Combined Domestic Homicide Review and Safeguarding Adults Review following the murder of Karen

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1.0 Introduction

1.1 This combined domestic homicide review (DHR) and safeguarding adults review (SAR) was commissioned by South Worcestershire Community Safety Partnership and Worcestershire Safeguarding Adults Board in response to the murder of Karen by her long term partner Simon.

1.2 Karen died on 15th April 2016 and Simon has since been convicted of her murder and sentenced to life imprisonment.

1.3 This murder meets the criteria for a domestic homicide review to take place in that the death of a person aged 16 or over has resulted from violence by a person with whom she had been in an intimate personal relationship.

1.4 In view of the fact that Karen had care and support needs, as did her partner Simon, Worcestershire Safeguarding Adults Board decided that the criteria for conducting a safeguarding adults review were also met, in that an adult in its area had died as a result of abuse and there was concern that partner agencies could have worked more effectively to protect her.

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

1.6 The methodology adopted for this review is set out in more detail in Appendix B.

A panel of senior managers from partner agencies oversaw the process by which this review was completed and membership of the panel is also shown in Appendix B. David Mellor was commissioned to be the independent chair of the panel and author of this combined report. He is a retired chief officer of police and former independent chair of a safeguarding adults board. He has been the independent author of a number of domestic homicide reviews and safeguarding adults reviews and has no connection to services in Worcestershire. "A statement of the independent chair's independence can be found in Appendix C"

1.7 All members of South Worcestershire Community Safety Partnership and Worcestershire Safeguarding Adults Board wish to express their sincere condolences to the family and friends of Karen.

2.0 Terms Of Reference

Timeframe

2.1 The scope of the DHR/SAR is from 1st April 2015 to 15th April 2016 with the inclusion of any significant incidents from 1st December 2005 to 31st December 2006, the period between Karen and Simon getting engaged and moving in to live independently together.

The Victim:

1. How and when the Mental Capacity Act (MCA) and Deprivation of Liberty Safeguards (DoLS) were applied and how this was documented. Were there grounds for Karen's capacity to be queried, was she seen with Simon or on her own, was there any indication of a coercive relationship

2. When, and in what way, were the victim's wishes and feelings ascertained and considered?

3. Is it reasonable to assume that the wishes of the victim should have been known?

4. Was the victim informed of options/choices to make informed decisions?

5. Were they signposted to other agencies?

6. Had the victim disclosed to anyone and if so, was the response appropriate?

7. Was this information recorded and shared, where appropriate?

8. Were procedures sensitive to the ethnic, cultural, linguistic and religious identities of the victim, the perpetrator and their families?

9. How accessible were the services for the victim and the perpetrator?

10. How the agency held Making Safeguarding Personal at the centre of the services provided to Karen.

The Perpetrator:

11. Was anything known about the perpetrator? For example, were they being managed under Multi-Agency Public Protection Arrangements (MAPPA), had they received a learning disability

diagnosis, did they require services, did they have access to services, where they acting as a carer to Karen?

12. Were procedures sensitive to the ethnic, cultural, linguistic and religious identities of the victim, the perpetrator and their families?

13. How accessible were the services for the victim and the perpetrator?

Practitioners:

14. Were practitioners sensitive to the needs of the victim and the perpetrator, what services were provided to each of them? Were practitioners knowledgeable about potential indicators of domestic abuse and aware of what to do if they had concerns about a victim or perpetrator?

15. Was it reasonable to expect them, given their level of training and knowledge, to fulfil these expectations?

Policy and Procedure:

16. Did the agency have policies and procedures for risk assessment and risk management for domestic abuse victims or perpetrators (Domestic Abuse Stalking and Harassment - DASH) and were those assessments correctly used in the case of this victim/perpetrator?

17. Did the agency have policies and procedures in place for dealing with concerns about safeguarding and domestic abuse?

18. Were these assessments tools, procedures and policies professionally accepted as being effective? Was the victim subject to a Multi-Agency Risk Assessment Conference (MARAC)?

19. Did the agency comply with safeguarding and domestic abuse protocols agreed with other agencies, including any information sharing protocols?

Assessments and Decision Making:

20. What were the key points or opportunities for assessment and decision making in this case?

21. Do assessments and decisions appear to have been reached in an informed and professional way? Did they consider Simon's criminal history?

22. Did actions or risk management plans fit with the assessment and the decisions made?

23. Were appropriate services offered or provided, or relevant enquiries made in the light of the assessments, given what was known or what should have been known at the time?

24. Were senior managers or agencies and professionals involved at the appropriate points?

Disability:

25. Was consideration for vulnerability and disability necessary?

General:

26. Are there other questions that may be appropriate and could add to the content of the case? For example, was the domestic homicide the only one that had been committed in this area for a number of years?

27. Are there ways of working effectively that could be passed on to other organisations or individuals?

28. Are there lessons to be learnt from this case relating to the way in which this agency works to safeguard victims and promote their welfare, or the way it identifies, assesses and manages the risks posed by perpetrators? Where could practice be improved? Are there implications for ways of working, training, management and supervision, working in partnership with other agencies and resources?

29. To what degree could the homicide have been accurately predicted and prevented?

3.0 Glossary

SafeLives **DASH** (Domestic Abuse, Stalking and "Honour"-based violence) is a commonly accepted tool which was designed to help front line practitioners identify high risk cases of domestic abuse, stalking and 'honour'-based violence and to decide which cases should be referred to the Multi Agency Risk Assessment Conference (MARAC) and what other support might be required.

A **Learning Disability** is described as:

- a significantly reduced ability to understand new or complex information, to learn new skills (impaired intelligence), with;
- a reduced ability to cope independently (impaired social functioning); and
- which started before adulthood, with a lasting effect on development.

Making Safeguarding Personal - is a sector-led programme of change which seeks to put the person being safeguarded at the centre of decision making. It involves having conversations with people about how agencies might respond in safeguarding situations in a way that enhances involvement, choice and control as well as improving quality of life, wellbeing and safety. It is about seeing people as experts in their own lives and working alongside them. It envisages a shift from a process supported by conversations to a series of conversations supported by a process.

Multi Agency Risk Assessment Conference (MARAC) is a meeting where information is shared on the highest risk domestic abuse cases between representatives of local police, health, child protection, housing practitioners, Independent Domestic Violence Advisors (IDVAs) and other specialists from the statutory and voluntary sectors. A victim/survivor should be referred to the relevant MARAC if they are an adult (16+) who resides in the borough and are at high risk of domestic violence from their adult (16+) partner, ex-partner or family member, regardless of gender or sexuality.

Multi-Agency Public Protection Arrangements (MAPPA) were established by the Criminal Justice Act 2003 in each of the 42 criminal justice areas in England and Wales. These are designed to protect the public, including previous victims of crime, from serious harm by sexual and violent offenders. They require the local criminal justice agencies and other bodies dealing with offenders to work together in partnership in dealing with these offenders. The core MAPPA members are the Police, Prison service and Probation service in each area.

The Supporting People programme was launched in 2003 as a £1.8 billion ring fenced grant to local authorities intended to fund services to help vulnerable people live independently. The ring fencing was removed in 2009 and the level of the grant gradually reduced and ended in 2014.

4.0 Care and Support Needs of Victim and Perpetrator

Karen (Victim)

4.1 After initially attending a mainstream primary school, Karen fell behind her peers and was diagnosed with a non–specific learning disability. After representations from her parents, she was moved to a special school and spent the remainder of her school career in special schools.

4.2 As she moved into adulthood she continued to live with her parents who bought a shop when Karen was around 21 years old. She worked in her parent's shop on tasks such as filling shelves and cleaning until her parents sold the shop in 1999. By this time Karen was in her mid thirties and was not known to social care services. During this period, she continued to live with her parents and only tended to go out in their company.

4.3 After her parents sold their shop, a referral was made into the social services team by a consultant psychiatrist requesting assessment for local day services. Karen was assessed by a social worker and arrangements were made for her to attend Day Centre 1 where she made a number of friends and eventually met Simon.

4.4 Karen appeared to lack capacity in managing her financial affairs, and required assistance to deal with correspondence. Although she could tell the time, she needed prompting to manage her time in order to attend work or appointments. This review has been provided with no evidence that her mental capacity was formally assessed other than to assess her capacity to consent to a health screening test in 2012.

4.5 Karen's father was a key source of support until his death in August 2014. In their contribution to this review, Karen's family recalled that "whenever she and her partner Simon had any problems with the flat (which they shared from December 2006), no matter how minor, he would jump in his car and go and sort them out".

4.6 From late 2006 until her death, Karen lived in supported accommodation with her partner Simon and received support commissioned by Worcestershire County Council (WCC) under *Supporting People* funding and provided by Lifeways Community Care. (When *Supporting People* funding ended in 2014, WCC funded the support provided to Karen thereafter. Lifeways Community Care is a private provider of support services for people with a range of needs within community settings. The support Karen received was described as "housing based support" and consisted of emotional support, support to maintain her tenancy and, after her father died, support relating to correspondence. She, and her partner Simon, were considered capable of cooking, cleaning, washing and general household tasks.

4.7 Karen was initially provided with five hours of support each week which was reduced to one hour a week – delivered in two half hour sessions - from 2008 on the grounds that she (and Simon) had successfully engaged with their support.

Simon (Perpetrator)

4.8 Simon was born in 1965 and lived at home by his parents. He had one elder and one younger sibling. All have learning disabilities.

4.9 Simon attended a school for children with learning disabilities until the age of 16. The school was closed in 1991 following an investigation which concluded that the school had a "culture of institutionalised sexual abuse". At this point there is no indication that Simon was abused whilst a pupil at the school.

4.10 After Simon left school he was employed in a saw mill, a cinema and for eight years prior to the murder, as a cleaner in a school setting.

4.11 As a young man Simon carried out three serious assaults. Shortly after midnight on 11th July 1987 Simon – then aged 22 – repeatedly stabbed his younger sibling in the shoulders with a pair of long bladed scissors and attempted to strangle her. There is also reference to an attempt to suffocate her. The assault took place within the family home Simon and his siblings shared with their parents, who, upon hearing their daughter's screams attempted to stop him. At this point he began to assault his father, stabbing him in the face with the scissors. He then pursued his mother downstairs but refrained from assaulting her after she pleaded with him to stop.

4.12 The police were called and Simon was arrested. He subsequently pleaded guilty to an assault under Section 18 Offences Against the Person Act 1861 (wounding with intent) upon his sister and an assault under Section 20 of the same Act (wounding without intent) against his father. He received a three year probation order.

4.13 Simon continued to live at home with his parents and siblings and it is understood that it was his parents who primarily managed the risk he may have continued to present to his younger sibling. Work was done by social services to try and improve the relationship between Simon and his younger sibling.

4.14 At around 3.45pm on 27th May 1991 Simon attacked a lone female on a rural footpath not far from his home where he continued to live with his parents and his two siblings. When his victim struggled and screamed, Simon ran off. He was later arrested and admitted he intended to rape the woman. He was charged with attempted rape but this charge was later withdrawn and he was convicted of the lesser charge of assault under Section 47 of the above mentioned Act. He again received a three year probation order.

4.15 It is also believed that Simon attempted to strangle his sister in law on an unknown date. This incident appears to have gone unreported and it has not been possible to obtain further details.

4.16 The original case papers from Simon's assaults on his sister and father and the assault on the female have been destroyed in accordance with guidance on the retention of police material. As a result, details are limited to what is recorded on the Police National Computer (PNC) system and within that system's archived microfiche.

4.17 In September 1991 a psychiatric report was prepared for solicitors prior to Simon's appearance at Court in respect of the attack on the lone female. It is not clear on whose behalf this report was commissioned. This report stated that "the current incident represents the third serious assault" (which appears to confirm the existence of an additional unreported assault), and that "all have in common that they were unpremeditated attacks on women, and certainly in the last two attacks alcohol seems to have played an important part."

