

Domestic Homicide Review

Joyce Jackson/2015

Overview Report

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Commissioned by:
Kent Community Safety Partnership
Medway Community Safety Partnership

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1 Introduction

- 1.1 This domestic homicide review examines agency responses and support given to Joyce Jackson, a resident of Thanet, prior to the point of her death on 27th December 2015.
- 1.2 In addition to agency involvement the review has also examined the past to identify any relevant background or trail of abuse before the homicide, whether support was accessed within the community and whether there were any barriers to accessing support.
- 1.3 Joyce Jackson died in hospital as a result of injuries inflicted upon her by three brothers named David, Sean and Dean Rose. Sandra Wilson (the mother of the Rose Brother's), befriended Joyce sometime in 2012 and later she moved into her council house in Thanet. The brothers at various times also resided at the house as did Dean's girlfriend, Kelly Cox. Over a period of time preceding her death, Joyce, who suffered from physical and mental health problems, was subjected to abuse and theft at the hands of these brothers. In November 2015, the Rose Brother's assaulted Joyce by practicing wrestling moves upon her and generally subjecting her to bullying and demeaning behaviour. Following this assault, Joyce was taken to hospital where she remained until her death some six weeks later. The three brothers were initially charged with assault and later murder. In July 2016, they were convicted of murder at Crown Court and received life prison sentences.
- 1.4 This Overview Report articulates the collective findings of the Kent Domestic Homicide Review Panel who, in the main, have based their findings on a number of Individual Management Review reports (IMR'S) produced by representatives of organisations that had contact or involvement with Joyce Jackson and with David, Sean and Dean Rose, Sandra Wilson and Kelly Cox.
- 1.5 On 21st October 2016, the Review Panel met to decide terms of reference when it was agreed the review should concentrate on the period from the 1st January 2012 (the approximate time Sandra Wilson first befriended Joyce) to the time of Joyce's death in December 2015. Terms of reference made clear that relevant events occurring prior to 2012 should also be summarised in the IMR.
- 1.6 The key purpose for undertaking a DHR is to enable lessons to be learned from homicides where a person is killed as a result of domestic violence and abuse. In order for these lessons to be learned as widely and as thoroughly as possible, professionals need to be able to

understand fully what happened in each homicide, and most importantly, what needs to change in order to reduce the risk of such tragedies happening in the future.

2 Timescales

The Domestic Homicide Review began on 21/10/2016 and was concluded on 18/07/2017. There was a substantial delay prior to the notification to the Community Safety Partnership (CSP). The delay was due to the case initially being considered by the Safeguarding Children Board before being passed to the Adult Safeguarding Board. The Adult Safeguarding Board considered the circumstances of the case under the Safeguarding Adult review (SAR) criteria. The SAR core group deemed it not to have met the criteria for a SAR but did meet the criteria for a DHR; it was at this point the CSP was notified and a decision taken by the Chair of the CSP to commission a review. Additionally, there has been some delay in submitting this report due to the number of perpetrators and the extensive involvement of several agencies. In total 12 IMR's have been completed together with 2 shortened reports. Their preparation and analysis by necessity has taken somewhat longer than usual.

3 Confidentiality

The findings of this review are confidential. Information is only available to participating officers/professionals and their line managers. Pseudonyms have been used in the report to protect the identity of the individuals involved

4 Terms of Reference

Written Terms of Reference were produced and can be found at Appendix A.

Terms of reference make clear that Domestic Homicide Reviews are primarily conducted for the following reasons:

- To establish what lessons are to be learned from the domestic homicide particularly regarding the way in which local professionals and organisations work individually and together to safeguard victims.
- To identify clearly what those lessons are, both within and between organisations, how and within what timescales they will be acted on, and what is expected to change as a result.

- To apply these lessons to service responses including changes to policies and procedures as appropriate.
- To prevent domestic violence and abuse homicide, and improve service responses for all domestic violence and abuse victims and their children through improved intra and inter-organisation working.
- To highlight good practice.
- To contribute to a better understanding of the nature of domestic violence and abuse.

5 Methodology

5.1 As mentioned above a DHR Core Panel Meeting was deemed unnecessary as the main agencies were represented at the Adult Safeguarding Board meeting. The agreement to hold a DHR was ratified by the Chair of the Kent Community Safety Partnership and the Home Office was informed in accordance with established procedure.

5.2 The main focus of this review has been on Joyce, however the perpetrators of her murder (David Rose, Sean Rose and Dean Rose) and two individuals associated with them (Sandra Wilson and Kelly Cox) also feature in accordance with the Terms of Reference.

5.3 The IMR's, on which this overview report is based, have been completed on a prescribed template and by the organisations that had contact with Joyce, David Rose, Sean Rose, Dean Rose, Sandra Wilson and Kelly Cox. IMR authors have based their information and conclusions on a scrutiny of relevant documentation and by interviewing members of their organisations

5.4 The Review Panel met on three occasions, first on the 25th January 2017 to consider the IMRs and subsequently on the 21st April and 12th May 2017 to consider the draft overview report.

A glossary of abbreviations and acronyms is included at Appendix B.

6 Involvement of Family, Neighbours and Support Groups

- 6.1 Joyce had two brothers and a sister who were kept informed of the homicide investigation by a trained Police Family Liaison Officer. On 28th October 2016, the Independent Chairman wrote to these family members informing them that this review would be taking place, explaining the DHR process, giving contact details of the Chairman and how they would be consulted prior to the publication of any findings. This letter was personally delivered by the Police Family Liaison Officer.
- 6.2 On 7th March 2017, the Independent Chair and the police Family Liaison Officer visited Joyce's sister and her husband at their home address. The sister, by agreement said she wished to represent the other family members. This meeting was arranged through the police Family Liaison Officer. The sister was again reminded of the DHR process and the terms of reference were explained. She was informed that, following the preparation of reports from the various organisations involved, the review panel had met, and findings were discussed. The Chairman summarised the main scope of the review and the sister agreed they accorded with her own areas of concern. A summary of the sister's observations is contained within the 'conclusions' section of this report. On 17th July 2017, the Independent Chair visited Joyce's sister and read through with her the salient features of the Overview Report. She chose not to take a copy but was content all the issues with which she was concerned had been covered and was pleased with the recommendations.
- 6.3 *Oh behalf of the Domestic Homicide Review Panel, the Author would like to extend his sincere condolences to Joyce's family members and thank them for the assistance they have given in conducting this review.*
- 6.4 Leading up to her death, the two immediate neighbours of Joyce contacted both the Police and East Kent Housing making a diversity of complaints about anti-social behaviour emanating from her address. On 7th March 2017, these two neighbours were visited by the Independent Chair and have been informed of the DHR in a similar way to family members (see above). One neighbour expressed reservations about participating in the review process whilst the other shared his concerns with the Independent Chair. These concerns are alluded to in the 'conclusions' section of this report.

7 Contributors to the Review

7.1 IMR authors were independent of any operational or supervisory involvement in this case. Each IMR has been signed off by a senior manager from the various organisations involved. Each of the following organisations completed an IMR report:

- Kent Police
- East Kent Housing
- Thanet District Council
- Kent and Medway NHS and Social Care Partnership Trust
- East Kent Hospitals NHS University Foundation Trust
- South East Coast Ambulance Service (SECAmb) NHS Foundation Trust
- Kent Specialist Children's Service
- Medway Children's Service
- Medway Adult Services
- NHS Thanet Clinical Commissioning Group (CCG)
- National Probation Service incorporating Kent, Surrey and Sussex Community Rehabilitation Company (KSS CRC)
- Kent Youth Offending Team
- Kent Adult and Social Care and Health (Shortened report only)
- Oasis (Shortened report only)

7.2 Joyce also attended a mental health support group called Speak Up the manager of which has expressed an interest in the review. The Independent Chair has spoken with the manager of this organisation and the DHR process has been fully explained.

7.3. On 7th March 2017, the Independent Chair visited the Offices of Speak Up and discussed with a manager the progression of the review and whether this organisation could contribute towards its findings. It was established Joyce visited this organisation on a regular basis it providing a place in which she could relax. The manager said that although Joyce visited shortly before her death she did not complain of abuse or any problems at her home. Joyce's interaction with this group does not add relevant factual information to the review, although the conclusions and recommendations reached may aid this organisation in the future. It was explained an anonymised version of the report would be published.

8 The Review Panel Members

The Review Panel consists of an Independent Chair and senior representatives of the organisations that had relevant contact with Joyce, David, Sean and Dean Rose, Sandra Wilson and Kelly Cox. It also included a specialist domestic abuse worker from the local voluntary sector and a senior member of the Kent and Medway Community Safety Team.

The members of the panel are:

Sallyann Baxter	-	Thanet CCG
Joanna Beckingham	-	Thanet District Council
Jacky Fearon	-	Medway Adults Services
Pamela Flight	-	Kent Police
Tina Hughes	-	National Probation Service (incorporating KSSCRC)
Iva Kosovo	-	Medway Children's Services
Carol McKeough / Annie Ho	-	Kent Adult Social Services
Shafick Peerbux	-	Kent County Council Community Safety
Bob Porter	-	Thanet District Council
Paul Startup	-	Kent Children's Services
David Stevens	-	Independent Chair
Liza Thompson	-	Domestic Abuse Representative (SATEDA)
Deborah Upton/ Matt Gough	-	East Kent Housing
Barry Weeks	-	Early Help – Youth Justice, KCC
Cecelia Wigley	-	Kent and Medway NHS and Social Care Partnership Trust

9 Author of the Overview Report

The Independent Chairman and Author of this report is a retired senior police officer who has no current association with any of the organisations represented on the Review Panel. He is the former head of the Kent Police Public Protection Unit and as such was responsible for domestic abuse policy and operational activity. He retired as a serving officer in 2003 and from this time until April 2016 was employed by the Kent Police to complete DHR IMR's, Serious Case Reviews (child and adult safeguarding) together with contemporary and historic homicide reviews. The Independent Chairman has also undergone Home Office DHR e-training. Since retiring in April 2016, the Author has had no professional association with either the Kent Police or any other police force, thus ensuring his independence in conducting this review.

10 Parallel Reviews/Enquiries

- 10.1 Following Joyce's hospitalisation and subsequent death, the police mounted a homicide investigation resulting in the arrest, charging and conviction of the Rose Brother's. The criminal investigation has now been concluded. In accordance with standard practice, the Coroner opened and adjourned an inquest pending the outcome of criminal proceedings. The Coroner has been informed of this review by the chair of the Kent Community Safety Partnership.
- 10.2 The Author/Independent Chair is aware that East Kent Housing carried out an internal review of this case prior to the commissioning of this DHR. The findings of this review are articulated in the EKH IMR and the relevant points have been incorporated in this overview report.
- 10.3 As far as the Author is aware, no other reviews or investigations have or are taking place with regard to this case. It has been recognised by the Review Panel that issues may arise which do not specifically relate to domestic abuse policy or working practice e.g. adult and child safeguarding, mental health and offender management; there was an expectation that this DHR would address these issues as they applied to the death of Joyce Jackson.

11 Equality and Diversity

Joyce, a white British woman, suffered from mental health issues and much of this report concerns the access she had to mental health services. Her gender and age have also been taken into account when reviewing and contextualising the actions of agencies.

The perpetrators were all white British males and as can be seen had a range of mental health, drugs and alcohol problems together with learning difficulties. Sandra Wilson was a white British woman as was Kelly Cox.

12 Dissemination

This overview report will be shared in accordance with the Kent and Medway Domestic Homicide Review Protocols and be made publicly available on the websites of the Kent and Medway Community Safety Partnership.

13 Background Information (The Facts)

- 13.1 At 12.45 hrs on 17th November 2015, SECAMB attended Joyce's home address in response to a call from a 'friend' who was concerned for her welfare. Joyce was taken to hospital where she was found to be suffering from serious injuries including a fractured spine, ribs, a damaged pelvis and extensive bruising. Joyce was later admitted to Kings College Hospital in London, and on the 27th December 2015 she tragically died as a direct result of these injuries.
- 13.2 It was established that David Rose, Sean Rose and Dean Rose had been residing at Joyce's address and, during the evening prior to her hospitalisation, for over six hours had systematically subjected her to a vicious assault.
- 13.3 A Home Office forensic pathologist carried out a post-mortem examination on Joyce's body and concluded her death was caused by complications arising as a direct result of the blunt force injuries to the chest received during the assault.
- 13.4 It was established that Sandra Wilson had previously befriended Joyce and some months prior to her death had moved into her house. She was followed by her three sons who periodically also began living at and visiting the address. At the time of Joyce's hospitalisation the three

Rose Brothers, their mother (Sandra Wilson) and Dean Rose's girlfriend (Kelly Cox) were all residing at the house.

- 13.5 In July 2016, the Rose brothers were found guilty of murder at Crown Court and received life sentences (23 year tariff).

14 Background of the Victim, Perpetrators and Significant Others

14.1 Joyce

14.1.1 Joyce was aged 54 years at the time of her death. She was unmarried and lived with her father until he died in 1991. Her mother left the family home when she was 11 years old. She had no children. Joyce continued to live in the same Thanet Council owned two bedroomed house until her death. She has two brothers and a sister who in recent months saw her rarely, but in the past had helped with her mental health problems.

14.1.2 For several years concerns had been raised by the various organisations contributing to this review regarding Joyce's mental health, and her increasing dependency and abuse of prescribed medication. Joyce alternated between receiving help from her GP and specialist mental health services. In addition to her dependency on prescribed drugs, she was also diagnosed as bipolar and suffering from depression. It would appear that from time to time Joyce had problems with alcohol and in 1998 she was arrested for being drunk and disorderly.

14.1.3 In 2013, Joyce experienced another down turn with her general wellbeing, living standards and hygiene giving cause for concern. At this time her family were able to provide her with support in conjunction with her GP and mental health services. Things improved when Joyce was receptive to receiving such support but then she relapsed entering a cycle of ups and downs in her wellbeing

14.1.4 Joyce had a number of issues going on in her life prior to the time frame of this review. She often presented as being in control of her life whereas on other occasions she was clearly very fragile and 'vulnerable' (even though not technically defined as such by the authorities). It is with this backdrop Sandra Wilson and later her sons entered Joyce's life.

14.2 Sandra Wilson

14.2.1 Sandra was aged 39 years at the time of Joyce's death. She had three sons (David 26/06/1992, Sean 15/07/1995 and Dean 03/08/1996) by her estranged partner from whom she had separated several years prior to the events subject of this review. Sandra befriended Joyce sometime in 2012 and moved into her house approximately two years prior to the events which led to Joyce's death. It was some time later that her sons moved into or began frequenting the house.

14.3 David Rose

14.3.1 David was 23 years of age at the time of Joyce's death. He was single, unemployed and had learning difficulties. He was supported by Medway Social Care Services both as a child, a care leaver and as a vulnerable adult. The Rose Brother's led chaotic life styles involving care/social placements punctuated with dysfunctional family contact.

14.3.2 David Rose first came to Police notice in March 2003 having been hurt during a domestic incident between his mother (Sandra Wilson) and her partner. David has a number of convictions but other than the murder of Joyce and an incident in 2006 when he was aged 16, none of these were for violent offending. The majority of his convictions were for theft and date from 2006 to 2016.

14.3.3 In 2010, David became 18 and at this time was residing in supported accommodation. In 2012, David went to live with his aunt in Thanet, but this relationship broke down due to his violence and drug taking. Even though David moved from Medway, as a care leaver he still remained the responsibility of Medway Social Services.

14.3.4 David was deemed to be a vulnerable adult with a learning disability and an IQ of 50-55, which in 2013, resulted in a referral being made to Medway Adult Services. He was deemed to be at risk of exploitation and emotional abuse. David also had a drug and alcohol addiction problems which included taking legal highs.

14.3.5 In February 2014, David was sent to prison and was released in April 2014. Upon his release efforts were made to find him accommodation. In November 2014 he was sent to prison again for theft and causing criminal damage, and upon release was found accommodation through Medway Council Home Choice, but was subsequently evicted for smoking cannabis on the premises. He was deemed to have made himself intentionally homeless and the housing providers discharged their responsibilities towards him.

14.3.6 Due to his identified vulnerability and learning difficulties David was placed under the Medway 0-25 Disability Team and efforts were made by his social worker/Personal Advisor to find him accommodation, but the service found the level of engagement challenging. In June 2015 David was deemed to have mental capacity and he was formally discharged from the 0-25 Disability Service.

14.3.7 It is not clear whether David was actually living at Joyce's house at the time of the assault or whether he was a visitor. Either way his background and circumstances at that time made him a potential threat to Joyce's safety. Unlike his brothers, David was not under the purview of any of the agencies and in essence could live where ever he wished.

