The Death of Lee Irving

Safeguarding Adults Review

Independent Overview Report Author: Tom Wood

Date: June 2017

Contents

1. The Case Review

1.1 Introduction

On 25 August 2015 a decision was taken by Newcastle Safeguarding Adults Board to undertake a safeguarding adult's review following the death of Lee Irving. Lee was a young man with care and support needs who was 24 years old when he died. Lee's family have agreed to the use of his name in this report.

On initial examination Lee's death appeared to be a disability hate crime, that is to say the crimes committed against him were motivated by his disability. This was subsequently refuted by the trial judge for the reasons given in 1.2.4 of this report.

This review has been delayed because of lengthy legal proceedings brought about by a mistrial and subsequent retrial of the four accused. The final trial was concluded in December 2016.

1.2.1 On Saturday 6 June 2015 the body of Lee Irving was found on a grass banking near the house at 33 Studdon Walk where he had recently lived with those who were accused of his murder.

1.2.2 Lee Irving had died of multiple injuries inflicted on 28 May and 5 June 2015. His injuries included fractures to the nose and jaw, the fracture of 24 ribs, and damage to underlying organs. The cause of death was given as respiratory failure due to these severe injuries all of which were consistent with sustained physical beatings.

1.2.3 Subsequently after a criminal investigation and long trial process, an adult male was convicted of the murder of Lee Irving while a male and two females were convicted of causing or allowing the death of a vulnerable adult. All four perpetrators were also convicted of attempting to pervert the course of justice.

1.2.4 In his sentencing remarks, the trial judge rejected for legal reasons the definition of a disability hate crime. The judge opined that:

> "In order to reach the conclusion (that the offence was aggravated by disability, namely because of Lee Irving's evident mental impairment) the statute requires me to be sure that, at the time of committing the offence or immediately before or after doing so you demonstrated hostility towards Lee Irving based on his disability or that your offence was motivated by hostility towards persons who have this or any disability. I am not satisfied on either basis. Although your texts (to one of the other accused) show repeated use of the repellent word 'spastic', I am not able to infer that such language was used towards Lee Irving at the time or immediately before or after your murderous assault. Furthermore, in my judgement you were motivated in this offence not by hostility towards those with disability but by your vicious and bullying nature which particularly takes advantage of those who are unable or less able to resist."

The man convicted of his murder was sentenced to 23 years imprisonment for the murder of Lee Irving while the other three accused received lesser sentences for causing or allowing the death of a vulnerable person and perverting the course of justice.

None of the accused were judged guilty of offences aggravated by disability.

The relationship between Lee Irving and the accused together with the living conditions at 33 Studdon Walk will be discussed in Section 2.

1.2.5 The relationship between Lee Irving and his killers was described as one of subservience with Lee beholden to the primary perpetrator for drugs and shelter and where Lee looked up to the primary perpetrator and desperate to fit in tolerated continued violence and abuse. This coercion and drugging were used to control him, prevent him seeking help and over a period of time drawing him back to the house at 33 Studdon Walk.

1.3 Purpose of the Safeguarding Adults Case Review

The purpose of having a Safeguarding Adults Review is not to re-investigate or to apportion blame, undertake Human Resources duties or establish how someone died. Its purpose is:

- To establish whether there are lessons to be learnt from the circumstances of the case about the way in which local professionals and agencies work together to safeguard adults.
- To review the effectiveness of procedures both multi-agency and those of individual agencies.
- To inform and improve local inter-agency practice.
- To improve practice by acting on learning (developing best practice).
- To prepare or commission a summary report which brings together and analyses the findings of the various reports from agencies in order to make recommendations for future action.

There is a strong focus on understanding issues that informed agency/professional's actions and what, if anything prevented them from being able to properly help and protect Lee Irving from harm.

1.4 Independent Review

In order to prepare a summary report, bringing together and analysing the findings of the various reports from the agencies, Tom Wood was commissioned to independently chair the panel of agency contributors and write an overview report. He has previously acted as Independent Chair of the Adult and Child Protection Committees in Scotland, was Deputy Chief Constable of a large police force in Scotland and has previously acted as both Chair and overview report writer in both Case Reviews and Domestic Homicide Reviews.

1.5 Agencies Involved

The following statutory agencies were involved with Adult G, his family and/or the perpetrators:

National Probation Service, Northumbria
Newcastle City Council (Children's Social Care, Adult Social Care, WorkFirst, CCMG)
Newcastle upon Tyne Hospitals NHS Foundation Trust
Northumberland Tyne and Wear NHS Foundation Trust
Northumbria Police
North East Ambulance Service
Newcastle Gateshead Clinical Commissioning Group
Your Homes Newcastle

Other agencies who have contributed to the Safeguarding Adults Review:

New Prospects
Percy Hedley School
Places for People – EDAN (Independent Domestic Violence Adviser)
Positive Life Choices

1.6 **Terms of Reference – responses to key issues**

At the outset, key issues were identified as important and worthy of consideration within the case review. The responses are as follows:

A q) - Were practitioners sensitive to the needs of Lee Irving in their work, knowledgeable about potential indicators of abuse or neglect, and about what to do if they had concerns about an adult at risk? In particular, were practitioners confident in responding to potential hate crime?

a) – Practitioners were generally sensitive to the needs of Lee and did their utmost to help him. There was a good knowledge of adults at risk and procedures to help them. The knowledge of hate crime was good and training adequate. Some professionals lacked intimate knowledge of legislation and all would benefit from the learning presented by this case.

