

**BOURNEMOUTH & POOLE
SAFEGUARDING ADULTS BOARD**

Safeguarding Adult Review

and

**POOLE COMMUNITY SAFETY
PARTNERSHIP**

Domestic Homicide Review

“Harry”

Final Report

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Appendix A – Single Agency Recommendations

**Appendix B – Process by which this review conducted including
membership of SAR/DHR Panel**

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.)

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 This murder meets the criteria for a domestic homicide review to be conducted in that the death of a person aged 16 or over has resulted from violence by a person with whom he had been in an intimate personal relationship. As a result, Poole Community Safety Partnership decided to commission a domestic homicide review.

1.5 In view of the vulnerability of the victim Harry, the services being provided to him, and the relative vulnerability of the perpetrators Karen and John, Bournemouth and Poole Safeguarding Adults Board decided that the criteria for conducting a safeguarding adults review were also met, in that an adult in its area had died as a result of abuse and there was concern that partner agencies could have worked more effectively to protect that adult.

1.6 A decision was taken to run the two reviews as a combined process. Whilst it was anticipated that the domestic homicide review process would provide a thorough and challenging review of this case and identify learning with which to improve practice, it was felt that there could well be additional learning for partner agencies by adding the health and social care perspective which the safeguarding adults review would bring.

1.7 A panel of senior representatives from local partner agencies was established to oversee the process by which information about the case was compiled and scrutinised and this report prepared. 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 within Appendix B to this report, which also describes the process by which this review was conducted in more detail. David Mellor was commissioned to be the independent author of this combined report. He is a retired chief officer of police and former independent chair of a safeguarding adults board. He has been the independent author a number of domestic homicide reviews and safeguarding adults reviews and has no connection to Bournemouth or Poole.

1.8 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 (MAPPAs) 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 MAPPAs 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 summary of their care and support needs and an overview of their life prior to Harry and Karen beginning their relationship.

Harry (Victim)

4.1 At the time of his death, Harry was 22 years old. He was described as having global developmental delay and had been diagnosed as having a learning disability which was described as “moderate”. He was also described as having autistic traits. He was said to have an anxiety disorder. When he became very anxious, a number of behavioural difficulties were manifested such as becoming angry, pacing, shouting with verbal threats of physical aggression. He also offered physical aggression to others and to property from time to time. Harry was also noted to become withdrawn and low in mood and report feelings of wishing to end his life at times.

4.2 Harry 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 him and care for her father who had recently been diagnosed with cancer.

4.3 Harry’s parents have contributed to this review and described the frustration their son experienced in wanting to embark upon a full adult life and feeling restricted by his learning disability and the concerns of others about his ability to keep himself safe.

4.4 Harry’s financial capacity was assessed in March 2013 which demonstrated that he had limited understanding of managing his finances. It was acknowledged that he was vulnerable to financial abuse so a plan for appointeeship was proposed with the Borough of Poole fulfilling this role. However, this was never actioned.

4.5 Harry was found to have capacity to engage in a sexual relationship when assessed in May 2013 by a Clinical Psychologist from Dorset Healthcare. It was recorded that Harry could differentiate between friends and girlfriends, understood dating and “who it was OK to have sex with”.

4.6 In June 2013 Harry was seen by the Psychiatrist from Poole CLDT after his pets were found dead. Harry was diagnosed with an anxiety disorder and was prescribed medication to manage this problem.

4.7 From September 2013 Harry was supported to live independently by The Care Division (TCD) a domiciliary care agency. TCD was commissioned by the Borough of Poole Council to initially provide 20 hours of support per week to Harry which was increased to 23.5 hours in October 2014. The support provided included wake up calls, hygiene prompts, medication prompts, healthy eating and meal prompts and support, flat management, finances and domestic task prompts and support. A

support plan was put in place which included a comprehensive summary of Harry's needs. Additionally, a risk assessment focussing on household and domestic tasks was also in place.

4.8 Support provided to Harry on a typical day was as follows:

- 8.30am (30 minutes) wakeup call to ensure he was prompted to take medication, wash, dress, breakfast, and get ready for the day,
- 6pm (30 minutes) prompting and support with taking medications and preparing his evening meal, checking the post, help with the laundry, support to wash up, pack his lunch the for next day.
- 9.30pm (30 minutes) support with tasks within the flat, washing and drying up, ensuring he was settled, ready for bed and all appliances were switched off.

4.9 In addition, TCD also provided support on a weekly basis as follows:

- 1:1 time for advice and support in independent living and to encourage community based activity.
- 7 hours of 1:1 support provided to deep clean flat, check his food was still in date, make a shopping list, budget money for a food shop and do a food shop;
- help to prepare menus for the week.
- management of finances, budgeting and advice
- support to do his laundry.

4.10 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. Harry's wishes and feelings were often ascertained through these entries and there were many examples of him recording how he was feeling and of TCD staff offering support to him on the system.

4.11 Harry appeared to have some self-confidence issues, considering himself ugly and having no friends. He said he wanted a girlfriend. He reported being lonely, bored and talked about wanting to be loved. Harry's "eagerness to please" was noted by more than one agency he came into contact with which may have left him more exposed to abuse by others. At times Harry's "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. Harry's parents say that their son was raped by a young male who had attended the same special school. This incident appears to have taken place in October 2012. The police investigated the matter and concluded that the sexual activity was consensual. TCD encouraged him to undertake community based activity and voluntary work to "keep him occupied", to increase his circle of friendship, and to support him to make and build appropriate relationships.

4.12 TCD say that there was no consistent pattern to Harry's presenting behaviours and how he reacted to staff support. There were times when he would accept support and advice and act upon this. Sometimes he would agree to do something but then his actions were noted to be the opposite of this. Sometimes he perceived

staff support as positive whilst at other times he seemed to reject it and said he wished to be independent.

4.13 When TCD began to provide support to Harry he was on medication to help him manage his anxiety. 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. The remit of Poole CLDT is to improve the health, wellbeing, independence and quality of life of adults with a learning disability.

4.14 The TCD support plan acknowledged that his relationship with his family could affect his mood and also referenced his desire to have a girlfriend. His desire for a girlfriend may have been a factor in his interest in under-age girls which became apparent from early 2012. After Harry's relationship with Karen began, TCD wrote a protection plan and protocol in August 2014 which described how he would be safely supported in his relationship with her. This protocol was agreed with the Borough of Poole and with Harry.

4.15 When the staff supporting Harry started to question his capacity to keep himself safe in his relationship with Karen, TCD requested a further mental capacity assessment. However, Consultant Psychiatrist 2 from Poole CLDT who had overseen the previous capacity assessment of Harry, which had concluded he had capacity to make decisions and choices about his relationships, was unable to repeat the mental capacity assessment because of the inconsistent responses Harry provided to questions asked. The staff supporting Harry therefore had to continue to assume that Harry had capacity to make decisions and choices about relationships, notwithstanding their concerns that his on/off relationship with Karen was abusive, primarily on her part.

4.16 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 was appointed to support Harry, periodically meeting him to discuss his feelings and behaviour regarding his relationship with Karen and forming other relationships.

Karen (Perpetrator)

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

4.18 Dorset Children's Services were involved with Karen's family from before her birth. Both parents had been brought up by people other than their parents for some part of their childhood, Karen's father being raised by a grandparent and her mother placed in the care of the Local Authority as a teenager when her parents could not manage her behaviour.

4.19 One of Karen's siblings was adopted after breaking an arm when under a year old. Arising from this incident, Karen's mother was convicted of wilful neglect.

4.20 Throughout the course of Karen and her sibling's childhoods, there were continued concerns regarding allegations of physical and emotional abuse against both parents towards their children. Concerns arose over another sibling's sexually inappropriate behaviour and he was removed from the family home and placed in Local Authority care after an investigation found that he had raped Karen (then 8 years old) and sexually abused another sibling.

4.21 By this time Karen's sexualised behaviour was also causing concern. She had been 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. However, the concerns should also have been seen in the context of the other worrying information about the functioning of this family.

4.22 Karen was initially placed in foster care but it soon 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 that 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.

4.23 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."

4.24 Throughout the involvement of Children's Services with Karen's family there was a repeated pattern of referrals due to the parent's inability to prioritise the needs of the children, manage their behaviour and provide them with a supportive and loving home in which to grow and develop. There were multiple incidents of physical and emotional abuse of the children perpetrated by the parents, for which the children were then blamed. The children all had difficulty in managing their emotions and were quick to resort to aggressive behaviour.

4.25 There were also repeated reports of sexually inappropriate behaviour received from the children from when they were very young, which appeared to increase in seriousness as they grew older. There were allegations of sexual abuse made against the maternal grandmother, mother's partner (Karen's father had left the family in 2008 and had limited contact with his children thereafter) and the children about each other. Sexual boundaries within the family appeared extremely blurred but when asked about the various incidents, the children often struggled to describe what had happened. Allegations made by the children invariably resulted in their parents rejecting them and ceasing contact for a period of time. Then it was often the children who modified or withdrew their original allegations in order to re-establish contact with one or both parents.

4.26 It would appear that the incidents of reported abuse were dealt with individually rather than being linked and seen as a worrying picture for all the children in the family.

4.27 Karen was repeatedly let down by her parents, who had such high needs themselves, that they could only manage Karen when she was able to meet their needs. Neither parent appeared able to provide consistent support for her, either emotionally or physically. Karen was aware that their love and attention was conditional, and she was frequently unable to meet the conditions. For a child with autism, the world is a confusing place and relationships are difficult to understand. When seen in the context of this extremely dysfunctional family, it is easy to see how Karen became lost in a world which was unpredictable and frightening from a very young age. Karen can have little idea about how positive relationships work or how to resolve differences calmly.

4.28 It is probably unsurprising that, on reaching adulthood, Karen was drawn towards others with similar needs and experiences to herself. She is likely to have spent most of her childhood in "fight or flight" mode as a learnt way of surviving. Research tells us that maltreatment in childhood can affect brain development "producing a brain that is focused on survival". This has a negative impact on the more advanced thinking that happens in the brain's cortex. (1) This impulsivity may lead young people to increased risk-taking as they get older, while remaining in a home environment in which maltreatment has featured, and where there may be poor or inconsistent boundaries, can increase opportunities to do so. (2)

4.29 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 workers comprehensive attempts to ensure that a supportive network is around Karen as she turns 18, but rising thresholds of support to adults, a lack of availability of housing opportunities and of Karen's changes of mind." The plan at that time was for further work to be undertaken to identify a housing solution.

4.30 After leaving the residential unit 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. Neither service felt that Karen met the criteria to receive a service from them and so no services were provided. 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, which meant that she missed opportunities to be assessed as she had moved out of the area. The result of this was that the process had to be restarted each time she moved and this built in many delays. It seems clear that those working with Karen continued to make efforts to secure services and accommodation for Karen, and, despite her lack of cooperation with these efforts, they persevered in re-referring her each time she moved.

4.31 Karen was noted to be using a range of illegal drugs, so-called legal highs and also drank heavily at times.

4.32 The lack of clarity over Karen's diagnosis appeared only to be resolved when she was subject to several psychiatric and cognitive assessments whilst awaiting trial for Harry's murder. There was a measure of agreement on her diagnosis of atypical autism which, combined with her traumatic childhood experiences and the development of personality disorders (Emotionally Unstable Personality Disorder – Borderline Type and Dissocial Personality Disorder were diagnosed whilst on remand) meant that she presented a risk to herself and others.

John (Perpetrator)

4.33 At the time he and Karen murdered Harry, John was 25 years old.

4.34 John is an only child who grew up in Poole with his mother and father. He left school at 16 and attended college where he gained qualifications in painting and decorating. He lived at home until his father died in 2012. His relationship with his mother appeared to deteriorate thereafter.

4.35 John did not appear to have a clear recorded diagnosis although there were references to him apparently having a moderate learning disability. The absence of a clear diagnosis probably hindered efforts to identify an appropriate service to assess and support him.

4.36 From 2013 John was homeless. However, 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. However, he was not assessed as having priority housing needs and was on a lengthy waiting list at the time of the murder of Harry. (Poole Quay Foyer is part of the Foyer Federation which is a not-for-profit organisation that aims to transform the circumstances of young people who have faced barriers in their lives.)

4.37 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. The police would then take him to St Ann'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 John did not have a severe and enduring mental illness. This happened no less than seven times during the two years prior to the murder of Harry. He was also an extremely frequent caller to South Western Ambulance Services (SWAST) and the NHS non-emergency 111 number.

4.38 This repetitive pattern of extreme behaviour suggests a degree of desperation on the part of John. However, the absence of any mental health diagnosis may also indicate an attempt to manipulate services. On several occasions John sought to advance his claims for supported housing by referring to his mental health problems, but when asked to provide medical evidence he was unable or unwilling to do so. However, 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.

4.39 John's extreme behaviour generated a response from agencies which did not appear to vary greatly. He was detained by the police, taken to a place of safety where he underwent a mental health assessment. In the absence of any indication of mental illness, he was then discharged. However, the mental health team at St. Ann's Hospital recorded that John's risk of overdose would increase with each episode of homelessness. They made referrals to the homeless team and the night shelter in 2013 in an attempt to reduce his risk of overdosing.

