BOURNEMOUTH & POOLE SAFEGUARDING ADULTS BOARD

Safeguarding Adult Review

and

POOLE COMMUNITY SAFETY PARTNERSHIP

Domestic Homicide Review

"Harry"

Executive Summary

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1.0 Introduction

1.1 This combined domestic homicide review (DHR) and safeguarding adults review (SAR) was commissioned by Poole Community Safety Partnership and Bournemouth & Poole Safeguarding Adults Board in response to the death of Harry. (The names of the victim and perpetrators have been changed.) This report is an executive summary of the full DHR/SAR Overview Report.

1.2 Harry died on 26th May 2015 and Karen and John have both since been convicted of his murder and sentenced to life imprisonment. In the months prior to his death Harry had been in an on/off intimate relationship with Karen and it was thought that he may have been the father of her baby. Karen was also in an intimate relationship with John.

1.3 Prior to the murder professionals from a range of agencies became aware of a number of incidents and threats arising from the relationship between Harry, Karen and John.

1.4 A panel of senior representatives from local partner agencies was established to oversee the review. The panel's independent chair was Jane Ashman who, as Independent Chair of the Bournemouth & Poole Safeguarding Adults Board, was not affiliated to and/or employed by any of the individual organisations involved in this review. Membership of the panel is shown at Appendix A to this report. David Mellor was commissioned to be the independent author of this combined report. He has no connection to Bournemouth or Poole.

1.5 All members of Poole Community Safety Partnership and Bournemouth & Poole Safeguarding Adults Board wish to express their sincere condolences to the family and friends of Harry.

2.0 Terms of reference

2.1 It was decided that the combined DHR/SAR would examine partner agency involvement with Harry, Karen and John from 1st April 2009 until the murder of Harry on 26th May 2015, subject to any information emerging that prompted a review of earlier incidents or events that were considered relevant.

2.2 Additionally, it was decided that the combined review would address the following specific questions:

- To what degree could the homicide have been accurately predicted and prevented?
- The application of individual agency policy and procedures, multi agency policy and procedures and legislation.
- A particular emphasis on the management of transition from children's to adult services.
- Were practitioners sensitive to the needs of victim and the perpetrators; did practitioners have adequate training, knowledge and experience?
- How accessible were services for the victim and the perpetrator?
- Were eligibility criteria applied correctly?
- Did agencies utilise risk assessment, if so were they correctly used?
- Was the victim subject to multi agency risk assessment conference (MARAC)?
- Were decisions reached and informed in a professional way?
- Did action/risk management plans fit with the assessment and decisions made?
- When and in what way were the victim's wishes and feelings ascertained and considered? Was the victim signposted to other agencies?
- Analysis of the victim/perpetrator relationship and management plans for perpetrators.
- Was the information known to the agency recorded and shared where appropriate? Particular reference to be made to the transfer of information across service and geographical boundaries.
- Were procedures sensitive to the ethnic, cultural and religious identity of victim, perpetrator and their families? Was consideration in respect of vulnerability and disability necessary?
- Were managers involved at the appropriate points?
- Was there a "mindset" that pre-determined how individuals were responded to and/or eligibility criteria applied, following on from how they used agencies?

- Is any good practice identified that can be passed on to other agencies;

- What practices can be improved on and lessons learnt?

3.0 Glossary

Autism is a type of pervasive developmental disorder that is defined by a) the presence of abnormal or impaired development that is manifest before the age of three years, and b) a characteristic type of abnormal functioning in all the three areas of psychopathology: reciprocal social interaction, communication, and restricted, stereotyped, repetitive behaviour. In addition to these specific diagnostic features, a range of other non-specific problems are common, such as, phobias, sleeping and eating disturbances, temper tantrums and (self-directed) aggression.

Atypical autism differs from childhood autism either in age of onset or in failing to fulfil all three sets of diagnostic criteria, i.e. reciprocal social interaction, communication, or restricted, stereotyped, repetitive behaviour.

CAADA (Co-ordinated Action Against Domestic Abuse) **DASH** (Domestic Abuse, Stalking and "Honour"-based violence) is a commonly accepted tool which was designed to help front line practitioners identify high risk cases of domestic abuse, stalking and 'honour'-based violence and to decide which cases should be referred to the Multi Agency Risk Assessment Conference (MARAC) and what other support might be required.

Child Protection Conference - following Section 47 enquiries (see below), an initial child protection conference brings together family members (and the child where appropriate), with the supporters, advocates and professionals most involved with the child and family, to make decisions about the child's future safety, health and development. If concerns relate to an unborn child, consideration should be given as to whether to hold a child protection conference prior to the child's birth.

Independent Domestic Violence Advisor (IDVA) Their main purpose is to address the safety of victims at high risk of harm from intimate partners, ex-partners or family members in order to secure their safety and the safety of their children. Serving as a victim's primary point of contact, IDVAs normally work with their clients from the point of crisis to assess the level of risk, discuss the range of suitable options and develop safety plans.

Global Developmental Delay: A child may be described as having global developmental delay if they have not reached two or more milestones in all areas of development (called developmental domains). These areas are:

- motor skills - either gross motor skills like sitting up or rolling over and fine motor skills, for example picking up small objects
- speech and language - which also includes babbling, imitating speech and identifying sounds, as well as understanding what other people are trying to communicate to them
- cognitive skills - the ability to learn new things, process information, organise their thoughts and remember things

social and emotional skills - interacting with others and development of personal traits and feelings, as well as starting to understanding and respond to the needs and feelings of others.

A **Learning Disability** is described as:

- a significantly reduced ability to understand new or complex information, to learn new skills (impaired intelligence), with;
- a reduced ability to cope independently (impaired social functioning); and
- which started before adulthood, with a lasting effect on development.

Making Safeguarding Personal - is a sector-led programme of change which seeks to put the person being safeguarded at the centre of decision making. It involves having conversations with people about how agencies might respond in safeguarding situations in a way that enhances involvement, choice and control as well as improving quality of life, wellbeing and safety. It is about seeing people as experts in their own lives and working alongside them. It envisages a shift from a process supported by conversations to a series of conversations supported by a process.

Multi Agency Risk Assessment Conference (MARAC) is a meeting where information is shared on the highest risk domestic abuse cases between representatives of local police, health, child protection, housing practitioners, Independent Domestic Violence Advisors (IDVAs) and other specialists from the statutory and voluntary sectors. A victim/survivor should be referred to the relevant MARAC if they are an adult (16+) who resides in the borough and are at high risk of domestic violence from their adult (16+) partner, ex-partner or family member, regardless of gender or sexuality.

Multi-Agency Public Protection Arrangements (MAPPA) were established by the Criminal Justice Act 2003 in each of the 42 criminal justice areas in England and Wales. These are designed to protect the public, including previous victims of crime, from serious harm by sexual and violent offenders. They require the local criminal justice agencies and other bodies dealing with offenders to work together in partnership in dealing with these offenders. The core MAPPA members are the Police, Prison service and Probation service in each area.

Pattern Changing is a course for women who have been affected by domestic abuse which is designed to help survivors to end the cycle of abuse, help them to explore personal experiences and learn practical strategies to gain empowerment.

Personality disorders are severe disturbances of the personality and behavioural tendencies of the individual not directly resulting from disease, damage, or other insult to the brain, or from another psychiatric disorder. They usually involve several areas of the personality and are nearly always associated with considerable personal distress and social disruption. They are usually manifest since childhood or adolescence and continue throughout adulthood.

Section 47 investigation – Children's Social Care must carry out an investigation when they have "reasonable cause to suspect that a child who lives, or is found, in their area is suffering, or is likely to suffer significant harm". The enquiry will involve an assessment of a child's needs and those caring for the child to meet them.

Sexual Risk Order - was introduced by the Anti-Social Behaviour, Crime and Policing Act 2014 and can be made where a person has done an act of a sexual nature leading to reasonable cause to believe that it is necessary for the order to be made, even though they may never have been convicted. A court needs to be satisfied that the order is necessary to protect the public, or any particular members of the public, from sexual harm from the defendant; or protect children or vulnerable adults generally, or any particular children or vulnerable adults, from sexual harm from the defendant outside the United Kingdom.

The order prohibits the defendant from doing anything described in the order for not less than 2 years. Failure to comply is an offence punishable by a fine and/or imprisonment.

4.0 The victim and the perpetrators: A brief summary of their care and support needs and an overview of their life prior to Harry and Karen beginning their relationship.

Harry (Victim)

- At the time of his death, Harry was 22 years old.
- He had been diagnosed as having a moderate learning disability.
- He lived at home with his parents with limited input from health and social care services during his childhood.
- He attended a local community special school for pupils aged 4-16 with a wide range of learning disabilities.
- After school he was unemployed and received Job Seekers Allowance. He subsequently attended a local College.
- Harry was first referred to Poole adult services in September 2012 following a request from his mother who was struggling to cope with caring for him and for her father who had recently been diagnosed with cancer.
- A Mental Capacity Assessment in March 2013 concluded that he had limited understanding of managing money. He was considered to be vulnerable to financial abuse so it was decided that the Borough of Poole would act as "appointee" in respect of his financial affairs. However, this was never actioned.
- A Mental Capacity Assessment in May 2013 concluded he had capacity to engage in a sexual relationship.
- From September 2013 he was supported to live independently by The Care Division (TCD), a domiciliary care agency. TCD was commissioned by the Borough of Poole Council to provide 23.5 hours of weekly support to include wake up calls, hygiene prompts, medication prompts, healthy eating and meal prompts and support, flat management, finances and domestic task prompts and support.
- TCD has an electronic system called My Diary on which staff recorded their visits to Harry. This system also allowed Harry himself to record entries and send them to the TCD office.
- His "eagerness to please" may have left him more exposed to abuse by others.
- At times his "desperate need" for friendship could lead him to say things people wanted to hear or take actions which were not necessarily in his best interests.
- His parents say that their son was raped in October 2012 by a young male who had attended the same special school. The police investigated the matter and concluded that sexual activity was consensual.
- His medication was regularly reviewed by Consultant Psychiatrist 1 from Poole Community Learning Disability Team (CLDT) who also ensured he was supported in managing his low moods and anxiety.
- TCD Staff were provided with additional support from Harry's care manager at the Borough of Poole and Community Nurse 1 from Poole CLDT who periodically met him to discuss feelings and relationships.
- His interest in under-age girls became apparent from early 2012.

Karen (Perpetrator)

- At the time she and John murdered Harry, Karen was 20 years old.

- Dorset Children's Services were involved with Karen's family from before her birth. Throughout the course of Karen and her sibling's childhoods, there were continued concerns arising from allegations of physical and emotional abuse against both parents towards their children.
- Incidents of reported abuse were dealt with individually rather than being linked and full appreciated as a worrying picture for all the children in the family.
- Karen was diagnosed with atypical autism at the age of 7 but there was some confusion about the extent to which her behaviour was linked to the difficulties caused by her autism. She was initially placed in foster care but it became clear that she required more specialist care and she spent time in a residential placement whilst her needs were assessed.
- Finding an appropriate placement for her proved challenging as most of the resources considered felt her needs were higher than they would be able to manage. In late 2009 she moved to a specialist residential unit for children and young people with autism in Devon where she remained until her 18th birthday.
- She changed her first name by deed poll at the age of 16 because "she wanted to make a new start and put her abusive childhood behind her."
- Karen left the specialist residential unit in Devon when she reached the age of 18 in 2013. At the time of her final Looked After Children (LAC) review in March 2013, there was no clear plan for where Karen would live when she left the unit.
- The Independent Reviewing Officer stated that "this is a very unsatisfactory situation for Karen to be in. This is not a reflection on the social worker's comprehensive attempts to ensure that a supportive network is around Karen as she turns 18, but (reflects) rising thresholds of support to adults, a lack of availability of housing opportunities and of Karen's changes of mind."
- Karen returned to live with her mother in Somerset for a period before entering into a relationship with a male with whom she moved to Devon.
- She eventually gravitated towards Poole as two godmothers and a sibling lived there. Attempts to assess her needs were frustrated by a lack of clarity over her diagnosis and levels of ability and the difficulty in keeping track of her movements.
- Referrals were made to both adult learning disability services and adult mental health services but neither service felt that she met the criteria to receive a service from them.
- It was agreed a community care assessment needed to be completed but accessing this, and adult services generally, was significantly hindered by Karen's constant moving between Local Authorities.
- She was noted to be using a range of illegal drugs, so-called legal highs and also drank heavily at times.

