Stockport Safeguarding Adults Board

The Murder of Adult A

A Serious Case Review

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“We do think of Adult A. He was good when he was a baby. When he was little he was a little terror running off. He didn’t like settling down. He could be well out of order but we all loved him and we still miss him. He loved his sports and he loved Bess, the family dog. We’ve got a rose tree in memory of him.” Adult A’s family

Acknowledgements

1. **Introduction**

1.1. On 1 December 2009, the body of 22 year old Adult A was found in a river. The injuries he sustained included a severed spinal cord and extensive brain damage. Two men were convicted of Adult A’s murder and a man and two women, one of whom was the mother of Adult A’s child, were convicted of conspiring to inflict grievous bodily harm. The murder trial revealed that Adult A had been murdered because he owed £15 to the girlfriend of one of the men convicted of his murder.

1.2. Adult A was a former Looked After Child (LAC), as was one of the individuals associated with his murder. In fact, all but one of those convicted were, to varying degrees, also known to Children’s Services. As an ex-LAC, Children’s Services had a duty, to advise, assist and befriend Adult A, with a view to promoting his welfare, until he ceased to be Looked After (Children Leaving Care Act 2000; Children Act 1989). By the time of his death Adult A, who had a mild learning disability, had not been deemed eligible to receive Adult Social Care services.

2. **About this Serious Case Review**

2.1. The SCR was commissioned by Stockport’s Safeguarding Vulnerable Adults’ Board in May 2010. It is based on written information provided by Adult Social Care, Stockport MBC; Children’s Social Care, Stockport MBC; Community Health, Stockport; Greater Manchester Police; Stockport Homes; Stockport Foundation Trust Board; The Wellspring; and two GP surgeries. Telephone and person-to-person interviews were also carried out during May-June 2011, since the written evidence provided only an incomplete chronology.

3. **The Scope of the SCR**

3.1. The Terms of Reference were as follows:

> The scope of the SCR will cover the period of time from April 2003 (Adult A’s 16th birthday) to his death on 29 November 2009.

> Information about Adult A’s life prior to April 2003 will be considered by the Panel if identified as relevant during the Review process.

> The SCR will specifically examine:

- Whether there are lessons to be learned from the circumstances of this case about the way in which local professionals and agencies worked together to safeguard Adult A

- If agencies could have communicated and shared information about Adult A’s circumstances more effectively and whether this case raises any general concerns about difficulties in information sharing and communication in safeguarding with an emphasis
on professional judgements about this young man and his behaviours and what happened about this? The review wants to understand the policies that were used to inform decision-making.

- The nature of any contact between Adult A and those involved in his murder prior to the incident itself.
- If there were legal routes that could have been taken by any of the agencies that would have had an impact in relation to safeguarding Adult A.
- If there were any policy gaps that impacted on the safeguarding of Adult A or on the action taken by the agencies.
- If there were any specific learning points about housing policies and practice for adults who may be vulnerable.
- What impact did Adult A’s status as a former Looked After Child have on all service responses.

3.2. The Terms of Reference, thus, hinged on the ways in which local professionals and agencies worked together to safeguard Adult A, paying particular attention to conceptualising “vulnerability,” to information-sharing, housing policies and practices in relation to vulnerable young adults, some of whom were associated with Adult A’s murder. The authors of the Individual Management Reviews (IMRs) were advised that the SCR would undertake to identify actions and recommendations which might reduce or eliminate similar tragic events.

3.3. In order to make sense of incidents in Adult A’s late adolescence and early adulthood, the following section outlines something of his infancy and early childhood.

4. Adult A’s early life

4.1. Adult A was born in April 1987 to parents with support needs themselves. His early life was not a haven of stability. He had little contact with his father. The family was already known to Children’s Services following “a number” of prior referrals.

4.2. Between 1990 and 1997, Adult A was the subject of three Child Protection Plans, an Interim Care Order and a Full Care Order before he was removed from the family home. Between 1996 and 2002, Adult A had seven placements, including foster care and children’s homes, not all of which were in Stockport. His eighth placement was at a residential special school where he was a weekday boarder. He spent the weekends and school holidays with his mother, (though his mother’s recollection is that these were few and far between) to whom he finally returned when he was 16. Their relationship was conflicted.

4.3. A psychiatric assessment when Adult A was 11 indicated that he had “complex and intertwined” problems and “…the symptoms of Attention Deficit and Hyperactivity Disorder.” Although the results of other assessments of Adult A as a child are not known, he was believed to have “a milder form of learning disability”, a term adopted by the
Department of Health in 1992, and used throughout this Review. It is, however, acknowledged that it is often unhelpfully used as interchangeable with “learning difficulties.”

5. Adult A’s life and circumstances between 2003 and 2009

5.1. During 2003, when Adult A was 16, he came to the end of a period of special residential schooling. When home from school, Adult A spent a lot of time absorbed in his computer. This was a source of conflict. He had a difficult relationship with his mother. Within two months, the conflicts which had been evidenced during Adult A’s weekend visits home had resumed, occasionally necessitating social work intervention.

5.2. Within three months, his family was very concerned about Adult A’s ‘aggressive, abusive behaviour, his running away [and] drinking at lunchtimes’, for example. Adult A’s mother informed Children’s Services that, when their relationship became abusive, she could no longer manage. She was persuaded “not to throw him out.” The concerns of Children’s Services were twofold (i) Adult A associated with much younger children, irrespective of advice not to do so, and (ii) his personal hygiene deteriorated. He declined to assist with any housework, most particularly with cleaning up after himself.

5.3. Adult A sampled a work-placement during 2003. This was blighted by a complaint about his “sexism.”

6. Adult A’s circumstances in 2004

6.1. In 2004, when he was 17, Adult A was described by a Social Worker as having “moderate learning difficulties”, sampling drugs and was described as “very sexist.” He “has been sleeping” outside the home of a girl [whose age is unknown] on whom he had developed “a crush.” He finally abandoned a college course which he had already left.

6.2. Adult A was reported to the police for damaging a window. The officer was of the belief that Adult A had “mental health issues.”

7. Adult A’s circumstances in 2005

7.1. At the beginning of 2005, when Adult A was almost 18, he appeared in court for damaging a window. He was bound over to keep the peace. Subsequently, he was arrested on two occasions for assaulting his mother. On the first occasion he received two cautions for Common Assault and Criminal Damage. It appears that “potential vulnerability issues were identified.” On another occasion Adult A had a cash card stolen while he played football.

7.2. A further work-placement was found for Adult A. This involved work with computers. However, the placement finished prematurely because Adult A downloaded “inappropriate” images on at least two occasions which clearly caused offence to women colleagues. Whilst on a further placement in a residential service, Adult A was sacked for theft, after which he signed on for the Job Seekers Allowance.
7.3. Adult A had an unsettled year in terms of accommodation. He presented as homeless after a particularly angry exchange with his mother which had resulted in his arrest. He was offered temporary accommodation but did not take this up immediately. He moved in with a friend who subsequently threw him out. Belatedly, he moved into a flat from which items of his clothing were stolen. (Although an arrest was made there was no prosecution because of inconsistencies in Adult A’s statement.) Adult A moved in with another relative who ultimately asked him to leave. He presented as homeless on a second occasion.