4.18 The author of the report concluded that **"**in addition to a degree of mental handicap, …..he has a personality disorder, with features of psychopathic personality disorder. His psychopathic traits seem to be exacerbated or released by the effects of alcohol." In the opinion of the author of the report, he "did not believe his personality disorder to be curable by any form of psychiatric treatment, but treatment could alleviate or prevent a deterioration of his condition," adding that Simon was considered "to be in need of long term management as he must be considered at risk of making further aggressive acts, especially after drink, over the long term".

4.19 The author of the report also recommended that addressing Simon's needs should be the "responsibility of the local Social Service Department and Mental Handicap Service" and specified those needs as accommodation, day centre support and **"**long term supervision"**.**

4.20 A further report was completed prior to Simon's court appearance for the attack on the lone female. The author was a locum consultant psychiatrist who recommended that Simon needed counselling on psycho-sexual matters, some speech therapy and "probably" training at college, but it would appear that the resources necessary to address these recommendations were not available at that time. (December 1991) Again it is not clear who commissioned this report.

4.21 Following his conviction for the assault on the lone female in 1992, Simon received support from the probation service and a social worker. The details of the support provided are not known although there is a reference to a number of short term activities "to keep Simon occupied". The probation order expired in January 1995. Probation records from this time have also been destroyed in accordance with policy but it would have been considered good practice at that time for the probation service to have had a discussion with other agencies involved with Simon prior to withdrawing when the Probation Order expired. The Worcestershire Health and Care NHS Trust (WHCT) IMR author commented that there seemed to be little recognition of the need for long term review and support from this point.

4.22 Simon is not known to have committed any further offences until he murdered Karen twenty five years after the attack on the lone female and nearly thirty years after the attacks on his sister and father.

4.23 However, in 1996 the co-ordinator of a day centre Simon was attending concluded that it was not an appropriate placement for him because she had some concerns about her safety adding that Simon "does act very strangely at times". No further detail is known of the concerns arising from Simon's behaviour at that time.

4.24 In a 1998 review of Simon, it was documented that his mother was of the view that her son could be "aggressive and quick tempered, but mainly when he had been drinking".

4.25 Simon was the victim of an assault in November 2002 when he was confronted by a group of male and female teenagers who punched him. During the assault, Simon dropped money onto the ground which was not recovered. When he reported the matter to the police he said that the same group had previously approached him and called him "gay" and a "pervert". None of the group were traced.

4.26 Simon began attending Day Centre 1 from at least 1997 and it was here that he later met Karen.

4.27 From late 2006 until he murdered his partner Karen, Simon lived with her in supported accommodation and received "housing based support" commissioned by Worcestershire County Council (WCC) under *Supporting People* funding and provided by Lifeways. His support consisted primarily of emotional support and was provided in two half hour sessions each week. As with Karen the level of support originally provided to Simon was five hours per week.

5.0 Synopsis

5.1 As previously stated. Karen met Simon at Day Centre 1 which they both attended on a part time basis. Simon had been attending the day centre since at least 1997 and Karen since 2003. They went on to develop a close relationship.

5.2 During 2005 there were changes in the provision of services at Day Centre 1 which necessitated the consideration of alternative support for Karen. These changes were part of reorganisation of day centre provision across Worcestershire. It is understood that Karen's father formally expressed concern at the withdrawal of day centre support for his daughter.

5.3 This imminent service reduction appeared to be quite a significant driving force in exploring shared accommodation for Karen and Simon who had decided they wished to live together independently as a couple.

5.4 The changes in day centre provision also triggered a re-assessment of both Karen and Simon's needs. On 31st May 2005 social worker 1 from the learning disability social work team completed a needs assessment of Simon which made reference to the aforementioned 1991 psychiatric report, referencing the fact that Simon had been identified as having a certain degree of learning disability, a personality disorder with features of psychopathic personality disorder, and that his psychopathic traits appeared to be exacerbated by alcohol. Social worker 1's needs assessment also referred to the three serious assaults committed by Simon. The assessment noted that Simon had worked hard to avoid difficulties, has abstained from drinking alcohol and had become more capable of controlling his temper and emotions. The assessment concluded that he appeared to be ready to move to supported living with Karen. The assessment stressed that as past difficulties were linked to a personality disorder, Simon would need regular structured support, and that should there be a recurrence of previous difficulties this could have serious consequences for Simon. (At this time learning disability services in Worcestershire were delivered by separate WCC social work and WHCT or predecessor nursing teams. Gradually they became more integrated over the period covered by this review leading to a largely fully integrated service in 2011.)

5.5 Social worker 2 from the same learning disability social work team undertook a reassessment of Karen's needs and contacted social worker 1 to say that she was aware of Karen's relationship with Simon. Social worker 1 is said to have advised that when social worker 2 reviewed Karen she would also need to consider Simon.

5.6 Around this time, referrals for both Karen and Simon were made to the Mencap Worcestershire Active Service for further assessment and to assist in identifying suitable daytime occupation. Mencap helped Karen participate in successful work placements at a pet store and the local Salvation Army cafe, whilst Simon continued his part time job at a local theatre. Social worker 2 also provided support for the couple to explore college opportunities, joint activities, and helped them to find accommodation.

5.7 On 21st September 2005 social worker 1 completed a social work transfer summary in respect of Simon just prior to leaving the learning disability social work team. The transfer summary detailed Simon's personality disorder, previous history of physical assaults and reiterated that he must not be allowed alcohol. It states that Simon needed continued social work support regarding transition from Day Centre 1 and with his plans to "get married" to Karen. Shortly after social worker 1's departure, social worker 2 was allocated Simon's case whilst also retaining responsibility for Karen's case.

5.8 During 2006 the Frameworki electronic record system was being introduced across the service and the records from that system show that on 23rd August 2006 social worker 2 uploaded the assessment of Simon completed by social worker 1 on 31st May the previous year (see Paragraph 5.4) onto the new system as a referral for continuing social work support.

5.9 On 24th August 2006 social worker 2 submitted a referral for a support service for Karen and Simon when they moved in together. Address 1, which was a flat in a local supported housing development, had been identified as potentially suitable accommodation. The referral stated that "they are a great couple whose skills complement each other", and that both would need support with budgeting, finance, household tasks, cooking, shopping, healthcare related appointments, and independent living advice. Social worker 2 left the learning disability social work team on 31st August 2006.

5.10 On 5th October 2006 the new social worker (social worker 3) for both Karen and Simon met with Karen and her parents at their home and discussed Address 1 which Karen and Simon viewed later that month. On 23rd November 2006 social worker 3 completed an updated needs assessment for Karen and a needs summary and care plan for Simon.

5.11 In early December 2006 Karen and Simon moved into Address 1 where they were each to receive five hours support each week from Lifeways which, as previously stated, had been commissioned under *Supporting People* funding to provide housing based support. Social worker 3 left the learning disability social work team at the end of December 2006 and it would appear that no social worker was allocated to either of them thereafter.

5.12 There is no indication that the learning disability social work team disclosed, or considered disclosing, any information about Simon's previous offending history to Karen or her family.

5.13 In January 2007 the support that Karen and Simon had accessed for many years at Day Centre 1 came to an end. However, they then began accessing weekly drop in services, primarily at drop in centre 1, until Karen's death. They would also less frequently visit drop in centre 2. They both benefitted from continuity of staff from the day centre to the drop in centre provision.

5.14 On 11th March 2008 Simon began employment as a cleaner with TTB Contracts, a commercial cleaning company. A Criminal Records Bureau (CRB) check had been completed on 5th March 2008 which disclosed his convictions for wounding his sister and father and his subsequent attack on the lone female. The outcome of the CRB check was apparently discussed by TTB with Mencap, who continued to provide Simon with support, the head teacher of the First

School in Evesham where Simon would be working and Simon himself.

5.15 It was decided that Simon would initially be employed on a three month trial and his behaviour monitored by an area manager from TTB. Mencap also provided support for a time. Simon's employment was subsequently made permanent. He continued working at the First School until the murder of Karen eight years later. His hours of work were 3.15pm until 5.45pm on term time week days. The review has been advised of no problems arising from his work in the school. A further CRB check on Simon took place on 6th May 2010.

5.16 The learning disability social work team conducted annual reviews of Karen and Simon in 2008 and 2010. In 2008 the support they both received from Lifeways was reduced from five hours weekly for each of them to one hour per week each to be delivered in half hour sessions. It seems likely that this reduction was triggered by the annual review carried out in 2008. At that point it was noted that they had both successfully engaged with their support. Karen's father was recorded as saying that the couple were doing very well and that their move to Address 1 had been very successful. However, he expressed concern that their support hours had been reduced. He added that he did "not want the hours to be reduced any further as he feels that at the moment Simon and Karen still need at least that level of support."

5.17 Both Simon's and Karen's cases were closed by the learning disability social work team by 2010 (Simon) and by 2011 (Karen). Their cases appear to have been closed on the basis that no further review was required by WCC as both of them were being supported through the *Supporting People* programme. Once closed, their cases would have been monitored by WCC only as part of the collective *Supporting People* provision. It seems reasonable to assume that Simon's offending history and the long term needs he had been assessed as having in 1991 were again overlooked.

5.18 Simon and Karen had little contact with the learning disability team, which in 2011 became an integrated health and social care team, until 2015. On this occasion contact was triggered by changes to the *Supporting People* funding and the requirements of the Care Act 2014. The housing related support received by both Karen and Simon had been funded by the *Supporting People* programme which had been available to those who did not necessarily meet the eligibility criteria for adult social care funding. From 2014 the Government incorporated *Supporting People* funding into the general settlement formula for local authorities which meant that service users in receipt of *Supporting People* funded services now needed to be eligible for social care funded services in order to continue receiving support. This necessitated re-assessments of Worcestershire service users whose support was funded from *Supporting People* in order to identify if they were eligible to continue receiving this support from adult social care.

5.19 During April 2015 social worker 4 completed assessments of Karen and Simon. The assessment of Karen identified that she needed support with housing related issues, managing finances and emotional and relationship issues. It was evident from the assessment how important Karen's relationship with Simon was to her, and she acknowledged that she needed support to manage and maintain the relationship. (Simon was present during the assessment of Karen) The support plan subsequently drawn up for Karen said that she would continue to receive one hour support each week to assist with finances and correspondence, and to provide

emotional support to help Karen maintain her relationship with Simon.

5.20 During social worker 4's assessment of Simon, he said he would like to continue living as independently as possible in the community with his partner Karen. He added that the support he received from Lifeways together with support from Karen's family helped him to live independently and he wished this to continue. (Karen was present during this assessment as was a support worker from Lifeways.)

5.21 Social worker 4 noted that Simon could need a lot of support to manage and maintain his emotional health and wellbeing. Simon had said that he could become very stressed and get quite angry at times, which had caused him to experience physical symptoms such as breathlessness or palpitations. He acknowledged that when he felt stressed he could sometimes take it out on Karen and so would leave the flat as soon as he felt distressed to go for a walk in order to calm himself down. Simon added that he would like ongoing support to help him manage his temper and maintain his emotional health and wellbeing which would have a positive effect on his relationship with Karen. (Simon also had the opportunity to discuss feelings of distress with the support workers at the drop ins he and Karen attended.)

5.22 The support worker from Lifeways contributed to the assessment by saying that Simon was an explosive, loud character which was the opposite of Karen's personality. The Lifeways support worker added that Simon needed to be given space to express his feelings and resolve what it was that was concerning him before his distress or anger spilled over to other areas of his life such as his relationship with Karen. The Lifeways support worker said that Simon could speak to Karen quite inappropriately at times which could quickly upset Karen and endorsed the need for continuous support for both in this area.

