Devon Safeguarding Adults Board

Safeguarding Adults Review

Learning from the circumstances surrounding the death of Adrian Munday

Lead Reviewer: Kate Spreadbury

December 2018

Contents

Adrian Munday

12 November 1963 to 3rd October 2015.

Family Memories.

Adrian was described as “a gentle giant with a generous heart”. He could be an imposing figure standing well over six feet tall, but he cared deeply about people and animals and hated injustice. He was very generous to anyone who he perceived as being less well off than him. His preferred way of being was polite and courteous, but often his mental health got in the way. Adrian was friendly and sociable, and always found it very hard to distinguish initially between people whose interest in him was genuine, and those who were out to use him. He was a loyal friend and enjoyed just being with his mates. He had good relationships with us, regularly visiting or meeting up with Mum, and seeing the rest of the family. Mum and he both supported Arsenal and used to have long conversations about the games or watch them together on TV. Twin sister Sarah lives in Ireland, so contact was not so easy, but he would phone her if he wanted to talk, and they always met up on her visits to Devon. Adrian got on well with her husband: they had been close friends as teenagers, and Adrian enjoyed Pete’s free-flowing sense of humour.

Adrian loved music: punk and heavy rock mainly, and had an extensive collection. He also liked an interesting mix of sci-fi, horror and children’s classic movies (e.g. early Disney). He was an avid collector of Zippo lighters, Steiff bears and military aircraft models. Adrian’s passion for planes was strong and he often attended air days with friends. He also loved computer games, but as these moved on-line, they presented more problems, both technically and with the on-line gaming community, causing great frustration, while also giving him greater pleasure. He loved his clothes and had a wide array of Animal and Weird Fish T-shirts.

Adrian was generally interested in politics: at the age of 8 he wrote to Ted Heath asking him to sort out the miners’ strike. At 16, he spent a week and half on the Right to Work march, from Northern England to London. His desire for justice stemmed from his deeply held belief that no one should be ill-treated or taken advantage of. He was also a Greenpeace supporter.

Adrian did not have an easy life. Born first of undiagnosed twins (no scans in those days), his delivery was slow, and he may well have suffered oxygen deprivation. As a young child it was clear he was not as forward as Sarah, and she always related to him as a “younger” brother, needing support. To his younger sister Georgia, he was very much the kind big brother. We grew up in Starcross, where Adrian was bullied badly at primary school, sometimes running home when it got too much. He received some educational assistance. In 1975 we moved to Exeter where Adrian went to Priory Comprehensive. He had one or two good friends and achieved several CSE’s.

On leaving school at 16, Adrian worked for a few months on a youth training scheme at a home for disabled children. He loved this and did really well, but sadly, the scheme came to an end, and there was no offer of permanent work. From there, things went steadily downhill for many years. As a way of staying in with a peer group, Adrian started using “soft” drugs frequently. This precipitated a psychotic breakdown at about the age of 20. From then on, he remained in contact with the mental health services. His attempts at living independently were fraught with difficulty, and he was frequently the victim of “mate crime” with so called friends ripping him off and stealing his possessions.

Eventually Adrian moved into a boarding house in Exeter, where his drug use worsened, clearly as a result of peer pressure. He finally moved to a residential home for full time care, following his family expressing their concerns that he might die of a drug overdose if he was not given somewhere better to live. He thrived there, and then with CCT moved into a flat, living semi-independently. This did not work out, and he returned temporarily to residential care in 2015. Although his move into the community was, in our opinion, rather precipitate, we were nevertheless hopeful that Adrian could make a fulfilled life for himself. This is what he had always wanted.

We deeply, terribly miss him.

1. Introduction:

1.1 Adrian Munday was 51 years old when he died. On the 6th October 2015 police were called to Adrian's home where they discovered his body. A fire had occurred in the room. A forensic post mortem held on the 15th October established that Adrian had suffered significant trauma injuries not consistent with a fire, and a murder enquiry was instigated.

1.2 On 17th October 2015 SH (date of birth 24th October 1974) was arrested on suspicion of Adrian's murder. He was later charged with the murder of Adrian between 2nd and 6th October 2015. SH was found guilty of murder on 14th June 2016. The court heard that SH had met Adrian on the 18th September 2015, had moved into Adrian's accommodation, and had exploited him for money and his possessions. Adrian had received significant injuries all over his body, his death was caused by head and brain injuries. SH had set fire to his body. SH was given a life sentence. He was diagnosed with cancer whilst serving this sentence [while on remand] and died in prison on April 2nd 2017.

1.3 Adrian's family made a statement after the court case,

"*Adrian's long-term mental health issues, coupled with his kind, caring and unusually trusting nature, made him particularly vulnerable. However, after a lengthy period of supported care he was finally living independently, and we were very hopeful for his future. Adrian had the misfortune to meet up with H, an incredibly manipulative and violent man, who immediately took advantage of Adrian's kindness and inability to stand up for himself*".

At the time of his death Adrian was being supported by a care agency and was seen regularly by a Recovery Coordinator and a Psychiatrist according to his Care Programme Approach plan.

1.4 Adrian case was referred to the Devon Safeguarding Adults Board Safeguarding Adults Review (SAR) sub group by Devon and Cornwall police in October 2015 and was considered by the sub group on 9th November 2015.

After receiving reports from all agencies involved, the SAR sub group determined that a Significant Incident Requiring Investigation (SIRI) undertaken by the NHS would be an appropriate response. In the event, a SIRI was not held, the Root Cause Analysis necessary for the SIRI could not be produced as there was an ongoing police investigation. The 72-hour (initial) report prepared by Devon Partnership Trust was used to inform their Report to this SAR.

Adrian's family wrote to the Safeguarding Adults Board in June 2016 regarding facts that had emerged during the trial of SH for Adrian's murder. They followed up with telephone calls but both they and their advocate found it hard to find the right person to speak to.

The SAR sub group reviewed the case in January 2017 after members of the sub group met with Adrian's family. The sub group recommended to the DSAB Chair that a Safeguarding Adults Review (SAR) was required. The Terms of Reference for the SAR were agreed on 29 September 2017, the SAR process could not commence at an earlier date as other investigations needed to be completed.

1.5 The commissioning of a SAR in order to learn from the circumstances surrounding the death of Adrian is consistent with the Care Act 2014 statutory guidance and guidance issued by Devon Safeguarding Adults Board (July 2017)

"Section 44 of the Care Act, 2014 requires local Safeguarding Adults Boards (SABs) to arrange a Safeguarding Adults Review (SAR) when an adult in its area dies as a result of abuse or neglect, whether known or suspected, and there is concern that partner agencies could have worked more effectively to protect the person at risk. It places a duty on all Board members to contribute in undertaking the review, sharing information and applying the lessons learnt".

2. Terms of Reference

2.1 The full Terms of Reference for the SAR can be found in Appendix 1 of this Report

2.2 The timeframe for the SAR is **1st September 2013 to the 30th October 2015.**

2.3 The SAR examines events in the life of Adrian in the two years before his death. This timeframe allows for a consideration of how Adrian was supported toward independence after spending some twelve years of his life in residential care, and what lessons can be learned about how people are able to protect themselves, or ask for protection, from those who exploit them.

2.4 In addition, the SAR examines events in the life of his murderer, SH. By including an analysis of the circumstances surrounding SH the Review can consider what can be learned from the way in which agencies worked singly or together with him.

2.5 The SAR focuses on how individual agencies followed agreed policies and procedures in working with both Adrian and SH: how agencies worked together in identifying and addressing concerns regarding Adrian's welfare, and SH's risk history; and how agencies and staff were supported by their organisations to follow agreed policies and protocols.

3. Methodology

The methodology used in this review seeks to promote a thorough exploration of the events prior to Adrian's death, whilst avoiding the bias of hindsight which can obscure the understanding and analysis of important themes. Agencies work within complex circumstances, and a systemic approach to understanding why people acted as they did, and why certain decisions were made, is essential if learning is to be derived from the Review. Individual agency reports informed by examination of records and interviews, interviews of relevant staff and examination of records by the lead reviewer, were all used to consider the organisational and wider systems context of decision making at the time in question. The Review was supported by a SAR Panel which included senior representatives of the agencies described below.

Activities to inform the SAR have included:

Individual agency reports, collation of the chronologies provided within the individual agency reports, interviews with Adrian's family and friends and with senior managers in some of the agencies involved at the time, examination of key documents, identification of key episodes, and analysis of themes.

Individual agency reports were commissioned from

Devon and Cornwall police

Devon Partnership Trust

Devon County Council

Dorset, Devon and Cornwall Rehabilitation Company

The National Probation Service

Step One

4. Family Involvement

A meeting was held with Adrian's family on the 21st August 2017 to discuss the terms of reference for the review. Adrian's family were able to read through and comment on the Terms of Reference at a draft stage prior to formal agreement. The family have submitted evidence to the Review in written and verbal form.

The SAR lead reviewer and the Chair of the Devon Safeguarding Adults Board met with Adrian's family on 27th August 2018 to discuss the content of the draft Report and receive further information from the family.

SH's next of kin was invited by the Devon Safeguarding Adults Board to be involved in the Review but has, at the time of writing, made the decision not to be involved.

5. Relevant history prior to the time in scope: Adrian Munday

Adrian spent his adult life in the Devon area. He is described by his family and friends as a kind, decent man who did not like to upset people. He was popular and liked company, including the company of his support workers. He is described as a "peace-loving person", a "gentle giant", warm and kind. Adrian loved animals, he liked collecting, his collections included coins, over 100 Zippo lighters and a collection of Steiff animals. Adrian's family remained close and supportive toward him but were not invited to be formally involved in planning his care and support in recent years.

Adrian could become angry and shout when frustrated or distressed. His friends agree that he could sound intimidating if you did not know him. Adrian did not drink alcohol but had always used various drugs. In his youth these included illegal drugs of various types. As he grew older he said that he used psychoactive substances, commonly known as "legal highs", often of the stimulant type which promoted an energised feeling. He would play on line games whilst high, and a typical scenario might be that as he came down the game or equipment would malfunction – something he got very upset about – and he would have a downer from the effects of the high wearing off as well as the frustration of the game not working. This would cause him to shout out. Adrian also became distressed and could shout in response to other frustrations, including noise and problems with bills and money.

Adrian had developed the symptoms of Schizophrenia around his 20th birthday. He tried to live independently in his early twenties, but his family report that he was often exploited by "friends". Adrian would remain at risk of exploitation through his adult life, the risk of such exploitation was, as will be seen below, regularly evidenced in risk assessments. His life became chaotic, he was living in common lodging houses, sometimes homeless, and had a serious drug problem. Around 2000 Adrian took up residence at a local residential home for adults with mental health issues. He was able to develop a more stable lifestyle there and his family report that he enjoyed strong relationships with fellow residents and held down various jobs. He worked in a plant nursery and had training in food hygiene and other aspects of kitchen work. Adrian's family regularly attended the case conferences held quarterly to discuss Adrian's progress and took a close interest in his wellbeing. He completed a drug rehabilitation programme in 2005 and was drug free for six years after this. In 2011, Adrian was able to move onto more independent but well supported housing. He was one of the first residents at "House 1", six-bedded accommodation with staff support during the day from the Community Care Trust (CCT) as part of their "Alternative to Care "or "A2C" provision. Adrian developed friendships at "House 1". Before he left he was receiving twenty-one hours a week support from the CCT. Adrian's CCT support plan of April 2013 documented how the twenty-one hours were being used and included three and a half hours a week support with anxiety management, and seven hours spent in *"helping Adrian with his triggers, namely his acute hobbies like*

PlayStation / mobile phone… supporting Adrian when he becomes frustrated because they don't work. This does become a major focus point for Adrian."

The remaining hours were spent assisting Adrian with household chores, cooking, budgeting and managing his time. This is the only detailed plan of how support hours were being used held on the Devon Partnership Trust system.

Detailed workplans were agreed with CCT on how to manage the stressors in Adrian's life which caused him to become highly anxious and distressed, often leading to him expressing that distress by shouting. These stressors included noise, technology going wrong, and money. Adrian had a workplan around managing his use of legal highs, with the Recovery goal of "*working through issues relating to legal highs and promoting general wellbeing*". He also spent a few hours each week at "House 2", a Recovery Approach orientated CCT 24-hour service, where he could talk over his worries. Adrian's life appeared well structured and supported. These workplans were reviewed and appear to be in place up until the time that he left "House 1".

Adrian was seen regularly by a "Recovery Care Co-ordinator", whilst he was open to Devon Partnership Trust, the Devon mental health service provider. The Recovery Care Coordinator's role is to monitor and review the care and support an adult receives as part of the Care Programme Approach, used to help people recover from serious mental illness. Recovery Care Co-ordinators can be one of any of the professions who work in Mental Health Services. Adrian's care coordinators were social workers or Community Psychiatric Nurses (CPNs). In this account the care coordinators will be referred to as Professional 1, 2,3 etc.

Adrian left "House 1" to live more independently in a flat in September 2013. The flat was in a housing association complex for people over fifty-five, and residents are reported to be predominantly older adults.

6. Key Events – Adrian Munday

6.1 September 2013 until June 2014

As noted above Adrian moved to more independent living on **September 16th, 2013.** Adrian did not have a tenancy, or therefore tenant's rights, within his flat. He occupied the flat under a license, and as a licensee could, for example, be moved to a different room. He would have 28 days' notice of the end of his licence. CCT is described as the Managing Agent for the property. The purpose of the property was described as "*temporary accommodation whilst you receive support services to enable you to move on to more independent / permanent accommodation*". Adrian was fifty years old. Generally other tenants were over fifty-five. The rationale for placing Adrian in this type of property with this age group is not known.

CCT report that support staff visited "*regularly*". His CCT support plan at the time stipulated that Adrian would be visited twice daily, once in the morning between 10 am and 10.30am to assist him to get up and organised and plan his day, once in the afternoon to talk through the day, and help with the evening meal. He was able to telephone "House 1" at any time from 10am – 5.30pm Monday to Friday. He was welcome to visit "House 1" and was invited to attend groups there.

The first two weeks in his flat appear to have gone well. However, on **29 September** 2013 Adrian is noted as asking staff "not to visit "that day. On the **2nd of October** there were complaints from other residents that Adrian was "*shouting and banging*". There were further complaints on the **4th October**. Adrian's support workers discussed the distress caused by his shouting with him on both occasions, and Adrian apologised. On the **5th October** Adrian's care coordinator (Professional 1) telephoned to see how he was settling into his flat and wrote in the notes that "*Adrian is doing fantastically well and loves where he is living. There have been no concerns*". On the **14th October** CCT staff were concerned that Adrian had taken a drug as his pupils were pin points and he was slurring his speech. He refuted this however.

Professional 1 met with him on the **15th October**. Adrian is reported to have said that he felt still in the process of settling in, "*50/50 mental health wise*", and that he had experienced a few outbursts but had received support with this. He said that noise was getting to him, and so was loneliness but he had made friends with neighbours, once especially called T.

There were further complaints recorded from other residents and staff about Adrian's shouting on **16th October, 18th and 21st October 2013**.

On the **4th November** Adrian attended a Care Programme Approach meeting with his Psychiatrist, Professional 1 and a support worker from CCT. Adrian reported that he found the move stressful but was pleased with his new accommodation. His shouting was discussed, he told the meeting that he had occasionally been shouting in his flat in response to noise from a neighbour above him. Adrian was getting some delusional thoughts but was not worried by these and felt that they were due to the stress of moving. The CCT support worker said that Adrian appeared to be doing very well. He was managing his money and buying food. There was a possibility of someone sharing the flat with Adrian, but this was still under consideration. CCT staff were aware that Adrian had been shouting and of the complaints, they were continuing to work with Adrian to help him to manage his behaviour. The CPA notes record that "*Adrian is doing exceptionally well and is well settled and continued to have contact with residents from "House 1*".

All agreed that Adrian moving to his own flat and independence had worked well, but he was distressed by the noise of the neighbour above him and was unable at times to manage his outbursts of shouting. He was lonely and waiting for another person to move in to the flat.

Adrian's Psychiatrist subsequently noted:

"*Has previous history of substance misuse (drugs and alcohol). When I reviewed him in January he had been using legal highs but has remained abstinent from all illicit substances for the last six months*"

Adrian's care coordinator (Professional 1) and Psychiatrist discussed if he should now be discharged from CPA, but, given that he was experiencing some delusional thoughts, decided to review this again at the next CPA meeting.

There are few notes from either CCT or Devon Partnership Trust (DPT) documenting the period between **November 2013 and January 2014**. A summary of notes made by CCT support workers indicated that all was going well, apart from Adrian's shouting about which there were still complaints. Adrian's care coordinator asked CCT for a breakdown of how the hours agreed were being used to support Adrian and arranged to review his progress on the **5th January 2014**. There is no detailed breakdown of how the support hours are used on DPT records.

Professional 1 undertook a thorough review of his support with Adrian and his CCT support worker on the **5th January 2014**. Adrian was reported to be happy and settled in his flat. However there had been some incidents of concern, a previous resident of "House 1" had tried to exploit Adrian of money and possessions, and a fellow resident in the flats was constantly asking for favours. This fellow resident, T, who Adrian had thought of as his friend, was subsequently evicted from the property. These incidents do not appear to have been reported to Professional 1 when they occurred, and there is no record of an Adult Safeguarding referral being discussed with Adrian or made to the local authority. Adrian is reported to have responded to each incident by requesting support from CCT staff and "*Adrian dealt very assertively with the two people that were attempting to take advantage of him and resolved the issues with support*". Adrian needed support in order to deal with these attempts at exploitation.