7.4. Another relative agreed to accommodate him until a vacancy became available at Accommodation 1 (i.e. temporary accommodation for c.20 men aged 16+). Adult A slept in a tent in his relative’s garden – an arrangement not approved by Children’s Services. He would not consider Accommodation 2 (a provider of housing, care and support for people in need, including care leavers and single, homeless people) and he refused to attend Homechoice (Stockport Homes’ choice-based lettings scheme). He moved in with his relative’s neighbour and turned down a flat he was offered at Brinnington. Towards the end of the year he moved into Accommodation 1 and then to a flat at Brinnington. During this period Stockport Homes were in contact with Adult A’s Social Worker, not least because Adult A had agreed to receive generic, “housing related support” but the service was discontinued because he was absent for four out of their six visits. It is possible that such events and circumstances could have justified intervention by means of child protection measures.

8. Adult A’s circumstances in 2006

8.1. At the beginning of 2006, Adult A was almost 19. He stayed intermittently at his flat in Brinnington. Stockport Homes’ chronology has six messages logged to contact Adult A’s Social Worker about a smashed window at the flat. On two occasions their log indicates that they made telephone contact with a Social Worker. Adult A reported that he did not know the origins of the damage to his flat.

8.2. Adult A became more visible to the police in 2006. He was “stop checked” on three occasions and he was the victim of burglary and assault during the year. The door of his flat was kicked down on two occasions. On the second occasion a washing machine and freezer were stolen. The assaults were stark. On two occasions he was “assaulted in the street by unknown males.” Adult A’s visibility also resulted from his criminal behaviour. He stole from a supermarket and was later arrested for attempted burglary. (It is now acknowledged that Adult A had no conviction for burglary.)

8.3. Adult A attended Accident and Emergency because of an injury he sustained at home after drinking six pints of lager.

8.4. Adult A had rent arrears almost from the outset of his tenancy. He did not make the “urgent contact” requested by Neighbourhood Housing Officers and tradesmen could not get into his home to make the necessary repairs. It appears that Adult A abandoned his tenancy within a few months. He did not reply to letters asking him to get in touch with Stockport Homes. During a meeting with his Social Worker Adult A was asked whether or not he would
work with a support service and he stated that he would not. He added that he was not staying at his flat because he did “not like it.”

8.5. He moved in with a friend in Lancashire Hill, reporting that he had had “problems with children playing outside his flat.” Adult A was “warned...that he will lose his tenancy if he does not work with people trying to help him.” His Housing Benefit was suspended. Within six months, Adult A had lost his tenancy in Brinnington. He had arrears of £356.47. He “had not been living there or utilising the help on offer to him.” Two months after Adult A received his Notice to Quit, he contacted Children’s Services and explained that he was staying with a friend in Lancashire Hill who had asked him to leave. There were concerns that Adult A was stealing from his friend. A week before Christmas, Adult A presented as homeless. Described as having “moderate learning difficulties” he was placed in Accommodation 1.

8.6. Throughout the year, and in previous years, Adult A attended Centre 1 – a resource centre for homeless and disadvantaged people in Stockport. There he was known for his enthusiasm for playing computer games and football and for his support of Stockport FC.

9. Adult A’s circumstances in 2007

9.1. At the beginning of 2007, Adult A was looking for accommodation with his partner, Woman 1. It was acknowledged that he would “have to pay off some of his arrears” in order for their application to be successful. A further application to Independent Options (a charity offering, inter alia, community and home support for adults with disabilities) noted that Adult A “Needs help with setting up a new home...utilities and form filling. Adult A is a qualified chef and could use help in finding employment.” [The origins of the erroneous statement that Adult A was a “qualified chef” are not known.]

9.2. This service assessed Adult A as having “low spectrum autism.” Adult A was provided with temporary accommodation, irrespective of his rent arrears and abandoned tenancy. He declined the first offer of a tenancy, located at Hazel Grove, stating that it was too small. He returned to Accommodation 1. Adult A was bullied when there “because some of the other residents have found out that Adult A is stealing from them.” He disclosed to the police that he was a casual cannabis user and an officer noted that Adult A had “minor learning difficulties.”

9.3. Eventually, Adult A was evicted “for intimidating other residents, stealing...damaging property and fittings, nuisance to staff and residents, abusing residents of local community...drinking alcohol in breach of...house rules.” A referral was made to Accommodation 2. Adult A went on to sleep rough in garages close to Accommodation 1, and then in a tent. As a result, Adult A’s hygiene and appearance deteriorated. (Adult A was in the company of another person who was subsequently arrested for breaching his bail conditions.) Adult A was homeless for approximately a month before a place was secured at Accommodation 3 (part of Accommodation 2). From the outset, Adult A accrued rent arrears. Adult A’s pattern of behaviour was to stay out all night and sleep during the day. It
was acknowledged by Stockport Housing that it was “not suitable for Adult A to have his own accommodation with no support.”

9.4. In association with another man, Adult A and his brother composed and delivered homophobic messages to an Accommodation 1 resident. These were reported as hate crimes for which the three men received a warning. Although there was an allegation that Adult A was playing games with young girls, this was not verified.

9.5. Adult A’s IQ was assessed after a referral from Children’s Services by a clinical psychologist. This determined that he had a learning difficulty i.e. “not a learning disability” and “dull, normal intelligence [It is not clear from where this classification is derived. However, it is acknowledged that “The field of intellectual disability continues to be plagued with inconsistent, uncritical and unscientific terminology…” (Friars, 1997)] He was also said to have…poor vocabulary and comprehension…does not appear to have autistic spectrum disorder.” The clinical psychologist decided that Adult A’s IQ assessment made him ineligible for support by the Community Learning Disability Team Service and by default, a Community Care Assessment. He was, however, assisted in applying for Disability Living Allowance at the end of the year.

9.6. Adult A was stop-checked by the police on seven occasions during 2007. On one occasion he was throwing stones at traffic. He explained that he had been kicked out of a hostel and was living rough. On another occasion he was warned against harassing one of those ultimately involved in his murder. Adult A was also the victim of a further street assault.

9.7. Adult A’s estrangement from his family was final by 2007. They perceived him as persistently troublesome and sought to limit contact. Adult A did not attend his Pathway Plan meeting. It was noted that “There is no real change to Adult A’s plan other than a referral to adult services when he reaches 21 years (i.e. when his case was closed) and for Social Worker to sort out finances.” Evidence of Corporate Parenting as it was experienced by Adult A is unclear. After his 21st birthday, his “assistance was of an informal type. He was not receiving a formal service and as such there was no-where to make the recordings.”

