Domestic Homicide Review

Joyce Jackson/2015

Overview Report

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Commissioned by:
Kent Community Safety Partnership
Medway Community Safety Partnership

Review Completed: 18th July 2017

Contents

Page(s)

Appendices

15.12.13 On 22/01/14 Sean appeared before Magistrates' Court for breach of the Community Order. The Order was revoked and he was re-sentenced to a Community order of 12 months and 150 hours UPW and 6 months Supervision. He failed to attend his first appointment post-sentence on 29/01/14. The Allocated Officer attempted to make contact with Sean regarding the missed appointment and in doing so telephoned his keyworker and was advised that he had 'attacked' his 'carer' and then left the accommodation where he was being supported.

15.12.14 On 30/01/14, there was recorded management oversight of the case when the Allocated Officer discussed Sean with her line Manager and expressed her concerns. It was recorded at this time that Young Lives Foundation Supported Living reported that Sean had left home before and would usually return but that they did not have any contact details for him and believed he would either be at his mother's address or that of a friend in mid Kent. The Allocated Officer requested that should Sean return, then she needed to be informed. There was good liaison by the Allocated Officer in escalating concerns with both her line Manager and the Police as well as those agencies supporting Sean. It was of concern that at this time no agency appeared to have any contact details for Sean

15.12.15 Sean failed to attend UPW on 01/02/14 and on 03/02/14.The Allocated Officer contacted Supported Living on 03/02/14 and was advised that Sean had returned briefly to his accommodation to collect some personal belongings and had stolen a Sky box, a wireless router and a duvet, which indicated he may not be returning. Again, Supported Living did not know of Sean's whereabouts and the Allocated Officer requested she be alerted upon his return.

15.12.16 On 05/02/14, Medway Social Services made contact with the Allocated Officer who explained that Sean was again in breach of his Community Order and that a Warrant for breach would be raised. She also advised that she was aware the Police were interested in locating him in respect of further offending.

15.12.17 On 26/02/14, the Allocated Officer received a telephone call from Supported Living and was told that Sean had returned (date not recorded) and assaulted a member of staff and indicated that he was getting a knife. The staff member had managed to lock themselves in a bedroom and telephoned both the Police and their Manager. Additional staff were sent to the address and managed to convince Sean to go with them to see a Senior Manager at Supported Living. The Police were in attendance and were then able to execute the Warrant.

15.12.18 Sean was produced at Court the following day when the Community Order was revoked. He was re-sentenced to a SSO 120 days custody suspended for 12 months with 6 months supervision and 150 hours UPW and a curfew. He provided the Court with an address in Medway. Post-sentence, his case was transferred to the Medway Probation office and he was issued with RI for 13/03/14. He failed to attend this appointment and on the same date the Allocated Officer was notified that he had breached his curfew by removing his electronic tag. Further attempts were made to fit the electronic tag, but Sean failed to make himself available on at least three occasions, and on 24/03/14 the Allocated Officer was advised that no further visit would be made unless requested by her.

15.12.19 On 15/05/14, Sean failed to appear before Magistrates' Court in respect of further offending; which included assault by beating. A warrant was issued for his arrest. At this time his Allocated Officer assessed him as posing an increased risk of harm i.e. a medium risk of harm in view of further offending related to violence against the person.

15.12.20 On 28/05/14, Transforming Rehabilitation allocation determined that from 01/06/14 Sean was to be allocated to the KSS CRC. This was an appropriate decision as allocation was based on his assessed risk of serious harm.

15.12.21 On 30/05/14, Sean, appeared before Magistrates' Court, having been arrested on the outstanding warrant for breach of the SSO. The SSO was activated and he received a total of 148 days custody which took account of further offending.

15.12.22 On 09/02/15, following further offending (burglary), Sean appeared before Magistrates' Court when matters were transferred to Maidstone Crown Court. Sean had stolen DVDs and silver bars to the value of £3,280.00 from a fellow resident. A further burglary offence was committed by Sean on 15/04/15.

15.12.23 On 14/05/15, Sean appeared before Maidstone Crown Court for Failing to Surrender/absconding and was sentenced to 1 months custody.