4.40 The general tendency of agencies not to deviate from their responses to John's behaviour may have limited their opportunity to better understand his underlying needs including the impact of his father's death in 2012. It is understood he found this bereavement difficult to cope with and it appears that this exacerbated an already conflicted relationship with his mother. His GP, with whom he engaged well until July 2014, provided him with support following the bereavement.

4.41 A disturbing feature of John's persistent homelessness was his 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. (It is assumed that this frequent sofa-surfing was the reason he was not often seen rough sleeping.) John made use of social media to initiate some of these contacts. In many of the associations with vulnerable adults of which the authorities became aware, John 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. On less frequent occasions John may have been, or complained of being, the victim of physical assault himself.

4.42 Individual agencies gradually began to appreciate that John presented a risk to the vulnerable adults he associated with although the absence of any organised sharing of information about the risks he presented, prevented agencies from gaining a fuller understanding of the threat he posed. This lack of informed, concerted multi-agency action was a factor which enabled John to continue to engage in predatory behaviour over a substantial period. Another factor was that the vulnerability of some of his victims may have limited their capacity or confidence in reporting John's behaviour to the authorities.

4.43 John was only rarely perceived to be vulnerable by agencies. In their many contacts with John, the police invariably did not record him as being vulnerable in

any way. He was referred to the IDVA service in May 2013 and a support plan was drawn up which indicated that he was of medium risk as a result of his dangerous behaviour on the basis that he could be impulsive and express anger and frustration. The IDVA service noted that efforts were being made to address John's mental health and his lack of housing at that time. His case appeared to be closed to the IDVA service by 6th June 2013.

4.44 Throughout his contact with professionals John is recorded as drinking alcohol, smoking cigarettes and using illegal drugs and so-called legal highs.

Demographic information

4.45 Accommodation instability and homelessness are features of this review.

4.46 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 (3).

4.47 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 (4).

5.0 Synopsis

5.1 Harry and Karen appear to have initially made contact via MeetMe a social media website which encourages users to meet and chat with new people primarily on mobile devices. The first contact was made on 21st March 2014. The relationship developed quickly and from 26th March 2014 Harry told TCD staff that he was meeting Karen in the community. He started to spend nearly every day with her.

5.2 On 3rd April 2014 TCD made the first (of a total of four) safeguarding alerts in respect of Harry. The alert related to concerns arising from his sexual relationship with Karen and was communicated to Poole Adult Safeguarding. TCD staff began to express 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 On 3rd 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. As Karen’s address was in Yeovil at that time, TCD was advised to report the matter to Avon and Somerset police. It is not known what the outcome of any call to Avon and Somerset police was.

5.4 On 11th July 2014 TCD made the second safeguarding alert in respect of Harry. Again the alert related to concerns arising from his relationship with Karen who was stated to have a history of physical and financial abuse of previous boyfriends. This alert was apparently amalgamated with the previous one (Paragraph 5.2) by Poole Adult Safeguarding.

5.5 The following day TCD contacted Dorset police to report nuisance text messages Harry had received from Karen demanding the return of her belongings. One message read “you got until 6pm or I will do something that Harry will be in trouble for”. The police decided that no offences had been committed but that Karen’s conduct necessitated words of advice. After several attempts to contact her by phone, the police left her a message.

5.6 On 17th July 2014 Dorset police missing persons’ unit contacted Poole CLDT to notify them that a pregnant 17 year old Looked After Child had made allegations of a rape against John who was later arrested and denied any sexual contact had taken place. There had been a delay in reporting the allegation which meant that no forensic evidence was available. The police ultimately decided that there was insufficient evidence to charge John.

5.7 On 22nd July 2014 Poole Adult Social Care made a MARAC referral in respect of concerns that Karen was financially, physically and emotionally abusing Harry. It was stated that Karen had a history of perpetrating similar abuse. Harry was noted to be anxious, stressed and had experienced suicidal thoughts.

5.8 On 23rd July 2014 Bournemouth Churches Housing Association (BCHA), which was the provider of the independent domestic violence advisor (IDVA) service in Poole at that time, accepted a referral in respect of Harry. They were advised that Harry had been assessed as "high risk" using the CAADA DASH risk assessment. Arrangements were made for the allocated IDVA to meet Harry in the presence of a TCD care worker. This meeting took place on 7th August 2014 when Harry showed the IDVA threatening text messages he had received from Karen. Harry decided he wished to report the messages to the police which was arranged. Harry 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 work. Contact was also made with phone providers to change Harry's landline and mobile numbers.

5.9 The police contacted Harry on the same date (7th August 2014) to discuss the threats by text messages from Karen. Harry decided he did not wish to make a complaint about the threatening texts and the police recorded that no offences were disclosed.

5.10 On 8th August 2014 the IDVA met Harry for a second time. 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 was unable to keep himself safe. However, Harry blocked Karen's phone number when advised to do so and TCD staff advised the IDVA that they had reduced the risk of further financial abuse by retaining Harry's bank card and cash to which Harry could request access when he needed money. TCD staff said that Harry had been spending all his money on Karen, leaving him nothing to live on. The IDVA was also advised by Poole Adult Social Care that a protection plan was in place for Harry and that this plan was due to be reviewed at a meeting on 4th September 2014, to which the IDVA was invited.

5.11 On 13th August 2014 TCD advised the IDVA that Harry was seeing Karen daily. The IDVA questioned whether Harry had capacity to make decisions about his relationship with Karen and was advised that he had been assessed as having capacity. It appears that TCD shared their emerging protocol which set out steps for keeping Harry safe with the IDVA at this point.

5.12 On 15th August 2014 Poole MARAC met. Amongst the referrals they considered was the one in respect of Harry. 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.

5.13 On the same date someone from MARAC 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.

5.14 It would appear that it was decided that the IDVA would withdraw at this point. It was envisaged that Harry's needs would be managed through the safeguarding plan without any further involvement of the IDVA. Harry was subsequently informed of this decision by TCD staff.

5.15 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.

5.16 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 version of the adult safeguarding plan shared with this review 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.

5.17 Shortly after midnight on 5th September 2014, TCD reported Harry as a missing person to the police. He was located at 1am on 6th September 2014 at a hotel in Dorchester. Following his return home, Harry was spoken to by the police and told them he had travelled to Dorchester by train to see Karen, who was described as his ex-girlfriend who had recently moved back to Somerset from Poole.

5.18 On 22nd September 2014 Harry contacted the police to report receiving threatening text messages from Karen who was now pregnant. The police log of the call states that Harry was believed to be the father. The messages warned Harry to leave Karen alone and originated from three separate mobile phones. Some of the messages referred to someone other than Harry being the father of Karen's unborn child. It is believed that these messages were referring to John. The police concluded that the text messages were not threatening and no further action was

taken. Professionals working with Harry recorded that the threatening texts were affecting his mental health and his living skills.

5.19 By 23rd September 2014 staff working with Harry concluded that the protection plan and protocol was not working, and so a professionals meeting was held the next day to discuss the concerns. Harry's capacity regarding relationships was discussed and he was re-referred to CLDT Consultant Psychiatrist 2 for reassessment of his capacity to engage in a sexual relationship.

5.20 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.

5.21 On 24th September 2014 Karen contacted the police about threatening text messages received from a former friend. (Not Harry) During the call she stated that John was her boyfriend. The police did not consider that the threatening texts constituted an offence and provided advice on this and other matters. The police did not apparently identify Karen as an adult at risk.

5.22 The next day – 25th September 2014 - Karen contacted the police to allege that John had raped her in a Poole hotel. The police initiated an investigation but eventually concluded that there was insufficient evidence on which to prosecute as a result of inconsistencies in Karen's account. John said that he had had sex with Karen but claimed that it was consensual. Karen was identified as a vulnerable adult but the notification required to the Dorset police safeguarding referral unit was not made.

5.23 On 29th September 2014 Avon and Somerset police contacted Dorset police to say that John was on a large traffic island in Yeovil threatening to hurl himself into oncoming traffic. The police in Yeovil suspected that John was trying to engineer a lift back to Dorset. The following night Dorset police were contacted by John who was threatening to throw himself into the road and end his life.

5.24 A further day later – 1st October 2014 – John again contacted Dorset police saying he wished to end his life. The police established that he had just been discharged from Poole hospital where he said his blood tests had indicated no health problems and he had been told to leave.

5.25 On 2nd 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.

5.26 On 8th October 2014 the police were called by female 1 who has a physical disability who said that John was harassing her at her home address and trying to

get money from her. The police attended and determined that no offences had been committed. However, they arrested John for breaching bail conditions in respect of an earlier rape investigation. (Paragraph 5.6 refers) Whilst in custody, John claimed he had taken an overdose and was taken to hospital.

5.27 The following day John again contacted the police saying he wanted to end his life and had taken an overdose. The police attended and provided him with advice.

5.28 On 20th October 2014 John contacted the police to say he had been discharged from hospital and claimed to be trying to strangle himself whilst banging his head against a brick wall. The police concluded that he was not harming himself at that time and advised him to attend Poole General Hospital for an assessment.

5.29 On 21st October 2014 Dorset Police were contacted by Avon and Somerset police who expressed concern for the welfare of Karen who they believed to be staying at a Bournemouth hotel with John who had been arrested for assaulting her two days previously. Dorset Police subsequently contacted Karen who was alone and unharmed.

5.30 At 8.40pm on 22nd October 2014 TCD staff reported Harry missing to the police who located him the following day after Karen was contacted and confirmed they were together. When spoken to by the police Harry said he had been with Karen in the Poole and Bournemouth area and no concerns were documented or raised by Police. Harry is reported to have said he no longer wanted to remain living in the TCD supported accommodation.

5.31 From October 2014, Harry began providing conflicting information to professionals. He began informing some professionals that he wanted to move from his supported accommodation whilst informing other agencies that he wanted additional support to remain there. Further safeguarding meetings were held to discuss the risks Karen posed to Harry on 21st October 2014 and 5th December 2014.

5.32 On 24th October 2014 Karen contacted the police to report that John, who she described as her "ex-partner", was stalking and harassing her. She added that she was 16 weeks pregnant by her "new partner" Harry. She went on to say that John had threatened to punch both her and Harry and had said that he hoped she loses the baby. Karen said that she wished her call to be logged by the police, but requested that no further action was taken. The police took no further action.

5.33 On 27th October 2014 Karen, in company with John, approached Poole Housing for emergency homeless assistance. She was pregnant and 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. TCD advised that 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. Bed and breakfast accommodation was secured for Karen that night and an emergency bed was provided at the Quay Foyer from 28th October 2014. (John was removed

from the Quay Foyer area by the police three nights later after complaints of anti-social behaviour.)

5.34 During the evening of 29th October 2014 John made numerous calls to the police, initially saying he had taken an overdose, later saying that he had been threatened for being a paedophile by two unknown males and later still saying that his girlfriend had stolen his mobile phone. When the police visited John some time later that evening they discovered that he had been taken to hospital by the ambulance service.

5.35 Also on 29th October 2014 the CLDT advised the police that Harry had a concerning interest in underage girls and had tried to contact a 13 year old female and others via Facebook and dating sites. The mother of this child had prevented contact. No offences were identified as having been committed.

5.36 On 1st November 2014 the police received information that John had a stolen bank card in the name of Harry which he had been using to buy clothing. The police recovered items of property but they have no record of any contact being made with Harry. Nor was the incident recorded as a crime.

5.37 In November 2014 TCD state they were informed that Harry was deemed to have capacity (assessed specifically in respect of his capacity to form relationships), this having been confirmed by CLDT Consultant Psychiatrist 2. (TCD appear to have been misinformed or misunderstood as no further assessment had actually been carried out under the Mental Capacity Act – see Paragraph 5.20)

5.38 On 3rd November 2014 the police shared a vulnerable adult form in respect of Karen with Poole Adult Social care help desk which was forwarded to Somerset Pathways Team the following day. The form made reference to concerns expressed by staff at the Quay Foyer, where Karen was staying on an emergency basis. They considered her to be vulnerable and in a relationship with John who they suspected had attempted to force himself upon other residents in the past. They considered that Karen was not able to say “no” to his advances and had exhibited poor judgement. They had some knowledge of Karen being the victim of an alleged rape and that John was the suspected offender. There was an opportunity to consider whether Karen needed to be safeguarded but this was not taken.

5.39 On 8th November 2014 Dorset police were contacted by Hampshire police requesting information on John, Karen and a male 1 as Karen was in Ringwood and had allegedly made threats that she had a gun on her and intended to shoot John. Enquiries revealed that John had made a malicious call to the police as enquiries suggested that Karen was elsewhere at the time.

5.40 Dorset police received reports of John feeling suicidal and indicating he may harm himself by running into traffic on 8th and 9th November 2014. On both occasions the police took him to St Ann’s hospital. On neither occasion did they formally identify him as a vulnerable adult.

5.41 On 13th November 2014 TCD staff notified the police of the theft of £803 from Harry's 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 building society 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.

5.42 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.

5.43 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. The National Probation Service completed a "same day" report in respect of Karen which was reported to the Court orally. Oral reports are not retained. The National Probation Service had no further involvement with Karen in respect of this case.