14.4 Sean Rose

14.4.1 Sean was 20 years of age at the time of Joyce's death. He, like David, was single, unemployed and had issues going on his life which attracted the attention of the Medway Social Care Services. Sean Rose first came to the notice of the police in 2003 having been reported missing by his father, then in 2004, when he was 9 years old, as a victim of assault by his stepmother. Sean has several convictions the majority of which were for theft. He has received prison sentences and indeed was released from prison shortly before the assault on Joyce. He also has a history of drug taking and alcohol abuse.

14.4.2 Sean Rose like his brothers led a very dysfunctional life as a child. He lived with his mother and later his father, and in 2004 became a looked after child (LAC) and was placed into foster care by Medway Children's Services. In 2006 he was temporarily returned home and by 2007 was back in foster care. At this time he was assessed as violent having assaulted his female foster carer. He was also assessed as a risk to himself and others and also at risk of abuse and sexual exploitation. In 2007 he was also assessed as having the emotional age of a 2 to 3 year old. In addition to foster care, Sean had also resided in specialist accommodation.

14.4.3 Sean turned 18 in July 2013 and was then made subject of the 18 plus scheme and was allocated a Personal Advisor. It was acknowledged he was a vulnerable adult and highly likely to reoffend. Since this time he has been to prison and there were periods when his whereabouts was unknown. Efforts were made to find him supported accommodation but largely through his own actions these did not materialise.

14.5 Dean Rose

14.5.1 Dean Rose was 19 years old at the time of Joyce's death and was the youngest of the three brothers. He too had issues going on in his life resulting in him coming under the purview of Kent Social Care Services. At the time of Joyce's assault/death he was staying in her house with his pregnant girlfriend Kelly Cox. Dean first came to the notice of the Police in 2005 when a referral was made to Social Services along with the other children in the Wilson family. He has a number of offences recorded against him the majority relating to thefts. Other than the offences relating to the death of Joyce Jackson, he has one conviction for an 'offences against the person' (common assault in 2013). Dean also had issues with drugs which included both illegal substances and legal highs.

14.5.2 Dean had a troubled upbringing and lived with his grandmother who in 2008 made a referral to Kent Children's Services as she was struggling with his behaviour. He lived with his grandmother until 2013 when she asked him to leave their home due to him 'being in trouble' and being beyond parental control: he was then accommodated by the Local Authority. In August 2014, he turned 18 and was transferred to the 18 plus scheme.

14.6 Kelly Cox

Within the context of this review Kelly is not seen as a significant party to the events leading up to Joyce's death, and as such reference to her within this DHR is minimal.

15 The Facts and Analysis of Organisations Involvement

15.1 Introduction

15.1.1 In order to fully understand the circumstances leading to the death of Joyce Jackson it has been necessary to review the activities of a number of organisations who had contact with Joyce, the Rose Brother's and to a lesser extent Sandra Wilson and Kelly Cox. Each of these organisations were required to complete an IMR. This section summarises and analyses the factual information contained in each of these reports.

15.2 Kent Police

15.2.1 Kent Police had far more dealings with Sandra Wilson and her sons than with Joyce Jackson. Much of this contact did not involve Joyce and concerned the dysfunctional, anti-social and criminal activities of Sandra Wilson and her son's David, Sean and Dean Rose.

15.2.2 Throughout the time parameters of this Review (01/01/2012 to 31/12/2015), there were a total of 26 incidents or calls that can be linked by association to Joyce or her address. Of those 26, Joyce was recorded as a victim on 5 occasions. There was one call of concern for her. All other incidents either made no reference to Joyce or a record was made that she was present during an incident involving others. The one call related to Joyce that was listed as anti-social behaviour was logged against the caller's details who was recorded as a 'victim'.

15.2.3 The first time the police had contact with Joyce in relation to Sandra Wilson was on 25th November 2012 when she reported that Sandra had stolen property from her home. Sandra was dealt with by way of 'restorative justice' and was told to stay away from Joyce's home. In the circumstances this was an appropriate course of action.

15.2.4 On 18th November 2014, Joyce reported to police that Sandra Wilson had stolen her phone and that damage had been caused to her house. When police arrived others were present including Sean Rose; the report states it was apparent all present had been drinking. Sandra was arrested and during interview stated she had mistakenly picked up the phone and the damage was almost incidental to her drunkenness. Sean Rose provided a statement to police as a witness. There was no evidence to support a prosecution and in the circumstances this incident was dealt with appropriately.

15.2.5 Between December 2013 and December 2014 Police were called to Joyce's house on four occasions relating to incidents involving Sandra and her sister and on one occasion involving Sandra and her son. These incidents were dealt with appropriately and did not overtly involve Joyce.

15.2.6 On 14th January 2015, a neighbour reported anti-social behaviour at Joyce's address. This incident was passed to the Police Community Safety Unit¹ and on the 22nd January 2015 was recorded on the police anti-social behaviour IT system, known as Themis. The incident was managed over a period of two months by a PCSO and a Housing Officer. On the 26th February 2015, the PCSO and the Housing Officer spoke to Joyce at her home. It was noted there was damage to the property which Joyce attributed to Sandra Wilson. She also explained that Sandra Wilson was a friend who at that time was

¹ The Police Community Safety Unit is a Thanet based police group of supervisors, officers and PCSO's working on community issues and based at the local police station. It should not be confused with the Thanet Community Safety Unit which is a multiagency group administered by the district council. The Police CSU and the Thanet CSU usually have a daily meeting to review overnight crime and ASB with a view to joint problem solving.

homeless and living at the property. Joyce was advised that Sandra Wilson should not be living in her house. Joyce was described within the police record as, 'quite vulnerable and making excuses for Sandra.' A further visit was made on 15th March 2015 when Joyce was advised that Sandra Wilson could stay at the house but the Housing Officer would review this on a monthly basis. On 17th March 2015 this record was closed by the Police Community Safety Unit Sergeant at the request of the PCSO, who recorded that, having checked with the housing authority, there had been no further reports of anti-social behaviour.

15.2.7 As stated, the aforementioned incident was 'managed' over a period of two months during which time there were three further calls or information reports linked to Joyce's address. On the 20th January 2015 there was a report relating to Sandra Wilson's drunken behaviour, and that Joyce was present in the house. On 29th January 2015, a neighbour made a further call expressing concern for an 'elderly female' at the address (Joyce) who he considered to be at risk from a male who was giving her drugs. This call perhaps gave a further indication of Joyce's vulnerability. In response to this call officers attended and spoke with Joyce who said she self-medicated and was safe. Joyce advised officers that Sandra Wilson was her friend and was staying with her as she was homeless. Officers were satisfied with this and reported that Joyce was safe, basing this on her presentation at the time. The third information report was dated 18th February 2015 and related to the arrest of a known drug user. He stated he was 'sofa surfing' at Joyce's address with Sandra Wilson. This arrest did not take place at Joyce's house, but the address given by the drug user caused the association to be made within police records.

15.2.8 On 25th March 2015, Joyce reported that Sean Rose had stolen property from her house. The police report states that Sean Rose was the suspect and Dean Rose as being present at the time. Joyce ultimately declined to pursue any prosecution as Sandra Wilson had told her she would replace the stolen property. Joyce was advised to contact the police again should she feel threatened or discovered any further property missing. It was recorded that Sandra Wilson was living at the address and the two Rose Brothers had been staying overnight.

15.2.9 The police attended this as a 'diary call' two days after the report was made. Attending officers considered Joyce was lonely and the presence of Sandra Wilson was a positive. Joyce assured the attending officers, that to avoid a reoccurrence she would not be letting Sean and Dean Rose back into her house.

15.2.10 Prior to the fatal assault the Police received allegations from Joyce that Sandra and at least one of her sons were stealing her property however there were no reports that she was being physically assaulted. Joyce's reluctance to support a prosecution was not unexpected and is common in such domestic settings. This reluctance should not be regarded as a criticism, or that her allegations were in any way false; victims are often influenced by things such as fear or misguided loyalty. A victim's unwillingness to give evidence is not always a bar to prosecution but in this case a prima facie case² could not be established without Joyce giving evidence. The Police would also have taken into consideration Joyce's wishes even if criminal offences could have been proven.

15.2.11 On 3rd April 2015, Joyce reported a domestic incident at her home address between Sandra Wilson and Sean Rose. Prior to police arrival Sean had left and there were no reported offences. The attending officers reported no vulnerability issues in relation to Joyce.

15.2.12 On 28th April 2015, a domestic incident occurred at Joyce's address between Sandra Wilson and Dean Rose. During this incident Dean assaulted Sandra Wilson and caused damage to Joyce's property. Sandra Wilson subsequently withdrew support for a prosecution; she advised officers that she had been staying with Joyce for 6 – 7 months.

15.2.13 On 22nd July 2015, several calls were made to police in relation to a male causing a disturbance at Joyce's address. He was reported to be a male with links to drugs who was a known associate of Sandra Wilson. He was located by Police and taken to hospital. Some of the calls were from Joyce and David Rose, whilst others were made by neighbours or from unknown persons.

15.2.14 On 2nd August 2015, a neighbour called the Police complaining of excessive noise coming from Joyce's address. This was the last call police received relating to Joyce or her house prior to the incident resulting in her death i.e. 16/17th November 2015. Police told the occupants to turn the music down and assessed noise levels as, 'not that loud'. No details of who was spoken to were recorded.

15.2.15 Kent Police had several interactions with Joyce Jackson and in the main each incident was dealt with on its face value and without reference to previous incidents or in consultation with other agencies. Had these incidents been looked at collectively and information shared

² Prima facie evidence (Latin-at first view). Prior to being prosecuted the ingredients of an alleged offence must be evidenced. At this stage evidence rebutting the case is not considered, only whether any party's case is sufficient to place before a court.

(both internally and with other agencies) a developing picture may have emerged with Joyce's vulnerability being recognised.

15.2.16 Whilst it was reported on some occasions that Joyce had mental health issues and there was an awareness at one stage that she was interacting with Thanet mental health services, there is no evidence of her presenting as a 'vulnerable adult' which would have necessitated a referral.

15.2.17 Joyce was unlikely to have met the technical definition of a vulnerable adult. Kent Police Policy states that professionals have a duty of care where an adult is identified as vulnerable because of their situation, for example, adults who self-abuse or abuse alcohol or drugs. Given the nature of these interactions it appears there was no obvious evidence of any such vulnerability.

15.2.18 The anti-social behaviour incident that occurred in January 2015 was managed by the Police Community Safety Unit (CSU), and specifically by a PCSO in conjunction with a Housing Officer; this collaborative approach is seen as good practice. The incident may have provided an opportunity to identify Joyce's vulnerability however the police viewed this as anti-social annoyance to neighbours and little work was undertaken to understand the cause. Prior to closing the police file, further analysis of other information may have triggered work with partner agencies and highlighted the negative effect Sandra Wilson and her sons were having on Joyce's life. It was also apparent that the focus of the incident was on the neighbour making the complaint rather than the cause of the reported nuisance. It would seem that Joyce was almost an invisible party to these events. Officers attending such calls must use their 'professional curiosity' and where necessary seek evidence to identify not only the perpetrators but also persons who may not overtly present themselves as victims **(See Recommendations 1 and 2)**.

15.2.19 The last call to police prior to Joyce's death was to a noisy party on 2nd August 2015. One of the officers attending recalled the incident to some degree and stated on arrival it was all quiet. When interviewed the officers had no actual recollection of the interaction with the person who answered the door, stating he was likely to have informed the person of the nature of the call and requested that noise levels be kept down. As there were no issues of confrontation or anything out of the ordinary there was no further record made. Under the circumstances it would have been disproportionate for the officer to have enquired into the occupants or circumstances of the household.

15.2.20 Officers did not undertake historic research prior to attending the calls leading up to Joyce's death, but this would have occurred if they had been classified as domestic abuse cases. In accordance with policy the Force Control Room provide officers with enroute information when attending calls relating to domestic abuse. This is not the case when responding to incidents where there is no obvious or recorded risk associated to the nature of the call or caller.

15.2.21 Many of the incidents to which the police were called could be classified as 'mate crime'³ a classification which the police have become increasingly aware of. It would seem appropriate that mate crime is dealt with in a similar fashion to domestic abuse thus attracting more information exchange and risk assessments. **(See Recommendation 3).**

15.2.22 Due to the nature of the calls and that few were directly associated with Joyce, she was never identified as a repeat victim or repeat caller. The majority of calls were a link either to her address, the Wilson sisters and/or the Rose Brothers. Additionally when she was spoken to by officers, she was not identified as vulnerable due to her presentation.

15.2.23 Based upon the information recorded and from interviews with officers who dealt with Joyce in the last year of her life, each call does appear to have been dealt with proportionately and in accordance with relevant policies and legislation, with the possible exception of the January – March 2015 anti-social behaviour incident, where a more robust approach may have led to further work being focused on Joyce. Whether this would have had any impact on the fatal incident some eleven months later is unlikely as at this stage the Rose brother's had barely featured within Joyce's life. It appeared that Joyce was effectively living below the radar of any clear risk or vulnerability.

³ Mate Crime - The College of Policing recognise this term in the most recently published guidance (2014) on Hate Crime with the following: This is a term used to describe the persistent problem of disabled victims who are harmed in abusive relationships by offenders who either set out to, or take the opportunity offered by the relationship to abuse the victim. Abuse can be financial or violent and often has an escalating nature. Although a category of mate crime is not recorded nationally, police officers need to understand the term. Kent Police recognise this as a growing issue and in August 2016 published on the internal website information in relation to this: Mate Crime occurs when someone 'makes friends' with a person and goes on to abuse or exploit that relationship. The founding intention of the relationship, from the point of view of the perpetrator, is likely to be criminal. The relationship is likely to be of some duration and, if unchecked, may lead to a repeat and worsening abuse.

15.3 East Kent Housing (EKH)

15.3.1 Joyce Jackson lived in a two-bedroomed rented property in Thanet owned by Thanet Council and administered by East Kent Housing. EKH is a management company which was set up in 2011 to manage the housing stock of four local authorities including Thanet. The company is owned by the four local authorities with an independent board of directors.

15.3.2 The East Kent housing stock is divided into 'patches' with housing officers responsible for each patch, (in the case of Thanet these are given the title of 'Neighbourhood Managers'). In Thanet, a patch is an area of approximately 740 houses.

15.3.3 During the period relevant to this review Thanet should have had a total of 5 Neighbourhood Managers but due to internal managerial changes and secondments, from June 2015 to November 2016 this was reduced to 4. (It has now been restored to 5).

15.3.4 EKH has an Anti-Social Behaviour (ASB) co-ordinator who was appointed to work across the whole EKH area. Between June 2015 and June 2016 this officer was seconded to another job i.e. incorporating the critical period leading up to Joyce's death.

15.3.5 EKH has a published and annually reviewed adult safeguarding policy. This is based on the KCC protecting vulnerable adults protocols and procedures, which in itself is reviewed annually. The policy gives guidance on the type of abuse that vulnerable adults might be subjected to and the legislative framework for safeguarding. The procedures for safeguarding vulnerable adults are based on those provided by the KCC but they are dated 2012 and are in need of review⁴.

15.3.6 The ASB policy and procedure contain a risk assessment matrix that staff are expected to complete, and this links to the Safeguarding Policy. This policy states all EKH staff are expected to promptly report any concerns they may have to the appropriate authority. An internal log of all safeguarding referrals is kept by the Independent Living Team, and staff at Thanet report that they all knew how to make a referral and had no difficulties in doing so.

⁴ At 2.2 of the Safeguarding Vulnerable Adults policy, specific reference is made to the risk assessments that officers will undertake to ensure that opportunities for abuse and mistreatment are minimised.

15.3.7 EKH should undertake a risk assessment when they are aware that someone has moved into a property with a potentially vulnerable tenant; such a risk assessment should not be restricted to cases of ASB. Many vulnerable people and families (including people with mental health issues, substance misusers and people experiencing violence and abuse) are accommodated within social housing. Many of these individuals are disproportionately susceptible to the effects of crime and anti-social behaviour. **(See Recommendation 4).**

15.3.8 Joyce took over the tenancy of her house following the death of her father in 1991. Contact prior to 2014 had been limited to a period in 2004-2007 when allegations were made that Joyce was involved in minor anti-social behaviour. Counter allegations were made by Joyce who stated her property had been broken into and she had been injured. In 2005 Joyce's psychiatrist wrote to Thanet Council regarding the charge for a broken window. The letter did not disclose any medical condition or vulnerability but said she had been the recipient of a consultant's services for many years.

15.3.9 During the period 2007-2013 there was no contact with Joyce and her rent account was clear and in credit.

15.3.10 Complaints regarding Joyce and alleged occupants of the property began on 16th May 2014 when EKH received a phone call from a neighbour complaining about five people living at the house with loud music playing and fighting outside.