9.8. Adult A discontinued regular contact with Centre 1. This was associated with Adult A having a girlfriend.

10. Adult A’s circumstances in 2008

10.1. In 2008, Adult A became 21. The months approaching his 21st birthday were busy for Children’s/Leaving Care Services in respect of Adult A: his year began with money and accommodation problems – he had no money for food and he was given notice to leave Accommodation 2 for non-payment of rent. Efforts to encourage Adult A to discuss his reluctance to pay his rent were fruitless. “He becomes verbally abusive and just walks out of the room when he hears things he does not like.” Ultimately, Adult A agreed to pay £20 a fortnight, directly from his Job Seeker’s Allowance. However, there was concern that Children’s Services were not alerted to the arrears in advance of their escalation. A referral
was made to Starters, [a floating support service contracted by Stockport for care leavers] “for extra support, especially for when Adult A turns 21, when social services will no longer be involved with him” (by Adult A’s Social Worker following a discussion with Accommodation 2 staff).

10.2. It was confirmed that Adult A should receive the Mobility and Care components of the Disability Living Allowance i.e. needs “guidance or supervision when walking outdoors...to avoid danger/ because of anxiety or panic attacks...help with personal care, unaware of common dangers, at risk of self-harm, dangerous aggressive or anti-social behaviour...self-neglect.” The confirmation also commended a back-payment of £612.50. Adult A had already broken his agreement to pay Accommodation 2, rendering further homelessness a stark reality. He declined to pay off his debts. He stated that he intended to “treat himself” and his refrain was, “It’s my money and I’ll do what I want with it.” It was subsequently confirmed that Adult A was to receive an additional back payment of £227.25. Adult A required a great deal of prompting to attend to some of his debts, open a savings account and lodge some money at a day centre, “until he is 21...a nice treat for him rather than frittering it away now.”

10.3. Adult A was arrested for bike theft (for which there was insufficient evidence to charge him). When the police searched his room they declared it a health hazard – a view shared by staff and other residents. Although Adult A’s hygiene was a subject of keen concern and efforts had been made to discuss it with Adult A, he had “not done anything about it.”

10.4. Adult A told his Social Worker that (i) a relative was instructing others to “knock him in the head” when they played football and that (ii) he had “split up with his girlfriend”, who was later involved in his murder. (Woman 1) He was not unduly dismayed about this decision since he believed that she still wanted to share a flat with him. His Social Worker asked Adult A whether he felt “he would be able to cope living in his own flat because I feel he cannot even manage his finances and therefore would not even be able to pay bills...” A day later Adult A was arrested for suspected attempted burglary and the police contacted Children’s Services to request an Appropriate Adult.

10.5. Adult A moved in with a couple with a small child. He had met them via another man with whom he had “sofa surfed.” He explained to his Social Worker that he baby-sat for them. His Social Worker advised him to move back into Accommodation 3 and to discontinue babysitting. Children’s Services state that Adult A was discouraged from babysitting because he was immature and insufficiently responsible to babysit a small child.

10.6. On his 21st birthday Adult A received the money he had been advised to lodge at the day centre. Since he had stopped paying rent he had once again accrued arrears which if unpaid, would compromise any subsequent housing applications; inattention to his personal hygiene was a persistent and unresolved problem for the staff and residents of Accommodation 3 – problems which would ultimately result in Adult A becoming intentionally homeless. In Adult A’s view, “Washing Monday, Tuesday and Wednesday is plenty enough. He feels three days a week is enough time spent on washing.”
10.7. The circularity which resulted from efforts to encourage Adult A to reconsider was noted, “We decided to end the meeting as we were going in circles...as he would not listen to what we had to say.” A week later, Adult A's Pathway Plan recorded, “Adult A is now at the end of the support that the Independence Team can offer...has not really made good use of the support...and has preferred to do things his own way. Adult A is a strong minded individual and now must make his way in the world, accessing universal services as appropriate.” There is nothing in the account of these piecemeal interventions - which punctuated what is known of Adult A’s troublesome and troubled life - to indicate that he could manage without attention from professionals, bearing in mind that Adult A was receiving the Disability Living Allowance.

10.8. Adult A’s initial sortie into universal services shortly after his 21st birthday was unpromising. He went to see his GP and, because he did not report to the reception staff, he waited for over an hour before he was noticed. He was perceived as a “vulnerable patient.”

10.9. Adult A moved in with a relative later in the year. Whilst there, Adult A reported a burglary (during which he was threatened with violence) to the police. However, since his account was confused and his relative was angry that he had contacted the police, no crime was recorded. Later in the year Adult A was stopped in the street by three men who demanded cigarettes and money. Although the offenders were arrested, and there were “some admissions,” because Adult A repeatedly failed to attend the police station to identify them, there were no prosecutions.

11. Adult A’s circumstances in 2009

11.1. During February 2009, Adult A reported that he had been assaulted and imprisoned by his relative. A police officer attended and recorded that the allegation appeared to be “tit for tat.” It was noted too that both “have learning difficulties.” He was assisted by Centre 1 to make an application to “accommodation projects in Stockport.” Towards the end of the month Adult A was arrested for “throwing bricks at a fish and chips shop window.” He offered to pay for the damage and was given a fixed penalty notice.

11.2. In March, Adult A requested two sick notes from his GP. In May, he was taken by ambulance to Accident and Emergency. He had been “kicked in the ribs whilst with a friend.” It is not known whether or not Adult A knew his attacker(s). Adult A was given analgesia and discharged home.

11.3. During July, Adult A presented himself to Stockport Homes as single and homeless. Although there was no legal duty to accommodate him, temporary accommodation was arranged. He had been living with a relative but had been asked to leave because of intimidation from his ex-girlfriend’s family. He contacted the police on three occasions. His initial contact sought their assistance in “checking” whether or not youths, who had been “harassing” him and his girlfriend, were still in the locality. The remaining two occasions were regarded as domestic disputes. Adult A reported that his ex-girlfriend had “set him up and that two named youths” intended to assault him. Subsequently, he was recorded by the police as being “upset and crying”. A visit established that Adult A was “intoxicated.” Adult A’s ex-girlfriend
reported Adult A to the police claiming that Adult A was threatening her on Facebook. This was checked and since there was no evidence of threats, no action was taken.

11.4. Between 28 July and 23 August, Adult A returned to Accommodation 1. He stated that he was attending appointments with the Community Drugs Team and that he had “not previously had a tenancy.” He also disclosed that he had previously self-harmed because of damaging relationships. Although Adult A was offered support, he “chose not to pursue” this. An application to the Resettlement Team uncovered a “note on file” which described Adult A in the following terms - “has autism but with little support can live independently.” Adult A’s behaviour within and beyond Accommodation 1 was a source of renewed concern. He was “found in another resident’s room,” in breach of the rules, and children’s home reported that Adult A was “hanging around” their premises. When challenged, Adult A agreed to discontinue contact. When Adult A sent a text message to Accommodation 1 stating that he was “staying out” for two days he was advised on two occasions to return if he wanted to remain in the hostel. Residents of Accommodation 1 reported a rumour to staff that “some men in a white van were looking for Adult A because he was seeing a young girl.” It is believed that Adult A was sent a text to tell him about this. At the end of August, Adult A went to Accident and Emergency. He was experiencing rib pain for which he was given analgesia.