Adrian regularly asked for help with his distress and shouting. He would contact a CCT worker over the phone, conversation would defuse the situation and the support worker would meet with Adrian the following day to explore ways of managing these outbursts. Adrian and his support worker were of the view that the outbursts of shouting would remain, and that Adrian would require on-going support to manage these. Adrian was also using the CCT crisis house ("House 2") for telephone support. Adrian attended "House 1" for activities once or twice a week including the Men's group run by his CCT support worker. Adrian had started attending the activities arranged by the staff of the sheltered housing complex including the keep fit club. Professional 1 noted,

"*Even though this move has been an extremely positive experience for Adrian, his mental health continues to remain fragile with him becoming easily stressed and anxious. This in turn increases his paranoia and rage. Without the consistent support of CCT staff Adrian's mental health would deteriorate with him likely to lose his flat.*

CCT support is an essential component to the continued success of Adrian's move to independent living. It is difficult to know if Adrian will ever be able to live completely independently but at present he requires the current support he receives".

Adrian continued to make progress as noted during **April 2014**, his CCT support worker recorded "*no concerns or risks at present".*

Adrian had not seen his Recovery Coordinator since the review meeting of 5th January, no further monthly visits were made to review his progress. Professional 1 was not at work, and no arrangements had been made to transfer Adrian's case during this extended absence.

6.2 June 2014 -December 2014

Adrian's CCT support worker became concerned that Adrian had not seen his Recovery Coordinator since January 2014. CCT contacted the DPT Community team who sent Professional 2 to see Adrian on the **13 June 2014**. Professional 2 saw him with a CCT support worker. Professional 2 recorded that

"*No concerns expressed or observed, and feedback from both Adrian and CCT was that - certainly at the moment - mental state is good/stable*."

In **June 2014** Adrian was joined in the flat by a new licensee, F, a woman. F and Adrian had known each other at House 1. There had been meetings between them and F had stayed over at the flat to check that the pair were compatible flatmates. F's arrival at the flat appears to have increased concerns about Adrian's behaviour, including the impact of his "shouting" behaviour on F as well as his fellow residents.

There are no records from either DPT or CCT until **August 2014**, when clearly all was not well with Adrian. On **August 7th** a neighbour of Adrian's called the police expressing fears for Adrian's wellbeing as he was shouting, the neighbour was concerned for both Adrian and F, aware that both had mental health issues. The police attended at 12.30 am and found that Adrian was frustrated as his play station was not working.

CCT staff met with Adrian on the **8th August** to discuss "*excessive shouting and disturbing neighbours.*" Also, on 8th August DPT recorded that CCT had requested an urgent assessment from the mental health crisis team, it was feared that Adrian has taken an overdose. CCT were advised to call an ambulance and if Adrian needed a mental health assessment then the hospital would arrange this. DPT did not follow this call up and there are no notes from CCT as to what happened after this incident

Professional 3 started as Adrian's new Recovery Coordinator in late August 2014 and on **29 August** made several attempts to contact him by telephone, leaving messages for him. CCT had an unplanned meeting with Adrian on the **3 September** following "*concerns*" from staff at the flats to "*discuss weekly planning to promote*

working towards a meaningful life style". Professional 3 was not involved in this meeting. Professional 3 made a visit to Adrian on the **9th September** but did not see him. Adrian telephoned to apologise the same day, he was out with his support worker. Professional 3 arranged to meet with Adrian on **16 September** and saw him for the first time on that date. Adrian described himself as

"*not very well at present…there is a game on his console which he finds very disturbing. He said there were other things bothering him as well and referred to losing his flat. He said he has received threatening letters from his care team (CCT) ….. because he shouts - more so recently over last few days (when he gets stressed?) I agreed to speak with the care team. Adrian said he gets support whenever he needs it and sees somebody most weeks (CCT)".*

Professional 3 followed this up with Adrian's CCT support worker the next day. The support worker explained that the "*issue with shouting and being threatened with eviction went back to around Christmas and is not a major problem at the moment*. *A gets a lot of support from the care team and he is able to call a support worker any time of day - and often does - and the CCT crisis team until 11.00 pm. He is quite well known by the neighbours and they are used to him".* The CCT support worker described the way in which Adrian was being supported, a 'traffic-light' system. "*Shouting equals amber; breaking things up equals red. As soon as Adrian gets to amber he will call support worker 2 who would advise Adrian to leave whatever it is that is stressing him - usually something fairly small like building a model aircraft or a computer game - and do something else".* The support worker indicated that Adrian did not shout as much as he used to but things like bills did stress him out.

CCT staff met with Adrian and F on the **1st October**, and recorded that F said that she would like to move out of the flat. Staff also met with Adrian individually the same day to discuss his use of "legal highs." From this date CCT appear to focus more on Adrian's use of psychoactive substances, and the impact use of these had on his behaviour. Professional 3 did not appear aware of the severity of those concerns until almost two months later, at a meeting on 27th November.

Professional 3's next visit to Adrian was recorded as the **21st October**. A CCT support worker also attended the meeting. Adrian is recorded as saying that F's lack of helpfulness around the flat was causing him to feel stressed and shout. Professional 3 thought Adrian was insightful and agreed to help Adrian and F work out how to live in the same flat more successfully.

Professional 3 agreed to meet with Adrian again in a month. This may indicate that Professional 3 did not feel there was an imminent urgency to resolving the situation. Indeed, his interactions with CCT support workers indicated to him that Adrian's "shouting" behaviour was well understood, and he was receiving support with this, and with support the behaviour tended to diminish. No reference was made to the relationship between Adrian shouting and using psychoactive substances, but other forms of stress were focused on.

Later on the **21st October** CCT rang Professional 3 to indicate that if matters between Adrian and F were not resolved both parties would be given notice and Adrian would have to return to "House 1". CCT proposed to meet with both to "*lay it on the line*" the next day. No records have been made of this meeting, and Professional 3 did not attend. However, a formal written warning was sent subsequently to Adrian by CCT regarding "*his use of legal highs and shouting/disturbing neighbours*." Professional 3 has not recorded that he was aware of this warning, which could result in Adrian losing his license to occupy the flat. CCT and Professional 3 were to meet with Adrian on the **29 October** to discuss his progress, but Professional 3 was off sick and Adrian went to the meeting alone.

On **18th November** Adrian met with Professional 3 who recorded that Adrian "looked well". Adrian told Professional 3 that

"*he had not used legal highs for four weeks and accordingly there has been no shouting incidents (though he has 'raised his voice' a couple of times). He said that relations with F have improved and acknowledged that his outbursts were behind the difficulties they were having and were also affecting everyone including neighbours. Adrian continues receiving regular and frequent visits from CCT".*

On **27 November** CCT, Professional 3 and a staff member from the housing association attended a meeting with Adrian. Professional 3 has recorded:

"Reason for meeting is that Adrian has been using 'legal highs' and becoming very unpredictable in his behaviour i.e. shouting, swearing and acting in a frightening manner. He has been disturbing the neighbours with his shouting and worrying staff at (the flats) who do not really know what to do when they observe Adrian looking and behaving so bizarrely. It was also pointed out to Adrian these 'highs' are bad for his health and he could do serious damage to himself. CCT laid it on the line and said if it happens again Adrian will be given notice to leave the flat. Adrian appeared to accept and understand what is at stake should he indulge again; he was encouraged to try and appreciate it is his decision and he must understand that if he uses legal highs again he is in effect making the decision to leave (the flat). It was agreed that CCT and staff from (the sheltered housing complex) will meet with Adrian every fortnight for at least the next six weeks or so and thereafter every month. He will also in the meantime continue frequent contact with CCT".

Although the emphasis of the meeting appears to have been on Adrian's use of unspecified drugs, no mention is made of a referral to services that may assist and support him regarding his drug use. It may be that Adrian did not accept that he needed support to stop using psychoactive substances, and drug services will only accept referrals regarding people who can accept that they have a substance misuse issue and are willing to engage with the drug service. However, consideration of referral is not documented. We also do not know how staff in CCT or at the flats were supported and whether they had access to information and advice on how to work with Adrian. The onus was on Adrian to stop using legal highs. CCT had used

strategies to support him, but these were no longer working. Professional 3 asked Adrian's psychiatrist to attend a home visit with him on the 16th December.

On **16th December** Professional 3, Adrian's psychiatrist and a trainee psychiatrist met with Adrian at his flat. CCT sent apologies and did not attend but are recorded as saying that there were "*no reports of concerns currently*". Adrian told the meeting that he was no longer using any psychoactive substances and was taking his prescribed medication regularly, he described how he accessed support from CCT, daily visits and telephone contact, and his connections with groups and social events. He was experiencing some auditory hallucinations which he thought were triggered by "stress", he thought that people were talking about him and laughing at him. The psychiatrist thought he should maintain his prescribed medication and continue to see Professional 3. No consideration was given at this meeting to any specific support regarding drug use or addiction, the CCT report of "no concerns" coupled with Adrian saying that he was able to stop taking legal highs may have influenced this. However, the failure to explore Adrian's drug use in any depth at this review represent a missed opportunity to refocus the secondary health interventions on Adrian's CPA pathway.

Concerns focused on Adrian's drug taking re-emerged only four days later and Adrian's situation at the flats began to deteriorate rapidly. On the **22nd December** his flatmate, F, called the police who report that

"*her flat mate was having an episode shouting and screaming. Officers attended and spoke with Adrian. It was stated he was not violent just loud. He believed someone was out to get him. He was told no one was out to get him and to be quiet and log was closed*".

Police have no record of contacting other agencies about this visit. No drug use was disclosed to or identified by the attending officer and was not raised as a concern, but officers noted that Adrian felt that someone was "*out to get him.*"

The housing staff at the flats contacted CCT the next day saying that they had had "*another weekend of issues with Adrian'. One resident has complained of having no sleep all weekend as a result of Adrian displaying behaviours that are challenging…… Police were called".*

CCT informed Professional 3 that there "*have been further complaints about Adrian shouting and thereby upsetting neighbours - it looks as though he is to be given notice. Meeting convened for 11.30 (today)".*

At the meeting of **23rd December** Adrian was served with 28 days' notice to leave the flat as per his licence agreement. He was to leave by 19th January 2015.

6.3 January 2015 – May 2015

Adrian's care coordinator (Professional 3) next saw him on the **5th January 2015** at his flat, accompanied by CCT. Options for accommodation were discussed with Adrian. There had been further concerns about Adrian's shouting behaviour over that weekend. Professional 3 noted that these were *"probably attributed to legal highs".* Adrian was "*advised*" to remain free of legal highs and warned that if further complaints were received he could face eviction within 24 hours. Professional 3 wrote that "*Adrian accepted the advice and said he understood its consequences although he has indicated similar in the past to little effect".*

The emphasis was again on Adrian controlling his own use of drugs, despite much evidence that he could not do so. No exploration of support over and above that offered by CCT was made although Professional 3 did report back on the meeting and Adrian's current situation to his psychiatrist who offered to see Adrian "*when requested".*

The first option for re housing was accommodation with an emphasis on working with people with mental health issues. Adrian visited the accommodation that week with support from CCT. Professional 3 was due to see Adrian again on **13th January** but no record has been kept of this visit.

Adrian's licence at the flat was extended to facilitate a period of consideration of his accommodation options. The mental health supported housing turned down his application, reportedly concerned about his drug use. The date for Adrian to leave the flats was extended to the 4 February. On the **30th January** Adrian was accompanied by both Professional 3 and CCT to Exeter to look at three potential supported accommodation options, all for people with mental health issues and owned by the same housing association. Adrian was unsuccessful in his application, again reportedly because of his use of drugs.

With no immediate options for new accommodation Adrian was offered a stay at "House 2" by CCT

"*for max of three months for 'back to basics' guidance then move onto a new shared living project in Paignton with higher levels of support*".

Professional 3 made an urgent funding application to the local authority funding Panel, funding for a placement at House 2 was agreed on **10 February**. Adrian was admitted to House 2 for a three month stay on **11 February 2015**.

Adrian's stay at House 2 was well planned. The goals for his stay were initially listed as

- *To move on to supported accommodation or a flat of own.*
- *Cooking skills*
- *Addressing cleaning/hygiene*
- *Support with managing anxiety/responding to voices*

- *Support with not taking legal highs*

A range of activities and plans were put into place to "*give Adrian structure and routine to support him in controlling his use of 'legal highs'.*

CCT agreed a "workplan" with Adrian on **17 February** which "*focuses on Adrian self-managing his anxiety as well as improving living skills, to enable him to move on safely to either supported accommodation, or his own flat".*

CCT reported that Adrian felt "*happy and safe at (House 2) after feeling lonely at his previous place'*

The contingency plan recorded by DPT in Adrian's care plan dated 6th February 2015 underlines the concerns about Adrian's use of psychoactive substances and the impact these had on him and others

''Serious consideration needs to be given to Adrian's use of 'legal highs', how they affect him mentally and physically. Also possible risk to others. House 2 staff are actively working with Adrian on this issue as Adrian has disclosed to them directly. Adrian appears to have capacity with regard to use. Should his mental state deteriorates hospital admission will need to be considered as this may put others at risk.''

Both CCT and Professional 3 appeared to be closely monitoring Adrian in terms of drug use, a planned trip to Exeter resulted in CCT contacting Professional 3 who telephoned Adrian on the **16th February**. He advised Adrian that if he bought legal highs he would be given notice to leave House 2, Adrian promised that this was not his intention

Professional 3 saw Adrian on **18 March**. "*Adrian looked well and was more talkative than I have ever seen him. He said he is getting on very well at House 2 and realises it suits him to have people around. He also had a severe UTI and medical problems which since being at House 2 have self-resolved. Has felt stressed a couple of times over last six weeks but talked through with staff and duly resolved satisfactorily. All-in-all Adrian appears very well at present and expresses satisfaction with his care teams".*

CCT staff were still concerned about Adrian taking drugs however and noted slurred speech and appearing to be "high" after a trip to the pub on **26 March** and possible cannabis use on **6 April**. These are the only two recorded references to concerns about Adrian taking drugs during his five months stay at House 2.

Adrian's goals were reviewed by CCT on **2 April**, he had achieved all, with the exception of *"seeking paid or voluntary work, education and training, taking regular exercise and managing addictive behaviours.*

Professional 3 telephoned to check on Adrian's progress on **the 22 April** "*Adrian seems to be doing ok without a great deal of change. Still irritable occasionally with*

some shouting incidences. Is working on self-sufficiency skills. Is due to attend a two-day course in Bradford in May - is going with a friend".

The proposal was that Adrian move back to "House 1" again on the 18th May.

On the **28 April** Adrian was discovered to have asked another resident of House 2 to buy a "legal high" for him on a trip to Exeter. When confronted Adrian left House 2 and did not return, he was reported by CCT to the police as a missing person at 7.45 pm that night. The police record that "*He (Adrian) left the home very angry following a row with staff regarding him buying legal highs and asking other residents to buy them for him. Caller was concerned that he may go off and hurt someone else as he becomes very angry and shouts. Adrian Munday returned to home of his own accord at 21:50 where he stated he visited Exmouth and went to the fair*". Uniformed response officers attended the address to ascertain Adrian's safe return.

Adrian was given notice to leave House 2 and the offer of a placement at "House 1" was withdrawn. CCT were active in recommending that Adrian's needs would be better met at supported accommodation for people with a dual diagnosis and had identified accommodation in Exeter, a "*14 bed supported accommodation for individuals with dual diagnosis requiring a medium level of support*".

Professional 3 discussed the options with Adrian on the **7th May**, but Adrian was not keen to move out of his local area. Adrian's family also report that he was wary of living in Exeter where he had been exploited by others in the past. He wanted to live in a flat on his own with support going in. With the strong focus on Adrian's drug use, supported accommodation for people with a diagnosis of both a mental health and substance misuse issue could well have been helpful to him. However, given his objection to the location of the service and expressed wish for independent accommodation a discussion about referral to drug support services in the community should have been considered. Adrian's friend reports that at the "transformation" weekend both attended in Bradford, Adrian expressed independent living as his lifelong goal, after an adulthood of living in supported housing he longed for a chance to live independently.

It is not recorded whether Adrian refused to go to the accommodation in Exeter or whether he was rejected. He was discharged from House 2 on **25th May** with a move on plan to stay with a friend until his tenancy was ready, he had found a small cottage to rent in Newton Abbot. The CCT discharge summary noted that Adrian was being discharged to his friends address and "*there is currently no further CCT support arranged for him*". The reason for his discharge is given as getting another resident to purchase a legal high for him.

This transition period is marked by an absence of support for Adrian. Professional 3 was on leave and he no longer had the support from CCT which he had used intensively for the previous four years. There was confusion over whether further support from CCT had been arranged for Adrian or not. Professional 3 recorded that

he told a CCT manager on **21st May** that the existing Funding panel agreement would cover Adrian's support but Professional 3 would need to provide an updated care plan and risk assessment to cover this. He telephoned CCT on **1st June** to say that he was sending these over but recorded that (CCT) "*are in the process of recruitment and will struggle to provide maximum requirements*". Professional 3 was also about to hand Adrian's case over after a mental health trust re-organisation. He provided some telephone support to Adrian, but it was left to Adrian's family and friends to help him to find a B&B once his time at his friends was over, and to assist him, practically and financially, to move into his new cottage.

