Executive Summary

This review has been undertaken jointly between the Bournemouth & Poole Safeguarding Adults Board having met the criteria for a Serious Case Review (SCR) and the Dorset HealthCare NHS Foundation Trust to meet the Trust's obligations under the Health Service Guidance and as agreed with the then responsible NHS South West Strategic Health Authority. *The three individuals considered in this SCR Report are semi-anonymised as X (the victim), Y and Z (the alleged perpetrators).*

X was found stabbed in his flat in Bournemouth on 27 July 2012 and despite treatment by paramedics pronounced dead a short time later. Y and Z were both charged and subsequently convicted with his murder.

The facts of this case show multiple interventions across a range of agencies relating to X, Y and Z. In relation to X and Y, agencies appeared to be working in isolation with little communication offered between organisations.

X had a number of convictions for a variety of offences and was on the sex offender register. X presented symptoms of schizophrenia and had expressed concerns about voices constantly telling him to commit suicide, rob others or kill others.

Y's NHS admissions have related to misuse of alcohol and illicit substances, stress-adjustment reactions, depressive episodes and an emotionally unstable personality disorder of the borderline type. It is noted that she has heard voices telling her to harm others, especially men.

Y and Z had a violent, dysfunctional, relationship of over 12 year's duration. Z had a history of alcohol abuse, illicit drug use and borderline personality disorder.

X and Y were under the care of the same CMHT and in the same block of flats. Y also reports on a number of occasions experiencing difficulties with her neighbour including her reporting that she had nearly stabbed them and worries that she will react with temper. The Housing Landlord received four complaints with regard to X's behaviour. These were made by Y on three occasions and by her stepfather on the other occasion. As a consequence of

perceived harassment, Y made formal requests via health agencies to be relocated which appear not to have reached housing authorities.

This report concludes that all agencies ought to have been aware of:

1. X's psychotic behaviour and alcohol/drug habits;
2. X's antisocial behaviour;
3. Y's violent history;
4. Y's consistent threats to X;
5. Z's frequent violence to Y and the,
6. Close proximity of Y/Z to X together in the same block of flats;
7. The Housing relocation requests and their urgency.

Recommendations have been made for individual agencies and the following are for multi-agency action:-

1. Partner agencies should review and improve the effectiveness of the process of CPA in the areas of information sharing, communication, multi-disciplinary work and risk assessment, especially in situations where violence is a known risk factor.
2. Partner agencies, especially Mental Health and Police should review their information sharing protocols and ensure they are fit for purpose in relation to safeguarding adults at risk. This should include how data is stored and accessed in line with the Data Protection Act.
3. The Policy and Guidance on working with Adults at Risk who do not wish to engage with services and are at serious risk of harm, should be reviewed, updated, disseminated and action taken to ensure it is understood and followed.
4. All staff should be reminded of the need to consider the effect of domestic violence in all aspects of risk management and to initiate the Multi-Agency Risk Assessment Conference (MARAC) process when indicated.