B q) – Did your agency have in place policies and procedures for safeguarding adults and acting on concerns about their welfare? Do these policies and procedures include any guidance around responding to hate crime or does your agency have specific policy, procedures or guidance in relation to hate crime?

a) – Policies and procedures for safeguarding adults were in place and most agencies had specific hate crime guidance. Additional issues have been identified in this review and these are specified in the recommendations of the review

C q) – What were the relevant points or opportunities for risk assessment and decision making in this case in relation to Lee Irving or the alleged perpetrators? Do the assessments and decisions appear to have been reached in an informal and professional way? In particular, provide details of any Mental Capacity

Assessments and Best Interest Decisions undertaken by your agency in relation to Lee Irving's ability to make specific decisions?

a) – The relevant points or opportunities for risk assessment, decision making and intervention are described in the Overview Report. Assessments and some decisions were made by individual agencies and this point is addressed in the recommendations from this report. The knowledge and application of the Mental Capacity Act were inadequate and this is also addressed in the recommendations.

D q) – Did action accord with assessments and decisions made? Were appropriate services offered or provided, or relevant enquiries made, in the light of assessments? Does it appear that all legal options were explored to safeguard the adult at risk? In particular, was there consideration of action under the Mental Capacity Act 2005 (including Deprivation of Liberty Safeguards) and the Mental Health Act 1983?

a) – Most actions did accord with decisions made but not all options were explored. In particular, all legal options were not explored. Specifically, options under the Mental Capacity Act (Deprivation of Liberty) and the Mental Health Act were not adequately explored. (See recommendations)

E q) - Where relevant, were appropriate Safeguarding Adults Plans (protection plans), risk assessments or care plans in place and were these plans implemented? Were there any factors present that prevented these plans being implemented successfully? Had review processes been complied with?

a) – Safeguarding plans were in place and implemented as far as was possible. Difficulties in delivering a service to Lee Irving prevented a full delivery of service. Individual agency review processes were complied with.

F q) – Did your agency have any information to suggest Lee Irving was being physically, financially or sexually exploited? If so, was this information appropriately acted upon?

a) – Some agencies had specific warnings (via safeguarding alerts) regarding the financial exploitation of Lee. In a complex scenario the actions taken to manage this risk proved unsuccessful.

G q) - When, and in what way, were Lee Irving's or his family's wishes, feelings and views ascertained, considered and action upon? Did action accord with the views expressed? Was this information recorded?

a) – The wishes of Lee and his family were ascertained and recorded but the family believe they were not adequately responded to. (See recommendations)

H q) – Was practice sensitive to any protected characteristics of Lee's in particular, his learning disability?

a) – All agencies were aware of Lee's characteristics and his Learning Disability although this was sometimes disguised at first meeting when he presented as having greater capacity than he actually had.

I q) – Were senior managers, or other agencies and professionals, involved at points where they should have been?

a) – There was considerable awareness of agencies and the appropriate level of managers had knowledge of the case.

J q) – Was work in the case consistent with agency and SAB policy and procedures for protecting adults at risk and wider professional standards?

a) – Generally speaking, work in this case was consistent with agency and SAB policies. It is also noteworthy that significant legislative changes occurred during the scope of this review. The introduction of the Care Act (2014) placed safeguarding adults procedures on a statutory footing. The Newcastle Safeguarding Adults Board responded to this change with a comprehensive review and re-launch of multi-agency procedures and training programme.

K q) – Please comment on any aspects of the case or the agency involvement that are examples of good practice.

a) – Aspects of good practice have been identified in SARs and under 'what we did well' in this report.

L q) – Are there any particular features of this case, or the issues surrounding the case, that you consider require further comment in respect of your agency's involvement?

a) – A number of features of this case are commented upon in SARs and in the recommendations of this report.

M q) – What are the lessons from this case for the way in which your agency works to protect adults at risk and promote their welfare?

a) – The lessons in this case are noted in the SARs and the recommendations of this report.

N q) – Are there any aspects of SAB policy and procedures that need to be reviewed as a result of this case?

a) – Recommendations regarding SAB policy and procedures are included in this report.

O q) – Were staff provided with appropriate training in relation to safeguarding adults?

a) – Staff are provided with a high level of training in regard to safeguarding adults. Further training in the application of the Mental Capacity Act is

recommended in this review. A case study focused on this review will make a valuable contribution to training for safeguarding adults.

P In addition to the terms of reference, the family of Lee Irving felt strongly that:

1. The transition from Children's to Adults' Services should be reviewed and
2. The meaningful inclusion of families in all decision making concerning vulnerable adults should be reinforced.

These points have been accepted and are reflected in the recommendations of this review.

2. The Life and Death of Lee Irving

2.1 Lee Irving was born on 16 February 1991 and was brought up with a number of siblings in the Newcastle area. Lee Irving had a Learning Disability. He had a statement of Special Educational Needs from the age of four. He attended a Special Educational Needs School. Throughout his life, he was involved with a number of services focussing on his complex special needs. Notwithstanding, the extent of his Learning Disability was not always apparent or clearly measured until 2009. Later in 2014 he was assessed as having an IQ of only 56. A further analysis of Lee's cognitive functioning is detailed in section 2.1.6 of this report.