5.44 On 25th 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 had now been asked to leave the Quay Foyer.

5.45 On receipt of the referral, Bournemouth Children's Social Care identified the need for a "broader concerns assessment" via "Partnership Plus" services within Children and Young People's Department (CYPD) as Karen was noted to have been diagnosed with autism, had a low IQ and appeared to have difficulty in retaining information. These factors raised concerns over her capacity to care for her unborn child. Positive factors were considered to be her engagement with pregnancy services and the support she was receiving from a godmother locally. Karen's case was referred to a Targeted Early Help Worker who was asked to explore pre-birth parenting support, "steps to wellbeing" and housing support.

5.46 Karen visited her GP in Poole in November 2014, accompanied by her godmother. At that point she was 18 weeks pregnant and living alone in a flat, with her godparents and social care providing support. She said she was hoping to be able to bring her baby up by herself with support.

5.47 On 8th 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 informed officers that John had followed her to her front door and made threats to punch her in the stomach and hurt her unborn baby. John had left by the time the police attended. Karen's account of events was considered to be "very vague" and the details "kept changing". No investigation of the threats apparently took place but 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.

5.48 The police also notified Bournemouth Children's Social Care who reviewed Karen's case, explored additional support for her (which she declined) and discussed the risks involved in her relationship with John with her.

5.49 Also on 8th December 2014 Harry was described as in a low mood and having suicidal thoughts. His appointment with his psychiatrist was brought forward to provide additional support. The psychiatrist advised Harry that his low mood would continue if he maintained contact with Karen. There is no record of any actions taken, such as risk assessment as a result of this appointment.

5.50 The police were again called to Karen's flat on 9th December 2014 over concerns that John was outside and refusing to leave. When the police attended John had left.

5.51 On 12th December 2014 a decision was taken to transfer the case of Karen and her unborn baby from CYPD 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.

5.52 On 15th December 2014 IDVA 2 attempted to contact Karen following the recent MARAC referral but she was not at home. However, IDVA 2 made telephone contact with Karen who said she had forgotten about the appointment and 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 friend's name and declined to meet IDVA 2 that day and a new appointment was made. This incident did not appear to be escalated by IDVA 2. It is not known who locked Karen in the flat. IDVA 2 later referred to this as an allegation of "false imprisonment" at the Bournemouth MARAC meeting in January 2015.

5.53 On 17th December 2014 IDVA 2 met Karen and explained the MARAC process and the role of the IDVA service. A CAADA Risk Assessment was completed during which Karen said she was scared of what John might do and that she may lose the baby. She was also fearful that John's 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. IDVA 2 undertook some safety planning with Karen which included advice not to visit the West Howe area of Bournemouth. According to the BCHA case notes, IDVA 2 contacted the police to report disclosures made by Karen during their

conversation. However, the police IMR states that that IDVA 2 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. Karen was given words of advice by the police who concluded that both Karen and John were breaching their bail conditions. (The police point out that the bail conditions had been imposed pre-charge and provided them with very limited options in the event of any breach of conditions.)

5.54 On the same date John alleged to the police that Karen visited his address and assaulted him. No further action was taken in respect of this allegation.

5.55 On 5th January 2015 Harry was seen by his GP to whom he reported that life was less chaotic and more structured. He appeared to be able to deal with stress better since having begun taking Risperidone in September 2014. However, the GP recognised that there were forthcoming stressors with Karen's pending court case and the issue of paternity of her baby to be resolved. Harry also had a learning disability review with the GP in January 2015, at which he was accompanied by his TCD support worker, and there were no concerns raised.

5.56 Also in January 2015 Harry was reviewed by his Psychiatrist who recorded that he appeared to be calmer and that his home was tidier. Harry reported that he hadn't seen Karen for a month.

5.57 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. IDVA 2 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.

5.58 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. They advised that here was a history of emotional and sexual abuse in Karen's childhood. 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.

5.59 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.

5.60 On 11th January 2015 the police were notified of John sending text messages of a threatening nature to Harry in an attempt to get Harry to drop the theft charge against Karen. The police did not follow up on this report either with the informant (male 1) or Harry.

5.61 On the same date 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 deleted the messages he had received from Gina which he said was accidental.

5.62 On 17th January 2015 the police became aware of conflict between Karen and John whilst in Weymouth. Verbal abuse had apparently been exchanged. The police attended and decided to take no further action.

5.63 Also on the 17th January 2015, Karen threatened to stab a male (details unknown) if he didn't give her his money, and was referred to the Street Triage team in Poole. This team aims to provide a swift assessment service at street level to triage a person's mental health. After assessing Karen's mental health, the team confirmed that she did not require any onward referrals.

5.64 Two days later Karen alleged that John and others had threatened her and her unborn baby. The outcome of this allegation is unknown.

5.65 On 21st January 2015 Karen contacted the police to say that a male 1 had forced her to enter into a mobile phone contract and had made threats against her and her unborn baby. The police established that Karen had willingly taken out a contract and given it to the male who had then run up a bill of £110. The police advised Karen to consider civil action against male 1.

5.66 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.

5.67 On 28th January 2015 John contacted the police from Poole hospital to say he intended to commit suicide. The police attended and took him to a friend's home.

5.68 The following day John alleged that male 1 had assaulted him but after investigating the matter, the police took no further action as they did not believe John's account. Later the same day John again contacted the police to say he intended to commit suicide. On this occasion the police took him to Sleep-Safe in Bournemouth.

5.69 On 29th January 2015 Bournemouth Children's Service referred Karen to the Learning Disability Team who appear to have advised that she did not meet their criteria. They also advised that she may not meet the criteria for the Mental Health team.

5.70 On 1st February 2015 male 1 contacted the police to allege that John had poisoned his autistic brother by putting fabric conditioner in his tea which had made him violently ill and unable to walk. Male 1 said that John had done the same thing to Karen in November 2014 but there was no record of this being reported to the police. The police decided that no offences had been committed.

5.71 Escalating concerns about the risks to Karen's unborn baby led Bournemouth Children's Social Care, Health and the police 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.

5.72 On 6th February 2015 John reported feeling suicidal to the police who took him to a friends' address.

5.73 On 9th February 2015 a female contacted the police to say that she was receiving harassing and inappropriate messages from male called John via Facebook. Advice was given about blocking the male and to report the matter again if the harassment continued. Very limited enquiries were carried out so it was not established whether the originator of the messages was John or not.

5.74 After the ongoing 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.

5.75 Also on 11th February 2015 a Protection Plan review meeting was held in respect of Harry. 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 as "continuing contact" was said to be "helping to retain the status quo". 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.

5.76 On 13th February 2015 John reported that his money had been stolen by someone who had changed the details of the bank into which his benefits were paid. Due to inconsistencies in his account, the police took no further action.

5.77 On 18th February 2015 Karen reported to the police that she was being harassed by John, male 1 and male 2 who had been sending her messages to the effect that her baby would be taken away from her. There was a delay in contacting Karen to investigate the matter but the messages were not deemed to be offensive or malicious.

5.78 On 19th February 2015 an Initial Child Protection Conference was held in respect of Karen's unborn child who was made subject to a child protection plan on the grounds of neglect. Both Karen and Harry attended.

5.79 Also on 19th February 2015 John contacted the police to say he was feeling suicidal. He subsequently admitted that he had been trying to secure a lift from the police. On the same date he alleged an assault by male 1, but when spoken to by the police several days later, John said that he was now living with male 1 and did not want to pursue a complaint. No further action was taken by the police.

5.80 On 26th February 2015 John contacted the police to say he wanted to end his life and intended to walk in front of traffic if he wasn't taken to St Ann's hospital. He was detained under the Mental Health Act and taken to the hospital.

5.81 Further abusive texts from Gina were recorded by Harry's Psychiatrist on 9th March 2015. Harry reported that he was with Karen at the time of the texts. There is no record of a safeguarding adults referral or police referral being considered or made at that point. The psychiatric report prepared following this meeting was shared with Harry's GP and stated that the Quetiapine, which he had commenced in December 2014, was helping him to feel calmer and more relaxed and that the plan was to stay on this as he currently has a number of stressors.

5.82 On the 18th March 2015 a multi-disciplinary team meeting discussed Harry's on/off relationship with Karen. His protection plan was reviewed. It is unclear from the records which agencies had a copy of the plan but it appears that it was not shared with the police.

5.83 On 20th 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.

5.84 Also 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 had his arm around her and described her as his girlfriend. Once separated from John, she alleged she had been raped by him. She said sex had been consensual at first but when she asked John to stop, he continued. John was arrested and denied rape, claiming sex was consensual. He was bailed pending further investigation, although no further action was eventually taken due to insufficient evidence.

5.85 The next 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. Contact had initially been via Facebook but when John rang her daughter, she (mother) had spoken to him and he had threatened to take the daughter into the woods and rape her. The mother had heard that John had a reputation for targeting vulnerable young women. The mother was advised to block John to prevent further contact by telephone or social media. This and other allegations against John led to the police instigating a review of his offending.

5.86 On 22nd March and 23rd March 2015, John contacted the police to threaten suicide. On both occasions the police took John to St Ann's hospital.

5.87 On 26th March 2015 a pastoral support worker from a community school reported inappropriate messages received by two 15 year old girls via Facebook and WhatsApp from John. This information was passed to officers dealing with the 20th March 2015 rape allegation against John. It isn't clear what action was taken by these officers in respect of the messages received by the schoolgirls.

5.88 On the same date Harry reported further threats by text message from Gina to the effect that she knew where he lived and was going to stab him. Harry was seen by the police on 29th March 2015 when his concerns were noted but it was decided that no offences had been committed.

5.89 Also on 26th March 2015 the police advised Poole Adult Social Care help desk of a verbal disagreement between John and female 1. She 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. Female 1 was known to CLDT and a decision was made that they should consider whether the current low level concern should be managed through care management or through safeguarding based on the history of concerns. The outcome is not known.

5.90 On 28th 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.

5.91 On 2nd April 2015 Harry reported further threats from Gina. Having reviewed the information provided by Harry the police decided there was insufficient evidence to progress the matter so no further action was taken.

5.92 On 8th April 2015 Harry reported further threats from Gina. It was found that Harry had initiated contact with Gina having been advised by the police not to do so. No offences were identified.

5.93 Harry was noted by a Learning Disability nurse to be in contact with Gina again on the 10th April 2015. Harry said he had also been in contact with Karen and was feeling lonely. As a result, work on relationships was planned to enable Harry to understand the emotional aspects of relationships as well as the physical.

5.94 At 5.30pm on 11th April 2015 Harry was reported as a missing person and was located by police at 9pm the same evening. He said he had gone to see Karen and a friend named "Sam", believed to be Gina. No concerns for the welfare of Harry were identified by police. Details of the incident were not shared with Adult Social Care.

5.95 The police have details of a further call received from Harry the following day in which he said he had been chased by John. The police apparently picked Harry up and took him home. Harry apparently asked the police if John would be arrested for contacting him in breach of his "tag". The allegation that Harry had been chased by John was treated as an argument over "friendship issues".

5.96 On 13th April 2015 Karen contacted the police to say that she had been receiving harassing text messages from Gina and Harry. Threats made by text from Gina included stabbing Karen and burning her house down. Gina was arrested on an unrelated matter and whilst in custody she was interviewed in relation to this incident. However, she wasn't charged with any offences in relation to this and there is no record of any enquiries being carried out with Harry.

5.97 On 14th April 2015 two vulnerable females previously contacted by John were reported missing and subsequently returned home two days later. It is suspected that they may have been with John but this was not confirmed by the young women.

5.98 On 16th April 2015 Karen again contacted the police over unwanted text messages from Gina who it was believed had been given her (Karen's) mobile number by Harry. Gina admitted to the police that the messages were sent from her phone but stated someone else had sent them, whom she would not name. The police subsequently decided that there was insufficient evidence to proceed further.

5.99 On 20th April 2015 John was taken to hospital by the police following a reported overdose. On 26th April 2015 John presented at Poole Hospital A&E saying he felt suicidal. Staff disbelieved him on the basis of previous behaviour. The

following day John contacted the police to say that he had taken an overdose and wanted to hang himself. As no ambulance was available, John was taken to hospital by the police. On the next day, 28th April 2015, John contacted the police after being discharged from Poole Hospital A&E having been told by the crisis team that he was "attention seeking". The police took him to St. Ann's hospital. The police also took him to St Ann's hospital the next day, 29th April 2015, after he again threatened to jump in front of a car.

5.100 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 the increase in hours referred to in Paragraph 4.7, TCD state that all requests were declined by the Borough of Poole. Harry was to be requested to try Benepiridol 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.

5.101 At the end of April 2015, Karen attended her GP practice with her godmother as she had apparently been staying with her. Concern was expressed over Karen's low mood, and fluctuating emotions which were affecting her sleep. She had expressed thoughts of self-harming and requested medication to help her sleep. Counselling was offered but it is unclear whether this was taken up.

5.102 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 in Paragraph 5.85 above led the police to consider applying for a Sexual Risk Order although the murder of Harry took place before this could be actioned.

5.103 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.

5.104 During May 2015, the 16+ care leavers support team requested Karen's GP to 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." The referral was made but it was not possible to carry out the assessment prior to her arrest for Harry's murder.

5.105 On 10th May John contacted the police, having been discharged from Poole hospital following an apparent overdose, asking to be detained under the Mental Health Act and taken to St Ann's hospital. When the police attended John was given the telephone number for the street triage service.