15.3.11 On 5th June 2014, Joyce's Neighbourhood Manager, (NHM 1) made her first visit to the house. During this visit Joyce advised that she had no support needs, and no vulnerabilities or disabilities other than dyslexia. There is no record of anyone else living at the property, and Joyce told NHM 1 that a friend had come to stay with her for a few days, and that she got on very well with her neighbours. The record of the visit indicates that the property was in good condition, and NHM 1 did not have any concerns about Joyce's appearance. This visit was documented, although to assist future visits it would have been helpful if forms contained more detail about the condition and appearance of the tenant, thus making the description less subjective.

15.3.12 There was no further contact with Joyce in 2014 and no further complaints were made.

15.3.13 In January 2015, Joyce's rent account started to go into debit resulting in the Income Team at EKH contacting her. Income is collected centrally and neighbourhood managers are not responsible for this function.

15.3.14 NHM 1 went on extended leave from Christmas to 6 February 2015. Three telephone complaints were received from Joyce's neighbours during this period.

15.3.15 On 15th January 2015, a neighbour (N1) telephoned EKH to make a complaint and spoke to a support officer. He advised that Joyce had mental health issues and was continually being exploited and taken advantage of. He said at least 5 people lived at the property and had been causing a noise/ nuisance since early 2014. He had called the police that night because there was fighting at the property, which had spilled into the street. He said this behaviour happened regularly and he did not believe Joyce had any control over the situation. He was asked by the support officer to complete diary sheets covering a two week period, which would then provide a record of any future occurrences.

15.3.16 On 21st January 2015, another of Joyce's neighbours (N2) telephoned EKH to say Joyce was subletting her house to at least 4 other people and that the property was being used as a 'drugs den'. He could smell cannabis in the garden, there was a lot of rubbish accumulating and lots of noise late at night/early morning. He was told EKH could not help unless he filled in diary sheets and that drugs offences required police involvement.

15.3.17 On 29th January 2015, N1 again telephoned EKH to complain about noise and obscenities which had been coming from Joyce's house all night. He said he had confronted one of the men he believed was living at the property, and this man threatened him with a Stanley Knife.

15.3.18 NHM 1 returned from leave on 6th February 2015 and on 13th February N2 telephoned to complain. He said that Joyce still had people living with her, and had a party which was causing a nuisance; he also said they were using his bins in which to dump their rubbish. N2 said he wanted to speak to a manager and NHM 1 said she would arrange this. On 19th February 2015, NHM 1 wrote to Joyce to advise her that she and the Housing Services Manager, would be visiting her

on 26th February to discuss her tenancy. She also wrote to N1 at the same time to ask him to fill in the diary sheets.

15.3.19 On 24th February 2015, NHM 1 and the Housing Services Manager visited N1 and N2. They repeated their complaints about the 5 people living with Joyce, the noise levels, the abusive language, the rubbish and the “ginger male” who visited the property and told N1 he was always “tooled up” – he had been the man with the Stanley Knife. Advice was again repeated by NHM 1 and the Housing Services Manager who said EKH could look to install a noise recorder if they received diary sheets. Both parties were reluctant to complete these sheets. EKH had its own noise recording equipment and could have installed this without recourse to diary sheets if it had considered it necessary.

15.3.20 It was reported that when officers visited a complaining neighbour in February 2015, he was derogatory towards Joyce, and appeared to just want her evicted; taking this view was likely to have given less weight to the complaint. A formal risk assessment was not used, leading officers to make subjective judgments.

15.3.21 NHM 1, her line manager and the police then visited Joyce’s house. The Police were asked to attend as the information provided by the neighbours made reference to threats being made with a knife. Joyce had no objection to officers looking around the property which was described as very neat and tidy and in good condition. Having looked in the upstairs bedrooms comment was made that that the property seemed to be occupied by only two women. The fridge contained plenty of food and Joyce was described as comfortable and co-operative. She understood issues about her housing benefit, and both NHM 1 and the line manager believed she had full capacity. Joyce denied that anyone was taking her medication or money. The line manager commented that Joyce’s appearance was reasonable, but NHM 1 felt she “looked older”, and offered her a referral to the Beacon mental health services and floating support. Joyce agreed that she would like this to happen. Joyce was upset at any suggestion that Sandra could not live with her, saying she liked her and was lonely.

15.3.22 Officers requested a police presence at the visit to Joyce on 26th February 2015 and 5th March 2015. A police officer and PCSO initially attended the first visit, but the police officer felt that this would be too “heavy handed” and agreed to leave the PCSO to conduct the visit with EKH staff. When requesting this support, housing officers said they believed the PCSO would attend the visit with an

understanding of police intelligence, and that any information they had would be shared. Housing officers were not advised of any background information by the PCSO and therefore assumed there was no adverse history or indicators they should have been aware of. This visit emphasises the need for effective information sharing between agencies.

15.3.23 EKH is party to the Kent wide multi agency information sharing protocol and the expectation of officers is that they will actively pursue the disclosure of relevant information from other agencies when dealing with ASB, and that they will provide information to other agencies in relation to safeguarding. The arrangements for this are formalised to ensure that the information shared is needed and that it will be used appropriately.

15.3.24 During this visit Joyce confirmed she wanted Sandra to stay with her and Sandra said she wanted to provide support for Joyce. Because of this a referral was not considered necessary. Officers felt that Joyce and Sandra were comfortable together, they made an equal contribution to the conversation and that Joyce was happy living with Sandra.

15.3.25 At the end of April 2015, a neighbour made a further complaint about the number of people staying at the property, and reported that a brick had been thrown through the front window. Another pre-arranged visit was carried out. Joyce and Sandra Wilson were spoken to and said they didn't know who had caused the damage. Sandra said her sons were still visiting but she had told them to stop doing so. NHM 1 raised the rent arrears with Joyce and believes she told Sandra that she needed to pay the non-dependant deduction. NHM 1 recalls that the house was spotless and that the garden was in a neat and tidy condition.

15.3.26 On 18th June 2015, as no further complaints had been received, the file was closed. On 22nd June 2015, NHM 1 moved to the Canterbury office and her cases were assigned to another Neighbourhood Manager (NHM 2).

15.3.27 On 24th July 2015, N1 contacted Thanet District Council Environmental Health department to complain about noise; records indicate this complaint was passed to EKH. On 3rd August 2015, N2 also contacted EKH to complain about swearing, fighting and saying that four police cars and an ambulance were called to the premises on 25th July. This information was passed to NHM 2, the new

Neighbourhood Manager. Although NHM 2 was new to Joyce's case, she had worked in Thanet since EKH commenced.

15.3.28 On 13th August 2015, Joyce received an unannounced visit from NHM 2 at which time a young man answered the door. NHM2 spoke to Joyce alone who said the complaints were the result of a 'ginger male' trying to get into the house. Sandra Wilson later joined the conversation and explained away the complaints by saying it was caused by an uninvited guest. NHM 2 reported that Joyce was quite articulate and said she wanted Sandra to remain at the property, but neither she nor Sandra wanted the Rose Brother's there. NHM 2 informed the IMR Author she had no concerns about the condition of the property.

15.3.29 On 24th August 2015 N2 (neighbour) telephoned to say that there was still rubbish at the property. NHM 2 telephoned Joyce and Sandra answered and said that she would arrange to remove the rubbish. She was asked who was living at the property, and said there was no one at the house apart from her and Joyce, but that they had a bit of a "get together" at the weekend for her sister's birthday. This was not logged as an ASB complaint.

15.3.30 On 26th August 2015, neighbour N2 telephoned again stating he was unhappy and that NHM 2 was not doing anything about his complaint. The focus at this time appears to be on rubbish accumulating at Joyce's house. As a result of this call NHM 2 went to see the Council's Enforcement Team who said they would serve a notice on Joyce if the rubbish remained.

15.3.31 In response to complaints from neighbours, NHM 2, her new Neighbourhood Manager made an unannounced visit to Joyce. NHM 2 did not recognise any deterioration in the condition of the property or of Joyce's appearance but had nothing to benchmark this against as the file note merely referred to her appearance as being "good". Fuller information would have allowed the officer to make a better judgment as to whether Joyce or the property had deteriorated. Joyce was originally spoken to on her own, but Sandra then joined them, and gave an explanation as to the complaints which again appear to have been accepted. This was not treated as an ASB issue but an isolated complaint.

15.3.32 On 1st October 2015, N1 (neighbour) called to say that there had been lots of noise which went on until 2.45am with people running up and down stairs, shouting and swearing, and that four additional individuals were still living at the property. He raised concerns that Sandra Wilson had “muscled her way” into the property and as a result had brought the others with her. Neighbour N2 also telephoned to make similar complaints, and said he felt that Sandra was taking advantage of Joyce. Both telephone calls were taken by a senior support officer, and very full written attendance notes were provided to both NHM 2 and her line manager. The neighbour (N2) was advised of the importance of keeping diary sheets.

15.3.33 The records do not show that any further action was taken. The phone notes were passed to the Acting Housing Services Manager, as NHM2 was off sick. The manager says she telephoned both complainants and left messages, but there is no file note to record this (and in any event the neighbour N2 had already advised he was going on holiday for two weeks).

15.3.34 Following complaints made by neighbours, on 30th September and 2nd October 2015 an opportunity for assessment was missed. Both neighbours alleged that Joyce was being taken advantage of, and that a number of people were living at the property; one alleged he had seen seven people moving in. These phone calls were not actioned, and Joyce was not contacted.

15.3.35 On the 18th November 2015, the neighbour N1 telephoned to advise that Joyce had been taken to hospital and that the police had attended from 5pm the previous day. He said that on 13/14 November (10pm – 4.20 am) the noise was horrendous but that he did not call the police. There had been constant banging and running up and down stairs. He was again asked to fill in diary sheets. A further telephone call was taken that day from neighbour N2 also alleging noise on the same times/days as N1 had reported. He also stated that on 11th November there was a young man in the alleyway smoking drugs and that Sandra was incoherent when he spoke to her. He said on at least one occasion he had seen Joyce through the window being teased in the house by young men.

15.3.36 On 19th November, (post the assault on Joyce) neighbour N2 called to say that the young men who had been removed from the property by the Police had returned and had caused a lot of damage as there were broken doors and other items in the garden.

15.3.37 Joyce was not recorded as a vulnerable tenant, although there is early correspondence dated 16th August 2005 stating she had regularly visited her psychiatrist, however neither her file nor her rent account indicated she was vulnerable or at risk of exploitation. She did not have regular contact with the EKH Team and in the past was neither a complainant, nor was she complained about by her neighbours other than a few isolated incidents. From May 2014 complaints about Joyce were received and as Joyce had a good record of previously maintaining her tenancy this should have potentially alerted officers to the existence of a problem.

15.3.38 Whilst specific safeguarding training had not been provided for several years, staff nonetheless reported they understood the indicators of abuse, and records indicate that staff at Thanet made safeguarding referrals, as well as making referrals for floating support services for tenants. Staff had all worked in front line housing services for a number of years. They also made mental health referrals to the Beacon.

15.3.39 Joyce did advise officers in 2015 that she was bipolar but this, in itself, does not make someone vulnerable, she also told them she had been discharged from the Beacon mental health service and was prescribed medication.

15.3.40 When officers visited Joyce there were no external indicators of abuse and she always seemed comfortable to be around Sandra Wilson. Although she had a period of rent arrears (which had never occurred previously), her rent account was brought back into credit in August 2015 and therefore there were no indicators of financial abuse.

15.3.41 Little consideration seems to have been given as to who the perpetrators of the ASB actually were, although staff accepted Joyce and Sandra were not causing the ASB but it was their visitors. When the Neighbourhood Manager NHM 2 visited in August 2015, she treated this as an isolated incident and not part of an ongoing ASB case. No enquiries were made of Joyce in relation to her vulnerability. As alluded to in the Police section of this report such cases should involve collating and considering past information about the address or individuals and using it to identify the true nature of a problem, and as a result identify potential victims of abuse or criminal activity. **(See Recommendation 2)**

15.3.42 EKH is a provider of housing management services, and does have a policy on domestic abuse. EKH will refer to an appropriate agency for them to carry out the CAADA risk assessment. It should be noted Joyce was never identified as the victim of domestic abuse. Although the circumstances, had they been fully identified, fitted the definition of Domestic Abuse in relation to a DHR (offender and perpetrator living in the same household) this was not the definition agencies were using operationally⁵. Whilst some form of criminality would have been acted upon it is unlikely to have been classified as Domestic Abuse.

15.3.43 EKH have appropriate Safeguarding Adults Policy and Anti-Social Behaviour policy and procedures that should have been applied in this case. There are a number of areas where it is clear that the EKH policy and procedures were not effectively applied.

15.3.44 All complaints of ASB and nuisance should be recorded and acknowledged within one working day and categorised for risk, in order that an appropriate response time can be agreed. These incidents should have been logged on the housing management IT system.

15.3.45 Prior to the formation of EKH, Thanet District Council decided to record and manage ASB cases via 'Civica', the Council's document imaging and workflow system. This system has very limited reporting and monitoring capabilities and many of the officers in the team were unfamiliar with how to log cases. This meant that cases were often logged as file notes. Once logged as a file note they did not appear as an open ASB case and for them to be monitored it would rely on the Neighbourhood Manager remembering that they had an open complaint, and diarising any follow-ups manually.

15.3.46 Failure to follow the ASB procedures meant that neighbourhood managers themselves decided upon the next action needed to resolve a case. This could lead to each complaint being looked at as an isolated incident, rather than a pattern of behaviour.

15.3.47 EKH have adopted a full toolkit for managing ASB which includes a risk assessment for the victim, which was to be standard practice across the organisation. However, in this case decisions appear to have been made locally by staff to continue with old policies on the basis that the new policies did not fit their existing Civica system. If the issues raised by Joyce's neighbours had been managed

⁵ Any incident or pattern of controlling, coercive or threatening behaviour violence or abuse between those aged 16 or over who are or have been intimate partners or family members regardless of gender or sexuality.

in accordance with policy and procedures then the following actions would have happened:

- Joyce and her neighbours would have been interviewed and records of same would have been signed and recorded on the file.
- Action plans would have been agreed with the neighbours, which would have helped manage their expectations of what EKH could and could not do.
- An action plan would have been agreed with Joyce to control the nuisance behaviour complained of, which would have helped to ensure action was not taken to end her tenancy.
- A Risk Assessment Matrix (RAM) would have been completed for both complainants due to the nature of the incidents they were reporting.
- A RAM would have been completed for Joyce if it was indicated she had a particular vulnerability and/ or those believed to be responsible for the nuisance could be in an exploitative relationship with her.

15.3.48 In August 2015 all managers were told to ensure that there was a risk assessment of cases at first point of contact. This does not appear to have been adopted by the Thanet Team. Although this would have been too late for the initial complaints received in January and February 2015, the case was closed in June 2015, and new complaints received in July and August should have prompted the opening of a new case. This would have allowed an opportunity to prioritise, and if this had happened then it is likely it would have been given high priority status.

15.3.49 Case prioritisation does not appear to have been routinely applied to cases in Thanet. When interviewed, officers believed they responded promptly to all reports of ASB, but it is unclear how they prioritised cases without any assessment tools. Some of the reported incidents were not responded to within agreed timelines, and the incidents recorded on 1st and 2nd October 2015 do not appear to have been responded to at all.

15.3.50 Officers report that the relationship between officers at EKH and the Thanet Community Safety Unit (CSU)⁶ is very good; however

⁶ The Crime and Disorder Act 1998 gave statutory responsibility to local authorities, the police and key partners to work together in order to reduce crime and disorder in their communities. The CSU at Thanet District Council works across diverse communities and partnerships within Thanet to improve neighbourhoods and reduce crime and anti-social behaviour.

this meant that information was often shared informally and not recorded. There are no formal recorded meetings with the CSU with an agreed agenda, which makes it difficult to understand what cases are raised. It is recommended that EKH attend the Thanet Community Safety Partnership Tasking and Coordinating Meeting (**see Recommendation 5**). If this case had been considered at a formal meeting, it is likely that there would have been follow up activity by the CSU. In this case officers believed they had discussed the case with the CSU and that, as a consequence of their informal discussions, were advised to inform the police prior to making a visit to Joyce as neighbours had alleged threats had been made with a knife.

15.3.51 Actions taken from 1st January 2014 - June 2015 fitted with Joyce's assessments. Visits made by NHM 1 took into account Joyce's wishes as well as any support needs, and there was no evidence to suggest a safeguarding referral should have been made at this time. The Police attended on two visits and no intelligence was provided to staff to suggest they needed to be more vigilant or make any further enquiries.

15.3.52 Complaints made in August 2015 were not treated as ASB. No enquiries were made at the time as to Joyce's vulnerability. The complainants said on a number of occasions that the police had attended the property and this should have caused staff to make further enquiries with the police. Officers have accepted that Joyce was not the perpetrator of the ASB, but that on at least one occasion a knife was alleged to have been used in a threatening way at the property. No efforts were made to find out any information on the perpetrators even though neighbours reported the Police being called on a number of occasions. If Joyce was not the perpetrator, then officers should have considered whether she was the victim of ASB and a risk assessment should have been completed.