5.23 The assessment process highlighted the "immense" amount of support Karen's father had provided to the couple not only in relation to finances and correspondence, but also their relationship. It was said that this support had helped Simon to realise when he was speaking to Karen inappropriately which her father would pick up on and address with Simon. (Karen's father had died in August 2014) Karen is said to have agreed that both she and Simon needed some relationship support and people they could talk to outside of their relationship who could help resolve any issues which may arise. There is no indication that Karen was offered or signposted to any services as a result of the upset Simon's behaviour could cause her. However, Lifeways made a referral to Connect Service to support Karen to find volunteering opportunities.

5.24 Simon's support plan said he would receive one hour support each week from Lifeways to help him manage his temper, emotional wellbeing and to maintain his tenancy.

5.25 Social worker 4 left the integrated learning disability team shortly after completing support plans for Karen and Simon and a request was made for new social worker(s) to be allocated to undertake follow up reviews for Karen and Simon.

5.26 On 25th June 2015 social worker 5 visited Karen to introduce herself and gather information

for a light touch review of the plan put in place following her earlier assessment. (1) (Simon was also present during this visit) It would have been good practice for this light touch review to have been carried out by the social worker who had completed the assessment for Karen in April 2015 but, as stated, social worker 4 had left the service by that time.

5.27 The following day social worker 6 visited Simon to undertake a similar light touch review of his support plan. During the review, social worker 6 advised Simon that the support he received from Lifeways, for which he was charged, was less than the amount he was being charged for. Simon came to the conclusion that he no longer needed the support and requested that this was ended. Social worker 6 advised Simon that she would end his support from Lifeways. She also recorded that Karen managed the finances with assistance from her support worker and that Simon was self-caring, and was independent in all personal care and domestic activities.

5.28 However, Lifeways support to Simon continued until the murder of Karen because the steps necessary to discontinue his support were inadvertently overlooked.

5.29 Social worker 5 subsequently visited Karen at home again as part of the light touch review of her support plan. Karen's mother and Simon were present. The outcome of the review was that Karen would continue to receive her current level of support from Lifeways which for her was not chargeable. Arrangements were also made for Karen to engage with the local Gateway Club and social worker 5 passed her case to the WCC Central Reviewing Team to facilitate future annual review.

5.30 Over the following months Karen received assistance from Connect services – which operate under the umbrella of WCC and provide free services to adults who have a disability or who are older adults. Connect supported her to explore volunteering opportunities including at a charity shop and a local cafe. Karen particularly enjoyed volunteering at the cafe and as her confidence grew was able to volunteer there without support. Karen and Simon also continued to visit the drop in centres where they were well known and had good relationships with the staff team.

5.31 On 31st March 2016 TTB Contracts were replaced by Clearview Cleaning Services as the commercial provider of cleaning services at the Evesham First School at which Simon had been employed as a cleaner for the past eight years. Simon's employment was to continue under the new commercial provider. A Disclosure and Barring Scheme (DBS) check was required. This was completed and Clearview Cleaning received notification that the check had disclosed an "issue". Simon had received the result of his DBS check and was therefore aware that it disclosed his previous offending. He was requested to attend a meeting with Clearview to discuss the outcome of the DBS check and appears to have become anxious about this.

5.32 In early April 2016 drop in support worker 1 recalls Karen and Simon visiting the centre and discussing Simon's anxieties regarding the DBS check. Simon said that the cleaning contractor at the school at which he worked had changed which necessitated a new DBS check. Simon disclosed that he had been in trouble with the police a long time ago for "pushing someone" and had received a caution. He asked the support worker whether this would show up on the DBS.

The support worker recalled Simon appearing very upset. She advised him to speak with his employer about his concerns. The support worker checked with the Connect team to see if Simon had made any similar disclosures to them which he hadn't.

5.33 On 11th April 2016 concerns over the support Simon continued to receive from Lifeways were apparently raised with the WCC Central Reviewing Team and a discussion with Simon took place. Whilst the precise nature of the discussion is unclear it may have related to the fact that Simon was receiving a chargeable service for which he was no longer paying. Karen and Simon were last seen by a Lifeways support worker on 14th April 2016 and both "appeared fine".

5.34 Also on 14th April 2016 Simon and Karen visited the drop in centre where Simon again expressed anxieties in connection with his work. These related to his tabard and some criticism of his cleaning he had received. The meeting with Clearview Cleaning to discuss his DBS check had still not taken place.

5.35 At 5.48 am on 15th April 2016 the police attended Address 1 following a call from the ambulance service. Karen had sustained a stab wound to her back and suffered a cardiac arrest and had died. Simon was present in the flat and was arrested.

6.0 Engagement with the Family of Karen

6.1 The mother, sister and brother-in-law of Karen contributed to this review.

6.2 They described Karen as very quiet and not comfortable with people she didn't know. They described the effect of her learning disability on her day to day life. Although she could tell the time, she had no conception of managing her time. For example, she would find it very difficult to meet someone, or be somewhere, at a set time. She couldn't manage money. She could identify individual coins and notes but when asked to pay for something she would offer money and ask the shop assistant to take what she owed. She also needed help in handling mail. Unless letters and forms were very uncomplicated she would need assistance.

6.3 After Karen met Simon at day centre 1, her parents invited him back to meet them and it became clear that Simon "thought the world" of Karen. However, as the relationship developed and they moved in together, Simon never introduced Karen's family to his parents and the parents of Simon and Karen only met for the first time in the past year.

6.4 When Karen moved into a flat with Simon in 2006, the family described how her father stepped in to organise all the financial matters and whenever Karen and Simon had any problems with the flat, no matter how minor, he would jump in his car and go and sort them out. The family described him as Karen's "safeguard" throughout her life.

6.5 The family said that they were a little surprised that Karen's father agreed to her moving in with Simon, but they believed he saw Karen's relationship with Simon as a way of her having support for the rest of her life.

6.6 The family said that Karen and Simon lived together for around ten years and that there appeared to be no problems between them or any indication of violence by Simon towards Karen. However, they felt that Karen would have been unlikely to tell her family even if there had been a problem.

6.7 Karen and Simon were said to complement each other. Simon could manage money and had a good sense of direction. He would help Karen with time management by setting her alarm for her. Simon was said to do nothing around the home and her family said that Karen would wait upon him "hand and foot".

6.8 Looking back at their relationship, the family were unable to can't recall anything which caused them concern. Simon had a tendency to speak for Karen much of the time. Because of this, the family understood that Karen's support worker eventually arranged to meet her away from the flat she shared with Simon, so that Karen could speak for herself. Simon was said to be the "boss" in the relationship. He organised everything.

6.9 They recalled one occasion when a family member asked Karen how her job was going and

she replied that it got her out of the house because she and Simon were always arguing. That was the only indication of problems they could recall.

6.10 The family said that they knew nothing of Simon's previous convictions until his trial for murdering Karen. They said that they were completely shocked to find out about his past, particularly the occasion on which he had attacked his sister and father. They offered the view that if Karen's father had known about Simon's past when she and Simon began their relationship, he would never have allowed them to move in together.

6.11 The family were aware of the fact that when Simon first met Karen he never drank alcohol at all although he later began drinking socially. The family wondered if he had given up drink after attacking his sister and father. (This has been confirmed to be the case by this review.)

6.12 The family said that they would like to know whether they should have been made aware of Simon's previous convictions at the time he and Karen were considering moving in together. They said that they would also like to know if Simon's support worker was aware of his previous convictions when he began his relationship with Karen. If so, what did they do? What should they have done?

6.13 The family also wonder how Simon obtained his job as a school cleaner if he was required to declare his previous convictions.

6.14 The independent author subsequently met with the family to share this report with them. They expressed themselves satisfied with the report. They said they were very concerned with the conduct of members of the WCC learning disability team in 2005 and 2006 when details of Simon's offending history were lost. They said that if they had been made aware of Simon's previous offending history, and he and Karen had remained a couple, the family would have been in a much stronger position to monitor Simon's behaviour towards Karen.

6.15 When asked what they thought should change as a result of the learning from this review, they said that staff needed to be more vigilant for signs of domestic abuse, there should be talks given to staff at drop in centres in order to raise their awareness of domestic abuse and that there should be flags on the social work files of people like Simon to ensure it was not possible for the risks they present to others to be overlooked.

Engagement with family of Simon

6.16 The family of Simon decided against contributing to this review. The family advised the independent author that they had been very fond of Karen but that her murder and Simon's conviction and imprisonment had been extremely upsetting and they did not wish to revisit these events.

Perpetrator contribution to the review

6.17 Simon agreed to contribute to this review and was interviewed at HMP Hewell. He was supported by his offender manager and the manager of the prison workshop.

6.18 Simon said that he hadn't told Karen or her family about his previous offences because he thought that if he did, they would stop him seeing Karen. He said he kept his offending secret for 15 years. (From the point at which he first met Karen until her death) He added that his mother had told him to tell Karen's parents about his past offending but he decided not to.

6.19 He described the stress he was under in the period prior to the murder of Karen. He said he had received a letter suspending his benefits. The letter said he would need to be examined by a doctor to see whether any benefits should be paid to him. However, he said that the benefits office invited him to see their doctor at an inconvenient time – 2.30pm - which would have made him late for his work at the school. He said that his employers had always told him he couldn't take any time off work. He therefore requested a different appointment time and then received a letter offering him a 2pm appointment which was again unsuitable because it could have made him late for work. (As Simon related this story he became visibly angry and frustrated) He said that a support worker from Lifeways had made a telephone call on his behalf and managed to get a suitable appointment time of 11am. He said that the Lifeways support worker drove him to the appointment but when they arrived it was cancelled because the doctor was off sick. He implied that the problem with his benefits remained unresolved at the time of Karen's murder but the precise timing and detail of the problems with his benefits were difficult to obtain from him.

6.20 (Lifeways say that they have no record of making any phone calls or accompanying Simon in respect of any issues relating to his benefits. They say that Simon appeared reluctant to share details of his financial circumstances with them. They say that they supported several service users whose benefits were being reassessed but that Simon was not one of them.)

6.21 Simon went on to say that when his benefits were stopped he was no longer able to contribute to the cost of the rent of the flat he shared with Karen. At the time of Karen's death, the couple were in arrears with their rent but this was for a relatively small amount which had accumulated following an increase in their rent in October 2015 which had not been matched by an increase in their housing benefit. The difference between the two figures was £6.15 per month. Nexus Housing contacted Simon by phone on 29th March 2016 to discuss the shortfall. Nexus has no information on any advice provided about contacting the Housing Benefit Office. It appears that the call ended when Simon hung up.

6.22 It is unclear whether this shortfall in his housing benefit which led to rent arrears was the

problem with his benefits to which he referred during his interview for this review. It has not been possible to establish whether there were issues with other benefits. Contact was made with the Department for Work and Pensions (DWP) which advised that written authority would be required from Simon in order to access his records. Delays in arranging the prison interview with Simon meant that there was insufficient time to progress matters with the DWP any further. Simon's reference to the need to be examined by a doctor suggests that there may have been problems with benefits other than his housing benefit although Lifeways have contradicted Simon's assertion that they had been assisting him in this regard. During the interview with Simon it was noticed that he could be very precise over dates but at other times he appeared to struggle to say when things happened and in what sequence.

6.23 Although it has not been possible to verify Simon's account of the stress he states he was under as result of concerns over his benefits, he went on to describe how the DBS check he was required to complete following the change in his employer affected him. He said that when he completed the DBS form he answered "no" to the question asking whether he had been in trouble with the police but he said he had meant to answer "yes". It seems he was worried that he would get into trouble for not answering this question truthfully. He said he was worried he might lose his job when the DBS check came back and revealed his previous convictions. He was worried it might be said that he was a danger to the pupils at the school where he was employed. Simon said he "liked kids" and would "never hurt them".

6.24 He said he was becoming increasingly stressed and began to drink heavily. He said he drank 6 pints of lager one night during this period although he added that that was a one-off. He said he also began gambling at this time.