John (Perpetrator)

- At the time he and Karen murdered Harry, John was 25 years old.
- He lived at home until his father died in 2012. His relationship with his mother appeared to deteriorate thereafter.
- He had no clear recorded diagnosis although there were references to him having a moderate learning disability.
- The absence of a clear diagnosis hindered efforts to identify an appropriate service to assess and support him.
- He was homeless from 2013 though he was not thought to be a regular rough sleeper.

- He made several attempts to resolve his lack of accommodation by presenting as homeless to Poole Housing which concluded that they had no statutory duty to provide him with temporary accommodation.
- He was assessed for supported accommodation by the Quay Foyer which concluded that both his needs and the risks he presented were too high for their service.
- He was eventually added to the waiting list for supported housing in Poole after a referral from the rough sleepers team.
- He was not assessed as having priority housing needs and was on a lengthy waiting list at the time of the murder of Harry.
- There was an over-reliance placed on him by Poole Housing to provide medical information to inform his housing needs assessment, in particular from mental health services. Although he appears unlikely to have met a statutory priority need and housing duty, services appeared unwilling to offer him advocacy or support in order to resolve his homelessness.
- There were a number of occasions when he expressed suicidal thoughts and attempted to lay down in front of traffic or jump in front of a train whilst in public places.
- This often resulted in the police detaining him under Section 136 of the Mental Health Act and taking him to St Anne's Psychiatric Hospital in Poole as a place of safety, where, on each occasion, his mental health was assessed.
- All of these assessments found that he did not have a severe and enduring mental illness.
- This repetitive pattern of extreme behaviour suggests a degree of desperation but the absence of any mental health diagnosis may also indicate an attempt to manipulate services.
- Repeatedly attempting and failing to access services in this extreme manner suggests John may not have been an entirely mentally well person. Indeed, concerns were expressed about John's mental health on several occasions by different agencies.
- It may have been pertinent for joint cross cutting work to assess him. However, as no formal community care assessment was undertaken there was no opportunity to consider this method of support.
- A disturbing feature of his persistent homelessness was a tendency to gravitate towards vulnerable adults or young people with whom he would stay for a period of time, sometimes entering, or attempting to enter, into sexual relationships with both vulnerable males and females.
- He appeared to seek to exploit the other person's vulnerabilities for his personal advantage or gratification.
- Three separate allegations of rape by John were reported to the police.
- Individual agencies gradually began to appreciate that he presented a risk to the vulnerable adults he associated with although an absence of information sharing about the risks he presented prevented agencies from gaining a fuller understanding of the threat he posed.
- He was recorded as drinking alcohol, smoking cigarettes and using illegal drugs and so-called legal highs.

Demographic information

4.1 Accommodation instability and homelessness are features of this review. Each year every local authority in England estimates or counts the number of people sleeping rough in their area. This information is then submitted to the Department for Communities and Local Government which publishes an annual estimate of the number of individuals sleeping out

on any one night in England. In the autumn of 2015 3,569 people were estimated to be sleeping rough on any one night in England. This represents an increase of 30% on the 2014 figure and there has been an increase of 102% since 2010. Levels of rough sleeping in Poole have remained consistently low over the period 2010 to 2015, increasing from 9 to 10. The picture is different in Bournemouth which experienced an increase over the same period from 12 rough sleepers in 2010 to 47 in 2015. (1)

4.2 Homeless Link - the national membership charity for organisations working directly with people who become homeless in England - publishes an annual report entitled *Young and Homeless.* The 2015 report found that "parents or carers no longer being willing to accommodate" continued to be the leading cause of youth homelessness, a causal factor in 47% of cases compared to 36% in 2014. This was the case with John. The proportion of young women in homelessness services was 46% in 2015 which was up from 40% in 2014. 55% of young people living in homelessness accommodation had complex needs and 34% had mental health issues. Whilst the percentage with complex needs was consistent with the previous year, the percentage with mental health issues was up from 23% in 2014. (2)

5.0 Synopsis

5.1 Harry and Karen initially made contact via social media in March 2014. The relationship developed quickly to the point where he started to spend nearly every day with her.

5.2 In April 2014 TCD made the first (of a total of four) safeguarding alerts in respect of Harry because of their concern that Karen was forcing the physical aspect of the relationship. Harry was also beginning to worry about Karen and her godmother bullying him for money.

5.3 In July 2014 TCD contacted Dorset police to report that Karen had "taken financial advantage" of Harry by taking out two mobile phone contracts in his name which had subsequently been cancelled. However, Karen had retained the handsets and was refusing to return them. This led to TCD making a second safeguarding alert in respect of Harry.

5.4 Later in July 2014 a pregnant female aged 17, who was also a LAC, alleged rape by John who was later arrested and denied any sexual contact had taken place. Delay in reporting the allegation meant that no forensic evidence was available and the police decided that there was insufficient evidence to charge John.

5.5 On 22nd July 2014 Poole Adult Social Care made a MARAC referral over concerns that Karen was financially, physically and emotionally abusing Harry who was assessed as "high risk" of domestic abuse using the CAADA DASH risk assessment.

5.6 Harry was allocated an independent domestic violence advisor (IDVA) who met Harry on 7th August 2014. He showed her threatening text messages he had received from Karen. Harry decided he wished to report the messages to the police which was arranged. Harry also expressed fear of what Karen would do if they did not remain friends. The IDVA went on to provide Harry with advice on safety planning and domestic violence awareness. Contact was also made with phone providers to change Harry's landline and mobile numbers. (When the police contacted Harry on the same date to discuss the threats from Karen, Harry decided he did not wish to take the matter any further.)

5.7 On 8th August 2014 the IDVA met Harry again to find that Harry had already called Karen from his new mobile number. The IDVA advised him that Karen would now be aware

of his new mobile number and would be able to continue to contact him. The IDVA was concerned that Harry was unable to recognise the risks involved in his relationship with Karen and whether he was able to keep himself safe. She also questioned whether Harry had capacity to make decisions about his relationship with Karen.

5.8 On 15th August 2014 Poole MARAC met to consider the referral about Harry amongst others. Poole MARAC noted the known details of the case including the fact that Karen had a history of domestic abuse of a previous partner and her brother. She was described as "controlling and manipulative". She was said to have a learning disability and autism. Karen's address was given as being in Yeovil but it was said that she was on a waiting list for Langdon House in Poole. Her relationship with Harry was said to be "over", although it was acknowledged that he continued to see her daily. Harry was noted to be scared of what Karen would do if he did not remain friends with her. Karen was noted to use others to threaten Harry. Harry was said to have capacity in respect of relationships but "not money or sex". It was said that a safeguarding meeting had taken place and Harry was now "under a plan" which was due for review on 9th September 2014. It was noted that Harry was receiving additional support from TCD and was engaging with the IDVA. No police action was considered necessary at this point.

5.9 It appears that it was decided that the IDVA would withdraw and that Harry's needs would be managed through the safeguarding plan. MARAC also made contact with Poole Housing to advise that Karen should not be accommodated in Poole because of the risks she posed to Harry. As a result, Poole Housing withdrew the supported housing application they had been progressing on behalf of Karen.

5.10 On 26th August 2014 TCD and Poole Adult Social Care agreed a "protection plan and protocol" document setting out how Harry would be supported safely in his relationship with Karen. The protocol acknowledged that Harry wished to live independently with Karen in the community with no staff support away from his TCD supported accommodation. The plan set out a number of steps to "help keep Harry safe" including arrangements for maintaining contact with him, that he would return to his supported accommodation nightly to sleep without Karen, arrangements for escalation of concerns about Harry within TCD and arrangements for contacting the police to file a missing person report.

5.11 In addition to this protection plan and protocol, an adult safeguarding plan was initiated by Poole CLDT on 3rd September 2014 and remained in place until Harry's death. The plan stated that the reason for the plan was the controlling behaviour of Harry's girlfriend Karen which included sexual and financial abuse. Amongst the actions required to ensure Harry's safety and wellbeing was continued support by TCD, the reporting of any changes in behaviour or concerns TCD might have for Harry, specific arrangements for preventing financial abuse and specific references to Harry having a fully charged phone to maintain contact with those supporting him. The plan was reviewed periodically by partner agencies and is said to have required little change.

5.12 TCD reported Harry as a missing person to the police on 5th September and 22nd October 2014. On both occasions he was found to be with Karen. Harry's parents say that on both occasions Karen had prevented him from leaving by locking him in with her.

5.13 By late September 2014 Karen was pregnant and Harry was believed to be the father. Around this time practitioners working with Harry concluded that the protection plan and protocol was not working, which led to a professionals meeting in late September. Harry's

capacity regarding relationships was discussed and he was referred to CLDT Consultant Psychiatrist 2 for reassessment of his capacity to engage in a sexual relationship.

5.14 However, the further planned assessment of Harry's mental capacity regarding sexual relationships did not take place due to Harry repeatedly giving conflicting information. A decision was made that it would be more appropriate to challenge his conflicting version of events which was apparently actioned by the CLDT, although the intended outcome of this challenge remains unclear.

5.15 On 25th September 2014 Karen contacted the police to allege that John had raped her in a Poole hotel. The police investigated but concluded that there was insufficient evidence as a result of inconsistencies in Karen's account. John said that he had had sex with Karen but claimed that it was consensual.

5.16 From late September 2014 John began contacting the police to say that he intended to take his own life by threatening actions such as hurling himself in front of oncoming traffic. There were four further calls of this nature to the police during the month of October and two such calls in November 2014.

5.17 In early October 2014 TCD staff reported "constant harassment" of Harry by Karen to the police. She was alleged to have been phoning the communal landline at Harry's supported accommodation to make threats. The police decided to take no further action after establishing that Karen had made no direct threats and Harry did not wish to make any complaint.

5.18 From October 2014, Harry began providing conflicting information to practitioners, informing some professionals that he wanted to move from his supported accommodation whilst telling others that he wanted additional support to remain there. Further safeguarding meetings were held to discuss the risks Karen posed to Harry in October December 2014.

5.19 In late October 2014 Karen, in company with John, approached Poole Housing for emergency homeless assistance. TCD had allowed her to stay with Harry at his supported accommodation over the previous weekend as a temporary measure in order to prevent Harry going missing with her. They could not permit Karen to stay with Harry and, in any event, he had decided that he did not want Karen to stay with him and had asked for help. An emergency bed was provided for Karen at the Quay Foyer but John was removed from that location by the police three nights later after complaints of anti-social behaviour.

5.20 Also in late October 2014 the CLDT advised the police that Harry had an interest in underage girls having tried to contact a girl aged 13 and others via Facebook and dating sites. The child's mother prevented contact. No offences were considered to have been committed.

5.21 In early November 2014 the police shared concerns about Karen with Poole adult social care. Staff at the Quay Foyer, where Karen was staying on an emergency basis, considered her to be vulnerable and was in a relationship with John who they suspected had attempted to force himself upon other residents in the past. There was an opportunity to consider whether Karen needed to be safeguarded but this was not taken.

5.22 On 13th November 2014 TCD staff notified the police of the theft of £803 from Harry's Nationwide building society account. Karen had persuaded Harry to allow her to look after his building society account instead of TCD staff who had been retaining Harry's debit card

and cash for him. Karen accompanied Harry to his branch having told him to tell the building society that he had lost his original debit card. She also told him to change the address on the account to hers. Karen was subsequently able to use the new debit card and new PIN number to withdraw £790 in cash from Harry's account in two transactions.

5.23 When arrested for the theft of money from Harry on 21st November 2014, Karen claimed that she had been dragged to the ATM by John who forced her to give him the money. Small purchases were also made. The Crown Prosecution Service (CPS) decided to charge Karen with theft and take no further action in respect of John due to insufficient evidence. Karen was subsequently convicted of theft at Bournemouth Magistrates Court.

5.24 On 19th November 2014 a second referral was made to the IDVA service in respect of Harry. The IDVA service did not re-engage with Harry as it was considered that there was no role for IDVA in view of the support he had in place.