2.1.2 As early as his teenage years, there were concerns about Lee being a victim of bullying at school, that he could be easily led, chose bad company and that he exhibited challenging behaviour. His mother and aunt (his principle carers) struggled to cope with his behaviour. In an assessment prepared by the Percy Hedley School, Lee then nearly 18 years old was described as socially immature and impressionable, a very vulnerable young man who could not ignore people who are distracting him, naïve in social situations, easily influenced by others and unable to identify other people's motivations and intentions. In the light of his eventual fate this assessment was accurate and prescient.

2.1.3 In 2009 as Lee approached adulthood he was first reported missing from home. From this point until his death he was regularly reported missing by his family and by professionals. When missing he was seen by the police as being at medium risk, because of his Learning Disability but often traced when arrested for drunkenness or some other minor offence. Lee often returned home of his own accord.

2.1.4 From 2011 Lee began a pattern of repeat offending that continued until his death. He frequently became involved in a wide range of offences, many involving alcohol and drugs. Offences included drunkenness, possession of weapons, shoplifting, burglary, begging, breach of the peace (domestic violence). In all it is recorded that Lee Irving was arrested by police 30 times in the four years between May 2011 and March 2015.

In addition, Lee was stopped, searched or checked by police on 17 other occasions mainly for disorder, vagrancy, drunkenness or possible drug use. Concerns were raised with Northumbria Police about his welfare or he was reported missing on 13 occasions between 2008 and 2013. Concerns included vulnerability or missing from home.

2.1.5 Between 2011 and 2012 following a criminal conviction Lee Irving came into contact with the National Probation Service (NPS). In December 2012 when Lee was sentenced to nine months adult imprisonment at Newcastle Crown Court for further offences of Burglary and Theft, Lee was treated as an adult fully responsible for his own actions and able to understand the consequences of the measures imposed. Like most services interacting with him, the NPS found it difficult to deliver a service due to Lee's lack of engagement. Despite this they identified behavioural characteristics which inevitably increased his vulnerability.

In September 2011 the NPS carried out an assessment and identified that Lee Irving –

> "Was incredibly vulnerable to the influence and harmful behaviour of others he encounters; that he was financially vulnerable from others. In addition, he was assessed as being vulnerable in custody and in a hostel setting."

Like other professionals, NPS officers found it difficult to deal with Lee because of his limited ability to understand issues and his tendency to withdraw and become uncommunicative when challenged. At no point during this contact did NPS undertake a Mental Capacity Act assessment in relation to his ability to understand these issues.

A further report prepared by NPS in November 2012 noted that –

> "Lee seems to understand that he is being used and bullied but seems to put up with it rather than be rejected by his peers."

It was believed that Lee was so committed to maintaining his identity as an offender among other offenders that he was prepared to accept bullying behaviour from them.

A later assessment noted that –

> "Lee Irving is not aware of the risks that he places himself in e.g. spending time with homeless people, sleeping rough, sharing taxis with strangers and giving his clothes and money away. His level of Learning Disability means that he behaves in a way which is focussed on pleasing people, to develop acceptance within groups and possibly to gain kudos through offending for others."

With the knowledge we have about the death of Lee Irving the pinpoint accuracy of the NPS assessments makes it clear that Lee's problems and vulnerability

were known to the fullest extent three years before his death. It is, however, notable that even following the NPS assessment no alarm was raised or safeguarding alert instigated by the NPS.

2.1.6 Lee's vulnerability was, however, known and recognised by some services and a Mental Capacity Act (2005) assessment was completed by Adult Social Care in 2010, which addressed risks associated with his desire for his independence. It has always been known and documented that he had a Learning Disability and lacked capacity in relation to risk. The MCA principle is that professionals should always seek the least restrictive option in collaboration with the person but Lee's true mental capacity was often disguised by his seeming ability and determination to make decisions albeit unwise ones.

In February 2014 Northumberland Tyne and Wear NHS Foundation Trust (NTW) carried out an assessment of Lee and noted that –

> "Lee Irving arrived on time with his support worker and presented as calm and engaged well throughout the 90 minute appointment. On tasks he was unsure but when encouraged to 'have a go' or 'make a guess' he appeared reassured and immediately re-engaged."

The Wechsler Adult Intelligence Scale 4th Edition (WAIS-IV) was used to assess Lee's level of intellectual functioning. The WAIS-IV is used to assess the general thinking, reasoning and understanding of individuals aged 16-90 years. The assessment consists of 10 subtests that assess 'Verbal Comprehension', 'Perceptual Reasoning', 'Working Memory' and 'Processing Speed' skills.

The results of the WAIS-IV place his general cognitive ability well into the learning disability range. He achieved a Full Scale IQ score of 56. This means his overall thinking and reasoning abilities are the same as or better than only 0.2% of adults his age. Another way of understanding this would be to say that if Lee's intellectual ability was compared with other adults of his age, his performance would place him at less than the bottom 1%. At least 99.8% of people would score better than him.

In looking at his scores across the different subtests Lee scored best on the Verbal Comprehension subtests. This reinforces the suggestion that at times his intellectual ability may have been overestimated, as his relatively better verbal skills may have masked his deficits in other areas. However, given the right levels of support, and in keeping with the principles of the MCA Lee would still have been able to be supported to make some decisions for himself.