6.4 June 2015 – October 2015

Professional 3 telephoned Adrian on the **1st June**. He was in a B&B in Newton Abbot, and said he was quite pleased with it. His new accommodation was almost ready. "*Adrian said he is ok and sounded relaxed about things at present".* A handover visit was arranged for Adrian to meet his new Recovery Co-ordinator, a Community Psychiatric Nurse (Professional 4), on the **15th June**. This was cancelled by Adrian as he was picking up the keys to his new place that day.

Adrian's new accommodation is described by his friends as

"*a small old cottage, very low ceilings, Adrian was over six-foot-tall and kept hitting his head! It had a lounge, bathroom and kitchen downstairs with a bedroom, toilet and small room upstairs. It had a yard. It was perfect, Adrian loved it".*

Adrian met his new Recovery coordinator at a handover visit on the **17th June**. It was noted that Adrian was receiving support from his family. He was about to pick up his medication and was also meeting a friend for coffee. He confirmed that he was continuing to take his prescribed medication. "*Adrian will apply for Housing Benefits and PIP which he said he can do but he will seek help if necessary. There were food shopping bags in the kitchen and Adrian seemed quite happy with his lot. (*Professional 4*) arranged to see him again in a couple of weeks. Case closure to (*Professional *3)".*

There was no mention of whether Adrian was getting any support from CCT at this time, although his care coordinator, Professional 3, added a note to his records "*CCT to remain involved. A to discuss with them how much time he requires. Up to fifteen hours a week has been agreed with Panel".*

Professional 4 visited Adrian on the **1st July**. *"He was clearly anxious",* he had not received housing benefit and Disability Living Allowance (DLA) despite completing the paperwork some time ago, his rent was due, and he needed the DLA payment to help pay the rent top up. Adrian also said that he had not had any support from CCT. Professional 4 supported Adrian to contact the housing benefit and DLA offices, and resolved all his concerns about benefits and finances that same day. Professional 4 also contacted Professional 3 and CCT to find out what had happened to Adrian's planned support, a CCT manager "*confirmed there had been a discussion but were*

waiting to hear from the community team as to whether this was needed, the manager was concerned to learn that Adrian had been without support and…..agreed that outreach support would be required".

Professional 4 and CCT agreed that 7 hours per week would be an appropriate start, this could be reduced once Adrian was more "*settled*". CCT also agreed to start the support prior to Professional 4 making an application to the funding Panel. The next day Professional 4 discovered that the Panel had already agreed 14 hours a week support for Adrian and that this agreement was still current. She conveyed this in a telephone call to CCT.

On **17th July** a crisis and contingency plan was made by DPT to reflect that Adrian was now living independently. In the case of a crisis the following resource could be drawn on

"CCT Outreach Support to provide increased 1-1 support within Adrian's home - currently entitled up to 15 (sic) hours a week. Adrian has disclosed past use of 'legal highs'. Consider Adrian's use of 'Legal Highs' and the effect of this of his mental and physical health. Also possible risk to others. Adrian has assaulted a member of the public within the recent past.

Serious consideration needs to be given to Adrian's use of 'legal highs', how they affect him mentally and physically. Also possible risk to others".

It is unknown why DPT believed that Adrian had assaulted a member of the public "*in the recent past*", there are no police records of this occurring within the time in scope of this SAR. Adrian was conditionally discharged in 1999 for punching a man at a bus stop in an unprovoked attack, and after hitting a man in May 2012 in another unprovoked assault, was dealt with via community resolution, i.e. writing a letter of apology. Adrian had been described as possibly aggressive when acutely psychotic, but he had not been that unwell for some time.

There is no mention in the crisis and contingency plan of the other factors that are believed to have caused Adrian to become distressed and unwell in the past, including exploitation by others, noise levels etc. but the emphasis of the plan was on the interaction between his mental health and drug use. There does not appear to have been any conversation with Adrian about what he would do if he was being exploited, or was physically unwell, or felt "stressed out", all issues he had previously quickly asked for help with when in a more supported environment.

CCT notes indicate that weekly visits were made to Adrian with telephone calls in between. Work appears focused on supporting Adrian to sort out various issues with his landlord (e.g. decorating) and paying bills with an element of monitoring of his wellbeing.

Adrian was seen by his psychiatrist and Professional 4 on the **7 August**. He reported no mental health concerns and seemed mentally well, he did have a "chesty cough" and was advised to see his GP and given a "*wellbeing passport.*" His recorded risk

history included "*damage to property and assault **when acutely psychotic** in the past. He has a previous history of substance misuse including illicit substances and legal highs. This has not been a problem recently. He rarely drinks alcohol*".

Professional 4 saw Adrian on the **11 August**. Although "in good spirits" he had a mouth ulcer for which he had been referred to a consultant by his GP, his mother was taking him to appointments at the hospital. "*From a mental health perspective, he remains well and concordant with medication. Getting out on a regular basis and having CCT support 1 x weekly. Denies use of legal highs for many months and no evidence to the contrary*".

Adrian was seen again by Professional 4 on the **28 August**. Again, he is described as in "*good spirits*" and his mouth ulcer had resolved.

Adrian was seen by a CCT support worker on the **4th September** who noted

"When asked if had taken any legal highs lately Adrian 'assured me he has not and told me they are now banned by the Queen, so he can't buy any even if he wanted to'. Noisy children a couple of doors away were making him anxious – suggested that Adrian put ear phones on and listens to some music. He appeared calm and relaxed. No issues or concerns presented'.

Adrian missed his next appointment with Professional 4 on the **8th September**, a decorator answered the door and said that Adrian had gone into town. Professional 4 left a message on Adrian's phone and sent him a letter for another appointment for the **29 September**, Professional 4 was on leave until then so could not see him earlier.

When seen by CCT on the **14th September** Adrian appeared anxious, but this appeared to be about the non-arrival of a parcel. "*Provided support for the anxiety and discussed coping strategies. Adrian calmed quite quickly and asked to be dropped in town on the way back to the office".* His support worker telephoned him the next day and he seemed "*calm and settled*" and did not take up the offer of staff visiting again that day. He was seen again by CCT workers on the **18th September** and appeared "*in a calm settled place*"

It is believed that Adrian met SH on a train on the 18th September and offered to help him by putting him up at the cottage. SH reported to his probation officer that he was "*living in a friend's cottage*" on **the 22nd September**. Corroborative evidence from Adrian's family indicate that he was preoccupied with someone who "*is and isn't a friend*" on the 19th September. Adrian's family believe that he told SH that he had to leave his cottage on **Monday 21st September** and indeed SH was seen that evening carrying his belongings in a bag. On the night of the **21st September** SH was out with Adrian and a friend of Adrian's, SH was seen to be ingesting large amounts of drugs and alcohol. He was felt to be an unpleasant character. At one point during the evening he waved Adrian's keys in his friend's face, boasting "*I've got his keys*." That night he returned to Adrian's cottage. Adrian appeared to be

sleeping on the floor after this point, with SH using his bed. Members of the public subsequently interviewed by the police noted that they thought that the pairing of Adrian and SH was unusual or concerning. Some thought that SH might be Adrian's carer, and indeed SH told a member of the public that as Adrian's carers were "*useless*" he was looking after him.

Adrian did not answer his phone to CCT workers on the **21st September**. He was seen on the **22nd September** briefly by a CCT worker who gave him a lift to the local supermarket. A CCT worker also visited on **26th September**, he was not at home but was seen walking down the road with two men. CCT workers telephoned Adrian again on the **27th and 29th September** but got no reply.

Professional 4 visited as arranged on the **29th September** but got no reply. She left a message with CCT to ask if there were any concerns but did not follow this up when CCT did not return her call.

Adrian asked his family for increasing amounts of money, £100, and another £100 and then another. He did not disclose what this money was for. Concerned, his family visited him in the first few days of October, he did not answer the door and was likely no longer alive at this point.

On **30th September** a friend of Adrian's contacted CCT to say that he was not answering his phone. This concern, plus the unusual difficulties in contacting him over the last ten days, prompted an unplanned visit from a CCT support worker "*Adrian didn't look his best when I visited him this morning. Said he was fine when I enquired if he was OK, I repeated the question twice and Adrian still said he was fine. I asked when it would be a good time to contact him re support and he said next week."* Adrian spoke to CCT workers on the phone on the **1st October** "*Had tried calling Adrian on Monday 28/9 and Tuesday 29/9. He did not answer. Tried again on 01/10 and he answered the phone. Had a nice conversation with him and arranged to call round at around lunchtime on Monday 5th October. His mood seemed good on the phone".*

In the event, a CCT support worker did not visit Adrian until the **6th October**. His body had just been found. Police records note that they attended Adrian's cottage following a report by his landlord that there had been a fire at the property and Adrian was "*deceased inside*".

The police response to the discovery of Adrian's body was to treat this as a serious incident, cordon off the scene and contact the appropriately trained personnel to attend. A Fire Service arson investigator and police scenes of crime manager, together with a Detective Sergeant, attended and formed a "*degree of doubt*" about the cause of death, whether this was an accidental death or something more suspicious. The doubt was sufficient that the scene, Adrian's home, was locked and preserved awaiting post-mortem and confirmation of the cause of death.

On the **13th October 2015** a forensic post mortem was authorised, it was conducted on the **15th October 2015**. On the **16th October 2015** a murder investigation was launched following the forensic post mortem findings.

7. Analysis of Key themes – Adrian Munday

7.1 Adrian had lived the majority of his adult life in either residential or supported living accommodation. His time at House 1, from 2011- 2013 marked the beginning of his journey to independence.

Adrian was a man who experienced serious mental health issues throughout his adult life. He was anxious and easily stressed, either physical or psychological stresses could result in the experience of rage and paranoid thinking or delusions and hallucinations. Adrian used the supports he was offered, when anxious or frustrated he would telephone for help, when exploited or "harassed" he asked for assistance from his support workers.

Adrian is described as using various forms of drugs throughout his life. Cannabis use did not appear to cause feelings of rage, but use of "energetic" drugs, including those psychoactive substances described at the time as "legal highs," exacerbated his feelings of frustration and anger especially when coupled with other factors which frustrated him, noise, computer games or the supporting technology going wrong, money issues. Even without the use of drugs he could be easily distressed and frustrated, he had worked with a Recovery coach and subsequent support workers to develop strategies to counter act these predispositions, and had, until the last few months of his life, willingly reached out to support staff to help him.

7.2 Below are the themes that the lead reviewer has identified from the key events described above:

- Consistency of support and communication between key agencies, including through transition.
- Understanding wellbeing: risk assessments and risk management
- Adult Safeguarding
- Access to specialist services

7.3 Consistency of support and communication between key agencies, including through transition.

Adrian had two key agencies in his life. Devon Partnership Trust (DPT) and the Community Care Trust (CCT).

DPT supported Adrian using the Care Programme Approach (CPA). CPA is "*the approach used in secondary mental health care to assess, plan, review and co-ordinate the range of treatment, care and support needs for people in contact with secondary mental health services who have complex characteristics*" – Department of Health 2008

The role of the Care Coordinator or “Recovery Coordinator” is to “coordinate care, keeping in touch with the person in their care ensuring the CPA Care Plan is delivered and reviewed as required”. Responsibilities of the Recovery Coordinator include

“*Ensure a comprehensive, multidisciplinary, and multi-agency assessment of the person’s health and social needs is carried out (including an assessment of risk and any specialist assessments)*
Co-ordinate the formulation and updating of the care plan, ensuring that all those involved understand their responsibilities and agree to them. Ensure that the care plan is sent to all concerned.” (2008)

A person on the CPA pathway must have a multi-disciplinary review every twelve months.

Although the Recovery Coordinator is responsible for coordinating care they will not always be the person delivering this, Adrian’s support was provided by CCT throughout the period in the scope of this SAR. Adrian did have regular CPA reviews with a psychiatrist, his Recovery Coordinator and CCT workers who were at times, but not always, in attendance.
However, Adrian does not appear to have had regular comprehensive reviews of his health and social needs, and he had no one coordinating his care from January to September 2014. Coordination of his care failed during June – July 2015 with no one from DPT ensuring that he had the support needed during transition to independence.

7.3.1 In the period two years prior to his death, Adrian had three DPT employed “Recovery Care Coordinators” and was seen regularly by the same psychiatric team, but not the same Psychiatrist, during this time.

Adrian’s DPT Recovery Care Coordinator, Professional 1, knew him during his time at “House 1”, but was unexpectedly absent after he had been at “the flat” for three months. Professional 1 appears to have known Adrian well, was aware that he had been, and could be, exploited by others, and was of the view that his mental health was fragile, and he may not be able to achieve independence without a high level of support. No arrangements were made by DPT to cover Professional 1‘s work with Adrian.

Adrian had no further input from a Recovery Care Coordinator until September 2014 when Professional 3 began to work with him. He had one visit from Professional 2 in June 2014 who proposed to act as his “point of contact” until a new Recovery Coordinator could be appointed but was not contacted by CCT after this date and appears to have played no role in coordinating Adrian’s support. During this time Adrian appears to have experienced a good deal of distress, CCT asked if he could have a mental health assessment during a time of crisis in August 2014 but no follow up was made by DPT. CCT attempted to manage a challenging situation at the flat

during this time as complaints from Adrian's neighbours were continuing, F had moved into Adrian's flat and his use of drugs was becoming more noticeable.

Professional 3 continued to support Adrian after his move to House 2, his focus appears to be on Adrian's potential drug use and monitoring his wellbeing during this period of high-level support from CCT. Professional 3 began to indicate that he would be passing Adrian to a new Recovery Coordinator in April 2015, as teams in DPT were reorganising. Professional 3 was on leave when Adrian moved out of House 2. Professional 4, Adrian's third Recovery Coordinator, was introduced to him in mid-June 2015. Professional 4 appeared unaware that Adrian was not receiving support until 1st July 2015.

7.3.2 Throughout the period in scope of the SAR, Adrian had various levels of support from CCT support workers and managers. Support whilst in the "flat" appears to be twice daily and with frequent telephone and personal contact between Adrian and CCT support workers. Adrian appeared to make good relationships with some of the CCT support workers, one male support worker during his time in the flats being creative, patient and consistent in his supportive interventions to help Adrian deal with his anxieties and frustrations and attempts to avoid using drugs. Support at House 2 was more intensive and underpinned with agreed workplans. CCT support for Adrian from July 2015 onward, whilst living independently, does not appear to be underpinned by a support plan or agreement, and may have been badly managed because of the confused start to the support and the change of Recovery Coordinator as well as the changing attitudes to Adrian's support (see 10.2.3. below)

CCT were active in trying to source appropriate accommodation for Adrian. CCT managers worked to try to find different and more suitable accommodation for Adrian and did attempt to arrange for him to be admitted to "dual diagnosis" supported accommodation. CCT also offered Adrian the chance to "*go back to basics*" with a three month stay at the more highly supported House 2. However, at the point at which he moved to independent accommodation Adrian had no support from CCT, and given his departure from House 2, may have felt abandoned. He had no support, for the first time in many years in the initial few weeks of his first independent living. He made no recorded attempt to contact CCT workers, a marked change from his usual frequent contact to ask for reassurance and advice. His support workers only appeared to visit once a week, and he does not appear to have a strong and confiding relationship with them.

7.3.3 Communication between the two key agencies working with Adrian was not consistently maintained. The absence of a Recovery coordinator for six months and the absence of CCT support after Adrian left House 2 are the clearest indications of this. The concerns that CCT have about Adrian's use of drugs appear to be inconsistently and intermittently communicated to his Recovery Coordinator (Professional 3) throughout September 2014 to just before Christmas 2014 and the notice to leave the flats of 23rd December. Whilst Professional 3 did attend some

"crisis meetings" about Adrian's behaviour in the "flat" and was aware of the plan to monitor his drug use, he was updated after each crisis by CCT support workers that problems were resolving or diminishing. Both DPT and the CCT support workers appear to have engaged in an optimistic view of Adrian's progress, without reflecting on the longer term issues with psychoactive substances he had experienced.

CCT did not attend Adrian's meeting with his Psychiatrist on 16th December 2014 and reported "*no current concerns*." At that meeting the Psychiatrist, who had not seen Adrian before, was only able to rely on Adrian's account that he was no longer taking psychoactive substances. The long-term nature of the concerns about Adrian's behaviour whilst in this accommodation were not understood and therefore not addressed, CCT workers were left without access to professional advice on how to work with Adrian, and Adrian was not offered specialist services.

Police attended Adrian on two occasions in 2014. The nature of their perceptions about him and his wellbeing was not communicated to any agency. At this point Devon and Cornwall Constabulary had not initiated the Vulnerability Screening Tool or "VIST" process which enables information to be logged and passed onto other agencies, see section 11.3 below for further detail on the "VIST" process.

7.4 Understanding wellbeing: risk assessments and risk management

Notes and assessments from 2013 indicate that a comprehensive view of Adrian and the factors which influenced his wellbeing were understood and used by the two key agencies supporting him. Adrian's occasional forgetfulness and confusion were referenced, together with a tendency to self-neglect, the various triggers for frustration and outbursts, and his vulnerability to exploitation by others. His CCT risk assessment for 2013 describes Adrian as

"*a very trusting person which leaves him vulnerable of (sic)exploitation by others. When Adrian is struggling with his surroundings or in a distressed stated he can become verbally loud and aggressive, which in turn leaves him open to harassment form others in unfamiliar settings"*

As stated in 7.1 above, Adrian's Recovery Coordinator was concerned, given Adrian's mental fragility, whether he could cope with independent living without a high level of support.

