Northamptonshire Safeguarding Adults Board

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Safeguarding Adults Review

Summary

Concerning the death of 'Dean' aged 42 years

on 22nd June 2018

Independent Reviewer
Malcolm Ross M.Sc.

Date agreed by NSAB: 2nd March 2021

List of Overview Report Recommendations

Recommendation No. 1

Where individuals who are under license but do not meet the criteria for MAPPA and where the police, probation or other statutory agencies have significant concerns regarding the risk that the individual poses to themselves or others, then a professionals meeting should be considered by the lead agency to ensure effective information sharing and management of risk. The concerns may be based on incidents that involve the use of weapons, violent behaviour, making threats or other concerning patterns of behaviour. Evidence should be provided to Northamptonshire Safeguarding Adults Board by both police and probation and that this process is embedded in practice.

Recommendation No. 2

With the introduction of Northamptonshire Police Prevention and Intervention Command, the Head of that Command should provide assurance and evidence to Northamptonshire Safeguarding Adults Board that they have made progress with plans to embed a process to prioritise the collation of information from Offender Management systems, MAPPA, Probation and risk management systems in order to gather and assess intelligence which results in proactive action.

Recommendation No. 3

All agencies and housing providers to provide assurance and evidence to Northamptonshire Safeguarding Adults Board that they are aware of Northamptonshire Adult Safeguarding Board Information Sharing Protocol of August 2019 and that this is embedded into training and practice.

Recommendation No. 4

The housing provider to provide assurance and evidence to Northamptonshire Safeguarding Adults Board that risk assessments will be conducted by adequately trained staff on all new and existing residents to ensure that their respective histories indicate that they are suitable persons to share accommodation and maintain a safe environment. Also, that any differing resident needs are considered by the housing provider appropriately and in a timely manner. That these risk assessments are kept up to date and are regularly reviewed and revised when circumstances change or new information comes to light. All risk assessments should result in a plan to reduce risk where necessary.

Recommendation No. 5

The housing provider, Northamptonshire Police and National Probation Service to provide assurance and evidence to Northamptonshire Safeguarding Adults Board that the training for all staff includes issues around professional curiosity and holistic and person centred assessment, to ensure that in such circumstances in the future, robust and immediate action will be taken to alleviate potentially volatile situations.

Recommendation No. 6

National Probation Service to provide assurance and evidence to Northamptonshire Safeguarding Adults Board that the service is compliant with the relevant recommendations made in the Inspection Report 'An inspection of central functions supporting the National Probation Service' January 2020.

Recommendation No. 7

All agencies to provide assurance and evidence to Northamptonshire Safeguarding Adults Board that they have implemented the learning, changes and recommendations set out in their respective actions plans following the Practitioners' Event by 30th June 2021.

1. Introduction

1.1 This Safeguarding Adult Review (SAR) was commissioned by Northamptonshire Safeguarding Adults Board (NSAB) in accordance with the NSAB Safeguarding Adult Review Protocol.

1.2 In accordance with the Care Act 2014, Safeguarding Adults Boards have a statutory responsibility for considering and commissioning Safeguarding Adult Reviews (SARs).

1.3 NSAB has taken the decision not to publish the full overview report due to the sensitive nature of the circumstances and in order to protect Dean's family; at the same time, wishing to ensure as much information as possible is shared. This summary includes the full set of recommendations.

1.4 The timeline of the review was determined as being from 1st August 2015, the date that the perpetrator was referred to the supported housing provider before he moved into the property in October 2015, to the date of Dean's death in 2018.

1.5 A practitioner's event was held where representatives from all agencies involved with the two men subject to this review came together to share their information and knowledge. This event, together with the detailed chronologies completed by agencies formed the basis of the review.

2. Summary of Events

2.1 Dean was 42 years old at the time of his death. Dean was addicted to painkillers and developed an alcohol problem which later caused him to live apart from his wife. He was sadly murdered in June 2018 by his housemate.

2.2 In September 2017, after a period of rough sleeping rough, Dean made an application for accommodation via a supported housing provider. The housing provider supports people in need of housing, substance use, and repeat homelessness. He moved into the property on 9th October 2017[1].