2.1.7 Throughout his long engagement with services Lee failed to attend nearly half his numerous appointments with various services. While in his early teenage years his family often ensured his attendance, when in his late teens, his family's influence declined and his chaotic lifestyle led to less frequent attendance at appointments, making it extremely difficult for all agencies to deliver the care and support that Lee needed.

2.1.8 From 2012 Lee's life slid into a chaotic cycle of offending, being reported missing and associating with so called 'friends' who exploited him. In October 2014 a decision was taken to award Lee with a direct payment – giving him control of some of his monies in order to directly purchase services or other forms of support.

A direct payment is a nationally recognised best practice approach to delivering person centred care. It involves Adult Social Care giving an individual (whose needs have been assessed as eligible) money directly so that they can buy the support that they need. The approach is monitored by regular reviews and support for the individual from both professionals and family members. In Lee's case a family member acted as a 'suitable person' to help Lee understand and manage his direct payments. Family members also held position of appointeeship for Lee's finances and managed the majority of Lee's finances including his receipt of benefits. This arrangement was monitored and appropriately reviewed by Adult Social Care. Initially Lee's direct payments were controlled by a family member but later that control passed to Lee himself.

2.1.9 By 2014 it was reported that Lee was being exploited by those he lived with. His mother continued to report her concerns for his safety and for a brief period Lee returned to live with her. It was short lived for in early 2015 Lee returned to live with the people who were suspected of exploiting him. In March 2015 NTW and Adult Social Care undertook a joint MCA assessment at which both Lee and his family were present. The assessment identified that Lee did not have the mental capacity to make decisions to keep himself safe when alone in the community. The assessment resulted in an exploration of supported living options, where Lee would be able to have independence but with the support of staff members when needed. Options of this nature were being explored at the time of Lee's death.

Although attempts to engage with Lee were ongoing the right up until the point of his death the last contact that agencies had been able to make with Lee Irving was on 13 April 2015.

Police did attend the house at 33 Studdon Walk between 28 May and 5 June, when we now know that Lee was in the house, already seriously injured.

The police call to the house concerned the behaviour of another resident (one of the accused) and was quickly resolved. It is now believed that Lee was kept in another part of the house during the police visit but the officers attending could not have known of his presence or his injuries and had no reason or justification for searching the house.

2.1.10 **<u>The Home at 33 Studdon Walk, Kenton</u>**

From 2014, Lee had begun his 'friendship' with the man convicted of his murder and was staying from time to time at the house at 33 Studdon Walk.

The house at 33 Studdon Walk is owned by Your Homes Newcastle (YHN), the local authority housing organisation and comprised upstairs and downstairs

accommodation. The house was tenanted by the mother of the man convicted of his murder as well as the two other individuals convicted of complicity in Lee's death and by a number of others who stayed for short periods. Lee Irving became a semi-permanent resident during 2014 and though he returned to his family home from time to time he eventually returned to Studdon Walk apparently drawn back by the influence of the man who murdered him and by the supply there of alcohol and drugs.

The two men and two women convicted in relation to Lee's death had a number of criminal convictions, with one still under a 12 month community order supervised by Northumbria Community Rehabilitation Company at the time of Lee's murder.

Northumbria Police were aware that the man convicted of his murder had convictions for violence, dishonesty and possession of drugs some of which had attracted custodial sentences.

The other three individuals also had a variety of convictions including violence, dishonesty and drug offences.

The living conditions at 33 Studdon Walk are best described as chaotic and controlled by the violent, unpredictable and dominant nature of the man convicted of Lee's murder, described by the trial judge as a violent bully.

Alcohol and illegal and misused prescribed drugs were readily available including opiate ad Ritalin. Lee became dependent on the alcohol and drugs and during his last days while already seriously injured by the murderer's beatings he was controlled and tranquilised by use of these drugs.

Sleeping arrangements in the house were reportedly haphazard with Lee sometimes sharing a bed with his murderer and on other occasions, during the last few weeks of his life, being consigned to an unfurnished 'dogs room' when he had incurred the displeasure of the other residents.

During the last days of Lee's life those responsible for his death exchanged text messaged and photographs of Lee showing his severe facial injuries. This callous and cruel disregard for Lee's suffering was a factor in sentencing the accused.

2.1.11 Lee Irving was found dead on 6 June 2015 near a towpath in Fawdon, Newcastle. Post mortem examination shows that Lee Irving had suffered extensive injuries which had occurred over a period of weeks (28 May – 5 June 2015) leading up to his death.

2.2 **Relationships with the family of Lee Irving**

The family of Lee Irving have co-operated wholeheartedly with the Review. They have endured a prolonged and extremely stressful period since Lee's death but remain determined that positive lessons are learned from the death of their family member.

They speak of their long struggle to care for Lee and their increasing difficulty in coping with him as he reached his teenage years. They knew that he had a severe Learning Disability from early childhood but they felt he was well protected while receiving holistic care at the Percy Hedley School. It was after leaving the school in his late teens that problems developed. They described the difference in the way professionals were able to respond to Lee as an adult as being frustrating and difficult to understand. They felt that the transition was disjointed and that Lee was thereafter "classed as an adult while his mental capacity remained that of a child".