5.25 In late November 2014 Karen was referred to Bournemouth Children's Social Care by midwifery services on the grounds that she was pregnant and vulnerable. She was said to have left her mother's address in Yeovil after relationships had broken down and had been living in emergency accommodation at the Quay Foyer, where she was considered to be too vulnerable for the service and where her relationship with John was also a source of concern. Karen had been asked to leave the Quay Foyer.

5.26 In early December 2014 Karen contacted the police to say that John was hanging around outside her flat and that she was not meant to have any contact with him following their arrests for the theft from Harry referred to above. She later added that John had followed her to her front door and made threats to punch her in the stomach and hurt her unborn baby. The police decided to make a MARAC referral in respect of Karen which was received by the IDVA service on the same date. Karen was assessed as at high risk from domestic abuse.

5.27 During December 2014 the case of Karen and her unborn baby was transferred to Bournemouth Children's Social Care for a statutory assessment, as appreciation of the risks the child could be exposed to had evolved to include Karen's troubled childhood and care history, her contact with violent partners and ex-partners and a propensity to dysregulate/behave aggressively.

5.28 On 15th December 2014 an IDVA made telephone contact with Karen who said was currently locked in a flat and her friend had taken the keys so she could not leave. When asked if she required police assistance, Karen said she was now being let out and was "OK". Karen refused to share the friends name and declined to meet the IDVA that day and a new appointment was made. This incident did not appear to be escalated by the IDVA. It is not known who locked Karen in the flat. The IDVA later referred to this as an allegation of "false imprisonment" at the Bournemouth MARAC meeting in January 2015.

5.29 On 17th December 2014 the IDVA met Karen and completed a CAADA Risk Assessment. She said she was fearful that John or his friends might hurt her and kill the baby. She added that John had threatened people with a knife and had raped both boys and girls. The IDVA undertook some safety planning with Karen and contacted the police to report disclosures made by Karen during their conversation. However, the police IMR states that that the IDVA advised them only that John was constantly phoning her in contravention of bail conditions that they were not to speak to each other following their arrest for theft

from Harry. The police concluded that both Karen and John were breaching their bail conditions and gave words of advice.

5.30 In early January 2015 Harry saw his GP who noted that his life appeared more stable whilst recognising that Karen's pending court case and the issue of paternity of her baby could be stressors. Harry also had a learning disability review with the GP the same month which generated no concerns.

5.31 On 8th January 2015 Bournemouth MARAC met and considered Karen's case. Her previous referral to Poole MARAC in August 2014 was noted. This was said to relate to "another partner" (Harry) but didn't make it clear that on that occasion Karen had been seen as the perpetrator. She was described as a vulnerable adult who was 22 weeks pregnant. She was noted to have also made an allegation of rape against John but no further action had been taken due to insufficient evidence. John was said to be a sex offender with previous convictions for harassment in which domestic abuse was a feature, assault and allegations of rape in which no further action had been possible. The IDVA expressed concern that Karen would continue to put herself at risk. She added that Karen's mother was supportive. Karen was said to have now disengaged from the IDVA service although she was noted to have committed to complete the "pattern changing" course for women affected by domestic abuse.

5.32 Children's Social Care advised that Karen was a former LAC who had previously been placed in "high need" residential care. She was said to have made no preparation for the birth of her baby. Karen's mother was again described as supportive but it was noted that Karen had left the family home and was now in the care of her father. (It is assumed that this information was inaccurate) It was suspected that Karen may have been sexually abused as child. The midwifery service said that Karen was engaging well but was not managing financially and leaving herself without food. Health advised that Karen had a diagnosis of atypical autism including issues with highly sexualised behaviour and poor understanding of consequences of behaviour. She was also said to have poor impulse and anger control. She was said to describe her partner (assumed to be Harry) and her unborn baby as positives in her life.

5.33 Amongst the actions which emerged from the MARAC discussion was the commencement of a multi-agency assessment by Bournemouth Children's Social Care. (This was apparently completed on 9th February 2015 and shared with Karen. It is unclear what further use was made of the multi-agency assessment.) The need for a mental health assessment was identified which would inform planning. Additionally, Children's Social Care would consider a professionals meeting.

5.34 During January 2015 the police were notified of John sending text messages of a threatening nature to Harry in an attempt to get him to drop the theft charge against Karen. The police did not follow up on this report.

5.35 Also in January, Harry reported that Gina (not her real name) had made threats to stab him. Harry and Gina had recently formed a friendship after initially meeting via social media. Gina was arrested but declined to make any comment. No further action was taken partly because Harry had accidentally deleted the messages he had received from Gina.

5.36 On 26th January 2015 Karen's case was closed to the IDVA service due to disengagement. Her case was described as being monitored by Children's Social Care.

5.37 John contacted the police to threaten suicide on two occasions in late January, three occasions in February and a further two occasions in March 2015. On three of these occasions he was detained under the Mental Health Act and taken to St. Ann's Hospital

5.38 Escalating concerns about the risks to Karen's unborn baby led Bournemouth Children's Social Care, Health and the police to hold a strategy meeting on 2nd February 2015. It was decided that the threshold for a Section 47 investigation had been met and that an Initial Child Protection Conference (ICPC) should be held. A Parenting Risk Assessment was also commissioned.

5.39 After the Parenting Risk Assessment uncovered significant concerns about Karen's capacity to care for her unborn child, a Prevention and Planning for Care Legal Panel meeting took place on 11th February 2015 at which it was decided that the child should come into the care of the local authority at birth, either by agreement or by court order and that an application would be made to the court to initiate care proceedings. At this point Karen was informed of the outcome of the meeting and advised to seek legal advice. Children's Social Care made a referral for an advocate for her.

5.40 Also on 11th February 2015 a Protection Plan review meeting was held in respect of Harry at which the adult safeguarding plan initiated in September 2014 was reviewed. The risk to Harry arising from the controlling behaviour of his on/off girlfriend Karen was considered to be continuing. It was agreed that the plan should remain in place for the time being and it was agreed to refer Harry to Occupational Therapy and Community Nurse for education on sexual relationships and advice on the risks of unprotected sex. It was also agreed to make application for the Borough of Poole to be his appointee in respect of his financial affairs. There was also a reference to Harry's tenancy being at risk because of his repeated failure to keep his flat clean. Harry's mother's view that her son would benefit from more support or from not living alone was discussed, but concern was expressed about the potential risk he might pose to other residents as a result of his "friendship groups" and the specific risk he may pose to female residents given that he was "actively seeking a relationship". It was decided to review the plan after the birth of Karen's baby.

5.41 During March 2015 Harry reported threats by Gina which the police did not consider as constituting an offence. Harry was provided with advice over the phone.

5.42 On 20th March 2015 the police received a report via Children's Social Care of a 17 year old female with learning difficulties who was deemed to be extremely vulnerable and at risk of Child Sexual Exploitation, who was believed to be with John, whom she had met on Facebook. She had been reported missing by her foster parents. She was located with John who described her as his girlfriend. Once separated from John, she alleged she had been raped by him. John was arrested and denied rape, claiming sex was consensual. He was bailed pending further investigation, although no further action was ultimately taken.

5.43 The following day the mother of another 17 year old female contacted the police over concerns that John was trying to arrange to meet her daughter, who had a diagnosis of autism. The mother alleged that John had threatened to rape her daughter and said she had heard that he had a reputation for targeting vulnerable young women. This and other allegations against John led to the police instigating a review of his offending.

5.44 On 26th March 2015 a pastoral support worker from a community school reported inappropriate messages received by two 15 year old girls from John via social media. It isn't clear what action the police took in response.

5.45 Also on 26th March 2015 the police advised Poole Adult Social Care of a verbal disagreement between John and a female who had been the victim of six previous safeguarding alerts, of which the four most recent related to John and concerned physical, financial and sexual abuse. It was thought that John was living at her property as he was described as being of no fixed abode.

5.46 In late March 2015 Karen gave birth to her child and subsequently signed a Section 20 agreement to enable the child to be placed in foster care. At this point it was noted that Karen would have three supervised contacts a week with her child whilst any decision over contact arrangements for Harry were deferred until a DNA test had been carried out to confirm his paternity. This test was scheduled for 7th May 2015.

5.47 In early April 2015 Harry reported further threats from Gina. Having reviewed the information provided, the police decided that no further action was justified.

5.48 During April 2015, John contacted the police four times expressing suicidal thoughts and was taken to St. Ann's hospital on each occasion.

5.49 On 27th April 2015 a multi-disciplinary meeting was held to discuss Harry which his mother also attended. She reported that Harry was feeling suicidal and lonely, probably due to him not being in a relationship. A residential placement was discussed but considered not to be appropriate due to the risks Harry would pose to other residents. TCD state that they requested a residential placement for Harry at this meeting and that this was the last of eight requests they made for additional support for Harry over a period of fourteen months. Apart from an increase in weekly hours from 20 to 23.5 hours, TCD state that all requests were declined by the Borough of Poole. Harry was to be requested to try Beneperidol to reduce his libido which he agreed to do. TCD were to inform Harry that he was in breach of contract and give him a written warning. The written warning was issued due to the uncleanliness of his flat and "the number of incidents where the Police were called due to acquaintances (he had) befriended". A verbal warning had been given earlier in the month. As the warnings potentially put his tenancy at risk it was decided to explore other vacancies for Harry but no action had been taken on this by the time of his death.

5.50 By 5th May 2015 partner agencies were beginning to explore opportunities to support and safeguard John and others who may be at risk from him. A request for a multi -agency approach to engage and support John was referred to the Poole Adult Social Care service manager for primary care on the same date. The review of John's offending referred to above led the police to consider applying for a Sexual Risk Order although the murder of Harry took place before this could be actioned.

5.51 Harry's DNA test which was scheduled for 7th May 2015 did not take place as a result of a "mix up" in the paperwork.

5.52 During May 2015, the 16+ care leavers support team requested Karen's GP make a referral to the Community Mental Health team for a "an assessment of her general mental state and capacity, history of Asperger's and Autistic spectrum disorder."

5.53 On 13th May 2015 Harry reported receiving threatening text messages from Karen and John to the effect that he was a dead man and should go and dig his own grave. It was agreed that the police would visit him the following day but they did not do so. After Harry re-contacted the police it was arranged that they would call on 15th May 2015.

5.54 On 14th May 2015 the police became aware of a concern that Harry was trying to meet an 11year old girl. Due to the fact that the police were going to speak with Harry regarding the threats from Karen and John he had reported the previous day, when the police visited Harry on the 15th May 2015 they also spoke with him regarding the concerns raised about his contact with the girl.

5.55 The police viewed the texts from Karen and John which did make threats to kill him if he continued to have contact with Karen. Harry confirmed he wished to make a complaint about the texts and that he was prepared to give evidence in court. The police officer felt that Harry would not make a good witness as he appeared to be easily led. The potential difficulty in securing a prosecution appeared to influence the officer to the view that John should be visited and warned about his conduct. Harry blocked John's number and was advised to have no contact whatsoever with John or Karen. John was not apparently visited and warned about his conduct and Dorset police have referred their handling of this matter to the Independent Police Complaints Commission (IPCC).

5.56 Harry was then strongly advised over his contact with the 11 year old girl. He claimed that John had in fact sent the texts to the girl, having taken Harry's phone off him on 13th May 2015. Harry's claim was not thought to be credible.

5.57 Also on 15th May 2015 the Dorset 16 plus Leaving Care team contacted the police to advise that they had not seen Karen for over a week. The Leaving care team advised that Karen had recently had a baby which had been taken into care and she had been receiving very abusive text messages from John. Later that night Karen was located in the company of a male who is believed to have been John.

5.58 On 18th May 2015 Karen told the police that she has been assaulted by John who she said had kicked her in the stomach and dragged her to the floor by her hair. When police attended John made a counter allegation that Karen had thrown a chair and butter knife at him. Both were arrested and later charged with assaulting each other. They were bailed to attend Bournemouth Magistrates Court and given bail conditions not to have any contact with each other.

5.59 (The subsequent investigation into the murder of Harry discovered that Karen had audio recorded the incident in the previous paragraph on her mobile phone. The recording suggests that she was the main aggressor and threw a knife at John's head causing a minor injury. Other audio recordings from Karen's phone reveal that Karen and John were back together at her flat and in breach of their bail conditions following their release from Police custody later that day.)