15.12.24 Sean appeared at Crown Court on 04/06/15, for the burglary (dwelling) committed on 04/12/14. An FDR was completed when his failure to comply with Court Orders was noted, also following his 18th birthday he had been asked to leave a social services placement in Medway and simultaneously his then girlfriend miscarried; his reaction to these losses was to use cannabis. The FDR author cited Sean's poor

problem solving skills, lack of victim awareness and minimisation of the impact of his offending on others. Indeed, he had an established pattern of acquisitive crime and an absence of support from family combined with a criminal peer group. His experience of the care system combined with both his youth and immaturity as well as a previous diagnosis of ADHD were seen to have had a bearing on his development and behaviour. The combination of adverse early childhood experiences together with his offending history might reasonably have raised a query about personality disorder, although this was not considered at the time. On 17/07/15, Sean was sentenced to an 8 month YOI custodial sentence.

15.12.25 On 21/09/15, Sean appeared at Magistrates' Court in respect of frauds committed on 22/04/15 including the theft and use of a credit card. He was sentenced to Offender Rehabilitation Act (ORA) Suspended Sentence Order (SSO) 18 months suspended for 8 months.

15.12.26 Sean was due to be released from the custodial sentence on 19/09/15 but was held in custody pending further criminal matters and was not released until 22/09/15.

15.12.27 Sean attended a planned supervision appointment on 23/09/15 and confirmed that his address had not changed. At this time he was residing with his mother who was lodging with Joyce Jackson. Sean stated he intended to secure his own accommodation elsewhere in the Thanet area. Sean said he had an allocated Social Worker. There is no evidence that the Allocated Officer made contact with the Social Worker from the Leaving Care Team until after the assault on Joyce, and therefore had not garnered any information about Sean's history or previous assessments which would have informed his supervision.

15.12.28 Sean failed to attend an appointment on 30/09/15 when his allocated Social Worker was visiting from Medway. The meeting was re-scheduled but the Allocated Officer might have used this as an opportunity to meet with the Social Worker and exchange information.

15.12.29 On 02/10/15, a Start Licence OASys risk assessment was completed and Sean was assessed as posing a low risk of serious harm with a reconviction calculation of 81% in 1 year and 90% within 2 years. Levels of need and the likelihood of reoffending were both high. The sentence plan outlined three objectives all of which the IMR Author considered were appropriate as they linked to Sean gaining an increased understanding of the cost of crime, attaining/improving a vocational skills and securing suitable accommodation.

15.12.30 Sean attended a further appointment on 09/10/15 accompanied by his mother. A number of areas were explored with him during supervision which focused on the sentence plan objectives. There was a missed opportunity to engage with Sandra Wilson which could have allowed the Allocated Officer to make an assessment as to whether or not she was a supportive and/or a protective factor in Sean's life given that family dynamics and pro-criminal attitudes had been highlighted as previous risk factors.

15.12.31 On 21/10/15, Sean attended a supervision appointment and it was reported to his Allocated Officer that:

"Things were getting tense at his mother's address due to his two brothers residing there and he indicated the need to find alternative accommodation".

15.12.32 It was agreed to try and provide Sean with supported accommodation albeit, consideration had to be given to him having committed burglary and theft in previous such residences. The Allocated Officer made no reference to the concerns raised by Sean regarding his accommodation situation in order to gather a holistic view of accommodation, lifestyle, associates and relationships. Professional curiosity should have been applied. **(See Recommendation 1).**

15.12.33 Sean failed to attend further appointments on 30/10/15 and on 04/11/15. On 16/11/15, Sean and his two brothers were arrested for the assault upon Joyce Jackson. Sean appeared before Magistrate's Court on 19/11/15 charged with Grievous Bodily Harm and was remanded in to custody. Appropriately, both Recall and Risk Escalation were initiated. The Risk Escalation was not finalised until the KSS CRC were in receipt of the CPS information so that they had all the evidence necessary to underpin the assessment of risk of harm. Initial discussion regarding Risk Escalation took place between the KSS CRC and the NPS on 20/11/15. Transfer to the NPS was accepted on 26/11/15.

15.12.34 It was not until 10/12/15 that the previous KSS CRC Allocated Officer received a telephone call from Sean's allocated Social Worker who confirmed that the Leaving Care Team would remain involved with Sean until he was 21 years, namely until July 2016. This telephone contact was the first between the Allocated Officer and the allocated Social Worker and is highlighted as poor practice.

15.12.35 **Dean Rose** during 2014/15 was known to Kent Probation and KSS CRC. He was initially subject to a 24 month Youth Rehabilitation Order (YRO) with 180 hours UPW when he appeared for sentencing

before Folkestone Youth Court on 28/01/14 for possessing a Class B drug (cannabis). The YRO was managed by the Youth Offending Service however the UPW was delivered by Kent Probation Trust. Dean's response to UPW was poor he failing to attend on numerous occasions. On 11/07/14, he appeared before Magistrates' Court for a breach of the 24 months YRO and UPW. The Order was revoked and Dean was re-sentenced to a 24 months Conditional Discharge.