When Professional 3 met Adrian in September 2014 he would have had access to Professional 1's notes and appeared to be trying to get to know all aspects of Adrian's life. Professional 3's involvement was marked by a decline in Adrian's circumstances at the "flat." He was being given warnings about his use of psychoactive substances and the impact these had on his behaviour. Professional 3 began to focus on how Adrian's drug use was threatening his tenancy, and latterly, with finding new accommodation for him. Adrian's essential vulnerability began to be obscured. Professional 3 did explore with Adrian what factors in his life were creating difficulties but did not explore these or put his knowledge of Adrian's concerns into action. We do not know if Adrian had always taken drugs intermittently, "legal" or otherwise, however his shouting behaviour was more exposed in the over fifty-fives flats in which he lived, and the other residents and staff were intimidated by this. We

do not know how F viewed Adrian's character. She is reported to be afraid of his outbursts and wanted to leave the flat. The impact of Adrian's living arrangements on the assessments made about him and his needs was not fully explored, or any review of the suitability of the accommodation arrangements undertaken.

A CCT manager consistently created boundaries around Adrian's drug use and focused on the impact of it on his behaviour and wellbeing. However, in the absence of any other more comprehensive assessment of Adrian's needs at that time his drug use and the behaviour which resulted from this was allowed to dominate the decisions made about him.

The CCT risk assessment of January 2015 emphasised that Adrian was distressed by loud noise and had a history of being verbally and physically aggressive to members of the public when distressed *especially* under the influence of psychoactive substances. Adrian's vulnerability to exploitation was mentioned in terms of "*being financially exploited in the past*." Risk concerns on Adrian's discharge summary from House 2 were "*concerns around Adrian's use of legal highs and the impact this has on both his mental and physical health*." Living more independently, both at the flats and at the cottage does seem to coincide with a decline in Adrian's physical wellbeing, but this was not attributed to his previously assessed propensity to self-neglect.

The DPT CPA crisis contingency plan for Adrian dated 17 July 2015 referred to the risks associated with his drug use, but none to the risk of his being exploited or harassed, or self-neglecting. The plan focused on the interaction between Adrian's mental health and drug use, and the possible risk to others. Adrian's vulnerability to others was lost as the emphasis of risk assessments appears to have altered with each change of worker.

The absence of a comprehensive review of Adrian's needs, including his vulnerabilities, had resulted in a simplistic view of the challenges he may face. This phenomenon is not unknown, especially when historical knowledge is lost with changes of staff and relationship, but steps must be taken to guard against this over simplification of the situation of people with complex needs;

"*One of the most common, problematic tendencies in human cognition, for example, is our failure to review judgements and plans - once we have formed a view on what is going on, we often fail to notice or to dismiss evidence that challenges that picture" SCIE 2009*

Adrian's family supported him throughout his transition to independence. There is no evidence that they were involved by professionals in any planning to support Adrian toward independence, or indeed in any aspect of his support. As family members they may have been able to advocate for Adrian, as well as support him. It may be that he did not wish them to be involved in his support, but there is nothing to establish this. Adrian's family had been very involved with reviewing and planning his support prior to his move to House 1 in 2011. After this point they were not invited to meetings or informed of any element of Adrian's progress by either CCT or DPT.

Adrian continued to spend time with his family on holidays and extended visits, but they were excluded from all aspects of his interaction with services.

The result of the failure to view Adrian as an adult who may be at risk of exploitation meant that no plans were made with him about how to summon help should he be worried about a "friend". Adrian's previous reaction to being exploited and subject to harassment at the "flats" in early 2014 was to ask for and use support to resolve such situations. Staff were alert to the possibility of this type of harm and worked with Adrian to resolve such issues. The emphasis on his use of legal highs had begun to affect his relationship with his support workers, and his departure from House 2 followed by a period without CCT support may well have reduced the likelihood that he would ask for support from that service again. It is likely that SH exploited Adrian by supplying him with drugs. Post mortem toxicology showed that Adrian had taken both methiopropamine (a psychoactive substance/ legal high) and diazepam some time before his death but had a low level of drugs in his system. Given Adrian's history with CCT and DPT regarding reactions to his drug taking, he would not have been inclined to disclose his fear and anxiety around SH.

7.5 Adult Safeguarding.

In early 2014 Adrian's CCT support worker told Professional 1 that Adrian had been subject to exploitation from an ex fellow resident and by a neighbour, T, who Adrian had initially thought was a "friend". These issues appear to have been dealt with effectively by CCT, but no report was made at the time to DPT, or any Adult Safeguarding referral raised. Had Adrian been referred via the Adult Safeguarding route it may have been that no action was needed, Adrian's support service was helping him through. However, he would have had two Adult Safeguarding referrals on record highlighting his vulnerability and emphasising this perspective in subsequent risk assessments.

Did workers of the time recognise exploitation as adult abuse? Awareness of "Mate Crime" has been developing since the late 2000s. "***Mate crime is when vulnerable people are befriended by members of the community who go on to exploit and take advantage of them" (Grundy, 2009).*** This awareness has been informed by Adult Serious Case Reviews, for example Gemma Hayter (2010) and Stephen Hoskins (2007) and focused projects, for example the Home Office funded "Safety Net" project in North Devon from 2009- 2011.

Awareness has largely focused on risks to people with learning disabilities, but such exploitation is also a strong theme in the lives of people with mental health issues, and those who use drugs and alcohol. Indicators that need to be borne in mind include "*People living alone may be more vulnerable, particularly when the adult is associating with peers where the subculture has normalised drug misuse, crime, violence and mate crime*". Stephen Hoskins 2006. Others may notice an "*overly critical or disrespectful friend*" (Hampshire SAB 2016).

There is some debate about the use of the term "Mate Crime". A more detailed analysis of the thinking around Mate Crime can be found in Bristol Safeguarding Adults Board recent review of Mate Crime in Bristol (2018). Mate Crime is viewed by

the Crown Prosecution Service a category of Hate Crime, i.e. a range of criminal behaviour where the perpetrator is motivated by hostility or demonstrates hostility towards the victim's disability, race, religion, sexual orientation or transgender identity. (CPS accessed 2018)

The concept of Mate Crime can be helpful in identifying a particular set of behaviours exhibited by the perpetrator of such crimes, for example creating an affinity with the victim, sometimes with friendship and sometimes through mutual use of drugs or alcohol, isolating the victim from friends and other sources of support, posing as a friend or carer, taking over accommodation, mobile phones, bank accounts, internet accounts. These indicators are present in SH's relationship with Adrian. The victims of Mate crime often do not report what is happening to them, sometimes they do not recognise the behaviour of the perpetrator as abuse, often they are fearful of the perpetrator and/or the police (Dunne 2009). Adrian had already experienced a good deal of disruption in his life through taking psychoactive substances and the reaction of others to the intervention of the police, i.e. to escalate the need for his removal from the flat. In addition, SH's known history would indicate that he must have been a frightening and threatening figure to Adrian.

The implications of A's lifestyle and previous indicators of vulnerability to exploitation or "Mate Crime" do not appear to have resulted in any systematic consideration of what DPT or CCT staff should be observant of, what risk factors were notable in A's life, or indeed any contingency plan created with A on what he could do and who he could turn to when faced with such a dilemma.

DPT report that the Adult Safeguarding policy in place at the time needed urgent review, the principles of the Care Act 2014 were not embedded into the policy, and no assurance could be provided that all DPT staff were clear where they could access safeguarding support within the Trust. Prior to July 2016 the Trust's safeguarding team was poorly resourced and consisted of a part time named nurse for children and a part time Adult Safeguarding lead. Safeguarding Training compliance was also limited at Level 3 in Safeguarding Adults during the period of 2013 to 2016. There is no evidence that the clinicians who were working directly with Adrian had completed their Level 3 Safeguarding Adults training (or any equivalent). Awareness of Adult Safeguarding in DPT at the time of events was poor.

7.6 Access to specialist services. Although the agencies who worked with Adrian were very concerned about his drug use only CCT made attempts to connect him with specialist services by trying to source accommodation for people with a "dual diagnosis" of mental health issues and substance misuse. DPT appeared to take an optimistic approach that there were "*no concerns*" as reported by CCT support workers. Adrian is reported to have taken a range of substances, legal and illegal, through much of his adult life. These patterns of behaviour may have formed part of his identity, and he most certainly had an addiction to them. No offers of referral to a local specialist community service, e.g. RISE (substance misuse services) are recorded. There appear to be extensive attempts by CCT to advise Adrian, but no advice or support from DPT to either Adrian or his support workers on the best

approach to take. We do not know if DPT staff viewed the impact of taking “legal highs” in the same way in which they might view illegal drugs or addiction to alcohol. Although the Psychoactive Substances Act came into force in May 2016 there was an awareness and concern about the impact and legal status of psychoactive substances in the years prior to this. In January 2015 Devon and Cornwall police undertook “Operation Parky” to gather information on the sale, use and effects of ‘legal highs,’ considering seizure and testing of such substance and arrest of those in possession as many tested substances were found to contain controlled drugs under the Misuse of Drugs Act 1971. In November 2011 guidance had been published by the Association of Chief Police Officers about Temporary Class Drug Orders which could be issued to make specific psychoactive substances illegal as their risk was identified. These Orders lasted for 12 months whilst a full risk assessment was made to decide on the permanent legal status. Specific drugs identified as being a risk were being made illegal. There were growing concerns about the impact of psychoactive substances or “legal highs” on children, people with mental health issues and the relationship between these substances and anti-social behaviour.

At the time the impact of “legal highs” on people with mental health conditions is also reported to be of great concern to DPT staff, who noted an increase in distress and aggression in people taking them. However, agencies are reported to not be clear about the best intervention, or how to access clear advice about these drugs, drug and alcohol teams are reported to have not developed the technical expertise to support agencies working with people who used these psychoactive substances. In addition, the specialist drug and alcohol team is reported to have been “overloaded”, it had just moved out of the umbrella of DPT and at the time, was a third sector independent organisation.

Adrian’s Recovery Coordinator did understand the impact of Adrian’s drug use on his ability to keep a tenancy and retain good mental health. It may have been that Adrian would have refused referral to RISE, in this case it would have been useful for Adrian’s Recovery Coordinator and/or psychiatrist to access advice from specialist services in order to adapt his CPA plan. However, evidence from 2005 indicated his willingness to accept and engage with a daily treatment programme, and resulted in his being drug free for several years.

8. Relevant history prior to the time in scope: SH

The reviewer has not been able to find anything about SH as a person, his family declined to be involved in the Review. Reports received describe a man who moved between at least three areas, Hampshire, Devon and Lincolnshire, was frequently homeless, had an addiction to alcohol and other drugs, and had perpetrated violence to partners or others who had strayed across his path. In 2014 SH was reported to have thirty nine previous convictions that related to eighty seven offences dating back to 1990. These included arson, assault, theft, driving offences, criminal damage, wounding, grievous bodily harm, robbery, battery, handling stolen goods, threatening behaviour and harassment. Some of the violent offences were domestic

in nature or against Police Officers. SH had stated to Probation Officers that these offences were related to his use to of illicit substances and alcohol.

SH was charged with Adrian's murder on the 20th October 2015, having left Devon and gone back to Hampshire. On the 14th June 2016 he was sentenced to life imprisonment with a minimum tariff of twenty years at Exeter Crown Court following a conviction for the murder of Adrian. SH knew he had an advanced cancer by this time, he had been diagnosed whilst in custody in 2016. SH died on 2nd April 2017.

There is nothing to connect SH and Adrian until the 18th September 2015, when it is believed they met on a train and Adrian invited the homeless SH to stay at his house. However, it is useful to consider key events in SH's life in the two years before Adrian's murder, in order to identify how the risks SH presented were identified and managed.

9. Key Events – SH

9.1 It has been hard for agencies to build up a picture of SH's whereabouts and behaviour during the time in the scope of the SAR. There are contacts recorded in three different police areas, Hampshire, Lincolnshire and Devon. There are incidents and investigations in different areas, sometimes investigations into one offence have not ended before SH was involved with the police again.

9.2 September 2013 to November 2013 SH was in Hampshire. He harassed a woman who was a volunteer he had encountered whilst homeless, he threatened her and her family with violence. A Court restraining order was issued against him which he breached, he was also reported to have used violence to enter premises, stolen cash from a domestic dwelling and intimidated witnesses.

9.3 From February 2014 to August 2014 SH is reported to have been in Lincolnshire for most of the time. He was arrested for being drunk and disorderly on **4th February** and was abusive to police officers. By the **12th February** he was back in Hampshire, was abusive to Library staff and committed an "assault without injury" on a Library Security guard. No-one wished to press charges. He committed a further offence at the same Library on **27th February** and was found guilty of racially and religiously aggravated intentional harassment which caused alarm and distress as well as using threatening and abusive words and behaviour.

In **March 2014** SH was back in Lincolnshire. A probation officer completed an OASys assessment to inform sentencing for offences of theft, drunk and disorderly and racially aggravated harassment. OASys is the abbreviated term for the **Offender Assessment System**, used by the NPS to measure the risks and needs of criminal offenders under their supervision. OASys is designed to assess a number of elements;

- how likely an offender is to be re-convicted

- identify and classify offending-related needs, including basic personality characteristics and cognitive behavioural problems
- risk of serious harm, risks to the individual and other risks
- assist with management of risk of harm
- link the assessment to the supervision or sentence plan
- indicate the need for further specialist assessments
- measure change during the period of supervision / sentence.

SH was assessed as presenting a High risk of serious harm to the public, to known adults, to staff and a Medium risk of serious harm to children. SH was also assessed to have a very high likelihood of committing a further violent and/or a non-violent offence.

The Probation Officer was concerned about the risks identified in the OASys assessment and referred SH into the Lincolnshire Multi-agency Public Protection Arrangements, or MAPPA. MAPPA arrangements are in place to ensure the successful management of violent and sexual offenders in the community. Arrangements enable agencies to work together to an agreed management plan, ensuring that all are aware of information known about the offender and the risks presented by them.

A MAPPA Meeting was held on **11th April 2014** and attended by Lincolnshire Police, Lincolnshire Probation Trust, Mental Health, the local District Council, and Children's Services. SH was registered as MAPPA level 2. Cases are managed at level 2 when an offender:

- *Is assessed as posing a high or very high risk of serious harm, or*
- *The risk level is lower but the case requires the active involvement and co-ordination of interventions from other agencies to manage the presenting risks of serious harm, or*
- *The case has been previously managed at level 3 but no longer meets the criteria for level 3, or*
- *Multi-agency management adds value to the lead agency's management of the risk of serious harm posed. (MAPPA guidance 2012 version 4.2)*

The MAPPA view of the level of risk of serious harm presented by SH was High. A psychiatric assessment was sought based on his presentation.

0n **6th August** in Lincolnshire a MAPPA Level 2 Review meeting was held. A Clinical Forensic Psychologist reported that SH had refused to engage with any psychiatric assessment. SH was assessed by the agencies present at the review to be "*aggressive and difficult*", as opposed to being dangerous. This assessment

appeared to focus on the risk to staff in the agencies rather than members of the public. The MAPPA view of risk of serious harm was downgraded to “Medium” and he was de-registered from MAPPA. A safety plan had been put in place for Probation staff and Job Centre staff. As SH was homeless at the time, relevant information was shared with housing providers and the Police of the area “*SH was deemed to be heading towards*”. It is not known which area this was. Recommendations were made in the MAPPA review minutes for SH to be allocated to Probation staff with Personality Disorder expertise.

On **7th August 2014** SH was arrested in Lincolnshire for using “threatening, abusive, insulting words or behaviour with intent to cause fear or provocation of violence.” No further action was taken, SH had been threatening police officers.

9.4 December 2014 – May 2015. SH next came to the attention of the police in Devon in **December 2014**, he committed a common assault against a woman known to him, with little evidence it was not possible to take the matter further. Police were concerned about SH’s relationship with a woman during December and the potential for domestic abuse, SH was living in her accommodation. The woman concerned did not report an offence and the concerns remained on file as “intelligence”. At the end of December 2014 SH committed a common assault in a Devon shop, he swore and spat at a female shop worker, but before he could be arrested and interviewed for the offence, he had left the area.

On the **12th March** 2015 SH was arrested in Hampshire regarding a public order offence and was also interviewed regarding the common assault in Devon. He was bailed to Torquay police station for 8th April. This offence was not prosecuted it did not meet the evidential test for a conviction. During March, whilst in Hampshire SH was arrested for possession of cannabis, shoplifting, criminal damage to a door whilst being held in custody and a woman described as his partner made two reports to the police regarding domestic abuse, neither of which could be progressed.

On **31st March** SH was charged with theft, committed in Devon in early March, of £600 from the elderly and infirm mother of a female friend. He had stolen her credit card and made three unauthorised withdrawals from her account. SH was found guilty of this offence in June 2016, after his imprisonment for the murder of Adrian.

SH was charged with the offence of theft when he was arrested on a charge of sexual assault. On **2nd April** 2015 SH was interviewed at Torquay custody suite. Officers noted that “*SH was extremely agitated and aggressive throughout his whole time in custody and during interview. He shouted continually and it was difficult to control him and get direct answers from him*”.