5.60 After his release on bail, at 8.15pm the same evening, (18th May 2015) John rang the police to say he intended to take his own life. He made mention of not being able to be with Karen as a result of their bail conditions. The police were unable to respond to John's situation until much later in the evening when he told them over the phone that he no longer intended to hurt himself and was staying at an undisclosed friend's address. (The audio recordings referred to above suggest he was with Karen again.)

5.61 On 19th May 2015 a multi-agency meeting was held to review concerns over Harry's contacts with under-age girls. Harry was said to have admitted that he found girls of 12 and over to be sexually attractive.

5.62 On Wednesday 20th May 2015 the police referred Karen to the IDVA service following the 18th May 2015 incident. However, the IDVA service was unable to open the referral email sent by the police. Apparently there were technical problems associated with a new IT system recently taken into use by the police. It was not until Tuesday 26th May 2015 (Monday 25th May 2015 having been a bank holiday) that the IDVA service was able to fully access the referral email.

5.63 On 20th May 2015 John is said to have tricked Harry into meeting with him in Boscombe by pretending to be a female called "Jessie". (The police investigation into the murder of Harry was unable to conclusively confirm the identity of "Jessie".) Harry was then taken back to Karen's flat where he was locked in and threatened with physical violence by John. From information gathered as part of the murder investigation, Karen tried to get Harry to admit to raping young girls. Harry was told that if he went to the police, John would kill him. In the recordings Harry states that he didn't rape anyone but had sent messages to young girls aged 12 and 13. John may also have been motivated by a desire to question Harry about an incident in which Karen alleged Harry had raped her in June 2014 which was never reported to the police. Harry eventually managed to leave Karen's flat unharmed. He didn't report the incident to the police but shared the details with TCD care workers the following day.

5.64 TCD care worker 1 made an entry on My Diary for Harry timed at 15.11 on 21st May 2015. She wrote that Harry had returned to his supported accommodation at 9.30pm the previous evening. He said he had caught the 4.15 bus to Poole to meet Karen and John after they had sent him numerous texts repeatedly urging him to meet them. Harry said he had met John and gone for a walk with him during which John had become threatening. The My diary entry reads: "John forced Harry to go to Karen's flat by threatening to kill him". Whilst there, John removed Harry's phone from him and said he was not allowed to leave Karen's flat until he told the truth. When TCD care worker 1 asked Harry what Karen and John meant by telling the truth, Harry replied that they wanted him to tell them why he called them names. Harry said he was locked in Karen's flat. He said he was scared. However, he managed to get his phone back and leave. He said he later smashed his phone out of frustration at being late. He handed his broken phone to another TCD member of staff when he returned on the evening of 20th May 2015 and told her that he had accidentally broken it on the way home.

5.65 Harry reiterated what had happened to him in Karen's flat on 20th May to TCD care worker 2 who also wrote an entry in the My Diary system – at 15.18 on 21st May 2015.

5.66 TCD advised CLDT of the 20th May 2015 incident and confirmed the details in an email sent to CLDT on 22nd May 2015, although the wording of the email may have slightly downplayed the seriousness of the incident by saying that they (Harry, Karen and John) "were all locked in". However, attached to the email was a copy of the My Diary entry referred to in Paragraph 5.67 above. Neither TCD nor CLDT reported the matter to the police. Community Nurse 1 from CLDT responded to the notification of the incident by contacting Harry on 21st May 2015 to tell him that his smashed smartphone would not be replaced quickly as he kept breaking them.

5.67 CLDT decided that a meeting was necessary to update Harry's protection plan but that it should be deferred until after Harry's DNA result test result was received. This meeting was arranged for 29th May 2015.

5.68 The subsequent murder investigation revealed that on 20th May 2015 Karen disclosed to her support worker that John wanted to hurt Harry or that he wanted to kill him. This information was not escalated or reported to police.

5.69 As a result of enquiries made during the murder investigation it has been established that when Harry visited his GP for the rearranged DNA test on 21st May 2015, he disclosed to his TCD support worker that he did not want to have the DNA test as John and Karen had threatened to kill him if he did. Whilst at the surgery Harry's behaviour was described as concerning as he was so scared he would not leave the support worker who was accompanying him. Harry said he was particularly scared of John who he said carried knives. Karen was also present at the surgery along with her baby for the purposes of the DNA test and John was believed to have been waiting for her outside.

5.70 Once again the DNA test was not carried out because payment for the test had not been arranged and Harry had not been prompted to bring identification. It was re booked for the 28th May 2015.

5.71 During the period 22nd -25th May 2015 mobile phone data obtained during the subsequent murder investigation demonstrated that Harry was in contact with Karen and vice versa.

5.72 Harry shared details of the incident at Karen's flat on 20th May 2015 with another TCD care worker on 24th May 2015. At this time, he also told a TCD care worker that Karen and John had a recording of Harry admitting to raping Karen. Harry told his care worker that he hadn't raped Karen adding that "it is John who raped her and he had seen the marks".

5.73 On 26th May 2015 an entry in the TCD My Diary a care worker recorded Harry telling her that he was thinking of locking himself in his flat all day because John had told Karen that he would beat Harry up at her flat. Harry was also noted to have referred to texts he had received from 4am that morning from Karen and John in which they described him as a rapist. In a later entry in My Diary, the TCD care worker wrote that Harry had gone out to meet Karen and another female.

5.74 The murder investigation confirmed that during the early hours of 26th May 2015 there was mobile phone text message and phone communication from John and Karen to Harry which was described as very abusive and extremely threatening to Harry.

5.75 Audio recordings subsequently recovered from Karen's mobile phone revealed that she and John had been in conversation during the morning of 26th May 2015. Karen talked of the alleged rape of her by Harry on 1st June 2014 which appeared to anger John and led him to demand that Karen contact Harry. Together they appear to have tricked Harry into believing that Gina was present in Karen's flat and wanted to meet him.

5.76 After Harry was lured to Karen's flat, he was stabbed twice in the neck, severing his carotid artery. He was also struck about the face several times. John and Karen then left Harry's body in Karen's flat and took a bus to Weymouth where they were arrested after Karen had contacted her support worker by phone.

6.0 Engagement with the family of Harry

6.1 Harry's parents have contributed fully to this review. They described the support Harry and they received once delays in his development had been identified in early childhood.

Harry was regularly seen at Poole hospital's child development centre for monitoring and assessment. His parents said he enjoyed the local Special School at which he spent his entire school career, benefitting from structure, routine and making many friends. His parents described his aptitude for technical matters, particularly computers. He also became very interested in trains and particularly buses. He was able to recite the local bus timetable from memory and as he grew older he enjoyed taking the bus to places. Buses gave him the freedom to travel which he relished.

6.2 His parents said there was an absence of school clubs and after hours distractions for Harry and that they and Harry felt isolated within the local community. However, Harry's maternal grandfather began to play a large part in his life and they developed a very close bond.

6.3 Other than through the annual review meetings at school, which she believed were attended by educational welfare, Harry's mother says she received no support from social services during Harry's childhood. She says that she repeatedly asked for support from social services only to be advised that as she was managing to care for her son satisfactorily, she didn't need social services support.

6.4 After leaving school at 16, his parents say that Harry appeared to be frequently frustrated because he became more self aware of his disability, whilst at the same time wanting the freedom to experience life, to make friends away from college and in particular to have a girlfriend. They add that neither the school nor the college Harry subsequently attended ever discussed his future, whether he would be able to find work or generally cope in adult life.

6.5 When his maternal grandfather became ill with cancer in the summer of 2013, Harry's mother sought help from social services because she felt she would struggle to care for both her son and her father, who lived alone. She was allocated a social worker who she described as "fantastic", although they were less impressed with the social workers who succeeded her. Additionally, Harry received regular support to help him learn to cook, input on sex education and help in managing his money.

6.6 With the help of the social worker Harry began to live independently of his parents supported by TCD. His parents said that he really liked his new flat where he settled in well although they noticed that he still had trouble sleeping, having got into the habit of spending hours on Facebook during the night.

6.7 Harry's parents referred to the alleged rape of their son by a male who they said was also ex-pupil of the same special school. They believe that a consequence of this experience was that it made him wary of, and less able to relate to, men.

6.8 Harry's parents barely met Karen who they felt that forced herself on their son in an effort to become pregnant. They didn't regard it as a truly consensual relationship and felt that it quickly became an abusive relationship. They felt that Harry kept going back to her because he thought he was the father of her child. He put the scans of the unborn baby up on his wall in his flat. He was proud of being a father.

6.9 They said that Harry knew John because he studied at their son's college at the same time, although he was on a different course. Prior to his relationship with Karen Harry was

chased through the park by John. He fell and injured his leg and his parents say that this left him petrified of John. They believe that John may have begun bullying Harry whilst they were both at college although it has not been possible to confirm this.

6.10 When Karen and John got together they would send Harry texts from around 2am onwards which prevented him from sleeping. They said that the texts were threatening including one occasion when Karen told Harry to expose his penis on Facebook or John would get him. His parents said that Harry had 25 separate Facebook pages. He created so many new pages in order to try and get away from Karen and John's threats and harassment they said.

6.11 Harry's parents said that they tried to get him into the TCD residential house until things had stabilised between him and Karen and John. They said that whilst TCD supported this step, it was opposed by Harry's social worker on the grounds of cost and the fact that Harry was considered to have capacity. (It would appear that professionals also had reservations about this proposal on the grounds that Harry and his "friendship group" could expose other residents to risks and Harry himself could be a risk to female residents given the intensity of his wish to have a girlfriend.) Harry's parents added that social services would not fund a member of TCD sleeping in Harry's flat with him either.

6.12 Harry's parents felt that Harry lacked capacity to make decisions to keep himself safe from Karen and John. They said that a capacity assessment had been cancelled in November 2014. And when it was rearranged for February 2015, Harry's mother said that she had accompanied her son but been excluded from contributing in any way and they felt that this was wrong. (Harry's mother may be mistaken in her recollection here as there appears to have been no further mental capacity test scheduled for Harry after the unsuccessful assessment in November 2014 to which she accompanied her son.) Harry's parents say that when they were told that their son had capacity they "raised an uproar" which led to an important meeting to discuss Harry on 27th April 2015.

6.13 At this meeting, Harry's parents say that his father warned social services that if anything happened to their son, "it will be on your head". They said they had thought about this meeting a lot after they had been told about their son's murder.

6.14 His parents described a visit home by their son on 12th May 2015. Before he arrived home he rang to say he had "wet himself" because John had chased him. They added that Harry sometimes wet himself –but only when he was frightened. When he arrived, his mother helped to remove his clothes so he could have a bath and she said she was shocked by how thin he had become, with his ribs clearly visible. She suspected he had not been feeding himself properly because he had been spending all his money on Karen.

6.15 His parents said that Harry rang them after the police had visited him on 15th May 2015. They said he sounded so happy and relieved. He told them that "John's going to get a telling off. I can go out and do things again".

6.16 Reflecting on events, his parents said that they did not realise the severity of the situation Harry was in. They said they kept telling him to contact the police and he would be looked after but, in their view, he wasn't looked after by the police. A month or so before he died Harry rang his father and told him that Karen and John were trying to kill him. His father said he thought it was "just kid's stuff" and decided not to intervene. His parents also felt that some professionals saw Harry as attention seeking and, as a result, did not treat

what he said with the seriousness it deserved. They also felt that not all professionals listened to their concerns about their son.

6.17 They felt that TCD tried so hard. They remembered a period when a TCD care worker slept on a mattress in Harry's flat for a couple of weeks which enabled him to feel safer and get some sleep despite the fact that they received no funding for this. They said that their main concerns were with social services and the police.

6.18 Harry's parents had the opportunity to read and comment upon a late draft of this report. They expressed particular concern that it had not been possible to complete the assessment of Harry's mental capacity in November 2014. They say that they were under the impression that the assessment of Harry's mental capacity had taken place at that time and that he had been assessed as having capacity. They also expressed concern about the references to their son's interest in under age girls. They wondered whether others had had access to his phone to make contact with under-age girls via social media and pointed out that, ever since childhood, many of Harry's friendships had been with people younger than himself. They said that this was because he had always been encouraged to befriend and support younger pupils at school and was also a consequence of his learning disability which meant that it was easier for him to make friendships with those younger than him rather than with his peers.

Contact with the perpetrators

6.19 The perpetrators were given the opportunity to contribute to this review which both Karen and John decided to accept. They separately met the independent author in the prisons in which they are serving their sentences.