11.5. It is not known where Adult A was living in September. At the beginning of October, he went “to a neighbour’s flat to ring the police.” A relative of his ex-partner had stolen his mobile phone having accused him of stealing £20. Police officers recorded this as a civil debt. It is now known that Adult A did not believe that the police “took him seriously” because he alleged that he was being “harassed by girls.” At the end of the month, Adult A was visible to professionals on three occasions:

- He attended Accident and Emergency with chest pains. Although he was “triaged and reassured” he did not wait to be seen;
- He went into a police station to report that he had been assaulted by a man and a woman who were ultimately convicted of his murder and grievous bodily harm respectively. Adult A gave his mother’s details as the point of contact but when she was contacted, she did not know where Adult A was living. She was asked to tell Adult A to contact the police and, because he did not do so, the matter was closed;
- Adult A met with Housing Support Officers as part of their weekly, one hour advice surgery at Centre 1. Adult A was “sofa-surfing” and sought a vacancy in temporary accommodation. Adult A had earlier told Centre 1 and Housing workers that he was concerned that Man 1 (see Annex A) was “waiting to beat him up” and sought refuge in the building. He disclosed that money had been taken from his bank account and that he was to meet with the police later in the day. Adult A remained at Centre 1 until it was safe to leave.

11.6. Subsequently, these were perceived as “precursor events” which culminated in Adult A’s murder i.e. the trial confirmed that October heralded the start of Adult A’s ex-girlfriend
“arranging assaults up to and including the final incident which led to his murder.”

11.7. During November, Adult A was in contact with the police on four occasions.

(i) He ran into a shop “clearly frightened” because he was being pursued by one of those who subsequently murdered him (and another male). Adult A asked the shop staff to contact his ex-girlfriend who “turned up with the two men.” The police arrived and sent all “on their way” - logging the incident as “domestic” arising from Adult A’s ex-girlfriend “seeing another male.” (It is of interest that the police officers attending this incident appeared less concerned about Adult A’s safety than members of the public who witnessed Adult A’s distress.)

(ii) Adult A went to the police station reporting that he had been assaulted by the same man who was subsequently arrested and bailed.

(iii) Adult A reported that £263 had been taken from his bank account. (It is now known that within hours of Adult A’s murder the offenders sought to use Adult A’s bank card.)

(iv) Adult A was observed to steal £30 from a sleeping patient in Accident and Emergency (where he had sought post-assault treatment). When in custody Adult A threatened to harm himself if he was released. He was kept in custody for 24 hours until his appearance at the next Magistrates Court.

11.8. This was Adult A’s final contact with any professional. At the murder trial it was revealed that Adult A was lured to his ex-girlfriend’s flat. She alleged that he owed her rent money because he had slept there. This had led to serial assaults by Man 1 and others who sought to enforce the debt.

11.9. Information gleaned from the police indicates that Adult A was subject to cyber-bullying as well as physical assaults. It is reported that Woman 1 posted, among others, the following messages to Adult A in July 2009:

- You need to die really badly because no one likes you haha tramp

- I don’t think I would want you in my bath you mite give me a disease you scabby homeless bastard

11.10. The police investigation established that Adult A was “enticed” to visit his former girlfriend’s flat. She alleged that he owed her rent money because he had slept there. Those responsible for Adult A’s murder were “seeking to enforce the debt.”
12. Lessons and Findings

12.1. The principal lessons to be gathered from this case concern how professionals and agencies worked together to safeguard Adult A. They are fourfold:

(i) hinges on the policy and professional debate about keeping families together vs. intervening and removing a child/young person

(ii) concerns the muddled views about Adult A’s classification and the implications of these for his support services and welfare benefits

(iii) is linked to the second and concerns the role of IQ testing in determining eligibility for support from Adult Social Care

(iv) is about the potential safeguarding mechanisms of the Mental Capacity Act 2005 and the duties arising from the European Convention on Human Rights.

12.2. Lesson 1: Although Adult A was referred to Children’s Services as a baby he was not received into care until he was nine. This delay was attributed to “a time when services sought to keep families together.” By the time he was 15, having had seven placements, once he was removed from the family home, it does not appear that Adult A had any experience of the security or anchoring which a stable home can offer. The challenges for his family included his mother’s difficulty in managing him; his reluctance to get up in the mornings and either sign on or get a job; his difficulty with money management; and the fact that he was “always losing his bank card” and important documentation.

12.3. Adult A’s return from residential school to the family home seems ill-judged given the many rows (9/03), the violence and threats of violence, a parent’s assertion that they could not cope (10/03; 4/04), and acknowledgement that the family was close to breaking down (1/04). In 2003, social services persuaded Adult A’s parent not to throw him out. By 2005, Adult A’s constant rudeness in the home and two arrests for assaulting his parent (7/05 and 10/05), accompanied by criminal damage had strained their willingness to help him. However, the parent was persuaded to take Adult A back after he had been “thrown out” on two occasions in 2005 (June and August), albeit with a plan. Adult A’s parent reported being sick of the lies, laziness and general trouble Adult A was causing. Even in 2007, a Social Worker asked if Adult A could at least sleep in [his family’s] shed...[they] would not allow this. It is striking that persuasion was similarly applied to the hostel where Adult A lived prior to his murder...it could be difficult to place Adult A somewhere else if he has to leave Accommodation 2 and was there anything they would accept for Adult A to continue living there (January 2008). It is possible that a mental capacity assessment might have brought a different perspective to professionals’ decision-making.

12.4. It does not appear that Adult A’s family shared the views of Children’s Services concerning what he needed at the age of 16 and in early adulthood. It is not clear whether or not the problems in the family home were related to Adult A’s difficulties or whether there was a
downwardly spiralling interaction in which his problems fed off family conflicts. Neither the domestic violence nor evidence of the distress evoked by Adult A’s emotional difficulties and behaviour were seen in the context of mental capacity, child protection or adult protection – irrespective of one Social Worker’s views (expressed to the police) that Adult A had been assaulted many times by his mother...and that they are as bad as each other. When Adult A left the family home there is evidence that animosity prevailed and that there were threats of violence between Adult A and a relative. Although a suicidal intention had been shared with one of Adult A’s relatives, it is not known whether or not professionals were aware of it.

