Item No 9

Adult Social Care and Health Overview and Scrutiny Committee

07 December 2011

Serious Case Review - Lessons Learnt

Recommendations

In response to members' request for more information, this report brings forward the public summary of the serious case review (SCR) into the death of GH published on 14th November. Members are asked to consider and comment on the report that has now been accepted by the Warwickshire Safeguarding Adults Board.

1. Background

1.1 The SCR was commissioned to establish whether lessons can be learnt from the circumstances of a case that may improve practice or the way in which agencies and professionals work together to safeguard vulnerable adults.

1.2 The SCR on GH was commissioned in December 2010, and chaired by an independent expert.

1.3 The case was subject to significant media interest through the trial held in summer 2011, and so a large volume of personal data is already in the public arena. We have tried to ensure that we do not re expose personal data, and only use those facts that pertain to judgements about agencies effectiveness in working together.

2. Lessons Learnt

2.1 Appendix A contains the lessons learnt and recommendations, information from the public summary to be found in full on the website

2.2 All recommendations have been accepted by WSAB who commissioned and own the report, and an action plan has been drafted to set out how we will address the recommendations. WSAB will monitor completion of actions at each meeting

3. Issues to Note

3.1 The key finding was that agencies could not have predicted or prevented GH's murder, though we could have improved the quality of her life.

3.2 A key finding is that previous systems relied on a medical diagnosis of learning disability, which was usually not confirmed. The last diagnosis was

that GH had a conduct disorder. Current systems rely on assessments of vulnerability, but there are two areas of risk that are hard to evaluate

3.3 Referrals could come through from multiple sources, each separately may fail to reach FACS eligibility or appear to be significant in themselves. There is a need to record centrally and collate / log all contacts so that patterns and trends can be identified should there be (as with GH) many concerns that would not prompt an assessment, investigation, or service delivery.

Big Society (Adult safeguarding is 'Everybody's business') also needs to play a part.

Clear records are now kept of mental capacity assessments carried out for all such referrals, but there remains a 'judgement of Solomon' to be made when vulnerable adults with mental capacity actively choose a risky lifestyle.

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SERIOUS CASE REVIEW

THE MURDER OF GEMMA HAYTER

9th August 2010

PUBLIC SUMMARY

This Report is the Public Summary of a Serious Case Review conducted in 2011 in relation to the murder of Gemma Hayter on 9th August 2010.

The Serious Case Review Panel consisted of eleven people none of whom had prior involvement with this case. The review was led by an independent chair:

- Independent Social Care Consultant (Former Director of Adult Social Care) **[Independent Chair]**
- Lay Member [Advocacy organisation]
- DCI, Protecting Vulnerable People Unit, Warwickshire Police
- Assistant Chief Probation Officer, Warwickshire Probation Trust
- Service Manager Child Protection, Children's Services, Warwickshire County Council
- Service Manager, Adult Services, Warwickshire County Council
- Manager, Warwickshire Youth Justice Service
- Lead Nurse, Safeguarding Vulnerable Adults, NHS Warwickshire
- Lead Nurse, Safeguarding Vulnerable Adults, Coventry & Warwickshire NHS Partnership Trust
- Lead Nurse, Safeguarding Vulnerable Adults, University Hospitals Coventry & Warwickshire NHS Trust
- Head of Safeguarding, West Midlands Ambulance Service.

In addition, the following two representatives attended specific meetings only:

- Head of Housing, Rugby Borough Council Housing Service
- Senior Solicitor, Legal Services, Warwickshire County Council

Acknowledgements

This independent review under Warwickshire's Multi-Agency Policy and Procedure for the Protection of Vulnerable Adults [Serious Case Review Policy and Procedure] would not have been possible but for the ready co-operation and information supplied to the Panel by those invited to contribute to its thinking and the administrative and professional support provided by the County Council's Adult Protection Co-ordinator. The input of agencies and services involved with Gemma throughout her short life, as well as those with knowledge of the lives of the alleged perpetrators and the environment in which these tragic circumstances were played out, has been invaluable. The assistance of the family and their willingness to provide evidence during what has been a harrowing and traumatic time has also been invaluable. This report reflects the views of the Review Panel whose hard work, commitment and expertise have been invaluable throughout the process.

The key findings

The overall findings of the Serious Case Review are that:

- There was no evidence that Gemma's murder could have been predicted or prevented but if she had received and accepted better support, she may have lived a better life and been less likely to fall into the company of people who presented her with serious risks.

- There was no evidence that it was known or suspected that any of the five perpetrators presented a serious risk of harm to Gemma or other vulnerable adults; the relationship of the group with Gemma was not known to the agencies involved with them.

- There was clear evidence that Gemma was vulnerable to the risk of abuse and that she had been a victim of "mate crime" on a regular basis over a period of time, by a number of people who were known to her. None of these people were, however, the perpetrators.

- No single agency had a full picture of what was happening in Gemma's life: there were a number of missed opportunities for initiating safeguarding procedures, assessments or other interventions and for agencies to share information.

- The panel identified a number of lessons to be learnt including:
    - The system for accessing specialist health services and social care services by people with lifelong disabilities who do not have a clear diagnosis was inadequate.
    - Risk assessments were not routinely or systematically undertaken or used by agencies to underpin decision making in relation to undertaking reassessments and the closure of cases.
    - Mental capacity assessments were not completed. Decisions were made on the assumption of capacity that were not tested out.
    - The adult safeguarding process and threshold of significant harm relies on the presence of a single large trigger and fails to identify people at risk in the community where evidence is through a larger number of low level triggers.
    - There was no prevention strategy that gives people who are living in the community, and may be vulnerable to mate crime, the skills to keep themselves safe.
    - There was no systematic approach by agencies to give or request feedback following referrals or contacts to report concerns.

It should be noted that the Panel examined agency contacts and input over a long time period, and that it needs to be acknowledged that there have been changes to how services are delivered throughout this time period.

Finally, this case raises wider issues about community safety for single adults who may be vulnerable to disability based harassment, hate or mate crime and exploitation. This case sets out evidence of the sub-culture that continues to prevail within some groups of people where drug and alcohol abuse is endemic, there is a lack of respect for others, and where violence and mate crime is normalised.

Kathy McAteer,
Independent Chair.

CONTENTS

GLOSSARY

Warwickshire Safeguarding Adults Board (WSAB): multi agency management committee for safeguarding adults.

Warwickshire County Council (WCC): the local authority responsible for provision of adult social services, education and children's social care services to the residents of Warwickshire.

Transition Services/Team: staff responsible for the effective transition of young people from children's health and social care services to adult health and social care services.

Rugby Borough Council (RBC): responsible for the provision of housing and other local council services for the residents of Rugby.

Supported Housing: a funding stream used by Warwickshire County Council to fund providers – often voluntary organisations or housing associations – to provide low level, preventative services to support vulnerable adults to manage their tenancy.

Coventry & Warwickshire NHS Partnership Trust (CWPT): The statutory organisation providing specialist learning disability and mental health services to the population of Warwickshire and Coventry. (Prior to 2006 this was North Warwickshire PCT).

University Hospital Coventry & Warwickshire (UHCW): NHS Trust providing acute and secondary health care services to the local population.

Primary Care Trust (PCT): the NHS body responsible for the commissioning and procurement of health services for the local GP population.

GP Consortia: A group of GPs who will replace PCTs as the new commissioning bodies following the implementation of the NHS White Paper "Equity and Excellence: Liberating the NHS".

CAMHS: Child and Adolescent Mental Health Service.

Fair Access to Care Services (FACS): national framework setting out the eligibility criteria for adult social care services. Based on 4 levels of risk and need (Low, Moderate, Substantial and Critical), local authorities have discretion to set local eligibility based on resources. Warwickshire County Council is set at substantial and critical.

MARAC: Multi Agency Risk Assessment Conference: a co-ordinated community response to domestic abuse.

1. INTRODUCTION

1.1 Purpose of a Serious Case Review

The purpose of a Serious Case Review is not to reinvestigate or apportion blame but to establish whether lessons can be learnt from the circumstances of a case that may improve practice or the way in which agencies and professionals work together to safeguard vulnerable adults. The focus of serious case reviews, in line with both multi-agency policy[1] and national guidance[2], is to:

- Learn from past experience and the specific event examined;
- Improve future practice and outcomes by acting on learning identified by the review;
- Improve multi-agency working and compliance with any other multi-agency or single agency procedures; including, regulated care services.
- Review relevant aspects of multi-agency policies and procedures to help ensure effectiveness in safeguarding adults at risk and more vulnerable to harm.

1.2 Reasons for this Serious Case Review

1.2.1. Warwickshire Safeguarding Adults Board (WSAB) commissioned a panel to undertake a Serious Case Review (SCR) following the murder of Gemma Hayter, a young woman with learning disabilities, on 9th August 2010.

1.2.2. A referral for a serious case review was made by Warwickshire County Council Adult Health and Community Services on 1st September 2010. It was considered by a multi-agency meeting chaired by the Chair of the Partnership and accepted on 28th September 2010. The grounds for doing so were based on the information available at the time:

- A vulnerable adult had died and abuse or neglect is known or suspected to be a factor in the death
- The case gives rise to concerns about the way in which local professionals and/or services work together to safeguard vulnerable adults.

[1] The Warwickshire Safeguarding Adults Partnership [Board] is a multi-agency partnership
[2] Vulnerable Adult Serious Case Review Guidance – Developing a Local Protocol, ADASS 2006

1.3. Terms of Reference

1.3.1. The terms of reference for the review were agreed and approved as follows:

a. To establish how effective agencies and the various assessment and support processes were in identifying Gemma's vulnerability and support needs, both as a child/young person and as an adult.

b. To review the effectiveness of the transition procedures from Children's Services to Adult Services, and establish whether any lessons can be learnt about how this can be improved.

c. To establish how well agencies work together and to identify how inter-agency practice could be strengthened to improve the identification of, and safeguarding of, vulnerable adults.

d. To establish whether it was known, or could have been suspected, that the five perpetrators posed a serious risk to Gemma or other vulnerable people

e. To establish whether Gemma was targeted for abuse or exploitation as a direct result of her disability and if so, to determine the lessons that can be learnt to identify early warning signs of possible hate crime.

2. WHAT WE LOOKED AT

2.1 The Key Lines of Enquiry

2.1.1. **Information:** How was information about Gemma and the perpetrators received and addressed by each agency and how was this information shared between agencies?

2.1.2. **Assessments and Diagnosis:** What assessments did Gemma receive, from which agencies, and when? What were the outcomes of assessments and what were the decisions about her eligibility for support? Which of these were completed by a single agency and which were multi agency?

2.1.3. **Contact with and Support from agencies:** What contact did each agency have with Gemma and the perpetrators? What support did Gemma receive and from whom? Was there any history or evidence of bullying or harassment as a child or an adult?

2.1.4. **Transition:** What was the process for transition to adult services and what was the outcome of this?

2.1.5. **Housing:** Where has Gemma lived and for how long? What were the reasons for housing moves including any periods of homelessness? What support or interventions were initiated to support Gemma in managing her tenancies?

2.1.6. **Anti-Social Behaviour:** What is the history of any anti-social behaviour at Gemma's addresses and at those of the perpetrators? Was any crime reduction activity initiated as a result of this, and if so what?

2.1.7. **Choice and Control:** Was there any formal assessment of Gemma's mental capacity? What choices was Gemma perceived to have made and how did this influence decision making regarding intervention by agencies?

2.1.8. **Relationship between Gemma, the perpetrators, and other members of the community:** What was known by agencies about the relationships between Gemma and the five perpetrators? Were there any warning signs that Gemma was being abused, exploited, harassed or bullied by any of the perpetrators or by anyone else in the community? Were there any indications that Gemma was being targeted by anyone because of her disability or vulnerability? Was Gemma caught up in the domestic abuse between Daniel Newstead & Chantelle Booth?

2.2. The process for collecting and analysing information

2.2.1. The report is based on information from Chronologies and Individual Management Reviews submitted by the following agencies:

- Warwickshire County Council Children's Social Care.
- Warwickshire County Council Education Services.
- Warwickshire County Council Adult Health and Community Services.
- Rugby Borough Council Housing Services.
- Orbit, Heart of England Housing Association.
- Warwickshire Police.
- Warwickshire Probation Trust.
- Warwickshire Community Services, South Warwickshire NHS Foundation Trust.
- Coventry & Warwickshire NHS Partnership Trust.
- University Hospital Coventry & Warwickshire NHS Trust.
- West Midlands Ambulance Service.
- Warwickshire Youth Justice Service.
- Enfield Youth Offending Service.
- Pengwern College.