6.20 Karen tended to portray herself as a victim who was dominated by both Harry and John. She said Harry exploited her financially and blamed her when their relationship got him into trouble, by being late for meetings with his support workers for example. She described John as a dominant person who used violence and the threat of violence to exert control over her and others.

6.21 Reflecting on the support she received, Karen said she wished Dorset Children's Services had taken her away from her abusive mother when she was 5 years old. She said she had mixed feelings about the residential school in Devon in which she was placed until the age of 16. She said she felt safe there but had found it difficult to adapt to being locked in. She went on to say that "it was like a nightmare" when she left the school. She said she felt she was all on her own, moving from hostel to hostel and "B&B" to "B&B" and mixing with people who used drugs and alcohol.

6.22 She said post 16 services provided a lot of practical support, including help to get a flat, but did not provide her with emotional support. She said that housing services were keen to house her when she was pregnant, but when she wasn't pregnant they "just left me to it". She described the IDVA service as supportive over the phone but added that she would have welcomed meeting them face to face.

6.23 John's contribution lacked credibility in key respects. Specifically, he maintained that he befriended Harry, had never bullied him and claimed never to have taken advantage of any of the women he stayed with. He also tried to distance himself from responsibility for Harry's death.

6.24 When asked about the support he had received, John said that none of the services he had been in contact with in Poole or Bournemouth had helped him. He said that agencies did not appreciate the difficulties homeless people faced and illustrated this with the example of having nowhere to charge his mobile phone, which was essential if he was to keep in touch with agencies. He made no explicit link between the impact of being homeless and his frequent calls to the police and other agencies to express suicidal thoughts. Rather, he attributed this behaviour to using drugs and alcohol which had "mucked up" his head.

6.25 When John began to talk about his relationship with Karen and Harry, it was difficult to distinguish facts from confused recollections and untruths. However, the manner in which he described the conflicts which arose in this three-way relationship gave the impression that they amounted to little more than a series of trivial adolescent tiffs. Listening to John, one could imagine how easy it might have been for professionals to underestimate the risks Harry faced from Karen and John.

7.0 Learning themes and Recommendations

7.1 This case demonstrates how challenging it can be to safeguard adults with learning disabilities who are living relatively independently in the community. Harry had every right to wish to live a life which was as rich in experiences and as fulfilling as possible. However, realising Harry's wishes brought risks, including the risk of abuse from relationships which became exploitative, coercive and ultimately deadly. Many agencies worked very hard to safeguard Harry and it is a tragedy that they did not succeed.

Transition from children's services to adult services.

7.2 Harry was largely unknown to children's services, which, given his diagnosis and the fact that he attended a special school is a little surprising. John had limited contact with Children's Social Care and CAMHS services.

7.3 Karen was a child looked after (LAC) by Dorset County Council. Her transition from children's services to adult services was not well managed. As her 18th birthday approached she faced the end of her placement at the specialist residential unit where she had lived since the age of 14. She was unprepared for independent living and her LAC pathway plan had little to offer in terms of accommodation options. And so she returned to live with her mother, an arrangement with a high probability of failure. Her stay with her mother lasted for barely two months and was followed by a very transient period in which her frequent moves took her across several local authority boundaries and made assessing her needs very challenging. Although Karen as a former LAC was entitled to support until at least the age of 21, she was assessed as not meeting the criteria for either adult mental health or adult learning disability services.

7.4 However, Karen was a care leaver with additional support needs in that she had a diagnosis of atypical autism, she was abusing substances and she became pregnant just over a year after leaving care. She received much support during and after her pregnancy but there was rightly a strong focus on safeguarding her unborn child.

7.5 Stein places care leavers in three broad categories; the "moving on" group who experience attachment, stability, continuity, gradual transitions and move from specialist to universal services; the "survivors" group who have experienced placement instability, need more formal support, require substantial leaving care support which often makes a big difference for them and who "move on" later; and the "strugglers' group who have suffered

severe maltreatment, have complex problems, instability and attachment problems and can become trapped within specialist services. (3) There seems little doubt into which category Karen would be placed.

7.6 Dorset County Council recognises that they did not succeed in ensuring Karen was adequately prepared for the challenges of adulthood. With hindsight, there was probably a strong case for much earlier removal of Karen from the harm she experienced within her family.

7.7 The Children and Families Act 2014 envisages a system from birth to 25 years in which preparation for adulthood is a key element. Dorset County Council has advised this review that there has been a programme of extensive engagement with stakeholders to identify how best to implement this legislation in order to improve the experience of young people and their families as they approach adulthood. This work has resulted in the decision to create an integrated 0-25 Service for the County Council.

7.8 Additionally the Care Act 2014 places a duty on local authorities to conduct transition assessments for children where there is a likely need for care and support after the child in question turns 18 and where a transition assessment would be of significant benefit. In order to fully meet these duties, local authorities should consider how they can identify young people who are *not* receiving children's services but are nevertheless likely to have care and support needs as adults. These provisions could have helped to anticipate and address the needs of Harry as he approached adulthood, and possibly John's.

7.9 It is therefore recommended that this report is shared with Dorset's Local Safeguarding Children and Safeguarding Adults Boards so they can use the learning from this review to seek assurance in respect of the arrangements by which looked after children – and children with care and support needs who are not receiving services from children's services – are supported in their transition to adulthood. For the same reason it is recommended that this report is shared with Bournemouth and Poole Local Safeguarding Children Board.

Recommendation 1

That this report is shared with Dorset's Local Safeguarding Children Board and their Safeguarding Adults Board so that the Boards can make use of the learning from this review to seek assurance about the effectiveness of arrangements by which looked after children and other children with care and support needs are supported in their transition to adulthood.

Recommendation 2

That this report is shared with Bournemouth and Poole Local Safeguarding Children Board so that that Board and the Bournemouth and Poole Safeguarding Adults Board can make use of the learning from this review to seek assurance about the effectiveness of arrangements by which looked after children and other children with care and support needs are supported in their transition to adulthood.

MARAC and adult safeguarding

7.10 When Poole MARAC considered the referral in respect of Harry in August 2014 they decided that the high risk of domestic abuse he was assessed as facing from Karen could be managed within an adult safeguarding plan. This review has found that the adult

safeguarding plan was not an entirely adequate vehicle for safeguarding Harry from domestic abuse. It was not a multi-agency plan in that the police appear to have had no involvement whatsoever, the risks to Harry were not fully updated and the plan only generated action to a limited extent. Yet MARAC took no steps to assure themselves of the adequacy of the adult safeguarding plan, either at the time they decided that Harry's risk of domestic abuse could be managed through the plan, or subsequently. Nor did MARAC propose that Harry's IDVA work jointly with the professionals involved in Harry's adult safeguarding plan which might have provided them with a measure of assurance that the plan was a robust vehicle for addressing the risk of domestic abuse to Harry.

7.11 When Karen was referred in January 2015, Bournemouth MARAC appeared to take comfort from the fact the Children's Social Care were involved with her. MARAC did not appear to consider that the primary focus of Children's Social Care would be to safeguard Karen's unborn child and that their involvement with Karen would diminish significantly once the child was born particularly if that child was removed from her - which it was.

7.12 The assumptions that the high risk of domestic abuse faced by Harry in August 2014 and Karen in January 2015 could best be addressed by an adult safeguarding plan in Harry's case and by the engagement of children's services in Karen's case, unaccompanied by any follow-up, hints that the MARAC process may have been experiencing strain. (This review has been advised that in 2015/16 Poole MARAC considered 175 referrals and Bournemouth considered 320)

7.13 Additionally the MARAC referrals for both Harry and Karen generated only brief engagement by the IDVA service. The service did not appear to be confident about working with people with learning disabilities (Harry), care and support needs (Karen) or with people who were difficult to engage with (Karen). There appeared to be insufficient consideration of the benefits of the IDVA working with Poole Adult Social Care and TCD.

7.14 Overall the referrals to Poole MARAC in respect of Harry (one referral) and Bournemouth MARAC in respect of Karen (two referrals) did not appear to contribute a great deal to their safety.

7.15 The MARAC process appeared to envisage a clear cut distinction between victim and perpetrator. Poole MARAC considered Harry to be the victim and Karen to be the perpetrator in August 2014 and took steps to prevent her obtaining supported accommodation locally despite her evident vulnerability. By January 2015 Bournemouth MARAC considered Karen to be a victim and John to be the perpetrator. At this point Karen's relationship with Harry was seen as a positive factor despite Harry's adult safeguarding plan highlighting his relationship with Karen as the most significant risk he faced at that time. Following the 18th May 2015 incident, the MARAC referral considered Karen to be the victim and John to be the perpetrator when in fact both had been arrested and charged for assaulting each other.

7.16 Despite the fact that it is well understood that in some relationships, the parties involved can be both victim and perpetrator, neither MARAC adopted a sufficiently fluid approach in this case.

7.17 Additionally, partner agencies appeared to find the fact that individuals could be both victims and perpetrators confusing. When the police responded to the threats to kill Harry he received by text from John and Karen on 13th May 2015, they had to make decisions on how to proceed on this issue as well as warn him about his behaviour in seeking a relationship with an eleven year old girl, which Harry disputed and tried to blame on John.

Working their way through complexity such as this is quite challenging for professionals. On reflection, it might have been preferable for the police to have managed these two issues separately.

7.18 MARAC and adult safeguarding do not appear to be well aligned. Commissioning a combined SAR/DHR review represents a golden opportunity to remedy this. For good reason the MARAC process has historically focussed on the risks of domestic abuse to women and children. This is entirely justified and will undoubtedly continue. However, the CAADA DASH checklist is known to have limitations for the identification of risk factors experienced by disabled and older people. (4)

7.19 The vulnerability to domestic abuse of women and men with disabilities including learning disabilities needs to be much better understood within the MARAC process and the IDVA service needs to ensure that their staff are equipped with the training and materials necessary to enable them to provide a service to people with disabilities which is both accessible and sensitive to their needs.

7.20 And there is much that adult safeguarding can learn from MARAC processes. For example, tracking of perpetrators – such as John - who abuse several victims over time is a feature of domestic abuse field which should be replicated within adult safeguarding. Poole Adult Social Care has advised this review that their systems are capable of tracking perpetrators and have committed themselves to ensure their systems are configured to achieve this objective.

7.21 It is therefore recommended that Bournemouth and Poole Safeguarding Adults Board and Poole Community Safety Partnership establish a joint task and finish group to make use of the learning from this review to ensure that the safeguarding adults and the MARAC agendas are more closely aligned and that professional practice in respect of safeguarding adults and tackling domestic abuse is as integrated as possible. Amongst the issues that the task and finish group could consider are:

- ensuring that staff understand that many circumstances are both safeguarding situations and domestic abuse, and that they have a range of social work and legal options with which to work with people
- ensure that organisational policies, protocols and procedures about safeguarding explain the links with domestic abuse and, similarly, policies, protocols and procedures about domestic abuse refer to safeguarding.
- considering integrated training that covers both safeguarding and domestic abuse rather than treating them as separate issues

Recommendation 3

That Bournemouth and Poole Safeguarding Adults Board and Poole Community Safety Partnership establish a joint task and finish group to make use of the learning from this review to ensure that the safeguarding adults and MARAC agendas are more closely aligned and that professional practice in respect of safeguarding adults and tackling domestic abuse is as integrated as possible.

Recommendation 4

That the joint task and finish group referred to above, should also conduct a review of the IDVA service in order to identify what changes need to be made to ensure that:

- *the IDVA service is effectively integrated with the MARAC process*

- *case closure is accompanied by an appropriate level of risk assessment*
- *the service is accessible and sensitive to the needs of disabled people including people with learning disabilities.*

Mental Capacity

7.22 Prior to entering into his relationship with Karen, Harry was assessed as having capacity to engage in relationships. After his relationship with Karen began, practitioners began to question whether he had the mental capacity to take decisions necessary to protect himself from what practitioners agreed was an abusive and exploitative relationship. And in Harry's case the coercive nature of domestic abuse was exacerbated by his strong desire, bordering on desperation, to be in a relationship. Harry repeatedly exposed himself to harm from Karen and later from Karen and John. Notwithstanding the basic principle of the Mental Capacity Act that individuals have the freedom to make unwise decisions, it was agreed that a further assessment of Harry's mental capacity would be undertaken.