15.12.36 On 13/03/15, Dean appeared before Magistrates' Court for sentencing for offences of possessing a blade in a public place and theft. The PSR described Dean as being homeless at the time of the offending, not in receipt of state benefits and had stolen in order to raise funds for both food and cannabis. It was noted he was living with friends and his brother at a temporary address having lived with his grandparents until the age of 16. He denied drinking alcohol but was said to have "lots of issues" with his family, especially with his mother whom he felt had "let him down", but he was interested in accessing counselling which he had benefited from previously.

15.12.37 On 18/03/15, Dean attended a full Induction and UPW. A sentence plan was drawn up which covered accommodation, referrals to a Probation Mentor, NHS Health Trainers, his GP for counselling, Turning Point in order to address previous use of cannabis and Education, Training and Employment (ETE) as well as work to address offending behaviour and to develop victim empathy.

15.12.38 On 20/03/15, Dean met with his Allocated Officer and enforcement of the Order was explained at length. A Safeguarding Adult registration was added to the electronic case recording system highlighting that he was a care leaver working with the 18+ Team and had an allocated Leaving Care worker, PA1.

15.12.39 On 31/03/15, an OASys assessment[20] was completed which drew upon information contained within the PSR noting the motivation to offend was driven by financial and perceived needs for drugs use. Dean took full responsibility for the offending although he was reluctant to discuss with the assessing officer why he was carrying a knife. The assessing officer stated that whilst the potential for harm were he to have used the knife could not be ignored, in the absence of any evidence that this was planned, she concluded it was not linked to a current or active risk of serious harm. This conclusion should not have been drawn. Alcohol misuse was identified as being linked to both the

[20] OASys is the abbreviated term for the Offender Assessment System used by HMP and NPS to measure the risks and needs of criminal offenders under their supervision.

likelihood of reoffending and risk of harm. Comment was made that in 2013 Dean committed an offence of battery whilst under the influence of alcohol and was said to have had so much that he required hospital treatment. His immaturity and the lack of positive role models were also identified as leading to deficits in his ability/capacity to problem solve. The possession of a weapon and the previous offence of battery triggered the completion of a full Risk of Harm analysis. The officer identified that further discussions with Dean were required in relation to his motivation for carrying a knife and she noted that little was known about the commission of the battery other than it had involved Dean attacking a male in a street fight, all of which was based on Dean's self-report. The Youth Offending Team (YOT) had not provided information about their previous involvement with Dean at the time of this assessment which was unfortunate as this would have contributed to the assessment of risk **(see Recommendation 11).**

15.12.40 On 10/04/15, Dean appeared before Magistrates' Court charged with shoplifting and was sentenced to a concurrent ORA 12 months Community Order and was again allocated to the KSS CRC.

15.12.41 On 22/07/15, Dean attended a supervision appointment accompanied by PA1 from the Kent 18+Team. The importance of him adhering to the Order was made clear and he was advised he had been fortunate that breach action had not been initiated. At this meeting, Dean admitted he had been in a fight. A way forward to support Dean to attend UPW was agreed and arrangements were subsequently made for him to recommence UPW weekly from 03/08/15.

15.12.42 Dean was suspended once more from the UPW scheme. During this time he also failed to attend supervision on 30/08/15 and on 13/11/15 as well as a Motivation to Work session on 06/10/15.

15.12.43 David, Sean and Dean Rose were known to a number of agencies, there was evidence of collaborative working however more could have been done by professionals to share information. Working together would complement activity and assessments to safeguard their welfare and to reduce future harm to others. For example; with regard to Sean Rose, it was not until 10/12/15 that the previous KSS CRC Allocated Officer received contact from the allocated Social Worker who confirmed that the Leaving Care Team would remain involved with him until he was 21.This contact was the first between the Allocated Officer and the allocated Social Worker and is highlighted as poor practice.

15.12.44 It was not until the offence against Joyce Jackson took place and Dean and Sean Rose were charged with assault, that the three Allocated Officers involved in their respective supervision became aware that the family were subject to statutory supervision and hence supervised by their colleagues. There was a missed opportunity for colleagues to work together to understand the dynamics of this family. **(See Recommendation 12).**

15.12.45 In the context of this DHR this case demonstrates how important it is that probation services contribute to assessing the suitability of accommodation in which those under their supervision are living. As with other agencies, attention should extend to the impact their charges are having on others living in the same accommodation. Again, within the context of this DHR, this case demonstrates the importance of effective collaboration with other agencies.