15.3.53 Senior managers were aware of the case and asked to attend meetings for the cases in the period February to March 2015. They were not involved for the period August 2015 to November 2015 as this was not recognised as a high risk case.

15.3.54 Very little management support was given to staff in the Thanet office and 'one to ones' did not happen on a regular basis. This is partly due to the close proximity of staff in Thanet – all Neighbourhood Managers sit together on one bank of desks and cases are routinely discussed in the office. Managers have now been

reminded of the importance of having regular one to one sessions and these must be documented.

15.3.55 EKH and the Police should have coordinated their activities with regard to this case given the nature and number of complaints. The neighbours said on several occasions they contacted the Police but had been referred back to EKH. There is nothing to suggest that formal disclosure of reported incidents was sought from the Police despite the fact that complainants repeatedly claimed the Police had been regularly attending the property.

15.3.56 EKH did not identify or manage any risks posed by the perpetrators, as it had no contact with them, and had no details or intelligence on them; further enquiries of the Police could have been made.

15.3.57 Staff did not consider that Sandra presented any risk to Joyce, and believed that she was providing support, despite the complaints made by the neighbours.

15.3.58 Unannounced visits were often made which is good practice (but this did not occur in every case). This allows officers to see what is actually going on with a tenant and is likely to reveal their true appearance and situation.

15.4 Thanet District Council

15.4.1 Thanet District Council had little operational involvement in this case but as housing features strongly in this DHR, and as the owners of Joyce's property, they were asked to complete an IMR.

15.4.2 The Thanet District Council case management process states that if a property is managed by East Kent Housing they will receive referrals regarding any report or complaint of noise, nuisance and ASB. The East Kent Housing team in turn will follow their own protocol for dealing with such complaints regarding their tenants.

15.4.3 In the first instance, East Kent Housing Neighbourhood Managers are allocated such reports and complaints and, acting in the capacity as landlord, will review and establish the circumstances of each case. It is then determined whether a contravention of tenancy is taking place and what needs to be addressed through tenancy management.

15.4.4 During the time period given there was only one call into Thanet District Council. From this one call there were two interactions with two departments. The first was with the Thanet District Council's call contact centre (managed by East Kent Services). The initial report came in from Joyce's neighbour (N1) via a telephone call. The call

centre operator logged the call onto the Thanet District Council recording/case management system after asking the caller a series of standard pre agreed triage questions. Following the responses to those questions, the call taker allocated the call to the Environmental Protection Team. The report was then subsequently passed over to East Kent Housing for initial review.

15.4.5 On 24th July 2015, N1 telephoned Thanet District Council to make a complaint about constant noise including music, shouting and swearing coming from Joyce's house. He said this was very distressing and he was unable to sleep properly. The report from the neighbour went on to state there were seven people currently living in the property although this number changed frequently. He said at 11:45 pm 22/07/2015 police had to be called because of swearing and shouting in the street. He said this was a frequent problem and music often started about 7pm and could go on until 3:30am, although it usually stopped about midnight. There was always fighting and swearing and this was a constant problem. In accordance with procedure this report was sent to East Kent Housing and details were scanned on to their Civica database.

15.4.6 Thanet District Council and East Kent Housing procedures state that, if a report appears to be substantiated and is not able to be resolved informally by an East Kent Housing Neighbourhood Manager by giving advice to the complainant and tenant and requires further investigation or specialist input, then it will be referred to the Environmental Protection Team. Following further investigation and assessment by Environmental Protection, a way forward would then be discussed e.g. joint visits, formal notices, prosecution, eviction (not an exhaustive list).

15.4.7 This case was not passed back to the Environmental Protection Team for support and as such they had no further involvement. There was no other recorded involvement with any other party subject to this review. No further discussions took place between East Kent Housing and Thanet District Council regarding this case until after Joyce's death when an internal fact finding review was undertaken.

15.4.8 Thanet Council have demonstrated how they wish to learn lessons from this case and have addressed the issues identified in this report both in relation to their own activities and EKH. Recommendations have already been implemented which include improving communication and information sharing between Thanet Council and EKH, random dip testing of ASB cases and the delivery of enhanced training programmes.

15.5 NHS Thanet Clinical Commissioning Group (CCG)

15.5.1 In separate parts, this sections deals with Joyce Jackson and each of the Rose Brother's involvement with the CCG.

Joyce Jackson

15.5.2 From 1990 to 2015 Joyce Jackson was registered with two GP practices in Thanet. She moved from Surgery 1 to Surgery 2 in the summer of 2012. Joyce had been suffering from anxiety and depression since 1991 when her father died of cancer. Her mother left her when she was eleven years old. She started taking Diazepam and Temazepam regularly from 1999. She had a diagnosis of mixed anxiety, depression, Bipolar Affective Disorder, benzodiazepine dependency with an underlying Personality Disorder.

15.5.3 Between 1990 and 2012, Joyce had a number of contacts with her GP. On three occasions Joyce alleged she had been assaulted and once that her medication had been stolen.

15.5.4 In 2006 Joyce presented with dizziness and falls resulting in two A and E attendances with head injuries. During this year the GP attempted to help Joyce reduce her reliance on Benzodiazepines. The GP surgery also received calls of concern for Joyce from her neighbours. She was being investigated and treated for vertigo, although it was suspected her dizziness was due to over use of Benzodiazepines.

15.5.5 In March 2012, Joyce was discharged from mental health services having been seen at the Beacon Health Centre. The psychiatric consultant discharged her back to her GP for reduction of her Benzodiazepines, to which Joyce agreed. She remained on Olanzapine, Fluoxetine, Temazepam and Diazepam. Joyce was in touch with two local charities that supported people with mental health problems, one of which was Speak Up referred to later in this report.

15.5.6 By the end of April 2012, Joyce was deregistered by Surgery 1 due to repeated requests for additional prescriptions for Diazepam and Temazepam. In total, from January until April, Joyce had made 13 additional requests for medication. This was mainly via the out of hours GP service.

15.5.7 There was a gap of two weeks between her leaving Surgery 1 and registering with Surgery 2. During these two weeks she increased her demand on the out of hours GP service contacting them on 11 occasions for additional medication. She either claimed she had ran out of medication, forgotten to get her scrip from the surgery, or could not get an appointment to see a GP. Once Joyce was

registered with her new GP she only made one additional request for medication that being in August 2012.

15.5.8 In June 2012, her GP referred her back to mental health services to support her with the management of her medication and as she was presenting with very poor hygiene. Joyce was seen by the team at the Beacon Centre and reported she felt low due to the death of her mother and stress regarding her benefits. She presented as self-neglecting and was discharged back to her GP. She was given contacts for the Crisis Team and advised to self-refer to IAPT (Improving Access to Psychological Services). This would have been accessed through her GP.

15.5.9 In August 2012, Joyce was reviewed at the Beacon and it was reported she was drinking alcohol as a replacement for her Benzodiazepines and this was backed up by her GP who recorded that Joyce had stopped her use of Diazepam.

15.5.10 In January and May 2013, Joyce was treated for falls and balance problems and attended A and E. She was referred for a CT scan of her head, ECG and blood tests. There is no record of any results of the CT scan in the GP records. The other results were normal and Joyce was treated for Vertigo with Prochlorperazine.

15.5.11 In July 2013, during a medication review Joyce presented to the GP with persistent head lice. The GP expressed concern as Joyce appeared to be self-neglecting. Joyce agreed to a referral to social care but they suggested a referral to mental health services, which was completed by the GP.

15.5.12 On 14th August 2013, Joyce attended the surgery with her sister and brother. They reported they were very concerned about Joyce self-neglecting and that she was not eating properly and was not cleaning the house which was becoming much neglected. The GP agreed that she would see Joyce weekly. By the following week Joyce had scabies and was reporting that she had not yet heard from the mental health services. Joyce was reporting that she lived alone and the family, at this stage, did not report she had anyone else living in the property.

15.5.13 On 3rd September 2013, The Beacon reported to the GP that Joyce had been screened by community mental health nurses. She was reported as presenting with a good flow of speech and was making good eye contact and as a result, the community mental health team discharged her back to her GP.

15.5.14 On 4th September 2013, Joyce returned to her GP with her family as they were concerned she had not given the Beacon the full story and her home situation had not improved. The GP felt that the mental health team needed to conduct a home visit. A further appointment was made for Joyce to be seen by a consultant psychiatrist.

15.5.15 On 20th September 2013, Joyce was seen at the Beacon by a consultant and she agreed to an informal admission for further assessment. The consultant was concerned that she had overdosed on her medication in the past with the intention of killing herself. The Crisis Team conducted a risk assessment the following day and Joyce was described as in a state of neglect.

15.5.16 The Crisis Team continued to support Joyce until 14th October 2013 and reported she was self-neglecting, isolating herself from her family and replacing Benzodiazepines with alcohol. They supported her with a medication review and daily visits. Joyce engaged with the team and showed signs of recovery. Her Temazepam and Diazepam was eventually stopped and she remained on Fluoxetine and Olanzapine. The plan was to transfer Joyce's care to the Community Mental Health Team at the Beacon, to have a weekly dosette box to manage her medication and for her to continue to attend the Speak Up group. The Crisis Team recognised that if Joyce isolated herself again she was at risk of relapsing.

15.5.17 In January 2014, Joyce went to her GP and requested sleeping tablets and asked for an appointment with a Consultant Psychiatrist at The Beacon. The consultant requested that the GP prescribe some night sedation for Joyce, however this appears not to have taken place.

15.5.18 By July 2014, the mental health services discharged Joyce as she was described as now managing her medication well, not overdosing or making any requests for additional medication. She was managing her personal hygiene and keeping her home in good order. Joyce declined a referral to the recovery group and further appointments with a CPN and a Consultant Psychiatrist. Joyce was

attending her local SpeakUp forum and did not want to be seen at that time.

15.5.19 In August 2014, Joyce asked for night medication but the GP did not prescribe it. This could potentially have been identified as an indication that Joyce's health was relapsing.

15.5.20 Joyce did not visit her GP again until April 2015 when she was diagnosed with a chest infection after having a cough for a week. She was referred for a chest x-ray but there are no results of any x-ray in her GP records.

15.5.21 Joyce returned to the GP surgery in October 2015 with a history of a cough for a week, she reported that she had a good appetite and no loss of weight. The GP prescribed antibiotics and advised her to return if not improving. This was the last time the GP saw Joyce. At this time there were no concerns regarding her mental health or any signs of self-neglect. Joyce did not report any issues with people living in her house.

15.5.22 The next record in the GP surgery is a letter from the Hospital regarding Joyce's admission on 17th November. Joyce reported that she had been assaulted by the people she was living with. The letter stated she was 'bruised all over' and presented as self-neglecting.

15.5.23 Whilst Joyce was at Surgery 1 there seemed to be no proactive plan to support her in reducing her Benzodiazepines and she only remained with the practice for a month following her discharge from mental health services. When Joyce requested medication outside the normal repeat prescribing route, GP's either in her own practice or in the out of hour's service were inconsistent in their response by prescribing medication on eight occasions out of twenty five requests. Compliance was finally achieved in September 2014 following a referral and interventions by the CRISIS mental health service in Thanet, and by her GP from Surgery 2.

15.5.24 When the Beacon Centre discharged Joyce after her first appointment in 2013 they did not triangulate any information from family, friends or neighbours. The GP did well to insist on a further referral back to mental health services following concerns raised by her family.

15.5.25 All primary care practices have safeguarding policies, but generally do not have sufficient information or content to support staff in Domestic Abuse, Stalking and Harassment and Honour Based Violence (DASH) risk assessments, and risk management for domestic abuse victims or perpetrators. Surgery 2 safeguarding policy does cover the basics of safeguarding and how to report, but would benefit from additional information relating to the assessment and support of people who may be at risk of domestic abuse and self-neglect. **(See Recommendation 6).**

15.5.26 When Joyce presented to her GP in 2015, she did not disclose or display any indicators of domestic abuse, or that she was vulnerable to abuse by others due to the nature of her mental health and self-neglecting.

15.5.27 The GP from Surgery 2 was sensitive to the needs of Joyce and was knowledgeable about potential indicators of domestic abuse and aware of what to do regarding concerns about a victim or perpetrator. During the summer of 2014, this GP and members of Joyce's family were very persistent in offering their support and getting her the help she required to address her medication issues, her self-neglecting and depression. Six weeks following referral by the GP, Joyce's family were consulted by mental health services as part of their assessment. It appears that community mental health practitioners initially took Joyce at face value and did not consider the significance of the GP's advice i.e. that Joyce had no insight into her mental and physical health needs.

Sean Rose

15.5.28 In August 2012, a copy of a Looked After Children RHA (Review Health Assessment) was placed on GP records. It stated the following:

'Sean is currently living in a children's home. Reports suggest he is fairly happy, no recent contact with his brother, David and denies any thoughts about self-harm. Reports state that he can 'sometimes get angry and become very verbally expressive and physically destructive. He is attending weekly therapy at the Chilston project. He was requesting that he moves into semi-independent lodgings'.

The report recommends he continues with therapeutic intervention at the Chilston Project.

15.5.29 On 1st December 2013 Sean attended A and E, having taken crack cocaine, alcohol and cannabis. He reported at this time he was living in a children's home in Medway.

15.5.30 On 1st January 2014 Sean attended Hospital with alcohol intoxication following New Year's Eve celebrations. He was given verbal advice and discharged on the same day. This is the last GP record for Sean. The NHS system has no further GP registrations for Sean after June 2013. It was pointed out in exercising their responsibility in assisting young adults leaving care, Social Services should endeavour to ensure such individuals are registered with a GP. **(See Recommendation 7).**

15.5.31 Sean has never given his address as Joyce's house.

15.5.32 These entries give an indication as to Sean's propensity to become angry and physically destructive and provides evidence of his drug taking.

Dean Rose

15.5.33 In July 2013, whilst a looked after child, Dean attended a hospital A and E department due to alcohol intoxication. He claimed he drank two bottles of vodka (he got someone to bring in for him) and that he was due in court the next day for an offence of Actual Bodily Harm. He was treated with IV drugs and fluids and discharged home.

15.5.34 On 23rd July 2015 Dean attended A and E and gave Joyce's house as his home address. He was complaining of a soft tissue injury to his right hand. The hand was x-rayed but no treatment was given and he was discharged the same day. No other reports were sent with the discharge letter and there was no history of circumstances on how he sustained the injury. This is the last record of any contact with health services in his GP records. This entry indicates that in July 2015 Dean was living at Joyce's address.

David Rose

15.5.35 On 5th December 2012, David was seen by his GP stating he now lived in supported accommodation in east Kent. It was reported he had ADHD and a learning disability but was not currently on any medication. He admitted to spending money unwisely, buying cannabis and giving it to other people and was being exploited by other people. He denied any IV drug usage but it was agreed his support worker

would arrange for a KCA referral. The GP arranged learning disability support team and social services vulnerable adult team referrals.

15.5.36 David has never given his address as Joyce's house.

15.6 Kent and Medway NHS and Social Care Partnership Trust (KMPT)

15.6.1 KMPT provide a number of different mental health services to those living in the Kent and Medway area including, community services under the Community Recovery Service Line (CRSL), inpatient services under the acute service line and a number of specialist services.

15.6.2 From the 1st January 2012 to the current time, there have been some changes in how mental health services are provided across Kent and Medway.

15.6.3 Joyce's contact with KMPT was generally with the Thanet Community Mental Health Team (CMHT). Community Mental Health Teams (CMHT's) for working age adults fall under the CRSL. These teams are defined by geographically based areas which provide assessment and interventions for those experiencing mental health problems.

15.6.4 Most people referred to a CMHT will only need to be seen for a short period of time and can expect to be cared for within the team by a named professional. The process has always been to offer individuals an initial assessment and identify interventions to aide recovery or give advice on where and how to access alternative support.

15.6.5 Discharge from secondary mental health services is reported back to the individual's GP/referring agency, and is supported within KMPT through the Transfer and Discharge of Care of Service Users policy.

15.6.6 Whilst CMHT's continue to undertake referral assessments and provide interventions, since the time services were provided to Joyce there has been significant organisational change.