5.106 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.

5.107 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.

5.108 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).

5.109 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.

5.110 It would appear that Harry did not heed the police advice to have no contact with Karen and John as, when he left his supported accommodation on the evening of 15th May 2015 he told TCD staff that he was going to meet with Karen. TCD did not apparently report this to the police.

5.111 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.

5.112 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 for assault 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.

5.113 (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.)

5.114 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.)

5.115 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.

5.116 On Wednesday 20th May 2015 the police referred Karen to the IDVA service following the 18th May 2015 incident. However, BCHA as provider of the service was unable to open the referral email sent by the police. Apparently there were technical problems associated with a new IT system which had been 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. (26th May 2015 was the date on which Harry was murdered.)

5.117 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, specifically text messages between Karen and John and audio recordings made on Karen's mobile phone, 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 or July 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.

5.118 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.

5.119 In an entry in the My Diary system for Harry timed at 15.18 on 21st May 2015 (i.e. next but one following the above entry from TCD care worker 1), TCD care worker 2 wrote that Harry told her he had had a bad week. He elaborated on this by telling her that Karen and John locked him in Karen's flat. He said they had taken his phone off him. He added that Karen had made him a cup of tea which was the only good thing. He said he managed to leave the flat but by this time he was really late, and in a burst of anger had jumped on his phone and smashed it on the pavement.

5.120 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 5.119 above. It has been suggested to this review that the CLDT may have made an incorrect assumption that this matter had been reported to the police by a TCD manager when, in fact, no such report had been made. This review has been provided with no evidence which would justify such an incorrect assumption being made. In the event neither TCD nor any other agency with knowledge of the 20th May 2015 incident 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.

5.121 TCD and the CLDT agreed 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.

5.122 (The subsequent murder investigation also revealed that on 20th May 2015, whilst with her Dorset 16 plus leaving care team support worker, Karen was in mobile phone contact with John. At this time Karen and John were on bail having been charged with assaulting each other following the incident on 18th May 2015. They both had bail conditions not to have any contact with each other. Karen also disclosed to her support worker that John wanted to hurt Harry or that he wanted to kill him. It would appear that none of this information was escalated or reported to police.)

5.123 On 21st May 2015 - as a result of enquiries made during the murder investigation - it was established that when Harry visited his GP to have the DNA test, 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 told the support worker that he was particularly scared of John, more so than Karen. Harry also mentioned to the support worker that apart from the threatening text messages John and Karen had sent him, that John also carried knives. Karen was also present at the surgery along with her baby son for the purposes of the DNA test and John was believed to have been waiting for her outside.

5.124 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 is not clear if Harry had received or been offered any counselling prior to the DNA test. This would have been the responsibility of his CLDT social worker. What is clear is that no assessment of Harry's capacity was carried out by his GP in order to ensure there was informed consent to the DNA test. The reason Harry's GP did not carry out the assessment of his mental capacity was because there was "an issue around funding". Without this test of capacity, the GP could not see Harry and this is a further reason why the DNA test did not take place on this date. The DNA test was re booked for the 28th May but did not go ahead as Harry was murdered two days earlier.

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

5.126 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".

5.127 On 25th May 2015 Harry began smoking, having not previously been a smoker. He told staff that he was smoking to relieve stress.

5.128 On 26th May 2015 there is an entry in TCD My Diary in which 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 referred to 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 female 2.

5.129 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.

5.130 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 referred to the alleged rape of her by Harry on 1st June 2014 which appeared to anger John which 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. Karen altered her voice to pretend to be Gina in a telephone call to Harry.

5.131 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.

5.132 At 12.05pm on 26th May 2015 an ambulance attended Karen's flat and informed the police that there had been a domestic incident between two males, involving the partner and ex-partner of a female and that one of the males was unconscious and possibly dead. The police joined the ambulance service and it was quickly ascertained that Harry was dead and had two puncture wounds to his neck.

5.133 On 4th June 2015 Bournemouth MARAC met and decided not to consider the referral from the police in respect of Karen following the incident on 18th May 2015, as both she and John, who was identified as the perpetrator in the referral, had been arrested for the murder of Harry.

6.0 Engagement with the family of Harry

6.1 The independent author met with Harry's parents who wished to fully contribute to this review.

6.2 They described the support Harry and they received once delays in his development had been identified in early childhood. Following assessment at Poole hospital Harry was regularly taken to the hospital's child development centre for monitoring and further assessment. His parents said he really enjoyed Winchelsea Special School where he spent his entire school career, and where he made many friends. They said the routine involved and the structure of the school timetable really suited him. They said he had an aptitude for all things technical and mechanical, particularly computers. He also became very interested in buses and trains, but 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 loved.

6.3 His parents said that outside of school hours things could be a little more difficult. Harry spent a lot of time with his mother as his father's job frequently took him away. They 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.

6.4 Whilst at Winchelsea School, Harry's parents recall that there was an annual review of his needs and the progress he was making. The Head of the school was always involved in these review meetings as were social services – believed to be education welfare. There was always a discussion about whether Harry should remain at Winchelsea or whether he was able to move to a mainstream school.

6.5 Other than through the annual review meetings at school, 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 but, having initially suggested that she might be entitled to support, social services concluded that as she was managing to care for her son satisfactorily, she didn't need social services support. Harry's mother says she was never happy with this outcome. She stayed at home to support her son throughout his childhood receiving Disability Living Allowance and Carer's Allowance once she discovered she was eligible for the latter benefit.

6.6 Harry's parents noticed what they described as a dramatic change in his behaviour around the time he left Winchelsea School at the age of 16. He appeared to be almost continually frustrated because he was becoming 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 he seemed desperate to have a girlfriend. His parents feel that he was anxious to have a girlfriend in order to fit in, however opportunities to meet girls were few and far between. Harry showed his

frustration by throwing his mobile phone on the floor. Harry's parents say that he asked tutors for help but "nothing was ever done". They say that neither the school nor college ever discussed his future or how he would cope in later life or whether or not he would be able to work.

6.7 Having left school at 16, Harry began a one year pre-vocational course at College. He then went onto a second pre-vocational year and in his third year he became involved with the Prince of Wales Trust which enabled him to participate in outdoor pursuits which he really enjoyed and helped to build his confidence. Harry was still living at home and his parents describe how ensuring that he was happy and fulfilling a useful role - such as charity shop work - was a struggle every day.

6.8 When his maternal grandfather became ill with cancer in the summer of 2013, Harry's mother related how she again 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.

6.9 Harry's mother described how upset she was when Harry killed two pet guinea pigs around this time. After initially suggesting that their deaths were accidental, Harry admitted that he had killed them whilst feeling frustrated because of the lack of contact he was receiving on Facebook.

6.10 With the help of the social worker Harry began to live independently of his parents supported by The Care Division. His parents said that he really liked his new flat and settled really well although they noticed that he still had trouble sleeping, having got into the habit of spending hours on Facebook during the night whilst living at home.

6.11 Harry's parents said that their son disclosed that he had been raped to his social worker. This had taken place at the end of 2011 or beginning of 2012 but he didn't feel able to report it until 2013. They said that Harry had not said much to them about the rape but the perpetrator was a man who had also been a pupil at Winchelsea School. Harry's parents believe that one consequence of the rape was that it made him wary of men and less able to relate to them.

6.12 Harry's parents barely met Karen. They felt that she 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.

6.13 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. Before their son met Karen he was chased through the park by John. Harry fell and injured his leg and his parents say that he was 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.

6.14 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.

6.15 Harry's parents said that they tried to get him into the TCD residential house next door to his flat 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.

6.16 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. (Paragraph 5.100 refers)

6.17 When the 27th April 2015 meeting took place, 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.

6.18 His parents described a visit by their son to wish his mother a happy birthday 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 did arrive home, his mother related how she helped to strip him down so he could have a bath and she said she was shocked by how thin he had become. She said that his ribs could clearly be seen. She thought he had not been feeding himself properly because he had been giving all his money away to Karen.

6.19 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".

6.20 On 25th May 2015 – which was the day before he died – Harry’s mother said that he rang her and asked her to go with him to the bank to draw some money out, saying he wanted £200. She told him he didn’t need this. She said it was an unusual request because someone from TCD would usually accompany him to the bank. After he was murdered, his parents wondered if there was any connection between wanting this much money and the threats he was receiving from Karen and Harry? (The police state that their subsequent investigation uncovered no financial motive for his murder.)

6.21 His parents described earlier occasions when Harry was prevented from leaving by Karen. They said she locked him in her flat in Yeovil in April or May 2014 time. On that occasion he managed to escape through the window, then walk to Dorchester where his parents picked him up. (Paragraph 5.17 refers) Later they say Karen locked him in the George Pub in Poole for two nights. They added 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.

6.22 Reflecting on events, his parents said that they simply 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.

6.23 They felt that TCD which 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 to help him feel safer and to help him 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.

6.24 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

6.25 The DHR/SAR Panel decided to approach the perpetrators to provide them with an opportunity to contribute to this review should they wish to do so. Both Karen and John decided to contribute and they separately met the independent author in the prisons where they are serving their sentences.

6.26 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.

6.27 She reflected on the support she had received. She 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 said 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.

6.28 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.

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

6.30 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.

6.31 He claimed to have first met Harry whilst attending Bournemouth and Poole College. He said he helped out at the College for around 18 months after completing his painting and decorating course there. He described himself as an "unofficial teaching assistant" during this period and said he provided support to Harry in this capacity. This has not been confirmed by the College. John completed his course

during the academic year prior to Harry commencing at the College. It may be that John gravitated towards the College as an ex-student and first came into contact with Harry at that point. Given Harry's abiding fear of John, it seems unlikely that John befriended or supported him, or at least not for very long.

6.32 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 Analysis

In this section of the report each of the terms of reference questions will be addressed.

7.1.1 A particular emphasis on the management of transition from children's to adult services.

7.1.2 Harry was unknown to children's services until his GP referred him for support for future independent living at the age of 17. Given Harry's diagnosis and the fact that he attended a special school it is a little surprising that he was known primarily to universal services until he was about to embark on his adult life. (Harry's parents describe their contact with health and social care services during his childhood in Paragraphs 6.1 to 6.9.)

7.1.3 John had some limited contact with Poole Children's Social Care as a result of an allegation that he had been physically abused by his mother as a baby, and concerns about his sexually inappropriate behaviour whilst a pupil of primary and secondary school age. He appeared to have accessed CAMHS services whilst at primary school.

7.1.4 The fact that these two men reached adulthood without any, or any substantial, contact with children's services hints at the scale of the challenge facing safeguarding adults partnerships which often become aware of the needs of care leavers who struggle in adulthood but are not infrequently ineligible for adult services. However, Harry and John are examples of adults with care and support needs who only became visible to agencies *after* reaching adulthood. It is not known how large this latter group of men and women is.

7.1.5 Karen was a looked after child with Dorset County Council and was placed in a specialist residential unit for children and young people with autism in Devon from 2009 until her 18th birthday in 2013. When she left she faced what has been described as "instant adulthood" in that her transition to adulthood was "accelerated and compressed", (5) thus denying her the "normative" psychological opportunity of dealing with issues over time.

7.1.6 Prior to leaving care Karen was assessed as ineligible for both adult learning disability services and adult mental health services. At 17 she was referred to Poole Learning Disability team where the clinical psychologist concluded that she did not meet eligibility criteria on the basis that her IQ was 93. However, the clinical psychologist identified that Karen would benefit from psychotherapy but this wasn't actioned because Devon services (where the specialist residential unit in which Karen was placed was located) declined to see her as she was funded from out of county. The clinical psychologist also identified that Karen might benefit from mental health services when she turned 18. However, as previously stated, when subsequently assessed by mental health services she was found not to be eligible.

7.1.7 Karen's final LAC review took place a month prior to her departure from the specialist residential unit when she reached 18 years of age. At this point, there was no clear plan for where Karen would live when she left the unit. This lack of a plan appears significant, as it resulted in a reactive service being provided where it was unclear what outcomes were being sought for Karen or how they might be achieved. While it is acknowledged that Karen may not have cooperated with a plan which did not suit her immediate and changing wishes, Dorset County Council, which had been her corporate parent for a number of years, should have had a plan in place from 2012 which should then have been reviewed regularly until she was 21 years old. Having a plan in place could have given Karen a measure of security.

7.1.8 Furthermore, the extensive knowledge of Karen held by the Council could have suggested that the need for a contingency plan for her. She had not lived independently and her specialist residential unit appeared reluctant to move forward with independence training at the pace required. As a result, it was entirely predictable that Karen would run into difficulties and would need a high level of support.

7.1.9 It is worthy of note that in October 2013 Ofsted conducted an unannounced emergency inspection of the specialist residential unit Karen had left earlier that year at the request of the Department for Education (DfE), following a complaint that related to the management of behaviour and the quality of teaching and learning. One of the key findings of the inspection was that whilst "all students have frequent opportunities to practise their independent skills, such as visiting the local community, travelling by local buses and using community facilities,.....the lack of a rigorous curriculum to guide this work means that students *are not being adequately prepared for adult life*". Ofsted also noted that "there is no careers guidance on offer".