15.13 Kent Youth Offending Service

15.13.1 The Kent Youth Offending Service (YOS) works with young people from Kent (excluding Medway) aged between 10 and 17. Dean Rose for a time was supported by the Kent YOS.

15.13.2 During this time the service did not carry large numbers of unallocated cases and staff had on average between 12 – 18 cases each. The service could be described as stable although was going through a process of restructure as part of the Kent Integrated Adolescent Support Service (KIASS).

15.13.3 The service had a clear set of policies around the assessment and support of young people within the Youth Justice system. These were underpinned by clear National Standards from the Youth Justice Board. Staff in the service were clear about the expectations of what support should be offered and how often, as well as how to respond to issues of non-compliance.

15.13.4 Dean had two orders with Kent YOS, but was missing from his accommodation for the majority of the time YOS were supporting him. There was a good assessment put in place, which identified clear concerns relating to his vulnerability due to his past life experiences.

15.13.5 There was a strong multi-agency approach to sharing information and working together throughout the length of the second order. There was not such strength to actively engaging with Dean in the times when he appeared to be willing to engage, or at the times when he may have needed support.

15.13.6 The Referral Order, in November 2012, did not start well as staff sickness resulted in the report being delayed, and Dean did not attend all scheduled meetings. He failed to attend the initial panel meeting, but did present at the office two days later as he was homeless. Between them YOS and Specialist Children's Services (SCS) carried out 'strong work' to find Dean accommodation and provide him with support.

15.13.7 Dean's assessment identified a young man with a difficult family history, an inability to make attachments with others and previous episodes of absconding. This should have triggered a Vulnerability Management Plan (VMP) but this was assessed as not required. In September 2013, such a plan was put in place at the request of management.

15.13.8 The case manager worked closely with Specialist Children's Services as there were ongoing concerns around the accommodation being used by Dean. There were missed appointments at the beginning of the order and the case manager was not assertive in engaging with Dean in a way which would have supported his compliance. Dean went missing in May 2013 and there was no knowledge of his whereabouts or regular contact with him until December 2013. The Referral Order was breached at this point and a Youth Rehabilitation Order (YRO) was imposed for the breach together with further offending.

15.13.9 The YRO assessment was well written and identified issues around family history, neglect, witnessing domestic abuse, experiencing physical abuse, an inability to form relationships, the risks of associating with older pro-criminal adults and going missing. The assessment identified Dean was at risk because of these factors. An assessment of his risk of serious harm to others was completed and identified him as being of medium risk. This meant that he was not a risk unless circumstances changed. This assessment was commensurate with what was known about Dean at that time.

15.13.10 The intervention plan agreed with Dean was written with Dean present, YOS, Kent Police, CXK, Speech and Language, and SCS were also in attendance. It identified priorities around thinking and

behaviour, peer influences, unpaid work, substance misuse, an ETE apprenticeship and the need for regular meetings with SCS.

15.13.11 A Vulnerability Management Plan (VMP) was also written which identified Dean as being of medium vulnerability. This was commensurate with what was known of him and his circumstances at the time, although it would have been reasonable to assume that his accommodation, and his ability to maintain it was precarious and a higher vulnerability level could have been decided upon. The VMP was agreed between the worker and their manager and there is no criticism of this.

15.13.12 From its beginning Dean failed to engage with all aspects of his YRO and missed some Unpaid Work appointments. Positive work was carried out by YOS to find Dean an apprenticeship, and there was a shared approach to planning and exchanging information with SCS. There was also good liaison with Kent Police. The liaison was evident while Dean was attending meetings and also when he went missing, which was at some point around April 2014. There was good work in trying to locate Dean and having him listed as a missing person.

15.13.13 The case manager had insufficient contact with Dean, which was significant given the assessment around his attachment issues. Dean's order started on 28th January 2014 and the first contact between he and his case manager that could be seen on the case records was a telephone conversation on 12th February. Prior to this Dean had been required to attend various Unpaid Work appointments. The first time the case manager saw Dean was 26th February 2014. Given what was known, it would have been critical to develop a strong relationship with Dean from the beginning of the order to help give him the best possible chance of completing it successfully.

15.13.14 In March 2014, Dean's Social worker expressed concerns about his increased substance use and that his accommodation placement was breaking down. It was not possible to see a response to these concerns.