15.6.7 Since Joyce's interaction with the KMPT, urgent and emergency referrals are now managed by the Single Point of Access (SPOA) team. The aim of the SPOA service is to provide stakeholders, service users and carers an easier way to access secondary mental health services. SPOA is a 24/7 telephone line service offering triage,

screening and onward co-ordination of care to the appropriate CMHT, and means that the process no longer relies on referral letters or a further screening process

15.6.8 During the time frame of this IMR, Joyce Jackson was also seen by another service provided by the KMPT i.e. the North East Kent Crisis Resolution Home Treatment Service (NEK CRHT).⁷

15.6.9 It was noted that Sean Rose had been historically referred to the KMPT and specifically to the Child and Adolescent Mental Health Services (CAMHS). KMPT historically provided CAMHS across Kent and Medway before services were taken over by the Sussex Partnership NHS Trust in September 2012. The role of KMPT CAMHS prior to September 2012 was to provide assessment and interventions to those under the age of 18 who were in need of mental health support.

15.6.10 On the 1st April 2014, the Care Act 2014 came into effect which significantly changed the arrangements for adult safeguarding both nationally and locally. KMPT working age adult services historically had a delegated responsibility for safeguarding adults in Kent. This worked by having seconded staff from Kent County Council (KCC) working within Kent based CMHT's. These seconded staff provided the role of Designated Safeguarding Officers (DSO). Following the implementation of the Care Act 2014 it was apparent that this arrangement needed to be reviewed as it was clear the role of safeguarding could no longer be delegated according to the requirements of the Act. Starting in October 2015, a new agreement between KMPT and KCC was formed with changes being made to the new way of working which included Safeguarding Co-ordinators (SGC) now being employed by the KCC. Other significant changes should be considered in relation to this IMR specifically the impact of joint Kent and Medway self-neglect policy which may have changed practice/services offered to Joyce had it been available in 2013.

⁷ The CRHT is managed through the KMPT acute line service line management structure. The purpose of the service is to :

- Provide rapid assessment of individuals with acute mental health problems 24/7.
- Provide multi-discipline community based treatment 24/7 for individuals with acute, severe mental health problems as an alternative to hospital admission and for which home treatment is appropriate.
- Ensure that individuals experiencing acute, severe mental health difficulties are treated in the least restrictive environment and as close to home as possible.
- Remain involved until the crisis has resolved.
- Facilitate inpatient treatment when home treatment cannot be undertaken.
- Reduce service users vulnerability to crisis and maximise their resilience.

15.6.11 Prior to 2012, Joyce Jackson was already open to secondary mental health services through the Thanet CMHT with a number of referrals already having been made.

15.6.12 Joyce experienced anxiety and depression when her father died in 1991 and received counselling. In 2004, Joyce was the victim, of a number of break ins and later in an assault and these experiences impacted upon her ability to manage her levels of anxiety and there followed a period of depression that again resulted in her GP making a referral to secondary mental health services. It was during this time concern was raised about Joyce's reluctance to inform mental health services of the truth of her experience, and concern was raised by the GP regarding her abuse of prescribed medication.

15.6.13 In April 2012, this opinion was further repeated in the discharge summary to Joyce's GP. The consultant who provided psychiatric medical reviews for Joyce for a number of years noted anxiety and depression as her primary diagnosis, but also noted a diagnosis of benzodiazepine dependency and probable personality disorder along with a secondary diagnosis of Bipolar Affective Disorder.

15.6.14 Although from 1991 to 2014 Joyce, on numerous occasions, received secondary mental health services, she also experienced periods of stability that enabled her to be discharged back to the care of her GP. In April 2012, Joyce was discharged back to primary care at her own request following a period of such stability, and where risks to herself and others was assessed as very low.

15.6.15 Joyce's pattern of engagement with the mental health team was inconsistent, however records show that at times of crisis she would engage, and the discharge summaries always included reference to her own knowledge of how to obtain support along with a clear plan of care for the GP, and an invitation to re-refer in the future if needed. This was further supported by Joyce being independent in occasionally accessing local voluntary and charitable support groups (Richmond Fellowship and Speak up⁸). The Thanet CMHT sign posted Joyce to these organisations as it was considered they could have a positive effect upon her. Joyce accessed these services both at times of being open and closed to secondary mental health services

⁸ The Independent Chair has made contact with Speak up who expressed some concern over the support given to Joyce during the period leading up to her murder. The DHR process was explained to them and their manager was informed the results of the DHR would be published in an anonymised format.

15.6.16 Although the next referral to the Thanet CMHT only occurred two months after her discharge in April 2012, it was made because Joyce had moved to a different GP practice. The new GP reported “no record of diagnosis only self-report by the patient”. It is unclear why the previous discharge information was not available to the new GP, however an appointment was offered within two weeks and a review of medication was made. A follow up review was arranged and at this time Joyce’s mental state was reported as stable.

15.6.17 In 2013, concern regarding Joyce’s self-neglect was raised to the CMHT by a local pub landlord and five days later by her GP. The concern was recorded by the GP in a referral letter and passed to the mental health team as it was viewed as being the result of Joyce’s relapsed mental state. Records indicate there was an initial delay in accessing a secondary mental health review. Her self-neglect was being triaged as non-urgent and was later viewed as not meeting the criteria for secondary mental health services as Joyce self-reported that she was managing her care needs. If this situation occurred now it could have been progressed through the SPOA service which now manages initial screenings rather than delays taking place waiting for screening days, as was experienced in 2013.

15.6.18 The NEK CRHT became involved with Joyce, and supported her by helping her address the issue of neglect, attending her daily, setting her small tasks and assisting her in cleaning her home. Her medication was also monitored to stabilise her mental state before transferring care back to the CMHT for ongoing intervention. Concerns of neglect appeared to be related to a relapse of Joyce’s mental state; later home visits and contact were made to monitor these concerns and to ensure her needs were being met and medication issues resolved.

15.6.19 In July 2014, presenting issues resulted in another period of stability and, at Joyce’s request, she was discharged back to her GP.

15.6.20 The information contained within this IMR tells us that Joyce had a long history of relapsing mental health that resulted in periods of increased vulnerability.

15.6.21 It was good practice that, even though SPOA had not yet been implemented, conversations did occur between the agencies, and further mental health assessment arrangements were made by the CMHT. It was also good practice that assessments involved practitioners known to Joyce and followed the current policy guidance of actions being taken where:

“An Individual is identified as self-neglecting when they appear to be at significant risk to self and others and they are not engaging with support”.

15.6.22 The implementation of the Care Act 2014 brought about changes to how self-neglect was considered and acted upon, but the concern for Joyce self-neglecting in 2013 occurred prior to the implementation of this legislation. During the period Joyce was reported as self-neglecting, safeguarding largely related to abuse perpetrated by a third party and not the person themselves. There was therefore no agreed process relating to a multi-agency approach to an individual self-neglecting. The discharge summary to the GP however demonstrated a reflection of balancing the individual’s rights alongside the organisations responsibilities, and noted that:

“Joyce has requested her discharge to your care. We have no reason to disagree, as she is fully compliant with all medication, keeping her home in a good order and managing her own self-care and personal ADLS.”

15.6.23 There is no doubt that Joyce at various periods leading up to her death was the victim of ‘self-neglect’. Whilst this was identified by KMPT, professionals from other agencies should also be made aware or reminded of this condition in order to identify vulnerable persons such as Joyce. For this reason a recommendation has been made in relation to this issue. **(See Recommendation 8)**. A comprehensive document covering this subject entitled the ‘*Kent and Medway Multi-Agency Policy and Procedures to support People who Self-Neglect*’ should be used as a reference point when dealing with this recommendation.

15.6.24 Records indicate Joyce was socially isolated which was recognised and addressed throughout her contact with secondary mental health services, and acted upon by the mental health team through early referrals to various support groups. There was no other evidence to suggest Joyce was the victim or perpetrator of potential and/or actual domestic abuse. In 2014, any changes to Joyce’s living arrangements were unknown to KMPT with home visits at that time not indicating anyone else moving into the property.

15.6.25 Joyce was not identified as the victim of abuse by KMPT because in July 2014 she was discharged from the service. At the point of her discharge Joyce had not informed the Thanet CMHT that Sandra

Wilson was living with her and there was no evidence to suggest there were changes to her living arrangements.

15.6.26 Sean Rose was referred to Medway CAMHS in 2005 by a paediatrician who had reviewed him as part of a routine Social Services medical examination. The referral to Medway CAMHS noted Sean had a diagnosis of Attention Deficit Hyperactivity Disorder (ADHD), and both his school and carer had raised concerns about his behaviour mainly in relation to anger, violence, disobedience and inappropriate language. The referral to CAMHS came after an incident where Sean had been violent at school and reported hearing a voice telling him to attack other people.

15.6.27 In 2011, Sean was identified as needing a specialist residential placement following increased concerns about his vulnerability to exploitation as well as presenting behaviours. It was noted he had increased anxiety, had started sniffing aerosols and urinating in his bedroom. From the records it is unclear if the local authority placement found was suitable and in line with the recommendation.

15.6.28 In October 2012, CAMHS conducted a review about how Sean, then aged 17, would manage once 18. At the time it was noted there was no plan for post 18 plus care both in terms of therapy or care placement, but that this would be addressed. Sean expressed a yearning to be part of a family. This review occurred at the time when CAMHS moved from KMPT to the Sussex Partnership NHS Trust. No further information was then available within KMPT records to explain decisions around the post 18 care plan for Sean.

15.6.29 Agencies were aware that both Sean and David Rose had witnessed domestic abuse when young. This indeed was known by CAMHS as it was reported in the initial referral to them in 2005 that both Sean and David had been removed from their mother's care some years previous due to domestic abuse and the physical abuse of Sean. Knowing this, does not directly relate to predicting the death of Joyce Jackson. There was no information held by the agency to link the perpetrators to Joyce and indeed no information that Sean Rose was even in contact with his mother, Sandra Wilson. However in considering the relevance of this information the experience of their childhood abuse and of domestic abuse becomes relevant when considering how risk behaviours were addressed and managed.

15.6.30 The importance of availability of specialist therapy in managing risk behaviours displayed by Sean was a repetitive theme, and was exacerbated by his continued return and exposure to further abusive situations.

15.6.31 At the point of Sean's discharge from CAMHS in 2008, there was a lot of joint planning, information sharing and seeking of specialist therapy. The point of discharge from the second referral is not as clear because in 2012 there were changes to how CAMHS was provided, and such discharge arrangements were not under the remit of KMPT. This is particularly relevant as the concern of managing him post 18 was noted in the last review held by KMPT CAMHS in 2012, when Sean was aged 17. At this time, although concerns were noted, there was no provision recorded. There was no evidence to suggest that Sean was ever referred to adult mental health services.

15.6.32 It is unclear from information held by KMPT how Sean Rose was supported post 18 as no adult referral to mental health services was made.

15.7 Kent Community Health NHS Foundation Trust

KCHFT submitted an IMR but the Panel concluded their involvement was not relevant to the terms of reference of this DHR.

15.8 East Kent Hospitals NHS University Foundation Trust

An IMR was submitted which referred to attendances by the subjects of this review at A and E department in East Kent. Joyce was not seen at hospital during the time frame under investigation until the event that led to her death. David and Sean Rose had no contact with the hospital and Dean received treatment for minor conditions irrelevant to this review. The Panel concluded this IMR takes the review process no further although provides some background information.

15.9 South East Coast Ambulance Service NHS Foundation Trust

15.9.1 SECAmb had only two contacts with Joyce Jackson during the time frame of this IMR. On the 15th May 2012, Joyce was seen by SECAmb following a fall down the stairs at her home. There was nothing recorded indicating any disclosure had been made or that the attending crew had any suspicion that this was related to a domestic assault. At this time SECAmb training did not include specific reference to domestic abuse making it unlikely the crew would have considered this as a possible cause of the fall. The second incident occurred two

and a half years later, on 17th November 2015 at 12:54 i.e. the incident which led to Joyce's death.

15.9.2 After a review of SECamb records, no contact with David or Dean Rose was found. Only one contact with Sean Rose was found when, in May 2014, he accompanied his mother to hospital after she had consumed excessive amounts of alcohol.

15.9.3 This IMR takes the review process no further although provides some supporting background material.

15.10 Kent Specialist Children's Services

15.10.1 Terms of Reference required Kent Specialist Children's Services to complete an IMR as Dean, for a period of time, was staying at Joyce's house in Thanet, and thus any contact and possible intervention opportunities needed to be identified. The reader should be reminded that this is a Domestic Homicide Review and not an all-encompassing scrutiny of agencies involvement with Dean Rose who, as a child and as an adolescent, was looked after and supported by the Kent County Council.

15.10.2 Dean was in the care of the local authority from 2013. At the time of the assault which led to the death of Joyce Jackson his case was open to the 18plus service, and Dean was allocated a Personal Advisor⁹ (PA1).

15.10.3 Kent County Council, in partnership with other agencies has a responsibility to support young people who are leaving care and to help them make a successful transition to adulthood, either through re-integrating with their families or becoming as self-supporting as possible.

15.10.4 The Children Act 1989 and its regulations and statutory guidance place a legal duty on local authorities to provide support to care leavers. The local authority is the "corporate parent" for children in care and therefore has a responsibility for their wellbeing. The precise

⁹Each Young person covered by The Children (Leaving Care) Act 2000 will have a Personal Advisor who-

- Does not have to be a Social worker
- Will not be a budget holder
- Will be involved in
- Drawing up a pathway plan and ensuring it addresses any changing needs
- Providing advice and support
- Keeping in touch with the young person, Co-ordinating services, linking with other agencies.

level of care required by each care leaver will depend on their assessed needs and on their leaving care status, as defined by statute.

15.10.5 Legislation and regulations place a strong emphasis on individuals leaving care and regards this as a transitional period rather than something that occurs at a particular point in time. Care leavers are expected to receive support from their responsible authority (the local authority that last looked after them) up to their 25th birthday if they so wish and are eligible. The aim of such continuing support is to ensure that care leavers are provided with comprehensive personal support so that they achieve their potential as they make the transition to adulthood.

15.10.6 Young adults aged between 18 and 20 who meet the criteria of an eligible and/or relevant child prior to their 18th birthday, and who have subsequently reached 18 years of age, are transferred to the 18 plus teams within Kent County Council. Dean was transferred to the 18 plus service on 01/09/20/14. The case was allocated to a Personal Advisor (PA1) within this service.

15.10.7 At the time when the case was allocated to PA1, Dean was missing and not in contact with the 18 plus service. The first recorded contact between PA1 and Dean was a telephone call on the 05/02/15.

15.10.8 Dean and his family had a history of involvement with Specialist Children Services, his mother had been in domestically abusive relationships which Dean had witnessed and Dean had no contact with his birth father. Whilst residing with his mother, Dean and his siblings led a chaotic lifestyle with many changes of addresses and schools. There were concerns in relation to the children witnessing domestic abuse and neglect.

15.10.9 In January 2013, (then 16 years old) Dean presented to the Out of Hours Service as homeless and in April 2013 was accommodated (Section 20 LAC), after stating he had been asked to leave his grandmother's home due to being in trouble. Previously, work had been undertaken with Dean's grandparents to ensure he remained within their care, however this was not viable. Dean was open to YOS and a Referral Order was in place following him causing criminal damage.

15.10.10 Dean's illicit substance misuse (legal highs) was of great concern and he was frequently under the influence of these substances to the point where he was putting himself and others at risk. Dean was known to KCA¹⁰ however he would often not attend appointments.

15.10.11 Dean gravitated back to his mother for short periods. He felt rejected and let down by his family, however, clung to the belief that they would one day provide him with the emotional support he had always wanted from them.

15.10.12 On 23/07/2015, Dean informed his Personal Advisor (PA1), that he had moved into his mother's address i.e. the home of his mother's 'friend', Joyce Jackson. Dean was visited and PA1 met his mother and viewed the accommodation. PA1 offered to assist in sourcing alternative accommodation options, but Dean did not wish to take up the offer. He was, on this date, also taken by PA1 to meet with his Probation Officer with whom he had not been engaging. Dean was supported by his mother who was keen to keep in contact with the PA. There was liaison between the Leaving Care Service and the Probation Services, but it was clear that Dean was not complying with his Probation Order.

15.10.13 On 25/08/2015, Dean's mother (Sandra Wilson) contacted PA1 to express her concerns that Dean had again been working with the fairground¹¹, but had returned home and was taking legal highs. Legal Highs are psychoactive drugs that contain various chemical ingredients, some of which are illegal while others are not. They produce similar effects to illegal drugs like cocaine, cannabis and ecstasy.

15.10.14 On the 26/08/2015, a discussion took place between PA1 and his Line Manager. It was noted how work was going with the Probation Service, and reference was made to Dean having swollen knuckles owing to an alleged fight with a stranger. It was recorded that Dean had self-reported and that he had no issues with drugs or alcohol. The focus of this session was around building the relationship between PA1 and Dean, longer term housing resolutions and a follow up on a ADHD assessment. There was no indication of 'curiosity' or discussions taking place with regard to his current living arrangements.

¹⁰KCA Young Persons' Services provide friendly and expert advice and information about drugs and alcohol to 10-17 year olds with options considered for lifestyle changes and choices

¹¹ Dean periodically worked with a travelling fairground.

