SYNOPSIS OF LEARNING – from the Domestic Homicide Review/Safeguarding Adult Review about "HARRY" March 2019

INTRODUCTION AND BACKGROUND TO THE CASE

The joint DHR/SAR review was undertaken following the fatal stabbing of Harry in 2015.

Harry had a learning disability and had lived independently in supported living since 2013. He used social media to meet new people but may not have been fully aware of the risks it posed. Harry had an on/off intimate relationship with Karen and thought he may have been the father of her unborn baby. Karen was also in an intimate relationship with John. Prior to Harry's murder, professionals from a range of agencies became aware of a number of incidents and threats arising from the complex and challenging relationship between Harry, Karen and John. Karen and John have since been convicted of Harry's murder. The Report identified areas of good practice as well as areas where learning should be developed. This synopsis will focus on the learning to enable professionals to build on their good practice.

GOOD PRACTICE

- The support services that enabled Harry to live independently
- Efforts by professionals to work in a person-centred way and respect the rights of individuals to make their own decisions

GENERAL LEARNING

Of the 13 recommendations identified - those listed below provide general learning points for all practitioners.

Multi-agency Sharing of information and working together

It was felt that Harry was susceptible to coercion as he was a vulnerable young adult. Key agencies could have identified additional protective measures which may have been put in place. However, it was recognised that the balance between the rights and responsibilities of an individual, with the professional 'duty of care' caused a dilemma for professionals which may have prevented all risks being identified and discussed with him and to try to understand if he had the capacity to make decisions to live with the risks.

Safeguarding meetings were held and a safeguarding plan was in place for Harry. However, this could have been more widely shared with all agencies.
Effective safeguarding planning meetings should involve all relevant professionals for comprehensive information sharing and an exchange of views from different perspectives, so that agencies can work together to effectively safeguard individuals.
Where appropriate professionals may now decide to call multi-agency risk management (MARM)* meetings as an effective way to support interagency working; this may include inviting the individual to hear their views. The MARM should identify a lead agency to coordinate the process and ensure relevant information is shared in a proportionate way. Whatever mechanism is used, agencies need to consider the balance of 'risk and responsibilities' with 'duty of care' to ensure that, if a person is allowed to make an unwise decision, then their capacity to understand the consequences of their decision must be discussed and support put in place to minimise risks.

Professionals should consider the impact of transition from children's to adult services and the importance of forward planning. This is especially important where children, families or adults move frequently across local authority boundaries so as to ensure consistency and avoid individuals 'falling through the gaps'.

* MARM protocol was not yet in place at the time of Harry's death.

Multi-agency Risk Assessment Conference (MARAC)

It was recognised that there were Multi-agency risk assessment conferences (known as MARAC) and adult safeguarding processes operating at the same time in this case. However, MARAC involvement ceased as there were adult safeguarding meetings in place. MARAC must seek assurance that any safeguarding plans are being followed and remain relevant. Checks need to be put in place to ensure these two processes work together to minimise risk to an individual. There is guidance in Appendix 6 of the multi-agency procedures.

Social media

Social media forms an important part of many young people's lives and consequently impacts on their lifestyle. However, if a person has difficulty understanding consequences of actions, then some aspects of social media can also have a detrimental effect on their life and the life of others around them. There is a need for professionals working with young people with a learning disability to be aware of how to support positive use of social media (internet usage, Facebook and internet friendship or dating sites etc.) but to also encourage discussion about the risks and consequences of actions undertaken for themselves and others.

Mental health and learning disability services

John was also presenting with mental health issues and frequently came to the attention of health services; it appeared that he was a young person who was falling through the gaps of service delivery. No lead agency was appointed to coordinate his case. John would have been eligible to be considered by MAPPA (Multi Agency Public Protection Arrangements) so professionals need to be aware of the 3 categories of cases that can be subject to MAPPA. A MARM may also now be a positive way of approaching someone with John's level of risk and need but where no one agency has any statutory responsibility.

Safeguarding adult enquiry review meetings

Progress of safeguarding adult enquiries should be checked regularly. All relevant agencies need to share appropriate information about adults at risk of harm and alleged harmers. It is vital that safeguarding plans and risk assessments are regularly reviewed and updated to include all aspects of the risks being posed. Professionals should recognise that risk types and severity fluctuate over time, and this should lead to risk management plans being reviewed and updated accordingly. It may be useful to hold Enquiry Review Meetings at the conclusion of an enquiry to review learning.

Legislative options must be considered

The DHR/SAR identified that there were missed opportunities where agencies could have considered the full range of legal interventions that may have offered further protection to Harry:

- Guardianship (under Mental Health Act)
- Mental Capacity Act 2005 and Court of Protection
- Mental Health Act 1983 amended 2017
- Human Rights Act 1998
- Use of an Independent Mental Capacity Advocate / advocate as stipulated in the Care Act 2014
- The Serious Crimes Act 2015 is now also in force

Criminal Justice and risk assessment.

Incidents relating to Harry, Karen and John were treated in isolation. This limited the ability to build up a wider picture of the true vulnerabilities and ongoing needs of the individuals and also to make an accurate assessment of the risks facing Harry.

It was known there were previous serious allegations against John. John was suspected to have committed a number of offences against vulnerable people; however, the threshold for prosecution for the more serious allegations was not met. Consideration should be given as to how such information can be shared with partners legitimately in order to protect individuals. Professional curiosity should also be encouraged at all times and professional judgement should be applied to understand the previous offending history of persons involved in any investigation

Financial abuse

Adults who are vulnerable and can be coerced are often victim of financial abuse. It is important for professionals to consider that where an individual is vulnerable to risk in one area of their life, they may also be vulnerable to other risks. Comprehensive risk assessments should be taken and regularly reviewed to limit these risks. Where these risks change, consider escalation.

ENSURE THIS REPORT MAKES A DIFFERENCE

The lessons contained in this synopsis will be relevant to other cases you may encounter. With this in mind, professionals and the people they work with can work together to understand and mitigate risks.