7.23 Unfortunately, this further assessment of his mental capacity could not be successfully completed. CLDT Consultant Psychiatrist 2 met with Harry twice in an effort to assess his capacity but he "told many lies and was unable to give a straight answer". He was also noted to be very suggestible. The Consultant Psychiatrist ultimately concluded that due to the inconsistencies and unreliability of the information provided by Harry, it was impossible to gain a completely true picture of his capacity, although "his ability for duplicity suggested an element of insight".

7.24 Had it been possible to complete the assessment of Harry's capacity and had any lack of capacity to comprehend the risks he faced in his relationship with Karen and make decisions to protect himself from those risks been demonstrated, then this would have opened up the opportunity to consider what decisions or actions could be taken on his behalf in his best interests. Other questions which could then have been considered were whether or not Harry required a Mental Health Act assessment for a Guardianship or whether any issues needed to be taken to the Court of Protection.

7.25 In the event, the staff working with Harry had no alternative but to continue to assume that he had the capacity to make decisions on his own behalf. However, another basic principle of the Mental Capacity Act is the requirement to do everything practicable to support individuals to make their own decisions before it is decided that they lack capacity, including making arrangements for them to have the services of an advocate. Having an advocate could have been beneficial for Harry.

7.26 Notwithstanding the difficulty in assessing Harry's mental capacity, it is regrettable that the assessment process was not persevered with or returned to at a later date. The Local Government Association (LGA) guide to support practitioners and managers "*Domestic Abuse and Adult Safeguarding*" advises that "skilled assessment and intervention is required to judge whether such decisions (which put a person in danger) should be described as unwise decisions which the person has the capacity to make, or decisions that are not made freely, due to coercion and control". (5)

7.27 This review has been advised that CLDT Consultant Psychiatrist 1 considered Harry to be susceptible to coercion. The case of A Local Authority v 'DL' (2012) appears to have established the principle that if the autonomy of a vulnerable adult has been compromised by factors other than mental capacity, including "coercion or undue influence", then the local authority can consider "protective measures". Whilst this is an evolving area of law, it

would have been of value for the multi-disciplinary group of practitioners monitoring Harry's adult safeguarding plan to have considered the extent to which his decision making was affected by coercion, once it had found not to be possible to re-assess his mental capacity in respect of relationships.

7.28 Dorset Healthcare Trust intends to review policies and procedural guidance on Mental Capacity Assessments in order to ensure that relevant staff across a range of agencies have professional knowledge of, and an understanding of the practical application of, these procedures. This is very welcome and fully justified by the learning which has emerged from this review.

7.29 It is recommended that the review of Mental Capacity Act policies and procedures to be undertaken by Dorset Healthcare Trust should encompass the difficulty in undertaking capacity assessments of people who give conflicting answers to questions. It may be possible to develop new, or bring together existing, good practice in this area. The review should also aim to shed light on how best to assess mental capacity where it is believed that the person is in a coercive relationship – as Harry was with Karen - and may be exhibiting an absence of voluntariness rather than an absence of capacity.

7.30 Additionally, it is recommended that the review examine the provision of assistance, including advocacy, to people about whom there are capacity concerns, so that they have access to every practicable support to assist them in making their own decisions. It is recommended that Bournemouth and Poole Safeguarding Adults Board monitor the progress of the Dorset Healthcare Trust Mental Capacity Act review to obtain assurance that the review fully addresses the learning from this DHR/SAR review and subsequently ensure that learning which emerges from the review is shared across the safeguarding adults workforce.

Recommendation 5

(a) That Bournemouth and Poole Safeguarding Adults Board monitor the Dorset Healthcare Trust review of knowledge and application of the Mental Capacity Act in order to gain assurance that the review fully addresses the learning from this DHR/SAR report.
(b) Bournemouth and Poole Safeguarding Adults Board should ensure that the learning emerging from the review is shared across the safeguarding adults workforce.

Sensitivity to disability and gender

7.31 The victim in this case had a learning disability and whilst neither of the perpetrators had a diagnosed learning disability, they both had care and support needs.

7.32 Since the enactment of the Disability Discrimination Act 1995, people with a learning disability have had a legal entitlement to equal access to public services. The Equality Act 2010 places a general equality duty on all public authorities. In the exercise of their functions they are obliged to have due regard to the need to eliminate unlawful discrimination, harassment and victimisation and other conduct prohibited by the Act; advance equality of opportunity between people who share a protected characteristic and those who do not and foster good relations between people who share a protected characteristic and those who do not.

Additionally, due regard must be paid to the need to remove or minimise disadvantages suffered by people due to their protected characteristics; take steps to meet the needs of people with certain protected characteristics where these are different from the needs of

other people and encourage people with certain protected characteristics to participate in public life or in other activities where their participation is disproportionately low.

Disability is a "protected characteristic".

7.33 The broad purpose of the general equality duty is to integrate consideration of equality and good relations into the day-to-day business of public authorities.

7.34 All public authorities have a legal duty to make "reasonable adjustments" to the way they make their services available to people with a learning disability, to make those services as accessible and effective as possible. Reasonable adjustments may include making whatever alterations necessary to policies, procedures, staff training and service delivery to ensure they work equally well for people with a learning disability. (6)

7.35 Notwithstanding the advances made in enhancing legal rights, the past quarter of a century has seen the substantial and wide-ranging health inequalities experienced by people with learning disabilities become increasingly well documented. (7) For example Mencap's 2007 report *Death by Indifference* described the circumstances surrounding the deaths of six people with learning disabilities who died whilst they were in the care of the NHS, exposing "institutional discrimination". (8)

7.36 In 2009 the Equality and Human Rights Commission (EHRC) published a report which concluded that the right to safety and security was a right frequently denied to disabled people. (9) The EHRC report points out that disabled people can be deemed "unreliable witnesses" and refers to a "vacuum of responsibility" arising from a lack of clarity over responsibilities between social care and criminal justice agencies, with the risk that disabled people fall between the cracks. (10)

7.37 The EHRC report implicitly makes the point that a failure to extend the same expectation of safety and security to disabled people that everyone else enjoys is a form of discrimination.

7.38 Arguably Harry's intrinsic vulnerability was increased by a number of acts and omissions which include the following:

- Despite Harry being assessed as lacking mental capacity in respect of financial matters, action to address the risk that he might be exposed to financial abuse within his relationship with Karen was not taken until after he had been financially exploited once (phone contracts) and were insufficient to prevent further financial exploitation (theft from his building society account).

- Despite the fact that it was identified that it would be a sensible step for the Borough of Poole to act as Harry's appointee in respect of his financial affairs once he had been assessed as lacking capacity in financial matters in 2013, this had still not been actioned by the time of his death in May 2015.

- Awareness of the vulnerability of people with learning disabilities and the barriers to them seeking help did not appear to be appreciated by the IDVA service. In particular, it appears that written materials provided by IDVA were not available in "easy read" format.

- The needs of Harry, and to an extent Karen when she complained of rape by John, may not have been fully recognised when they provided accounts of what had happened to them which did not always appear credible. It is unclear whether any adjustment was made for the possibility that a person with a learning disability might not always give an account which was logical and ordered (11).

- The police officer who dealt with the text messages threatening to kill Harry which were sent to him by Karen and John on 13th May 2015, considered that Harry would not be a good witness in any court proceedings as he was easily led and this appeared to be a factor in the officer's decision to deal with the case informally (Paragraph 5.79). The officer appeared to be unaware of the special measures, such as the practice of using intermediaries, allowed in court to assist witnesses whose quality of evidence is likely to be diminished because they have a significant impairment of intelligence and social functioning.

7.39 Several agencies appeared to operate from a mindset that a person with a learning disability should be expected to follow advice to stay away from someone who posed a risk to them. People with a learning disability are susceptible to behaving unwisely as are people without a learning disability. People with a learning disability can find themselves in relationships in which they are subject to coercive control as can people without a learning disability. However, research suggests that there are additional impacts of domestic abuse on people with care and support needs which agencies need to be aware of. These additional impacts include increased powerlessness, dependency and isolation, and perpetrators often use forms of abuse that exploit, or contribute to the abused person's impairments (12).

7.40 When they contributed to this review, Harry's parents said that they simply did not realise the severity of the situation Harry was facing. Harry's father said that a month or so before he died Harry rang him to say that Karen and John were trying to kill him. His father said he thought it was "just kid's stuff" and decided not to intervene. It is possible that professionals inadvertently took a similar approach and had a mind set which played down the seriousness of the threats being exchanged. There is a hint of "infantilisation" in professional responses to Harry's concerns. For example, when the details of the 20th May 2015 incident in which Harry was locked in Karen's flat were shared with TCD and CLDT, there seemed to be undue professional attention paid to chastising Harry for destroying his phone and advising him that it would not be replaced quickly and any replacement may have less features.

7.41 Research indicates that disabled women may be assaulted or raped at a rate that is at least twice that of non-disabled women (13). However, the statistics collected by CAADA about people identified as being of high risk of domestic abuse shows relatively low numbers of people with health and social care needs which suggests that for this group, domestic abuse is even more under reported or recognised than in the general population (14). There has been insufficient research to clarify whether men with health and social care needs – such as Harry - are more likely to be abused than non-disabled men.

7.42 As stated above, all public authorities have a legal duty to make "reasonable adjustments" to the way they make their services available to people with a learning disability, to make those services as accessible and effective as possible.

7.43 This review has highlighted examples of services in which "reasonable adjustments" have yet to be made, such as the IDVA service; services in which there is a lack of staff

awareness of existing "reasonable adjustments" such as police officer awareness of the availability of intermediaries to assist witnesses with communication difficulties in court, and services where reasonable adjustments were made or considered only after a foreseeable problem had come to light, such as TCD, and the Borough of Poole in response to the financial abuse of Harry.

All agencies which have contributed to this review are invited to reflect on the services their agency provided to Harry and the services they currently provide to people with learning disabilities.

7.44 The concept of hate crime arose out of the need to focus extra attention and awareness on crimes targeted against a person because of hostility or prejudice towards the person's disability, race or ethnicity, religion or belief, sexual orientation or transgender identity.

7.45 In Dorset there is an excellent "easy read" hate crime factsheet and an innovative hate crime app developed by the police and Bournemouth and Poole Councils. Yet disability hate crime does not appear to have been an option considered by Dorset police or their partners when investigating the threatening texts received by Harry.

7.46 Turning to gender, it is worth considering whether Harry would have been treated any differently had he been a female in an abusive relationship with a male in which the female was being emotionally abused, financially exploited and where concerns existed that sexual intercourse was not entirely consensual. Might the situation have generated a more robust response? Any attempt to answer this question is complicated by Harry's learning disability which arguably had a much more profound impact on the way in which he was viewed by practitioners than did his gender.

7.47 However, there is a hint of trivialisation in the responses of the police to Harry's reports of threats from Karen. And only one MARAC referral was made in respect of Harry and the outcome was that his high risk of domestic abuse was to be addressed via an adult safeguarding plan. It is not known how often this outcome is chosen when female victims of domestic abuse are considered by MARAC. It was not an option apparently considered when Karen was referred to MARAC as a victim. And whilst the risk of domestic abuse remained a very active concern for practitioners, Harry was facing the risk of being evicted from his supported living accommodation partly because of "the number of incidents where the police were called due to acquaintances (he had) befriended". These acquaintances presumably included Karen and John.

7.48 Additionally, assumptions based on gender may have influenced the decision to view Karen as the victim and John the perpetrator in the MARAC referral made after the incident on 18th May 2015 after both had been arrested and charged with assaulting each other.

Sexual Exploitation of vulnerable young people and adults

7.49 John was a predator who sexually exploited both children and adults with care and support needs. Individual agencies gradually began to appreciate that John presented a risk to the vulnerable young people and adults he associated with although the absence of any organised sharing of information about him prevented agencies from gaining a fuller understanding of the threat he posed. It is also possible that the vulnerability of some of his victims may have limited their capacity or confidence in reporting John's behaviour to, or in

being believed by, the authorities. The failure to recognise and address John's predatory behaviour exposed Harry and others to risk for longer than should have been the case.

