would self-harm and make an increasing number of serious accusations. Something was going very wrong but the NHS Trust responsible did not seem to know what to do, other than to move her on somewhere new whenever something went wrong. Throughout this period of around 11 months, Melissa had numerous placements and our concerns were ignored by the NHS Trust and social services. We warned the Trust that Melissa had picked up learnt behaviours from her time in the unit but this did not prevent them from moving her on through a number of similar institutions. We were never given any information on the counselling she was receiving and so we were unable to ensure continuity in her care when she returned home on weekends. We had initially requested family therapy at the outset from the Trust and social services, but this was not offered for 7 months and when it was, we had already taken extensive time from work to visit Melissa and had used up all our savings and were by that point, completely broke as a family.

Karen and I had always understood that Melissa was extremely vulnerable. She did not understand how her condition affected her behaviour and her desire to be accepted meant that she was very impressionable. While she lived at home we went to great lengths to instil boundaries in her life and to remove negative influences and set up a network of local friends to look out for and help Melissa. As she moved between care homes and hospitals it was clear that none were able to implement the boundaries that she needed.

This was clear to us at the time. Having raised Melissa, we knew how her condition affected her behaviour better than anyone, but no one seemed to listen to us. Not once in 11 months were we invited to sit down together with social services and the psychiatrists responsible for her care to work out a plan together for what was best for Melissa. Services seemed more interested in ticking their own boxes regardless of the disability or the family.

As Melissa approached her 18th birthday, a new social worker became involved to prepare her for the transition to adult care services. The social worker talked to us about sending Melissa to live in a residential care home and suggested Care Home 1 in Bristol which specialised in Asperger's syndrome. We did not want to send her away to another care home, especially one as far away as Bristol. Given her vulnerabilities, specifically her impressionability and lack of maturity, it was clear to us that she did not need to be sent off on her own again away from an already set up network of friends and family. All we had ever wanted was to be given the support we needed to become Melissa's primary carers again. She needed a stable environment and we felt that we should have been given the chance to provide her one. We had requested an advocate for several months, someone to act as a neutral representative for Melissa so that we could work through her problems with her. Social services had shown sympathy to the idea initially, but nothing ever happened. They were more interested in Melissa saying she wanted to be in care. I do not understand why more efforts were not made by social services to support the family or to take a bit more time to find a care home that was at least closer to the family home where we could help support her. It felt as though they just wanted to get Melissa out of the way now that she was an adult. Melissa was sent to the home the day after she was 18, adult services in her home authority spent no time at all working with the family.

After hearing the social worker's proposals, Melissa was adamant that she wanted to go to the residential care home. Again the social worker did nothing to explain to Melissa what going into care would mean. We were sure that sending Melissa to another care home was not going to help her but we assumed that the social worker had done full assessments of Care Home 1 to ensure Melissa would be safe there and properly cared for. We thought that Melissa's care would be fully monitored by her social worker and that the social worker would sign off any care plan done by the home, given Melissa's young age and vulnerability, but we weren't provided with any of the assessments or care plans. If we had been asked, the first thing we would have advised is that Melissa would struggle with locking her own door every night (which was something required by her care plan) and would need help and supervision in remembering.

When Melissa did move, it was clear that Care Home 1 was not the right place for her. Karen shared our concerns with the representative of Care Home 1 just before she left and explained how vulnerable Melissa was, that she found it difficult to relate to her own age group and that she had little experience with relationships with lads of her own age. He assured us they would be able to take care of her. As a family, we feel they did not look after Melissa properly.

We always expected that something would go wrong at Care Home 1 and that we would have to bring Melissa back home. In fact I told Karen that we had no choice and we had to stop and let Melissa find out for herself, Melissa would be 18, she had made her

decision, so initially, it was not such a shock when I learned she had been admitted to hospital again. To be honest after the 11 months we had just been through I was expecting the call. It was not clearly explained what had happened at first and it was only when I arrived at the hospital and saw her that I realised how bad it was and what had actually happened.

Melissa would not have been sent to Care Home 1 had it not been for the failings of our own local social services and NHS Trust and we hope this will be explored by the inquest. As parents, we knew Melissa would come home eventually to obtain her life skills. The one thing that was missing wherever Melissa was placed was the constant love and support the family gave her, regardless of what she said or did. What we never expected was for her to come home in a coffin.

James Mathieson