While pertinent, it is important to note that transition into adulthood for Lee took place six years before his death and was done so in accordance with legislative and practice guidance. It is also noteworthy that much work has been done in Newcastle over recent years to improve young people's experience of transition. In March 2016 Newcastle City Council asked the Local Government Association (LGA) to undertake a Peer Review of Safeguarding Transition Arrangements. In particular, the review looked at how effective safeguarding procedures are for individuals transitioning into adulthood. The review identified numerous strengths in local working arrangements and approaches to practice. The report reserved particular praise for the effectiveness of transition into adult social care for children with disabilities.

Lee's family spoke of their concern for Lee's personal safety, he was easily led and manipulated, open to exploitation, lacked concentration and was easily distracted. They said he was desperate to fit in and make friends and this led him to keep the company of "street drinkers" where he would drink or take whatever substance given to him. He became a target for the unscrupulous, shoplifting to order and frequently losing his clothes, shoes and money to his street "mates".

His family struggled to control him and while he would stay with his Mother and Aunt for periods, he would frequently go missing, ending up in police custody or being traced via Facebook to various parts of Tyneside.

During this period of his life his family felt Lee's vulnerability increased for while he looked like a fit young man and could hold a conversation for a short period, he suffered "an invisible disability". He had no concept of time, day or money, was extremely gullible, with poor personal hygiene, no sense of right or wrong or of social boundaries. He was desperate to please and to fit in.

Over the course of his adult life his family reported Lee missing on numerous occasions and struggled to deal with his unpredictable and sometimes violent behaviour.

They report their experience of services as being mixed. They spoke highly of the Percy Hedley School and were grateful to the police for the many times they returned Lee home having been reported as a missing person. While they felt that they were treated well by some of the other professionals dealing with Lee

in adult services, they felt excluded from some of the key decisions about his care. They felt that some professionals excluded or disregarded them and that decisions about options for the ongoing care of their family member were made without their input. In particular, they express severe concern that despite their specific warnings about Lee's living conditions at the home at Studdon Walk, the measures taken to protect him were unsuccessful.

In conclusion, the family felt that while more should have been done to protect Lee towards the end of his life such was Lee's determination to place himself at risk that only secure accommodation would have protected him. Whilst they had resisted this option at the time, with the benefit of hindsight they recognise that other measures were unlikely to have succeeded.

Lee Irving's family had two main recommendations following the harrowing loss of their family member:

1. That the move from Children's to Adults' services be better managed to ensure a smoother transition without loss of support and that services consider the capacity rather than the age of the individual.

2. That families remain part of the decision-making process in the case of vulnerable adults and be fully involved/consulted on "best interest" and other decisions relating to family members.

It is evident that throughout their contact with Lee, Adult Social Care did make consistent efforts to engage with both Lee and his family, and that when decisions were required to be made, these were done so in consultation with the family but also, in accordance with practice standards, with Lee's views firmly in mind. Examples of this approach can be found in the decision to arrange Lee's care through a direct payment, a decision made with both the consultation and support of family members.

These matters are further dealt with in the recommendations of this report.

3. Analysis of Agency Involvement

3.1 Fourteen agencies, statutory and non-statutory, are recorded as being involved with Lee Irving during his lifetime (see para 1.4). Some agencies had extensive contact with him. Agency involvement is best described as complex and interwoven in what was a very difficult case.

It is clear that all agencies tried hard to deliver a service to Lee and/or his family but on many occasions this was made difficult due to Lee's lack of engagement and his determination to keep bad company.

3.2 From 2009 all agencies recognised and recorded Lee Irving's Learning Disability although the true extent of his disability was disguised by his physical ability and determination to make his own decisions. Likewise, all agencies had

some knowledge of disability hate crime though procedures to address it differed considerably.

3.3 All agencies recognised that Lee was at some risk either because of his learning disability, his regular status as a missing person, or his victimisation at the hands of associates.

3.4 On six occasions between 2010-2014 agencies/services considered the risk to Lee Irving to be such as to merit formal multi-agency safeguarding adult's written referrals. These were:

A 17/5/2010 - made by 'Positive Life Choices'

<u>This referral raised concerns relating to the organisation rather than specifically to Lee</u>

Positive Life Choices self-reported that there may be concerns in relation to neglect by one of their support workers as instead of following the plan to accompany Lee home they placed him on a bus to travel home independently (Lee had been assessed as having the ability to travel independently on familiar routes).

This referral resulted in a formal organisational strategy meeting being held on 18/5/2010, the outcomes of which were:

- A referral to the Independent Safeguarding Authority in relation to the worker.
- Social Care Assessment Officer to complete relevant capacity assessments and review and update risk assessment.
- Consideration to be given to use of social media as a means of engaging with Lee.

B 9/10/2013 - made by EDAN (Domestic Violence Service)

<u>This referral related to a report of Assault by Lee on his mother</u>

Lee was allocated an assessment of his care needs. His mother was referred to multi-agency domestic abuse procedures (MARAC), the outcomes of which was support for his mother through EDAN and referral via the GP for Lee around alcohol awareness and a referral to adult services for him for further assessment.

C 28/1/2014 - made by 'Positive Life Choices'

<u>Concerns re Lee going missing from his mother's and was threatening suicide</u>
At this time, in accordance with No Secrets (2000), concerns with no alleged perpetrator such as self-harm were not managed via the safeguarding process. Lee returned home independently on 29/01/2014.