There is a limit to how long a person can be detained, with little time left in which to question him and an outstanding enquiry, SH was bailed till 4pm on **17th April** 2015 with bail conditions not to enter Newton Abbot or to speak to the woman he allegedly assaulted. SH was arrested for theft in Newton Abbot on **16th April**; being in the town was breach of his police pre-charge bail conditions and he was arrested for this breach. This lead to the cancellation of bail conditions as a breach of pre-charge bail

can only be resolved by a charge for the original offence or a change or continuation of the pre-charge bail conditions. For bail conditions to be applied, the police custody time of 24 hrs (in these circumstances) must not have been passed. In this case the custody time was passed, and pre-charge bail conditions could not now be applied. CPS decided to summons SH for the offence of sexual assault allegedly committed on the 17th November 2015. He was found not guilty of this offence at Exeter Crown Court on 21st June 2016.

During April the police were very concerned about SH's presentation whilst in custody. He was extremely threatening toward the police and about other members of the public. A recommendation was added to SH's local police record:

"During recent interviews whilst in custody SH has been volatile and unpredictable. He can appear completely calm and relaxed and then with little warning become very angry, abusive and aggressive, shouting and getting out of his seat. It is recommended that officers should be double crewed whilst interviewing SH in custody".

SH was arrested for shoplifting a small amount of food on **16th April.**

On **17th April** 2015 SH was charged with a public order offence committed in a shop on 2nd April and a linked offence for possession of cannabis. He was remanded to court due to comments he made insinuating he should harm people who made false allegations against him and because of committing further offences whilst on bail.

He was arrested for common assault on a pub landlord on **23rd Ma**y and charged with this offence and possession of cannabis.

9.5 June – September 2015.

The charge of common assault on the pub landlord resulted in SH appearing in Plymouth Magistrates Court on **25th May**, the hearing was adjourned until 9th June for a pre-sentence report to be undertaken. An OASys assessment and Fast Delivery Report (FDR) were completed by a National Probation Service (NPS) officer for the Magistrates' Court hearing. SH was interviewed in HMP Exeter. The pre-sentence report author noted that

"The victim had previously banned SH from his pub. SH was homeless. It is not clear if SH was under the influence of drugs or alcohol at the time of this offence, but he admitted to "drinking wherever he can" around the time he committed this offence".

SH was assessed by the report author to pose a very high likelihood of re-offending, in either in a violent or non-violent way, a Medium risk of serious harm to the public and Medium risk to a known adult and to staff. He was assessed to pose a Low risk of serious harm to children.

A Fast Track Delivery pre-sentencing report was completed, together with a Risk of Serious Recidivism (RSR) tool, which is used to identify whether offenders should be allocated to the Community Rehabilitation Company (CRC) or the National Probation Service (NPS). NPS generally works with High Risk offenders, people who are subject to MAPPA, are on the Sex Offenders Register or pose a high risk of harm to

the public. CRCs work with offenders who are a Medium to Low risk to the public. RSR scores are based on the number of convictions an offender has and are intended to be a guide only as to which organisation would be most suitable to work with an offender. Professional judgement must be used by the NPS officer undertaking the RSR. Offenders who score above 6.89% must be allocated to NPS. The RSR score for SH was 6.08. The assessor inputted SH as having seventeen violent offences whereas thirty should have been counted. Both the CRC and NPS agree that the RSR tool was incorrectly calculated. SH should have been automatically allocated to the NPS. Even with the incorrect score, given SH's previous risk assessments, which are described in section 10 below, there was an option of allocating to the CRC with a view to reviewing within three months as to whether the case should be held by the CRC or the NPS.

SH was sentenced to a six-month Community Order and allocated to the CRC on **15th June 2015**. He had a 20 day "Rehabilitation Activity Requirement" and was to undertake forty hours of unpaid work. His case was allocated to a Probation Service Officer (PSO), i.e. an unqualified officer, by the CRC line manager. There is no reason recorded for this allocation and the CRC case allocation tool was not completed by the line manager responsible for this allocation. At this point the line manager may have had limited information about SH, the NPS Court team is reported to have told the manager that SH needed support in finding accommodation, and the PSO did have previous experience in housing work. The line manager could have reviewed this allocation once he received the NPS assessments and report.

SH attended his first unpaid work appointment for induction on the **18th June**. He presented "in crisis" as a homeless person, the PSO secured accommodation for SH and a food parcel. Although induction paperwork was completed the PSO did not complete the required risk assessment but noted the assessed risk of SH reoffending as Medium to High, linking this with having no money. On **24th June** SH attended the CRC offices again, and a work instruction was given for **30th June**, a late instruction as this should have been done within seven days of sentencing. A note was made by the PSO of a medium risk of harm due to violence on SH's record. SH attended unpaid work on the 30th June but was noted to be agitated about having no food or money. He was visited at his accommodation by the PSO on the **3rd July** who referred him to the "Hub" as he still had no money. The Community Hub is a way of accessing support from several agencies, but is aimed at low risk offenders and was not suitable for SH who was at this stage identified as having a Medium to High risk of re offending associated with no money and a Medium risk of violence to others.

SH missed his next unpaid work appointment and was reminded two days later to attend or "*enforcement action would be taken*". He came into the CRC offices on the **9th July** and was aggressive both to the duty probation officer and to DWP over the phone. The PSO saw him and appeared to diffuse the situation but made no notes of the conversation. Although the duty officer wanted to address SH's behaviour there is no evidence that the PSO challenged or addressed this and no warning was given to SH regarding his behaviour.

By **21st July** SH was homeless, he had missed three unpaid work appointments and attended one. The failure to attend was made "*acceptable*" by the line manager due to SH's circumstances, he was sleeping in tent. CRC did telephone SH's landlord to find out why he was evicted, it was alleged that he stole cigarettes and did not pay bills despite having money. SH was referred to an accommodation worker and linked to a homelessness outreach worker. There does not appear to be any revision of his risk assessment or liaison with others involved in the case. SH's aggressive behaviour and "*need to test boundaries*" was noted by CRC. On **21st July** SH was seen at the Community Hub, he was reported to be aggressive and erratic and had "*red eyes*". The line manager assessed that SH was presenting increasing risk and was unsuitable for Community Hub services as he was difficult to work with "*as approaches everything from an aggressive stance".*

During this period Devon and Cornwall police noted intelligence that SH was using drugs in a local library and had tried to stay with an ex-girlfriend who refused, as she was afraid of him. SH attended Court on **23rd July**, visiting the police station beforehand in an agitated state to say he was of no fixed abode, the trial was recorded by CRC as adjourned although there are no notes to substantiate what this was in relation to.

Between **27th July and 6th August** SH failed to attend two unpaid work appointments but attended the CRC office twice. During the unplanned visit of SH to CRC on **27th July** he was seen by the PSO and his manager. Contact was made with the Hub housing officer who reported that SH was being vague about where his tent was located so it was hard to offer support. The Housing officer shared concerns about SH's aggressive behaviour and unsavoury associates. No enquiry was made by CRC about SH's reported further offence and no changes were made to his risk assessment. The PSO did talk with SH about his aggressive behaviour during a visit to the CRC offices on **31st July** but gave no warning about the consequences of missing unpaid work appointments or his behaviour. By **3rd August** SH stopped attending unpaid work and was demanding food parcels and assistance. The PSO arranged a food parcel and contacted the housing officer to arrange a three-way meeting.

On **6th August** SH attended the CRC office and was seen by the PSO's manager. He complained that Housing were not helping him. He disclosed that he was in a relationship with a woman and that he was due in court for shoplifting the next day. There is no evidence that the line manager informed the PSO of this visit, or of any checks being made regarding the woman he said he was having a relationship with, or whether the woman had any children. In addition, there are no CRC records regarding the shoplifting offence. The same day SH was suspended from unpaid work "*due to homelessness. All absences to date accepted".*

From this point the CRC focus appears to be on SH's welfare rather than his criminal behaviour, or his sentence, and the consequences of not completing his sentence.

Devon and Cornwall police continued to record intelligence on SH. They were aware that he was living in one of two tents outside Newton Abbot racecourse. There was a couple living in one tent and SH in the other. On the **12th August** police note that SH

was actively targeting "*vulnerable lone females*", and that he "*is very calm and persuasive in his manner*". Information received on the **11th August** was noted by the Police, that SH had used alcohol and cannabis together with some intimidation to persuade a young couple to attend a house with other men where there was talk of gang rape. SH was seen at the Haven the next day by the young woman, he again tried to give her cannabis. On the **13th August** Devon and Cornwall police published a briefing for officers in the Torbay area identifying concerns regarding SH targeting women. This briefing and these concerns were not shared with CRC, there was no mechanism with which to do so. It is reported that there was a national information sharing agreement which concentrated on probation informing police of information, but not on the police sharing information with probation services.

On **17th August** SH was seen by the PSO in a local pub as he was still living in a tent. SH was recorded as saying he was "*having problems with women at the Haven project*". The PSO "*discussed support services available to him*" and confirmed he was still living in the tent. The same day SH spoke to local police and said he had just seen his "probation worker". He said that he would not be attending the Haven anymore, it was "*full of weirdos*".

SH was charged with a public decency offence committed on **30th August**.

On **20th August and on 3rd September** SH attended the CRC offices again wanting help with food and accommodation. There was no exploration of his situation, no risk assessments or any evidence of SH's behaviour being addressed as required by the Community order.

On **28th August** SH's case was assessed using a new allocation and risk assessment tool, "Blue Red Amber Green" or "BRAG". SH was assessed as a Medium risk of harm. This tool was new to CRC and the assessment of the case was carried out by someone who did not know him, contrary to the practice guidance.

On the **4th September** the PSO completed the OASys assessment tool for SH. The impetus for doing this appears to have come from the local housing team who requested SH's risk assessment before they were prepared to work with him. This should have been completed within 15 days of the sentence he was given in June, i.e. by the 29th June, and was by this time ten weeks overdue. The document was pulled through from previous documents and was missing information. It did not meet the required standard of assessment as the sentence plan objectives did not cover the areas originally discussed at start of order and did not address any of the risks. The line manager countersigned the assessment on the **7th September** but did not check the accuracy of the report, focusing instead on the need to sign off the assessment to enable SH to gain access to housing support. The PSO shared the OASys assessment with the local housing team and made an appointment for SH to meet with them.

On **9th September** the Police interviewed SH regarding an allegation of rape. He had allegedly raped a woman in his tent. The police described him as "*massively unpredictable. He has severe anger problems and reared up probably 10 times*

during the interview. He is very aggressive and intimidating and openly speaks of his dislike of the police." SH was charged with rape whilst he was in prison for murder. The case did not progress as by that time SH was terminally ill.

CRC were unaware of the encounters that SH was having with the police. There was and is no arrangement to share information, and CRC did not make any enquiries of the police until the 7th September when SH failed to attend the arranged meeting with housing. The PSO called the police station to be told that SH was being investigated for rape. CRC do not appear to have taken any enforcement action regarding this serious allegation, no further checks were made, or information recorded. There is no record of risk escalation to NPS which would be expected given this allegation of further serious offending. There is no record of an instruction letter or contact with SH as would be expected. Rather, it is understood that the line manager advised the PSO not to escalate as this was an allegation only.

SH called into the CRC offices on the **18 September**. He was reported to be in an "*agitated state, saying needs to leave the area, has been accused of Rape linked to Haven, community centre. Has no support*".

9.6 September – October 2015

Devon and Cornwall police continued to record intelligence on SH, noting his whereabouts and activities when seen. On **22nd September** SH telephoned the PSO to say that he had secured accommodation at friends' cottage and would come in on Friday with details to arrange home visit. SH did not attend, ringing in on someone's else's mobile to say he was ill. It is highly likely that the "friend" was Adrian, and that he was phoning using Adrian's phone as he done previously when contacting Adrian's friends. CRC made no attempt to ascertain the address SH was staying at, or the name of the friend, the nature of the relationship or gender of the friend. There was a further call from SH on **28 September** to say he could not come in and was staying with a friend. This was accepted by the PSO, who told SH to keep in touch by phone.

During the time that SH lived at Adrian's address, some 14 days, SH took money from Adrian and persuaded him to sell his collections. He may have been physically violent to him prior to the attack in early October which resulted in Adrian's death. SH had begun to pose as Adrian's "carer" to neighbours and to alienate Adrian's friends in order to isolate him further.

SH killed Adrian at sometime around the **4th October**. He fled to Hampshire and committed a theft, taking a vulnerable man to a cashpoint as he had Adrian, and withdrawing £240, telling the older man that he was getting £10 out for tobacco for him. SH was arrested on the **17th October** and charged with the murder of Adrian on the **20th October 2015**.

10. Analysis of Key themes – SH

10.1 Reports about SH indicate a man who often tried and sometimes could manipulate individuals, situations and agencies, using demands for help and attempted portrayals of himself as in need, as well as threats, persuasion, violence and offers or supply of drugs. As seen with Adrian, he knew how to isolate his victims and attempted to portray himself in a light which was intended to reduce suspicion. He was prepared to exploit other's vulnerability to get money and is known to have done so on three occasions during the time in scope. He exploited women and was alleged to be the perpetrator of violence toward them on numerous occasions. He was capable of violence toward men and women and, as the police have documented, was capable of escalating aggression very quickly and without warning.

Several themes emerge from the key events described above:

- The absence of risk assessment informed by shared information.
- Interpretation of information about risk
- The impact of transitions in organisations.

10.2 The absence of risk assessment informed by shared information

SH appears to have been a difficult man to keep track of as he moved from area to area frequently. There was key information about MAPPA, including the advice that he should be allocated to a Probation Officer with experience in personality disorder, held on the ViSoR system. The full Risk Information on SH was not used when determining his pre-sentence report in June 2015, deciding on which agency should supervise his sentence, or on how the breach of his sentence should be responded to. Agencies in Devon, most notably the Police and CRC, had information about SH and the risks he presented, which was not shared.

10.2.1 The Lincolnshire NPS referral into the MAPPA system is backed by very thorough background information gathering and risk assessments. Although the Probation officer was undertaking an OASys for sentencing for a relatively low-level offence, the officer was concerned by SH's presentation in interview, and accessed historic OASyS reports and court reports dating back to 2010. SH had been MAPPA registered in Basingstoke, had been on Police bail for an allegation of rape and was assessed to be a High risk of serious harm in all domains at that time. The Probation Officer also had information from Lincolnshire Police about SH's threats and intimidation of the female volunteer in 2013. The Probation Officer referred SH into MAPPA as a "Category 3" offender. There are three categories of MAPPA offenders. Category 1 are those on the Sex Offender Register. Category 2 are those sentenced to 12 months or more custody for a 'Schedule 15' offence (Schedule 15 is a list of serious violent and/or sexual offences). Category 3 is for any offender who is does not fit Category 1 or 2, but who has a qualifying previous conviction for a violent or sexual offence and whose current risk merits being discussed at Level 2 or 3. At

level 2, a Multi Agency Panel will be convened to assess and manage risks to the public. The MAPPA process did result in a shared view of risk that SH could present a risk to

- any intimate partner

- any male or female member of the public, predominately people he spent time with,

- his pattern of acquisitive crime was noted.

- noted that SH could have a Personality Disorder.

- SH could target vulnerable people for funds and accommodation.

The MAPPA Review meeting in August 2014 identified that SH had refused to engage with any mental health assessment and continued to move addresses frequently. The Salvation Army hostel where he lived reported no concerns regarding his behaviour and SH had not come to recent Police attention. SH was still awaiting sentence and therefore no statutory agency was involved. The MAPPA Panel view of his risk of serious harm was changed to Medium and SH was removed from MAPPA. This decision appears to be consistent with the practice of the time. However, a rationale should have been recorded in the minutes to explain the decision to reduce the level of risk posed by SH. It is not recorded how SH's non-compliance was considered and balanced with other evidence during the risk assessment process. There is little evidence that SH's Risk Management Plan was developed. SH could have remained assessed as being High risk but not heard at MAPPA Level 2.

The purpose of MAPPA is to ensure that every step that can be taken to mitigate and manage risk has been taken. Once this has been achieved, a case can legitimately be reduced or, as in SH's case as a "Category 3" the person can be removed from MAPPA. How would agencies outside of Lincolnshire know that SH had been considered at a MAPPA panel and recommendations made, for example that he should be seen by a Probation Officer with experience of personality disorder? MAPPA minutes are not easily accessible due to their confidential nature. MAPPA information is available on ViSoR, the Violent and Sex Offenders Register, a national confidential police system which records details, risk assessments, risk management plans and actions in relation to violent and sexual offenders particularly those managed under the MAPPA process. Only the police, NPS and prison staff have access to ViSoR, but this is limited to a very small number of officers in these services who have the security clearance to do so. CRC staff have no access to ViSoR. The onus is therefore on NPS to utilise any information during subsequent pre-sentence report activity. A search on ViSOR, would have located the previous MAPPA minutes, but the use of ViSOR by Probation staff was not widespread at the time. It is understood that NPS is currently implementing policies to improve the access to and use of ViSOR by NPS staff.

10.2.2 During the period on scope NPS did undertake two OASys assessments regarding SH in 2014 and 2015 in the course of compiling pre-sentence reports.

The risk ratings and assessments regarding SH changed between the 2014 and 2015 OASys reports, risk ratings for harm to the public reducing from High to Medium.

The OASys in 2014 was written at the time SH was discussed at MAPPA, and the Risk Management Plan in the OASys reflects the involvement of MAPPA and the actions set, demonstrating that the Risk Management Plan regarding SH was not made in isolation. At this time, SH was assessed to pose a High risk of serious harm to the public, known adults and staff, with a Medium risk of harm to children. Serious harm is defined in OASys as "*an event which is life-threatening and/or traumatic, and from which recovery, whether physical or psychological, can be expected to be difficult, or impossible*". By assessing the risk as High, the author of the OASys considered that they had evidence that "*there are identifiable indicators of risk of serious harm, the potential event could happen at any time and the impact would be serious*".