2.2.2. Additional information was submitted by:

- Mayday Trust.
- Westside Medical Centre submitted computer print-outs of medical records for Gemma only, including copies of some correspondence.
- Gemma's family.

2.2.3. In addition, the Panel considered the additional evidence that became available following the murder trial. Following the verdict on 28th July 2011, the Panel received a copy of the Case Summary from Warwickshire Police which outlined the circumstances of the murder and a summary of the witness statements.

3. WHAT WE FOUND OUT

3.1 Summary of Events

3.1.1. The full details regarding Gemma's murder were elicited from the trial.

3.1.2. Chantelle Booth had known Gemma for some years and it is evident that Gemma perceived Chantelle to be her friend. At the trial it was reported by witnesses that Chantelle Booth had previously mistreated Gemma, calling her names, referring to her as having Down's Syndrome, and on one occasion shaving Gemma's hair off.

3.1.3. On Saturday 7th August 2010, Gemma was drinking with the 5 perpetrators in Rugby town centre. Gemma started telling doormen and bar staff that Chantelle was only 15 years old, with this information being shared via the pub watch scheme, resulting in the group being refused entry into a number of pubs and being ejected from others. This caused some anger and an assault against Gemma who "had spoiled their night".

3.1.4. On Sunday 8th August, Chantelle Booth and Daniel Newstead invited Joe Boyer and Jessica Lynas to join them at about 4-5pm at their flat for Sunday lunch. Joe Boyer took along his friend Duncan Edwards. The group are said to have been drinking lager and smoking weed throughout the afternoon and evening. Following an exchange of texts between Gemma and Chantelle, Gemma joined them at their flat a couple of hours later. During the course of the evening, Gemma was subjected to prolonged and serious assaults over a period of 4 hours. Perpetrator witness statements suggest this was motivated by the alleged theft of £800 from Chantelle Booth and the fact that Gemma had failed to pay it back, however, the true motivation for the assaults is debateable. The assaults included sustained physical assaults and being head butted, resulting in several fractures to her nose, being hit with a mop, being forced to drink urine out of a lager can, and being locked in the en-suite bathroom. Her phone was taken from her and the battery flushed down the toilet. All 5 perpetrators were found guilty of assault, though each attempted to blame the others and minimise their own part in it.

3.1.5. At just past midnight on 9th August, Gemma and the 5 perpetrators were captured on CCTV leaving the flat. Gemma had asked to go home, and the group decided that they would all walk her home. The group, however, took a route in the opposite direction to Gemma's flat and subsequently took her onto the disused railway line. Here, Gemma was subject to further physical assaults resulting in her death. She was stripped of her clothes which were set on fire along with her other belongings, had a black bin bag put over her head and was also (superficially) stabbed in the back of the neck.

3.1.6. The 5 perpetrators were captured on CCTV walking back to their flats between 1.09 and 1.30am. Gemma's badly beaten body was found by a jogger at approximately 5.30am.

3.1.7. Chantelle Booth, Daniel Newstead and Joe Boyer were found guilty of murder; Jessica Lynas and Duncan Edwards were found guilty of manslaughter. All were found guilty of assault.

3.2 Gemma's Life Story

3.2.1. Gemma was the youngest child in a family with 2 older siblings and during her childhood and adolescence lived with her mother and step-father., her birth father having left the family home when she was 9. Gemma had a number of life-long health difficulties and development issues, though there was never any clear diagnosis of a specific medical condition underpinning this. There are conflicting diagnoses regarding Learning Disability and Autistic Spectrum Disorder. As a child she was diagnosed as having a learning disability with differing reports about severity, from mild to severe, and at 18 was diagnosed as being on the Autistic Spectrum. When tested as an adult the diagnosis was that she did not have a learning disability or Autistic Spectrum Disorder, and in 2008 she was diagnosed with Conduct Disorder.

3.2.2. Gemma received additional support within mainstream education throughout her primary school years and transferred to a special school for her secondary education, and subsequently to a local residential school and then to a residential college in Wales for the final years of her education.

3.2.3. Throughout Gemma's childhood her mother consistently raised concerns relating to her behaviour at home and though these problems were not initially experienced by her primary schools, these difficulties became more apparent as she got older. The difficulties escalated to the point that social care services were subsequently provided during her adolescence.

3.2.4. As well as several incidents of concern that highlighted Gemma's vulnerability, a common theme throughout her life was about her difficulties in making friends and she was perceived as being at risk of being abused or exploited. It was stated that Gemma would "never tell on people" - "she would accept abuse as long as the abuser acknowledged her as a friend".

3.2.5. There is no evidence of a planned transition from children's to adult social care services although an adult social care assessment was completed to plan for her leaving College and returning to her home area. Gemma was

assessed as meeting High (Critical) Fair Access to Care Services (FACS) eligibility for adult social care services due to her needs around managing risks, diet & nourishment, social support networks, housing, money management, shopping and home cleanliness.

3.2.6. Gemma returned to Rugby in July 2004 at the age of 21, and moved into shared supported housing with Mayday Trust, a specialist supported housing provider, living in two tenancies during this period. Her tenancy broke down within two years as a result of Gemma's behaviours related to her difficulties in social communication and her strong desire for independence - "not to be treated as a child". There were worrying examples of Gemma's behaviour putting her at risk.

3.2.7. Adult Social Care closed Gemma's case shortly after her return to Rugby, though continued to have intermittent contact, which increased when her tenancy became at risk in late 2005. In early 2006 Gemma was referred briefly to mental health services. Throughout this period Gemma's behaviour towards professional support is described as aggressive and unco-operative and she refused assessments. Following this episode, though several re-referrals were made to Adult Social Care, she was deemed ineligible for services on the grounds that she did not have a diagnosis of a learning disability and had previously failed to engage.

3.2.8. After her eviction from the Mayday tenancy in September 2006, Gemma lived in a private shared tenancy. In December 2007 Gemma was again referred to mental health services and an assessment commenced, including psychiatric, psychological and OT assessments and she was allocated to a community psychiatric nurse (CPN) for community nursing support, though she was not referred for a social work assessment. The mental health assessments, which included psychology, psychiatry and Occupational Therapy (OT), took an extended period of time to complete due to Gemma's sporadic engagement.

3.2.9. Whilst undergoing the range of mental health assessments throughout 2008, Gemma's lifestyle was becoming more risky and chaotic and she was again in crisis with her tenancy. There was a high level of contact with the police during this 12 month period (2-4 contacts per month) mostly around Gemma being the victim of thefts and concerns about her being subject to extortion. In February 2008, the police made a safeguarding referral to Adult Social Care, which was not investigated, with the police advised to contact mental health services.

3.2.10 Whilst the OT assessment identified that Gemma needed a more structured living environment and supervision, the overall assessment concluded that Gemma did not have a learning disability or autism. Following this

assessment process the intention was to convene a vulnerable adults meeting to consider the findings of the assessments and appropriate action; this meeting did not take place. Subsequently, following eviction from her private tenancy, Gemma was accepted as homeless and moved to her final tenancy with Rugby Borough Council (RBC) housing department in August 2008, and from this time onwards until her death received floating support from Orbit, a voluntary organisation funded by Supporting People money to provide low level, preventative support to people who need help to maintain their tenancies, pay bills etc.

3.2.11. Throughout 2009, Orbit and RBC had continuing concerns about Gemma's vulnerability and potential for exploitation, and her inability to cope with her tenancy. Gemma's living conditions continued to deteriorate with evidence of self-neglect, a chaotic lifestyle, debts and inability to manage her finance, with a pattern of intermittent engagement with support workers. Further unsuccessful attempts were made to refer her to Adult Social Care, and the CPN, being unaware of the full circumstances, closed the case on the grounds that she seemed to be coping. By this time police contact had reduced significantly until Gemma was assaulted in May 2010. Following this assault, which was not by or linked to any of the perpetrators, and until her murder on 9th August, Gemma was continuing to fail to engage with support workers and was subsequently facing eviction from her tenancy, being distressed about this on the day of her murder.

3.2.12. In summary, the pen picture of Gemma prior to her death is of a young woman of 27, whose physical appearance is described as being similar to that of a congenital disorder, despite all medical tests being negative. She was of small stature and it can be speculated that her physical appearance would become more distinctive as she got older, and many people who had contact with her describe her as "looking different". Despite the lack of a learning disability diagnosis, she was generally seen as someone who did have difficulties and vulnerabilities associated with a learning disability. Gemma was in debt and unable to cope with paying her bills and was considered at risk of extortion or exploitation by others. Her lack of social skills and her behaviour towards others put her personal safety at risk. Over a period of 6 years between leaving college and her murder, Gemma's lifestyle had become increasingly chaotic and risky. She was not attending college or working, and she was associating with other young people living in her local community who also had chaotic lifestyles, who were immature, were not working or in college, and who tended to be both the victims and perpetrators of violence and petty crimes. She mixed with a community of young people where violence was considered a normal part of life and where drug and alcohol abuse was a significant factor. Gemma would have been vulnerable in

situations where she came into contact with people who did not have her best interests at heart and her social circumstances made this inevitable.

3.3 The lives of the perpetrators

3.3.1. The perpetrators consist of 2 couples and a single man, these being Daniel Newstead & Chantelle Booth, Joe Boyer & Jessica Lynas, and Duncan Edwards. The 2 couples were neighbours in privately rented tenancies and lived approximately 2 miles from Gemma's flat. Duncan Edwards lived nearby with his mother, having recently returned to the area after some time away. Daniel Newstead, Chantelle Booth and Joe Boyer were all found guilty of murder, Jessica Lynas and Duncan Edwards were found guilty of manslaughter. All five were convicted of assault occasioning actual bodily harm.

3.3.2. Chantelle Booth is believed to have been known to Gemma, and perceived by Gemma to be a friend, for at least 18 months prior to her murder. Chantelle Booth's relationship with Daniel Newstead was known to have started around October 2008. It is not known how long Chantelle Booth & Jessica Lynas had been friends but it is alleged that they were both involved in bullying and assaulting a vulnerable young woman who was living in a hostel in June 2010 (this was not Gemma and this allegation has not been corroborated by other agencies). Jessica Lynas had only recently developed a relationship with Joe Boyer, who she appears to have met in supported accommodation in May 2010 and she moved into his private tenancy in July 2010.

3.3.3. **Daniel Newstead:**

3.3.3.1. Daniel Newstead was 19 at the time of the murder and was living with his girlfriend, Chantelle Booth, 21. He had been known to both the Warwickshire Youth Justice Service, and Warwickshire Probation Trust. His contact with Youth Justice service was between January 2008 and February 2009, when he was transferred to Probation supervision. He was convicted of a number of offences between 2004 and 2008, including an offence of affray when he was in possession of a metal bar and a knife, and was known to the anti-social behaviour group. Daniel was known for his violence towards women having a history of domestic abuse against his mother, sister, previous girlfriends and Chantelle.

3.3.3.2. Daniel is described as having a chaotic lifestyle that featured emotional immaturity, and persistent substance misuse.

3.3.3.3. Daniel was identified as both a perpetrator and a victim of violence and a key feature seems to be the normalisation of violence – the evidence

suggests that he appears not see violence as anything unusual and accepts it as a normal part of everyday life.

3.3.3.4. Daniel Newstead was known to mental health services for his substance misuse and anger management issues. The mental health assessments found no evidence of mental illness or active suicidal thoughts. There was no knowledge of his relationship or contact with Gemma and no evidence that he presented a risk to others because of these incidents.

3.3.4. **Chantelle Booth:**

3.3.4.1. Chantelle Booth was 21 at the time of the murder and living in a private tenancy with Daniel Newstead. She lived a chaotic lifestyle, appeared emotionally immature, and was subject to regular episodes of domestic abuse and violent altercations with other individuals.

3.3.4.2. Chantelle was known to Probation following an offence of Grievous Bodily Harm resulting in a Community Order with a supervision requirement, curfew requirement and education, training and employment requirement. Chantelle maintained regular contact with her supervising Probation Officer throughout the period of supervision.

3.3.4.3. Both Chantelle Booth and Daniel Newstead were subject to on-going concerns of anti-social behaviour involving abusive, aggressive and violent behaviour, and Chantelle was identified as both a perpetrator and victim of this behaviour. Chantelle however received only one further conviction, this being for common assault of a female in May 2010. Though this took place at Chantelle Booth's home, the victim was not known to Probation and was not linked to this review.

3.3.4.4. One agency stated that Chantelle was involved in an incident with Jessica Lynas in June 2010 when they allegedly bullied and assaulted a vulnerable young woman living in a hostel (this was not Gemma). This incident was not corroborated by other agencies.