6.25 During the week of Karen's murder, he said he had received a letter about his benefits on Tuesday 12th April and then the following day he had received the letter setting out the results of his DBS check which Karen had opened or seen. He said that Karen had been able to make sense of the DBS letter and discovered for the first time that Simon had a serious criminal record. This discovery led to a heated argument between them according to Simon. He said he was angry that Karen had opened the DBS letter as he had intended to tell her about his previous offences that same night. He said he shouted and screamed at her.

6.26 Simon said that the pressure had become so great that he decided to commit suicide by jumping in the river on his way home from work on the evening prior to the murder of Karen. He was unable to end his life and returned home. He said he went out again to the pub nearby and drank "a couple of pints" before returning and killing Karen during the night. He said he didn't talk to anyone about his problems. He said he had "lost his mind". He said he was angry and wanted to hurt someone.

6.27 He said his relationship with Karen had been under strain for some time. He had become friendly with a woman who lived nearby. He would visit her and spend time talking to her. He said that Karen became suspicious that he was having an affair but he said he wasn't.

6.28 Simon said he had physically assaulted Karen twice. He described striking her across the

face “about a month” before he murdered her. They had begun arguing after Karen had criticised the woman he was friendly with. Simon added that Karen was also having difficulty in working their washing machine at the time of their argument. He said he understood how to use the machine and was trying to show Karen how to use it properly and became frustrated with her. Simon said he grabbed Karen by the shoulders and struck her firmly across the face.

6.29 He said he disclosed the assault to one of his regular Lifeways support workers the following day. He said that Karen had bruising and reddening to her face but that she was unwilling to divulge what had happened. Simon said that he had told the Lifeways worker the truth about how Karen had come by her injuries. Simon said that no action was taken other than the Lifeways worker advising them to contact their service if they had disagreements in the future.

6.30 The review had not been previously advised of this allegation of assault and there is no mention of it within the IMR provided by Lifeways. If true, this represented a key opportunity to intervene in the period prior to the the murder. Lifeways were contacted and a senior manager in that service investigated the disclosure made by Simon. The worker named by Simon said she had no recollection of the incident. It has not been possible to obtain corroboration of Simon’s allegation from any other source and so this issue remains unresolved.

6.31 However, it is worthy of note that when questioned about Simon’s disclosure, the Lifeways support worker said that she could recall an incident in which bruising to Karen’s neck had been noticed by herself and another Lifeways support worker approximately six years previously. This incident was not included in Lifeways IMR and had not previously been disclosed to this review. However, the incident had been included in a statement to the police as part of their investigation of Karen’s murder. The police have now provided the review with a copy of the witness statement made by the above Lifeways support worker which reads as follows:

6.32 “About 6 years ago I worked with another support worker called….. I recall that she once asked me if I had noticed any bruising on Karen’s neck. I had not but the next time I saw her which was within a couple of days I looked and did notice that Karen had a number of prominent bruises on her neck (and) the pattern and distribution looked like finger marks to me. I cannot recall if I asked Karen about the bruises because Simon was always there but I think we did make a report about the marks which should be in their file with Lifeways, it would have been an incident and accident report”.

6.33 This appears to have been a serious incident in which Simon may have assaulted Karen by grabbing her neck. The incident was not included in Lifeways IMR. Nor is there any indication that the incident was reported to WCC as commissioners of the support provided by Lifeways or the police.

6.34 In her police statement, the Lifeways support worker went on to say that “often during support meetings Simon would twist Karen’s wrist in what used to be described as a “chinese burn” if she was trying to get the TV remote from him for example. This would cause Karen some pain but he thought it was just messing around and we used to warn him not to do it”. Again there is no mention of this behavior – which Simon appeared to engage in “often”, and in the presence

of support workers – in the Lifeways IMR or any indication that the issue was escalated.

6.35 In his prison interview Simon described the earlier occasion on which he assaulted Karen. He said that this took place “a couple of years before” Karen’s death when he blamed her for a mix up over a party they had been invited to. She had apparently cancelled their places on a minibus arranged to transport guests to the party which necessitated the booking of a taxi instead. This made Simon angry and he hit Karen in the face.

6.36 During his interview, Simon said that “I get angry easy”. He added that Karen was fully aware of this. He said that sometimes he couldn’t help himself. He said that when he was angry the female friend he referred to was able to calm him down.

6.37 During his interview, Simon appeared to speak truthfully although there was some difficulty in clarifying the points he was trying to communicate. He appeared to lack the guile to make things up although it must be acknowledged that he kept his criminal convictions from Karen and her family for many years. At times he became visibly frustrated and angry as he recalled events which had upset him such as the problems with his benefits. He appeared to lack coping strategies when under stress. When trying to resolve difficulties without support he appeared to lack problem solving skills and also a sense of perspective with which to view the problems which confronted him. The twin challenges of the DBS check which he felt put his job at risk and the suspension of his benefits which put his tenancy at risk, appeared to overwhelm him. The disclosure of his criminal convictions which he had kept from Karen for over a decade appeared to be significant for him.

7.0 Analysis

Management of the risks presented by Simon

(This section consisting of Paragraphs 7.1 – 7.14 addresses terms of reference question 11)

7.1 When Simon was convicted for the attack on the lone female in 1992 formal multi-agency management of the risks presented by violent and sex offenders did not exist. The 1997 Sex Offenders Act was the first piece of legislation which required the police and probation service to work together to monitor sex offenders. And in 2001 the Criminal Justice and Courts Act 2000 first established Multi-Agency Public Protection Arrangements (MAPPA) which were designed to protect the public, including previous victims of crime, from serious harm by sexual and violent offenders. They require the local criminal justice agencies and other bodies dealing with offenders to work together in partnership in dealing with these offenders. The core MAPPA members are the Police, Prison service and Probation service in each area.

7.2 Had Simon's offending taken place when MAPPA arrangements were in place he seems likely to have been considered to be a Category 3 offender. Category 1 relates to registered sexual offenders; Category 2 relates in the main to violent offenders sentenced to imprisonment for 12 months or more; and Category 3 relates to offenders who do not qualify under categories 1 or 2 but who are considered to currently pose a risk of serious harm. His MAPPA status could have been disclosed to potential victims such as KAREN or others such as the managers and staff – and potentially other service users –in the supported accommodation to which he and Karen moved in December 2006.

7.3 The period an offender remains a MAPPA offender varies significantly. For Category 3 offenders if it is decided that the risk of harm has reduced sufficiently or the case no longer requires active multi-agency management then an offender's MAPPA status can be terminated. Given the length of time of time without re-offending after the 1991 offence, it seems likely that, had MAPPA been in place at that time, Simon's MAPPA status would have been terminated well before he met Karen.

7.4 Criminal Records Bureau (CRB) checks were introduced in 2002, enabling the criminal background of all people who work with children or vulnerable adults in schools, voluntary organisations or professional bodies to be checked. CRB checks were replaced by the Disclosure and Barring Scheme (DBS) in 2012. The CRB process enabled Simon's previous convictions to be considered at the point at which he began work for TTB Contracts as a cleaner at a First School in 2008. From the records available to this review a meeting between the employer, the head teacher of the school and Simon, who at that time was receiving support from Mencap, took place and it was decided that Simon could begin work at the school subject to an initial three month trial period during which his conduct was monitored by a TTB Contracts area manager. It is understood that there were no concerns noted during this monitoring period.

7.5 However, employing Simon within a school environment must have represented a calculated risk. Although his working hours commenced at the end of the school day there would probably have been after school activities taking place on some days and there would certainly have been

female teachers and staff working on the school premises during the times Simon was engaged in his cleaning duties. It seems possible that those involved in the decision to employ Simon at the First School may have been unaware of the sexual element in the attack on the lone female in 1991 since the charge on which he was convicted was reduced to a Section 47 assault (actual bodily harm). However, they seem likely to have found the absence of any offending history for 17 years to have been a crucial factor in their decision.

7.6 From 2005 the possibility of Simon living independently with his girlfriend Karen began to be explored. At this time the learning disability social work team were fully aware of the offences Simon had been convicted of and had access to the psychiatric assessment of Simon carried out in 1991. However, the information about his offending history was not shared with Karen, her family, Nexus Housing, Lifeways or any other party nor was there any consideration given to sharing this information with them.

7.7 Nor did the learning disability social work team make any use of the information about Simon's offending history in assessing or managing the risks entering in a relationship with Simon presented to Karen. Nor did the learning disability team make any use of the information they held about Karen's offending history in any of the further assessments of Simon and Karen they carried out during the years the couple lived together in supported housing between December 2006 and the murder of Karen in April 2016. And when the assessments the integrated learning disability team carried out in 2015 disclosed possible signs of domestic abuse by Simon, no connection was made with the offending history of Simon contained within the file they retained.

7.8 These were significant missed opportunities to intervene which left Karen and her family completely uninformed about Simon's offending history and the risks he could present and prevented any risk management plan being put in place. The question of how this unsatisfactory state of affairs came about will now be explored.

7.9 Karen and Simon had expressed their desire to move to independent living and to share a home and future together. Crucial to achieving this was holistic assessment to identify their needs and effective person centred planning to ensure they received the right support to meet their needs. In 2005 Simon's social worker carried out an assessment of him in which the social worker documented what he described, with ample justification, as the "tremendous progress" Simon had made since attending Day Centre 1 and that he felt Simon was ready to move to independent living. However, the assessment also made clear potential risks associated with Simon's personality disorder, detailing previous physical assaults on others and the need for continued structured support to prevent a recurrence of such behaviour.

7.10 There is evidence in the learning disability social work paper files that Simon's social worker and Karen's social worker made contact and shared some information regarding Simon. However, Karen's social worker has advised the review that she had no knowledge of Simon's personality disorder and past history of physical assaults, and that if she had been made aware of this, then she would have sought advice about any potential risks to Karen.

7.11 Karen's social worker then also became Simon's social worker around October 2005. It is

assumed that Simon's paper social work file, in which his personality disorder and past offences were well documented, was passed to her at this time. Additionally, records indicate that the social worker who was now managing the cases of both Karen and Simon uploaded an assessment for Simon onto the Frameworki system which detailed his diagnosis and full history relating to the physical assaults.

7.12 This social worker has advised this review that she must not have read Simon's 2005 assessment or other historic information in Simon's social work paper file. With reference to the assessment she uploaded onto the Frameworki system, she feels that it is likely that she put Simon's 2005 assessment onto the system as a referral for continuing social work support for Simon just prior to her leaving the team but did not read the contents.

7.13 A third social worker assumed responsibility for Karen and Simon's cases just prior to their move in together and did not include any information about Simon's offending history and psychiatric report in his needs summary and support plan. It is therefore assumed that she too did not read Simon's 2005 assessment. It is also assumed that the decision to close Simon's case with the learning disability social work team in 2010 was taken without considering the information about his offending history contained in his 2005 assessment. This would have required the person making the decision to go back two assessments in the absence of any flagging system to highlight the risks Simon could present. At the practitioner learning event arranged to inform this review there was a degree of professional disagreement over how far back a social worker would be expected to check. Looking back was regarded as good practice by some whilst others felt it was unnecessary to go further back than the last assessment unless specific concerns had been brought to light. The need to adopt a proportionate professional approach was also highlighted.

7.14 Whilst it is reasonable to expect social workers to discuss cases they hand over to each other and it is reasonable to expect them to familiarise themselves with the files of cases they assume responsibility for, it is not sufficient to assume that these activities will always take place. Social workers carry very significant responsibilities including substantial case loads, many of them complex and demanding. Their working lives can be disrupted by unplanned matters which may require urgent attention. As in this case, a number of different social workers may manage a particular case over time. In all of these circumstances it is vital to have robust systems in place which limit the potential risk of the omissions observed in this case. This review has not received information about the extent to which systems were in place during the period from 2005 to 2016 to ensure that the risks presented by service users were clearly flagged on their case files, or whether any system for handover of cases from one social worker to another was in place and what role was played by management and supervision in ensuring risks presented by service users were fully visible to social workers.