12.5. Lesson 2: Attendance at a residential special school may not result in any particular clarity regarding a young person’s classification as learning disabled, for example whether or not Adult A had autism. In April 2007, Adult A’s former residential school reported that they had no information about Adult A. Although competence and incompetence are familiar constructs – individuals continually make and revise judgements about each other’s abilities as they interact - Adult A was subject to an array of diagnoses and labels, some of which were contradictory, i.e. in 1998, a psychiatrist suggested that Adult A had ADHD; Children’s Services described Adult A as having “moderate learning difficulties” and a police officer believed Adult A to have “mental health issues” in 2004; Police officers referred to his, “learning disabilities...in an attempt to provide some form of descriptive shorthand to articulate concerns...without possibly having a grasp of the impact;” in 2005, Adult A was described in a housing application as “a young person in need, not a care leaver;” he was described as having “low spectrum autism” by Independent Options and as having a “learning difficulty...dull, normal intelligence...poor vocabulary and comprehension...does not appear to have autistic spectrum disorder” by a clinical psychologist in 2007; in 2007 Adult A identified himself to the police as having “learning difficulties;” although Adult A received the mobility and care components of the Disability Living Allowance in 2008, and on one occasion during the same year the police sought advice from Children’s Services concerning the services of an Appropriate Adult.

12.6. Although the classification of learning disability is a complex and confused area, with little agreement on terms and classes, it is remarkable that there was apparently no attempt to secure a measure of agreement on whether or not Adult A had a learning disability and/ or autism. Issues of perceived stigma, offensiveness and correctness aside, Adult A was disadvantaged by the proliferation of labels, none of which appeared to act as signposts to the best available support, not least in terms of keeping himself safe.

12.7. Lesson 3: It is significant that a single IQ test/psychologist’s assessment rendered Adult A ineligible for a Community Care Assessment. Adult A was not deemed eligible for services from Adult Social Care - even though this can only be determined by a Community Care Assessment.

12.8. Lessons 2 and 3, should be considered together since the former fed into the belief that Adult A could and should attend to his own protection. This is surprising given Adult A’s increasing visibility to the police and the belief of some officers that he did have support needs i.e. two officers noted that Adult A appeared to have “learning disabilities.” The police did not know that Adult A was a former Looked After Child. Bearing in mind that there were occasions when
the IPCC judged the police responses to Adult A as failing to meet the required standard, it is regrettable that their collective intelligence about how some officers perceived Adult A resulted in neither a “Vulnerable Person Marker” nor a safeguarding referral.

12.9. Lesson 4: This Review has sought to make sense of the assertion by Children’s Services that when Adult A reached 21, his “services increased” and “that plans were in place to ensure ongoing support for Adult A post his 21st birthday.” Although Adult A was referred to Starters and to Independent Options, events in Adult A’s life during 2008-2009, suggest that he was disadvantaged because there was no family member, no professional and no agency working assertively on Adult A’s behalf to ensure, *inter alia*, his physical health and safety, emotional security, physical shelter, as well as offering reliable and reasonable supervision.

12.10. It follows that the impact of Adult A’s status as a former Looked After Child cannot be explained by scrutinising a partial chronology of events leading up to Adult A’s murder. Multiple placements prefaced Adult A’s move to a residential special school before he was returned to his family – with their own emotional and practical support needs, including the need for parenting advice. Adult A had experience of sleeping rough as a 17 year old. Bearing in mind that this was just a year after leaving a residential special school, it proved a marker that things were not going well for Adult A and his family. Although Stockport Housing sought to engage with Adult A and provided him with accommodation, even though they had no statutory duty to do so, their input was not sufficiently complemented by those of other agencies. There was no individual or agency to coordinate support to Adult A when he reached 21.

12.11. A scan of the identified ‘person(s) involved’ listed in the chronology regarding Adult A suggests that between 2003 and 2006, Stockport Housing was the agency most engaged with Adult A, followed by the Police, the NHS and Children’s Services. In 2007-2009, the identified ‘person(s) involved’ list suggests that the police were the most engaged, followed by the NHS, housing, the hostels and Children’s Services. (Children’s Services state that they *provided a consistent worker to support Adult A. The same Social Worker with the Independence Support Team was allocated from 1/9/03-6/4/09, and they consistently demonstrated attempts to access a wide range of support services for Adult A.*) The dates when Adult A was in accommodation or homeless, are not known. Although Stockport Housing records can confirm dates of tenancies, these do not in themselves indicate whether or not Adult A was living at a specific address at any one time. While it is very apparent that Adult A exercised professionals in Children’s Services and housing, they have different experiential knowledge of housing opportunities and options for former Looked After Children. Although leaving care professionals believe that housing options in terms of location are limited for former Looked After Children, this is not borne out by Stockport Housing’s own data. Adult A did not disclose that he was a former Looked After Child and there is no mechanism within existing IT systems to address this. Adult A did disclose to Centre 1 and Housing staff that Man 1 and others were “waiting to beat him up,” yet did not reveal the escalation of the bullying, cyber-bullying and associated assaults he had endured. The extent to which Adult A’s growing contact with the police in the months leading up to his murder was known to other agencies cannot be confirmed from the
chronology. Arguably therefore, the effectiveness of information sharing about Adult A’s circumstances was limited.

12.12. In relation to the effectiveness of communications regarding safeguarding with an emphasis on professional judgements, accommodation looms large in considerations of Adult A’s 16+ circumstances. In the light of his seven placements, planning for “permanency” appeared overly ambitious. The simplistic binary of “engaged” and “disengaged” prevailed for Adult A. He was a member of a minority who found it difficult to sustain a tenancy without on-going support. Although Children’s Services noted, “The types of tenancy available to single people are concentrated within areas of Stockport” this position is contradicted by Stockport Homes as “factually incorrect” noting that it “may be the case for younger people, not single people as differing age groups may be able to access other areas more readily. The choice based system used allows applicants to choose from what is available for letting with additional priority given to former Looked After Children...as a result...most are re-housed outside of Brinnington and Lancashire Hill, unless it is by their own choice. In Adult A’s case he initially secured the offer of a property in Hazel Grove, considered a high demand area of the borough.”

12.13. Since former Looked After Children want to be with their peers, there is a sense among some professionals of their co-location in Brinnington and Lancashire Hill, for example, which recalls geographies of exclusion (Sibley, 1995), and to the exclusionary landscapes of hostels and estates associated with poverty. In both Accommodation 1 and Accommodation 3, Adult A experienced difficulties with the boundaries of other people’s spaces. Control through appeals to the collective interests of residents, staff and neighbours were ineffectual. In February 2006, Adult A’s tenancy had a smashed window. In the same month he was burgled, it was noted that he had “shaving foam on [his] front door,” he had rent arrears and Stockport Housing was investigating whether or not Adult A had abandoned the tenancy. In March 2006, Adult A was burgled and he was a victim of street mugging. In April 2006, the door of his accommodation was damaged and insecure. All of this suggests that Adult A and/or his tenancy were being targeted.

12.14. Although both Children’s Services and the police had crucial information about one of the men involved in Adult A’s murder (in that he was linked to missing children and young adults and was associated with serious crimes, because these did not result in convictions), it does not appear that consideration was given to (i) a risk assessment or risk management activities or (ii) circumscribed information sharing. It is not known whether or not the two strategy meetings regarding one of the men involved in Adult A’s murder made reference to either (i) or (ii).

12.15. It remains puzzling that Adult A’s dramatically deteriorating circumstances, most particularly when they appeared to compress in 2009, did not result in safeguarding concerns or investigation.