3.3.4.5. Though there was some knowledge of Chantelle's links with Gemma, this was at a very general and infrequent level and there was no evidence that this was of concern.

3.3.5. **Jessica Lynas:**

3.3.5.1. Jessica Lynas was 18 at the time of the murder and living in a private tenancy with Joe Boyer, 17 years. Jessica had previously lived in shared, supported accommodation which rapidly broke down and she subsequently

moved into Joe Boyer's tenancy, with whom she had recently started a relationship.

3.3.5.2. Jessica was known to the police as both a perpetrator and victim of crime, being both the subject of and perpetrator of various assaults, the latter for which she was cautioned. Though there was some knowledge of her friendship with Chantelle Booth, there was no knowledge of her contact with Gemma.

3.3.6. **Joe Boyer:**

3.3.6.1. Joe Boyer was 17 at the time of the murder and he had been living with Jessica Lynas for a short time in his private tenancy, where they were neighbours of Daniel Newstead & Chantelle Booth. Joe was made subject to a 4 month Referral Order in August 2009 for possession of cannabis, and a further order in June 2010 for the same offence. He was in breach of the order and in the process of being returned to court at the time of the murder. He was not, however, known for any violent offences and was considered low risk of harm to others, and was known to the police as a victim of crime.

3.3.7. **Duncan Edwards:**

3.3.7.1. Duncan Edwards was 19 at the time of the murder and had recently moved back to Rugby to live with his mother, close to the flats where the 2 couples lived. Previously living in Enfield, Duncan Edwards was known to Enfield Youth Offending Service (EYOS) from 2003 onwards and between 2001 and 2010 he had been convicted of nine offences, and investigated for a further nine.

3.3.7.2. There was no knowledge of Duncan having any contact with Gemma or of his friendship with the other 4 perpetrators.

3.4 Contacts with Gemma.

3.4.1. Adult Social Care Interventions:

3.4.1.1. Gemma had 11 separate assessment events open to Adult Social Care between July 2001 and February 2008 and had 6 allocated workers plus regular contact with duty social workers/duty managers. The reasons for case closure of these episodes are not always clear.

3.4.2. Health Interventions:

3.4.2.1. From the age of 11 years until her death, Gemma attended Walsgrave/Rugby Hospital and subsequently University Hospital Coventry & Warwickshire on 18 occasions. As an adult, between 2000 and January 2010 she was under the care of 5 adult consultant teams including General Medicine & Endocrinology, ENT, Orthodontics, Rheumatology and Opthalmology. She attended outpatient clinics on 10 occasions and had 2 failures to attend. In May 2010 she attended Rugby Urgent Care Centre with injuries due to an alleged assault.

3.4.2.2. As a child Gemma had contact with North Warwickshire PCT (now Coventry & Warwickshire Partnership Trust) children's learning disability services and was initially assessed as having learning difficulties with an IQ of 62-65. Between 1995 and 1998 there were a total of 14 contacts. As an adult she had 5 contacts in 2000 and 10 contacts in 2001 with adult Learning Disability services, with tests indicating that she did not have a significant learning disability, plus one additional contact in 2004 when the police were seeking judgement about her capacity to consent to sexual intercourse, following an alleged rape.

3.4.3. Mental Health Interventions

3.4.3.1. Between 2006 and December 2008, Gemma had 64 contacts with Coventry & Warwickshire Partnership Trust mental health services plus a number of appointments in 2009, of which she attended one and failed to attend at least 4. The majority of the contacts – 41 – were in relation to the Psychiatric, OT and Psychology assessments that were completed during 2008.

3.4.4. Police Contacts

3.4.4.1. There were 20 contacts with Gemma between September 2004 and her death. However, the majority of contacts – 14 in total - were between February and December 2008.

3.4.5. **Housing and Floating Support**

3.4.5.1. From when Gemma moved into her Rugby Borough Council tenancy in August 2008 there was regular contact between Gemma and Rugby Borough Council Housing and Orbit floating support service up until her death. Rugby Borough Council housing service had at least 67 contacts of which 27 were face to face and 40 by phone or text. There are 6 recorded instances of Gemma's failure to attend appointments with RBC. Orbit had 30 face to face contacts and 13 recorded contacts by phone. Gemma failed to attend 18 appointments and records suggest that many of the phone calls were related to unsuccessful attempts to book appointments.

3.5 Timeline

DATE	KEY EVENTS	ADULT SOCIALCARE (ASC)	MENTAL HEALTH (MH)	LANDLORD & HOUSING SUPPORT	POLICE
Sept 02- July 04	Placed at Residential College, Wales				
May 2004		Assessed for leaving college: HIGH Fair Access to Care Services eligibility			
July 2004	Returns to Rugby			Shared tenancy with Mayday Trust	
Aug 2004		Case allocated to new social worker			
Sept 04	Alleged rape		Contacted re capacity to consent	Remains at Mayday tenancy with new contract	Police contact
Feb 05		Review: "going well"			
17th July 2005		Case closed			
22nd July 2005		Request for social worker to attend review		Has moved to new address (shared tenancy) with Mayday	
Sept – Nov 05	Deteriorating situation – bills/money; stopped college and work placements	Requests for social worker to attend reviews		Tenancy at risk;	
December 2005		Case re-allocated			
Feb 06	Behaviour – aggressive & unco-operative throughout this period – refusing assessments but clear risks		Referral to Psychiatrist – behavioural		
April 06			Mental Capacity assessment re managing money (at outpatients appointment with Psychiatrist and support workers)		

June 06				Notice to quit served by Mayday	
July 06		ASC decision to offer one accommodation and to close case if this is refused (it was refused as out of Rugby)		Alleged refusal to offer housing due to Learning Disability (social care records)	1st record of police contact
August 06		Case closed (recorded May 07)			
Sept 06				Evicted from Mayday tenancy. Moves to private tenancy	
October 2006			Decision re: no input from Learning Disability or MH services but may benefit from counselling re relationships		
August 2007		Re-referred to ASC – reassessment refused due to no learning disability diagnosis		At risk of losing private tenancy	
Oct 2007		Re-referral to ASC – reassessment refused on same grounds			
December 2007			MH assessment offered and commences		
Feb 2008	deteriorating		Full assessments recommended and vulnerable adult meeting		Police contact begins and continues on a regular basis throughout 2008 (2-4 contacts each month)
Feb/Mar 08	Concerns regarding extortion etc.	Police refer to ASC re risks – Adult Safeguarding referral declined	MH still actively involved	Clear crisis with tenancy and other people potentially exploiting her	
May 2008			MH still actively involved; OT recommends structured environment	In crisis with tenancy	

			with more supervision		
July 2008				Accepted by Rugby Borough Council (RBC) as homeless	
August 2008	Moves to RBC tenancy			Moves to RBC tenancy and referred to Orbit for support to maintain tenancy	
Dec 2008			MH assessment being completed		
Jan 09				Support Plan with Orbit	
Mar - April 09	Evidence of not coping with tenancy		Some contact with RBC & Orbit	Concerns about vulnerability	
May 2009					Police contact x1 (drunk)
Sept 09			"seems to be coping"	"not engaging"	
Oct 09	Concerns re extortion				Police contact
Nov 09		Attempts to re-refer – refused on ground of no diagnosis of learning disability or mental illness	CPN to close case	In crisis and not engaging: decision to take recovery action	
Feb 2010				Taken off support as not co-operating	
March 2010	Flat dirty, hygiene, self-neglect; rubbish;			Support re-starts & Crossroads input to help with cleaning	
April 2010	Bills & debts			Support plan for bills & debts	
May 2010	Assault				Police contact
April – Aug 2010	Generally not engaging, debts and not paying bills, up to death on 9th August.			Generally failing to engage	
July 2010	Daniel Newstead & Chantelle			Threat of eviction; report of fall & injuries	Police contact x 1 (theft)

	Booth split up but back together by 29th.			29th July	
9th August 2010	Gemma murdered			Distressed re eviction	

3.6 Contact with the perpetrators

3.6.1. There are only three contacts that have linked Gemma to any of the five perpetrators, this being only with Chantelle Booth. Two of these contacts were when Gemma contacted the police regarding the theft of her friend Chantelle's purse. The only other contact was with Rugby Borough Council housing when Chantelle accompanied Gemma to her meeting to discuss her eviction on the day before her murder. On each of these occasions there was nothing to cause concern about their relationship.

3.6.2. The majority of police contact with Gemma was during 2008 and during this period there were 7 police contacts with Daniel Newstead and 6 with Chantelle Booth, with 4 joint contacts due to their domestic abuse, these being after October when their relationship began. Between January 2009 and August 2010, there were 17 contacts due to their domestic abuse and 6 separate contacts with each of them. On none of these occasions was Gemma involved.

3.6.3. There were no contacts with any agency that linked the two couples with each other except the one reported incident when Chantelle Booth and Jessica Lynas allegedly bullied and assaulted the young woman in the hostel. There were no contacts that linked Duncan Edwards with the two couples.

3.7 Analysis and Findings

3.7.1. **(a) To establish how effective agencies and the various assessment and support processes were in identifying Gemma's vulnerability and support needs, both as a child/young person and as an adult.**

3.7.1.1. Gemma's vulnerability and support needs were apparent from early childhood and all agencies that came into contact with her as an adult generally recognised her as being vulnerable. However, agencies use different definitions of vulnerable, often based on specific legislation relating to the type of service offered (for example "vulnerable" in terms of the Housing Act in relation to homelessness is different to the definition of "vulnerable" in

No Secrets). Overall, Gemma's vulnerability and support needs relate to a combination of her disability and her behaviours.

3.7.1.2. A key difficulty for professionals involved with Gemma has been a lack of an agreed diagnosis that explains succinctly her difficulties and needs. She was diagnosed as a child as having learning difficulties variously described as ranging from a mild learning difficulty to a moderate or significant learning disability. As a teenager she was diagnosed as being on the Autistic Spectrum. As a young adult she was diagnosed as *not* having a learning disability or Autism and has also been described as having a borderline learning disability and her most recent diagnosis being that of Conduct Disorder, this being a recognised mental disorder. She did not have a diagnosed mental illness. Gemma also suffered from a range of physical health conditions and her appearance has been described as being suggestive of a congenital disorder, genetic syndrome or birth defect, though all clinical tests for such conditions have been negative.

3.7.1.3. There is much evidence that despite the lack of diagnosis, professionals often recognised her difficulties and tried hard to identify her needs and how these could best be met. However, the issue of a lack of diagnosis was a key factor in preventing Gemma from receiving timely and effective social care support when she needed it. For adults with social care needs, eligibility to access specialist services in many local authorities has generally tended to be based on diagnosis. The system of accessing specialist support from the learning disability service with Warwickshire requires a diagnosis of a learning disability, and access to mental health social care services has required a diagnosis of severe and enduring mental illness (though it needs to be noted that the new CMHT draft specification would not now exclude someone with a Conduct Disorder). However, Valuing People (2001) states clearly that IQ level alone should not be the main determinant of a learning disability and that other factors, including for example social functioning, should be taken into account.

3.7.1.4. A community care assessment is the only way a person can access provision of community care services. The duty to assess as set out in the NHS and Community Care Act (1990) does not replace assessment duties in earlier legislation such as the Chronically Sick and Disabled Person's Act (1970) and it is clear that the local authority had a duty to assess Gemma's needs on the basis of her disability – the fact that the diagnosis changed over time isn't relevant and in more recent years she had a diagnosis of a Conduct Disorder, a recognised mental health condition within the legislative framework. For Gemma, there were two prospective routes for accessing an assessment – via the learning disability team or the community mental health team.

3.7.1.5. Gemma did receive a community care assessment in 2004 from the learning disability team when she left the college in Wales to return to Rugby (the residential college being a specialist placement for people with a learning disability). She was assessed as meeting the high (critical) level of Fair Access to Care Services (FACS) criteria and identified with the following needs:

- Risk management
- Diet & nourishment
- Social networks
- Housing needs
- Money management
- Shopping
- Home cleanliness

3.7.1.6. Fair Access to Care Services (FACS) eligibility criteria are set out in 4 tiers of risk/need – low, moderate, substantial and critical – and those assessed as substantial or critical are eligible to receive services in Warwickshire. It is important to note that FACS criteria only applies to the provision of services – it does not determine eligibility for an assessment (as clearly a person needs an assessment to determine eligibility). However, the Adult Social Care case records regularly state that Gemma was not eligible for an *assessment* because she "did not meet FACS criteria". Not only is this an inaccurate interpretation of FACS but Gemma already had an "active" FACS assessment that stated that she met Critical needs, and this had not been reassessed or up-dated.