7.50 *Unprotected, Overprotected: meeting the needs of young people with learning disabilities who experience, or are at risk of sexual exploitation* (2015) found that the needs of children with learning disabilities who experience, or who are at risk of sexual exploitation were frequently not fully recognised and largely unmet (15). The report, which was undertaken by Barnardo's and others, issued a number of challenges to Local Safeguarding Children Boards including ensuring that the needs of young people with disabilities are included in mapping of prevalence of child sexual exploitation, considered in assessments of the effectiveness of multi-agency responses and that services for children and young people at high risk of sexual exploitation are able to identify and support children and young people with learning disabilities.

7.51 In meeting the challenges contained in *Unprotected, Overprotected*, Bournemouth and Poole Local Safeguarding Children Board may be assisted by considering the learning from this review, particularly the manner in which John targeted young people with learning disabilities or other care and support needs and the issues which appeared to inhibit partner agencies in collaborating effectively to address his predatory behaviour.

Recommendation 6

That this report is shared with both Bournemouth and Poole Local Safeguarding Children Board and Dorset Local Safeguarding Children Board in order that they can consider the learning from this review about the sexual exploitation of children with disabilities including learning disabilities.

7.52 John's behaviour has also shed light on a "model" for the sexual exploitation of adults with care and support needs in which primarily young adults were sexually and financially exploited by a predatory male who was either homeless or experiencing accommodation instability and may also have had care and support needs which may have partially obscured his status as a predator. It is unknown how many more "Johns" there are out there but it is suggested that this is an area which would benefit from further exploration, whether by prevalence study, research or other means in order to raise awareness and develop policy in this area. It is therefore recommended that Bournemouth and Poole give consideration as to how to further explore this model of sexual exploitation.

Recommendation 7

That Bournemouth and Poole Safeguarding Adults Board examines the insights gained from this review into the sexual exploitation of adults with care and support needs and considered how best to advance the further exploration of the "model" of sexual exploitation apparent in this case.

MAPPA

7.53 For a person to be referred to the MAPPA process, there has to be a qualifying conviction or caution. A number of serious allegations were made against John, including three allegations of rape by separate victims. However, the absence of cautions and convictions arising from these and other allegations may have been regarded as a bar to consideration of MAPPA by some agencies. In the event this review has been advised that John did have "qualifying convictions". It is however recommended that Poole Community

Safety Partnership seeks assurance that all agencies involved in the MAPPA process are clear about the criteria for making referrals to MAPPA, particularly where concern about the risks presented by an offender rely on multiple allegations rather than cautions of convictions.

Recommendation 8

That the Dorset MAPPA Strategic Management Board seeks assurance that all agencies involved in the MAPPA process are clear about the criteria for referral to MAPPA where the concerns about the risks to public safety the individual is believed to present are based primarily upon multiple allegations rather than cautions or convictions.

The role of the police in safeguarding adults

7.54 Safeguarding meetings in respect of Harry tended to be multi-disciplinary, in that they were limited to health and social care, rather than multi-agency. The police did not appear to have been generally invited.

7.55 The police appeared to work in isolation from key partner agencies to address the risks faced by Harry. They acknowledge that many of the incidents reported to them by, or in respect of Harry appeared to have been dealt with on an individual basis, restricting the opportunity to make links between incidents and bring the bigger picture into view. This may have contributed to the delay in their, and partner agencies', realisation that John presented risks to a range of adults and young people who could be considered vulnerable in some way. The police also acknowledge that the responses to the individual incidents involving Harry lacked consistency and frequently reflected a lack of knowledge of policy and procedure.

7.56 If this case is in any way typical of their engagement with the safeguarding adults agenda, it is in marked contrast with the police's very active and automatic involvement in the safeguarding *children* arrangements in respect of Karen's unborn baby. The police appear to be very clear about the need to "raise their game" in order to fulfil their statutory duty as one of three core partners in arrangements to safeguard adults and their single agency action plan strongly reflects this. However, this is such an important issue that a recommendation that the police fully engage in safeguarding adults agenda is merited.

Recommendation 9

That Dorset Police review their safeguarding adults policies and practice in the light of this report in order to provide assurance to Bournemouth and Poole Safeguarding Adults Board that they are fully engaged in the safeguarding adults agenda at all levels and fully compliant with the requirements of the Care Act 2014.

The role of the providers of care and support

7.57 The Care Division (TCD) was commissioned by the Borough of Poole to provide 20 hours of care and support per week for Harry which was increased to 23.5 hours in October 2014. As the agency in most regular contact with Harry, they had a vital role to play in safeguarding him from abuse, including domestic abuse. However, in their contributions to this review, it is apparent that TCD perceived themselves to be unequal partners who were able to exert little influence over the statutory agencies with which they worked to safeguard Harry. This is concerning as the Care Act statutory guidance makes clear that strong multi-agency partnerships are essential in order to provide timely and effective

prevention of, and responses to, abuse or neglect. (Care Act 2014 statutory guidance paragraph 14.12)

7.58 The Care Division also say that information was not adequately shared with them, particularly about the risks that Karen and John presented to Harry and that, apart from the increase in commissioned hours referred to in the paragraph above, their requests for additional support for Harry were regularly declined. Reflecting on their learning from this case, TCD propose a formal escalation process where a partner agency has safeguarding concerns which they do not feel have been adequately addressed. This is a helpful suggestion which appears in the single agency recommendations at Appendix A of this report. However, such an escalation process would deal only with exceptional cases. For day to day safeguarding to be effective, "strong multi-agency partnerships are essential". It is the responsibility of all agencies, whether statutory, private, voluntary or independent to contribute to strong multi-agency partnerships. Therefore, it is incumbent upon all agencies which worked together to safeguard Harry to reflect upon what more they could do to ensure that multi-agency partnership working is as strong and effective as possible in the future.

Assessment and mitigation of risk

7.59 Risk assessment in respect of Harry appeared to be frequently reactive and insufficiently fluid. For example, Harry had been assessed as lacking capacity to make decisions about financial matters in March 2013 but this assessment was not recorded and shared with partner agencies until December 2014. Arrangements for the Borough of Poole to fulfil the role of appointee in respect of Harry's affairs had still not been put in place at the time of his death. Had these arrangements been put in place promptly, they might have helped the Nationwide Building Society to prevent the theft of cash from Harry's account by Karen and John in November 2014.

7.60 The protection plan and protocol devised by TCD to keep Harry safe, which was agreed with Poole Safeguarding, is a practical one page document which was designed to provide a step by step guide to TCD staff to help them keep track of Harry's whereabouts and specifies the circumstances in which a missing person report would be filed with the police. It specifically relates to Harry's relationship with Karen. It contains no mention of John who was not identified as a threat to Harry until later, or Gina who became a threat to Harry for a time in the following year. It is unclear how frequently the protection plan and protocol was updated, if at all.

7.61 The Borough of Poole adult safeguarding plan for Harry appears to have been the vehicle through which a range of professionals – primarily from Poole CLDT and TCD – strove to safeguard Harry. The plan makes no specific reference to domestic abuse, although risk to Harry is articulated as "some controlling behaviour from his girlfriend" Karen. The plan goes on to state that Harry had reported that she has forced him into sexual acts that he did not want to do" and "forced him to spend money on her and also convinced him to upgrade both of their mobile phones that he was not wanting to do". There is no reference to John, the theft of cash from Harry's building society account by John and Karen and there is no reference to Gina who appears to have begun to present a threat to Harry from January 2015.

7.62 The plan appeared to drive some activity, though not with a great deal of urgency. The long running issue of Borough of Poole assuming the role of appointee for Harry's financial affairs was included in the list of actions which required attention.

7.63 The question marks over the effectiveness of this adult safeguarding plan assume greater important given that Poole MARAC decided that the high risk of domestic abuse Harry faced from Karen would be addressed via that plan.

7.64 Agencies involved in supporting Harry remained focussed on the risks arising from his relationship with Karen until the end of his life. There was little focus on safeguarding Harry from Karen *and* John. John *and* Karen began to emerge as a threat to Harry from November 2014 when both of them were involved in the theft of money from him, although lack of evidence against John meant that only Karen was prosecuted. In December 2014, Karen's support worker highlighted the relationship between Karen and John as a potential threat to Harry. She was concerned that John may be abusing and manipulating Karen and that she, in turn, may be manipulating Harry. Karen's support worker also pointed out that John was known to the police for a number of offences for which he had never been prosecuted. Whilst the threat that Karen and John jointly presented to Harry was most strongly visible only in the final month of his life, indications of this threat were apparent from November 2014.

7.65 The failure of TCD and Poole CLDT to escalate concerns about the 20th May 2015 incident in which Harry was locked in Karen's flat in circumstances which were very similar to the circumstances of his murder six days later is concerning. As previously stated this incident represented an escalation of the risks faced by Harry which is very clear in hindsight but was not apparent to a range of professionals from different disciplines at the time.

7.66 This failure is one of several indications of a lack of appreciation of risk. Managing risk over a fairly lengthy period requires a watchful approach in which staff are attuned to notice differences or variations from the norm. In Harry's case staff appeared to become de-sensitised to the risks he faced. The number and frequency of threatening texts received by and sent from Harry probably contributed to this. The 20th May 2015 incident was not the first time Harry had been locked in a flat or room by Karen but it should have been recognised as a change in the pattern of events which merited escalation.

7.67 There also seemed to be a lack of a "whole system" approach to risk in that TCD carried quite a substantial share of the burden of the risks Harry faced. One wonders whether TCD staff were asked to operate at or beyond the edge of their capability at times?

7.68 There is a case for any training and briefing of staff which takes place as a result of this review to have at least a partial focus on the understanding and mitigation of risk.

Recommendation 10

That Bournemouth and Poole Safeguarding Adults Board and Poole Community Safety Partnership ensure that the learning from this case is widely disseminated and informs single and multi-agency training. They should ensure that understanding and mitigating risk should be a key focus of dissemination of learning and training arising from this review.

Social Media

7.69 A prominent factor in this case is the extent to which social media was used as a means of making contact, initiating and maintaining relationships and making threats.

7.70 Social media offers many life enhancing opportunities for people with learning disabilities such as the freedom to interact with others without their disability "getting in the way", reducing social isolation, broadening the horizons of people with mobility issues or who are fearful about going out and improving literacy skills.

7.71 As this case demonstrates, unsafe use of social media by a person with a learning disability can expose them to risk. This places a strong emphasis on those supporting people with a learning disability to be aware of how to support them in the safe use of social media. Any organisation employing people who support people with learning disabilities need a social media policy underpinned by training so that staff are confident and well equipped to provide support in this area.

7.72 It is unclear whether TCD had an effective social media policy or made use of resources designed to help people with learning disabilities use social media safely. Harry's adult safeguarding plan makes reference to (unspecified) attempts being made to restrict his access but that he "continually created new Facebook accounts etc. as a way around this". It is not known whether any other action was taken to mitigate the risks from social media, such as a contract of behaviour with Harry to self moderate his use of social media.

7.73 There is much valuable guidance available online which provides advice for people with learning disabilities and those who support them which aims to help them use social media safely. Additionally, many apps have been developed with the needs of people with learning disabilities in mind.

Recommendation 11

That Bournemouth and Poole Safeguarding Adults Board promotes the wide dissemination and use of resources including "easy read" materials to increase awareness of safe use of social media amongst people with learning disabilities and the range of partner agencies which provide support to people with learning disabilities.

Information sharing

7.74 There were a number of information sharing challenges highlighted by this review. Improvements in information sharing are likely to flow from implementation of some of the recommendations set out above. Additionally, a number of the single agency recommendations shared with this review also address the need to improve information sharing. Rather than add an additional recommendation on information sharing, it is suggested that in monitoring progress against the Overview Report recommendations and the single agency recommendations, Poole Community Safety Partnership and Bournemouth and Poole Safeguarding Adults Board challenge agencies to demonstrate how the action they have taken in implementing those recommendations improves the effectiveness of information sharing.

Financial abuse

7.75 The apparent ease with which Karen and John were able to gain control of Harry's building society account raises concerns about how well our banks and building societies safeguard their vulnerable customers from financial abuse. The Nationwide Building Society has advised this review that they were unaware of Harry's learning disability. There was no appointee in place to help Harry manage his financial affairs. As such the Nationwide say that they were not in a position to implement any of the necessary steps to support Harry.

The Nationwide Building Society has advised this review that they have established a specialist support team to meet the needs of customers who require additional help and support. They plan to expand the remit of this specialist support team to encompass the needs of customers who lack mental capacity and who may be at risk of financial abuse.