15.13.15 Management oversight of the work was evident throughout both the Referral Order and the YRO. There was clear evidence of managers agreeing assessments or requiring additional information, and also evidence of management challenge where assessments were not sufficiently robust. There could have been stronger consideration at the beginning of the order to establish what might have worked to help Dean engage better with YOS

description and exercise 'curiosity' to identify vulnerable/ abused individuals who do not fall within that primary role.

17.9 Sean Rose had been classified as representing a high risk to himself and others and thus must have been a potential risk to Joyce. In June 2015, he was sent to prison and during this time was visited by his Personal Advisor under the Medway 18 plus arrangements. It was established upon release he would reside with his mother at Joyce's address. There appears to have been no risk assessment in relation to the suitability of this address, and in particular no reference to the potential vulnerability of Joyce. It should be pointed out that no risk assessment took place either by the PA or the CRC and no consideration was given to the appropriateness of the address as he was not identified as high risk upon his release. Had such a risk been identified further efforts could have been undertaken to provide Sean with alternative accommodation[21]**.** Whilst his PA seems to have agreed that Sean could live with his mother at Joyce's house, information was not shared with either EKH or the CRC/probation provider: EKH have made it clear that permission for Sean or indeed any of the sons to live at this address would never have been granted as it was only a two bedroomed house, and thus too small.

17.10 David Rose was the elder of the three brothers and like them was a care leaver and for a time was helped by the Medway 18 Plus/ Leaving Care Team. David unlike his brother was referred to Medway Adult Services because of his learning disability and was subsequently aided by the 0-25 Disability Team. The Medway Council Housing Service deemed David to have made himself intentionally homeless. Despite their previous efforts the Disability Team were unable to help him and following an assessment of his mental capacity the case was closed. This was in accordance with recognised procedures.

17.11 As stated the three brothers all had profound problems after leaving care including the issue of where they should live. Over a period of time, individual members of staff from the two local authorities were assigned to each of the brothers, but they seemed to work independently of each other. Similarly information sharing between Children's Services, Probation, housing providers and the Police could have been better, particularly in relation to identifying the risks these individuals posed to Joyce.

[21] A previous DHR (Christopher2011) concerned a man who during home detention from prison killed his partner. Questions were raised regarding the lack of a risk assessment regarding the address to which he was to reside. It was concluded that as he was not deemed a high risk prisoner no risk assessment was required to be undertaken by HMP. This case emphasised the need for agencies to share information prior to a prisoner's release.

17.12 This case appears to fall under the heading of ‘mate crime’. This is a relatively new expression, but is a useful classification, which could trigger a greater awareness of agencies to vulnerable people being befriend and exploited by individuals such as Sandra Wilson and her three sons. It is quite clear that Joyce was seen as an ‘easy touch’ with her possessions being stolen and her house used for inappropriate and anti- social activity, however she was never identified as the victim of ‘mate crime’. Kent Police have now embraced the concept of ‘mate crime’ and have introduced it into their training programmes. During the course of this review, with the exception of the Police and KMPT, IMR’s have not referred to ‘mate crime’ as such, however it should be incorporated into these organisations policy and practice regimes and included in training programmes. Panel members did refer to ‘cuckooing’ explaining this was an established description of drug dealers who take over the property of a vulnerable person, and use it from which to run their drugs business.

17.13 Building on the concept of ‘mate crime’, a document entitled ‘Hidden in Plain Sight’ first published in 2011 by the Equality and Human Rights Commission included a study into 10 cases in which a disabled person had been killed or suffered serious injuries at the hands of another. This document has been useful in reaching conclusions in relation to the type and classification of criminality to which Joyce was subjected. The key findings from these case studies can be found at **Appendix C**.

17.14 In considering Joyce’s vulnerability, if one excludes Sandra Wilson and her sons from the equation, then a pattern of peaks and troughs emerge in relation to her mental and physical health. There were times when she presented as deeply disturbed whereas on other occasions she appeared well and able to adequately take care of herself. At the time of the assault there were no particular concerns raised by her GP, and she was not then receiving any specialist mental health support. What is apparent is that Joyce on occasions was masking (either deliberately or unintentionally) the reality of her situation. It would appear Joyce had been ‘self-neglecting’ and was making herself more vulnerable. In such cases professionals should not rely on a person’s self-appraisal, but take evidence from other individuals or agencies. There was some degree of collaboration, but in the main, professionals described her improved condition without taking a wider view only basing their assessment on how she presented at a particular time.