Communication to Karen and her family of the risks presented by Simon

7.15 A key question for Karen's family, and this review, is if the risks presented by Simon had been appropriately considered at the point at which he and Karen were preparing to move into supported accommodation together, would it have been possible to disclose this information to Karen and/or her family?

7.16 Had this scenario arisen today, the Domestic Violence Disclosure Scheme may well have provided the means for disclosing information about Simon's offending history. The aim of the scheme is to give members of the public a formal mechanism to make enquiries about an individual who they are in a relationship with or who is in a relationship with someone they know, and where there is a concern that the individual may be abusive towards their partner. If police checks show that the individual has a record of abusive offences, the police will consider sharing the information with the person(s) best placed to protect the potential victim.

7.17 Had the scheme been in place in 2005/6 it would have been accessible to Karen's father to use it to make enquiries on behalf of his daughter had he felt any concern that Simon may be abusive to her. However, it seems unlikely that the scheme would have been accessible directly to Karen as a person with a learning disability who may have experienced difficulty in understanding the "Your right to ask" leaflet prepared by West Mercia Police.

7.18 Additionally, it is noted that the police will disclose information only if it is lawful, necessary and proportionate to do so in order to protect the person or their children from harm. Had the scheme been in place in 2005/6 it seems likely that the police would have concluded at that time that it was lawful, necessary and proportionate to disclose the information about Simon's record of abusive behaviour. However, had an application been made in 2015, when concerns began to emerge that Simon could be abusive towards Karen, the question may have arisen of how proportionate it was to disclose information about Simon's offending which was by this time, 24 years old. The police have advised this review that any application made by Karen or on her behalf would have been assessed on its merits at the time. A detailed check of Simon's offending would have been carried out including the triggers such as alcohol. Any concerns expressed by the applicant would also have been taken into account. The police advise that it is likely that a disclosure would have been made to Karen notwithstanding the lengthy period of time since Simon was known to have offended.

7.19 However, the Domestic Violence Disclosure Scheme, introduced in 2014, is a recent innovation. Going back to 2005/2006 the then WCC learning disability social work team would have owed a duty of care to Karen and had a responsibility to safeguard her as a "vulnerable adult", in the language of the period. (2) At the age of 43 she was to be supported to live independently for the first time in her life and also share her life with a boyfriend –who also had a learning disability - for the first time in her life. Whilst this had the potential to be a very positive change in Karen's life, which was supported by her family, it was acknowledged that both she and Simon would need continued support.

7.20 As well as owing a duty of care to Karen, the learning disability social work team also had a duty to handle the sensitive personal data they held in respect of Simon in accordance with the Data Protection Act 1998. In particular, any decision to share sensitive personal data held in respect of Simon would need to have been managed in accordance with the relevant code of practice associated with the above Act. Had Simon's offending history been considered at the time when arrangements were being made to support him and Karen to live independently together, it is assumed that it would have been necessary to convene a multi-agency group consisting of WCC learning disability team, the police and any providers of support and housing

to Karen and Simon. It is also assumed they would have accessed legal advice as necessary. Advice has been provided to this review by the current WCC principal solicitor that he considers that it would have been possible in 2005/6 for information to be shared about Simon's offending history with Karen and her family subject to robust evaluation and clear justification for disclosure

7.21 There is no record of any planning meetings regarding arrangements for Karen and Simon to live independently together taking place in 2005/6 although social worker 2 recalled planning meetings at Day Centre 1 prior to them moving in together but was unable to recall the details or who attended.

7.22 Whether or not a decision had been taken to share information about Simon's offending history with Karen and her family at that time, one would have expected a risk management plan to have been drawn up to monitor Simon's progress including his use of alcohol, and any evidence of domestic abuse experienced by Karen. One would have expected that any risk management plan would have been shared with key agencies such as Nexus Housing, Lifeways and Simon and Karen's General Practitioners who would then have been in a much stronger position to pick up on any indicators of domestic abuse. Any risk management plan would also have tempered the understandable optimism about the relationship which may have had the effect of obscuring risks. For example, social worker 2 recorded at that time that "they are a great couple whose skills complement each other".

7.23 However, it is unknown how long any risk management plan would have remained in place in the absence of any cause for concern being recognised. It seems possible that the indications of concern about the relationship which later came to light could have triggered greater professional curiosity had professionals been aware, and remained aware, of Simon's offending history. However, Karen and Simon lived together, apparently successfully, as a couple for nearly a decade.

7.24 One option which might have been considered in 2005/2006 would have been to support Simon to consider whether to make a disclosure. He was not known to have committed any offences for 14 years by this time. He had abstained from alcohol for a considerable period. He was said to be tee total as late as 2007. He was noted in his 2005 social work assessment to have made "tremendous progress". He clearly deserved credit for turning his life around. There would have been a risk that sharing information about his offending history could have ended his relationship with Karen. This seems to have been a risk that Simon was acutely conscious of as Karen's family has advised this review that at the time his relationship with Karen began, and thereafter, Simon appeared very reluctant for any contact to take place between his family and Karen's family.

7.25 Staff from Day Centre 1 and the drop in service which replaced it, also maintain that they were not aware of Simon's personality disorder or past history of physical assaults. They also reported that the senior manager of the centre at the time that Simon first began attending the day centre held the view that people who attended should have a "clean slate", and that any detrimental information about them might bias staff against them. It has been confirmed that the "clean slate" approach was a personal view which did not reflect policy at that time.

7.26 Social worker 1's 2005 assessment of Simon detailing his full history was kept in the Day Centre 1 paper records, however the staff interviewed for this review have said that they would not have read the assessment but would have relied on their senior manager to verbally inform them about any information they needed to know about a person attending the centre.

7.27 Following Karen's murder, Simon's mother advised the police that she had previously asked Simon's social worker whether her son's offending history should be disclosed to Karen. Simon's mother stated that a decision was made not to tell Karen. Social worker 2 cannot recall this conversation nor are there any records of the conversation taking place. As Simon's family decided not to contribute to this review it has not been possible to shed further light on this.

7.28 As previously stated the relatively limited records containing details of Simon's previous offending were carried over from earlier paper notes onto the electronic Frameworki system in 2006. However, these records do not appear to have been read by any of the social workers who carried out further reviews of Simon during the period 2006 – 2016. The WHCT IMR author has advised this review that this does not seem to be unusual practice.

7.29 Additionally Lifeways and Nexus Housing have advised this review that they have no record of any information about Simon's offending history being shared with them. Mencap, which provided support to Simon until around 2009 were advised of his offending history by the learning disability social work team on an unknown date and in a letter from Day Centre 1 to Mencap in 2000 there is reference to "the problems Simon's has had, but (that) these have never presented us with any worries".

Indications of domestic abuse and agency responses

(This section consisting of Paragraphs 7.30 – 7.47 addresses terms of reference questions 1 – 10, 14, 15, 20, 21, 22, 23 and 24)

7.30 There were many indications that Karen and Simon had maintained a positive relationship over the near decade they were supported to live independently together. Their respective strengths appeared to complement those of the other. Simon had sustained part time employment as a cleaner in the local First School since 2008 whilst Karen appeared to enjoy her role as home maker although her family expressed some concern at how little Simon contributed to domestic chores.

7.31 Throughout their lives together they both received support from Lifeways who have advised this review that they had no concerns about the relationship although they were aware of the concerns expressed by Karen's father over what were described as Simon's obsessive behaviours and also that Simon was known to raise his voice to Karen. However, following the interview with Simon to enable him to contribute to this review, further enquiries have disclosed that Lifeways support workers did have concerns about the relationship which were not adequately addressed.

7.32 Both Karen and Simon continued to regularly attend the drop in centres where the staff had got to know them well over many years. At the practitioner learning event which was held to inform this review, staff from the drop ins said that they had become aware of no indication that Karen was unhappy and saw no sign that she was in any way frightened or intimidated by Simon. They felt that Karen did not have the capacity to hide her feelings from those around her. However, the staff went on to add that there were opportunities for Karen to disclose any concerns whilst she was being supported by the Connect service to volunteer as this was time when she was not in the company of Simon. However, the staff went on to reflect that Karen did not express grief or feelings about the death of her father in 2014 despite that being perceived to be a deep personal loss to her. This caused the drop in staff at the practitioner learning event to question their earlier certainty that Karen would have disclosed concerns arising from her relationship with Simon with them.

7.33 Contact with the learning disability social work team – which became an integrated health and social care team from 2011 – consisted of annual reviews in 2008 and 2010 followed by case closure for both Simon and Karen. Thereafter their cases were managed as part of the collective *Supporting People* provision. Further reviews took place in 2015 which were triggered by changes to *Supporting People* funding and the introduction of the Care Act 2014.

7.34 When social worker 4 re-assessed Karen's and Simon's support plans in April 2015, she identified clear signs of tension between the couple. Neither social workers 5 or 6 (who carried out a follow up light touch review for Karen in July 2015) offered Karen the opportunity to meet with them without Simon being present which would possibly have enabled Karen to speak more freely about her relationship with Simon and the issues relating to his behaviour. The lack of opportunity for Karen to speak to services without Simon being present is a striking feature of this case. No formal referral or signposting was considered for Karen or indeed Simon.

7.35 Additionally there appeared to be a lack of clarity over the support Lifeways were providing as the tensions in Simon and Karen's relationship began to emerge in 2015. The assessment of Simon appeared to envisage that Lifeways would provide support to help him manage his temper and support his emotional wellbeing (Paragraph 5.24) yet Lifeways say that their support to Simon was primarily housing related support to enable him to maintain his tenancy. In any event by June 2015 social worker 6 agreed to end the support Simon was receiving from Lifeways, without apparently considering how Simon would now be supported to manage his temper and maintain his emotional wellbeing.

7.36 Lifeways always provided support to Karen in the flat she shared with Simon, and he was present for the majority of these sessions. Lifeways has described how Simon would try and take over the sessions which would lead to the support workers reminding Simon that some sessions were for him and some for Karen. Only in the two months prior to her murder had Lifeways begun organising support sessions for Karen whilst Simon was at work. This change could and should have been made earlier.

7.37 However, a Lifeways support worker contributed to the 2015 social work assessment of Simon (Paragraph 5.20) by saying that he was an explosive, loud character who needed to be given space to express his feelings and resolve what it was that was concerning him before his

distress or anger spilled over to other areas of his life such as his relationship with Karen. The Lifeways support worker said that Simon could speak to Karen quite inappropriately at times which could quickly upset Karen.

7.38 Additionally, Lifeways has advised this review that bruises were noticed on Karen's arm on an undated previous occasion in respect of which an accident form may have been submitted. They have no copy of any accident form and the support worker involved is no longer employed by them. Domestic abuse does not appear to have been considered as a potential explanation for Karen's injury.

7.39 At a very late stage in this review it came to light that two Lifeways support workers had noticed bruising to Karen's neck around six years prior to her murder. (Paragraphs 6.31- 32) The bruises had the appearance of being caused by a someone applying pressure to her neck with their fingers. It appears that Karen was not asked about how she sustained the bruising to her neck because Simon "was always there". There is no record of this injury being reported to the commissioners of the service or the police. Nor was the incident referred to in the IMR submitted to this review by Lifeways.

7.40 Also at a very late stage in the review it came to light that Lifeways support workers "often" observed Simon giving Karen what they described as Chinese burns when, for example, there was a slight disagreement over who should have the TV remote. The only action which appears to have been taken was to advise Simon to desist from this behaviour which he ignored.

7.41 Nexus Housing provided the supported housing in which Karen and Simon lived from 2006. In March 2014 they arranged for a mediator to try and resolve a dispute between Simon and Karen and a neighbour. The mediator noted concerns about the behaviour of Simon towards Karen and shared these concerns with Nexus Housing who appear to have taken no further action.