3.7.1.7. Following her initial assessment and the provision of a supported tenancy on her return to Rugby, Gemma's case was quickly closed. Though she received some further input at various times, generally her lack of a diagnosis become the focus of decision making and a barrier to accessing effective support, and the evidence identifies that:

- a system based on diagnosis was the key deciding factor (rather than vulnerability or risk) that prevented Gemma from receiving effective and timely assessments and/or provision of support – the fact that Gemma received *some* support from Adult Social Care "despite her not meeting criteria" illustrates the inconsistency and inequity of the policy.
- the use of diagnosis as a criteria for accessing specialist learning disability services is used by many local authority learning disability teams to control referrals and workload and is not in line with a personalised approach to risk, need and vulnerability.
- the use of a system that is based on diagnosis rather than risk or vulnerability is likely to result in staff losing sight of Gemma as a person – and it is clear from the evidence that the team "had developed a

cultural need for a diagnosis" and that "despite Gemma's diagnosis and support needs being established in 2001, from 2006 onwards social care practitioners/management focus seems to have been around whether there was an official diagnosis".

- the issue of not being eligible for social care support from the learning disability team in itself should not deny someone access to an assessment and support from a different part of the adult social care system, had there been alternative means of accessing services. There was no system in place to signpost Gemma to other adult social care services that could offer her an assessment and support, and though she was receiving support from Mental Health health professionals she was not referred for social work support from within the mental health team and there was no process for joint working across mental health and learning disability services.
- the requirement for a diagnosis, combined with assumptions about her mental capacity to make her own choices, also denied Gemma access to adult safeguarding investigations at those times when there was clear evidence that she was at risk of significant harm.
- the focus on a lack of diagnosis resulted in outcomes whereby other agencies making referrals and raising concerns about Gemma were given advice (about her not having a learning disability and having capacity to make her own choices) that influenced their own decisions and reduced their ability as single agencies to support her adequately.

3.7.1.8. As she was deemed ineligible for learning disability psychiatric services, Gemma was referred on several occasions to Coventry & Warwickshire Partnership Trust (CWPT) adult psychiatric service in relation to her behavioural difficulties. In October 2007, following a re-referral from Gemma's sister to the CWPT learning disability service, the Learning Disability Consultant Psychiatrist wrote to the learning disability social work team requesting a joint reassessment of Gemma, but social care input was declined based on his earlier diagnosis in 2001. The outcome of this was a referral to the adult psychiatric service resulting in the completion of psychiatric, occupational therapy (OT) and psychology assessments during 2008, as well as support from a community psychiatric nurse (CPN). A carer's assessment was also offered but declined by her family.

3.7.1.9. Though Gemma did not present with a mental illness, her difficulties were recognised and the assessment process was an attempt to identify her needs and how these could be met. The assessment did not follow the usual multi-disciplinary team process (for example a social care assessment from a mental health social worker was not requested), the assessments were not effectively co-ordinated, and though there was a stated intention to convene a vulnerable adult meeting, this didn't happen and the case was subsequently

closed on the grounds that she was not eligible for services due her lack of a diagnosed mental illness, with no support plan being proposed. It should be noted that, at this time, the adult mental health service was an integrated team, with social work input to the multi-disciplinary team, though this was prior to the more formal Partnership Agreement that is now in place with the Council to fully integrate health and social care services.

3.7.1.10. A key feature of Gemma's contact with health and social care services is regarding decisions to close cases and terminate input. On occasions, this appears to have been because of her lack of engagement and in one episode of assessment, her aggressive behaviour and refusal to complete the community care assessment process. The pattern of contact with Adult Social Care shows a lack of consistency due to regular changes of worker (due to staff leaving or structural changes, case closure and contact with duty when she did not have an allocated worker). The evidence suggests a tendency to close her case too early – on many occasions there were re-referrals and concerns raised within days or weeks of the case being closed. The evidence suggests that there was no systematic assessment of risks at the point of closing her case, as well as arbitrary decision making regarding "eligibility" that was not based on the outcome of any reassessment of her needs.

3.7.1.11. Finally, a key factor in decision-making, regarding the refusal to offer assessments/re-assessments and support, has been assumptions regarding Gemma's mental capacity and her right to choose her own lifestyle, neglect herself and make decisions that put herself at risk. There has been no assessment of Gemma's Mental Capacity in line with the Mental Capacity Act (2005) to underpin these decisions. On one occasion a psychiatric opinion was taken regarding her capacity to manage her money – this was prior to the Mental Capacity Act being implemented and was completed at a psychiatric outpatients appointment rather than via a multi-disciplinary meeting.

3.7.1.12. The issue of choice and control over her life was also a key factor in some decision making by agencies regarding the adult safeguarding processes, especially when Gemma denied that she was being exploited and stated that she wanted no further action. This raises questions about whether the right systems are in place to enable professionals to discuss concerns about adults deemed to be vulnerable without their explicit consent – such a system would have ensured that information about the extent of the risks was better shared between agencies and would have enabled a more accurate assessment of the risks of harm or abuse.

3.7.1.13. Valuing People (2001) sets out a key principle of Independence but states very clearly the role of the public sector to support people to achieve this – "*independence in this context does not mean doing everything unaided*".

There is clear evidence that agencies, whilst often recognising her vulnerability, were over reliant on the belief that Gemma "chose" to put herself at risk and that it was her right to do so. In 2006 a letter from a psychiatrist to her GP stated that "Gemma has the ability to make her own decisions about contact with the services (but) she is perhaps poor at judging some risks". There was a failure to adequately investigate, or explore with Gemma, the impact of her vulnerability. This is not to suggest that agencies should be risk averse and should not take into account Gemma's views and wishes, but "choice" should not be used as a rationale to ignore the duty of care or stop providing a service. Though Gemma had periods of disengagement and on a minority of occasions had been aggressive towards workers, she would usually quickly come back to ask for help. Supporting people who are difficult to engage is a particular skill and is not uncommon, with specialist learning disability and mental health services having considerable experience and expertise in working with people whose behaviour places them at risk.

3.7.1.14. The chronology sets out clearly the support Gemma received from housing services, and she was appropriately referred for floating housing support services to help her maintain her tenancy and manage her debts. Gemma's engagement was spasmodic, and intervention tended to focus on the latest crisis relating to rent arrears and threat of eviction. It is clear that RBC housing services and Orbit worked hard to engage Gemma and to provide assistance, that in the case of RBC went beyond the norm, to ensure that she paid her rent, including enabling access to additional housing benefit on an exception basis to help her out of her backlog of debt. This cycle of crisis intervention, however, meant that Gemma's situation was never sufficiently stable to work with her on other aspects of her life, such as college and employment, or to explore her social needs and contacts.

3.7.2. **(b) To review the effectiveness of the transition procedures from Children's Services to Adult Services, and establish whether any lessons can be learnt about how this can be improved.**

3.7.2.1. It is important to note that Gemma's transition to adult service was 10 years ago and that there have been significant changes in procedures and practice since that time. However, the lack of an effective transition process for Gemma *at that time* potentially had a significant impact on the future response from adult services and influenced longer term decision making that subsequently reduced her ability to access timely and effective support.

3.7.2.2. It is clear from the evidence that Children's services held a large amount of knowledge about Gemma's needs and her family circumstances. This included a wealth of information about her health needs and attempts to

diagnose a condition that could explain her needs and vulnerability. The evidence from Children's Services records indicate that transitional issues were considered and it was believed that a Transition Plan was put in place. However, there are no records of this in either Children's Services or Adult Social Care. The evidence from Adult Social Care suggests that there was no formal transition plan or process.

3.7.2.3. The first recorded contact with Adult Social Care was in July 2001 and was initiated by Gemma's mother, whilst Gemma was attending Exhall Grange school and due to her recent diagnosis of Autism. There is no evidence that information was sought at that time from Children's Services to inform the adult assessment, establish her history or undertake any joint working. A multi-disciplinary assessment was completed, the outcome of which determined that Gemma did not have a learning disability or Autism but that her behaviour indicated a conduct disorder. Gemma was informed that she did not have a learning disability or autism a few days before it was recorded that the case was to be subsequently closed. The transfer summary states that the Gemma had applied for a place at a residential college in Wales and that if she was successful, the case would be closed, otherwise she would be given advice on housing and employment options.

3.7.2.4. The evidence from the residential college in Wales shows that Gemma was still open to Children's Services when she commenced her placement and notes that the case was subsequently transferred to Adult Services in December 2002. The chronology shows that both Children's Services and Adult Social Care were involved with Gemma at the same time between July 2001 and December 2002, but there is no evidence of communication or joint working during this period, other than a note in the adult records to state that the "review of education and care plans" was received and filed in March 2003.

3.7.2.5. It is disquieting that there are stark differences in diagnosis between Children's Services and Adult Health and Community Services during such a short period of time given that diagnosis was such a significant determinant of eligibility for accessing adult services. However, the type and level of services available to adults with disabilities are different to those available to children with disabilities, and this issue is not just pertinent to this case but is a cause of concern and anxiety to many families at this time of their lives. Throughout her contact with Children's psychiatrists & psychologists there was general agreement that Gemma had a learning disability, though this in itself is a very broad definition that encompasses a diverse range of conditions and needs. The independent assessment commissioned by Gemma's mother and its findings regarding Autism were accepted by Children's Services and were not challenged. A more formal transition process would have enabled a more

rounded and realistic assessment of her vulnerabilities and the opportunity for a more personalised approach but this would have only been effective if it was not so heavily biased towards the need for a confirmed diagnosis as the main criteria for accessing services.

3.7.3. **(c) To establish how well agencies work together and to identify how inter-agency practice could be strengthened to improve the identification of, and safeguarding of, vulnerable adults.**

3.7.3.1. As a generalisation, the evidence suggests that in the main agencies tended to deal with the issues pertaining to their own remit and, despite efforts to make referrals to Adult Social Care, the links were not made that are a pre-requisite to the effective protection of vulnerable adults. This was evident as early as the transition process outlined above, with a lack of joint working across Children's and Adult services. There was also little attempt to complete an assessment regarding suitability of the proposed placement at the residential college in Wales. It would appear that Gemma's parents identified and arranged this placement independently of any agency input. Adult Social Care records suggest that the placement was to be funded by health, but this is not corroborated and is unlikely. It has not been possible to identify how this was funded (presumably via Further Education funding). The decision to move away from home should not be taken lightly given the risk, for someone with Gemma's poor social skills, of being unable to maintain or develop local friendships or the support networks that will be so important in adulthood.

3.7.3.2. At no time during Gemma's adult life did one agency have a full overview about what was happening in her life and a full understanding of the risks to which she was exposed. However, there is evidence that some agencies not only tried hard to make appropriate referrals and engage other agencies in supporting Gemma, but also went further than the norm in trying to support her as a single agency.

3.7.3.3. Some of the earlier decisions about eligibility based on diagnosis clearly had an impact on agencies attempts to flag concerns with Adult Social Care about Gemma's well-being. For example, the police made attempts to refer Gemma under the safeguarding procedures, but the referral was not accepted. RBC Housing Services made repeated attempts to refer to Adult Social Care and to seek clarity and advice on Gemma's disability and needs, but were told that she did not have a learning disability and had capacity to make her own choices. Decisions about whether to make a vulnerable adults referral under safeguarding procedures were considered by agencies in isolation, largely based on single agency evidence, and Gemma's word that she was not being exploited.

3.7.3.4. There is little evidence of effective multi-disciplinary working – often the focus of any multi-disciplinary working that did happen appeared to be about whether or not she had a diagnosis of a learning disability, rather than to develop a care plan that brought together the various services and agencies in any structured way to provide on-going support to Gemma. The mental health assessment that was carried out was ineffectively co-ordinated and did not include social care input. Opportunities to convene a multi-agency vulnerable adult meeting were missed.

3.7.3.5. Agencies often did not have access to information that was known to other agencies. There is clear evidence during 2008 that RBC Housing and Orbit worked closely together to support Gemma in maintaining her tenancy. There was awareness that mental health services were involved (specifically a CPN). However, although there were some joint visits and some evidence of communication, the evidence points to this being ad hoc and occasional rather than systematic. The decision to close the CPN input to the case is first set out in August 2009 based on Gemma's failure to keep appointments, then in September 2009 that "she appears to be coping with living independently". This is in stark contrast to the crisis that was known to Orbit and RBC Housing Services during this period in relation to her tenancy and debts and evidence that she was vulnerable to exploitation.