12.16. There are references to Adult A’s behaviour in respect of children which did not consistently result in a clear response. When Adult A was 16, he was advised not to play with an 8 year old. Adult A and the 8 year old went missing the following day. In 2007, when Adult A was living in
Accommodation 1, he went missing with another young person from the hostel and an underage girl. Additionally, Adult A was reported as having been in a local park playing “kiss and run” with some “young girls.” This event resulted in contact with the Child Protection Unit, not least given the hostel’s poor understanding of how to deal with matters pertaining to child protection. The outcome of the referral is not known. In March 2008, Adult A moved in with a couple and their child, for whom he babysat; he was advised not to babysit and to return to the hostel, not least because of his perceived immaturity. Finally, in the weeks leading up to his death, there were complaints from a children’s home that Adult A was “hanging around” their premises and he was advised that this could cause concern. Ultimately, hostel residents reported a rumour that some men in a white van were looking for Adult A because he was seeing a young girl. It appears that Adult A’s association with younger girls was not merely apparent to his peers, but regarded as requiring their policing.

12.17 In April and May 2006, Adult A was assaulted in the street. In March 2007, Adult A was being bullied in Accommodation 1. In April 2007, Adult A was again assaulted in the street and in the same month, a hostel resident poured cider over Adult A’s play station. In August 2008, a [named offender] threatened to shoot Adult A. It is regrettable that neither the hostel nor the police referred Adult A to Adult Safeguarding for further investigation, although it should be noted that Adult A appeared unable and/ or unwilling to assist police investigations.

12.18. In June 2007, Adult A was evicted from the hostel for homeless men for intimidating other residents, stealing from other residents, damaging property and fittings, nuisance to staff and residents, abusing residents of local community and repeatedly drinking alcohol. It does not appear that this decisive event resulted in risk assessment and risk management activities.

12.19. There were two legal lenses that might possibly have had an impact in relation to safeguarding Adult A – the Mental Capacity Act 2005 and the European Convention on Human Rights. Given the parallels with the circumstances of the murder of a vulnerable adult in Luton (Luton Safeguarding Adults Board, 2011) this section draws extensively on material which featured in the Luton SCR. Children’s Services noted that Adult A “refused to accept advice from professionals and at times disengaged…was regularly advised by professionals about paying his rent arrears and debts but chose to ignore this advice…non-attendance at Pathway Plan review meetings…despite professionals providing advice, Adult A made his own decisions and at times refused or disengaged with support and services. Similarly with accommodation…refused to stay in his tenancy which he subsequently lost and he made choices about his behaviour and where he wanted to stay. This made it very difficult for agencies to support Adult A. Despite professional advice, at times Adult A chose to place himself at levels of risk through his choices and behaviour.” In February 2008, on an occasion when Adult A was arrested, a duty Social Worker proposed that an Appropriate Adult would be needed…Adult A had…stated that he did not want a solicitor present, but given his mental capacity, duty Social Worker requested that duty solicitor be present.

12.20. It is noteworthy that no professional assessment of Adult A’s mental capacity was undertaken. There were occasions, however, when he made decisions which rendered him vulnerable to harm and abuse e.g. he
- absented himself from hostel accommodation, (which compromised his eligibility for subsequent hostel accommodation), and became homeless (“he was intransigent about paying rent and service charges...”);
- was advised to stay away from young children and under-age girls but he did not do so;
- threw bricks and stones, (in 2003, 2005 and 2009) and threatened people with these, and smashed windows, irrespective of the inevitable police involvement;
- sought accommodation but declined both offers of tenancies and did not remain in the tenancies he was offered;
- declined support in the tenancies he was offered, and ran up debts (which compromised his eligibility for subsequent accommodation), and became homeless;
- when advised to contact the police about some of the problems he identified in one tenancy, he did not do so;
- drank alcohol and used cannabis which triggered his eviction from one hostel;
- was “sleeping in a field alone which is very dangerous” and later, “said he was living in a tent”(Children's Services, 2007);
- stole money from vulnerable persons - an elderly person and a sleeping person, as well as fellow residents at a hostel;
- eviction from one hostel resulted from “numerous” warnings which Adult A ignored;
- was advised by hostel staff to attend counselling, but declined to do so;
- was advised by a GP to attend counselling in response to his low mood, erratic sleep patterns and desire to self-harm, but did not do so;
- expressed concerns regarding pains which were not matched by a willingness to discover the outcome of blood tests.

12.21. Individually and collectively, Adult A made many “unwise decisions.” In terms of Adult A’s response to and engagement with medical treatment, it is possible that his behaviour manifested unwilful dissent (Grisso and Vierling 1978), i.e. saying “no” and not accepting help from adults. In Adult A’s dealings with services, his refusal to accept help was not met with purposeful or tenacious responses. This is not to suggest that individual professionals and agencies were not concerned about him. However, the chronology indicates that, between 2006-09, there were nine dates which specifically reference working with other professionals. These dates include a period noted in one IMR as, “Case notes seem to indicate some difficulty establishing contact with the Social Worker when Adult A had a tenancy at Keston Crescent.”

12.22. Yet it was known that Adult A was using cannabis and alcohol - factors which might have affected his mental capacity to the extent that he was unable to make particular decisions. Arguably, the above incidents should have alerted services to the fact that Adult A’s
decision-making may have been compromised by a range of factors which also rendered him vulnerable - see below.

12.23. With regard to Adult A’s decision-making it is clear that he was seen by some professionals as having mental capacity with the ability not only to make, but to act on his decisions and assume the consequences. His failure to conform was construed as a personal problem – requiring him to take responsibility for resolving it. Whilst the Mental Capacity Act 2005, which provides a framework for decision-making in respect of people over 16 who lack capacity to make decisions about finances, health and welfare, presumes individuals to have capacity, this does not and should not mean that professionals are exempt from asking challenging and searching questions in relation to individuals who are making problematic choices. The presumption of capacity does not exempt authorities and services from undertaking robust assessments where a person’s apparent decision is manifestly contrary to his wellbeing. The law states that a person will lack capacity if, on balance of probability they are unable to understand information about a decision (including the reasonably foreseeable consequences of making that decision or not), weighing information in the balance in order to reach a decision and to communicate a decision.

12.24. The assumption that Adult A had capacity seemed to prevail in all services which had contact with him – bar that of a duty Social Worker in 2008. Whilst professionals should act reasonably and circumspectly in making determinations of incapacity and, in the event of a finding of incapacity, act in an individual’s best interests, in retrospect may perhaps be questionable whether or not the across-the-board assumption that Adult A had capacity was reasonable.

12.25. Crucially, failure to take reasonable steps to safeguard individuals from abuse or life threatening events is in breach of Articles 2 and 3 of the European Convention on Human Rights. It is important that adult safeguarding is triggered when someone is believed to be at risk of harm/ abuse and not only at the point where there is demonstrable evidence of harm.