15.10.15 On 28/08/2015, PA1 undertook his second home visit to Joyce Jackson's address and met Dean, his brother and his mother. The home conditions were described as 'not good' at that time and Dean's mother informed PA1 that it was due to both brothers taking legal highs and play fighting which had resulted in broken furniture. PA1 spoke to Dean regarding his drug taking and offered him specialist drug addiction services, but Dean refused. He was also offered other accommodation such as supported lodgings or a placement with other private housing providers, which he again refused. Advice was given regarding his behaviour whilst living with his family. Dean's Mother was advised to contact PA1 if any further behaviour or concerns arose. Dean's Mother showed PA1 a bag containing legal high's and stated, 'They were like zombies when they had used these substances'. PA1 is recorded as addressing the issue of drug use and the state of the property during this visit with Dean. PA1 also concluded it was detrimental to Dean living with his Mother and brother. PA1 focused on potential accommodation issues but there was no mention made of Joyce Jackson during this visit, and it is unclear whether PA1 saw Joyce on this occasion. There is no record of any action being taken by PA1 with regard to the state of the property and the potential vulnerability of anyone else at the address. It is not unreasonable for a visitor to this address, whether professional or not, to have been more questioning of what the home owner thought about what was going on, and to have considered Joyce within a broader picture.

15.10.16 On 14/10/2015, PA1 spoke to Dean who again stated he had been working on 'the fair', but now wished to move into accommodation with his girlfriend. He was advised how to complete a housing application and that the service would seek alternative accommodation for him, with or without his girlfriend.

15.10.17 On 23/10/2015, PA1 went to Joyce Jackson's house on a pre-planned visit, but Dean was not there. PA1 spoke to Dean's mother who again expressed concern over the level of drug taking involving Dean and his brothers. There was no improvement in the general state of the house. As Dean was an adult (19 years) he could not be forced to participate in drug rehabilitation programmes although these were consistently offered.

15.10.18 On 06/11/2015, Dean's girlfriend rang PA1 to inform him they had jointly made an application to Thanet housing. PA1 gave advice regarding other levels of help available but Dean refused to speak to him.

15.10.19 On 17/11/2015, Dean's mother contacted PA1 and informed him of an assault that had taken place on her 'friend Ms Jackson' whose house they were staying in. PA1 contacted the Police.

15.10.20 On 20/11/2015 Dean was arrested in respect of the assaults on Joyce.

15.10.21 PA1¹² had never spoken to Joyce Jackson, and had only seen her briefly when he visited her house. During this occasion she was in her nightclothes, and he did not want to engage her in conversation. From scrutinising the records of PA1's home visits and from reading the records of discussions with his line manager, it would appear that PA1 concentrated on trying to engage with Dean and offer him a range of alternative accommodation, which Dean did not want to consider. The lack of engagement by Dean with Probation Services is evidenced on the case file. PA1 appeared to feel he had a positive relationship with Dean's mother who did contact him for advice.

15.10.22 In summary PA1 undertook three visits to the address between July and October 2015. The first visit took place on the 23rd July and PA1 records that he largely focused on the work that Dean was required to do with Probation, and how he could support him. At this stage Dean had only just moved in with his Mother and Joyce, and it appeared to be a very temporary arrangement. No other concerns were noted during this visit. PA1's primary focus would have been making contact with Dean, discussing his accommodation options and ensuring he engaged with his Probation Officer. This was perfectly appropriate in the context of PA1's role in dealing with Dean's immediate needs at this time. It was noted by PA1 that Dean was staying with his Mother and the property did not belong to her but to his mother's friend; Joyce Jackson was not referred to by name and therefore it is not clear if PA1 knew who she was or saw her on this occasion. Without seeking to use hindsight, PA1 could have been more professionally curious' and should have spoken with the homeowner to determine whether this arrangement was viable. **(See Recommendation 1).**

15.10.23 On the 14th and 20th October 2015 PA1 made two phone calls regarding Dean's housing situation. The first was with Dean's girlfriend and the second with a Housing Officer at Thanet Council. Both calls discussed finding accommodation for Dean and his girlfriend; PA1 agreed to help Dean with the relevant housing application forms.

¹² PA1 left Kent Children's Services by the time this IMR was commissioned and the IMR Author had no opportunity to interview him.

15.10.24 During a supervision session on the 11th December, and after the critical incident, PA1 is recorded by his line manager as having been threatened by Dean Rose.

15.10.25 PA1 appears not to have been as proactive in assessing the home situation and monitoring risk as would have been expected when working with a young person with the behaviours Dean displayed. PA's are not qualified social workers and are dealing with young people who are adults and who can make their own choices and who can be hard to engage with. PA1 is recorded during a supervision session, following the critical incident, as saying that he was now concerned that he had not spoken to Joyce more when he had visited the address. He also commented that he had not observed anything that he could connect with the violence that transpired.

15.10.26 It was clear PA1 had picked up some concerns about Dean specifically regarding the environment he was living in. These are noted as the use of legal highs and the impact these had upon him, and his brother. In addition, PA1 was clearly concerned about the state of the property and the damage that had taken place. PA1 also recorded concerns about an incident when Dean reported being in a fight when his hand was damaged. PA1 should have assessed the risk to Dean and to others within the household, based upon his clearly recorded observations. PA1 should have also been more curious about how the 'Rose' family had come to be at this address and should have spoken to Joyce Jackson.

15.10.27 The records held by Children's Services did not include indications that Dean was violent, they did record that Dean functioned at a level below his chronological age and that perhaps he could be influenced by others. The impact on Dean of the drugs he was taking did appear noticeable and this was reported by his mother to PA1. PA1 had sought to persuade Dean to address his drug use but it did appear that he would not engage with drug services. The use of drugs, the dynamic created with his brothers, the apathy of his mother and his level of functioning would appear to have been factors in this case.

15.10.28 The role of the Personal Advisor and particularly that of PA1 has been of particular significance in this case. In Kent, cases are allocated to Personal Advisors on a geographical basis, with each Personal Advisor having a planned caseload of 30 young people. At the time when PA1 was working with Dean, he had 35 cases, but upon speaking with his then supervisor, this increased number of cases was not considered a factor in determining his actions.

15.10.29 Although Personal Advisors are not qualified Social Workers, PA1 was an experienced youth worker and would have undertaken training in safeguarding, signs of safety and pathway planning. He would also have undertaken basic child protection training and would have an awareness of adult services and adult safeguarding.

15.10.30 Each agency seems to have focused their attention on single issues within their own remits and did not connect them with other important events. The evidence would suggest that each held a piece or pieces of a jigsaw puzzle without any sense of the picture they were creating, or indeed the timeframe within which the puzzle had to be completed. Within the case work undertaken with Dean, and within the supervisory relationship it would appear the vulnerability of Joyce Jackson, in the context of what the PA was observing within the household, was simply not connected. PA1 subsequently reflected that he had not engaged with Joyce and she did, from the PA's perspective, appear a somewhat invisible presence within the property.

15.10.31 There was no evidence that PA1 witnessed any abuse towards Joyce or was aware of any threats or risk towards her; this was confirmed by his supervisor.

15.10.32 The supervisor informed the IMR Author that after the death of Joyce Jackson, PA1 reflected he could have done more to have 'protected' her. The supervisor could not be absolutely clear as to what PA1 thought he could have done, but did indicate he could have discussed the situation with other agencies, specifically the Police and Housing.

15.10.33 Kent Specialist Children's Services have clear policies regarding individuals leaving care. This case demonstrates how difficult it is to work with young people who are reluctant to accept help. Dean had profound negative issues going on in his life not least of which was his intake of drugs including legal highs. The role of the PA in this case is significant as this individual had the opportunity to identify the risk Dean and his brothers posed to Joyce and to a certain extent their mother. In terms of this review assessing and risk managing the accommodation in which Dean was living was largely absent certainly in terms of identifying Joyce's vulnerability. This case should be used in demonstrating to Personal Advisors the importance of risk assessing accommodation and exercising 'professional curiosity' when undertaking home visits or conducting interviews with their clients (**see Recommendation 9**).

In addressing the above issues the following should also be considered.

- The use of risk management meetings to discuss young adults like Dean, who exhibit risk taking behaviour and where a clear risk management assessment and plan can be put in place.
- The introduction of joint working of cases at 17.5 years prior to the transition into the 18 plus service.
- The improvement of links with the Probation Service.
- Increased management oversight of cases, through supervision and/or case file reading.

15.11 Medway Children and Adult Services

15.11.1 Medway Social Services completed an IMR as Sean and David Rose for a period of time, were staying at Joyce's house in Thanet, and thus any contact and possible intervention opportunities were required to be identified. As with Dean, the reader should be reminded that this report is a Domestic Homicide Review and not an all-encompassing scrutiny of agencies involvement with these two individuals, both of whom had been in the care of the Medway local authority.

Sean Rose

15.11.2 Having lived initially with his mother (Sandra Wilson), Sean and his brother David, went to live with his natural father and his partner. This was agreed as whilst living with his mother and stepfather, he witnessed ongoing domestic violence and was also the victim of assault himself. He was consequently placed on the Child Protection register, and Sean's natural father was granted a Residence Order in respect of both he and his brother, David. At that stage Sean had already suffered neglect, and emotional and physical abuse. His speech was delayed and his concentration span limited. He was also described as having behavioural difficulties. No contact arrangements were put in place for him to continue seeing his younger brother Dean who remained living with his mother and his two half-siblings.

15.11.3 Since 2004 various agencies had an involvement with Sean.

15.11.4 In 2004, Sean was placed with foster parents and thereafter spent most of his childhood in care with temporary returns to his father and stepmother and his aunt.

15.11.5 Although a package of support was put in place this did not assist with a return home and a Section 20¹³ consent was given. He remained in foster care until 2006 when, at his father's request, he was temporarily returned home.

15.11.6 Sean was described as violent and verbally abusive and threatening to others; whilst in foster care in 2007 he assaulted his female foster carer and also assaulted his teacher at school and caused criminal damage.

15.11.7 In March 2007, Sean was deemed to be a potential risk to himself and others and was assessed as having the emotional development of a 2-3 year old at age 12 years. At this early stage Sean was showing signs of disturbed behaviour.

15.11.8 Sean also abused drugs e.g. on 02/02/2013 he was admitted to hospital after taking a cocktail of drugs including crack cocaine, LSD and alcohol. He explained to a residential worker that he took the drugs and alcohol because he was assaulted by his stepmother and by his father when he was 7 years old.

15.11.9 On 26/01/2014 Sean assaulted a female member of staff at his accommodation as he wanted money to buy drugs. On 03/02/2014 he threatened staff whilst demanding money. When he was told money was not kept on the premise he left abruptly. On 19/02/2014 he returned and tried to take a television from the premises. Sean made contact with staff on 26/02/2014 and it was noticeable that he had lost weight and was still choosing not to stay at his accommodation.

15.11.10 On 27/02/2014, Sean appeared in court and received a 12 month suspended sentence for breach of his Community Order, theft and assault; he was given a curfew and fitted with an electronic tag. On 19/03/2014, concerns were raised by his accommodation placement as Sean had not returned the previous night, but when he returned the next day he had removed his tag.

15.11.11 On 02/06/2014, Sean was sentenced to 148 days in prison and on 05/08/2014, his mother made contact with his Personal Adviser (PA2) enquiring about his release date. Sandra Wilson informed the Personal Advisor that she only had a one bedroom flat and so could not accommodate Sean on his release from prison.

¹³ Section 20 Children Act 1989 concerns the Local Authorities duty to provide a child with somewhere to live because the child does not have a safe home.

15.11.12 Sean was released from prison on 11/08/2014 and accommodation was found for him. It was established Sean was not staying at this accommodation and on 11/02/2015 the Medway housing authority discharged their duty to accommodate him.

15.11.13 Between December 2014 and July 2015, Sean was not seen by his Leaving Care Personal Adviser, as his whereabouts was unknown to the Medway Authority. During this time efforts were made to locate him but to no avail, however in May 2015 his brother, David Rose, informed the Personal Advisor (PA2), that Sean could be living with his mother in Thanet. No evidence could be found of this being followed up with a home visit.

15.11.14 Sean was sent to prison for burglary in June 2015 during which time his Personal Advisor, PA2, contacted his mother Sandra Wilson and requested that upon his release Sean live with her (Sandra was living at Joyce's address). His mother agreed but stressed that she would require support to secure adequate housing for both her and Sean.

15.11.15 On 21/07/2015, the PA2 made telephone contact with Sandra Wilson who confirmed that Sean had been living with her. Sandra also confirmed that Dean was also living with her and that David often visited with his girlfriend (no name given).

15.11.16 On 27/07/2015, PA2 visited Sean in prison and a release date of 17/09/2015 was given. On 02/10/2015 Sean's address was confirmed as Joyce's house, where his mother was living.

15.11.17 After Sean's release from prison in September 2015, PA2 carried out two visits to Joyce's house. She explained that on the first visit she met Joyce who informed her that Sean and his mother were not at home. Neither the record nor the PA was able to confirm the date of the visit.

15.11.18 On the second visit on 9th October 2015, the PA and her manager met with Sean and Sandra Wilson at Joyce's house. The PA mentioned that during the visit she saw Joyce briefly who came downstairs and went into the kitchen. She also mentioned that Dean came downstairs in his underpants with his girlfriend Kelly Cox.

15.11.19 Sean's PA explained that she believed (erroneously) that Sandra Wilson had a joint tenancy agreement with Joyce, and because of this she did not discuss with her Sean living at the premises.

15.11.20 It would appear that from the 09/10/15 Sean was not seen by his Personal Adviser.

15.11.21 On 13/10/2015, in order to find him supported accommodation, Sean's case was presented to the Medway Access to Resource Panel¹⁴. It was acknowledged at this stage Sean was a vulnerable adult and was highly likely to re-offend. His mother was described as an alcoholic with a history of substance misuse and not being able to keep any accommodation for a sustained period.

15.11.22 As Sean did not wish to return to Medway it was agreed by the panel to support him with rent money and a deposit for accommodation in Thanet. However the Probation Service referred him to NACRO for supported housing but he did not keep his appointment. The Probation Service also confirmed that since his release from prison in September 2015 he had not kept his appointments.

15.11.23 Sean over the years had contact with his mother and it would appear that in 2015 his Medway Personal Advisor, PA2, supported their relationship. It is clear that in July 2015 it was known that Sean would be living with his mother at Joyce's house. There is evidence that efforts were made to accommodate Sean, however it is unclear why professionals felt it was appropriate for him to be released from prison to this address without a risk assessment taking place given his background and his mother's history and vulnerability (**see Recommendation 10**).

15.11.24 On 25/11/2015 Sean was arrested and charged (GBH) with the assault on Joyce Jackson.

15.11.25 There was good evidence of regular supervision advice and direction taking place by Medway LAC in assisting the Personal Advisor in trying to track down Sean's whereabouts. There was also good evidence of Sean being encouraged and supported to achieve in education and employment, however he was unable to sustain this and was never in full employment. Sean was offered therapeutic intervention over a long period of time but he did not always fully engage.

15.11.26 The Pathway Plan review in relation to Sean took place on 27/08/2015 by PA2 and whilst he was in prison. She discussed with Sean his use of cannabis and his risk of re-offending. She also explained that she would complete a DUST¹⁵ referral tool and an

¹⁴ Makes decisions on placements, independent provision and support packages for young people, looked after children or children in need.

¹⁵ Drug Use Screening Tool (DUST) is a screening tool used to identify substance misuse risks and other risk factors to assist in 'holistic assessment' of the young person's needs. It should therefore assist in the professional delivering low level interventions where substance misuse and other risk factors are low.

assessment of risk to determine which services and support he would require. It is not clear if this was completed. This assessment would have gone a long way in helping the practitioner to understand the level of risk Sean presented whilst under the influence of drugs. For example, his capacity to empathise with others, show self-control and appropriate self-awareness.

15.11.27 The issues relating to Sean and Medway Children's Services are similar to that of Dean and Kent SCS. Medway have clear policies regarding individuals leaving care. Again this case demonstrates how difficult it is to work with young people who are reluctant to accept help. Efforts were made to find him accommodation but he was generally not receptive to this help. Sean like many care leavers was often difficult to locate making it a problem for Personal Advisors to work with him. As with Dean the role of the PA in this case is significant as shortly before the assault on Joyce, Sean was released from prison and it was known he would be staying with his mother at Joyce's house. Again no risk assessment took place regarding the suitability of this accommodation particularly with regard to the vulnerability of any existing occupants. Such risk assessments should be a collaborative process with probation providers and the housing authority. He was visited in prison in August 2015 by his Personal Adviser prior to his release and at that stage, with the help of probation and NACRO¹⁶, alternative accommodation in Thanet could have been considered. This would have involved forward planning and should have been in line with Sean's Pathway Plan¹⁷.