3.7.3.6. A key learning point that emerges is the importance of follow up and feedback. There are many examples of information being passed on to agencies, but with no follow up. There is a lack of a systematic approach to either give feedback to agencies following a referral or receipt of information, or to proactively seek feedback – this needs to be a two way process with an obligation to both give and ask for feedback.

3.7.4. **(d) To establish whether it was known, or could have been suspected, that the five perpetrators posed a serious risk to Gemma or other vulnerable people.**

3.7.4.1. There is no substantial evidence from any agency that the five perpetrators posed any risk of harm to Gemma or other vulnerable people. All five were well known to a range of agencies, and a key feature of their lives was the normalisation of violence with their being both the victims and perpetrators of assaults. Daniel Newstead was a known risk (categorised Medium) in relation to domestic abuse and his partner Chantelle Booth was considered vulnerable within the police definition (that is in relation to domestic abuse, not the No Secrets definition). Drugs and alcohol, anger management issues, loss and bereavement were all a key feature of their chaotic lifestyles.

3.7.4.2. There was one alleged incident of Chantelle Booth & Jessica Lynas harassing and bullying a vulnerable woman (not Gemma) in a hostel, this being in the June prior to Gemma's murder. However, this was not corroborated through either the adult social care or police records and other than this, there were no indicators, triggers or escalating factors that could have led to a prediction of the events which took place in August 2010.

3.7.4.3. Though the police had investigated various allegations made by Gemma, including an assault on her by a male during May 2010, none of these incidents were related to any of the alleged perpetrators. There was no knowledge of Gemma's relationship or contact with Joe Boyer & Jessica Lynas, Duncan Edwards, or Daniel Newstead and only limited knowledge of her perceived friendship with Chantelle Booth. The police were aware of her contact with Chantelle Booth when Gemma contacted them on Chantelle's behalf regarding a stolen purse in September 2009. The day before her death, Gemma attended a meeting with the RBC Housing officer accompanied by a friend who was later identified as Chantelle Booth. On none of these occasions were there any issues that triggered concern about this relationship.

3.7.5. **(e) To establish whether Gemma was targeted for abuse or exploitation as a direct result of her disability and if so, to determine the lessons that can be learnt to identify early warning signs of possible hate crime.**

3.7.5.1. Gemma's vulnerability to exploitation is well documented, with anecdotal evidence of her willingness as a child to accept abuse for the sake of being acknowledged as a friend, and clear evidence of her potential sexual vulnerability both as a teenager and an adult.

3.7.5.2. As an adult there is evidence that Gemma was subject to exploitation by people who knew her (but not by the alleged perpetrators). The first indication was during her first supported tenancy with Mayday when she was allegedly asked to look after drugs by the landlord of a local pub and being subsequently charged with possession. There were clear concerns identified by Orbit and RBC Housing Services about extortion and/or exploitation during early 2008 and subsequently in October 2009. These incidents included having possessions taken from her and not expecting to get them back and suspicions that she was giving people money on a regular basis. The police were involved on each occasion. A safeguarding referral was made to adult services by the police as a result of the first incident but was closed by adult services without being investigated. On the second occasion Orbit and RBC discussed making a POVA referral but did not proceed due to Gemma stating

that she was not being extorted but was “spending her money on rubbish”. However, these concerns continued to be recorded regularly after this decision, which was not reviewed or revisited in the light of additional evidence mounting.

3.7.5.3. Though there is no concrete evidence that Gemma was targeted for abuse or exploitation as a direct result of her disability, she was living in a social environment where young people were regularly perpetrating crimes against each other. There is evidence that she was the victim of “mate crime” based on her allegations to the police against people she associated with (though these were not the alleged perpetrators, there were repeated complaints about named individuals who she was known to be associating with at different times). Gemma presented as someone who “looked different” and her behaviours and lack of social and communication skills placed her at high risk of being targeted for abuse or exploitation. She would find it particularly difficult to protect herself and her need for social contact and friendship to combat loneliness and isolation would lead her into situations where she did not have the skills to recognise the dangers.

3.8 The known facts

3.8.1. It is important to establish fact from supposition or assumption and to ensure that the findings are reflective of the evidence.

Issue	Factual evidence	Assumption	Agency
Gemma had delayed development as a child	Statement of Special Education Needs, 1987		Local Education Authority
Behavioural difficulties at home (as a child)	Family reporting and various assessments		Coventry & Warwickshire Partnership Trust (CWPT) Children’s services
Diagnosis of borderline Autistic Spectrum or Asperger’s Syndrome	a) Psychology assessments 1997 b) Private Psychology assessment		a) CWPT – children’s learning disability service
Diagnosis that Gemma had a learning disability	**a)** IQ tests of 62 and 65 **b)** Private		a) CWPT – children’s learning disability service

	psychology assessment		
Diagnosis that Gemma did not have a learning disability or Autism	IQ and psychological tests 2001		CWPT – adult learning disability Psychiatric Service
Diagnosis that Gemma had borderline learning disability and behavioural difficulties	Mental Health assessments 2008		CWPT – adult Mental Health psychiatric service
Gemma had a diagnosis of Conduct Disorder	Assessment Summary. Letter from MH Adult Psychiatrist to GP, refers to LD Psychiatric diagnosis (2001)		CWPT
Gemma did not have a mental illness	Psychiatric assessments 2008		CWPT
Gemma was perceived by agencies that came into contact with her as someone who had a learning disability or a mental health condition		Observations of staff based on Gemma's appearance, behaviour and social communication	Police RBC Housing Services UHCW Schools & Colleges
Gemma was vulnerable and at risk of exploitation	Recorded contact with agencies relating to the allegations made against others, her inability to manage money, poor personal hygiene and self-neglect, suspicions/evidence of exploitation; family evidence; episodes showing sexual vulnerability.		All agencies that came into contact with her- Police RBC Housing Orbit Mayday CWPT – children's and adult services Adult Social Care Children's Services UHCW Residential College Schools attended

Gemma was considered to have the mental capacity to make choices about lifestyle and to take risks	No factual basis as no Mental Capacity Assessment undertaken	Psychiatric opinion sought by RBC re her ability to manage money; Police sought advice re her mental capacity to consent to sex following alleged rape	Adult social care CWPT adult services
Gemma's perceived friendship with Chantelle Booth	Phone call to police and attendance at RBC offices		Police RBC
Though Gemma's contact with Chantelle Booth was known, there was no knowledge of her relationship with the other parties	Case records from all agencies show no links except the 2 contacts with Chantelle Booth referred to above		All agencies
There was no evidence that Gemma was at risk from the alleged perpetrators.	Case records from all agencies show no incidents or warnings		All agencies
Chantelle Booth and Jessica Lynas harassed and bullied a vulnerable adult (not Gemma) in June 2010	Orbit IMR	No record of adult safeguarding referral or action; no police records.	Orbit RBC Housing Service
Gemma failed to engage with services, was aggressive to staff and refused to co-operate with assessments	Engagement with floating support services was inconsistent and she failed to attend 18 appointments out of 48; with RBC she failed to attend 6 out of 33 possible face to face appointments; Gemma kept 10 out of 11 OPD	Though the facts show that Gemma's engagement was spasmodic, the evidence does not indicate a significant or sustained refusal to co-operate. There are 2 records only of her aggressive	Orbit RBC Housing Services Adult Services CWPT UHCW

	appointments. Out of 11 separate assessment events with ASC, Gemma refused to co-operate with one.	behaviour towards staff – these being Mayday and one specific social worker.	

3.9 Missed opportunities

3.9.1. There is no evidence that Gemma's murder could have been predicted and, other than one alleged but uncorroborated incident of harassment involving Chantelle Booth & Jessica Lynas, there is no evidence that any of the perpetrators presented a risk of serious harm to vulnerable adults. However, there is clear evidence that Gemma was vulnerable to the risk of abuse and she had been a victim of "mate crime" on a regular basis over a sustained period of time, by a number of people who were known to her. None of these people were however the perpetrators. The panel have found some evidence of inadequate systems, poor professional practice and decision making, and of weak multi-agency working.

3.9.2. The threshold for initiating an adult safeguarding assessment is currently defined by the risk of "significant harm" (the recent Law Commission[3] consultation paper proposes changing this to "harm"). The obligation for agencies to take reasonable steps to safeguard a vulnerable adult from abuse is set out in Articles 2 and 3 of the European Convention on Human Rights and the requirement is to take action if a person is *believed* to be at risk of harm, not when there is demonstrable evidence that abuse has actually happened. There were a number of incidents that indicated that Gemma was believed to be at risk of significant harm due to financial exploitation and these were missed opportunities to assess under the Adult Safeguarding procedures.

3.9.3. There were other incidents that indicated that Gemma was at risk due to a lack of daily living skills and self-neglect, and was repeatedly making decisions that put herself at risk, that did not meet the adult safeguarding threshold of significant harm, but were missed opportunities to complete a community care assessment, risk assessment, and to consider or offer the provision of additional support.

3.9.4. Whilst there is no guarantee that Gemma would accept help, there is clear evidence that she did develop and maintain good relationships with the police and would contact them regularly, and though she often refused to engage

[3] The Law Commission (LAW COM No 326): Adult Social Care; May 2011

with agencies, she always contacted agencies when she perceived herself to be in crisis. This led to a repetitive pattern of Gemma asking for help when in crisis but being unwilling to engage in any follow up on the occasions that it was offered.

3.9.5. Given the lack of knowledge about Gemma's relationship with the perpetrators, and her strong desire to protect her independence (and anecdotal evidence that she may cover up abuse if she perceived the abusers to be friends) it is probably unlikely that intervention could have predicted or have prevented the tragedy that happened to her – the evidence set out in the missed opportunities relates mainly to financial exploitation, sexual vulnerability and self-neglect and, with the exception of the assault in May 2010, does not suggest a high risk of physical abuse. However, it may be that timely and effective intervention could have resulted in better outcomes for Gemma in terms of managing her finances, finding more meaningful day time occupation (such as college or employment) and finding alternative social contacts that would have avoided her becoming sucked into the company of people who were leading such chaotic lifestyles and who were not going to be mindful of her welfare.

3.9.6. The missed opportunities - for initiating safeguarding procedures, assessment or other interventions, and for multi-agency communication and sharing of information - are set out in the following table:

Missed Opportunity	**Agency actions**	**Comment**
Completion of adult assessment in 2001 that Gemma did not have a learning disability or autism but her behaviour is indicative of a conduct disorder	Assessment completed by December 2001 – Gemma informed of outcome. Adult Social Care decision to transfer case for monitoring by a community care worker until she left school and to close case in the event of securing place at residential college out of area – date of closure unclear, recorded as May 2003, but chronology suggests limited input during 2002.	Though this occurred 10 years before her murder, this early focus on a diagnosis of a learning disability by adult services had a long term impact on future decisions regarding intervention and support. Case was also open to Children's services until December 2002, but there was no joint working between Children's and Adult services for a planned handover.
Alleged rape in supported accommodation with Mayday in September 2004.	Meeting convened with Adult Social Care and Mayday Trust to discuss whether Gemma should live elsewhere whilst perpetrator	No adult safeguarding investigation, and no formal assessment of mental capacity to consent to sexual intercourse was completed.

	bailed. Police asked Psychiatrist for judgement about mental capacity to consent to sexual intercourse – advised that she does not have a learning disability. Risk assessment completed in October 2004 that Gemma was contractually required to adhere to (by Mayday) and moved accommodation. Decision to close case was recorded by Adult Social Care in December 2004, a review was subsequently held in February 2005 and then no further contact until case formally closed 17th July 2005.	
Breakdown of placement at Mayday with deterioration from late 2005 through to her eviction in September 2006. Included evidence of exploitation by pub landlord (when Gemma was asked to look after drugs) and arrested for possession.	Adult Social Care had allocated the case during this period. Social worker stating that Gemma doesn't meet Fair Access to Care Services (FACS) criteria – this is not based on a re-assessment as Gemma is refusing to co-operate. RBC Housing Services allegedly refuse to re-house her due to her learning disability and need for support. Adult Social Care management decision to make one offer of accommodation and to close case if Gemma refuses it. Gemma refuses the offer because the property is in Bedworth and she does not want to move out of her local area. The closure summary is dated August 2006 and formally closed in September 2006.	No adult safeguarding investigation completed. No Mental Capacity Assessment completed. No review of FACS eligibility - previous FACS assessment of critical is still therefore in place. Decision appears to be on the grounds that Gemma does not have a diagnosis of a learning disability and assumptions that she has capacity to make this choice - the social worker states clearly in the notes that Gemma has a choice between accepting the offer or of being homeless. This episode of intervention is a critical turning point in Gemma's life and her ability to access support. There was significant evidence of Gemma's vulnerability and difficult behaviours - this required skilled social work intervention to engage her. However, the records indicate that relationships

		became strained – the tone of the case recording is emotive and decisions are heavily reliant on assumptions about Gemma's right to make choices about her life, even if this places her at risk. No risk assessment was completed and no vulnerable adults meeting was convened prior to closing the case. It is after this episode that referrals about Gemma were dealt with by duty workers and Adult Social Care consistently declined to become involved on the grounds of her lack of a diagnosis and failure to co-operate.
New referral from Gemma's mother in August 2007 as Gemma at risk of losing another tenancy "because of her behaviours related to her learning disability", and that she is "living in a pigsty".	Adult Social Care advise her mother that Gemma does not have a learning disability and to contact her GP.	It is by this point over a year since the case was last allocated and there was a duty of care to re-assess given the on-going concerns.
New referral from LD Psychiatrist in October 2007 requesting a joint health & social care assessment as she is still experiencing difficulties.	Adult Social Care decline to do a joint visit on the grounds that Gemma does not have a learning disability. Learning Disability Psychiatrist refers to Adult Psychiatrist for assessment – Mental Health services allocate for psychiatric, psychology and OT assessments and family are offered a Carers Assessment which was declined. It is recommended that a	This was the opportunity for a full multi-disciplinary assessment, including a community care and social work assessment, that cut across Learning Disability and Mental Health services. The planned Vulnerable Adult meeting did not take place, which would have brought together all agencies to share information and identify risks.