In 2015, the OASys assessment defined SH as posing a Medium risk of serious harm across all domains. Medium risk of serious harm is defined in OASys as "*there are identifiable indicators of risk of serious harm. The offender has the potential to cause serious harm but is unlikely to do so unless there is a change of circumstances, for example, failure to take medication, loss of accommodation, relationship breakdown, drug or alcohol misuse*".

Although SH's current offences were analysed in some detail in the 2015 OASys, little information was considered in terms of his previous offending history. Not every category of potential victim was identified, there was no mention of the potential to harm Adults at Risk although this had been highlighted at the MAPPA review meeting the previous year. The previous OASys recorded that SH was managed as a Category 3, Level 2 MAPPA case. This should have alerted the NPS OASys author in 2015 that risk concerns had been previously identified, albeit twelve months previously. The MAPPA review recommendation that SH should be allocated in the future to a Probation Officer with personality disorder experience does not appear in the 2015 report.

A lack of analysis within the risk of serious harm summary section of OASys is reported to be a recurring theme nationally, possibly because OASys assessments are 'pulled through' (i.e. authors of reviews update previous assessors' work, rather than writing a new assessment). An OASys assessor should nevertheless ensure that each OASys is a thorough critical analysis and evidence is proactively sought. OASys authors are expected to base their assessments on current and disclosed information. However, there is a section of OASys that is not disclosed to the offender, and this can be used to document and analyse historical unproven intelligence and allegations regarding risk.

NPS report that the 2015 assessment does not meet the minimum quality standard for OASys.

"The assessment of Medium risk may well have been defensible, but not enough information is contained within the overall assessment to provide evidence for this. Judging whether SH actually was Medium or High risk of harm, as per the OASys definitions, is very difficult given the extent to which the most serious risks related to allegations, not proven behaviour, and because it is impossible at this point to accurately assess the imminence of further such behaviour. On balance, my view is that SH could have been assessed as High risk, and therefore allocated to the NPS."

The assessment of SH as posing a "Medium" risk of harm but "*is unlikely to do so unless there is a change of circumstances, for example, failure to take medication, loss of accommodation, relationship breakdown, drug or alcohol misuse"* may have lead the CRC to overly focus on SH's wellbeing in terms of accommodation and resources in order to avoid further offences. No attention was paid by CRC to other aspects of SH's risk history, e.g. drug and alcohol use.

10.2 3 The pre-sentence "Fast Delivery "Report (FDR). Despite the implication of the title "Fast Delivery Report," there was an adjournment from 25 May until 15 June to write the pre-sentence report for SH's court appearance. This would leave sufficient time for checks to be made, information verified and a detailed analysis to be completed. This FDR was supported by an OASys risk of harm assessment. However, the quality of this risk assessment lacked detail and thorough analysis, as discussed in 10.2.2 above.

The FDR did not state risk levels for different potential future victims or provide a sufficient analysis of risk or protective factors. There was no evidence of checks being made with the Police regarding any information on domestic abuse incidents, or incidents involving Adults at Risk, which would have been relevant given the identified risk to partners, Adults at Risk and/or the children of partners**.** Considered with the serious previous allegations, an update from the Police should have been requested to assess these risks at the time. Probation Instruction 04/2016 (Para 1.17) states that "*Staff must initiate safeguarding checks regarding children and adults at risk at the earliest opportunity to enable a response to be received at the earliest stage*".

The lack of risk assessment informed by shared historical information resulted in the June 2015 sentence failing to match SH's level of risk or need. The NPS state that

"*a short Community Order with 20 Rehabilitation Activity Requirement (RAR) days does not appear to sufficiently match SH's level of risk and need. His suitability for an accredited programme, alcohol treatment or a drug rehabilitation requirement is not explored. Additionally, Unpaid Work is deemed suitable, but how this could be achieved given his substance misuse issues, history of aggression to staff and homelessness is not addressed*".

10.2.4 Risk assessment information should have also informed the decision about the most suitable organisation to work with SH through his sentence. The decision is supported by a calculation – the Risk of Serious Recidivism (RSR) score - which is

intended to support professional judgement in allocating offenders to the appropriate organisation for their sentence. When calculating SH's score, the NPS RSR assessor missed some thirteen previous violent offences. These were offences which fall under Criminal Damage, Drunkenness and Public Order / Harassment. Even with these fundamental errors made when calculating the RSR score, calculations still resulted in the RSR score being well over 6%. When considering the reliability of an RSR score, the assessor should assess if there is significant information that this tool has not considered. Some offenders, like SH, have an extensive history of allegations which have not resulted in convictions and/or the offences for which they are convicted do not fully represent the harmful nature of their offending. A professional judgement could have been made by NPS that the RSR score (albeit incorrectly calculated) did not fully reflect the likelihood of SH causing serious harm in the future. This is evidenced by the assessor having identified that there were circumstances in which the offender would be assessed as High risk of serious harm such as when in an intimate relationship.

In view of SH's history, the allocation to CRC could have been made with a recommendation of a risk review within a set period of time. The case would be risk reviewed by the NPS (when informed by CRC) if circumstances changed indicating an increase in risk of serious harm. This option is available to assessors under Probation Instruction 05/2014.

10.2.5 In summary, the Community Rehabilitation Company (CRC) were informed by inadequate OASys assessments and received an offender who was not within their service capability and who was serving a sentence inappropriate to his actual needs and the risks he presented.

CRC did very little to assess the level of risk SH posed, and how changing circumstances affected that risk. No effort was made to ask for information from Devon and Cornwall Police, who were themselves very concerned about SH's behaviour and risk, to women, and to officers themselves.

10.2.6 Based on his RSR score, SH should have been allocated to a Probation officer but was allocated to an experienced Probation Service Officer (PSO) who was deemed "suitably experienced" to hold the case based on the information provided to the CRC at allocation. This allocation decision is reported to have been influenced by a failure to check the initial assumptions made by CRC about SH's needs and to also relate to the lack of qualified probation officer staff at the time. The PSO was not always kept informed of his own managers intervention in SH case, and indeed the manager had become involved enough in managing SH crises presentation as to risk losing objectivity about the actual risks posed by SH. There are no records of formal supervisions being given to the PSO by his manager, records may have been lost or misfiled or may simply not exist. The expectation would have been of a formal supervision session every six to eight weeks. The line manager's advice to the PSO was not informed by the agreed guidance of the time, i.e. the PSO was advised to focus on new OASys assessments rather than try to catch up on those which were

late, and not to escalate the increasing risks presented by SH. As such the managers decisions were not defensible and the oversight provided did not support the PSO to maintain the expected standards of practice.

10.2.7 CRC did not communicate with the police until they were unable to trace SH in September 2015. There is no mechanism for the police and CRC to routinely share information about an offender. The police were increasingly concerned about the risks SH was presenting to the public, and to themselves. The police were aware, from a conversation in August 2015 with SH, that he was on Probation, but did not initiate information sharing with CRC. CRC was at this point a new organisation, and such information sharing arrangements, formal or informal, had not been brokered. CRC did not liaise with other agencies to share information about risk. There are no records of liaison with the Community Hub where SH had previously stated that he was having problems with women. SH had previous convictions for domestic violence, and women would potentially have been at risk from him.

10.2.8 The procedures in place at the time in scope expected CRC to undertake an OASys within 15 days of sentence in order to highlighted risks posed by SH and potentially identify a need for re allocation or escalation to NPS. This assessment was not carried out until ten weeks into the order, this meant there was no risk assessment or management plan completed or a sentence plan or formal assessment of how SH was reacting to his sentence. The assessment was undertaken in response to a request from the housing team, they could not work with SH without a risk assessment. When the OASys was undertaken the assessment was pulled through from a previous order, and as such did not reflect the changing and escalating nature of the risk of SH re offending. As a response to the needs of the housing team the OASys became a means to an end, it was rushed through and was not written as an accurate and well evidenced and considered plan to address the risks SH now posed. The OASys should have triggered discussion with the line manager, regarding re-allocation to a CRC qualified Probation Officer and a review of the case. By this time SH was not complying with his sentence, had committed a serious offence (Rape) and his actual whereabouts was unknown. Opportunities were missed to re-evaluate the risks and the order as a whole. The impact of not undertaking the OASys in a timely manner also put others at risk. SH had been referred to the Hub, which was only appropriate for low risk offenders, he also went to the Haven where he was able to identify and exploit women and commit further offences. No safety plans were put in place for non-CRC staff, in particular housing workers. No thought was given as to risks posed to any person SH might live with, and the arrangements made by SH to live with Adrian were never examined in any detail, Adrian's identity was not enquired into, and the accommodation was not visited.

As can be seen in section 10.3 below, CRC had lost sight of the risk of harm posed by SH and had focused on his needs, concerned that unmet need would increase the risk of re offending.

Enforcement action could have been taken to ensure that the very apparent increasing level of risk of re-offending and harm was being robustly managed. There were several occasions throughout the order where enforcement action could have been taken but there is no record of why it was not, especially when information came to light from other agencies, including the courts, regarding alleged further offences of shoplifting and, significantly, an alleged offence of Rape. This alleged offence of Rape should have resulted in a risk review and consideration should have been given as to whether the case should be escalated to the National Probation Service as well as enforcement action, but neither took place.

If CRC had returned SH to Court for Enforcement of his Court Sentence, in accordance with the Guidance in existence at the time, what would the impact have been? If a disciplinary breach had occurred, it might have altered how the rest of the order was conducted and managed. It is very unlikely that SH would have been sent to prison had enforcement action been taken as most usually breaches are dealt with by courts with fines or further conditions. Even when community orders are revoked and the individual is re sentenced, only infrequently does this lead to a prison sentence being imposed. However, such an action would have provided an opportunity to change the conditions of SH's order, or which organisation was over seeing this.

10.3 Interpretation of information about risk

10.3.1 SH was known to the probation service prior to this sentence and had attended the then probation service office on numerous previous occasions. It is not clear whether previous experience of SH influenced how the CRC approached his case. CRC officers interviewed have spoken about trying to get an offender "*through the order*", in the knowledge that not much will change for them.

10.3.2 CRC experienced SH as difficult, aggressive and demanding from the beginning of the order. He was assessed as having financial and housing needs and the offender manager focused primarily on these areas, believing, in the absence of any more rigorous risk assessment, that SH would be at an increased risk of re offending if he had no money. Given the level of risk of harm presented by SH, it was concerning that behaviours influencing risk and likelihood of re offending were not addressed more directly. There was no indication of discussion about use of drugs and alcohol, or attention to SH's behaviour. No work was done to deliver the element of SH's sentence which included attendance at a "victim awareness" course, six sessions which can be delivered in a group setting or on an individual basis. Both the PSO and his manager allowed interactions with SH to be focused on his presenting "crisis" needs. This resulted in him avoiding completing the unpaid work requirement or addressing those factors most closely associated with risk of harm. The CRC

response was largely crisis management and this approach enabled SH to manipulate CRC officers toward meeting his expressed needs rather than focusing on his offending behaviour, the completion of his sentence or risks posed to others.

10.3.3 How well were risks posed by SH understood? Analysis, reflection and scoring had been undertaken, but not always in a timely manner, and not sufficiently shared. There is a very appropriate emphasis on risks to partners, women and children within risk assessment and planning documentation, but no equivalent emphasis on Adults at Risk. There appears to have been no "box" in the N – delius recording system to capture risk to vulnerable adults. SH, with his skills at exploitation, pattern of acquisitive crime and record of exploiting vulnerable people, was a risk to any Adult at Risk he would be likely to encounter.

10.3.4 The National Offender Management Service (NOMS) issued a policy statement regarding NPS role in Adult Safeguarding in January 2016. There does not appear to be an adult safeguarding Policy prior to this date, most particularly during the period in the scope of this Review. The NOMS policy underlines NPS responsibility toward both offenders who are also Adults at Risk and responsibility in

"3.3 The assessment and management of the risks of harm posed by offenders to adults at risk must be identified, assessed and managed effectively. NPS staff must be alert to and respond appropriately to any changes in an offender's circumstances that could lead to or indicate situations that may pose a risk of harm to their own or to another adult's safety and well-being".

The 2016 NOMS Probation Adult Safeguarding Policy statement references Children's Safeguarding concerns: Domestic abuse: Hate crime and vulnerability to Extremism but is not detailed in terms of indicators, learning and development expectations or, crucially within the context of this SAR, any information on exploitation or the indicators of exploitation. No further guidance on Adult Safeguarding appears to have been published regarding risks posed by those under NPS supervision. NOMS no longer exists, Her Majesty's Prison & Probation Service currently fulfil the roles undertaken by NOMS.

Working Links (the CRC) does not currently have any safeguarding policy, either for children or adults, on it's website.

10.3.4 Devon and Cornwall police had sufficient information to refer SH through the MAPPA process in Devon as a category 3 offender. The information they had was not known to Probation services and was largely understood by non – specialist police officers who were not familiar with the MAPPA processes and the rationale for referral. As a multi-agency process, MAPPA could have provided the opportunity for risks to be understood and interpreted, and supported agencies to work together to prepare a detailed and robust multi agency Risk Management Plan.

10.4 The impact of transitions in organisations.

SH received a community order in June 2015. As part of the Transforming Rehabilitation Programme the UK Probation Service had undergone major organisational change, the Probation Trusts were dissolved, and in June 2014 the service was split into a National Probation Service and twenty-one Community Rehabilitation Companies. Existing staff were split between the two organisations. The government's rationale for these changes was to enable the Ministry of Justice to extend statutory rehabilitation in the community to the 45,000 offenders sentenced to less than twelve months in custody. These major structural changes were not piloted, the significant problems relating to these changes during 2014/2015 are well documented in inspection reports, parliamentary committee, media and trade journals. The problems which arose in Devon are apparent in other areas of the country.

This was a time of major change. Contemporary reports of the time document profound morale issues within the newly created organisations, staff had taken industrial action to oppose the changes in 2014 and did not welcome the loss of their colleagues or a different way of working. Staff sickness in the CRCs was high, and in Devon;

"*Staff morale was very low, with some presenting in a state of bereavement with high levels of stress and anxiety*"

In it's first inspection of Transforming Rehabilitation (December 2014) Her Majesties' Inspectorate of Probation (HMIP) identified a number of concerns nationally relating to the post transformation ability of the Probation services to deliver a quality service

"*The splitting of one organisation into two separate organisations is bound to create process, communication and information sharing challenges that did not previously exist. This report highlights that challenge for probation services in a fast moving and complex programme of reform. It is clear that many of the issues will not be solved overnight and will remain a challenge for some time to come – but they need close attention and must be addressed in a timely way by all concerned. (HMIP 2014)*

The Inspectorate noted that the speed of implementation had caused operational problems that could have been avoided, or at least mitigated, by improving communication about the changes between staff and managers. In December 2014 the Inspectorate identified

"an urgent need for operations and processes to reach a 'steady state' in order for managers and staff to be able think, plan and deliver effectively". HMIP 2014

In February 2015 the twenty-one CRCs passed from public to private ownership, and CRCs were expected to comply with a system of performance related targets. There was uncertainty about jobs, roles, locations and how the Devon and Cornwall CRC new owners, Working Links, were going to operate and behave. This is reported to have had a negative effect on staff and the quality of supervision provided.

Both NPS and CRC report that both organisations were finding it challenging to cope with new ways of working and the new relationship between them. The two organisations could not share all information and, as now separate identities, did not have access to each other's work. There was no escalation pathway at that time between NPS and CRC. CRC staff report anecdotally that there seemed little point in attempting to return a case to NPS as these were usually refused and there was no provision to discuss cases jointly to resolve concerns. Relationships between the two organisations are reported to have acrimonious as both tried to cope with the new ways of working.

New processes were introduced to both NPS and CRC staff, these covered several aspects of offender management but were not well understood or embedded in practice. As can be seen from the findings of this SAR, this had a very significant impact on the level and quality of service offered during this period. NPS staff were using the new RSR tool and misunderstood which offences should be counted, in SH's case the RSR score was calculated wrongly because the officer concerned did not fully understand new guidance. The Inspectorate for Probation Services (HMIP) found this to be a common issue in its Report on Transforming Rehabilitation published in May 2015

"*Staff were often overconfident in their understanding of these rules. Common mistakes were the exclusion of cautions, reprimands and warnings, the inclusion of breaches and failure to follow the guidance on what counts as a violent offence. Many staff were incorrectly recording offences of drunk and disorderly, criminal damage and public order as non-violent, conversely offences such as aggravated vehicle taking were incorrectly counted as violent by some staff". Page 19 2015*

CRC appears to have been struggling to cope with the initial stages of coming to terms with the changes, with agreed risk assessment and planning processes, enforcement actions and wider offender management not being enacted in the case of SH. These themes are echoed nationally in the HMIP Report 2015 cited above: in the newly created CRCs

"*Once a case is allocated to the CRC, it is essential that a robust plan is put in place to manage the risk of harm presented. This had not happened in too a high a proportion of cases. We found that in only 28 out of 74 cases which required a risk management plan (RMP), a good plan was in place; in 31 (42%) of cases the initial RMP was insufficient and in 15 (20%) cases there was no plan" HMIP* 2015

These changes had a profound effect on how the risks SH presented were identified and managed.