Escalation policy for agencies to raise concerns where disagreement exists

7.76 The absence of defined arrangements for the escalation and resolution of concerns where professional disagreements arise was highlighted by TCD in the IMR they contributed to this review. Given the complexities which can arise in decision making over adult safeguarding, it would seem prudent to develop a multi-agency procedure which sets out how professional disagreements will be resolved. The Care Act statutory guidance advises that adult safeguarding procedures *may* include how professional disagreements are resolved. (Paragraph 14.41 Care and Support Statutory Guidance)

Recommendation 12

That Bournemouth and Poole Safeguarding Adults Board oversees the development of a multi-agency procedure which enables professional disagreements to be escalated and resolved.

National repository for SARs

7.77 This case is similar to earlier SAR or SAR equivalents in which adults who were vulnerable in some respects were murdered by people they regarded, or had regarded, as friends. These similar cases also featured the perpetrators exploiting the vulnerability of victims to an extent. An underlying issue in this case is the challenges involved in ensuring the safe transition from children's services to adult services of a Looked After Child. This is an issue which frequently features in SARs.

7.78 Safeguarding Adults Board were placed on a statutory basis by the Care Act 2014 as was the requirement of Boards to carry out SARs where the criteria for commissioning them are met. It seems reasonable to anticipate an increase in the number of SARs being completed across England and Wales as a result. Currently there is no national repository for SARs to enable learning to be shared more widely and for recurring issues, such as so called "mate crime" and transition from children's to adult services, which feature to an extent in this case, to be more readily highlighted. The NSPCC maintains a national library of Serious Case Reviews completed by Local Safeguarding Children Boards and the Home Office monitors Domestic Homicide Reviews and periodically publishes papers which draw attention to emerging themes. No such arrangements exist in respect of SARs. It is therefore recommended that Bournemouth and Poole Safeguarding Adults Board writes to the Department of Health to recommend they consider making arrangements for a national repository for SAR reports.

Recommendation 13

That Bournemouth and Poole Safeguarding Adults Board writes to the Department of Health to recommend that the Department considers making arrangements for a national repository for SAR reports in order that the learning emerging from SARs is more readily accessible to the safeguarding adults community across England and Wales.

8.0 To what degree could the homicide have been accurately predicted and prevented?

8.1 In terms of considering whether the homicide could have been predicted, the test used is that it is considered that the homicide would have been *predictable* if there was evidence from the perpetrators' words, actions or behaviour at the time that could have alerted professionals that they might become violent imminently, even if this evidence had been unnoticed or misunderstood at the time it occurred.

8.2 In terms of the test used for preventability, it is considered that the homicide would have been *preventable* if there was evidence that professionals had the knowledge, the legal means and the opportunity to stop the violent incident from occurring but did not take the steps to do so. Simply establishing that there were actions that could have been taken would not provide evidence of preventability, as there are invariably things which could have been done to prevent any tragedy.

8.3 Professional concern that Harry was at risk as a result of his relationship with Karen triggered two safeguarding alerts, a MARAC referral and a later further referral to the IDVA service. There was considerable and longstanding professional concern that Harry was putting himself at risk of financial, emotional and physical abuse as a result of his relationship with Karen.

8.4 Partner agencies took action to safeguard Harry. In August 2014 TCD developed a protection plan and protocol to which the CLDT signed up. In September 2014 the CLDT developed a safeguarding plan for Harry. Harry was referred to MARAC as being of high risk of domestic abuse in August 2014 where it was decided that the risks faced by Harry as a result of his relationship with Karen would be managed through the aforementioned adult safeguarding plan.

8.5 Whilst Poole's adult safeguarding plan for Harry addressed the controlling behaviour of Karen as a key risk, the plan was not updated to reflect changes in the risk that Harry faced. The plan contains no reference to the emerging risks presented by John or subsequently Gina. Whilst the plan acknowledged that Harry's relationship with Karen was on/off, there appeared to be insufficient appreciation that the risk of domestic abuse could increase at a time of separation. There was no reference to the theft of cash from Harry's building society account and there appeared to be no urgency to arrange for the Borough of Poole to assume the role of appointee in respect of his financial affairs. The plan appeared to be static whereas the risks Harry faced evolved. Importantly, the police do not appear to have had any involvement in the safeguarding plan nor was the plan apparently shared with them.

8.6 The IDVA service was offered, but did not take up, the opportunity to work with Poole Safeguarding to ensure the adult safeguarding plan addressed the domestic abuse risks Harry faced. Nor did Poole MARAC seek assurance that the adult safeguarding plan for Harry addressed the domestic abuse risks he faced as a result of his relationship with Karen.

8.7 There appeared to be a widely held assumption that the risks Harry faced as a result of his relationship with Karen could be satisfactorily managed through the Adult Safeguarding plan. This assumption was what is sometimes described as a "load bearing assumption", (Dewar 2002) in that if that "load bearing" assumption is found to be faulty in any way, then other assumptions are put at risk. In Harry's case there was an assumption that the adult

safeguarding plan was an effective vehicle for keeping him safe from a number of risks, including the risk of domestic abuse. This does not appear to have been the case.

8.8 Complementary to the adult safeguarding plan was the TCD protection plan and protocol. This was a practical document giving step by step guidance to TCD staff, but was far from comprehensive and, in common with the adult safeguarding plan, did not appear to be updated in any way from the time that it was originally drawn up in August 2014.

8.9 And TCD staff, who were a critical part of efforts to safeguard Harry, continued to assume that he had capacity to make decisions in respect of relationships, including his on/off relationship with Karen. Representations from TCD staff and other professionals had led to a request for a second assessment of Harry's capacity to make decisions about relationships in the light of concerns that he may be being exploited and coerced in his relationship with Karen. It is regrettable that this capacity assessment was not undertaken because Harry's inconsistent answers to the questions put to him frustrated the assessment of his capacity to the point where it was not considered possible to undertake the test. Thus professionals assumed capacity which had a limiting effect on the range of measures which could be contemplated in order to safeguard Harry.

8.10 The risks faced by Harry appeared to escalate in the last two weeks of his life. On 13th May 2015 he received text messages from Karen and John in which they threatened to kill him. The police response was delayed by two days, and having decided to handle the threats informally, they did not follow through on their commitment to warn John and Karen about their conduct.

8.11 The incident on 20th May 2015 in which Harry appeared to have been pressured into meeting Karen and John by an incessant stream of texts, together with an element of trickery, then taken to Karen's flat, locked in, prevented from leaving, and physically threatened by John, was an event which bore a number of similarities to the circumstances of Harry's murder in Karen's flat six days later.

8.12 After he managed to leave Karen's flat on 20th May 2015, Harry smashed his phone. When he later discussed the incident with a TCD care worker, he said he had smashed the phone out of frustration at being delayed. This may have been true but it is also possible that he may have smashed his phone out of fear, as his phone was the primary method by which Karen and John threatened and intimidated him and were able to persuade him to do things he may have not wanted to do, such as meeting them on 20th May 2015.

8.13 And Harry was noted to be extremely anxious when he was accompanied by a TCD care worker to visit his GP for a DNA test the following day. He was noted to be worried about taking the test because he was concerned about how Karen, and particularly John, would respond to the news that he (Harry) was the father of Karen's child, if that is what the test revealed. He also disclosed that John possessed a knife to his TCD care worker whilst at the GP surgery.

8.14 The escalation of risk to Harry in the final two weeks of his life seems clear in hindsight. However, it is unlikely to have been clear to professionals who were in contact with him at the time. That said, when Harry related what had happened to him at Karen's flat on 20th May 2015, it should have rung alarm bells with the two TCD care workers he separately informed on 21st May, the TCD care worker he told about it on 24th May 2015, and Poole CLDT who were advised of the incident on 21st and 22nd May 2015 by TCD. Any or all of the professionals who became aware of the incident should have raised a safeguarding

concern and contacted the police. This did not happen. Additionally, the fears expressed by Harry when visiting his GP on 21st May 2015 could have been linked to the incident at Karen's flat the previous day and escalated. And when Karen told her Dorset 16 plus leaving care team support worker on 20th May 2015 that John wanted to hurt or kill Harry nothing appears to have been done with this information either.

8.15 It is not possible to say with certainty what would have happened if the police had dealt with the threats Harry received on 13th May 2015 more effectively and had the range of professionals who were aware of the 20th May 2015 incident escalated matters appropriately but clearly there would have been opportunities to arrest Karen and John for offences including false imprisonment, and take action for their breach of bail conditions by being in contact with each other. Had there been robust responses to the 13th May and 20th May 2015 incidents, Harry's subsequent murder may have been prevented.

8.16 However, it is not possible to conclude that the murder of Harry was predictable. His murder was certainly imaginable. There have been a number of Safeguarding Adult Reviews (or equivalent) conducted into cases where adults with a disability have been murdered by people with whom they were, or had been, in an intimate relationship or with whom they believed themselves to be friends. However, whilst Harry experienced a very frightening experience at the hands of Karen and John on 20th May 2015, which clearly left him very fearful, he was not physically harmed. Although there is a great deal of similarity between how Karen and John behaved towards Harry on 20th May 2015 and when they murdered him six days later, there is quite a distance between threatening a person with violence and actually stabbing them to death.

8.17 Both Karen, and particularly John had shown themselves to be capable of violence in the past and it was alleged that John carried a knife. John had been accused of three rapes in which a degree of physical force was apparent. He preyed on vulnerable people such as Harry, but a capacity for extreme violence had not previously been exhibited.

8.18 It seems abundantly clear that there was "evidence from the perpetrators' words, actions or behaviour at the time that could have alerted professionals that they might become violent imminently", however professionals could not have predicted that any violence that Karen and John might use against Harry could include fatal violence.

8.19 Although this domestic homicide was not predicable it may have been preventable. There is undoubtedly evidence that "professionals had the knowledge, the legal means and the opportunity to stop the violent incident from occurring but did not take the steps to do so". The police should have intervened more robustly when Harry reported the threats from Karen and John to them on 13th May 2015. TCD care workers and Poole CLDT should have taken steps to escalate matters when they became aware of the incident which took place on 20th May 2015. These were key opportunities to intervene which seem likely to have afforded Harry greater protection and may have restrained the behaviour of Karen and John for a time.

8.20 Tragically for Harry and his family these opportunities were not taken.

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(12) ibid.

(13) ibid.

(14) ibid.

(15) Barnardo's et al (2015) Unprotected, overprotected: meeting the needs of young people with learning disabilities who experience, or are at risk of, sexual exploitation

Appendix A

Process by which this review conducted including membership of DHR/SAR Panel

This combined Domestic Homicide Review and Safeguarding Adults Review largely followed the statutory guidance which applies to the former type of review.

A joint DHR/SAR Panel was established to oversee the work necessary to conduct the combined review. The membership of the Panel was as follows:

Jane Ashman Independent Chair of Panel
Detective Superintendent, Dorset Police
Domestic Abuse Co-Ordinator, Poole Community Safety Partnership
Safeguarding Adult Lead, Dorset HealthCare
Business Manager, Bournemouth and Poole Safeguarding Adults Board Service
Manager, Dorset County Council Safeguarding Adults Team
Head of Patient Safety & Risk, Dorset Clinical Commissioning Group
Service Manager, Adult Disability, Bournemouth Borough Council
Service Unit Head, Adult Social Care-Services, Borough of Poole
David Mellor Independent Author

Individual Management Reviews (IMR) were provided by the following agencies:

- Borough of Poole Adult Social Care
- Borough of Poole Children's Social Care
- Borough of Poole Housing and Community Services
- Bournemouth Churches Housing Association (providers of the Independent Domestic Violence Advisors (IDVA) service during the period covered by this review)
- Bournemouth Children's Social Care
- Bournemouth Strategic Housing
- Dorset Children's Services
- Dorset NHS Clinical Commissioning Group (CCG)
- Dorset Healthcare University NHS Trust
- Dorset Police
- Poole Housing Partnership Ltd.
- The Care Division

Additionally, contributions were made by Bournemouth and Poole College, Streetwise and Yeovil Hospital from whom it was not considered necessary to commission IMRs. All IMRs were completed to at least a satisfactory standard. In general, IMRs were thorough and generated a large number of single agency recommendations.