7.42 Neither the bruising on Karen's arm, the marks on her neck, the frequent Chinese burns nor the concerns of the mediator were shared with the learning disability team or generated a safeguarding alert by Lifeways or Nexus Housing.

7.43 There appears to have been little contact between Nexus Housing as supported housing provider and Lifeways as the provider of support to enable Simon and Karen to live independently and maintain their tenancy. Nexus Housing has advised this review that this lack of contact with Lifeways arose because the flat occupied by Karen and Simon was not within a designated housing scheme. There were only two properties in the scheme in which Karen and Simon lived to which they provided support. They added that small pockets of support such as this demonstrate how fragmented the care and support system can be. There also appeared to be no contact between Lifeways and the drop in service used by Simon and Karen.

7.44 One place where Karen was routinely seen on her own was at her GP surgery. There she received the annual review to which she was entitled as a person with a learning disability. The

annual learning disability review does not include a question on domestic abuse although GP's are expected to take the opportunity to sensitively question patients about domestic abuse. (3) It appears that Karen was never asked about domestic abuse.

7.45 Agencies in contact with Karen appeared to given little consideration to the possibility that she could be experiencing domestic abuse in her relationship with Simon, particularly after the death of her father. Research indicates that disabled women may be assaulted or raped at a rate that is at least twice that of non-disabled women (4). However, the statistics collected by CAADA (now known as SafeLives) about people identified as being of high risk of domestic abuse shows relatively low numbers of people with health and social care needs which suggests that for this group, domestic abuse is even more under reported or recognised than in the general population (5).

7.46 Research also suggests that there are additional impacts of domestic abuse on people with care and support needs which agencies need to be aware of. These additional impacts include increased powerlessness, dependency and isolation, and perpetrators often use forms of abuse that exploit, or contribute to the abused person's impairments (6).

7.47 Had the possible indications of domestic abuse been acted upon, it is not possible to be entirely confident that any risks she may have faced would have been adequately assessed as the SafeLives DASH checklist is predisposed to assess risks for women with children and is known to have limitations for the identification of risk factors experienced by disabled and older people (7). The importance of professional judgement is therefore reinforced for cases which fall outside the understandably dominant "women with children" focus.

7.48 The absence of professional curiosity about the experience of Karen within her relationship with Simon indicates a marked lack of awareness of domestic abuse amongst practitioners providing care and support to adults with learning disabilities. At the practitioner learning event it was evident that there was a particular lack of awareness of the broadening of the government definition of domestic abuse to encompass coercive control.

7.49 There can be little doubt that domestic abuse was present in Simon's relationship with Karen prior to her murder. In his contribution to this review he acknowledged that he assaulted her by hitting her in the face on two occasions although it has not been possible to corroborate either of these assaults.

7.50 The voice of Karen went largely unheard. Her father was a substantial protective factor but his advocacy on her behalf may have stifled her opportunity to speak for herself. And the learning disability team and Lifeways did not offer Karen an individualised approach.

Death of Karen's father

7.51 Having said that Karen and Simon lived together apparently successfully for almost a

decade, it is necessary to stress the importance of the support they received from Karen's father. His continuous availability to Karen and Simon whenever they encountered any problems, however minor, is described by Karen's family. In one social work assessment it was noted that Karen's father "provided an immense amount of support to the couple not only relating to correspondence and finances but also their relationship. This support had helped Simon to identify when he was speaking to Karen inappropriately and her father would pick up on this and address with Simon".

7.52 However, his death in August 2014 does not appear to have been regarded as particularly significant by the agencies involved in commissioning or providing support to Karen and Simon. Whilst Karen's mother and sister continued to support the couple with their finances and provided emotional support as required, it has been acknowledged that they did not have the same impact on the relationship as Karen's father. It is recognised that when people with a learning or other disability outlive the relatives who provided essential support to them, they can become particularly vulnerable. (8) This was a point at which there should have been a recognition that Karen could have benefitted from more formal support given the supportive, and in many ways protective influence her father had provided.

7.53 Lifeways provided more support with correspondence following Karen's father's death as he had previously dealt with all of the couple's correspondence.

Support provided to Simon

(This section consisting of Paragraphs 7.51 – 7.58 addresses terms of reference questions 11-13, 14 and 15)

7.54 Simon murdered Karen during a period in which he appeared to be experiencing a high level of anxiety. His transfer from the employment of TTB to Clearview Cleaning at the end of March 2016 was problematic. There appeared to be little or no information shared by TTB with Clearview about Simon's learning disability or the offending history disclosed by two previous CRB checks which had led to risk management measures being put in place, although it is accepted that 8 years had elapsed since the first CRB check. Clearview also state that when they met with staff from the First School no concerns were raised about Simon. Again the years which had elapsed since Simon began working at the school and potential turnover of school staff may have resulted in a loss of "corporate memory" of this issue.

7.55 Additionally, the DBS process differed from the CRB process it had replaced in ways which appear to have added to Simon's anxiety. The previous CRB process allowed the applicant (Simon) and his employer (TTB Contracts) equal access to the information recorded about Simon's offending history. The DBS process worked differently in that the result of the check is only provided to the applicant (Simon) whilst the employer (Clearview) would only have been advised that there was an issue to discuss. Not unreasonably, Clearview sought a meeting with Simon to discuss the outcome of the DBS check but appear to have treated Simon as a "regular" employee and not recognised that he would benefit from support in participating in a discussion about such a sensitive issue. It should also be noted that at the time Simon's CRB check result was first disclosed to his employer (TTB) and the First School in 2008, Simon was supported

through the process by Mencap.

7.56 That Simon was worried about the implications of disclosure of his offending history is evidenced by his conversation with support worker 1 at the drop in centre around a fortnight before Karen was murdered. Karen was also present. Simon appears to have played down the seriousness of his previous conviction, referring to “pushing someone” and receiving a police caution. The support worker advised him to discuss the matter with his new employer. The support worker did not share Simon’s concerns with the learning disability service although by that time Simon’s case was closed to the integrated learning disability team although a case would not need to be open for a concern to be raised.

7.57 Simon also expressed anxieties about his work when he and Karen visited the drop in centre just prior to the murder. These anxieties did not appear to specifically relate to his still unresolved DBS check, although they may have been an indication of his continued concern over the DBS check.

7.58 The unresolved concerns over the impact of his DBS check on his future unemployment appears to have been a key factor in the argument with Karen which led to Simon fatally stabbing her. In his contribution to this review, Simon confirmed this to be the case but also referred to worries over the suspension of his benefits which it has not been possible to confirm.

7.59 Although Simon continued to receive support from Lifeways until shortly before the death of Karen, this support should have ended in June 2015 when the social worker reviewing his support plan acceded to his request to stop his support from Lifeways without apparently considering of there were any implications in so doing.

7.60 By the time of the murder Simon had begin drinking again. Drinking alcohol had been considered a trigger to his previous assaults on women. It is not clear when he resumed drinking although he had previously successfully abstained from drinking for many years.

7.61 It is also worthy of note that Simon’s GP practice for much of the period he was in a relationship with Karen did not place him on their learning disability register. Apparently a coding error prevented the transfer of information about Simon’s learning disability when the GP surgery system was updated and the annual learning disability health checks were begun. A key consequence of this omission is that he did not receive the annual health checks to which a person with a learning disability is entitled. It is unclear what impact the absence of annual checks had but on his registration his GP practice in April 2007 it was recorded that he was now tee total and that he had given up alcohol because he had been in trouble with the police. The annual reviews would at least have allowed monitoring of his alcohol abstinence.

7.62 It is clear from the interview carried out with Simon for this review that he felt under substantial pressure during the weeks prior to the murder of Karen. He appears to have become overwhelmed by the implications of his previous offending history being revealed – both for his employment and his relationship with Karen – and by worries over the suspension of his benefits.

Because of his learning disability he appeared to lack the problem solving skills to resolve these issues or put them into perspective. It is very sad indeed that he was unable to access the support which could well have helped him to work his way through these problems and possibly avoided the violence which followed.

Mental Capacity

(This section consisting of Paragraphs 7.59 – 7.61) addresses terms of reference question 1)

7.63 Both Simon and Karen were deemed to have capacity although there is no evidence that either had their mental capacity formally assessed other than an assessment of Karen's capacity in 2012 to determine her capacity to consent to a health screening test. She was deemed to have capacity on this occasion.

7.64 On the basis of information shared with this review there appears to be reason to question whether Karen had capacity to manage her financial affairs which would probably not have manifested itself prior to her father's death.

7.65 It is unclear how much "agency" Karen had to make her own decisions. In her two key relationships – with her father and subsequently with Simon – she appeared to have exercised limited autonomy. Several services offered support and assistance to help her exercise greater agency and choice over her life particularly when she decided to move in with Simon and to access volunteering opportunities for example. It is unclear whether or not she was subjected to coercion or control in her relationship with Simon but there are indications that this may have been the case in 2015 and 2016.

Disability

(This section consisting of Paragraphs 7.62 – 7.67 addresses terms of reference question 25)

7.66 Since the enactment of the Disability Discrimination Act 1995, people with a learning disability have had a legal entitlement to equal access to public services. The Equality Act 2010 places a general equality duty on all public authorities. In the exercise of their functions they are obliged to have due regard to the need to:

- Eliminate unlawful discrimination, harassment and victimisation and other conduct prohibited by the Act
- Advance equality of opportunity between people who share a protected characteristic and those who do not
- Foster good relations between people who share a protected characteristic and those who do not

The second of the three aims listed above involves having due regard to the need to:

- Remove or minimise disadvantages suffered by people due to their protected characteristics

- Take steps to meet the needs of people with certain protected characteristics where these are different from the needs of other people
- Encourage people with certain protected characteristics to participate in public life or in other activities where their participation is disproportionately low.

Disability is a “protected characteristic”.

7.67 The broad purpose of the general equality duty is to integrate consideration of equality and good relations into the day-to-day business of public authorities.

7.68 All public authorities have a legal duty to make “reasonable adjustments” to the way they make their services available to people with a learning disability, to make those services as accessible and effective as possible. Reasonable adjustments may include making whatever alterations necessary to policies, procedures, staff

training and service delivery to ensure they work equally well for people with a learning disability (9).

7.69 Notwithstanding the advances made in enhancing legal rights, the past quarter of a century has seen the substantial and wide-ranging health inequalities experienced by people with learning disabilities become increasingly well documented (10).

7.70 In 2009 the Equality and Human Rights Commission (EHRC) published a report which concluded that the right to safety and security was a right frequently denied to disabled people (11). The report quotes the former Director of Public Prosecutions Ken Macdonald who said that “we must overcome a prevailing assumption that it is disabled people’s intrinsic vulnerability which explains the risk they face” (12).

7.71 The EHRC implicitly makes the point that a failure to extend the same expectation of safety and security to disabled people that everyone else enjoys is a form of discrimination.

8.0 To what degree could the homicide have been accurately predicted and prevented?

(This section consisting of paragraphs 8.1 – 8.13 addresses terms of reference question 29)

8.1 In terms of considering whether the homicide could have been predicted, the test used is that it is considered that the homicide would have been *predictable* if there was evidence from the

perpetrators' words, actions or behaviour at the time that could have alerted professionals that they might become violent imminently, even if this evidence had been unnoticed or misunderstood at the time it occurred.

8.2 In terms of the test used for preventability, it is considered that the homicide would have been *preventable* if there was evidence that professionals had the knowledge, the legal means and the opportunity to stop the violent incident from occurring but did not take the steps to do so. Simply establishing that there were actions that could have been taken would not provide evidence of preventability, as there are invariably things which could have been done to prevent any tragedy.