15.11.28 As with Kent, Medway should use this case to demonstrate to Personal Advisors the importance of risk assessing accommodation and exercising 'professional curiosity' when undertaking home visits or conducting interviews with their clients **(see Recommendation 1)**.

15.11.29 Visits to care leavers are of great importance and their regularity is governed by individual circumstances. Policy regarding such visits was adequate but not always interpreted in the correct way. In Sean's case LAC visits were taking place every 8 weeks but given Sean's background, vulnerability and propensity to go missing, it would have been appropriate to see him every 2 weeks.

15.11.30 Another aspect which could have been explored is Medway Leaving Care liaising with Thanet Leaving Care and making them

¹⁶ National Association for the Care and Resettlement of Offenders who also work with offenders experiencing homelessness and are in need of support.

¹⁷ The Children (leaving care) Act 2000 requires a Pathway Plan for all eligible, relevant and former relevant young people.

aware that there was a vulnerable and high risk care leaver in their area, exploring with them the resources in their area, which could support Sean. This would have been in line with Medway's Leaving Care and Transition guidance.

David Rose

15.11.31 David Rose initially lived with his mother and stepfather in west Kent. In 2002 David went to live with his father who had obtained a Residence Order in respect of both David and his brother, Sean.

15.11.32 Whilst living with his mother, David witnessed domestic violence towards his mother. He was also the victim of familial violence and in 2003 was placed on the Child Protection Register for emotional and physical abuse.

15.11.33 David came to the attention of Medway Social Services on 04/03/2004 after he made allegation of physical abuse by his father and stepmother.

15.11.34 When David was 13 years old he was placed into the care of his maternal aunt, and on 06/06/2006 was placed into foster care when his father signed a Section 20 consent.

15.11.35 David had two foster placements and after leaving foster care in 2010 went into supported accommodation.

15.11.36 Over a period of time a number agencies had contact with David:

- Medway Council from March 2004 - Child Protection
- Medway Integrated Looked After Service including Leaving Care - June 2006 – September 2014
- Medway 0-25 Disability Team - Referral 17/04/13 and case allocated on 02/09/14
- Kent Adult Learning Disability Team - 2012
- CAMHS - 2006
- The Sunlight Family Centre 2004 - 2005
- The Sexual Inappropriate Behaviour Service - 2006
- Pyramid Partnership - Fortnightly Counselling - Fiona Chandler - 2006
- Youth Offending - 2006
- Housing - 2014 - 2015

15.11.37 In April 2012, David elected to live with his paternal aunt in Thanet. This arrangement broke down in August 2012 due to David's violence towards his aunt and his drug taking. On 03/09/2012 David moved from his aunt's address into bed and breakfast accommodation in Thanet. On 07/09/2012 following his stay in bed and breakfast, he was given temporary accommodation, which was organised through his Medway Personal Advisor (PA3).

15.11.38 On 31/12/2012, David was given notice to leave his accommodation as he broke the rules by allowing Dean and his mother to visit. On one occasion Dean had to be forcibly removed by the police. David also committed criminal damage by breaking into another young person's room in order to use her laptop.

15.11.39 On 02/01/2013, alternative accommodation was found for David in Medway, however this placement broke down due to him stealing from the property. On 10/04/2013 he moved into supported accommodation in Medway¹⁸.

15.11.40 On 17/04/2013, a referral was made to Medway Adult Services as David was deemed to be a vulnerable adult with a learning disability with an IQ of 50-55. He was deemed to be at risk of exploitation and emotional abuse. David also had a drug and alcohol addiction problem.

15.11.41 On 20/02/2014, David was sent to prison for past offences of theft and was released on 10/04/2014 when he was placed into accommodation in mid Kent. David was seen on 19/05/2014 and on 23/06/2014 after which a decision was made to close down his placement. On 21/07/2014 David went to a supported accommodation establishment and explained to the manager that he was homeless.

15.11.42 On 20/10/2014, David voluntarily terminated his tenancy with the aforementioned supported accommodation and left no forwarding address, or contact details. He was later located by a Medway 0-25 social worker (SW1) living in a rented house in Gillingham, with his girlfriend who was a looked after young person. He was evicted from this address and was given emergency accommodation arranged by his social worker. This was a short lived arrangement as in November 2014 he was imprisoned for 4 months for theft and criminal damage.

¹⁸A privately owned residential care home for younger adults with mental health, learning disabilities and substance misuse issues.

15.11.43 David was released from prison on 28/01/2015 and received emergency accommodation through Medway Council Home Choice. On 02/02/2015, he was evicted from this accommodation after breaching the tenancy agreement by smoking cannabis on the premises. Following this, David was deemed to have made himself intentionally homeless and became of no fixed abode; the housing providers discharged their duties to re-house him under Sect 188 part 7 of the Housing Act 1996.

15.11.44 David struggled to find a place in which to live and spent some time with a friend who was living at his previous supported accommodation. There were various professionals including the Medway 0-25 Disability Team and housing officers communicating with David about his homelessness, but they felt powerless to help him.

15.11.45 In February 2015, David's social worker (SW1) met him but David would not disclose where he was living other than saying he was staying with a family member. He also said he did not wish to be assessed for services and support and felt he could manage without additional support and only had housing needs. At this point SW1, under the Mental Capacity Act, deemed David as an independent adult who had the capacity to make decisions. He was deemed not to require any further help or support, and in June 2015 the 0-25 Disability team closed his case. Since this time there was no further contact with David apart from an occasion in June 2015 when he requested his life story book. He was not seen again by Medway Social Care.

15.11.46 David's case was closed by the leaving care/LAC team on 15/09/14 as he was no longer entitled to services at age 21. This decision was correct and in line with the Leaving Care Act. Had he been in education this could have been extended until he was aged 25 years old. There clearly had to be a cut off age however David's learning difficulties appropriately led to a referral to the Medway 0-25 Disability team.

15.11.47 The IMR shows that numerous efforts were made to house David but he was making his own decisions to leave his accommodation. The Medway 0-25 Disability team were unable to work with David and were often unable to contact him and he did not keep appointments.

15.11.48 Prior to David's case being allocated to SW1 in October 2014, there is very little evidence of the Medway 0-25 Disability team trying to engage with David. His case was referred in April 2013 and remained

unallocated until September 2014 and an assessment of needs remained outstanding until February 2015.

15.11.49 Over the years there has been some evidence of supervision and management oversight of the case, however the risk management of David's behaviour could have been more formulated. For example having a greater understanding of his background and therefore the potential risks he was likely to pose as an adult.

15.11.50 After leaving care he was placed in supported accommodation, and struggled with budgeting self-care and hygiene. He was also financially exploited and developed drug and alcohol addiction problems.

15.11.51 In terms of adult safeguarding, as David was assessed as a vulnerable adult and a risk to himself and the community, there remained a duty to him under Section 42 and 46 of the Care Act 2014¹⁹. Also by virtue of David being in contact with Joyce he represented a potential risk to her, and so she would have been in need of protection; therefore these sections of the Act also applied to her.

15.11.52 Sean and David's placements had safeguards in place to protect others from them, however Medway Children Social Care had no safeguarding strategy or protective factors in place to continue with this once they became 18 years of age, and consequently they drifted back to their mother and were caught up in her drug culture.

15.11.53 No evidence could be found of Medway Social Service Department considering David and Sean as a potential risk to Joyce, and her views were never sought in relation to either of them residing in or visiting her home.

15.11.54 As with Kent Social Services, collaborative risk assessments are needed between the Probation Service and the Medway Leaving Care Team in relation to young people leaving prison and being in need of accommodation and counselling. Such a risk assessment should take into account other occupants residing in the accommodation (**see Recommendation 10**).

15.11.55 There did not appear to have been ongoing risk assessments of David and Sean Rose by Medway Leaving Care/LAC and other agencies. Various agencies shared their concerns over a period of time but there was no strategy in place to manage the potential risks they

¹⁹ S 42 Care Act 2014 contains a duty to make inquiries if an adult with care and support needs is experiencing or is at risk of experiencing abuse or neglect and is unable to protect himself against abuse or neglect Act.

presented to the public. From 2004, Sean and David had a history with Medway Social Care, which included drugs, violence, and repeat offending. These factors made them a high risk within the community and to vulnerable people. It was inappropriate for Sean to have been living at Joyce's house and there was no evidence that her safeguarding was considered.

15.11.56 Leaving Care Regulations and guidance around statutory visits needs to be more robust and tailored to cater for a care leaver's level of risk to themselves and the community. Whilst it is acknowledged that 18+ care leavers are a difficult group to engage with, a strategy should be in place to monitor those who are most vulnerable and a risk to themselves and others.

15.12 The National Probation Service (incorporating KSS CRC).

15.12.1 Until 31/05/2014, probation services in Kent fell under the Kent Probation (Trust). On 01/06/2014, following Government changes (known as Transforming Rehabilitation reforms or TR), this was divided into two separate organisations i.e. the National Probation Service (NPS) and Community Rehabilitation Companies (CRC) of which nationally there were 21. All references up to and including 31/05/2014 refer to Kent Probation (KP) and thereafter the National Probation Service (NPS) aside from references to the Kent, Surrey and Sussex Community Rehabilitation Company (KSSCRC). The allocation of adult offenders to either the NPS or the CRC is governed by the Case Allocation System (CAS). There are three steps to this process and they are recorded in the CAS document and include: the Risk of Serious Recidivism (RSR) Tool, the Risk of Serious Harm (RoSH) screening and the final stage of the CAS identifies which agency the case should be allocated to from the RSR score, the Risk of Serious Harm level, Multi Agency Public Protection Arrangements (MAPPA) status, public interest and whether sentence has been deferred. The NPS delivers services to high and very high risk of harm offenders. Medium and low risk of harm offenders are allocated to CRCs. Some other offenders are automatically allocated to the NPS for example, those given a life sentence.

15.12.2 **Joyce Jackson** was not known to Kent Probation (KP), the National Probation Service (NPS) or the Kent, Surrey and Sussex Community Rehabilitation Company (KSS CRC).

15.12.3 **Sandra Wilson** was known to the probation service both pre and post TR and the establishment of the NPS and CRC. She was subject to various Community Orders for offences of shoplifting and/or criminal damage. Both her response to community supervision and engagement with professionals was poor and was marred by issues relating to various changes in temporary accommodation arrangements.

15.12.4 **David Rose** was known to both the NPS and the KSS CRC. Within the time scale of this DHR there were a total of eight separate court hearings between 11/03/14 and 28/01/15 including one breach hearing.

15.12.5 On 22/09/14, David appeared at Magistrates' Court and pleaded guilty to theft and was sentenced to a Suspended Sentence Order (SSO) 120 days custody suspended for 18 months with two requirements namely a supervision requirement 12 months and a curfew to be managed via an electronic monitoring device (a tag). He failed to turn up for the fitting of the tag.

15.12.6 On 02/10/14, the allocated Offender Manager (OM) for David spoke with the accommodation provider where he was residing and was advised that he was "hardly ever there". He did not engage and was "abusive and intimidating" towards staff, and had been issued with a warning and faced eviction. This was a sound attempt by the OM to establish factors which might have influenced David's negative presentation with professionals. This was good practice given there was no Pre-Sentence Report available from which to draw an assessment and no previous contact had been made with Children's Services in order to glean information about his life experiences as a child.

15.12.7 On 28/10/14, David failed to attend a Breach Hearing at Magistrates' Court and a warrant was issued for his arrest. He subsequently appeared before Magistrates' Court on 26/11/14, for a breach of the SSO and shoplifting. The SSO 120 days custody was activated and David was sentenced to a further 7 days custody for the shoplifting matters. David was released from custody on 20/01/15. There was no further statutory supervision until his conviction for the murder of Joyce on 14/07/16 when he appeared before Canterbury Crown Court and was sentenced to Life Imprisonment with a 23 year tariff.

15.12.8 David Rose's response to statutory supervision and engagement with professionals was poor. Initially he failed to attend for a PSR appointment with the NPS and then latterly, once sentenced and allocated to the KSS CRC, failed to attend an induction appointment.

15.12.9 **Sean Rose**, within the timescale of this DHR, was known to Kent Probation Trust and both the NPS and the KSS CRC. Like his brother, David, Sean Rose's response to statutory supervision and engagement with professionals was poor.

15.12.10 There were fifteen separate Court Hearings between 14/11/13 and 17/02/16 including a total of six Breach Hearings scheduled as a result of his failure to respond to statutory supervision. Also during this period, there was contact between the allocated Offender Manager (OM) and a Leaving Care Personal Advisor (PA2) from the Medway Looked After Children (LAC) Team, the Young Lives Foundation, Supported Living (an accommodation provider) and an allocated social worker, all of whom were giving him support.

15.12.11 Sean appeared before Magistrates' Court on 14/11/13 for sentencing in respect of an assault on a Police Constable committed on 09/08/13 and was sentenced to a Community Order of 12 months and 200 hours Unpaid Work (UPW). Following failures to attend for UPW he appeared before Magistrates' Court in respect of Breach of the Community Order when matters were adjourned to 22/01/14 whilst a Breach Report was prepared.

15.12.12 On 08/01/14 and on 10/01/14, a leaving care personal advisor (PA3) from the Medway Looked After Children (LAC) Team, contacted the allocated UPW Officer and agreed to email a Consent to Share form. This enabled professionals to share information regarding Sean's history and to work together to understand each other's role/s in supporting him. It was established during these conversations that Sean had been statemented due to learning difficulties and that PA3 had been working with Sean for some time. Sean was described as demonstrating "very impulsive behaviour", was "struggling to manage things in his life", had a long history of being the victim of abuse and that he appeared to be following his brother's example of getting into trouble. The status of the Community Order was explained by the UPW Officer and whilst Breach action had to be pursued, there were concerns raised by PA3 regarding the impact that a custodial sentence might have upon Sean. As a consequence of the liaison between the two professionals, the recommendation to the Court in response to the Breach was for a period of community supervision to be imposed.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

15.12.39 On 31/03/15, an OASys assessment²⁰ was completed which drew upon information contained within the PSR noting the motivation to offend was driven by financial and perceived needs for drugs use. Dean took full responsibility for the offending although he was reluctant to discuss with the assessing officer why he was carrying a knife. The assessing officer stated that whilst the potential for harm were he to have used the knife could not be ignored, in the absence of any evidence that this was planned, she concluded it was not linked to a current or active risk of serious harm. This conclusion should not have been drawn. Alcohol misuse was identified as being linked to both the

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

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

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

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

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

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

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

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

15.13 Kent Youth Offending Service

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

15.13.16 Dean's order was ended in August 2014 when the Magistrates imposed a 24 month conditional discharge and revoked the 24 month YRO. The revocation was not requested by the case manager and, when interviewed, the case manager expressed surprise that the order had been revoked with no statutory order in place. No attempt was made to offer support to Dean after this point.

15.13.17 In November 2016, following the revocation, the NPS made their only contact with YOS when they asked for Dean's 'Asset' to assist in their assessment of him (**See Recommendation 11**). There is no record of Dean having offended between the time the order was revoked and the murder of Joyce Jackson.

15.13.18 The risk of harm Dean posed to others was assessed and did identify impulsivity, a lack of regard for victims and for the consequences of any actions he committed. There were no factors that lead to concerns about increasing levels of risk to others. The case manager did not identify indicators that Dean represented a risk of serious harm to others and there was little seen in the case notes which suggested otherwise.

15.13.19 Information sharing between agencies was positive. There was a strong sense of multi-agency working between YOT, SCS and Kent Police to help keep Dean safe.

15.13.20 Management could have challenged the approach adopted where 6 professionals were actively involved with Dean during the time he was on his order. There was a clear assessment around the difficulties he had in making positive attachments, and this knowledge should have been applied to the thinking around how he would be supported during his order.

15.14 Kent Adult Services and Oasis Domestic Abuse Service were asked only to complete a short report covering any involvement they may have had with Joyce and the other individuals subject of this DHR. Having received these reports it was concluded their content took matters no further.

16 How Organisations Worked Together

16.1 Joyce, throughout her life, was never identified as the victim of Domestic Abuse an issue that has been commented upon in previous sections of this report. The Police, EKH, probation providers and other agencies referred to in this report have established procedures to deal with Domestic Abuse which would or should have been implemented

had Joyce been identified as such a victim. An integral part of domestic abuse policy and working practice involves collaborative activity the degree of which, in part, is determined by a structured risk assessment process.