7.1.10 After leaving care Karen led a largely itinerant lifestyle moving across local authority boundaries, making it challenging to assess and meet her needs. There was a lack of clarity about her diagnosis which ironically only appears to have been resolved through the various psychiatric assessments commissioned by prosecution and defence whilst she was awaited trial for Harry's murder.

7.1.11 Many of the recognised ways in which young people are supported to successfully leave care were not present in Karen's case. "Staying put" was not an option for Karen and her return to live with the mother with whom she had had such a troubled relationship seemed unlikely to succeed and didn't. She quickly entered into a relationship with a man over thirty years her senior and experienced homelessness and unsuitable accommodation such as bed and breakfast. Supported housing was arranged but her needs were considered to be higher than the provider could meet and her later relationship with John may have counted against her because of the risks he presented to others.

7.1.12 Additionally, 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.

7.1.13 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.
- The “strugglers’ group who have suffered severe maltreatment, have complex problems, instability and attachment problems and can become trapped within specialist services (6).

7.1.14 There seems little doubt into which category Karen would be placed.

7.2.1 Were practitioners sensitive to needs of victim and the perpetrators; did practitioners have adequate training, knowledge and experience?

7.2.2 The coercive nature of domestic abuse is much better understood than it was. Being at risk of harm often limits an individual’s capacity to safeguard themselves. This is due to the psychological process that focusses an individual on acting within the immediate context of the threats that they face, in order to limit the abuse and its impact. This can lead victims to identify with the perpetrator and can prevent them from acknowledging the level of risk they face. It commonly prevents people leaving or ending a relationship (7).

7.2.3 However, several agencies seemed to assume that telling, or advising Harry not to contact Karen was likely to be a successful strategy and appeared to become frustrated with Harry when he went against their advice and contacted her. For example, the police IMR states that “on 15th May 2015 the police *clearly told* Harry not to have any contact with John and Karen however later that same day he left (his supported accommodation) and went to see Karen.”

7.2.4 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 and the concerns of many professionals that there were limitations in his capacity to safeguard himself.

7.2.5 Prior to entering into his relationship with Karen, Harry was assessed as having capacity to engage in relationships. The evidence shared with this review raises questions over whether he had sufficient mental capacity to take decisions necessary to protect himself in an abusive and exploitative relationship. Many of

those involved in supporting Harry questioned his mental capacity and it was agreed that a further assessment of his mental capacity would be undertaken.

7.2.6 However, the further assessment of his mental capacity scheduled for November 2014 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. After consulting with other members of the CLDT, Consultant Psychiatrist 2 met Harry again. When she challenged him about the inconsistencies in what he said previously, he is said to have agreed that he had lied but then went on to provide further inconsistent information. Consultant Psychiatrist 2 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”.

7.2.7 Had it been possible to complete the assessment of Harry’s capacity and had this demonstrated a lack of capacity to comprehend the risks he faced in his relationship with Karen and make decisions to protect himself from those risks, 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.

7.2.8 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, including decisions which appeared rash, unwise or irrational.

7.2.9 However, one of the principles 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. This wasn’t arranged for Harry.

7.2.10 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” (8).

7.2.11 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.

7.2.12 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 (9).

7.2.13 It is not known whether Harry had full access to all the relevant information which could have helped him to make decisions about risk. There is reference to IDVA 1 doing safety planning with him for example. It is not known whether this and other information for the victims of domestic abuse was available in "easy read" format. This review has been advised by the then provider of the IDVA services that services for people with learning disabilities were an "issue" at that time.

7.2.14 However, it is clear that agencies found understanding Harry's needs to be challenging. The TCD IMR says that there was no consistent pattern to his presenting behaviours and how he reacted to staff support. There were times when he would accept support and advice and act upon this. Sometimes he would agree to do something but then his actions were noted to be the opposite of this. Sometimes he perceived staff support as positive whilst at other times he seemed to reject it and said he needed to be independent.

7.2.15 So achieving an appropriate balance between the provision of support and encouraging independence, whilst carefully monitoring the risks Harry was exposing himself to required a high degree of skill and judgement by TCD staff. It would appear that there was quite a heavy reliance placed on TCD as a provider of domiciliary care to Harry for addressing risks as they arose, in making safeguarding alerts and making contacts with the police. And towards the end of Harry's life, TCD failed to contact the police when it was necessary to do so. But one wonders if TCD were operating or being asked to operate beyond their training, knowledge and experience?

7.2.16 Harry was not always seen as a victim. On some occasions he was also suspected of being a potential perpetrator of abuse of underage girls and boys who he tried to contact via social media. This may have obscured or confused any appreciation of his needs. The contrast between Karen's status as a victim and a perpetrator was often quite extreme and made sensitivity to her needs quite challenging for a range of agencies. John was invariably seen as a perpetrator which may have obscured the full assessment and recognition of his needs.

7.3.1 How accessible were services for the victim and the perpetrators?

7.3.2 Once services became fully aware of Harry, he was able to access a range of services. He may have benefitted from an independent advocate to help him understand the services available to support him and understand what those

services expected of him. As stated earlier, an advocate is an example of the support which should be considered to help people make decisions where there are doubts about their capacity to do so.

7.3.3 Karen had difficulty in accessing services. Her itinerant lifestyle made it difficult for agencies to assess her needs. The constant moving from place to place, particularly during her first year after leaving care may have contributed to a view that she was “somebody else’s problem” and prevented agencies taking ownership of her. Additionally, a lack of clarity over her diagnosis and the fact that in some respects she was seen as fairly “high functioning” may have contributed to her not meeting eligibility criteria for either learning disability or mental health services. And when she became pregnant, the focus subtly shifted away from meeting her needs towards ensuring the unborn baby was safeguarded. At the time of Harry’s murder she was living in a privately rented flat supported by post 16 services and her godmother.

7.3.4 John’s approach to accessing services was largely unconventional and ultimately unsuccessful. He fell between mental health services which repeatedly concluded that he did not have a severe or enduring mental illness, and learning disability services because there was an absence of any detailed assessment to underpin the suggestion that he had a learning disability. It may have been pertinent for joint cross cutting work to assess John. However, as no formal community care assessment was undertaken there was no opportunity to consider this method of support.

7.3.5 There was an over-reliance placed on John 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.

7.3.6 It is unclear whether his predatory behaviour was in part a function of his homelessness. Had the planned multi-agency meeting to consider the risks John presented to others been convened before he murdered Harry, help with his homelessness might have helped to bring some stability to his life and possibly reduced his offending.

7.4.1 Were eligibility criteria applied correctly?

7.4.2 The Care Act 2014, which did not come into force until a few weeks prior to the murder of Harry, states that local authorities must undertake an assessment for any adult with an appearance of need for care and support, regardless of whether or not the local authority thinks the individual has eligible needs or of their financial situation. (Paragraph 6.12 Care Act statutory guidance)

7.4.3 The national eligibility criteria set a minimum threshold for adult care and support needs which local authorities must meet. And in considering whether an

adult with care and support needs has eligible needs, local authorities must consider whether

- the adult's needs arise from or are related to a physical or mental impairment or illness
- as a result of the adult's needs the adult is unable to achieve two or more of the specified outcomes*
- as a consequence of being unable to achieve these outcomes there is, or there is likely to be, a significant impact on the adult's wellbeing.

All three of these conditions must be met.

* specified outcomes are

- managing and maintaining nutrition
- maintaining personal hygiene
- managing toilet needs
- being appropriately clothed
- being able to make use of the home safely
- maintaining a habitable home environment
- developing and maintaining family or other personal relationships
- accessing and engaging in work, training, education or volunteering
- making use of necessary facilities or services in the local community including public transport and recreational facilities or services
- carrying out caring responsibilities the adult has for a child

7.4.4 Karen was not assessed as having needs arising from or related to a mental impairment or illness although she had been referred for a mental health assessment in the month prior to the murder of Harry which did not take place.

7.4.5 As stated earlier, John received frequent mental health assessments carried out at St Ann's hospital under circumstances where he had been detained by the police under the Mental Health Act. Whilst there is no record of other assessments being offered, he was referred to other agencies including addictions services, the night shelter and steps to wellbeing. Each service would have completed their own assessment of his needs as part of their process although it is known that John terminated his assessment by steps to wellbeing.

7.5.1 When and in what way were the victim's wishes and feelings ascertained and considered? Was the victim signposted to other agencies?

7.5.2 TCD, Poole Adult Safeguarding and Dorset Healthcare staff sought to work with Harry in a person-centred way. There is abundant evidence that the staff providing care for Harry were committed to ascertaining and considering his wishes and feelings. This was done on a one to one basis and via the TCD My Diary system on which Harry frequently shared his wishes and feelings.

7.5.3 Harry was supported to make friends and form relationships. He was known to be desperately seeking a relationship and wished to live an independent life. Respecting Harry's wishes and feelings became much more challenging once staff

supporting him came to the conclusion that his relationship with Karen was exposing him to the risk of exploitation. Thereafter there was often a tension between Harry's wishes and the concerns for his safety which proved difficult to reconcile.

7.5.4 Harry was signposted to other agencies on occasions such as the time he was seeking volunteering opportunities.

7.6.1 Were procedures sensitive to ethnic, cultural and religious identity of victim, perpetrator and their families? Was consideration in respect of vulnerability and disability necessary?

7.6.2 The victim and the perpetrators were recorded as white British. Harry was born overseas into a family in which his father was then a member of the UK armed services and returned to the UK early in his childhood.

7.6.3 No information has been provided about the religious or cultural identity of the victim or perpetrators.

7.6.4 Turning to vulnerability arising from disability, 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
- Foster good relations between people who share a protected characteristic and those who do not

The second of the three aims listed above involves having due regard 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
- 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".

7.6.5 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.

7.6.6 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 (10).

7.6.7 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 (11).

7.6.8 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" (12).

7.6.9 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 (13). The report quotes the former Director of Public Prosecutions Ken Macdonald who said that "we must overcome a prevailing assumption that it is disabled people's intrinsic vulnerability which explains the risk they face" (14).

7.6.10 The report goes on to observe that "it is not disabled people who create their oppression. It is others". 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 (15).

7.6.11 The EHRC 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.

7.6.12 Research indicates that disabled women may be assaulted or raped at a rate that is at least twice that of non-disabled women (16). 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 (17). 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.

7.6.13 The victim in this case had a learning disability and whilst it is not completely clear whether the perpetrators had a learning disability, they both had care and support needs.

7.6.14 Arguably Harry's intrinsic vulnerability was increased by the following acts and omissions:

- 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 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 5.108). 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.

7.6.15 Karen's exit from the IDVA service suggested that there may have been a perception that the client group of which she was seen to be part were "non-engagers" which may have led to a tendency to give up on them too quickly.

7.6.16 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
- Transgender identity

7.6.17 This can be in the form of verbal abuse, physical assault, domestic abuse, harassment and damage to property. If someone is bullied as a result of their disability, race, religion, sexual orientation or transgender identity this is also dealt with, either as a Hate Crime or non-crime Hate Incident. Bullying can be name-calling, being spat at or kicked, or having your things taken or damaged".

7.6.18 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.

7.6.19 The fact that the threatening texts were sent by Karen and John who themselves may have had care and support needs does not preclude disability hate crime being considered. It is possible that adopting a "hate crime" or "non-crime hate incident" perspective might have led to a more substantial response to the reports of threatening texts that Harry and his TCD care workers reported to the police.

7.6.20 Gender is not referred to in this terms of reference, but it is worth pausing for a moment to consider whether Harry would have been treated any differently had he been a female victim of male domestic abuse. Had he been a female in an abusive relationship in which he 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.

7.6.21 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 professionals, 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.

7.6.21 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 (Paragraph 5.113, 5.114 and 5.134 refer) after both had been arrested and charged with assaulting each other.

7.7.1 Did the agency utilise risk assessment, if so were they correctly used?

7.7.2 Risk assessment in respect of Harry appeared to be frequently reactive and insufficiently fluid.

7.7.3 As mentioned earlier, action to mitigate the risk of financial abuse of Harry was not taken until he had been financially exploited by Karen. (Paragraph 5.3 describes the incident involving two mobile phone contracts.) Harry had been assessed as lacking capacity to make decisions about financial matters in March 2013 (Paragraph 4.4) 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. Such arrangements could have helped the Nationwide Building Society to prevent the theft of cash from Harry's account by Karen and John in November 2014. (Paragraph 5.41)

7.7.4 The range of risks that Harry could face in intimate relationships did not appear to be anticipated until they arose. TCD appropriately encouraged him to undertake community based activity and participate in voluntary work to keep him occupied, to increase his circle of friendship, and to support him to make and build appropriate relationships. Although Harry had been previously assessed to have capacity to form relationships, this did not mean that such relationships would be devoid of risk. The risks to Harry arising from his relationship with Karen first became apparent in April 2014 but it wasn't until late August 2014 that the protection plan and protocol devised by TCD to keep him safe was finalised and agreed with Poole Safeguarding and Harry himself.

7.7.5 The protection plan and protocol is a practical one page document which is 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. It is unclear whether the plan was consulted upon or shared with the police. It would appear that the plan was shared with IDVA 1 but there is no evidence that the IDVA service contributed to it.

7.7.6 The TCD IMR also refers to a Borough of Poole adult safeguarding plan for Harry which was prepared a month after the TCD protection plan and protocol. The version of Harry's adult safeguarding plan dated 6th March 2015 has been shared with this review. The plan 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.