	Vulnerable Adults meeting is convened once assessments are completed. Assessments are completed by December 2008, but no further action is taken to convene a Vulnerable Adults meeting or arrange support on the grounds she is not eligible for CWPT services. CPN involvement continues into 2009 until case closed due to Gemma not attending appointments and a belief that she is successfully living independently. No risk assessment completed to check that this was the case.	
Police refer concerns regarding the condition of the accommodation and Gemma's vulnerability to Adult Social Care on 27th & 28th February 2008	Though logged as a Safeguarding referral, Adult Social Care decision is to close the case without investigation on the grounds that Gemma does not meet criteria, despite acknowledging her vulnerability. Police are advised that Gemma has not been diagnosed with mental illness, has capacity to make decisions and does not need support to ask Housing to re-house her. Police are informed that "every assistance has been offered to Gemma in the past and she has refused all support".	An adult safeguarding investigation should have been completed at this stage. The statement that "every assistance has been offered to Gemma in the past and she has refused all support". is incorrect as there is clear evidence that Gemma has not rejected all support in the past and in fact the previous decision to "offer one accommodation only" had not taken into account Gemma's wishes to stay in the Rugby area and could not be described as "every assistance". Gemma is still assessed as meeting critical FACS criteria at this time, as this has never been reassessed. There is no assessment of her Mental Capacity to support the statements made.
Letter from Financial Company to CPN in March 2008 regarding debts and	CWPT actions unclear, case closed April 2008.	No adult safeguarding referral or investigation.

allegations that Gemma is being manipulated and duped.		
OT assessment started in April 2008 and completed in May 2008 states that Gemma requires an environment that provides on-going supervision and support with all activities of daily living. It is also stated that she would benefit from a structured daily routine in order to increase her motivation and increase her confidence with life skills.	There is no record of the outcome of the assessment being discussed in the CWPT SPA meeting. Notice to quit was served a week after the completion of the assessment and she was accepted as homeless by RBC in July. RBC speak to CPN and are sent a copy of the OT report. CWPT informed of her housing move.	There is no evidence of multi-agency working to agree a care plan or agree housing provision (mainstream tenancy offered by RBC and referral for floating support).
On 27th May 2008 the police were involved following Gemma reporting a theft of money from her room by Stan[4] and Sam[5]. Gemma's mother also rings the police to state that "the males knew how to take advantage of her because of her learning difficulties". Gemma rings again to say she has no money for food and describes herself as vulnerable due to her disability. Further 999 call on 29th May regarding another	Police investigate the crime and arrange to see Gemma with her mother. Police records state that they would up-date her mental health worker as they feel she doesn't understand advice given. Following further 999 calls 2 days later, also linked to Sam, police records note that Gemma is being assessed by Mental Health services.	No safeguarding referral or investigation or evidence of this leading to a multi-agency discussion to share information and agree plans.

[4] pseudonym
[5] pseudonym

male.		
Further 999 call on 22nd July 2008 regarding stolen purse, linked to Sam and his friend - Gemma described as very distressed.	Police noted that due to Gemma's autism, need to involve mother, but mother not available for a further week. Gemma and her parents spoken to and her vulnerability re Sam and his friend noted.	No safeguarding referral made. 2nd incident linked to Sam.
Further 999 calls on 11th August and 14th August 2008 when Gemma says that Sam and 2 others have threatened to assault her (11th) and banging on her door (14th).	Police Officers attended – Sam and the other 2 people were visiting someone else at the bedsits. No offences committed. On second occasion Gemma was seen on 24th August and requested no further action.	A total of 4 incidents linked to Sam, all linked to similar theme . No safeguarding referral made.
Gemma makes further complaints of theft against Sam, on 9th September 2008, and on 11th September when she claims Sam has stolen her friend Chantelle Booth's purse and states that Chantelle Booth is frightened of Sam who keeps harassing her and asking for sex.	After the first complaint, Gemma is issued with an harassment warning because of repeated unproven allegations against Sam. On the 2nd occasion police tried to contact Chantelle Booth but unable to do so.	This period – from May to September is starting to show a repetitive pattern of complaints that indicated that all is not well in Gemma's life. As her allegations against Sam are unproven, Gemma is issued with an harassment warning – which in itself is indicative of her difficulties and potential vulnerability and should have been used as an opportunity for a vulnerable adults meeting.
On 8th December 2008 the concierge calls police as he is monitoring Bill[6] who has been bothering Gemma.	Police make telephone contact with Gemma and give advice. .	During the same time period, issues regarding non-payment of rent have been escalating with RBC and Gemma has been consistently failing to keep appointments. On 9th December 2008 CWPT records suggestion to make

[6] pseudonym

		social care referral and to hold a professionals meeting. Clear lack of communication between housing, mental health and police
On 13th March 2009, Orbit support worker concerned about Gemma's behaviour (hanging around the flats, looking "shifty").	Reported to RBC, who also witness same behaviour on 16th March 2009. No communication with MH team - CPN records dated 16th March state "remains very stable. To consider discharge". RBC & Orbit joint visit on 25th March 2009 and discuss their concerns with Gemma, who insists she is fine and no-one taking advantage of her or taking her money off her.	Repeated concerns about financial exploitation combined with Gemma behaviours would have warranted better inter agency communication to share concerns.
Orbit raise concerns on 16th April 2009 regarding debts, personal hygiene, housekeeping, and that people may be taking advantage of her. RBC identify Gemma is hanging around a known drug dealers flat and may be taken advantage of sexually. Gemma has said she is "smoking weed and drinking".	Orbit report to RBC and consider POVA referral. RBC discuss with Gemma who insists she is not having money taken off her "just spends it on rubbish" and thus decide not to make a safeguarding referral. RBC ring and inform CPN and arrange a joint visit (RBC, Orbit and CPN) for 1st May 2009. Gemma was not in on 1st May so joint visit didn't happen but RBC worker saw her later the same day. Gemma inferred someone owed her money and she did not expect to get it back – was advised not to lend people money or visit people taking advantage of her. Next record from CWPT is decision on 12th May 2009 to discharge Gemma. Followed	Though 3 agencies involved at this stage, and aware of current concerns, no safeguarding referral was made due to Gemma's response. At the very least, a multi-agency meeting, involving Mental Health services, should have been arranged to share information and concerns.

	by record on 8th June that there are “some concerns”.	
On 1st May 2009, Gemma tells RBC that Colin[7] has sold her X box and she won’t get her money back.	This was during a joint visit between RBC and Orbit to discuss rent arrears and state of the flat. Gemma advised not to visit people who take advantage of her.	The focus was on de-fumigation of the flat and living conditions. The decision not to make a POVA referral should have been re-visited in view of the continuing evidence of vulnerability.
In the early hours of 20th May 2009, Gemma drunk and causing a disturbance with 2 other females.	Police take Gemma home and state displaying signs of possible Mental Health issues. No further action.	
Following Gemma failing to keep appointments earlier in the year, face to face contact by CPN during early August.	CWPT - closed as an episode on EPEX (the electronic database system).	No summary and unclear whether risk assessment completed prior to discharge
Gemma tells RBC in October 2009 that Colin is taking £50 a week off her and she doesn’t know how to say “no” to him.	RBC report it to Police who request social services to attend interview with Gemma. RBC attempted to involve Victim Support or family and friends. Gemma did not keep the appointment. Orbit had followed up with Gemma, who said she was seeing the police with her sister, but then Gemma avoids meeting with Orbit for several months. RBC make referral to Victim Support	This is the same person who sold her X box and who RBC had advised her not to visit. No evidence of any further follow-up by any agency. No adult safeguarding referral made. No link made between the episodes with Colin and earlier history of episodes with Sam.
By mid November 2009, Gemma has failed to keep appointments with Orbit or Victim	Rugby Borough Council contact Adult Social Care Learning Disability team who advise them to speak to a health professional for advice	No Mental Capacity assessment is carried out to support the advice given to RBC. The advice that she does not meet eligibility of

[7] pseudonym

Support and has built up rent arrears and debts.	about a referral for Mental Health support or a capacity test. Both Adult Social Care and the health professional tell Rugby Borough Council that Gemma doesn't have a learning disability and has refused all support in the past. RBC are advised that as Gemma does not have a learning disability, does not meet criteria for services, and has the capacity to understand her actions, it is recommended RBC take recovery action.	services is 10 days after CPN had closed the case. The record states that "(health professional) felt she may continue her behaviour and that perhaps recovery action was the only way forward in order to get her to engage". Though at this point RBC and Orbit are consistently attempting to engage Gemma, there is no referral accepted for a social care assessment and advice to try and make her engage by carrying out recovery action is not based on any multi agency assessment or planning meeting. However, it should be noted that after court action is taken, Gemma does start to re-engage with Orbit and RBC.
In May 2010 Gemma is assaulted by a male – Tom[8] – who denies the charge. Gemma has bruising and pain for which she requests medical treatment.	Police arrest Tom but no corroboration so no further action taken. Gemma attended Rugby urgent care centre (UHCW). Bruising observed by RBC and Orbit and both are told by Gemma that she was assaulted at a friend's house and police are dealing with it.	This is the first and only report of an assault and, based on Gemma's account, by someone she knows and took place at a friend's house. Though she is seen by 4 agencies on 4 separate occasions, no adult safeguarding referral is made even though Gemma is recognised as vulnerable within No Secrets definition.
Engagement of Gemma's parents and family	Police had regular contact with Gemma's mother, with local police holding her contact details. CWPT offered a Carers Assessment which was declined. Adult Social Care had some contact with Gemma's mother and sister at various times, usually when they rang	Once Gemma reached adulthood the main contact between health and social care agencies and the family was when Gemma's mother or sister contacted to make a referral or ask for help. On only one such occasion was a Carers Assessment offered (which was declined).

[8] pseudonym

	to make a referral, or relating to a specific incident.	

4. LESSONS FROM THIS REVIEW

4.0.1. The lessons learnt by each individual agency have been set out within the agency reports (IMRs) along with individual agency recommendations for improving multi-agency working. This section summarises the overarching lessons that have been learnt from the Serious Case Review.

4.1 The system for accessing specialist health and social services by people with lifelong disabilities and/or vulnerabilities, who do not have clear diagnosis, was inadequate.

4.1.1. The review has identified critical issues about people who are vulnerable and are at various levels of risk, but who don't meet the "eligibility criteria" to access specialist support. Many people, like Gemma, are often described as "borderline" in such cases. Based on IQ levels and to a lesser extent other psychological functioning tests, as an adult, Gemma was not diagnosed as having a learning disability. Valuing People states that "*This definition encompasses people with a broad range of disabilities. The presence of a low intelligence quotient, for example an IQ below 70, is not, of itself, a sufficient reason for deciding whether an individual should be provided with additional health and social care support. An assessment of social functioning and communication skills should also be taken into account when determining need.*

4.1.2. As the term learning disability is so broad, and encompasses such a diverse range of needs, using diagnosis alone is not an appropriate determinant for accessing services. Valuing People is clear that the term learning disability "*does not include all those who have a 'learning difficulty' which is more broadly defined in education legislation"*. The term *learning difficulty* refers to a problem related to learning, such as dyslexia, and is understood by most people to be something slight, or a set back, that can be overcome. It is very different to a learning disability that is always a recognisable life-long condition with life-long support needs.