12.26. Irrespective of the parallels with the Luton case, it is disappointing that so little is known about the nature of Adult A’s contact with those responsible for his murder, such as the stresses, bullying and jealousies which occurred in this group (see Annex A). When Adult A faced homelessness in May 2007, his Social Worker advised him to approach friends etc. as housing will no longer help...Given that Adult A’s network included some of those convicted of his murder, and that he had allegedly stolen from at least one friend with whom he had sofa-surfed, it turned out to be a suggestion that did not work for Adult A.

12.27. The policy gaps which had an impact on safeguarding Adult A and the action taken by the agencies hinge on (i) perceptions of his vulnerability; (ii) his inability or unwillingness to seek help and follow this through; (iii) addressing specific behaviour which rendered Adult A visible.

12.28. At different stages in Adult A’s adulthood, certain professionals believed he was vulnerable.

He was a vulnerable, naïve, easily led young man...an easy, soft target, a pushover, not street-wise – he wouldn't get the joke if he was the butt of it// He looked younger than he
was. He wouldn’t have got served in a pub... he didn’t hold grudges – he’d have run away from a fight... (and yet) he didn’t stand out as someone in need of protection// He wasn’t street-smart... he was young for his age and he looked vulnerable.

12.29. On the occasion when Adult A sought refuge in Centre 1 because one of the men subsequently involved in his murder and others were “waiting” for him has parallels with the Luton case; similarly too, Adult A’s requests for help were incomplete.

12.30. Legislation such as the Care Standards Act 2000, Youth Justice and Criminal Evidence Act 1999 and the Safeguarding Vulnerable Groups Act 2006, provide various definitions of the term “vulnerable.” The definition set out in No Secrets (Department of Health 2000) comes from the NHS and Community Care Act 1990, i.e. it is grounded in the duty of local authorities to assess people’s needs for community care services. Furthermore, statutory guidance on Fair Access to Care states that abuse and neglect constitute “critical” or “substantial” community care needs for the purpose of local authority intervention. Broadly, agencies’ considerations of Adult A’s “vulnerability” follow the legislation and specifically the NHS and Community Care Act 1990. However, Adult A was deemed ineligible for Adult Social Care services (apparently on the basis of an IQ test). It appears that irrespective of his isolation from family and peer support, concerns regarding his orientation to children, and his deteriorating circumstances, this ineligibility was believed to be absolute. Agencies describing Adult A alluded to such dictionary definitions as capable of being wounded; liable to injury or hurt to feelings; capable of being persuaded or tempted; and exposed to being attacked or harmed either physically or emotionally. One professional spoke of self-consciously “being nice to him.” At different stages of Adult A’s life he was known, inter alia, as a care-leaver, a homeless person, a user of cannabis, an associate of criminals and responsible himself for crimes against the person, against property and crimes of theft, and unemployed. Such roles powerfully affected some professional judgements about his vulnerability and his perceived “ineligibility” for adult social care support.

12.31. Adult A became visible in his work placements because of his “sexism.” It is not known what interventions resulted from this – not least because he lost his work placements, even though it appears that he could manage the work. If one scans back to his early life in a single parent home, Adult A’s behaviour towards his mother suggests that he had a keen sense of gender roles and what constituted women’s work for example. Although the origins of Adult A’s sexism are not known, it is clear that women did not like his treatment of them. What may be experienced as sexism by some individuals may not seem so to others. Adult A was disadvantaged by his sexism and yet it does not appear that he was helped to understand how it made the women feel who complained about it or even to apologise. This unexplored part of Adult A’s life, and specifically his masculinity, was one focus of the cyber-bullying. A further focus was Adult A’s idiosyncratic beliefs about attending to his personal hygiene. While a long-term source of frustration for those seeking to support him, (his personal hygiene was so bad it was remarked upon by the police), it conspicuously impacted on his peers and featured in the cyber-bullying.
12.32. It is not possible to identify the policies that were used to inform the decision-making of professionals. In the chronology, professionals refer to his aggression in the family home, his want of reliability, his inconsistent engagement with professionals, his status as a disabled man, his money management skills, his mental capacity, vulnerability and gullibility. Also, some comments suggest troubling ambivalence about Adult A. In terms of specific learning points about housing policies and practice for adults who may be vulnerable, the Professionals’ views strongly suggest that it is not clear how these agencies believed they complemented each other.

13. Conclusions

13.1. Although the following was published when Adult A was two, it is highly pertinent to his life and circumstances:

“...training young people to be independent, to survive on their own, has become an important issue in contemporary leaving care policy. Yet research findings should make us question this – particularly the evidence of loneliness, isolation and the eventual breakdown of young people living alone...We should...seek to learn more from the existing patterns of ‘good’ parenthood...question the qualitative dimensions of independence training with its emphasis upon practical survival and emotional detachment at the expense of personal development and interpersonal skills...For local authorities the most important issues raised by research are those which identify their failure to behave as a caring parent and the possibilities open to them to do so” (Stein, 1989, 211-212).

13.2. Adult A did not have to be “vulnerable” according to legislative definition to be eligible for adult protection/safeguarding. Vulnerability is part of the human condition:

Although it is sometimes seen to be a stigmatising label, we are all vulnerable at times when we do not know enough about a transaction, or if we have been misled or duped about another person’s intentions towards us. Friends, family members, interest groups, advice agencies, advocates and ultimately the criminal justice system stand up for us all in these situations. Sometimes these interventions are very informal, a word here or a raised eyebrow there, but at other times they are more insistent or formal. It may go as far as removing someone who presents a threat from our home, or from the workforce serving our needs, and in dangerous circumstances this is necessary and appropriate. (Flynn and Brown, 2010, p218)

13.3. At the murder trial, the Trial Judge described Adult A as “a defenceless and vulnerable man...” and, allowing for variations, his evaluation echoes that of most of the professionals with whom Adult A was in contact. Neither Adult A’s history nor serial homelessness (including refusals of help) resulted in effective and coordinated professional responses or a risk assessment.

13.4. Adult A had seven placements before becoming a former Looked After Child. His service officially discontinued when he became 21. It was envisaged that he would pro-actively
make use of generic, universal services, including housing support. Too much was expected of Adult A as a 16 year old – a young person in that unspecified period between adolescence and adulthood – when he had neither the maturity nor judgement to identify the safe companionship of trusted others. Adult A’s life after 16, and most keenly after 21, begs questions about the capability and effectiveness of corporate parenting.

13.5. Although a complex young adult, an engaging picture of Adult A emerged from discussions with professionals:

He was very energetic...had played football with a local Youth Team. He never ate very much and he looked young...was very much into sport. He was a very good football player...he loved it – and playing computer games// he was amenable, likeable and got on with everyone...not a bad lad. Interested in sport and liked football. He’d really engage around football// He was easily frustrated and perceived as having a learning disability – which are characteristics associated with early neglect// He was pleasant and well thought of but needed help.

14. Recommendations

14.1. That the “case study” of Adult A’s circumstances feature in training in Stockport’s children and adult services: Adult A was functionally alone and when he ceased to be the responsibility of Children’s Services there was no further sustained interest in his welfare.