8.3 When Simon murdered Karen in April 2016 twenty five years had elapsed since his last known attack on a female. Until shortly before her death, Karen appears to have been unaware of Simon's offending history although she was aware of his concern over what his DBS check had revealed. Karen's family were completely unaware of Simon's offending history as were Lifeways which provided both Simon and Karen with support and Nexus Housing which provided their supported accommodation. No assessment of Simon carried out by the integrated learning disability team had made reference to his offending history or the 1991 psychiatric assessment since 2005. The drop in regularly attended by Simon and Karen retained a copy of the 2005 assessment of Simon which disclosed his offending history but the staff working at the drop ins were unaware of its contents. His previous employers TTB contracts had been made aware of his offending history by the CRB check conducted in 2008 and repeated in 2012 but he had recently transferred to new employers who were aware that his DBS check had raised an "issue" but were unaware of any detail of his previous offending.

8.4 In these circumstances it was not possible for any professionals to have predicted that Simon might become violent imminently. Staff at the drop in and Connect Services became aware of Simon's anxiety over the contents of the DBS check but when he disclosed his concerns he appears to have substantially minimised the conduct which the DBS check revealed. They could not have anticipated that his anxiety over his DBS check was behaviour that could have indicated the likelihood he could murder Karen.

8.5 However, in his interview for this review Simon disclosed that he assaulted Karen around a month before he murdered her and that the assault and the injuries inflicted were shared with a Lifeways support worker. The Lifeways support worker has no recollection of the assault. Without corroboration, this issue currently remains unresolved. If the assault did take place and it was disclosed to Lifeways then this would have represented a significant opportunity to intervene and possibly prevent the murder.

8.6 Turning to preventability, professionals in contact with Simon could have done more to ease the anxiety which Simon was feeling about the contents of his DBS check and the implications for his future employment. The support worker at the drop in could have escalated his concerns to a manager or referred them to the integrated learning disability team. The fact that Simon's case had been closed to the learning disability team for many years may have been a factor which inhibited the support worker from referring Simon to them although the learning disability team state that this should not have been a factor in deciding whether or not to refer.

8.7 Had there been better communication between TTB Contacts and Clearview Cleaning Services at the point at which the latter took over the contract for cleaning the First School at which Simon had been employed since 2008, it seems possible that the DBS check and what it potentially revealed may have been handled more effectively. And had Clearview Cleaning recognised that Simon had a learning disability and provided him with support during the process of sharing the DBS check results, this may have lessened his anxiety.

8.8 Had Simon been able to access more support and advice over the DBS check this may have prevented the murder of Karen. As previously stated, Simon has disclosed to the review that he was also worried about the suspension of his benefits. Although it has not been possible to confirm that his benefits had been suspended, Simon was clearly in a state of anxiety prior to the murder, he was drinking and says he contemplated suicide. However, the extent of his distress was not known to professionals.

8.9 There were many earlier missed opportunities to safeguard Karen from violence from Simon. The WCC learning disability social work team should have considered Simon's offending history and 1991 psychiatric report when making arrangements to support Simon and Karen to live independently together in 2005/6.

8.10 The learning disability social work team should also have considered disclosing Simon's offending history to Karen and her family at this time. One can only speculate what their reaction would have been and whether the disclosure would have prevented them moving in together.

8.11 Had they still moved in to live independently together in 2006, the learning disability social work team should have made use of the information they held about Simon's offending history and the 1991 psychiatric report to work with providers of support and accommodation to monitor the risks Simon could present to Karen.

8.12 When Karen's father died in August 2014 the significance of this loss of a substantial protective factor in Karen's life should have been recognised and additional support considered. And when potential indications of domestic abuse were picked up in the assessments of Karen and Simon conducted in 2015 there should have been greater professional curiosity and support should have been offered to Karen.

8.12 Had any of these earlier opportunities been taken then it seems possible that the murder of Karen may have been prevented.

8.14 However, Simon was not known to have offended for a quarter of a century and Simon and Karen had been supported to live independently together for nearly a decade. Their ability to maintain their relationship and their tenancy appears to have been perceived to be a "success story" which may have obscured indicators of concern.

9.0 Findings and Recommendations

Service user risk history

9.1 Whilst it seems likely that practice may have changed over the period from 2005 to 2015, this case discloses concerns about the extent to which social workers in the integrated WCC/WHCT learning disability team:

- familiarised themselves with a services user's history at the point at which a case is handed over to them from another social worker (Paragraphs 5.7, 5.10, 7.9 and 7.10 refer),
- consider previous assessments when conducting fresh assessments (paragraph 7.13),
- consider the risk history of a service user at the point of case closure or service discontinuation (Paragraphs 5.17 and 7.13)

9.2 The question of how far it is reasonable to expect a social worker to go back in examining a service user's history, including previous assessments, is an issue which provoked debate amongst the practitioners and managers who contributed to this review. There is a need for clarity on this issue and it is suggested that this may well be an issue which is wider than the WCC/WHCT learning disability team.

9.3 A related issue is whether there should be a system of flagging of risks presented by service users in order to alert practitioners to the fact that there are risks which they need to consider. However, flagging is accompanied by a number of issues such as consistency of approach, authority to apply flags, policy for weeding of flags etc. In this case Simon's history gradually became invisible as did his identified need for long term support also gradually became invisible so case closed etc.

9.4 The WCC/WHCT learning disability team has acknowledged that the questions prompted at the point of case closure need to be updated to comply with the Care Act 2014 and to include greater consideration of risk.

Recommendation 1

That Worcestershire Safeguarding Adults Board seeks assurance that clear guidance is provided to staff from all relevant agencies over the need to check previous assessments when conducting a fresh assessment.

Recommendation 2

That Worcestershire Safeguarding Adults Board seeks assurance that all relevant partner agencies have robust processes for the handover and closure of cases and effective managerial oversight of those processes.

Practitioner awareness of domestic abuse

9.5 This case also discloses a lack of awareness of domestic abuse and the specialist support services available to victims of domestic abuse amongst practitioners involved in assessing and providing support to service users with care and support needs. Practitioners from almost all of the agencies and services provided to Karen demonstrated this lack of awareness including the WCC/WHCT learning disability team, the drop in services, Connect services, Lifeways Community Care and Nexus Housing. The fact that the absence of awareness of domestic abuse was so widespread in this case suggests that there is an adult safeguarding sector wide challenge and that knowledge and awareness of domestic abuse may need to be enhanced across all those commissioning and providing services to adults with care and support needs.

9.6 Worcestershire benefits from an extensive programme of multi-agency awareness raising, campaigns and training around domestic abuse. (In 2015 Worcestershire was awarded National White Ribbon (men working to end violence against women) status. There is reported to be strong take up of multi-agency training which is currently under review in order to include a focus on coercive and controlling behavior in future. A programme of work is underway with WASB, including awareness raising through a well attended single agency conference in December 2016 and sharing profiles of types of abuse.

Alignment of safeguarding adults and domestic abuse agendas

9.7 Notwithstanding the impressive progress made in raising practitioner awareness of domestic abuse, this case suggests that there may be a need to better align the domestic abuse and safeguarding abuse agendas. Indeed, the decision to commission a joint DHR/SAR in this case has been instrumental in identifying areas in which further progress needs to be made. It is therefore recommended that Worcestershire Safeguarding Adults Board and South Worcestershire Community Safety Partnership establish a joint task and finish group to make use of the learning from this review to ensure that the safeguarding adults and the domestic abuse agendas are more closely aligned and that professional practice in respect of safeguarding adults and tackling domestic abuse is as integrated as possible. Amongst the issues that the task and finish group could consider are:

- ensuring that staff understand that many circumstances are both safeguarding situations and domestic abuse, and that they have a range of social work and legal options with which to work with people
- ensure that organisational policies, protocols and procedures about safeguarding explain the links with domestic abuse and, similarly, policies, protocols and procedures about domestic abuse refer to safeguarding.
- considering integrated training that covers both safeguarding and domestic abuse rather than treating them as separate issues.

Recommendation 3

That Worcestershire Safeguarding Adults Board and North and South Worcestershire Community Safety Partnerships request that Public Health establish and co-ordinate a joint task and finish group to make use of the learning from this review to ensure that the safeguarding adults and domestic abuse agendas are more closely aligned and that professional practice in respect of safeguarding adults and tackling domestic abuse is as integrated as possible. Amongst the issues that the task and finish group could consider are:

- *ensuring that staff understand that many circumstances are both safeguarding situations and domestic abuse, and that they have a range of social work and legal options with which to work with people*
- *ensure that organisational policies, protocols and procedures about safeguarding explain the links with domestic abuse and, similarly, policies, protocols and procedures about domestic abuse refer to safeguarding.*
- *considering integrated training that covers both safeguarding and domestic abuse rather than treating them as separate issues.*

Rule of Optimism

9.8 There is evidence that some practitioners in this case may have been affected by what has become known as the "rule of optimism" - a tendency by social workers and healthcare workers towards rationalisation and under-responsiveness in certain situations. In these conditions, workers focus on strengths, rationalise evidence to the contrary and interpret data in the light of this optimistic view. (13) The rule of optimism was evident at the time when arrangements were being made for Simon and Karen to live independently together in 2006 and the apparently problem free longevity of their relationship may have obscured indications of domestic abuse when they began to emerge in 2015.

Recommendation 4

That Worcestershire Safeguarding Adults Board and North and South Worcestershire Community Safety Partnerships ensure that the learning from this case is disseminated widely and informs single and multi-agency training and amongst other key issues, highlights the impact of the rule of optimism in this case.

Annual Learning Disability Review

9.9 There appears to be considerable benefit in incorporating a question on domestic abuse into the annual learning disability review which, in this case, provided one a the few opportunities for Karen to be seen alone by a practitioner. Simply incorporating a question would not be sufficient however. Careful consideration would need to be given to how the question could be asked sensitively. The review has been advised that plans are being put in place to include a direct question supported by easy read material to address the issue of what constitutes abuse and how to report it. It is also intended that this easy read material will be shared with learning disability champions within the NHS acute trust to enable individual discussions to take place on wards with patients.

9.10 The review noted that Simon did not receive the annual learning disability review to which he was entitled. It is therefore possible that other service users, including service users who may be vulnerable to domestic abuse or perpetrators of domestic abuse such as Simon may not be receiving their annual reviews.

Recommendation 5

That Worcestershire Safeguarding Adults Board requests local CCG's and GP Confederations incorporate questions on domestic abuse into the learning disability annual review and seeks

assurance that GP surgery staff and partner agencies receive the training and support required to enquire about domestic abuse.

Recommendation 6

That WSAB seeks assurance from local CCGs and GP Confederations and partner agencies that all patients with a learning disability are identified by their GP in order that they can receive the learning disability annual review to which they are entitled.

Engaging partners in assessments and reviews

9.11 Reviews and assessments carried out for Karen and Simon do not appear to have included consultation with all of the agencies involved in supporting them. It was good practice to involve Lifeways in the assessments of Karen and Simon carried out in 2015 but services which had known both of them very well for many years such as the drop in services were not involved. Nor were the concerns which emerged in 2015 shared with Nexus their housing provider or the aforementioned drop in staff.

Recommendation 7

That Worcestershire Safeguarding Adults Board obtain assurance that assessments of service users with care and support needs are carried out in as holistic a manner as is practicable and that all agencies providing relevant support to the person being assesses are consulted as part of the assessment.

The voice of the victim

9.12 The voice of Karen was insufficiently sufficiently heard. The majority of her interactions with practitioners took place in the presence of the perpetrator Simon. The support from Lifeways was provided to her in the presence of Simon except for the final two months of her life. The assessments and reviews of assessments carried out by the integrated learning disability team in 2015 took place in the presence of Simon. The only opportunities for practitioners to speak with Karen alone were at her GP surgery and whilst she was being supported by Connect to volunteer. It is not known what the level of Karen's knowledge and awareness of domestic abuse was. She had led a relatively sheltered life until her mid thirties. Her knowledge of intimate relationships may have been restricted to observing the long marriage of her parents and the relationships of family members. Doubtless she observed the way in which relationships were depicted in popular culture. Her single experience of being in an intimate relationship was with Simon, a relationship formed at the day centre they both attended and then formalised when they were supported to move in and live independently as a couple. It seems quite likely that she may not have seen herself as a person at risk of, or experiencing domestic abuse. It is unclear how the increased attention given to domestic abuse in the media and through high profile campaigns would have entered the consciousness of Karen and indeed any victim, or potential victim of domestic abuse who has a learning disability. It is suggested that the range of organisations which tray and raise awareness of domestic abuse – from the Government down – may need to consider how they can raise the awareness of people with learning disabilities.