17.15 In reaching conclusions one must also take regard of the house in which Joyce lived and the potential it represented for agencies to identify her vulnerability, and to take into consideration safeguarding issues. As can be seen, there were several calls neighbours made

about Joyce's house, usually complaining of anti-social behaviour and the number of undesirable people frequenting the property. These calls were directed at the Police and East Kent Housing. On at least one occasion concern was expressed for Joyce's wellbeing. Complaints by neighbours could have resulted in more expedient action, and more robust inquisitive activity should have taken place to identify the root cause of the problems. Particular attention should have been given as to who were the victims and who were the perpetrators. Prior to the arrival of Sandra Wilson and her sons there was little or no history of complaints at Joyce's address and thus, when complaints began arriving, this should have alerted Neighbourhood Managers that something was amiss. Home visits did take place some of which were unannounced, but some were made by appointment but arguably should not have been. Neighbourhood Managers had not been specifically trained in safeguarding, an issue which is now being addressed by Thanet Council and EKH.

17.16 As part of the review process the Independent Chair in reaching conclusions has taken into consideration the views of Joyce's immediate neighbours. One neighbour described the arrival of Sandra Wilson and particularly the Rose Brother's and how they caused him immense distress, which in turn had a detrimental effect on his health. He described the house being occupied by up to eight people who kept his family awake with shouting, banging and generally disruptive behaviour. He described these individuals as intimidating who could not be reasoned with. Although the Rose brothers were at the heart of the problem, they acted as a magnet for other undesirable individuals who neighbours referred to as 'drug abusers'. Not only was the neighbour concerned for his own sake but he feared for the safety and wellbeing of Joyce at the hands of those living in her house. Prior to the arrival of Sandra Wilson and her sons the area was peaceful and the neighbour had no concerns for Joyce's safety. The neighbour had no doubt that Joyce was being taken advantage of by Sandra Wilson and her sons.

17.17 The neighbour informed the Independent Chair he phoned the housing authorities on a number of occasions complaining of noise and generally anti-social behaviour; he also expressed concern for Joyce. The neighbour was unimpressed by the response. He spoke of EKH asking him to complete diary sheets before action could be taken; he declined to do this as he was often working away from his house. He informed EKH that they could visit at any time and they would see for themselves the immense disruption these individuals were causing to the neighbourhood. He agreed EKH made some visits to the house, but stated most of these visits were by appointment, which he described as

a nonsense as the house would be tidied and cleared prior to the officer's arrival. He also contacted the Police who sometimes attended but they seemed to deal with each incident separately and had no concept of the overall problem. At one stage the police told him not to call again unless the complaint concerned activity outside the house. The neighbour was so concerned for the safety of his family and property that he installed digital surveillance cameras at his own expense. The advice given by the police suggesting the neighbour should not call unless their complaint concerned activity outside the house appears simplistic and lacked subtlety. The police are there to be contacted to deal with offending behaviour, safeguarding issues and antisocial behaviour whether this activity occurs in a public or private place. On this occasion the advice given was not consistent with recognised police procedures.

17.18 The views of Joyce's immediate neighbours have formed an integral part of this review. N1's main concern was that the organisations involved did not communicate with each other either internally or externally. The neighbours views have been echoed from information contained in the IMR's particularly in relation to the lack of co-ordinated agency activity.

17.19. There were some examples of collaboration with other agencies (see section 16), but this was sporadic. Such cases do call for a coordinated multiagency approach rather than dealing with each incident in isolation. Achieving this is easier said than done given the number of cases and the resources available. The use of local Community Safety Units such as the one hosted by Thanet District Council is seen as perhaps an existing method of achieving this.

17.20. The Police received a number of calls relating to Joyce's address, usually from neighbours complaining of anti-social behaviour. The complainants were generally treated as the victim and those in Joyce's house as the perpetrators. Officers could have also identified Joyce as a victim had they looked more closely into the circumstances. To deal with such cases in this manner requires knowledge and background intelligence both from previous police attendance to the address and information from partner agencies.

17.21. In addition to calls from neighbours, the police investigated allegations made by Joyce of theft of her property by Sandra Wilson and her sons. These complaints generally resulted in Joyce's reluctance to support a prosecution. These allegations were generally treated in isolation, but if looked at collectively gave a clear indication that Joyce was the target of 'mate crime'. Comments regarding Joyce's reluctance to support

formal action against Sandra Wilson or her sons should not be construed in any way as attributing blame to her. As mentioned at 15.2.10, in such situations it is not uncommon for a victim to become reluctant to support a prosecution against the alleged perpetrators.

