Introduction to the Safeguarding Adult Review and Domestic Homicide Review into the death of 'Harry'

A combined Safeguarding Adult Review and Domestic Homicide Review has been completed following the death of Poole resident, 'Harry' in May 2015.

Harry died in Bournemouth on 26 May 2015 aged 22. The two perpetrators, named Karen and John throughout the review, were convicted of his murder and sentenced to life imprisonment.

It was tragic that Harry lost his life in these circumstances and on behalf of the Safeguarding Adults Board I would like to express sincere condolences to his parents and wider family members.

The Combined Review

Following his death, a decision was made for Poole Community Safety Partnership (CSP) to carry out a Domestic Homicide Review (DHR) due to the intimate relationship between the victim and one of the perpetrators. A Safeguarding Adult Review (SAR) was also commissioned by the Bournemouth and Poole Safeguarding Adults Board (SAB) as Harry was receiving care and support and there was concern that partner agencies could have worked more effectively to protect him.

It was agreed that both reviews should be carried out together as whilst the DHR would provide a thorough and challenging review and identify learning in order to improve practice, it was felt that the SAR findings from both the health and social care perspective would also provide additional learning.

The combined review can now be published following the conclusion of an Inquest Hearing on March 8th.

The overall conclusion of the combined review completed in December 2016 stated that 'although this domestic homicide was not predictable it may have been preventable. There 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.

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

The independent author of the review made 13 recommendations for the Safeguarding Adults Board and the Community Safety Partnership. Work undertaken to implement these recommendations is set out in the multi-agency action plan.

The Inquest

An inquest was opened in February 2019 as the Senior Coroner determined that Article 2 of the Human Rights Act was engaged. Having heard evidence directly from witnesses, a conclusion of unlawful killing was recorded.

The jury believed that Harry's learning disability was a contributing factor to his death "because it was reported that he was easily led, a suggestible and vulnerable adult who wanted to please. This left him susceptible to manipulation, abuse and unable to fully assess the risk posed to him.

Although he was told not to have contact with certain people, he still chose to have contact with his ex-girlfriend and her current partner.

There is evidence that there was a lack of communication despite a Protection Plan being in place.

Although he was under the care of a multiple professional team he was still susceptible to be put in positions of manipulation and abuse."

Responses to the combined review

The organisations represented on the Safeguarding Adults Board have accepted and been implementing the conclusions of the SAR/DHR. They have each developed improvement plans to seek to prevent further tragic events occurring in these circumstances. Individual agency responses are described in more detail in the appendices provided by

- Borough of Poole Adult Social Care
- Dorset Police
- Dorset County Council

In addition the SAB and CSP have worked closely together to integrate the approaches to adult safeguarding and prevention of domestic violence through the Multi Agency Risk Assessment Conference (MARAC). Actions from the review of the MARAC arrangements are set out in response to recommendation 3 of the multi agency action plan, but include:

- Clear guidance to staff in the multi agency procedures (appendix 6) concerning joint working between Safeguarding Adult Services and MARAC.
- The appointment of a Business Manager in MARAC to improve coordination of the process
- Business Managers and training leads of the SAB, Safeguarding Children Boards and the CSPs meet regularly to develop a combined approach to embedding shared lessons from reviews
- A training framework has been developed for adoption by statutory agencies which addresses the lessons learned from reviews in terms of risk assessment, risk management and information sharing

Learning

A number of important themes for learning and improvement have been highlighted through the review.

- Information sharing
- Risk assessment and management
- Mental capacity
- Engagement with the perpetrators
- The impact of social media
- Mate crime

Information sharing

It is important that all agencies accurately record information when a person is at risk and share this with partners also involved with the individual. When an incident such as threats to Harry occurred, each episode was treated separately which limited the ability to build a picture of the seriousness of the risk he was facing.

A safeguarding plan was in place, but a revised protection plan was not shared with the Police. The Care Division, an independent provider that was supporting Harry in the community, did not share photographs of the text threats with the Police at a critical point.

John was believed to be an individual who took advantage of vulnerable people and serious sexual allegations had been made against him, which did not proceed to a caution or conviction. He was subject to Police bail for an allegation of rape. This information was not shared more widely.

Although a number of agencies were in contact with Harry, no one had a complete picture of the risks that were building in the last weeks of his life.

What action has been taken

An improved Personal Information Sharing Agreement between agencies has been implemented through the Safeguarding Adults Board, which strengthens staff authority to share information with partners.

Adult social care audits evidence good levels of communication and information sharing in cases reviewed. A specialist safeguarding team has been created which reviews all safeguarding referrals, manages the most complex cases and provides advice, information and support to other teams.

Dorset Police have implemented a new system of public protection notices which are shared with adult social care when an adult safeguarding enquiry is judged to be necessary.

Meetings have been held with independent providers at which the Chair of the SAB has emphasised the importance of gathering and sharing information about risks to adults in their care.

Risk assessment and management

MARAC and safeguarding procedures were both operating in respect of Harry and Karen, but the meetings were not integrated. A safeguarding plan was in place but the range of risks faced by Harry were not sufficiently assessed.