7.7.7 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.

7.7.8 The author of the Dorset Health Care and Borough of Poole IMR considered the adult safeguarding plan to be lacking in a number of respects. When the plan was considered not to be working, a professionals meeting was not held to review it, it was not clear which agencies had a copy of it and there was no evidence that risk management tools were used to underpin the management plan. Overall the IMR author concluded that there was no evidence that multi-agency risk management plans were considered in order to identify all the risks Harry faced, and how these risks might be reduced.

7.7.9 This is disturbing particularly as the Poole MARAC which considered the referral in respect of Harry in August 2014 decided that the high risk of domestic abuse he was assessed as facing from Karen should be addressed via the adult safeguarding plan. MARAC appears to have assumed that the adult safeguarding plan would address the high risk of domestic abuse. There is no evidence that they sought assurance that this was actually the case.

7.7.10 It would appear that 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. The risks John presented to others only gradually became apparent to agencies and the sharing of information about the risks he presented was incomplete. 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 Harry, 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 has 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.

7.7.11 A very noticeable 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. MeetMe, the social media website through which Harry originally made contact with Karen, focusses on helping users discover new people to chat with on mobile devices. Approximately 90% of the traffic on the website comes from mobile users. The service is said to have over one million daily active users. It is classed as a social discovery site as opposed to a dating website or traditional sites such as Facebook which focus more on helping people stay in touch with existing friends.

7.7.12 Websites such as Safekids.com provides advice on how to stay safe on social discovery sites such as MeetMe which includes limiting location information, sharing contact information with care, looking out for "tell tale" signs of exploitation and reporting abuse such as sexting or bullying. Such guidance is extremely valuable but has been written for children, young people and parents of average intelligence or above. However, 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.

7.7.13 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.

7.7.14 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.

7.7.15 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 effective 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.

7.8.1 Was the victim subject to MARAC?

7.8.2 The referral to Poole MARAC in respect of Harry in July 2014 prompted only very brief engagement by IDVA 1 who did some work with Harry on safety planning and domestic violence awareness, put him in touch with police in respect of threatening texts from Karen and helped him change his landline and mobile phone numbers. This latter step was quickly undermined when Harry rang Karen from his new mobile number. The IDVA also did some work with Harry around healthy relationships but appears to have reached the conclusion that Harry did not recognise the risks some of his actions exposed himself to which compromised his safety. The IDVA questioned whether Harry had capacity to make decisions about relationships.

7.8.3 The referral was accepted by IDVA on 23rd July 2014, two meetings were held with Harry on 7th and 8th August 2014 and the IDVA withdrew following the MARAC meeting on 15th August 2014. There appeared to be insufficient consideration of the benefits of the IDVA working with Poole Adult Social Care and TCD. The IDVA was invited to the safeguarding meeting scheduled for 4th September 2014 but had disengaged by this time and did not attend.

7.8.4 Whilst there is a risk that safeguarding activity may duplicate the work of the MARAC, it is important to have local protocols in place to indicate how and when MARAC will fit into adult safeguarding procedures and vice versa. In the case of

Harry there seemed to be an assumption that Harry's domestic abuse risks would be effectively managed through the safeguarding process.

7.8.5 On the second occasion Harry was referred to the IDVA service – in November 2014 – there was again an assumption that there was no role for IDVA because of the support Harry already had in place.

7.8.6 The IDVA service was provided by the Bournemouth Churches Housing Association at that time who have advised this review that awareness of learning disability was an "issue" at that time, implying that the IDVA service may have lacked sufficient confidence to engage with victims with a learning disability. The speed with which Harry's referral was relinquished by the IDVA service reinforces this view.

7.8.7 The IDVA mindset at that point – and that of other agencies - appeared to be that in each case there was a victim and there was a perpetrator. Some work was done with Harry as victim but very little consideration was given to the perpetrator Karen's evident vulnerability at this point. The perspective that working with her to address her vulnerability might contribute to Harry's safety was not in evidence. Indeed, MARAC advised Poole Housing 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. This was a decision which seemed likely to make Karen even more vulnerable - and could have had the unintended consequence of Karen trying to stay with Harry – which she later did for a short time. And if Karen continued to experience accommodation instability as a result of the withdrawn supported housing application, it might well be harder to keep track of her.

7.8.8 Karen was twice referred to Bournemouth MARAC as a victim. On the first occasion in January 2015, information sharing was incomplete and possibly inaccurate. Her relationship with Harry was inexplicably seen as a positive. There was no apparent challenge to IDVA disengagement. There was little linkage made with the previous referral to Poole MARAC when Karen was seen as the perpetrator. There seemed an absence of follow up. Children's Social Care was said to be monitoring her.

7.8.9 When Karen was referred to MARAC a second time – on 20th May 2015 – the IDVA service was unable to open the referral email sent by the police until 26th May 2015. It seemed to take rather a long time to overcome the technical problems which prevented access to the referral which appears inconsistent with the effective management of high risk cases.

7.8.10 Overall the MARAC process appeared to add very little value in respect of either Harry or Karen. The CAADA DASH checklist is predisposed to assess risks for women with children and is known to have limitations for the identification of risk factors experienced by disabled and older people (18). The importance of professional judgement is therefore reinforced for cases which fall outside the understandably dominant "women with children" focus.

7.8.11 Also the MARAC process seemed to envisage a clear cut distinction between victim and perpetrator. Within the space of a few months, different MARACs (Poole and Bournemouth) were considering Karen as first a perpetrator and then a victim. 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. The MARAC process may need to adopt a more fluid approach to reflect that fact that in some relationships, the parties can be both victim and perpetrator and that they will be faced with people like Karen who at times could be extremely vulnerable whilst at other times could pose significant risks to others.

7.8.12 This case generated only three MARAC referrals. There were probably opportunities when other MARAC referrals could have been considered.

7.8.13 This case also raises the question of where responsibility lies for the "high risk" contained within the cases that MARAC considers. Does the "high risk" of domestic abuse continue to be held by the agencies involved with the victim? Or does MARAC take ownership of the "high risk" once a case is referred to it? Who owns the "high risk" once MARAC has considered a case?

7.8.14 In the August 2014 MARAC referral in respect of Harry, MARAC appeared to be satisfied that the "high risk" of domestic abuse that Harry was assessed to be facing would be addressed via the adult safeguarding plan for Harry. But MARAC appeared to take no steps to assure themselves that that safeguarding plan was fit for purpose and robustly addressed the "high risk" of domestic abuse he faced. In respect of the January 2015 MARAC referral in respect of Karen, MARAC appeared to take comfort from the fact the Children's Social Care were monitoring Karen. But were they aware that the primary focus of Children's Social Care was to safeguard Karen's unborn child as opposed to reduce Karen's risk of victimisation from domestic abuse?

7.8.15 TCD as the primary support for Harry say that they received no feedback from the referral that Poole MARAC considered in August 2014.

7.9.1 Did action/risk management plans fit with the assessment and decisions made?

Please see Paragraphs 7.7.1 to 7.7.14 above.

7.10.1 Were decisions reached and informed in a professional way?

7.10.2 Sound decision making requires accurate, complete and timely information. There were occasions when decision makers took decisions in the absence of accurate, complete and timely information. For example, the information considered by Bournemouth MARAC in respect of the referral of Karen as victim of John in January 2015 was inaccurate in some respects. And Bournemouth Children's

Services initial response to concerns raised by midwifery about Karen and her unborn child were hampered by incomplete information.

7.10.3 There were also several examples of incidents being dealt with in isolation from knowledge of other relevant incidents. This is particularly apparent in the police response to incidents involving Harry as victim and John as perpetrator.

7.11.1 Were managers involved at the appropriate points?

7.11.2 There were a number of key events which did not appear to be overseen by managers or escalated to managers.

7.11.3 For example, IDVA 2 became aware that Karen was locked in a flat and unable to leave on 15th December 2014. It is unclear how sinister this incident was although at the subsequent MARAC meeting IDVA 2 refers to the incident as one of "false imprisonment", yet apparently no action was taken to escalate matters at the time.

7.11.4 In the days before Harry was murdered there were a number of incidents which should have been escalated. Harry related his account of being locked in Karen's flat on 20th May 2015 separately to two TCD care workers the following day. He again shared the details of the 20th May 2015 incident with another TCD care worker on 24th May 2015. When he visited his GP for the DNA test on 21st May 2015, Harry was noticed by his TCD care worker to be very frightened. Details of the 20th May 2015 incident were shared by TCD with Poole CLDT but there is little evidence in either agency of effective managerial intervention.

7.12.1 Analysis of the victim/perpetrator relationship and management plans for perpetrators;

7.12.2 TCD was the single agency which accumulated the fullest picture of Harry's relationship with Karen. The TCD IMR noted that Harry's relationship with Karen fluctuated over time. Sometimes they were together. Sometimes they were not. Sometimes they were seemingly happy. Sometimes the relationship was abusive. Sometimes Harry told staff (and other professionals) about matters. Sometimes he did not. Sometimes Harry was threatened. On occasions he did the threatening. Sometimes Harry was open with staff about his relationship with Karen and sometimes he was not.

7.12.3 A number of key events altered the dynamics of Harry's relationship with Karen included her pregnancy and the generally held (but ultimately erroneous) belief that Harry was the father, Karen's involvement with John, the birth and removal of Karen's child and the delayed DNA test planned to establish Harry's paternity.

7.12.4 The pre-birth assessment carried out in respect of Karen's unborn child was an opportunity to gain a better understanding of the dynamics of the relationship

between Karen and Harry as the presumed father but the assessment was said to be less than holistic and picked up only “snippets of risk”.

7.12.5 As stated earlier, the adult safeguarding plan did not appear to reflect the changes in the relationship between Harry and Karen nor the entry of John into the picture, or indeed the threats that Gina appeared to pose to Harry for a period.

7.12.6 TCD say that they found great difficulty in obtaining information about Karen from partner agencies which they say hampered their efforts to safeguard Harry.

7.12.7 The relationship between the victim and perpetrator was complicated by the presence of a number of other people who drifted into and then out of view for periods of time. It was very challenging to keep track of all of these people, particularly as individuals may have assumed the identify of others when using social media, may have borrowed the phones of others to send texts and in some cases manufactured the identities of people who did not actually exist.

7.12.8 However, it is noticeable with hindsight that no agency or multi-agency grouping appears to have spent time trying to come to an informed understanding of the dynamics and risks present within the triangular relationship between Harry, Karen and John.

7.13.1 Was their a “mindset” that pre-determined how individuals were responded to and/or eligibility criteria applied, following on from how they used agencies?

7.13.2 There are a number of examples where single or multi-agency mindsets led to less than optimal approaches.

7.13.3 This case really challenges the mindset that the victims of sexual exploitation are predominantly children and young people. John was a perpetrator of sexual exploitation but whilst some of his victims were under the age of 18, the common feature which linked all of his victims was disability arising from a learning disability, autism, mental health problems and/or physical disability. This is an extremely valuable insight which may illuminate clusters of abuse which might previously have remained hidden or viewed in isolation.

7.13.4 As previously stated, 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 (19).

7.13.5 IDVA appeared to have a mindset that certain types of clients did not engage and appeared to close their cases due to lack of engagement without persevering or trying more creative approaches to engagement. Premature closure of cases is unlikely to reduce the risks the person is experiencing.

7.13.6 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. Over time, it seems likely that professionals could have become de-sensitised to the threats because there were so many threats sent by text message which were not carried out. However, 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 to chastising Harry for destroying his phone and advising him that he could not expect it to be replaced quickly and that he could not expect the replacement to be "all singing and dancing".

7.14.1 Application of individual agency Policy and Procedures, Multi Agency Policy and Procedures and legislation;

7.14.2 Dorset Police has reviewed the information available in respect of John and concluded that he appears to have met the qualifying criteria for a Multi Agency Public Protection Arrangements (MAPPA) referral.

7.14.3 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. They 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.

7.14.4 There are three categories of MAPPA offenders:

Category 1 – Registered sexual offender;

Category 2 – Murderer or an offender who has been convicted of an offence under Schedule 15 of the Criminal Justice Act and who has been sentenced to 12 months or more in custody; and

Category 3 – Other dangerous offender: a person who has been cautioned for or convicted of an offence which indicates that he or she is capable of causing serious harm and which requires multi-agency management. This might not be for an offence under Schedule 15 of the Criminal Justice Act 2003.

7.14.5 There had been three allegations of rape made against John; in July 2014 when there was considered to be insufficient evidence to charge, in September 2014

when Karen was the victim and there was again insufficient evidence to charge and in March 2015. John was on police bail in respect of this latter allegation at the time of the murder of Harry.

7.14.6 To register a category 3 offender, the “responsible authority” must establish that the person has committed an offence which indicates that he or she is capable of causing serious harm to the public, and reasonably consider that the offender may cause serious harm to the public which requires a multi-agency approach at level 2 or 3 to manage the risks. (Level 2 requires an active multi-agency approach and level 3 is for cases which meet the criteria for level 2 but the management issues require senior representation from the core MAPPA members.)