D 4/4/2014 - made by NTW (Northumberland Tyne and Wear Foundation Trust) (Mental Health)

Referral highlights intention by NTW to terminate their involvement due to Lee not engaging despite his vulnerability and presenting risks

Specialist Services On-Call worker agreed to contact provider regarding Lee's current engagement and alert Specialist Services Support Planning Team to request progression with the allocation of Lee Irving's case.

E 19/11/2014 - made by NTW (Northumberland Tyne and Wear Mental Health)

Third party concerns raised by mother in relation to family Lee was living with and concerns about possible financial abuse/exploitation

A joint visit between Adult Social Care and Northumbria Police took place as a result. At this visit, Lee's allocated social worker arranged to meet with Lee alone the following day at a city centre café. Lee attended this meeting and was able to explain to his social worker his desire to remain at Studdon Walk noting that he liked staying there.

F 2/12/2014 - made by EDAN (Domestic Violence Service)

Third party concerns raised by mother of Lee re his place of residence, not wearing own clothes/footwear – dishevelled. This was not progressed as a safeguarding referral. Other action was taken. Adult Social Care arranged meeting with the family to discuss concerns. A subsequent meeting was planned with Lee but by this time he had returned to his mother's.

It should be noted that four of the six safeguarding adult's referrals were made by non-statutory agencies, one with only indirect contact with Lee Irving. The small agencies in particular should be commended for their professionalism. Of further note, only two of the concerns raised relate to Lee directly experiencing or being at risk of abuse, with the other concerns raised relating to organisational issues or Lee's general welfare.

Whilst not all of these referrals progressed through the formal safeguarding process, steps were taken by Adult Social Care to try to address the risks. However, had these issues been addressed by safeguarding adults' procedures there may have been a more robust multi-agency approach to the presenting issues.

Two of the referrals raised serious concerns that subsequently proved strong warnings of serious threat to Lee Irving. Safeguarding alerts E and F raised specific concerns that could have prompted greater consideration and action within the safeguarding process. The first of these concerns prompted a joint welfare visit to the property by Adult Social Care and Northumbria Police but consideration should also be given as to whether background checks by

Northumbria Police on the accused at this point should have exposed a violent record of the accused significant enough have escalated the level of concern.

Any failure of the system of Safeguarding Adult's Alerts in this case will be discussed further in Section 4 (Lessons Learned).

3.5 It is inevitable that agencies will see a case through the lens of their own professional expertise and responsibility. This was the case with Lee Irving for while his Learning Disability was known to agencies like the police he often presented as more troublesome than troubled, a nuisance offender, an abuser of alcohol and drugs who chose a lifestyle that laid him open to risk. The fact that he did not have the mental capacity to make such choices was not recognised by some of the professionals who had contact with him.

3.6 Finally, while all agencies tried hard to provide a service to Lee Irving and his family – and there were significant efforts and interventions – these efforts were not adequately co-ordinated or led by each the main agencies. Throughout the long engagement with agencies the lead changed according to the circumstances, for example probation, the police, adult social care and NTW all took the lead at points and this was dependent on the presenting issue at hand. Therefore, no agency was able to take overall responsibility for co-ordination and leadership, however, as noted in the report agencies were in contact on a regular basis with each other.

This will be further discussed in Section 4 (Lessons Learned).

4. Key Learning Points – Lessons Learned

4.1 What we did well

All agencies involved with Lee Irving recognised his disability and tried hard to deliver a service in difficult circumstances.

EDAN (Domestic Violence Service) recognised his acute need and the risk he was in, and raised the alarm by means of multi-agency safeguarding adult's written referral. Their concerns were justified and their actions were professionally appropriate.

4.2 All agencies have co-operated wholeheartedly with the Case Review. Individual Management Reports have been completed to a high standard, displaying candour and a high degree of critical self-analysis. Their approach and the standard of their work is commendable. A number of agencies have identified learning and made recommendations for their internal adoption. These recommendations are well founded and are worthy of adoption by the agencies concerned.

4.3 Agencies had safeguarding procedures in place and most shared information well. While there were administrative delays in some of the multi-agency

safeguarding adult's written referrals, it is clear that agencies saw and dealt with the case of Lee Irving as a 'Partnership' issue.

4.4 The decision by Adults Social Care to meet with Lee alone to discuss concerns which had been raised should be recognised as good practice. This action demonstrates a proactive approach to engage with Lee in a safe environment, away from those who were accused of harming him, to ascertain his views and wishes.

4.5 Lee Irving was a difficult person to help. His reluctance to engage with services and his failure to attend appointments made it extremely difficult for agencies to support him and his family. Despite this, agencies persisted in their attempts to help and protect him. It is clear that all agencies approached Lee Irving with the best of intentions.

4.6 **What could have been done better**?

4.6.1 **Missed Opportunities**

Many agencies were involved in Lee's complex case over a lengthy period. They saw him in different ways according to their discipline and while much was done to help him many did not appreciate the risk attached to his lifestyle and disability. There were, however, clear indications of Lee Irving's vulnerabilities and recorded Safeguarding Alerts pointing to the threats present at the house at 33 Studdon Walk where he lived latterly and where he was killed.

From his family to his school to recent assessments, his specific vulnerabilities were accurately identified.

The cumulative effects of these risk factors were not, however, weighed or considered in a multi-agency forum when planning for his care.