The risks to Harry escalated when John became involved with Karen. Shortly before his death Harry was held against his will in Karen's flat, but the implications of this were not recognised.

It is critical that risk management plans are dynamic and revised when circumstances change.

What action has been taken

Multi Agency Risk management Meetings (MARMs) are now held on a regular basis. These bring together those agencies involved with a person to share information and develop a

more comprehensive plan to minimise risks to them. Clear guidelines for carrying out these meetings are embedded in the multi agency procedures.

A MARM is also called for victims of domestic abuse where a MARAC has been engaged on 3 occasions, bringing a focus on higher risk situations where it is proving difficult to reduce risk.

Adult social care auditing shows an improvement in use and documentation of risk assessments and risk management plans.

A further independent audit has been commissioned by the Safeguarding Adults Board to examine the effectiveness of agency responses to people with a learning disability who are victims of domestic abuse.

Mental capacity

There were questions concerning Harry's mental capacity. Although he had earlier been assessed as having capacity to engage in a sexual relationship, staff were concerned at the impact of the relationship with Karen and he was referred for a further assessment in November 2014. It was concluded that there was no clear evidence that he did not have capacity. Staff therefore had to assume capacity and faced dilemmas concerning how far to seek to restrict his choices concerning relationships.

A further assessment in 2015 could have examined specifically whether Harry had capacity to protect himself from the increasingly serious threats which were being issued firstly by another woman, named Gina in the review, and subsequently John and Karen.

What action has been taken

Dorset Healthcare has updated its relevant Policies to reflect the expectations of staff around Consent and Capacity. Mental Capacity Act training is required of all target staff in Community Mental Health Teams. Staff review consent and where necessary undertake best interest assessments.

DHC has further reviewed its MCA policy to include guidance on the actions to take when a service user gives differing answers during a mental capacity assessment.

Adult social care staff consistently consider an individual's mental capacity during a safeguarding enquiry and where appropriate take advice about other legal measures available to protect an individual.

Engagement with the perpetrators

Karen had been in the care of Dorset County Council. Her transition from children's to adult services was problematic and there was no clear plan for where she would live when she left care. She subsequently moved around between local authorities and proved difficult to engage.

Although he had not been in care, John also presented a level of emotional ill health. He threatened suicide on a number of occasions and the Police and ambulance services were

called out to him. There was no coordinated plan to address either the risk he posed to others or his own needs.

He would have been eligible to be considered under MAPPA (Multi Agency Public Protection Arrangements) but this was not recognised at the time.

What action has been taken

The Children and Social Work Act 2017 requires authorities to extend the time care leavers can choose to have a personal advisor until their 25th birthday, enabling them to better develop the necessary skills to make a successful transition to adulthood. Dorset County Council has restructured its children's services to create a 13+ service and monitors Care and Pathway plans on a weekly basis.

Work has been commenced led by the Police within the Safeguarding Adults Board to enable better identification of perpetrators who may pose a risk to vulnerable adults.

Quarterly training events concerning MAPPA are held with good take-up by a variety of agencies. The new MARM process would now be another vehicle by which John's risk and need could have been assessed.

Impact of social media

Harry first made contact with Karen on line. They met 2 days later and over time formed an intimate relationship. Karen became pregnant and Harry was unsure if he was the father of her child. Once Karen formed a relationship with John, Harry was subject to frequent bullying and abuse by text on his phone, including messages threatening to kill him.

What action has been taken

The risks of social media are being addressed through the Bournemouth and Poole Learning Disability Partnership Board, working jointly with self advocates and carers, identifying the best resources available to tackle these risks. Dorset Police have been involved to advise people with learning disability on how to keep safe online. This theme remains part of the Bournemouth and Poole Learning Disability Partnership's Keeping Safe work plan and an event is planned for 2019 focussing on social media exploitation and domestic abuse.

The Safeguarding Adults Board highlighted the risks of social media to a person with learning disability and how they should be reported through its poster campaign in 2017.

Mate crime

Mate crime is a form of crime in which the perpetrator befriends a vulnerable person with the intention of then exploiting him/her financially, physically or sexually. Perpetrators may take advantage of the isolation and/or vulnerability of their victim to win their confidence.

Harry was a young man with a learning disability who was being supported to live independently in the community. He was keen to develop friendships, especially with women. He was abused by Karen and John not only emotionally and physically, but also financially.

What action has been taken

Recent audits of safeguarding cases supervised by adult social care indicate that examples of financial and sexual abuse are regularly encountered. Where the Police have been involved, they have taken a proactive approach. A perpetrator of inappropriate text messages was shown in the audit to have been cautioned by Police.

The Borough of Poole has recruited additional staff to provide financial deputyship to people at risk.

Dorset Police have provided additional resources to adult safeguarding and invested in the training of front line officers to enable them to be able to identify and respond appropriately to vulnerable adults.

Barrie Crook

Independent Chair

Bournemouth and Poole Safeguarding Adults Board

March 2019