7.14.7 Any MAPPA referral in respect of John would have to have contained information relating to convictions or cautions and pattern of offending and/or incidents of concern. A risk assessment would be completed where risk factors were identified and a risk reduction strategy proposed. Any referral would need to evidence how active multi-agency management would add value to the management of the risk of serious harm. Although many of the offences John was alleged to have committed did not result in conviction or caution, John did have “qualifying convictions” in that he had received a final warning for sexual assault on a female in 2006 and was later convicted of witness intimidation relating to threats of violence towards the same victim. The original disposal for sexual assault could have been used to fulfil the criteria for MAPPA referral even though it significantly predated the concerns which later emerged about his sexually predatory behavior towards vulnerable females and males.

7.14.8 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 in that the police did not appear to have been generally invited. For example, the police were not invited to a professionals meeting held on 21st October 2014 to discuss the risks posed to Harry. A further safeguarding meeting in February 2015 apparently agreed a revised protection plan for Harry but it appears that the police were not sent a copy.

7.14.9 Whilst multiple meetings were held to review Harry’s protection plan these were not always formally held as Safeguarding Case Conferences.

7.14.10 To an extent the police worked 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. The opportunity to make links between the incidents and bring the bigger picture into view was not taken despite the number of calls received. 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.

7.15.1 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.

7.15.2 Failures in information sharing appear to be a more or less constant theme in SARs, DHRs and SCRs. Sadly, this case is no different. Vital information which indicated that the risks presented to Harry by Karen and John had escalated in the last week of Harry's life was not shared, or not shared sufficiently widely by TCD or Poole CLDT.

7.15.3 The failure to engage the police in multi-agency efforts to safeguard Harry restricted the exchange of information and the limited number of adult referrals made by the police following their contacts with Harry, Karen and John restricted the flow of information from the police to the agencies working together to keep Harry safe.

7.15.4 The movement of Karen and her unborn child across local authority boundaries generated more information sharing difficulties than this should have done given the requirement of the Pan- Dorset Safeguarding Policy which states that "in all cases, information should be shared immediately as all information about a child should be held where the child is residing".

7.15.5 Several IMR authors identified that there were issues arising from staff using several electronic recording systems, particularly when recording safeguarding activities which, at times, led to a delay in all professionals involved in Harry's care, treatment and support having access to relevant information.

7.15.6 There were times when it may have been beneficial during the safeguarding interventions to have nominated one person as the main contact point for all safeguarding communication.

7.16.1 Any good practice identified that can be passed on to other agencies;

7.16.2 There were a number of examples of good practice highlighted in the IMRs submitted to this review:

7.16.3 The Dorset Health Care Trust IMR made mention of an easy read report shared by a psychologist with Harry in May 2013. The same IMR regarded the identification of a suitably trained safeguarding adults practitioner who went on to work well with Harry and staff who knew him well, as good practice.

7.16.4 The Bournemouth Children's Services IMR considered the actions of a midwife in ensuring Karen and her unborn baby were identified to local services following Karen's move from Yeovil, to be "above and beyond" expected practice.

7.16.5 The Dorset CCG IMR highlighted the practice demonstrated by the Royal Bournemouth Hospital who discussed John's frequent attendance at A&E at a multi-

disciplinary meeting and recognised that he was repeat attender largely due to his homelessness. They arranged psychiatric reviews and sign-posting to other support services.

7.16.6 The Dorset Police IMR identified two areas of good practice. When the theft of money from his building society account was investigated in November 2014, the police took the wishes and views of Harry into account in accordance with the "Making Safeguarding Personal" agenda. The police also highlighted the positive action they took in response to a number of allegations of serious sexual offences by John, carrying out detailed investigations despite a lack of available evidence.

7.17.1 What practices can be improved on and lessons learnt?

(Single agency action recommendations and plans are shown at Appendix A)

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.

9.0 Findings and Recommendations

9.1 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. All agencies involved in supporting Harry have committed to this review and the findings and recommendations arising from it are set out below.

Transition from Children's to Adult Services

9.2 Karen's 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 Kate 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 and fell into the gap in adult services in which many young adults with care and support needs can find themselves.

9.3 Dorset County Council were Karen's corporate parents. They recognise that they did not succeed in ensuring she 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.

9.4 Safe transition to adulthood for Looked After Children such as Karen is an issue which has received much attention from legislators in recent years. 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. The Care Act guidance also states that 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. They should consider how to establish mechanisms to identify young people as early as possible in order to plan for, or prevent the development of, care and support needs. These provisions could have helped to anticipate and address the needs of Harry as he approached adulthood, and possibly John's.

9.5 Sitting alongside the Care Act 2014 is the Children and Families Act 2014 which 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, over the past year, it has undertaken a programme of extensive engagement with stakeholders to identify how best to implement the new legislation and 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.

9.6 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

9.7 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. In particular, the information considered by Bournemouth MARAC about Karen in January 2015 was not completely accurate. The fact that Poole MARAC decided that the high risk of domestic abuse faced by Harry could best be addressed via his adult safeguarding plan without seeking assurance that the adult safeguarding plan was robust, and without any further follow up, hints that the MARAC process could have been experiencing some strain. A similar observation could be made about the decision by Bournemouth MARAC that the high risk of domestic abuse faced by Karen could best be monitored by Children's Services, again without seeking assurances or follow up. This review has been advised that in 2015/16 Poole MARAC considered 175 referrals and Bournemouth considered 320.

9.8 In respect of both Harry and Karen, the IDVA service engaged only briefly. 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).

9.9 The MARAC process appears 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.

9.10 The MARAC process needs to adopt a more fluid approach to reflect the fact that in some relationships, the parties involved can be both victim and perpetrator and periodically they will be faced with people like Karen who at times could be extremely vulnerable whilst at other times could pose significant risks to others.

9.11 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 had 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. (Paragraphs 5.106 -5.109 refer) 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.

MARAC and Adult Safeguarding

9.12 When Poole MARAC considered the referral in respect of Harry in August 2014 (Paragraph 5.12) they decided that the high risk of domestic abuse he was assessed as facing from Karen could be managed within the adult safeguarding plan. As this review has demonstrated, that 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 in terms of domestic abuse and adult safeguarding 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. Indeed, the IDVA discharged Harry's case very shortly after the meeting of Poole MARAC.

9.13 The two processes – 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

focused on the risks of domestic abuse to women and children. Whilst this will undoubtedly continue to be a key concern of MARAC because of the harm experienced by women and children from domestic abuse, much more work needs to be done to ensure that the MARAC process is *as* aware of the safeguarding adults agenda as it is of the safeguarding children agenda.

9.14 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.

9.15 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.

9.16 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

9.17 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. (See single agency recommendations in Section 10 of this report.)

9.18 This is very welcome and fully justified by the learning which has emerged from this review. Many professionals doubted whether Harry had the capacity to make decisions in his relationship with Karen, a relationship in which he was assessed as being at high risk of domestic abuse. Harry had been assessed as having capacity to make decisions in respect of relationships prior to entering into his relationship with Karen. It was entirely right that professionals should seek a further test of his capacity in respect of relationships given the development of this abusive relationship. It is regrettable that it was considered not possible to undertake this further assessment of his capacity because of the conflicting answers Harry gave in response to questions asked.

9.19 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.

9.20 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.

9.21 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.

Social Media

9.22 As this review has demonstrated, although the use of social media has the potential to enhance the life of people with learning disabilities in many ways, not surprisingly, unsafe use of social media by a person with a learning disability can expose them to considerable risk. This places a strong emphasis on professionals working with people with learning disabilities to be aware of how to support them in the safe use of social media. And any organisation employing staff 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.

Recommendation 6

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.

Sexual Exploitation of vulnerable young people and adults

9.23 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.

9.24 *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 (20). 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.

9.25 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 7

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.

9.26 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 8

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 consider how best to advance the further exploration of the "model" of sexual exploitation apparent in this case.

9.27 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 complaints of rape by separate alleged 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 or convictions.

Recommendation 9

That 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

9.28 Without wishing to pre-empt the IPCC investigation, it is possible to perceive the apparent police failure to follow through on the commitment they gave to Harry on 15th May 2015 to visit and warn John and Karen about the texts they had sent Harry threatening to kill him, as characteristic of a lack of engagement with the safeguarding adults agenda. Generally, their approach was characterised by a tendency to treat each incident in isolation, to infrequently follow their policy of making vulnerable person notifications and to adopt an informal as opposed to formal approach except when there was the clearest possible evidence of criminality as when Karen and John stole over £800 from Harry's building society account.

9.29 Treating each incident in isolation limited the ability of the police to even begin to build up a picture of Harry's vulnerability but also obstructed their view of the risks that Karen and particularly John presented to Harry. It may also 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.

9.30 At operational level there appears to have been a marked lack of awareness of adult safeguarding and a tendency to treat many of the incidents involving Harry as being of a relatively low level of priority. Nor did the police appear to be sufficiently engaged in adult safeguarding at the partnership activity level. They appear generally not to have been invited to any of the meetings called to review efforts to safeguard Harry. Clearly some responsibility must fall on the partner agencies issuing the invitations to these meetings but there was also a responsibility on the police to adopt a far more proactive approach to partnership working in this field. This 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.

9.31 However, 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 10

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

9.32 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)

9.33 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.

The assessment and management of risk

9.34 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.

9.35 This failure is one of many indications of a lack of appreciation of the assessment and management of risk. Managing risk over a fairly lengthy period requires quite a watchful approach in which staff are trained to notice differences or variations from the norm. This did not appear to happen in Harry's case with evidence that over time staff became 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.

9.36 There seemed to be a lack of watchfulness and alertness in respect of Harry's adult safeguarding plan which was not updated to reflect John's arrival on the scene for example and did not appear to be driving actions with a great deal of urgency.

9.37 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?

9.38 There seems to be 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 11

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.

Financial abuse

9.39 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

9.40 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

9.41 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.

9.42 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.

Information sharing

9.43 There were a number of information sharing challenges which are highlighted in Paragraphs 7.15.1 to 7.15.6 and elsewhere in this report. 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 listed in Appendix A 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.

Making reasonable adjustments for people with learning disabilities

9.44 As stated earlier, 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.

9.45 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. 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.

List of Recommendations

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.

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.*

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.

Recommendation 6

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the range of partner agencies which provide support to people with learning disabilities.

Recommendation 7

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.

Recommendation 8

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 consider how best to advance the further exploration of the "model" of sexual exploitation apparent in this case.

Recommendation 9

That 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.

Recommendation 10

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.

Recommendation 11

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.

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.

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.

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(20) 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*

Single Agency Recommendations:

Borough of Poole Adult Social Care

- That any triage or initial screening process includes links with the relevant local authority children's services as information sharing, including any past information about a victim or alleged harmer (perpetrator), is vital when safeguarding adults concerns are raised.
- When it appears that an individual may require support, Adult Social Care will ensure that an assessment of needs is undertaken in line with the Care Act 2014 to determine if an individual adult is in fact in need of support including any specialist interventions. Alternatively, individuals will be given advice and support to access non statutory services
- Risk assessments will be undertaken routinely and used to underpin decision-making in relation to undertaking reassessments and the closure of safeguarding cases.
- Consideration will be given for community safety strategies to address harassment, hate or mate crime and exploitation.
- Safeguarding adults training will include updates on legislative changes and the full range of legal interventions available to staff working to protect adults from harm and abuse.
- Mental Health and Learning Disability Services will determine which specialist area is appropriate to assess people who appear to have social function and conduct disorders to enable health and social care staff to refer accordingly.
- Staff will be reminded of the need to hold formal Case Conferences (Enquiry Review Meetings) to include all relevant agencies in order to share intelligence about adults at risk of harm and alleged perpetrators.
- When managing and responding to safeguarding concerns all staff engaged with these activities should consider all legislative options available to safeguard the adult at risk of harm. These must be documented and a record made of why it was not appropriate to pursue the specific course of action.
- A nominated professional will be identified as the central contact point for all communication during safeguarding interventions.

Borough of Poole Adult Social Care (Multi-agency recommendations)

- When a range of concerns are raised in relation to an alleged harmer who poses risks to other adults deemed to be vulnerable, multi-agency assessment and management of risk meetings will be considered as part of the safeguarding process, either through Vulnerable Victims Conferences or Multi-Agency Risk Assessment and management meetings, to enable the development of risk management plans.
- The Bournemouth and Poole Safeguarding Adults Board should consider running a joint agency campaign raising awareness of the potential dangers of Internet and Facebook targeting to alert people to Mate Crime /Hate Crime and what actions to take if they are concerned. This should be considered as part of the SAB's Prevention Strategy.
- That consideration should be given to the Dorset Information Sharing Charter being offered to Local Authorities outside of the wider Dorset area. (However, the ADASS Cross Border Safeguarding Protocols should negate the need for this.)
- That all staff across agencies are reminded that the Safeguarding Adults Multi-Agency Policy and Procedures for the Protection of Adults with Care and Support Needs in Bournemouth, Dorset and Poole, (August 2014), apply to anyone over the age of 18 years with the requirement for the Local Authority to make enquiries if an adult meets the criteria. (It was clear that Karen who was pregnant was unable to protect not only herself, but that her chaotic and at times abusive behaviour posed a risk to her unborn child.)
- Karen was vulnerable, complex and difficult to engage at times. As such it may have been helpful for professionals to have held a multi- agency meeting to include all relevant professionals including Children's and Adults Social Care, Housing and health. This would be an opportunity to share concerns and risk histories; to identify if Karen was a risk to others and whether she was also at risk of harm and agree levels of intervention. This does not specifically apply to Poole ASC but also to other agencies with whom she had contact.
- Stronger links to be made between Safeguarding Adults and Safeguarding Children for all professionals and agencies working with adults and children.
- Protocols for Transitions from Children's Services to Adults Services are being reviewed and need to include clear lines of accountability for the transfer of information, background histories, risk assessments and responsibilities for the specific individual for accommodation and support including health and social care. In addition, clarity around the responsibility of the Post 16 Care Leavers team and Pathways Team.