4.6.2 **Multi-Agency Safeguarding Adults Written Referrals**

The Newcastle Safeguarding Adults Board has an agreed threshold tool designed for the purpose of monitoring risk and the cumulative effect of safeguarding concerns. The tool identifies that when four concerns have been raised within a six month period, concerns should automatically be escalated into further stages of safeguarding adults enquiry. In Lee's case, six referrals across a four year period would not have triggered this level of escalation under the present arrangements.

While agencies all tried to engage and support Lee Irving and on the whole information was shared, the threshold did now allow recognition of the cumulative effect of the concerns raised and co-ordination in the multi-agency response.

In a partnership – all partners bear responsibility and in complex cases the need to both challenge and support other agencies is critical to success. In the case

of Lee Irving there was insufficient challenge and support within the partnership when the co-ordination of the lead agency was perceived to be unsatisfactory.

Some agencies, including Northumbria Police and the National Probation Service failed to share information or raise appropriate safeguarding referrals when risk was identified.

4.6.3 **Partnership Communications**

There were some difficulties in the channels of communication between agencies. There were occasions when professionals found it difficult to contact one another. Notwithstanding, good supervision should have ensured the continuity of high quality service and agencies dissatisfied with responses should have challenged if they felt outcomes were unsatisfactory. Information sharing between agencies is important for instance where there may be worker gender preference issues for the person or their family as these preferences would be considered when a worker is allocated.

4.6.4 **The Capacity of Lee Irving**

It was always known that Lee had a Learning Disability. His mental capacity was assessed in 2009 and 2014, yet many agencies dealing with him failed to identify concerns around his capacity and therefore did not adhere to the Mental Capacity Act (2005) which would have required them to undertake a capacity assessment. As previously noted, capacity assessments were appropriately undertaken by Adult Social Care and NTW.

Remembering that the MCA is decision and time specific, had all agencies assessed Lee Irving's capacity at the time of their involvement in adherence with the MCA the response of these agencies may well have been different.
In this regard the understanding and application of the Mental Capacity Act (2005) is legislatively essential. All agencies had knowledge of the Mental Capacity Act but some, including Northumbria Police and the National Probation Service had inadequate understanding of its workings and of their role in applying it.

The Mental Capacity Act is complex legislation and a clear understanding of its powers and responsibilities is essential to its operation. All agencies working with the legislation need to ensure a sound understanding so as to play their full role in its application.

4.6.5 **Options for Lee Irving**

Perhaps as a consequence of a lack of co-ordination a number of options for intervening in the case of Lee Irving were not considered. No legal advice was sought from agencies solicitors and the possibility of Court of Protection proceedings or other legal options were not pursued.

There was an exploration of supported living options, where Lee would be able to have independence but with the support of staff members when needed. Options of this nature were being explored at the time of Lee's death.

The responsibility for consideration of such options did not lie solely with the one agency. Specialist knowledge and responsibility lay across the partnership. These were options that should have been more actively pursued given the evidence that was collectively known to agencies.

Whether any of these options would have succeeded in intervening in Lee Irving's decline and eventual death will never be known.

4.6.6 **The interpretation of Lee Irving's behaviour**

Lee was a difficult person to help and his case was complex. His lack of engagement with services designed to help him meant that agencies, despite their best efforts, could only deliver a 'part service'.

The behaviour of Lee was perhaps interpreted by some professionals as consistent with his choice of an antisocial and criminal lifestyle. Whilst not held by all agencies this interpretation meant that his criminal conduct was not always considered as a symptom of his disability, increasing vulnerability or the exploitation that he was subject to.

The interpretation and response to non-compliance and non-attendance is a recurring theme in case reviews and will be considered further in the recommendations from this review.

5. Conclusions and Recommendations

5.1 This overview recognises the reality of safeguarding vulnerable adults in a modern society where there must be a balance between control and care.

In cases like Lee Irving's the various complex components are moving all the time. Police, Probation and Mental Health Services.as well as Adult Social Care, had extensive contact with Lee, over a protracted period.

The Newcastle Safeguarding Adults Board must continue to encourage a culture and reinforce systems to ensure joint responsibility and decision making in a climate of support and positive professional challenge.

It is too easy to leave a lead agency holding all responsibility and for a lead worker to feel they have total authority. Both these scenarios are inadequate in dealing with a case like Lee Irving's.

5.2 Disability Hate Crime

This review began by considering the death of Lee Irving as a disability hate crime. As discussed earlier in this report the judge in the criminal trial of the

four individuals convicted of the murder and complicity in his death, rejected this definition for legal reasons as the evidence led did not prove that the brutal assaults on Lee were motivated by his disability but rather happened because of the violent and bullying nature of the principal accused.

It is not the role of this review to question the legal decisions of a judge, but in seeking to learn lessons it is important to identify the underlying causes of Lee Irving's death.

Lee was obviously disabled and suggestable to anyone who knew him, he was vulnerable and indeed the three individuals found guilty of complicity in his death were convicted of 'causing or allowing the death of a vulnerable adult.' Accordingly, while the decision of the court is not to be questioned, for the purposes of this review and the lessons learned it is still considered appropriate to view the death of Lee Irving as directly connected if not motivated by his disability and vulnerability.