14.2. That the Serious Case Review is shared with Greater Manchester Police, the PCT - Clinical Commissioning Groups, Social Landlords, Stockport Homes, care leavers’ services and services for homeless people and is promoted by local authority members with a view to creating a forum for training and development: As an offender and a victim, Adult A was visible to leaving care services, housing providers, the police and services for homeless men. Learning from the conjunction of events which led to Adult A’s murder is a fitting way of remembering him.

14.3. That the Serious Case Review brings to a halt the practice of IQ testing young people who are believed to have learning disabilities to establish their eligibility for the generic support of adult services. Adult A’s assessment of June 2007, concluded that although he had “learning difficulties” he did not have a “learning disability.” A diagnosis is only meaningful in the context of “explaining behaviour,” treatment and support efficacy. No outcomes appeared to result from the sum of Adult A’s assessments and labels other than the decision that at 21, he was ineligible for support from Adult Social Care. This was wrong. Further, it was incorrect to assume that Adult A’s ineligibility was absolute and could not be reviewed. Adult A should have had a Community Care Assessment at 21 years and on other occasions i.e. had there been an “alert” to Adult Safeguarding. The specialism of “learning disability” is not, and should not be a gatekeeper to generic adult social care.
14.4. That Greater Manchester Police refer adults in distress, who they acknowledge have labels which imply support needs and/or eligibility, for an Appropriate Adult to Adult Safeguarding. In the sum of contacts with Adult A he was known to be distressed and fearful. The police believed that Adult A had support needs/required an Appropriate Adult and yet did not make a referral to Adult Safeguarding.

14.5. That Stockport’s Safeguarding Children’s Board promotes training in assessing mental capacity and decision-making. An observation to the review implied that mental capacity legislation has no bearing on services for former Looked After Children and/or young adults in general:

“Has any agency suggested he was not mentally capable? Benefits accepted claims, housing accepted claims, health professionals agreed to treat, psychologist assessed IQ and made no recommendation that he needed further assessment...” However as the SCR regarding the murder of vulnerable adult in Luton noted,

“Whilst the Mental Capacity Act 2005, which provides a framework for decision-making in respect of people over 16 who lack capacity to make decisions about finances, health and welfare, presumes individuals to have capacity, this does not and should not mean that professionals are exempt from asking challenging and searching questions in relation to individuals who are making choices that are problematic. The presumption of capacity does not exempt authorities and services from undertaking robust assessments where a person’s apparent decision is manifestly contrary to his wellbeing. The law states that a person will lack capacity if, on balance of probability, they are unable to understand information about a decision (including the reasonably foreseeable consequences of making that decision or not), weighing information in the balance in order to reach a decision and to communicate a decision” (Flynn/Luton Safeguarding Adults Board, 2011).

14.6. That Stockport’s Safeguarding Children Board invite Children’s Services to outline how their obligations to young care leavers and prospective care leavers are being enacted and the implications of these for the role of corporate parenting: via (i) strategic and operational links with Adult Social Care and (ii) by assessing the circumstances of young people in “transition” case studies which reflect the coordination of engagement across services as well as evidence of planning for and with young adults and learning corporately. Such a learning review holds out the promise that what is learned will impact on Stockport’s young citizens and provide strong messages about what counts as progress in working cooperatively.

14.7. That the Children’s Safeguarding Board invite schools and residential services to report on their preventive work to reduce bullying, including cyber-bullying, their knowledge of its effectiveness, and to establish that these feature in all anti-bullying policies. It is likely that Adult A’s assaults and fear of the same were both prefaced and accompanied by bullying. Adult A reported the fact of his bullying to Children’s Services and to the police and yet there was apparently no outcome
focused effort to address this. Drawing on perceptions of safety in different spaces, and the ways in which these convey meanings or threats, fear of assault confined Adult A to particular places, until not even his home was a refuge (e.g. Panelli, 2004). As the cyber-bullying testifies, Adult A’s sense of masculinity was starkly challenged.

14.8. That Children’s Services and Stockport Housing identify care leavers who are at risk of becoming and remaining homeless and focus multi-agency attention and resources on them thereby ensuring that this work is overseen corporately: Adult A’s homelessness was not transitional. His numerous addresses confirm that homelessness punctuated his late adolescence and adulthood. Critical themes within Adult A’s life were injurious and conflicted relationships, unstructured days, turbulent life on the streets and fear of those who were drawn into collusion against him. Because he was a former Looked After Child, a multi-agency solution was not going to work unless it combined coordination, tenacity and was purposeful. It should be possible for organisations to develop indicators or mechanisms that trigger a response if specific cases, for example, experiencing repeat-damage to property, burglaries, having disputes with neighbours and having rent arrears occur.

14.9. As a whole local authority, Stockport undertakes a member-led priority review of its corporate parenting policy: Providing alternatives to futures of peer groups associated with criminal activities, drugs and addictions for young people who have been known to Children’s Services requires corporate effort and a coordinated channelling of the joint resources of partners. Parenting responsibilities rarely adhere to prescribed activities or timelines laid down in statutory duties.

Adult A’s prospective future included early employment, computing and sporting promise. It might have been possible to nurture these with timetabled mentoring advice. It appears remarkable that a 17 year old is admitted to a hostel for homeless young men and that this did not merit any corporate action. Remarkable too that there was not one person or agency with a track record of supporting Adult A through personalised training, help in seeking and sustaining employment, addressing time-keeping and self-presentation, while, at the same time, addressing his expression of masculinity. Adult A was always going to take time to surface from what was perceived to be a self-destructive and self-limiting life.

15. References

Flynn, M. (2011 The Murder of Adult A Luton: Safeguarding Adults’ Board


Annex A

<table>
<thead>
<tr>
<th>Woman 1</th>
<th>At 16 she became Adult A’s partner. At 18, became Adult A’s ex-girlfriend. She was pregnant with Adult A’s child. Having admitted to getting males to assault Adult A, she pleaded guilty to conspiracy to cause grievous bodily harm. She entered into a relationship with Man 3</th>
</tr>
</thead>
<tbody>
<tr>
<td>Woman 2</td>
<td>At 20, as Man 1’s girlfriend, she would not cooperate with child protection procedures and her baby was placed in foster care. She was involved with the October assault. She pleaded guilty to conspiracy to cause grievous bodily harm</td>
</tr>
<tr>
<td>Man 1</td>
<td>For at least a month, when 23, Adult A lived in Man 1’s flat. At 24, was involved in the October assault and was identified to Housing Officers as waiting to beat Adult A up because of a £30 debt he was enforcing. He pleaded guilty to Adult A’s murder – having become Woman 1’s self-appointed protector. He regarded the placing of his own child on the at-risk register as a trigger for Adult A’s murder</td>
</tr>
<tr>
<td>Man 2</td>
<td>At 28, he pleaded guilty to Adult A’s murder.</td>
</tr>
<tr>
<td>Man 3</td>
<td>At 17, he pleaded guilty to conspiracy to cause grievous bodily harm.</td>
</tr>
</tbody>
</table>