- 16.2 Joyce was not regarded as the victim of domestic abuse but there is no criticism of agencies as, operationally, a victim merely living in the same household as the perpetrator does not in itself warrant such a classification. Having said that, events leading to her death could have involved more information sharing which may well have led to her identification as a vulnerable victim at the hands of the Rose brothers. Whilst Joyce may not have been defined as the victim of Domestic Abuse she was undoubtedly a victim. Arguably Joyce did fall into the category of 'mate crime' which warrants a structured response from agencies similar to Domestic Abuse (**see Recommendation 3**).
- 16.3 There was no real collaborative work between agencies which addressed Joyce as a victim of any type of abuse or criminal activity. There were sporadic examples of the Police and EKH working together, but this activity was not addressing the issue of Joyce as a victim but rather one of incidents of ASB at her house. It was also apparent that agencies were, in the main, dealing with complaints relating to Joyce's house in isolation whereas had information been shared she may have been identified as a victim.
- 16.4 In relation to the Rose brothers this report gives a number of examples of how agencies were working together to aid and accommodate them as care leavers or, in the case of David, as a vulnerable adult. Both Kent and Medway Social Services, the probation services and Medway Council Housing Services worked together, but this was directed at supporting the Rose brother's and did not specifically relate to Joyce.
- 16.5 Medway Council and Kent County Council's policies and systems on information sharing are based on national guidance, however information was not shared with other agencies in terms of any risks the Rose brothers posed to Joyce. A multi-agency approach in managing the risks the Rose brother's posed was not evident. Whilst there was information sharing in respect of their accommodation, there is very little evidence of a joined up strategy to safeguard the public.
- 16.6 In relation to Joyce's mental health issues, there is evidence as to how GP's and mental health specialists worked together to address Joyce's fluctuating problems. As alluded to in the report, working arrangements have changed which now makes referral to mental health services a

more streamlined process. By the time the Rose brothers were frequenting Joyce's house she was no longer receiving mental health services, and visits to her GP at this time centred on her physical ailments rather than on her mental health or self-neglect. In view of this, collaborative activity between health professionals at this time was not prevalent.

17 Conclusions

17.1 In reaching conclusions consideration has been given to three areas that could have provided agencies with an opportunity to identify Joyce's vulnerability, and in consequence trigger safeguarding activity:

- Risk assessment of the Rose brother's and their mother i.e. the threat they represented to Joyce and others.
- Risk assessment of Joyce as an individual and her vulnerability to abuse and exploitation.
- Management of incidents and activity occurring at Joyce's Council owned property.

17.2 As with so many of these reviews if one considers the case in the round, and with the benefit of hindsight, it seems the profound danger to Joyce could have been identified prior to her assault/murder. It is not suggested the appalling circumstances which lead to Joyce's death could have been predicted, however had the information referred to in this report been shared between agencies then perhaps more robust risk assessments would have ensued, and measures taken to address and improve her safeguarding.

17.3 Much of this review centres on activities at Joyce's home address and whether or not Sandra Wilson and her sons should have been living or visiting the house. It should be pointed out that at the time of the assault, Joyce was deemed to have mental capacity and expressed a desire to have Sandra Wilson living with her. It should also be recognised that Sandra and her three sons were adults and there was no legal restriction on them as to where they should live.

17.4 There was evidence available to most of the agencies that Sandra Wilson's sons were living or frequenting Joyce's house and they could have represented a risk to her. Had these risks been recognised and agencies began working proactively together then steps could have been taken to ensure Sandra and her sons lived elsewhere, and more advice given and measures taken to help safeguard Joyce from these and other individuals who may seek to exploit her as a vulnerable person. It should be recognised that some attempt was made to discuss

alternative housing arrangements with the brothers but they failed to interact with EKH.

- 17.5 Having considered the background of these brother's and indeed their mother, it would seem quite obvious they were not a healthy addition to Joyce's home and quality of life.
- 17.6. There was evidence that Sandra Wilson was increasingly exploiting Joyce by using her house for her own dysfunctional activities. Sandra's life style either directly or indirectly resulted in Joyce's home becoming a magnet in attracting individuals and activity that was disruptive, illegal and most certainly harmful to this vulnerable woman. Once in the premises little could be done to force or persuade Sandra to live in alternative accommodation. Sandra seems to have first befriended Joyce in 2012 and only moved in with her when she failed to find appropriate accommodation. There is evidence that agencies endeavoured to help her in this task, but were largely unsuccessful. In the final analysis there was no order or restriction on Sandra Wilson to prevent her living with Joyce.
- 17.7. The Rose Brothers were all adults but were, or had been, subject to care leaving activity by Kent or Medway Children's Social Services. It can be seen that efforts were made to help them make this transition which included finding them accommodation. Despite this, all three came together in Joyce's house each having profound problems, which included establishing a suitable place in which they could live. Whilst they were in care or when they were subject of a statutory/court order, restrictions could have been imposed as to where they lived, but this was not the case at the time Joyce was attacked. In essence if given permission by the occupant/house owner they could have lived where ever they wanted.
- 17.8. In the case of Dean he was still part of the Kent Specialist Children's Service 18 plus scheme and was allocated a Personal Advisor (PA1), who visited him shortly before he and his brothers attacked Joyce. This PA undoubtedly had an opportunity to identify a potential threat to Joyce particularly when undertaking these home visits. This PA was focussed on supporting Dean and failed to consider any threat he may have posed to others, including Joyce. The expression 'professional curiosity' has been used frequently throughout this report and is highly applicable to this case. Professionals understandably have a primary responsibility to the agency they represent, and in the case of PA1 this was to offer support to Dean as part of the 18 plus scheme. Such front line staff however must extend their activities beyond their specific job

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

- 17.9 Sean Rose had been classified as representing a high risk to himself and others and thus must have been a potential risk to Joyce. In June 2015, he was sent to prison and during this time was visited by his Personal Advisor under the Medway 18 plus arrangements. It was established upon release he would reside with his mother at Joyce's address. There appears to have been no risk assessment in relation to the suitability of this address, and in particular no reference to the potential vulnerability of Joyce. It should be pointed out that no risk assessment took place either by the PA or the CRC and no consideration was given to the appropriateness of the address as he was not identified as high risk upon his release. Had such a risk been identified further efforts could have been undertaken to provide Sean with alternative accommodation²¹. Whilst his PA seems to have agreed that Sean could live with his mother at Joyce's house, information was not shared with either EKH or the CRC/probation provider: EKH have made it clear that permission for Sean or indeed any of the sons to live at this address would never have been granted as it was only a two bedroomed house, and thus too small.
- 17.10 David Rose was the elder of the three brothers and like them was a care leaver and for a time was helped by the Medway 18 Plus/ Leaving Care Team. David unlike his brother was referred to Medway Adult Services because of his learning disability and was subsequently aided by the 0-25 Disability Team. The Medway Council Housing Service deemed David to have made himself intentionally homeless. Despite their previous efforts the Disability Team were unable to help him and following an assessment of his mental capacity the case was closed. This was in accordance with recognised procedures.
- 17.11 As stated the three brothers all had profound problems after leaving care including the issue of where they should live. Over a period of time, individual members of staff from the two local authorities were assigned to each of the brothers, but they seemed to work independently of each other. Similarly information sharing between Children's Services, Probation, housing providers and the Police could have been better, particularly in relation to identifying the risks these individuals posed to Joyce.

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

- 17.12 This case appears to fall under the heading of 'mate crime'. This is a relatively new expression, but is a useful classification, which could trigger a greater awareness of agencies to vulnerable people being befriended and exploited by individuals such as Sandra Wilson and her three sons. It is quite clear that Joyce was seen as an 'easy touch' with her possessions being stolen and her house used for inappropriate and anti-social activity, however she was never identified as the victim of 'mate crime'. Kent Police have now embraced the concept of 'mate crime' and have introduced it into their training programmes. During the course of this review, with the exception of the Police and KMPT, IMR's have not referred to 'mate crime' as such, however it should be incorporated into these organisations policy and practice regimes and included in training programmes. Panel members did refer to 'cuckooing' explaining this was an established description of drug dealers who take over the property of a vulnerable person, and use it from which to run their drugs business.
- 17.13 Building on the concept of 'mate crime', a document entitled 'Hidden in Plain Sight' first published in 2011 by the Equality and Human Rights Commission included a study into 10 cases in which a disabled person had been killed or suffered serious injuries at the hands of another. This document has been useful in reaching conclusions in relation to the type and classification of criminality to which Joyce was subjected. The key findings from these case studies can be found at **Appendix C**.
- 17.14 In considering Joyce's vulnerability, if one excludes Sandra Wilson and her sons from the equation, then a pattern of peaks and troughs emerge in relation to her mental and physical health. There were times when she presented as deeply disturbed whereas on other occasions she appeared well and able to adequately take care of herself. At the time of the assault there were no particular concerns raised by her GP, and she was not then receiving any specialist mental health support. What is apparent is that Joyce on occasions was masking (either deliberately or unintentionally) the reality of her situation. It would appear Joyce had been 'self-neglecting' and was making herself more vulnerable. In such cases professionals should not rely on a person's self-appraisal, but take evidence from other individuals or agencies. There was some degree of collaboration, but in the main, professionals described her improved condition without taking a wider view only basing their assessment on how she presented at a particular time.
- 17.15 In reaching conclusions one must also take regard of the house in which Joyce lived and the potential it represented for agencies to identify her vulnerability, and to take into consideration safeguarding issues. As can be seen, there were several calls neighbours made

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

- 17.16 As part of the review process the Independent Chair in reaching conclusions has taken into consideration the views of Joyce's immediate neighbours. One neighbour described the arrival of Sandra Wilson and particularly the Rose Brother's and how they caused him immense distress, which in turn had a detrimental effect on his health. He described the house being occupied by up to eight people who kept his family awake with shouting, banging and generally disruptive behaviour. He described these individuals as intimidating who could not be reasoned with. Although the Rose brothers were at the heart of the problem, they acted as a magnet for other undesirable individuals who neighbours referred to as 'drug abusers'. Not only was the neighbour concerned for his own sake but he feared for the safety and wellbeing of Joyce at the hands of those living in her house. Prior to the arrival of Sandra Wilson and her sons the area was peaceful and the neighbour had no concerns for Joyce's safety. The neighbour had no doubt that Joyce was being taken advantage of by Sandra Wilson and her sons.
- 17.17 The neighbour informed the Independent Chair he phoned the housing authorities on a number of occasions complaining of noise and generally anti-social behaviour; he also expressed concern for Joyce. The neighbour was unimpressed by the response. He spoke of EKH asking him to complete diary sheets before action could be taken; he declined to do this as he was often working away from his house. He informed EKH that they could visit at any time and they would see for themselves the immense disruption these individuals were causing to the neighbourhood. He agreed EKH made some visits to the house, but stated most of these visits were by appointment, which he described as

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

- 17.18 The views of Joyce's immediate neighbours have formed an integral part of this review. N1's main concern was that the organisations involved did not communicate with each other either internally or externally. The neighbours views have been echoed from information contained in the IMR's particularly in relation to the lack of co-ordinated agency activity.
- 17.19. There were some examples of collaboration with other agencies (see section 16), but this was sporadic. Such cases do call for a coordinated multiagency approach rather than dealing with each incident in isolation. Achieving this is easier said than done given the number of cases and the resources available. The use of local Community Safety Units such as the one hosted by Thanet District Council is seen as perhaps an existing method of achieving this.
- 17.20. The Police received a number of calls relating to Joyce's address, usually from neighbours complaining of anti-social behaviour. The complainants were generally treated as the victim and those in Joyce's house as the perpetrators. Officers could have also identified Joyce as a victim had they looked more closely into the circumstances. To deal with such cases in this manner requires knowledge and background intelligence both from previous police attendance to the address and information from partner agencies.
- 17.21. In addition to calls from neighbours, the police investigated allegations made by Joyce of theft of her property by Sandra Wilson and her sons. These complaints generally resulted in Joyce's reluctance to support a prosecution. These allegations were generally treated in isolation, but if looked at collectively gave a clear indication that Joyce was the target of 'mate crime'. Comments regarding Joyce's reluctance to support

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

- 17.22 As with other agencies, the attending police officers did not exercise their 'professional curiosity' in relation to Joyce, and had they done so, her vulnerability may have been identified.
- 17.23 Police policies and working practice in relation to Domestic Abuse are robust and appropriate, however Joyce was never classified as the victim of domestic abuse. This was the result of applied legislation not including perpetrators who merely live in the same house. However there were elements of mate crime present and it is important that front line officers are aware of this type of offending. Once mate crime has been identified it should be dealt with in a similar way to domestic abuse and indeed, in many cases, it could be classified as such, particularly if the perpetrators are residing in the same household as the victim. It is for this reason 'mate crime' will be incorporated into police policy, and training will be delivered accordingly.
- 17.24 In reaching conclusions the views of Joyce's family have been taken into consideration and have formed a key part of the review process. Like the neighbours, Joyce's sister was concerned that agencies failed to work together and were not dealing with a worsening situation by taking note of all the information available. She also felt Joyce herself was not always able to care for herself, and although she may not have complained of abusive behaviour, or even been aware it was occurring, professionals should have been more inquisitive and proactive in identifying how vulnerable she was.
- 17.25 Joyce's siblings were clearly very concerned for her wellbeing, and prior to the arrival of Sandra Wilson and her sons into her life, her sister and brothers took an active role in managing her physical and mental condition (see section 15.5). Joyce's willingness to accept Sandra Wilson as her friend and, to some extent her protector, resulted in her family members being marginalised in terms of her medical and safeguarding needs. When a vulnerable person's life is invaded in such a way it should be of no surprise that members of that person's family are alienated.

18 Lessons Learnt

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

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

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

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

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

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

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

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

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

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

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

19 Recommendations

- 1. Front line officers or staff who, as part of their job description, visit premises or interact with members of the public, have the opportunity to identify potential victims of 'Mate Crime' or Domestic Abuse. Officers and staff should be encouraged to exercise 'professional curiosity' and follow up on indications of an abusive relationship or safeguarding issues that relate to a person who may not be the primary focus of their work. *Police, EKH, Thanet Council, Kent and Medway Social Services, KMPT, SECamb, NPS, CRC, Kent YOS.***
- 2. Where there are complaints of Anti-Social Behaviour, it is important to establish who is the victim, who is the perpetrator and whether they are vulnerable and in need of assessment. *Kent Police, East Kent Housing, Thanet District Council***
- 3. The concept of 'Mate Crime' or the harming of vulnerable persons in abusive relationships by offenders who set out or take the opportunity to abuse a victim, should be incorporated into agencies policies and working practice, and staff should be trained accordingly. This type of offending should be treated in a similar way to Domestic Abuse e.g. structured risk assessment, information sharing protocols, victim safeguarding plans etc. *Police, EKH, Thanet Council, Kent and Medway Social Services, KMPT***
- 4. Housing providers should undertake a risk assessment when they are aware that someone has moved into a property with a potentially vulnerable tenant. *East Kent Housing, Thanet District Council***
- 5. To facilitate information exchange, East Kent Housing to attend formal and minuted Tasking and Coordinating Meetings held by the Thanet Community Safety Unit. *East Kent Housing, Thanet District Council, Thanet CSU***
- 6. To provide each GP practice with an up to date adult safeguarding policy that reflects national and local guidance and best practice to guide and support staff in responding to victim and perpetrators of domestic abuse and self-neglect. *Kent and Medway CCG's/NHS England***

- 7. In exercising their responsibility in assisting young adults leaving care, Social Services should endeavour to ensure such individuals are registered with a GP, (none of the Rose Brothers were registered with a GP at the time they attacked Joyce). *Kent and Medway Social Services***
- 8. Agencies should recognise that an individual's safety and wellbeing may be, in whole or in part, compromised by self-neglect rather than abuse inflicted by a third person. Agencies should ensure that published guidance on self-neglect is both delivered in training and conformed to as outlined in the Kent and Medway Adult Safeguarding Board Policy. *All agencies***
- 9. Social Services have a responsibility to assist young adults leaving care, which will include helping them find suitable accommodation in which to live. In addition to establishing the accommodation is suitable for the care leaver, a risk assessment should also take place intended to identify safeguarding issues in relation to the existing occupants. *Kent Social Services, Medway Social Services***
- 10. In considering the appropriateness of accommodation for persons leaving prison or detention centres, agencies involved should use their own risk assessment processes to determine the suitability of the premises in respect of the vulnerability of existing occupants. Information from risk assessments should be shared with other agencies. *Social Services, NPS, YOS, Housing Providers***
- 11. When adult offenders have been previously subject to youth offending supervision, liaison must take place with the previous allocated YOT worker/s in order to gather information to inform risk assessment and risk management. *NPS, YOS***
- 12. When offenders subject to statutory supervision are related, professionals with offender management responsibility must work collaboratively in order to build a holistic view of the family to inform the assessment and management of risk. *NPS, YOS***
- 13. This review and its recommendations should be brought to the attention of the Kent and Medway Adult Safeguarding Board. In so doing the Board and its member organisations may be able to provide guidance and a degree of consistency to those charged with implementing recommendations particularly relating to the**

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

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