5.3 The case of Lee Irving was complex and he was difficult to help. It was always known that he had a Learning Disability and as he reached his teenage years his family found it increasingly difficult to cope with him. While a number of statutory agencies knew the extent of his disability his physical capability and his determination to make his own decisions belied his true disability and gave the false impression of capacity to some agencies.

In addition, his non-attendance at many of his numerous appointments with agencies meant that they saw only snapshots of his life rather than a complete picture.

Notwithstanding agencies never gave up on Lee and over the years were proactive and creative in trying to get him to engage with them even when his contact with them was sporadic.

5.4 There were, however, weaknesses in the multi-agency support to Lee Irving and they deserve attention and reflection in the recommendations of this review. The transition from childhood to adulthood was, in the view of Lee's family, disjointed with inadequate recognition of his true capacity. The legal options that children's services have under current legislation are no longer applicable once a child reaches the age of 18 regardless of their ability. Protection that children's legislation affords is replaced by legislation applicable to adults which inevitably means there needs to be a higher regard for an adult's autonomy and involvement in decision making. In some circumstances this can result in less consultation with family but whenever possible families' views should be sought and respected.

While individual agencies tried to engage with Lee there was not a co-ordinated information sharing, response to the presenting issues and a lack of professional challenge.

The powers and legal requirements of the Mental Capacity Act (2005) were not understood by all agencies. Consequently, the powers of the Act (such as consideration of referral to the Court of Protection) were not fully considered.

Lee's reluctance/inability to engage with services meant his care was badly interrupted but this behaviour was not always interpreted as a symptom of his disability.

5.5 In conclusion many individuals and agencies tried hard to engage with Lee Irving. His family struggled over years to protect him from harm. He was difficult to help and while lacking the capacity to make some decisions in his own interest he seemed determined to exercise his own autonomy which sometimes placed him at risk.

Whether any of these changes would have saved the life of Lee Irving will never be known.

5.6 The case of Lee Irving, like other reported disability hate crimes, highlights wider issues about community safety for adults who may be vulnerable to disability based harassment, hate and exploitation.

This case once again highlights a subculture that prevails in certain groups where alcohol and drug misuse is endemic, where bullying, violence and crime is normal and where there is a general lack of respect for others.

5.7 The co-operation with this review has been outstanding, the Single Agency Reviews were completed to a high standard and the participation of Lee Irving's family has been both helpful and positive. In particular, the multi-agency training events were useful and contributed much to the review. These events should be seen as best practice and considered in any future Safeguarding Adults Case Review.

Recommendations

1. **Transitions between Children's and Adults Services**

The transition from Children's to Adults Services took place in 2008 and cannot be associated with the circumstances surrounding his untimely death. Nevertheless, Lee's transition has been viewed by his family as a major and negative change in his life.

It is recognised that legal requirements direct agencies and that in any case much has changed and improved in the transition process since 2008.

Nevertheless, it is recommended that the Newcastle Safeguarding Adults Board examine again the transition process to ensure as smooth and integrated a

process as possible. In particular, whenever possible the family of the vulnerable person should be informed and consulted about the care of their family member notwithstanding legal requirements and the 'Adult' status of the subject.

2. **Partnership – Theory and Practice**

It is recommended that the Newcastle Safeguarding Adults Board examine the realities of Partnership working with particular emphasis on joint decision making, the inclusion of all relevant agencies and the consideration of legal options. These issues may be addressed by training or reinforcing guidelines.

3. **Safeguarding Adults Alerts**

It is recommended that the Newcastle Safeguarding Adults Board examine their guidelines concerning the management of Safeguarding Alerts to ensure that they are individually scrutinised and that the cumulative effect of a number of alerts is seen as an escalation of risk to be separately considered as a priority.

4. **The Mental Capacity Act**

It is recommended that the Newcastle Safeguarding Adults Board consider the application and legal requirements of the Mental Capacity Act. It is a powerful piece of legislation placing responsibility on all agencies but it is complex and requires detailed knowledge. To facilitate this, it is further recommended that a Senior Mental Capacity Act "Champion" is appointed in all statutory agencies so as to ensure ownership and a high degree of familiarity and compliance.

5. **Managing (Did not attend) failure to attend appointments**

It is recommended that the Newcastle Safeguarding Adults Board address partner agencies response to clients who regularly do not attend appointments. While it is costly and frustrating and often leads to a cessation of service, in the case of Lee Irving it was symptomatic of his disability. Agencies and the partnership should consider non-attendance on a case by case basis and jointly agree actions to respond to this issue.

6. **Training**

Newcastle Safeguarding Adults Board has a well-developed training programme which has been regularly updated and widely attended. Most of the staff who worked with Lee Irving had attended training specifically addressing disability hate crime yet some did not recognise it when they met it. It is recommended that training is once again refreshed, using experience of this case as a case study.

7. **Social Media**

Latterly the only way to track Lee's chaotic lifestyle was via social media, as he regularly used Facebook and other sites to communicate with associates and

family. While children's services regularly use social media to communicate with clients, this is less common in agencies who deliver services to adults. It is recommended that consideration be given to improving agencies familiarity and use of social media so as to improve service delivery.

8. Recommendations for Single Agency Reviews

As part of this review agencies submitted detailed Single Agency Reviews including recommendations for improving their own service. These recommendations were of a high standard and should be implemented by the relevant agencies.

Tom Wood
June 2017