4.1.3. The panel found that there was clear evidence that Gemma had a life-long condition that included significant difficulties relating to social functioning and communication, and risks related to her behaviour. Gemma did not have a diagnosed mental illness though she was diagnosed with a recognised mental disorder, that of Conduct Disorder.

4.1.4. Fundamentally, the evidence shows that professionals recognised her life-long difficulties but felt restrained by the systems and protocols around diagnosis to offer her support – so there was confusion about who was ultimately responsible for offering that support. If health and social care agencies are going to put into practice the personalisation agenda, as set out in Putting People First, there needs to be a significant culture change that moves away from determining eligibility based on diagnosis or IQ levels

towards an approach that is based on vulnerability, need and risk and takes into account the whole person.

4.1.5. In cases where people appear to have cross cutting needs and issues relating to a mild or borderline learning disability and what is often described as a behavioural, conduct or personality disorder, there needs to be effective joint working across mental health and learning disability services to identify the appropriate support.

4.2 Risk Assessments were not routinely or systematically undertaken or used to underpin decision-making in relation to undertaking reassessments and the closure of cases. This is especially important when someone is reluctant to engage with services, refuses support or cancels services. Some professional practice was too heavily weighted towards the "right to choose" rather than the duty of care.

4.2.1. The Review identified a number of issues relating to reluctance or failure to engage with services, or noncompliance with follow up actions that have been agreed. This applied to Gemma and to the alleged perpetrators who had also failed to attend therapeutic appointments or take advantage of support to address issues relating to substance abuse. It is a reality that there are people who will always choose to reject support, and in Gemma's case it is clear that she valued her independence, often telling people that she was an adult with the right to do what she wanted. Furthermore, though someone may have a diagnosis of a mental disorder, they cannot be forced to accept treatment without a Treatment Order.

4.2.2. Working with people who are difficult to engage requires skill and expertise, and this requires cases to be allocated to staff who possess the appropriate skills and experience. Sometimes it does involve people having to face the consequences of their decisions (such as understanding that not paying your rent leads to court action and losing your home) but this needs to be done as part of a planned approach and in a structured way that ensures that the support mechanism is ready to be activated once the person re-engages.

4.2.3. It has to be recognised that the willingness to accept help often fluctuates. Gemma always came back to ask for help, and always when she perceived herself to be in crisis, and yet her reputation as someone who "failed to engage or co-operate" was constantly used as a reason to reject re-referrals or to refuse to reassess her changed circumstances and current level of vulnerability.

4.2.4. Whilst recognising the realities that some people will always exert their right to refuse support, it is important that the risks are fully understood and documented – and this requires ensuring that all information is gathered to ensure that an appropriate decision is made. It is essential that the "right to choose" to disengage is not used as an excuse to ignore the duty of care. Gemma's choice to disengage with services increased her vulnerability. She became more and more in debt and at risk of losing her home, but she also

became more and more isolated and dependent on a community of perceived friends and acquaintances who were living chaotic lifestyles and were frequently both the victims and perpetrators of crime. Though there was no evidence of Gemma's relationship with the alleged perpetrators, there was evidence of her vulnerability to exploitation or financial abuse by the people around her.

4.2.5. The new social care model of personalisation, based on self-directed support, provides opportunities for people to decide what support they need and how they want to be supported. However, it needs to be recognised that some people, like Gemma, are unaware of the risks presented by their lifestyle and repeatedly make decisions that place themselves at risk of harm. It is essential that the procedures for accessing community care assessments and services via self-directed care are based on robust risk assessments and do not further dilute the duty of care. This is not to suggest that services should become risk averse and ignore choice and self-direction, but that a balanced approach is taken based on positive risk taking that is underpinned by appropriate safeguards.

4.3 Mental Capacity Assessments were not completed. Decisions were made on an assumption of capacity that was not tested out through a professional assessment.

4.3.1. There are numerous occasions when professionals stated that Gemma had the capacity to make her own decisions and choices. This was applied to her difficulties in managing her money, her personal hygiene, her living conditions, her ability to consent to a sexual relationship and her lifestyle. On none of these occasions was it recorded that a Mental Capacity Assessment had been completed.

4.3.2. Principle 1 of the Mental Capacity Act (2005) starts with a presumption of capacity – "*every adult has the right to make his or her own decisions and must be assumed to have capacity to do so unless it is proved otherwise. This means that you cannot assume that someone cannot make a decision for themselves just because they have a particular medical condition or disability".* One of the factors in assessing whether someone can make a decision is whether they can weigh up information about the decision and understand the consequences. If someone "repeatedly makes decisions that put them at risk or result in harm to them or someone else" this could indicate that they do not understand the risk or are unable to weigh up the information about a decision.

4.3.3. However, a person should not be treated as unable to make a decision just because they make an "unwise decision". This is covered in Principle 3 of the Act that states "*people have the right to make decisions that others might regard as unwise or eccentric. You cannot treat someone as lacking capacity for this reason. Everyone has their own values, beliefs and preferences which may not be the same as those of other people."*

4.3.4. A pattern of behaviour that puts a person at risk – such as losing their accommodation – indicates a need to question their capacity and to consider requesting a mental capacity assessment. Rugby Borough Council housing service and the Police did request an opinion about capacity early on in their contacts with Gemma (this pre-dated the Mental Capacity Act and the opinion of a Consultant Psychiatrist was sought). However, on the other occasions when professionals stated that Gemma had capacity, no consideration was given to the repetitive pattern of behaviour, and no Mental Capacity Assessment was completed.

4.3.5. It is highly likely that a Mental Capacity Assessment would have found that Gemma did have the mental capacity to make decisions and manage these elements of her life, but this was never properly tested. Her history of failing to manage her money and suspicions of financial extortion certainly suggest that her inability to manage her money may have been deeper than her own statement that she "just spent her money on rubbish". Completing a Mental Capacity assessment would not necessarily have resulted in a decision that she lacked capacity but it would have brought the agencies together and enabled a proper assessment of her level of functioning and identification of the risks to which she was being exposed, especially as her Community Care Assessment in 2004 identified her as meeting the High (Critical) needs because of some of these issues, that had now become part of the pattern of her life.

4.4 The Adult Safeguarding process and the threshold of significant harm relies on the presence of a single large trigger and fails to identify people at risk in the community where the evidence is through a larger number of low level triggers.

4.4.1. The review raises issues regarding the threshold for adult safeguarding and the trigger processes used. The Chronology identified a significant number of incidents that taken on their own indicated a risk of "harm" but didn't meet the threshold of "significant harm". In some cases several incidents considered together by a single agency would also have been insufficient to indicate a risk of significant harm. (To note that the Law Commission report on Social Care does recommend lowering the adult safeguarding threshold to "harm"). The current system does not easily identify people in the community who may be at risk when there are a lot of low level triggers rather than one bigger incident.

4.4.2. In Gemma's case, no single agency had the full picture of what was happening in her life and the current safeguarding processes do not provide a means of identifying cases with many low level triggers, or of pulling all of the intelligence together to provide an accurate assessment of risk to harm. To address this, it would be worth exploring a new approach, for example through the use of Multi Agency Integrated Safeguarding Hubs.

4.4.3. A further issue identified was the fact that some detailed information about Gemma's day to day life was held by front line support staff, who rarely have

the opportunity to share that information. Current systems are often targeted at public sector procedures when in fact direct support staff from smaller voluntary organisations are often the ones who will pick up the low level triggers.

4.5 There was no prevention strategy that gives people who are living in the community, and may be vulnerable to mate crime, the skills to keep themselves safe

4.5.1. Gemma was involved with a group of young people who were often the perpetrators of crimes against each other, with these behaviours being normalised and therefore an expected part of their lives. For people who are vulnerable (in the No Secrets definition) this is a real risk, as they will be less able to protect themselves and will be seen by their contemporaries as an easy target. People with lifelong disabilities and vulnerabilities, like everyone else, want friends and a social life, but may be unable to judge when the motivation of a perceived friendship is based on a desire to exploit.

4.5.2. There needs to be increased awareness of “mate crime” and consideration of how to reach people who may be in Gemma’s position. It was noted that often police recorded “advice given” and Rugby Borough Council also advised Gemma to “keep away from people” but there is no formal multi-agency approach to giving people the skills to “keep safe”.

4.6 There was no systematic approach by agencies to give or request feedback following referrals or contacts to report concerns.

4.6.1. A key theme across agencies was the regularity with which concerns were reported back to agencies – for example, the police actions almost always included notification of Adult Social Care or mental health services, and Rugby Borough Council frequently made contact with those services. However, there were no systems in place to follow up such contacts and seek feedback on actions taken.

4.6.2. The responsibility for feedback does not just lie with the referring agency, but highlights a lack of procedural process to ensure that referrers are given information on what action has been taken. In some cases assumptions were made that follow up actions would be taken – for example the correspondence between the Adult Psychiatrist and the GP when the GP assumed that the Mental Health team would take action based on being copied into the letter, rather than making a direct approach to the team to request this.

4.7 There was a lack of oversight or clear co-ordination between housing support services and other adult social care services.

4.7.1. Central to Gemma's adult life were decisions about her access to housing and housing related support. The link between Supporting People funded floating support services and Adult Social Care is unclear. Whilst recognising that some people only need a low level preventative service of this nature, it is unclear how additional support can be accessed when there are clear indicators that someone like Gemma needs a higher level of support. This raises issues about how housing support is managed and the level of oversight. The evidence shows that the housing support provider was arranged by Rugby Borough Council, and though the front line support workers probably knew Gemma better than anyone else, there is no evidence of other health and social care agencies seeing them as playing a key role (other than some apparently ad hoc joint visits with a CPN).

4.7.2. The principles set out in Valuing People about people with learning disabilities having the right to access an ordinary life and having the same right as anyone else to access mainstream social housing should not be a barrier to receiving the sort of structured support identified in the OT assessment. It was only when Gemma was faced with her final eviction that consideration was given to her needing a higher level of support than could be offered by a floating support service, and the records imply that this could only be achieved by Gemma being referred to a building based supported living service. People with support needs should not have to move house or move into shared accommodation to access the level of support needed in their own home.

4.7.3. It is also important that people who are vulnerable are not allocated tenancies in areas, or properties, where it could be reasonably predicted that they may be subject to targeted anti-social behaviour or abuse. It is essential that a range of accommodation and support options are available that provide greater flexibility and choice – for example, Shared Lives Schemes and Key Ring type schemes. Supporting People services that are available in Warwickshire tend to be very specific, with little flexibility to offer a more bespoke service.

4.8 Panel Recommendations

4.8.1 Specific Actions

Warwickshire Safeguarding Adults Board

1. That the Warwickshire Safeguarding Adults Board develops procedures and/or issues guidance to:

a) ensure that multiple low level concerns/referrals are escalated. This should enable agencies to identify, monitor and report multiple low level concerns over a period of time, and to request escalation to a multi-agency meeting.

b) put in place a mechanism for ensuring that the guidance on the feedback process is implemented when safeguarding referrals are received.

c) remind all agencies of their responsibilities to protect and safeguard vulnerable adults, that this is based on concerns that a person may be at risk of being abused rather than the need to demonstrably prove that abuse has already happened, and reviews the operational procedures to ensure that this is adequately reflected.

d) ensure that when multi-agency meetings are arranged to discuss a particular individual, it is important that housing managers and housing support staff are included. On many occasions housing support providers are missed out or their views are not taken as seriously, yet they more often than not spend the most time in someone's property and will have detailed information that may not seem significant in isolation.

2. That the Warwickshire Safeguarding Adults Board works with the relevant partners to develop a strategy on mate crime as part of a wider Prevention Strategy. This must include an awareness raising exercise to raise awareness of mate crime across all agencies and the development of advice for people who are vulnerable on how to "keep safe".

3. The Board should review the multi-agency training plan to ensure that staff working in housing, and other District and Borough council services, receive mandatory safeguarding awareness training and are aware of the procedures.

4. The Board should review housing representation and, jointly with housing services, put in place an action plan to identify how the arrangements can be improved. There is a need to involve housing services, districts and boroughs

(county-wide) in a review of inter-agency safeguarding vulnerable adults procedures and that this should happen as soon as possible.

5. The Board will put in place arrangements to independently review and evidence progress against the recommendations 12 months after publication of the public summary.