17.22 As with other agencies, the attending police officers did not exercise their 'professional curiosity' in relation to Joyce, and had they done so, her vulnerability may have been identified.

17.23 Police policies and working practice in relation to Domestic Abuse are robust and appropriate, however Joyce was never classified as the victim of domestic abuse. This was the result of applied legislation not including perpetrators who merely live in the same house. However there were elements of mate crime present and it is important that front line officers are aware of this type of offending. Once mate crime has been identified it should be dealt with in a similar way to domestic abuse and indeed, in many cases, it could be classified as such, particularly if the perpetrators are residing in the same household as the victim. It is for this reason 'mate crime' will be incorporated into police policy, and training will be delivered accordingly.

17.24 In reaching conclusions the views of Joyce's family have been taken into consideration and have formed a key part of the review process. Like the neighbours, Joyce's sister was concerned that agencies failed to work together and were not dealing with a worsening situation by taking note of all the information available. She also felt Joyce herself was not always able to care for herself, and although she may not have complained of abusive behaviour, or even been aware it was occurring, professionals should have been more inquisitive and proactive in identifying how vulnerable she was.

17.25 Joyce's siblings were clearly very concerned for her wellbeing, and prior to the arrival of Sandra Wilson and her sons into her life, her sister and brothers took an active role in managing her physical and mental condition (see section 15.5). Joyce's willingness to accept Sandra Wilson as her friend and, to some extent her protector, resulted in her family members being marginalised in terms of her medical and safeguarding needs. When a vulnerable person's life is invaded in such a way it should be of no surprise that members of that person's family are alienated.

18 Lessons Learnt

1) In the main, organisations contributing to this DHR have in place appropriate policies and defined working practice relating to domestic abuse. These procedures involve well established risk assessment tools and contain guidance on joint working and information sharing protocols. In this case Joyce was never identified as the victim of 'domestic abuse' as defined by legislation, and as such none of these organisations put these policies into practice. Even if Joyce's general ill treatment by the Rose Brother's had been recognised, it is still possible she would not have been classified as the victim of domestic abuse, and these procedures would not have been implemented. Agencies are unlikely to define a situation as domestic abuse if the victim is only living in the same household rather than being related to or the intimate partner of the perpetrator.

2) This report makes a great deal of reference to 'mate crime' and this case appears to fit into this category of offending. 'Mate crime' may also fit the definition of domestic abuse, but this need not always be so as the perpetrator may not always live in the same household as the victim. This case would indicate that 'mate crime' should generally be dealt with in the same way as domestic abuse with defined policies and risk assessments being established by each of the agencies. Whilst the Kent Police have now introduced guidance on 'mate crime' this does not seem to be the case with other agencies with the exception of KMPT and Kent Adult Services.

3) Professionals visiting Joyce's house failed to identify her vulnerability at the hands of Sandra Wilson and her three sons. They were focussed on their own field of activity, but should have extended their observations to include the ambient condition of the house, and the vulnerability and safeguarding of its occupants. This throughout the report has been referred to as 'professional curiosity'.

4) Calls made to Joyce's house by agencies were often dealt with in isolation with no account being taken of previous events or intelligence. It is important such cases are managed as a progressive and chronic situation rather than a reaction to each call as a single issue. Such an approach, where relevant, should also involve multi-agency activity with information being exchanged between organisations.

5) Agencies that respond to calls relating to Anti-Social Behaviour should make appropriate enquiries to establish who are the victims and who are the perpetrators. In this case only the complainants were regarded as the victims, but it would seem Joyce and potentially Sandra were also victims, but living in the same house as those responsible.

6) In addition to the abuse perpetrated by the Rose Brother's, it would seem Joyce was self-neglecting by failing to take care of her own needs. Professionals often took Joyce's own self-assessment at face value and did not seek information from other sources when identifying her needs and potential vulnerability.

7) Social Services perform a crucial role in assisting care leavers move into adulthood and independent living. As can be seen throughout this report assisting care leavers in finding suitable accommodation is a vital part of that role and some efforts were indeed made to find the Rose Brother's appropriate housing. These efforts were made in conjunction with the Medway Council Housing Service. Having said that, professionals must also take account of potential risks to the person with whom the care leaver is to reside. In this case there was much emphasis on providing the brother's with accommodation and little or no recognition that they may have a detrimental effect to Joyce's welfare and safeguarding.