Borough of Poole Adult Social Care (recommendation for Dorset and Somerset County Councils)

- That staff in both Dorset and Somerset need to be reminded that good practice dictates that it is the Local Authority where the alleged harm has taken place that has the responsibility for coordinating any Investigation /Enquiry. (There appears to have been some confusion that the incident that happened at the George Hotel would be dealt with by Dorset or Somerset)

Borough of Poole Children's Services

- A system will be implemented to flag cases where a new electronic record of a person bears similarity to another existing record. The record will be tracked until sufficient information is gathered to rule the match in or out.
- Management scrutiny of timely responses to assessments will continue in order to ensure assessments are completed within timescales that address risk to children and vulnerable adults.
- Managers will be reminded, through a synopsis of this case, of their responsibility for good information sharing across Local Authorities when cases close due to a child moving.
- Practitioners will be reminded that one of the causes of drift in cases is slow information sharing and that they must use strategies to track progress and to escalate with other agencies where responses have impacted on the timeliness of assessment.

Dorset HealthCare University NHS Trust (DHC) (Harry)

- Because there were several missed opportunities when staff failed to identify that raising a safeguarding concern with the local authority may have been of benefit to Harry, it is recommended that mandatory safeguarding training is completed by all staff within the Community Learning Disability Team who haven't already completed the training. This will ensure that staff recognise safeguarding concerns and make appropriate safeguarding referrals.
- It is also recommended that domestic violence training is completed by all staff within the Community Learning Disability Team who haven't already completed the training. DHC will also review the current requirement for staff to complete MARAC and domestic violence training so that relevant staff understand when and how to complete a CAADA risk assessment and referral to MARAC.

- Staff from DHC's CLDT and BoP's Safeguarding Adults team will be informed of the risk assessment tool which is contained within the Multi-agency safeguarding procedures. Staff from the CLDT team to be recommended to hold multi-disciplinary team meetings in response to any disclosures of abuse.
- Members of DHC's CLDT and staff undertaking safeguarding activities will be directed to complete risk assessments to underpin decision making and the development of management plans.
- All agencies including police, where appropriate, will be invited to safeguarding meetings so that information and concerns can be shared.
- Protection plans will include specific actions to reduce or minimise risks and risk assessments will be shared with all relevant agencies including police and the Social Care Out of Hours Service, thereby ensuring a consistent approach is adopted by all professionals and to share decision making and safeguarding responsibilities.
- Policies and procedural guidance on Mental Capacity Assessments will be reviewed to ensure that relevant staff across the range of agencies have professional knowledge and understand the practical application of these procedures.
- Consideration will be given to reviewing how relevant safeguarding records can be accessed by staff within the CLDT.
- The actions required of provider organisations under Safeguarding Policies will be considered and included in the Protection Plans.

Dorset HealthCare University NHS Trust and Borough of Poole

(Karen)

Multi-Agency Recommendations

- Out of county placements have been recognised to create inequalities in accessing services in previous cases (DoH 2012). Exploration of this area is outside the terms of reference for the IMR. It is recommended that the overview author considers exploration of this to be included in the combined SAR and DHR report.
- The Health Visitor records evidence that Karen expressed her fear of losing her baby and that she was only happy when she saw him. The records also document that the legal team decided that Karen was not suitable for a mother and baby placement but the rationale for this was not shared. Examination of this decision is outside the terms of reference for this IMR. It

is recommended that the overview author considers evaluating this decision as part of the combined SAR and DHR report.

- From this IMR it is clear that Karen was often seeking accommodation either in Poole or Yeovil and at least two referrals were made regarding future support. When information was not forthcoming requests for assessments were not pursued however it appears that this was not formally put in writing as such this is an issue of future good practice.
- Agencies advised to hold multi-disciplinary meetings to discuss concerns that have been identified to agree shared management plans. Representatives from adult and children services to be invited to all meetings to establish a "Think Family" approach and facilitate a cohesive response to care provision.

Dorset HealthCare University NHS Foundation Trust

- Consideration is given to the continued provision of the Criminal Justice via Liaison and Diversion (CJLD) and street triage services continue to be provided after the pilot period to ensure that liaison between health services and the criminal justice service continue to be effective and person centred.
- Consideration be given to the Health Visitor service developing its own network of Health Visitors with experience of supporting families who have Looked After Children, so that peer support can be provided to Health Visitor's.
- Dorset Health Care to consider completing a scoping exercise to explore if the Specialist Nurses for Looked After Children are able to provide support, advice or training to Health Visitors who provide support to the birth parents of looked after children. (Recommendation made by Borough of Poole Adult Social Care)

Dorset Police Developments:

- This case has led to the review of how Dorset Police triage Adults At Risk (AAR) information from other agencies – removing individual officer responsibility, through the implementation of a system based process – i.e. SRU single point of contact.
- Dorset Police is developing its understanding of Adult Social Care arrangements and their referral mechanisms.

- Dorset police recognise it would benefit from an AAR specialist service/investigation team (including financial investigation support) with specific oversight by a Detective Inspector. This development is underway and features as part of the review.
- Dorset Police needs to develop a force AAR policy and procedure guidance for front line staff – in support of the Pan Dorset Multi-Agency Safeguarding Adults policy.
- Knowledge of MAPPA and referral procedure has been shown to be inconsistent. Force training needs to be refreshed.
- Dorset Police is developing its decision making model, to ensure its consistent use and approach to assessing and managing threat and risk in Public Protection issues.
- Dorset police has already recognised the need to scan for and identify high risk victims, offenders and locations through an automated and risk based approach – this work is well underway.
- Daily POLE (Person, Object, Location, Event) Alerts search (searches for incidents involving those already flagged as an Adult at Risk) as well as those locations flagged as Care Homes (or establishments providing care) and finally all incidents/logs are now searched by an automated system including key words such as Vulnerable, Dementia, Alzheimer's etc.
- A multi-agency risk review meeting now takes place on a quarterly basis, where escalating concerns are discussed and reported to the Adult Safeguarding Board. This has been implemented as a result of the Serious Case Audit (SCA) flowing from issues at a Dorset care home.
- Members of the CLDT team identified that the police service did not always perceive the risks to Harry to the same degree as members of the CLDT. This was attributed to the specialist knowledge that the CLDT have about the requirements of their service users. The CLDT team therefore proposes that the Police have a named person who has specialist knowledge of the challenges faced by people with a learning disability to act as a central contact person which would help to resolve this issue. (Recommendation made by DHC)

Dorset Post 16 Services

- That Dorset County Council Children's Services involvement with Karen is further explored with a view to improving practice through the lessons to be learned. There should be a particular focus on the whole picture rather than individual incidents and the reality of day to day life for children in families where there are multiple concerns.

- That an audit of Pathway Plans for young people whose choices leave them in chaotic situations and/or transient accommodation is carried out to ensure that a plan is in place and is reviewed regularly. It may be helpful to consider whether this is managed separately to the day to day management of the case so that the crisis response does not detract from robust short, medium and long term planning.
- That there is a discussion between the providers of adult social care and children's services to identify any lessons to be learnt from Karen's situation. These discussions should consider whether new ways can be found to manage the referral and assessment processes across County boundaries so that they more effectively meet the needs of young people like Karen and prevent them from falling through the net.
- Had she not been imprisoned, it seems clear that Karen would have continued to need a high level of support for many years to come. However, what is not clear is which service could/should have provided this support. It may be useful to discuss this aspect of the case with adult services so that social workers for young people can have a good understanding of where to refer young people in similar situations in the future.

The Care Division

- TCD will submit a formal written request to senior management within the Commissioning body asking for concerns to be escalated to a multi- agency review if they believe matters have not been satisfactorily addressed following a review, safeguarding meeting, or multiple requests for such meetings, especially where there are multiple vulnerable individuals involved, and multiple agencies.
- TCD has established a Clinical Governance Committee which meets bi-monthly to consider issues that have arisen in the operations of the service and the effectiveness of policy and procedures. The Clinical Governance team has reviewed the effectiveness of policy and procedures in all areas of operations including health and safety; safeguarding; quality assurance, Complaints and risk assessment measures and outcomes. Following the death of Harry, the team conducted case reviews of individuals considered at high risk, reviewed existing measures and agreed any additional actions to further mitigate the risks and consider information to be shared with Care managers, CQC and the Police. It also considered if any further actions or escalation was required.
- Safeguarding policy: TCD is commissioned by local authorities and CGG's to provide a service and has an absolute and unequivocal duty to report any allegations or suspicions of abuse or potential abuse of a vulnerable person to the commissioning organisations. This is reflected in TCD's safeguarding

policy that requires all support workers to report such matters to their line manager but has now been extended to ensure maximum transparency and to make it clear that any staff member may, if they deem it appropriate, report concerns regarding actual, alleged or suspected abuse directly to social services and/or to the police. This may be by phone, e mail or in writing.

- In addition, TCD has strengthened their safeguarding reporting process as follows:
 - Managers must follow up a safeguarding report or alert with the local authority/CCG within 48 hours if they have not received a call back or further instructions regarding actions required
 - Managers must ensure they are fully aware of who is to complete the investigation once this is decided by safeguarding
 - If requested by the commissioning body, managers must attend a strategy meeting to discuss the safeguarding and actions to be taken and required to safe guard the individual
 - Managers must request a safeguarding meeting from the commissioning body if they believe the risks to service users and staff are increasing or high and require multi-disciplinary consideration
 - If managers are asked to conduct an internal investigation by safeguarding, they will appoint an investigation officer who will complete a full investigation using the terms of reference agreed with the safe guarding officer
 - If managers are dissatisfied with a decision not to hold a safeguarding meeting, or with the outcome of a safeguarding meeting or they do not believe all the relevant parties were present to fully consider the incident and risks, then they will escalate this to the TCD Operations Director
 - The TCD Operations Director will submit a formal written request to senior management within the Commissioning body, asking for concerns to be escalated to a multi-agency review if they believe matters have not been satisfactorily addressed following a review, safeguarding meeting, or multiple requests for such meetings, especially where there are multiple vulnerable individuals and multiple agencies involved. TCD's continuing improvement process now requires an internal review to be carried out if the matter has been dealt with as a large scale enquiry, a serious safeguarding concern, or safeguarding adults review.
 - A member of TCD senior management will conduct an internal investigation to reconsider the facts of the incident, conclusions reached and any lessons learned or recommendations that can be implemented; in addition to any actions agreed as part of a safeguarding plan. They will consider whether procedural, policy or training changes are required and recommend these.
 - A Senior Manager/Director who has not been involved in the previous investigations will then chair a meeting with all TCD involved parties to review the findings of the investigation. The role of the chair is to consider any themes, trends or patterns and further lessons learned; any recommendations, policy and procedural changes, and to ensure all

appropriate actions have been taken and a date set for these actions to be taken.

- Incident and accident reporting systems: In order to collate clear themes, all incidents reported are now scrutinised by the Clinical Governance team to identify themes which are then communicated across the organisation.
- Risk assessment: Changes have been made to TCD's matrix of risks to assist managers and supervisors to identify the escalation of risk and the actions to be taken to mitigate these.
- Support planning: Changes have been made to support planning to focus more clearly on outcomes and risk in support planning.
- Communication strategy and Management of incidents and risks: Changes to TCD's processes have been made to ensure that revisions to support plans, risk assessments, incidents and accidents are communicated to all involved agencies and are over seen by the Registered Manager.

Appendix B

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

As previously stated an independent chair of the Panel was appointed as was an independent author of the DHR/SAR Overview Report.

The Panel determined the terms of reference for the review and the time period which the review would cover. Individual Management Reviews (IMR) were commissioned from 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 searching and the large number of substantial single agency recommendations generated is evidence of this.

The authors of all IMRs were invited to an extended meeting of the DHR/SAR Panel to enable all IMRs to be scrutinised. During the course of the review, all issues or questions raised by the panel were promptly addressed by the relevant agencies.

Working with the police family liaison officers, the Panel provided advice to Harry's parents about the review. Harry's parents met with the independent author and contributed their account of these tragic events. Harry's aunt also contributed valuable perspectives. When the Overview Report had been approved the independent author and the independent chair of Bournemouth and Poole Safeguarding Adults Board met with Harry's parents to enable them to read the report and make any further comments they wished to make. The Panel is very grateful for the contribution of Harry's family to this review.

The Panel decided that it would be beneficial to provide the perpetrators, John and Karen with the opportunity to contribute to the review. Both decided to contribute and they were seen by the independent author in the prisons where they are serving their sentences. The accounts they provided have informed the review.

The Panel oversaw the work of the independent author in preparing this Overview Report and an Executive Summary.