Warwickshire County Council Adult Health and Community Services

6. That Warwickshire County Council adult services takes the following action to improve procedures and issue guidance as follows:

a) To set quality standards and issue guidance to improve case recording to ensure that all key decisions and the rationale behind them are recorded and easily identified, ensuring a robust framework is established that ensures a consistent approach to case recording across all services.

b) To ensure that the Adult Social Care screening process is compliant with the duty to assess, and does not focus on eligibility for provision. To develop a policy that ensures people who do not meet the criteria for accessing specialist services (whether learning disability, mental health or other) can easily access a needs and risk assessment at the first point of contact with the department. The policy must be subject to an Equality Impact Assessment to ensure that people with a mild or moderate Learning Disabilities/Learning Difficulties or who do not have a specific diagnosis, are not denied access to an assessment.

c) To review operational procedures for Adult Social Care and implement a process to ensure that agencies making referrals for community care assessments, or to raise concerns about the welfare of people living in the community, are given feedback on the outcome.

d) To issue guidance to all staff to remind them of the statutory duty to make an assessment and that clarifies the role of Fair Access to Care Services (FACS) – i.e. that FACS eligibility is determined as part of a community care assessment to determine council funding, not to determine eligibility for an assessment. The guidance should ensure that all staff check existing FACS eligibility and ensure that this is only changed following a review or reassessment.

e) To issue guidance that sets out the expectations of managers in overseeing and supporting staff with casework and ensure consistent management oversight.

f) To put in place operational procedures that ensure that the personal safety of people receiving self-directed care is effectively monitored

7. To revisit the remit of the Learning Disability Team. There is a need for a clearer definition of customers who are entitled to support and to ensure the team has an appropriate response framework for people with needs that do not meet the definition, to ensure they are enabled to get the service they need from the right place.

8. That Warwickshire County Council puts in place formal links between housing support services (funded by Supported People funding) and community care services and develops procedures and/or protocols that ensure that there is a timely review when additional support needs are identified by the supported housing provider.

9. That Warwickshire County Council ensures that electronic recording systems readily flag the existing or active FACS assessment so that re-referrals and concerns are linked to known levels of risks.

10. That adult services conducts a management review of the learning disability team's professional practice in relation to this case and takes appropriate management action to address shortcomings. This review should be carried by a senior manager not connected to the team, to afford transparency

11. That adult services complete an audit of safeguarding process and practices in the Learning Disability Service to ensure the Team provides a consistent service to all vulnerable customers.

12. That Warwickshire County Council reviews the current Transitions process against the findings of the serious case review to provide assurance that all young people moving from Children's Services receive a Transition Plan.

Warwickshire County Council Adult Health and Community Services, and Coventry & Warwickshire NHS Partnership Trust

13. That Warwickshire County Council and Coventry & Warwickshire NHS Partnership Trust (CWPT) issue guidance to their adult learning disability services that:

a) decisions to accept referrals for assessment are based on risk, vulnerability and need and not on diagnosis/IQ levels alone, and put in place clear protocols for determining diagnosis based on the guidance set out in Valuing People (2001). This must ensure that all adults who clearly have a lifelong condition are recognised as disabled and eligible for assessment for services.

b) risk assessments will be routinely completed when a case is closed for the reason of a failure to co-operate or engage, or repeated failure to keep clinical appointments. This must include the requirement to actively check with other agencies that are known to be in contact with the person

c) that staff undertake Mental Capacity Assessments and ensure that this is recorded.

14. That Warwickshire County Council Adult Services and CWPT adult services put in place written protocols to enable a structured approach for MH and LD services to work jointly in cases where there is a lack of clarity regarding which service should take lead responsibility and where a bespoke commissioned service can by agreed and coordinated.

15. Both agencies should review and appropriately amend operational procedures to ensure that assessments of young people being transferred from Children's Services to Adult Services includes an assessment of their social communication skills and their ability to understand the consequences of behaviour.

Coventry & Warwickshire NHS Partnership Trust

16. That Coventry & Warwickshire NHS Partnership Trust (CWPT) implement their agency action plan to ensure effective case co-ordination, effective clinical supervision and management, and that documentation is kept up to date.

17. That CWPT issue guidance to ensure that all staff follow the multi-disciplinary team approach and case co-ordination procedures when completing assessments.

18. That CWPT approve the draft service specification and operational policy and formally implement it with immediate effect.

Local Medical Council, GP Consortia and Warwickshire Safeguarding Adults Board

19. That there is a discussion between the Local Medical Council, GP Consortia and the Chair of the Warwickshire Safeguarding Adults Board to identify appropriate GP representation on the Warwickshire Safeguarding Adults Board.

20. That the Local Medical Council, GP Consortia and the Warwickshire Safeguarding Adults Board jointly develop a protocol that sets out clear expectations and duties of GPs in adult safeguarding procedures and that this includes clear advice on the involvement of GPs in Serious Case Reviews.

21. That the Local Medical Council and GP Consortia write to all GPs to remind them of the importance of following up recommendations and actions, rather than assuming that other agencies will do so.

22. The process of removing people from GP lists inappropriately when complex issues arise needs to be addressed, as identified in the closure of Chantelle Booth from her G.P.'s caseload at the time she was in custody

Rugby Borough Council Housing Services

23. Rugby Borough Council implement their agency action plan to embed the principles of safeguarding across all front line services, review the way front line services share knowledge of vulnerable adults, signpost or refer vulnerable adults for support, develop procedures for the implementation of the Domestic Abuse Policy, and share the action plan with other districts and boroughs.

Warwickshire Police

24. Warwickshire Police to issue guidance that details of the advice given to people involved in incidents, when there is no substantive offence recorded and no other type of police intervention, should be recorded.

25. Where referrals are made to other agencies, the feedback on the outcome of this referral should be sought so there is a complete picture of the support/work being undertaken with an individual by all agencies.

Warwickshire Probation Trust

26. Warwickshire Probation Trust to further highlight and develop awareness of Safeguarding Vulnerable Adults procedures as part of current risk assessment and risk management processes. This must include ensuring that attention is given to both potential perpetrators and victims, as well as those already known to the Trust.

4.8.2 Broader Issues that need to be explored

1. That Warwickshire Safeguarding Adults Board explore the feasibility of setting up a Multi-Agency Safeguarding Hub (MASH). This is a model that can be used to gather intelligence that may act as an alert that someone living in the community is vulnerable and is especially useful in pulling together a pattern of individual events that on their own may not appear significant. This should include a proactive trigger plan system that flags address and regular callers/users to the various services/agencies so a multi-agency approach could be put into place far earlier. This would enable improved communication networks to be put into place between the various agencies to allow for easier information sharing.

2. That Warwickshire Adult Social Care commissioners explore the development of alternative housing options for people who need greater levels of support, such as a Shared Lives Scheme and Key Ring type schemes.

3. There needs to be multi agency exploration of strategies that can be employed to encourage active compliance/engagement with therapeutic interventions offered across the multi agencies and to develop better understanding and expertise in working with people who are hard to engage.

4. When young people receive residential further education out of the Council area, it is important to ensure that such decisions are well thought through and take into account longer term plans to return to the area so as to ensure the maintenance of strong social networks. This should include risk assessments around proposed placements and advice for young people on keeping safe.

5. There is a need to consider a mechanism for early intervention similar to the Common Assessment Framework (CAF) as used for children. The adults CAF is not as comprehensive as children's but could be a useful link to preventing people falling through the net. This could have been used at the time a POVA was considered for Gemma. This was also suggested by housing in respect of Daniel Newstead but did not go ahead as he had entered the criminal justice system.

6. Warwickshire consists of five districts with five different District and Borough councils providing housing. Joint working between housing services and

Warwickshire County Council Adult Social Care needs to be strengthened to identify:

a. How information about the needs of vulnerable tenants/potential tenants (as in the No Secrets definition) can be better shared between agencies.

b. How housing providers can be better involved in the assessment and risk assessment process.

c. Ensuring that Support Plans are clear about the support people will receive to manage their tenancy

d. A clear escalation policy for reporting concerns about tenants who are vulnerable and appear to be at risk.

4.8.3 National Issues

4.8.3.1. This case raises a wider issue about community safety, and the accessibility of social housing for single adults who may be vulnerable to harassment, mate crime or exploitation. The chronology demonstrates that Gemma's circumstances deteriorated significantly following her being re-housed after becoming homeless. It was during this tenancy that contacts with the police increased significantly and that there were increasing concerns about her vulnerability to exploitation and "mate crime". This is no criticism of Rugby Borough Council Housing Services who gave Gemma high priority for social housing on the basis of her needs and who made many attempts to refer her for a community care assessment. The case does highlight however a national issue regarding the shortage of suitable social housing that is available as general needs housing. People who are vulnerable (in terms of the No Secrets definition) have the same rights as everyone else to access general housing options that are available from the public sector and registered housing providers. Social Housing is let through choice-based lettings schemes where people 'bid' for advertised properties (often on-line), where high priority banding is determined by medical or welfare needs. The 'homelessness route' as covered by housing law (the Housing Act 1996 Part VII as amended by the Homelessness Act 2002), is essentially a fast-track route for those who are on the extreme end of the housing needs spectrum: the homeless or about-to-be-homeless. Case law provides that the test for vulnerability is whether a person, if street homeless, would, due to that special reason, be less able to fend for him or herself than another homeless person, so that injury or detriment would result (known as the Pereira test).

4.8.3.2. Whilst it is important that each case is treated individually and the priority determined under both homelessness and allocations and it is essential that all agencies involved with vulnerable people work together to keep partners informed and assist at an earlier stage the reality is that in Rugby, as in many parts of the UK, the housing options for single people are primarily in multi-

storey blocks and other blocks of flats, sometimes designated as “hard to let”, and inevitably place people in neighbourhoods where the risks of mate crime, hate crime, harassment and exploitation are higher. Though the OT assessment completed whilst her private tenancy was breaking down was not shared with housing providers, there appear to be few alternative housing options available.

4.8.3.3. As stated by the Department for Communities and Local Government[9] “*A home should help people be independent and give them the security to be active members of their communities*”. This goes much further than housing stock and allocations policies – a home will only be a safe haven if the neighbourhood and community is also a safe place to live. Despite national policy initiatives to combat anti-social behaviour, hate crime and to create safer communities, this case, like many before it, highlights the challenges facing local agencies Finally, this case raises wider issues about community safety for single adults who may be vulnerable to disability based harassment, hate or mate crime and exploitation. This case sets out evidence of the sub-culture that continues to prevail within some groups of people where drug and alcohol abuse is endemic, there is a lack of respect for others, and where violence and mate crime is normalised.

[9] www.communities.gov.uk/housing

5. NEXT STEPS IN THE SERIOUS CASE REVIEW PROCESS

5.1. Completion of this review will be evidenced by the Independent Chair signing the overview report, together with the summary report. Both were presented to the Serious Case Review Sub-Group of the Warwickshire Safeguarding Adults Board on 30th September 2011. It's role was to:

- ensure contributing agencies are satisfied their information is fully and fairly represented in this report,
- ensure that a draft public summary report has been prepared for the consideration of the multi-agency adult safeguarding board,
- translate recommendations from the report into the action plan for endorsement at a senior level within each agency,
- ensure the public summary report, recommendation and action plans are sent to individual agencies and sub groups of the partnership for action,
- ensure that the Care Quality Commission receive a copy of the final report and actions.

5.2. There was a formal presentation of the report to the Warwickshire Safeguarding Adults Partnership Board on 19th October 2011 for approval, sign off and action to take forward its learning points and recommendations. The resulting action plan will remain on the Board agenda until it is confirmed all the actions within it are completed. The Board considered and approved the Public Summary report for publication.

5.3. The Chair of the Board will ensure the Statutory Director of Adult Social Services is informed on progression and outcomes of this review.

5.4. Additionally, there may be potential learning points about the serious case review process itself. These are matters for the Partnership Board and its Serious Case Review Sub-Group to consider as part of the normal process of learning and review around local policy and practice that should occur following each review.

5.5. The Family were given a copy of the "draft public summary for consideration" and offered the opportunity to discuss the findings and raise any questions with the chair of the panel. The family chose to discuss the report with the Adult Protection Coordinator and submitted their written views to the SCR sub group. The family will be given a copy of the final Public Summary report. The family will also be included in the 12 month review, although this is not at present a formal requirement of the multi-agency policy.

Signed by,

Kathy McAteer
Independent Chair, Adult Safeguarding Serious Case Review Panel

[Signed copy held by Warwickshire County Council]

Appendix

Sources and References

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