11. Developments since the period in scope:

11.1 Agencies working with Adrian Munday:

11.1.1. Devon County Council:
The Council did no direct work with Adrian but had delegated their responsibility for ensuring the delivery of quality commissioned social care services to people with mental health needs to DPT via a Section 75 Partnership Agreement. Devon County Council recognised the need to have better oversight and quality assurance of the support commissioned for people with mental health needs through DPT and has therefore reviewed the Section 75 Partnership Agreement to clarify the delegated responsibilities of social care. Measures are in place to ensure that both DCC and DPT are now working on contracting and commissioning with a much more consistent and partnership approach. Devon County Council have also reviewed supported living arrangements in some mental health services and introduced procedures to ensure that providers are delivering a quality service.

11.1.2 Devon Partnership Trust:

A new Director of Nursing and Practice was appointed in 2015 who secured Board support to invest in a more robust safeguarding service to support DPT clinicians. The Trust subsequently made a significant investment to recruit clinicians with safeguarding expertise. In July 2016 a Managing Partner for Safeguarding and Public Protection was recruited. In 2017 the Trust recruited a further two full time Clinical Specialists for Safeguarding to support and train staff in relation to safeguarding practice.

DPT Safeguarding Adults policies have been updated and now comply with the Care Act 2014 and the principles of the Mental Capacity Act. The Trust now provides compulsory Adult Safeguarding training for all clinicians at the appropriate level of competence required by their role. 90% of the Trust's qualified staff (Band 5 and above) are now trained to Level 3 as specified in the NHS adult safeguarding Roles and Competencies for Health staff intercollegiate document published in August 2018. This training provides clinicians with high quality information about safeguarding practice and aims to increase the levels of professional curiosity and respectful uncertainty in relation to safeguarding issues. Adrian's family have given permission for his case to be presented during training as an example of '*when safeguarding goes wrong'* to emphasise the need to maintain respectful uncertainty and professional curiosity in practice. In addition to training the Trust has introduced a monthly safeguarding bulletin which contains regular updates regarding safeguarding research, practice and updates. DPT clinicians now have access to safeguarding supervision from clinical safeguarding specialists and are reported to use more robust safeguarding incident report protocols. The use of the DPT Risk Management System to report all safeguarding related matters allows the Safeguarding and Public Protection Team, Directorates and the Trust Safeguarding Operations Committee to identify potential patterns of under reporting across the trust. The system also means

that all safeguarding related activity reported by clinicians will be quality assured by Senior Managers and the Safeguarding and Public Protection Team.

11.1.3 Community Care Trust (CCT) merged with another organisation – St Loyes – to become Step One in January 2017.

The service is currently undertaken a comprehensive review of its' operational policies and procedures and has introduced a system for people supported in a community setting which involves actions to be taken after an adult has missed appointments and attempts to make contact have failed. Each person supported in the community is expected to sign up to the agreement so that all parties understand the implications of a failure to respond to contact and the potential for Police involvement early on.

11.2 Agencies working with SH

11.2.1 The Community Rehabilitation Company

The CRC has undergone extensive changes since 2015 with the period of "transformation" lasting into 2017. CRC work is supported by a new technology infrastructure and software, with IT training provided to all staff. A new operating model designed and implemented for all areas of the business, including offender management has introduced a central administration hub in Plymouth with strict procedures and processes for every element of interaction with both external agencies and service users. This has provided a consistent approach to how orders are processed, ensuring correct allocation to the CRC from NPS is monitored and any errors are quickly identified and acted upon. CRC teams have been separated into offender management, interventions and hub activity. Community hubs for low risk offenders are run by PSO's and offenders with medium risk/complex needs are managed by Probation officers. A workload indicator tool now addresses the issue of appropriate allocation and workload to staff. There has also been the introduction and embedding of the BRAG assessment, which is completed every 6 weeks by Offender Managers. This rates cases in a traffic light system according to risk and need, with those with complex needs and increased risk of harm and offending assessed as Red and attracting more resources and contact, than those assessed as Green and low risk. This has meant that cases are now appropriately allocated to the right level of resource. The interventions team deliver all the RAR and specified programme activity, referrals to which come straight to the team via the hub and are not reliant upon the Offender Manager.

There is a new training and development programme for all grades of staff within the organisation using a mixture of e learning and workshops regardless of previous training or experience.

Staff supervision is undertaken every six weeks and is recorded on a template, there are case audits and observations of practice throughout the year.

11.2.2 National Probation Service (NPS)

The template for MAPPA referrals and minutes changed nationally in 2017. All MAPPA Level 2 cases have a greater emphasis on risk assessment and risk management planning. The decision and rationale for risk assessment and the level of management is now required to be recorded in the minutes at each review meeting. MAPPA cases are regularly audited by MAPPA Coordinators, in collaboration with colleagues from “Lead and Duty to Cooperate” agencies, to ensure these standards are maintained. NPS is also currently implementing policies to improve the access to and use of ViSOR by its own staff.

NPS now routinely assesses the quality of OASys and Court reports with nationally agreed Practice Improvement Tools. This work is undertaken by managers and Quality Development Officers. It should be noted, though, that this is a retrospective process and so does not prevent the submission of OASys of insufficient quality. That said, if an OASys is subsequently assessed as insufficient, using a Practice Improvement Tool, then the expectation is that OASys is rewritten to meet the required standard. In addition, a new policy is being introduced whereby all Officers will have three consecutive OASys assessments quality assured and will have to achieve three consecutive assessments of ‘sufficient’ or better to gain accreditation as OASys authors.

The current Probation Instruction regarding the allocation of Court reports has changed since the scoped period in relation to Court practice and promotes minimising adjournments for reports. An adjournment of 15 days may be required when sufficient information is not available to enable sentence, such as when a:

1. Complex multi-agency assessment required

2. Diagnosed mental health and/or vulnerability issues

3. Serious sexual or violent offending including domestic abuse/child safeguarding

4. Dangerousness assessment

Although the Probation Instruction gives guidance as to whether an adjournment should be requested, it does not stipulate the format of report to be completed. Only the most complex reports are adjourned. There is an expectation that most reports will be completed by Probation staff in Court on the actual day of sentence.

There is a now one-page guidance document available for RSR assessors which clearly state how previous offences should be scored when using this tool.

11.2.3 Relationship between NPS and CRC

There are now monthly interface meetings between NPS and CRC managers at both operational and senior management level to discuss cases of concern and any allocation issues. These meetings are also used to discuss potential risk escalations. It must be noted that there is now in place a two-week period post allocation to the CRC, so that if further information comes to light which suggests the case has been wrongly allocated then the case can swiftly be transferred back to the NPS. This was not in place in 2015. All allocations and referrals are closely monitored by the hub and by a central quality assurance team.

11.3 Agencies working with both Adrian Munday and SH:

11.3.1 Devon and Cornwall Police

Devon and Cornwall Police introduced a Vulnerable Individual Screening Tool or "VIST" in Devon in December 2015. The tool gives frontline officers a means to identify vulnerability, assess the needs of an individual and determine the appropriate response. A police Central Safeguarding Team was also developed to receive the VISTs, review these and share the information as necessary with other agencies. The current Devon and Cornwall Police Safeguarding Adult policy (2016) is based on definitions contained within the Care Act 2014 and replaces the term "Vulnerable Adult" with "Adult at Risk". However, the VIST widens the definition of who is vulnerable to "*anyone who has been or believed to be at risk of harm, abuse or exploitation following consideration of their individual circumstances and who is or may be in need of support or intervention*." The VIST allows officers on the ground to grade the risk, this assessment is reviewed at the police Central Safeguarding Team (CST) and further intelligence added before the decision is made to pass on the information to the appropriate agency. The rate of VISTS submitted continues to rise, in March 2018 six hundred and six VIST reports were submitted to the CST by police officers. The adult concerned had given permission for the Police concern to be shared with other agencies, usually adult care services/adult safeguarding, in 392 cases. It must be remembered that not all VIST reports are shared as they may well not meet the Care Act definition of an Adult at Risk, or an adult in need of care and support. These reports may be shared with other agencies, for example a person's GP, in order to get the help that the person may need. There may be no obvious agency to refer very low levels of concern to, however if three VISTs are made for the same person the CST will review them and consider if a referral should be made to Adult Care.

Devon and Cornwall police are also developing a refinement to their information systems. Probation services, including CRCs, will be added to an "Interested Parties" tab on the police Unifi computer system, so flagging that the person is known to Probation. This will be used as part of information sharing with Probation services, a "Probation Direct Access" Process. This will be managed by personnel with a high level of security clearance and will require joint investment to progress.

12. Findings and Learning Points

12.1 There was no relationship between Adrian and SH prior to the 18th September 2015. However prior to this date, for both men, how events were responded to, the assumptions that were made and how risks were understood and reacted to, increased Adrian's vulnerability to exploitation, and increased the risks that SH posed to all members of the public, including Adults at Risk.

After the 18th September, had the relationship between Adrian and SH been known and the impact on Adrian explored; or had Adrian been able to ask for support in dealing with SH, perhaps his death could have been avoided.

Findings and Learning Points: Adrian Munday

12.2 The focus on Adrian's use of drugs had the effect of obscuring his other essential vulnerabilities and resulted in no contingency plans being made with Adrian on how to get support if exploited once living independently. It also resulted in Adrian perhaps being distanced from his previous supporters, unwilling to let them see that he was struggling and, under SH's influence, taking drugs again.

DPT did not take account of the history of Adrian's struggle with drugs, illegal or "legal" and appeared to expect him to manage his own addiction.

Knowledgeable advice to CCT from a drug treatment service may have helped, or the involvement of such a service in a holistic assessment of Adrian's need.

The absence of a pro-active approach by DPT, the organisation with the responsibility for coordinating Adrian's care, meant that the support providers' assessment of Adrian's needs was not challenged, or any alternative view taken by clinicians to inform CCT 's approach. DPT failed to re assess Adrian's needs once he was living independently and did not produce a risk management plan which reflected Adrian's true situation. The assessment process had become skewed toward aspects relating to drug use, the totality of his needs and the potential risks that had been prevalent in his life were not considered.

Learning Points:

i) Before an adult moves accommodation or their circumstances change significantly, it is essential for the appropriate agency to proactively undertake a new holistic assessment to inform plans around any needs, risks, and challenges in the new situation. Such assessments must be multi- agency and reflect historical information, and include the perspectives, concerns and expressed outcomes of the adult. The adult's strengths and the supports within the system around them including their family (see12.4 below) must be considered alongside behaviours that may increase risk.

ii) In situations where substance misuse is a significant factor in the life of an adult with severe and enduring mental health issues, specialist advice must be sought by the person reviewing the assessments and plans.

12.3 Up until May 2015 CCT demonstrated a strongly committed approach to Adrian, working to support him in a range of circumstances, helping him to find accommodation and offering a "back to basics" second chance at House 2 after he lost his license at the flat. CCT did not communicate their concerns about Adrian consistently to his Recovery Coordinator, for example DPT was assured that all was well with Adrian, only to be told days later that he was at risk of losing his license to occupy the flat.

Partnership work between DPT and CCT appears inconsistent, with communication a specific issue regarding firstly, the absence of Adrian's Recovery coordinator, Professional 1, for several months and secondly a breakdown in support for Adrian during his transition to independent living. After Adrian's move to independent living DPT was aware that he was only seen once weekly by CCT but did not arrange any review or discussion regarding whether this was adequate to meet his needs at the time.

Learning Point: Long term work with an adult on a CPA pathway must be characterised by a Partnership approach between agencies with each agency aware of and acting according to their role and responsibility. How each partner shares information should be discussed with the adult, agreed and acted upon. Individual's contingency plans should ensure that provider agencies are aware of how to obtain early help in the absence of a (Recovery) Coordinator.

12.4 Adrian's family were not involved in any of his reviews or formal discussions about his future after he left residential care in 2011. His family were a vital support to him and DPT had recorded his mother and sister as being significant supportive networks. It may be that Adrian did not wish them to be involved but there is nothing to document this. His family may well have acted as an advocate and given a different perspective on Adrian's needs. His family were certainly the key supports in his move to independent living, paying his deposit, acting as guarantor and facilitating the move, supporting him with medical appointments and helping him manage money. DPT currently have a published commitment to working with families and other informal unpaid carers, Adrian's family should have been formally involved in planning his move from House 2 and supported by DPT to do so.

Learning Point: Even when families or other supporters are not formally involved in all reviews and planning, consideration must be given whether and how an adult's family can be involved at key transition points in their lives, with the adult's consent.

12.5 Adrian appeared to struggle with the concept of exploitation, was SH "*a friend or not a friend*", and needed support, as he had in the past, to identify SH's

motivation and strategies to escape from him. Devon has been a pilot site for the "Mate Crime" national awareness project which focused on improving awareness of this type of exploitation, with an emphasis on people with learning disabilities. SH demonstrated a number of exploitative behaviours which he continued to develop and used to exploit a range of vulnerable people, including women who were homeless or otherwise vulnerable.

Learning Point: **Agencies need to promote their own and the awareness of adults and their families/carers about exploitative friendships or "Mate Crime". Strategies to combat exploitation or "Mate Crime" need to be discussed with adults before such situations arise and, if an adult has a history of being exploited as Adrian had, a contingency plan about who to contact and how, will be invaluable.**

Each contingency plan will be unique to the adult's circumstances, but particular attention should be paid to ensuring that the adult is confident to report their experiences, even if they have been persuaded by the exploitative person to act against their own best interests. With the adult's consent, those who support the adult, i.e. their family, friends, or advocates, can be involved in drawing up a contingency plan so that they can give support and discuss options as needed.

Findings and Learning Points: SH

12.6 Information to inform accurate risk assessment regarding SH's offending behaviour was not routinely sought or shared.

The OASys assessment undertaken by NPS in Lincolnshire in 2014 utilised a range of historical and current information from a range of sources. SH's frequent changes of location would make a detailed assessment necessary in order to reach a coherent understanding of the pattern of offending behaviours he demonstrated, in particular his interest in identifying vulnerable men and women and exploiting any relationship with them for personal gain. The 2015 OASys assessments carried out by NPS in Devon missed vital information, either because this was not sought or because the report author did not use the non-disclosable information available to inform professional judgement.

There was ample time given to undertake such an assessment, an adjournment had been granted to enable a detailed exploration of SH's circumstances and the risks he posed. It remains of concern however that current Probation service guidance (see section11.2.2) requires the majority of pre-sentence Reports to be completed on the day of sentence. The offence SH was appearing before the Court for in May /June 2015 would not now require an adjournment for a multi-agency report, a report is now completed on the day of the appearance.

The lack of thorough assessment informed by accurate historical and contemporary information led to SH being given a sentence which did not accurately reflect his level of need or risk posed, and to being allocated to a service which was not appropriate to his level of need and risk.

The CRC did not undertake any OASys assessment until SH was ten weeks into his order. The escalation of SH's offences and risk to others was not identified or responded to. The risks that SH might pose to any "friend" he was staying with were not explored by the CRC, and no effort was made to check the circumstances that SH was living in.

The lack of formal risk assessment and planning also meant that the original allocation to CRC was not challenged or escalated back to NPS. It is understood that the mechanisms for doing so were very poorly developed at the time, but that CRC and NPS now have "interface meetings" and a two-week period for identifying poor allocation decisions.

The police held a good deal of information on risk posed by SH in Devon, his offences, whereabouts and, to some extent, his associates. Information was not requested from the police by NPS when drawing up the May/June 2015 OASys or by CRC during the time they were supervising SH. Although the Police had concerns about SH they did not share information with CRC or any probation service after the 17th August 2015 when they were made aware by SH that he had "*a probation worker* ". They had no formal mechanism for sharing information with probation services unless requested to do so. The police held sufficient information to consider a referral to the MAPPA process but did not do so after the allegation of rape against SH in September 2015. MAPPA is the ideal mechanism for information sharing between police and probation services when there are concerns about potential risk to members of the public.

Learning Points: i)Thorough and timely identification of risk and shared understanding of the indicators of escalated risk, as well as an agreed plan for managing risk, must be informed by exploration of historical information as well as information sharing protocols between all agencies working with offenders. This is particularly pertinent when offenders move between areas and information is not easily available.

ii) As the Responsible Authority for MAPPA, Police and Probation Services must consider using the MAPPA process for Category 3 offenders, i.e. offenders who do not meet the criteria for either Category 1 or Category 2 but who are considered by the Responsible Authority to pose a risk of serious harm to the public which requires active multi-agency management. Identification and consideration of MAPPA by police staff needs to be improved, non-specialist police officers may need particular awareness of the potential of a referral to MAPPA.

12.7 Awareness of Adults at Risk and Adult Safeguarding is low within the Probation Service. Risk assessments must include risk to the full range of adults who are vulnerable, as well as children. The electronic recording system used by Probation services (n Delius) is reported to not be updated with potential risk to adults which would alert staff to early identification of an issue. Detailed training is required to help staff assess risk to all Adults at Risk and to know what to do, how to make concerns known to adult safeguarding services and how to work together to mitigate and address risks. These processes are in place for safeguarding children but are not regularly used for Adults at Risk. Offenders who use exploitation for gain are capable of using these techniques to exploit any vulnerable person. The Probation services also need to be aware of risks to "friends" of these offenders, to visit their homes, and to understand what the relationship is between the offender and the "friend". Probation services must have an understanding of hate crime and its manifestation as "Mate Crime." In addition, an understanding of the vulnerabilities of people with mental health issues, learning difficulties, addictions, and the impact of age and frailty on these relationships, will be invaluable. Probation Services are not currently supported by adequate Guidance and Practice regarding Adults at Risk

Learning Point: All Probation services need to be aware of how risk indicators to Adults at Risk are manifested, actions that must be taken and agencies that must be informed. This awareness must be reflected in all assessments and plans and be an integral part of all recording on safeguarding. Probation services must evidence their awareness and application of statutory obligations as defined in the Care Act 2014. Training in Adult Safeguarding needs to become part of the national curriculum for qualifying as a Probation Officer.