9.13 It may therefore be appropriate for the North and South Worcestershire Community Safety

Partnerships to suggest to the Home Office that they consider the question of how to tailor messages about domestic abuse to victims, potential victims, and perpetrators and potential perpetrators with learning disabilities. The community safety partnerships should also review their own domestic abuse publications and consider whether "easy read" versions should be made available.

Recommendation 8

That North and South Worcestershire Community Safety Partnerships write to the Home Office to ask them to consider how to tailor awareness raising messages about domestic abuse to people with a learning disability. That those Community Safety Partnerships also review their own domestic abuse publications and consider whether "easy read" versions should be made available.

Making reasonable adjustments for people with learning disabilities

9.14 As stated earlier, all public authorities have a legal duty to make "reasonable adjustments" to the way they make their services available to people with a learning disability, to make those services as accessible and effective as possible. Reasonable adjustments may include making whatever alterations necessary to policies, procedures, staff training and service delivery to ensure they work equally well for people with a learning disability. For example, providing an easy read version of the leaflet which explains the Domestic Violence Disclosure Scheme (see Paragraph 7.17) would be a reasonable adjustment.

9.15 All agencies which have contributed to this review are invited to reflect on the services their agency provided to Karen (and Simon) and the services they currently provide to people with learning disabilities to assess what further reasonable adjustments need to be made to ensure that their services are accessible by people with a learning disability.

Services commissioned to provide care and support

9.16 Lifeways provided support to Karen and Simon for almost all of the time they lived independently together. It has become clear that their staff became aware of suspected domestic abuse by Simon and did not take appropriate action. Around six years before the murder of Karen two staff observed bruising which appeared to indicate that she had been grabbed around the neck. Karen does not appear to have been asked how she sustained the bruising. Whilst internal incident reports may have been submitted at the time, there is no record of this incident being escalated to WCC as commissioners or reported to the police. Nor was the incident included in the Lifeways IMR submitted to this review. Lifeways support staff also saw Simon inflict what they described as "chinese burns" on Karen "often". The only action taken was to advise him to desist which he ignored. Again this was not included in their IMR. And in his contribution to this review Simon stated that he assaulted Karen around a month prior to the murder and that this was reported to Lifeways. The relevant Lifeways support worker has no recollection of this incident and this matter remains unresolved at the present time.

9.17 It is recommended that WCC as commissioners of the services provided by Lifeways challenges them to produce an action plan rather more substantial than the one they have

submitted to this review (See Appendix A) and also considers how to obtain assurance that Lifeways and any provider of care and support they commission has the policies and training in place to ensure their staff take appropriate action to address domestic abuse effectively.

Recommendation 9 (single agency)

That Worcestershire County Council challenges Lifeways to produce a single agency action plan which substantially addresses their learning from this review and also considers how to obtain assurance that Lifeways and other providers of care and support have the policies and staff training in place to enable them to address domestic abuse effectively.

List of Recommendations

Recommendation 1

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Recommendation 2

That Worcestershire Safeguarding Adults Board seeks assurance that all relevant partner agencies have robust processes for the handover and closure of cases and effective managerial oversight of those processes.

Recommendation 3

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- *ensuring that staff understand that many circumstances are both safeguarding situations and domestic abuse, and that they have a range of social work and legal options with which to work with people*
- *ensure that organisational policies, protocols and procedures about safeguarding explain the links with domestic abuse and, similarly, policies, protocols and procedures about domestic abuse refer to safeguarding.*
- *considering integrated training that covers both safeguarding and domestic abuse rather than treating them as separate issues.*

Recommendation 4

That Worcestershire Safeguarding Adults Board and North and South Worcestershire Community Safety Partnerships ensure that the learning from this case is disseminated widely and informs single and multi-agency training and amongst other key issues, highlights the impact of the rule of optimism in this case.

Recommendation 5

That Worcestershire Safeguarding Adults Board requests local CCG's and GP Confederations incorporate questions on domestic abuse into the learning disability annual review and seeks assurance that GP surgery staff and partner agencies receive the training and support required to enquire about domestic abuse.

Recommendation 6

That WSAB seeks assurance from local CCGs and GP Confederations and partner agencies that all patients with a learning disability are identified by their GP in order that they can receive the learning disability annual review to which they are entitled.

Recommendation 7

That Worcestershire Safeguarding Adults Board obtain assurance that assessments of service

users with care and support needs are carried out in as holistic a manner as is practicable and that all agencies providing relevant support to the person being assesses are consulted as part of the assessment.

Recommendation 8

That North and South Worcestershire Community Safety Partnerships write to the Home Office to ask them to consider how to tailor awareness raising messages about domestic abuse to people with a learning disability. That those Community Safety Partnerships also review their own domestic abuse publications and consider whether "easy read" versions should be made available.

Recommendation 9 (single agency)

That Worcestershire County Council challenges Lifeways to produce a single agency action plan which substantially addresses their learning from this review and also considers how to obtain assurance that Lifeways and other providers of care and support have the policies and staff training in place to enable them to address domestic abuse effectively.

10.0 References

(1) Care Act guidance Para 13.15 – the first planned review should be an initial "light-touch" review of the planning arrangements 6-8 weeks after sign off of the plan in order to provide reassurance to all parties that the plan is working as intended and will help to identify any teething problems

https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/315993/Care-Act-Guidance.pdf)

(2) "No Secrets" guidance.

(3) GMC guidance on asking DA question of patients

(4)Local Government Association, (2013) Adult Safeguarding and Domestic Abuse: A guide to support practitioners and managers retrieved from

http://www.local.gov.uk/c/document_library/get_file?uuid=5928377b-8eb3-4518-84ac-61ea6e19a026&

(5) ibid

(6) ibid

(7) ibid

(8) Reference to people with care and support needs outliving their support systems

(9) "The Essential Guide to the Public Sector Equality Duty" (2014) Equality and Human Rights Commission retrieved from:
http://www.equalityhumanrights.com/sites/default/files/publication_pdf/PSED%20Essential%20Guide%20- %20Guidance%20for%20English%20Public%20Bodies.pdf

(10) "Reasonable Adjustments for People with a Learning Disability in England" (2010) Learning Disabilities Observatory retrieved from:
http://www.improvinghealthandlives.org.uk/uploads/doc/vid_10118_IHaL%20NHS%20Trust%20Reasonable%20Adjustments%20survey%202010.pdf

(11) "Promoting the Safety and Security of Disabled People" (2009) Equality and Human Rights Commission retrieved from:
http://www.equalityhumanrights.com/sites/default/files/documents/research/promoting_safety_and_security_of_disabled_people.pdf

(12) ibid

(13) Learning Lessons from Serious Case Reviews 2009-2010 -Ofsted

11.0 Appendix A - Single Agency Recommendations:

Clinical Commissioning Group

- Flagging or highlighting of significant risk histories on transfer from GP practice to GP practice.

Nexus Housing

- Following production of final report and SAR/DHR concluding to share findings with Group Head of Policy and Strategy to ensure any learning points are incorporated within our procedures.
- Review of ASB procedures to incorporate all aspects of safeguarding
- To ensure all agencies are involved and information shared on ASB issues where we know that the customer has other agencies involved with them
- Highlight the issue of DV across our customer base
- Housing officers being more mobile and out and about on our estates

Worcestershire County Council / Worcestershire Health and Care NHS Trust

- To improve knowledge, skills and competence in relation to assessment support planning and reviewing practice with a focus on:
  - Assessment as an intervention in its own right
  - Identification of the totality of the person's needs including knowledge and awareness of previous assessments and interventions
  - Full consideration of risk and safeguarding issues
- To improve professional supervision with a focus upon reflective practice and accountable decision making
- To improve knowledge and understanding regarding domestic abuse
- To improve the quality of reviews

Worcestershire Health and Care NHS Trust

- The Trust must have a robust system for alerting staff to patients with a history of violent behaviour that may put others at risk.

- The management of risks associated with transferring key historical data during moves to new record keeping systems should be discussed and actions agreed at the Integrated Safeguarding Committee

Lifeways Community Care

- Review and update of support plans for all service users

Clearview Cleaning Services

- Improve layout of DBS risk assessment

No recommendations:

- Worcestershire Acute Hospitals Trust
- West Mercia Police
- TTB Contracts

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

This combined Domestic Homicide Review and Safeguarding Adults Review largely followed the statutory guidance which applies to the former type of review.

A joint DHR/SAR Panel was established to oversee the work necessary to conduct the combined review. The membership of the Panel was as follows:

Operations and Integration Manager (South), Worcestershire County Council
Head of Safeguarding, Worcestershire Acute Hospitals NHS Trust
Area Manager, Lifeways Community Care
Assistant Director, Nexus Housing
Safeguarding Services Manager, Worcestershire Health and Care NHS Trust - enabled the panel to access specialist advice on learning disability from the service
Detective Constable, West Mercia Police
Head of Safeguarding, Designated Nurse for Safeguarding, Clinical Commissioning Groups
Director, TTB Contracts Ltd.
Director, Clearview Cleaning Contracts Ltd.
Deputy Head of the National Probation Service for West Mercia
Community Safety and Resilience Manager, South Worcestershire Community Safety Partnership
Advanced Public Health Practitioner, WCC (Domestic Abuse lead for Worcestershire)
Co-ordinator, Worcestershire Safeguarding Adults Board
David Mellor Independent Chair of Panel and Author

The Panel determined the terms of reference for the review and the time period which the review

would cover. Individual Management Reviews (IMR) were commissioned from the following agencies:

- Clearview Cleaning Services Ltd.
- Lifeways Community Care
- Nexus Housing
- Redditch and Bromsgrove CCG, South Worcestershire CCG and Wyre Forest CCG on behalf of the victim and perpetrator's General Practitioner.
- TTB Contracts
- West Mercia Police
- Worcestershire Acute Hospitals NHS Trust
- Worcestershire County Council
- Worcestershire Health and Care NHS Trust

All IMRs were completed to at least a satisfactory standard although some agencies were unfamiliar with the DHR/SAR process and required varying degrees of support. Many IMRs were thorough and searching.

A practitioner learning event was held at which managers, practitioners and volunteers who had been involved in the case were invited to comment on an early draft of the DHR/SAR overview report and contribute their views on emerging learning themes and the changes which needed to be made as a result of learning from the review.

The family of the victim met with the independent author and provided their account of this tragic event. The independent author later met with the victim's family to enable them to read the final draft of this report and make any further comments they wished to make. The SAR/DHR Panel is very grateful for the contribution of Karen's family to this review.

The family of the perpetrator were also approached to ascertain whether they wished to contribute to the review. They decided not to do so.

The SAR/DHR Panel decided that it would be beneficial to provide the perpetrator with the opportunity to contribute to the review.

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

13.0 Appendix C – Statement of Independence

The independent chair and author David Mellor was a police officer in Derbyshire Constabulary, Greater Manchester Police and Fife Constabulary between 1975 and 2005. He retired as a Deputy Chief Constable.

Since 2006 he has been an independent consultant. He was independent chair of Cheshire East Local Safeguarding Children Board (2009-2011), Stockport Local Safeguarding Children Board (2010-2016) and Stockport Safeguarding Adults Board (2011-2015).

Since 2012 he has been an independent chair/author/lead reviewer of a number of Serious Case Reviews, Safeguarding Adults Reviews and Domestic Homicide Reviews.

He has no current or previous connection to any agency in Worcestershire.