8) Whilst the main responsibility of managing a person leaving care falls to Social Services, this case demonstrates decision making should involve the sharing of information from a variety of sources and agencies; in this case the Probation providers (NPS CRC), Youth Offending Service, Police and East Kent Housing. This activity should commence prior to the care leaver reaching the age of 18 years.

9) This case demonstrates the need to risk assess the accommodation to which a prisoner is to reside upon release from HMP. There was no risk assessment and no objection by Sean Rose's Personal Advisor that he should reside with his mother at Joyce's house.

10) This case demonstrates the need for EKH (and where relevant other agencies) to undertake unannounced visits when dealing with cases of potential abuse, ASB or allegations of 'mate crime'.

This section of the report outlines some of the main lessons to be learnt, but this list is not exhaustive and other lessons, which are specific to individual organisations, are included in agency IMR's and have already resulted in remedial activity.

19 Recommendations

1. **Front line officers or staff who, as part of their job description, visit premises or interact with members of the public, have the opportunity to identify potential victims of 'Mate Crime' or Domestic Abuse. Officers and staff should be encouraged to exercise 'professional curiosity' and follow up on indications of an abusive relationship or safeguarding issues that relate to a person who may not be the primary focus of their work.** *Police, EKH, Thanet Council, Kent and Medway Social Services, KMPT, SECAmb, NPS, CRC, Kent YOS.*

2. **Where there are complaints of Anti-Social Behaviour, it is important to establish who is the victim, who is the perpetrator and whether they are vulnerable and in need of assessment.** *Kent Police, East Kent Housing, Thanet District Council*

3. **The concept of 'Mate Crime' or the harming of vulnerable persons in abusive relationships by offenders who set out or take the opportunity to abuse a victim, should be incorporated into agencies policies and working practice, and staff should be trained accordingly. This type of offending should be treated in a similar way to Domestic Abuse e.g. structured risk assessment, information sharing protocols, victim safeguarding plans etc.** *Police, EKH, Thanet Council, Kent and Medway Social Services, KMPT*

4. **Housing providers should undertake a risk assessment when they are aware that someone has moved into a property with a potentially vulnerable tenant.** *East Kent Housing, Thanet District Council*

5. **To facilitate information exchange, East Kent Housing to attend formal and minuted Tasking and Coordinating Meetings held by the Thanet Community Safety Unit.** *East Kent Housing, Thanet District Council, Thanet CSU*

6. **To provide each GP practice with an up to date adult safeguarding policy that reflects national and local guidance and best practice to guide and support staff in responding to victim and perpetrators of domestic abuse and self-neglect. Kent and Medway CCG's/NHS England**

7. **In exercising their responsibility in assisting young adults leaving care, Social Services should endeavour to ensure such individuals are registered with a GP, (none of the Rose Brothers were registered with a GP at the time they attacked Joyce).** *Kent and Medway Social Services*

8. **Agencies should recognise that an individual's safety and wellbeing may be, in whole or in part, compromised by self-neglect rather than abuse inflicted by a third person. Agencies should ensure that published guidance on self-neglect is both delivered in training and conformed to as outlined in the Kent and Medway Adult Safeguarding Board Policy.** *All agencies*

9. **Social Services have a responsibility to assist young adults leaving care, which will include helping them find suitable accommodation in which to live. In addition to establishing the accommodation is suitable for the care leaver, a risk assessment should also take place intended to identify safeguarding issues in relation to the existing occupants.** *Kent Social Services, Medway Social Services*

10. **In considering the appropriateness of accommodation for persons leaving prison or detention centres, agencies involved should use their own risk assessment processes to determine the suitability of the premises in respect of the vulnerability of existing occupants. Information from risk assessments should be shared with other agencies.** *Social Services, NPS,YOS, Housing Providers*

11. **When adult offenders have been previously subject to youth offending supervision, liaison must take place with the previous allocated YOT worker/s in order to gather information to inform risk assessment and risk management.** *NPS, YOS*

12. **When offenders subject to statutory supervision are related, professionals with offender management responsibility must work collaboratively in order to build a holistic view of the family to inform the assessment and management of risk.** *NPS, YOS*

13. **This review and its recommendations should be brought to the attention of the Kent and Medway Adult Safeguarding Board. In so doing the Board and its member organisations may be able to provide guidance and a degree of consistency to those charged with implementing recommendations particularly relating to the**

use of professional curiosity, mate crime and self neglect.' Kent and Medway Adult Safeguarding Board

In addition to the above, individual IMR Authors have made some recommendations which are specific to their own organisation. These additional recommendations will be progressed through that agencies own internal management arrangements.