12.8 The impact of the Transforming Rehabilitation structural and operational changes on the way in which SH was managed during his sentence is undeniable. Both NPS and CRC staff were unsure of how to operate within new structures and new ways of working, organisations were not working together, and new procedures had confused key staff. This SAR documents a number of errors and omissions made in the case of SH. CRC and NPS in Devon now appear to be working closely together to create a safe system within which to manage offenders.

Learning Point: Organisational transitions, at a small or large scale, will always risk a level of systems failure. There are a number of well documented change management measures which can reduce this possibility and will these not be discussed here. The level of organisational transition encompassed sector wide structural change, cultural change and systems change, the impact of undertaking such a programme of change within a relatively short period should not be underestimated.

13. Recommendations

13.1 Recommendations for Devon Safeguarding Adults Board:

General Recommendations

13.1.1. The Findings of this SAR must be presented to the Ministry of Justice unit that oversees Transitional arrangements for the purpose of learning. (Finding 12.8)

The Public Protection Unit at the Ministry of Justice should be asked to respond to the Findings, Learning Points and Recommendations to Probation services. Findings 12.4; 12.5 and 12.6 are relevant together with Recommendations 13.2.7 and 13.2.8.

13.1.2 The regulatory bodies for all agencies considered within this SAR must be made aware of the Findings and Recommendations. These bodies will include NHS England, the Care Quality Commission and Her Majesty's Inspectorate of Probation.

Recommendations for the Devon Safeguarding Adults Board

13.1.3 In accordance with Finding 12.5 Devon Safeguarding Adults Board are recommended to develop a Strategy to address the exploitation of Adults at Risk including "Mate Crime". The Board is recommended to learn from the approach taken by Hampshire Safeguarding Adults Board which encompasses **all** Adults at Risk as potential targets for Mate Crime. The DSAB strategy could potentially include:

Best practice guidance for staff in all agencies which is included in all learning and development programmes.

Identification of members of the public who may be able to spot exploitation of Adults at Risk – including taxi drivers, bar workers, banks, pawnbrokers, bookmakers etc. There is a telephone point of contact (CareDirect) and online advice for those at risk or concerned about someone who might be.

Promotion of awareness of exploitation for Adults at Risk, their families and carers.

Presentation of case studies at DSAB and other relevant forums.

Assurance that exploitation of Adults at Risk is part of risk assessment and planning in all services provided to Adults at Risk.

13.1.4 The Safeguarding Adults Board is recommended to seek clarification and assurance that the macro and micro commissioning arrangements within the Clinical Commissioning Groups, Local Authorities (Devon County Council in this instance), DPT and other providers include appropriate oversight around the quality of the support provided.

13.1.5 The SAB will receive regular reports from the agencies below as part of the overarching SAR action plan. Reports will specify the progress made toward the

fulfilment of the recommendation supported by evidence, for example audit reports, training records.

13.2 Recommendations for individual agencies

Step One

13.2.1 Step One is recommended to have a “Mate Crime” or exploitation strategy in place and to ensure all staff have an awareness of the exploitation of Adults at Risk. Step One to review the threshold for access to Level 3 safeguarding training (which does include identification of exploitation) across the organisation, and to implement a training programme to increase access to this training, prioritising lone working staff. This will increase awareness of potential safeguarding issues and increase staff confidence in taking the recommended approach. (Finding 12.5) Whilst this recommendation is made to Step One it does apply to all providers of services.

Devon Partnership Trust

13.2.2 As part of the Quality Review of Clinical Records programme, Devon Partnership Trust to quality assure a regular sample of risk assessments and plans carried out with people who are on the CPA pathway to ensure that these are informed by multi agency and relevant historical information on risk. (Finding 12.2)

Devon Partnership Trust must also ensure that, before an adult moves accommodation or their circumstances change, a new holistic assessment is undertaken to inform plans around any needs, risks, and challenges in the new situation. Such assessments must be multi- agency and reflect historical information, and include the perspectives, concerns and expressed outcomes of the adult. The adult’s strengths and the supports within the system around them including their family must be considered alongside behaviours that may increase risk.

13.2.3 Devon Partnership Trust to develop a shared expectation document with the providers it works with, detailing mutual expectations and requirements on information sharing, roles and responsibilities and escalation pathways for concerns including long term unaddressed staff absence. (Finding 12.3)

13.2.4 Family/ informal carers to be involved in care planning with the person’s agreement. Devon Partnership Trust to audit engagement with families and use of the DPT Carers Charter and the “Together“ commitment to work with informal carers in the light of Finding and Learning Point 12.4 This audit should demonstrate the application of staff’s knowledge. Assurance should be gained through and be part of clinical supervision.

13.2.5 Every adult should have a copy of their care and support plan.

Providers and Commissioners of Services

13.2.6 It is important that all agencies can ensure that their staff have a level of understanding of drug and alcohol addiction issues appropriate to their role. This should include when to refer on, and to whom. This applies to Devon Partnership Trust and Step One in this context, but will apply to all providers of services. The learning and development undertaken should be able to be evaluated and compliance ensured, methods should be adopted to understand how service responses have changed as a consequence of increased understanding (Finding 12.2).

13.2.7 Public Health as the commissioners of drug and alcohol services should review Health and Care Providers' access to drug and alcohol advice in the light of the findings of this Review. (Finding 12.2).

Probation Services

13.2.8 The CRC must ensure that staff are aware of how risk indicators to Adults at Risk are manifested, actions that must be taken and agencies that must be informed. This awareness must be reflected in all assessments and plans, and be an integral part of all recording on safeguarding. The CRC is recommended to train staff to Adult Safeguarding "level three" competence standards. Training compliance and impact must be audited. (Finding 12.6 and 12.7)

13.2.9 Her Majesty's Prison and Probation Service together with the National Probation Service must review and revise Guidance and Practice regarding Adults at Risk in the light of the Findings of this SAR. The theme of exploitation, either within or outside the context of a "friendship," is particularly pertinent. (Finding 12.7)

The Probation Services and Police

13.2.10 Devon and Cornwall Police, the National Probation Service and the CRC must continue to review and revise information sharing protocols and practices in the light of the Findings of this SAR in order to ensure that relevant information is available to enable criminal justice services to make timely assessments and plans regarding potential harm to the Public. This must include attention to understanding the use of MAPPA for Category 3 offenders for non -specialist police officers. (Finding 12.6)

13.2.11 The Devon and Cornwall MAPPA Strategic Management Board is recommended to consider the awareness of all Responsible Agencies and Duty to Co-operate agencies regarding the use of MAPPA for Category 3 offenders in Devon. (Finding 12.6). It should be noted that referrals to MAPPA can be made by any Responsible Authority or Duty to Co-operate Agency.

14. Glossary of terms used in this Report

CCT – Community Care Trust

CPA – Care Programme Approach

CRC- Community Rehabilitation Company

CPN – Community Psychiatric Nurse

CST – Central Safeguarding Team (Police)

DCC – Devon County Council

DLA – Disability Living Allowance

DPT- Devon Partnership Trust

DWP- Department of Works and Pensions

FDR- Fast Delivery Report

HMIP – Her Majesties Inspectorate of Probation

PSO – Probation Support Officer

OASys – Offender Assessment System

OM – Offender Manager

PACE- Police and Criminal Evidence Act

PSO – Probation Support Officer

MAPPA- Multi Agency Public Protection Arrangements

N-Delius- the National Probation Service case management system

NPS – National Probation Service

NOMS – National Offender Management Service

RAR - Rehabilitation Activity Requirement

RSR – Risk of Serious Recidivism

Section 75- A section of the Health and Social Care Act 2012

ViSoR – Violent and Sex Offender Register

ViST – Vulnerability Screening Tool used by Devon and Cornwall Police.

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Appendix 1 Terms of Reference

Terms of Reference:

Devon Safeguarding Adults Board

Safeguarding Adults Review (SAR)

Subject: Adrian Munday

Date of Birth 12 November 1963

Date of death between 3rd and 6th October 2015: age 51 years.

1. Introduction:

Adrian Munday was 51 years old when he died. On the 6th October 2015 police were called to Adrian's home where they discovered his body. A fire had occurred in the room, a forensic post mortem later established that Adrian had suffered significant trauma injuries not consistent with a fire and a murder enquiry was instigated.

On 17th October 2015 SH (dob 24/10/1974) was arrested on suspicion of Adrian Munday's murder. He was later charged with the murder of Adrian between 2nd and 6th October 2015. SH was found guilty of murder on 14th June 2016. The court heard that SH had met Adrian on the 18th September 2015, had moved into Adrian's accommodation, and had exploited him for money and his possessions. Adrian Munday had received significant injuries all over his body, his death was caused by head and brain injuries. H had set fire to his body. H was given a life sentence. He died in prison on April 2nd 2017.

Adrian's family made a statement after the court case,

"Adrian's long-term mental health issues, coupled with his kind, caring and unusually trusting nature, made him particularly vulnerable. However, after a lengthy period of supported care he was finally living independently, and we were very hopeful for his future. Adrian had the misfortune to meet up with H, an incredibly manipulative and violent man, who immediately took advantage of Adrian's kindness and inability to stand up for himself".

At the time of his death Adrian was being supported by a care agency and was seen regularly by a Community Psychiatric Nurse and psychiatrist according to his Care Programme Approach plan.

1.2 This Safeguarding Adults Review (SAR) is commissioned by the Devon Safeguarding Adults Board (DSAB) in response to the death of Adrian Munday. The review is conducted in accordance with the Devon Safeguarding Adults Board SAR policy and procedures (2017) which are underpinned by the statutory guidance requirements of the Care Act 2014 (section 44).

"The purpose of conducting a Safeguarding Adults Review is to establish whether there are any lessons to be learnt from the circumstances of the case, about the way in which local professionals and agencies work together to safeguard adults at risk. The Safeguarding Adults Review brings together and analyses the findings from individual agencies involved in order to make recommendations for future practice where this is necessary.
(DSAB SAR policy and procedures (2017) s4.1)

"Specifically, the purpose of the Safeguarding Adults Review is to:

- Determine what might have been done differently to prevent the harm or death;
- Identify lessons and apply these to future cases to prevent similar harm again;
- Review the effectiveness of multi-agency safeguarding arrangements and procedures;
- Inform and improve future practice and partnership working;
- Improve practice by acting on learning (developing best practice) and
- Highlight any good practice identified". DSAB 2017 s4.2

The purpose of a SAR:

"is not to hold any individual or organisation to account. Other processes exist for that, including criminal proceedings, disciplinary procedures, employment law and systems of service and professional regulation, such as CQC and the Nursing and Midwifery Council, the Health and Care Professions Council, and the General Medical Council.

It is vital, if individuals and organisations are to be able to learn lessons from the past, that reviews are trusted and safe experiences that encourage honesty, transparency and sharing of information to obtain maximum benefit from them. If individuals and their organisations are fearful of SARs their response will be defensive and their participation guarded and partial". DSAB 2017 s4.4. and 4.5

1.3 Principles which inform SARs

SARs should reflect the six safeguarding principles: empowerment, protection, prevention, proportionality, partnership and accountability. SABs should agree Terms

of Reference for any SAR they arrange and these should be published and openly available.

The following principles should also be applied by SABs and their partner organisations to all reviews:

1. There should be a culture of continuous learning and improvement across the organisations that work together to safeguard and promote the wellbeing and empowerment of adults, identifying opportunities to draw on what works, and to promote good practice.
2. The approach taken to reviews should be proportionate. This could range from a single agency review to a multi-agency Safeguarding Adult Review, with an independent author and chair according to the scale and level of complexity of the issues being examined.
3. Professionals should be fully involved in reviews and invited to contribute their perspectives without fear of being blamed for actions they took in good faith.
4. Families should be fully engaged and invited to contribute to reviews. They should be supported to understand how they are going to be involved, and their expectations should be managed appropriately and sensitively. (Care Act statutory guidance s 14.167)

In addition, agencies are under a legal duty as DSAB partners to cooperate in and contribute to the carrying out of a review under Section 44 of the Care Act 2014 with a view to:

a. identifying the lessons to be learnt from the adult's case, and
b. applying those lessons to future cases

1.4 This SAR will explore, as relevant, the DSAB specific areas of focus for 2016/2017, i.e.

1. Improving people's experience of safeguarding which includes the delivery of "Making Safeguarding Personal" across all partner organisations
2. Prevention of harm and neglect in care and health services, whilst promoting independence
3. Improving awareness and application of the Mental Capacity Act and Best Interests

2. Scope and specific area of focus of the SAR:

2.1 The SAR will examine events in the life of Adrian Munday in the two years before his death. In addition, the SAR will also examine events in the life of his murderer, SH.

Specific timeframe: 1st September 2013 – 30th October 2015

Rationale:

The timeframe allows for a consideration of how Adrian Munday was supported toward independence after spending some 12 years of his life in residential care, and what lessons can be learned about how people are able to protect themselves, or ask for protection, from those who exploit them.

The timeframe of two years also allows for an extended view of SH's life, and how various agencies worked with him, prior to the murder of Adrian.

2.2 The areas of focus will be on how individual agencies followed agreed policies and procedures in working with both Adrian Munday and SH: how agencies worked together in identifying and addressing concerns regarding Adrian Munday's welfare, and SH's risk history; and how agencies and staff were supported by their organisations to follow agreed policies and protocols.

3. Methodology:

The methodology used in this review seeks to promote a thorough exploration of the events prior to Adrian Munday's death, whilst avoiding the bias of hindsight which can obscure the understanding and analysis of important themes. Agencies work within complex circumstances, and a systemic approach to understanding why people behaved as they did, and why certain decisions were made, is essential if learning is to be derived from the Review.

The methodology utilises a blended approach of systems-orientated models in order to maximise opportunities for learning in the specific circumstances of this review. Activities will include: collation of chronologies, individual agency reports, conversations with key staff, family and friends of Adrian Munday, examination of key documents, identification of key episodes, and, if indicated, an event to review learning with a relevant group of staff.

A SAR overview report will be produced including thematic analysis of findings, key learning points, and recommendations to the Devon Safeguarding Adults Board on any improvements identified in multi-agency working.

The process will be supported by a SAR Panel which will include senior representatives of the agencies described below.

The review will be informed by the adult safeguarding policies and procedures in place during the timeframe within the scope of the SAR.

3.1 Family participation:

Adrian Munday's family have met with the independent reviewer to discuss the proposed terms of reference prior to the beginning of the SAR activity. They will also be invited to be interviewed further as needed to contribute background information for the Review, including information about Adrian and his life.

A second meeting will be held with Adrian's family once a draft of the overview report has been approved by the DSAB Executive. Findings, learning and recommendations will be discussed in order for the family to question or comment prior to final draft approval at Board. A written draft will be provided to Adrian's family prior to publication.

3.2 Key Agencies:

- Devon and Cornwall Police
- Devon Partnership Trust
- Devon County Council
- National Probation Service
- Devon, Dorset and Cornwall Community Rehabilitation Company
- South Devon and Torbay Devon CCG
- Community Care Trust (now Step One)
- GP practice

3.3 Chronology:

Agencies will be asked to provide a chronology of significant events and safeguarding issues in respect of Adrian Munday and SH. This could include an event that falls outside of the timeframe if these are considered significant to learning.

When agencies have changed names, roles and responsibilities since the timeframe in scope, every effort must be made to identify records by the agencies involved and an account submitted regarding any records that cannot be found.

A report template, and a briefing on the expectations of an individual agency report writer, will be provided by the lead reviewer.

3.4 Conversations:

Agency reports will be analysed to identify key individuals for follow up conversations or documents for further analysis. Individuals who have left agencies will be invited to contribute to the review as well as those still employed. Conversations will be conducted by the independent reviewer and an agency representative and follow the Social Care Institute of Excellence (SCIE) Conversation structures. Friends or family will be invited to bring a supporter or advocate to any conversation with the lead reviewer.

3.5 Key episodes:

Key episodes will be identified from agency reports and conversations for deeper analysis.

Below are a set of initial questions which will form the basis of the individual agency report template. Further questions may emerge following analysis of the agency reports, and of the individual conversations, which can then be explored within the SAR Panel meeting or via other avenues as appropriate.

4. General questions underpinning the agency reports:

Events: Critically analyse and evaluate the events that occurred, the decisions made and the actions taken or not taken. Were there any missed opportunities or episodes when there was sufficient information to have taken a different course? Were assessments conducted effectively and appropriate conclusions drawn? When risks were identified, were plans made to prevent or mitigate the risk? Were agreed actions carried out? Were there any indications that practice or management could be improved? Try to get an understanding of not only what happened, but why.

Policies and procedures in place at the time: Review the effectiveness of policies and procedures (both single and multi-agency). Were staff aware of these policies and procedures? Did they have management support and training to follow these appropriately?

What was happening in the agency at the time: Were there periods of transition or limited resource/capacity?

Inter agency working: Were processes and communication effective between agencies? Did each agency understand the role and duty of others? Were professionals proactive in escalating concerns and providing effective challenge when appropriate?

Support to effective working: What supervision and management oversight was provided during the period of the SAR? Were these in accordance with the agency's policy and procedures?

Identify examples of good practice, both single and multi agency.

Identify what has changed since the scoped period (1st September 2013 – 30th October 2015).