2.3 The perpetrator was 50 years old at the time of Dean's murder. He had a history of violent behaviour, domestic abuse and an extensive criminal record including terms of imprisonment. In 2019, he was convicted of arson with intent to endanger life for which he received 2 years' imprisonment. In April 2000, whilst the perpetrator's wife visited him in prison, he attacked her with a bladed weapon. He subsequently received 10 years' imprisonment for Grievous Bodily Harm (GBH).

2.4 In June 2007, the perpetrator was released from prison to a hostel in Northampton. Records indicate that the perpetrator had been a MAPPA[2] 3, MAPPA 2 and MAPPA 1 offender during his criminal history, and was de-registered from MAPPA on 3rd October 2010.

2.5 The perpetrator moved into the supported housing in October 2015. He had a known drug and alcohol problem and was often verbally aggressive with staff during his tenancy.

2.6 Between 2016 and 2018, the perpetrator was involved in three separate acts of violence involving a bladed weapon, including:

- On 23rd May 2016, he was arrested for GBH against another resident from the supported housing provider.
- On 25th March 2018, he was arrested for assault and being in possession of a bladed article following an altercation he had with a woman for which he received 26 weeks' imprisonment suspended for 12 months. He was also required to undertake a drug rehabilitation programme.

[1] The perpetrator was already living in the property when Dean moved in; having moved into the property in October 2015.
[2] MAPPA – Multi Agency Public Protection Arrangement - 3 being the most serious offender.

- 1st June 2018, the perpetrator disclosed to BeNCH (Bedfordshire, Northamptonshire, Cambridgeshire and Hertfordshire Community Rehabilitation Company) that he had been the victim of cuckooing and that he had held a knife to a man's neck and threatened him.

2.7 From the information gathered during this review process, it appears that Dean and the perpetrator were very dissimilar and presented with different needs. There were a number of complaints from the perpetrator and a number of warning signs that the relationship between the two men was deteriorating whilst they lived in the property together.

2.8 A short time before his death, Dean had confided in the street drinkers he associated with, that he was scared of his housemate and that the perpetrator had threatened him with a knife. Matters came to a head in June 2018, and Dean complained to staff at the supported housing provider that the perpetrator's behaviour towards him was unbearable and he wanted to move to different accommodation. Arrangements were made to move him the following day, which Dean was happy about. That same evening, the perpetrator went into Dean's room and stabbed Dean to death while he was sleeping in his bed.

2.9 The perpetrator was subsequently convicted of Dean's murder and sentenced to life imprisonment with a recommendation that he serves at least 18 years.

3. Conclusions

3.1 The decision by Northamptonshire Safeguarding Adults Board was to commission this review in accordance with a systems based approach. Three main themes were identified:

1. Failure to adequately share information between agencies;
2. A lack of professional curiosity; and
3. The lack of timely and effective risk assessments during the review period.

3.2 There were a number of missed opportunities for multi-disciplinary meetings to discuss concerns regarding the perpetrator's risk to others, particularly when the formal arrangements for public protection or when MAPPA were deemed inappropriate, and the perpetrator was not subject to any re-assessment of risk or his sentencing plan. The incidents the perpetrator was involved in were dealt with in isolation of each other and there was a lack of professional curiosity and information sharing between public protection agencies and the supported housing provider. Northamptonshire Safeguarding Adults Board Information Sharing Protocol is clear that information can be shared between agencies where there is a safeguarding issue, and it is safe and legal to do so. However, consent should be sought where possible.

3.3 The supported housing provider appeared to consider the perpetrator a risk only when involved in 'domestic' incidents but in reality he was a dangerous man and anyone was at risk of his violent behaviour.

3.4 There is no evidence that a risk assessment was completed for either the perpetrator or Dean in respect of being offered supported housing accommodation; in particular, their suitability to share a house together. There were missed opportunities to re-assess the risk to both Dean and the perpetrator as a result of the complaints made to staff.

3.5 The author spoke at length to Dean's wife and sister. It is clear that there is a variation in views about Dean's life history and circumstances, and the reasons for his alcohol problems. However, both women made similar comments in that they felt the housing provider had let Dean down by not considering how different both men were. Dean's sister is of the view that to put a kind gentle man with a drink problem in a house with a violent drug addict was an unwise decision. An account of the conversations with Dean's wife and sister are contained in the overview report.