SUMMARY

The Death of Lee Irving

Safeguarding Adults Review

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Summary

1. The Case Review

1.1 Introduction

On 25 August 2015 a decision was taken by Newcastle Safeguarding Adults Board to undertake a safeguarding adult's review following the death of Lee Irving. Lee was a young man with care and support needs who was 24 years old when he died. Lee's family have agreed to the use of his name in this report.

On initial examination Lee's death appeared to be a disability hate crime, that is to say the crimes committed against him were motivated by his disability. This was subsequently refuted by the trial judge for the reasons given in 1.2.4 of this report.

This review has been delayed because of lengthy legal proceedings brought about by a mistrial and subsequent retrial of the four accused. The final trial was concluded in December 2016.

1.2.1 On Saturday 6 June 2015 the body of Lee Irving was found on a grass banking near the house at 33 Studdon Walk, Fawdon where he had recently lived with those who were accused of his murder.

1.2.2 Lee Irving had died of multiple injuries inflicted on 28 May and 5 June 2015. His injuries included fractures to the nose and jaw, the fracture of 24 ribs, and damage to underlying organs. The cause of death was given as respiratory failure due to these severe injuries all of which were consistent with sustained physical beatings.

1.2.3 Subsequently after a criminal investigation and long trial process, an adult male was convicted of the murder of Lee Irving while a male and two females were convicted of causing or allowing the death of a vulnerable adult. All four perpetrators were also convicted of attempting to pervert the course of justice.

1.2.4 The relationship between Lee Irving and his killers was described as one of subservience with Lee beholden to the primary perpetrator for drugs and shelter and where Lee looked up to the primary perpetrator and desperate to fit in tolerated continued violence and abuse. This coercion and drugging were used to control him, prevent him seeking help and over a period of time drawing him back to the house at 33 Studdon Walk.

1.3 Purpose of the Safeguarding Adults Case Review

The purpose of having a Safeguarding Adults Review is not to re-investigate or to apportion blame, undertake Human Resources duties or establish how someone died. Its purpose is:

- To establish whether there are lessons to be learnt from the circumstances of the case about the way in which local professionals and agencies work together to safeguard adults.

- To review the effectiveness of procedures both multi-agency and those of individual agencies.
- To inform and improve local inter-agency practice.
- To improve practice by acting on learning (developing best practice).
- To prepare or commission a summary report which brings together and analyses the findings of the various reports from agencies in order to make recommendations for future action.

There is a strong focus on understanding issues that informed agency/professional's actions and what, if anything prevented them from being able to properly help and protect Lee Irving from harm.

2. The Life and Death of Lee Irving

2.1 Lee Irving was born on 16 February 1991 and was brought up with a number of siblings in the Newcastle area. Lee Irving had a Learning Disability. He had a statement of Special Educational Needs from the age of four. He attended a Special Educational Needs School. Throughout his life, he was involved with a number of services focussing on his complex special needs. Notwithstanding, the extent of his Learning Disability was not always apparent or clearly measured until 2009. Later in 2014 he was assessed as having an IQ of only 56.

2.1.2 From 2011 Lee began a pattern of repeat offending that continued until his death. He frequently became involved in a wide range of offences, many involving alcohol and drugs. Offences included drunkenness, possession of weapons, shoplifting, burglary, begging, breach of the peace (domestic violence). In all it is recorded that Lee Irving was arrested by police 30 times in the four years between May 2011 and March 2015.

In addition, Lee was stopped, searched or checked by police on 17 other occasions mainly for disorder, vagrancy, drunkenness or possible drug use. Concerns were raised with Northumbria Police about his welfare or he was reported missing on 13 occasions between 2008 and 2013. Concerns included vulnerability or missing from home.

2.1.3 From 2012 Lee's life slid into a chaotic cycle of offending, being reported missing and associating with so called 'friends' who exploited him. In October 2014 a decision was taken to award Lee with a direct payment – giving him control of some of his monies in order to directly purchase services or other forms of support.

Initially Lee's direct payments were controlled by a family member but later that control passed to Lee himself.

2.1.4 By 2014 it was reported that Lee was being exploited by those he lived with. His mother continued to report her concerns for his safety and for a brief period Lee returned to live with her. It was short lived for in early 2015 Lee returned to live with the people who were suspected of exploiting him. In March 2015

NTW and Adult Social Care undertook a joint MCA assessment at which both Lee and his family were present. The assessment identified that Lee did not have the mental capacity to make decisions to keep himself safe when alone in the community. The assessment resulted in an exploration of supported living options, where Lee would be able to have independence but with the support of staff members when needed. Options of this nature were being explored at the time of Lee's death.

2.1.5 **Relationships with the family of Lee Irving**

The family of Lee Irving have co-operated wholeheartedly with the Review. They have endured a prolonged and extremely stressful period since Lee's death but remain determined that positive lessons are learned from the death of their family member.

They speak of their long struggle to care for Lee and their increasing difficulty in coping with him as he reached his teenage years. They knew that he had a severe Learning Disability from early childhood but they felt he was well protected while receiving holistic care at the Percy Hedley School. It was after leaving the school in his late teens that problems developed. They described the difference in the way professionals were able to respond to Lee as an adult as being frustrating and difficult to understand. They felt that the transition was disjointed and that Lee was thereafter "classed as an adult while his mental capacity remained that of a child".

Lee Irving's family had two main recommendations following the harrowing loss of their family member:

1. That the move from Children's to Adults' services be better managed to ensure a smoother transition without loss of support and that services consider the capacity rather than the age of the individual.

2. That families remain part of the decision-making process in the case of vulnerable adults and be fully involved/consulted on "best interest" and other decisions relating to family members.

3. Conclusions and Recommendations

3.1 This overview recognises the reality of safeguarding vulnerable adults in a modern society where there must be a balance between control and care.

In cases like Lee Irving's the various complex components are moving all the time. Police, Probation and Mental Health Services.as well as Adult Social Care, had extensive contact with Lee, over a protracted period.

The Newcastle Safeguarding Adults Board must continue to encourage a culture and reinforce systems to ensure joint responsibility and decision making in a climate of support and positive professional challenge.

It is too easy to leave a lead agency holding all responsibility and for a lead worker to feel they have total authority. Both these scenarios are inadequate in dealing with a case like Lee Irving's.

3.2 **Disability Hate Crime**

This review began by considering the death of Lee Irving as a disability hate crime. As discussed earlier in this report the judge in the criminal trial of the four individuals convicted of the murder and complicity in his death, rejected this definition for legal reasons as the evidence led did not prove that the brutal assaults on Lee were motivated by his disability but rather happened because of the violent and bullying nature of the principal accused.

It is not the role of this review to question the legal decisions of a judge, but in seeking to learn lessons it is important to identify the underlying causes of Lee Irving's death.

Lee was obviously disabled and suggestable to anyone who knew him, he was vulnerable and indeed the three individuals found guilty of complicity in his death were convicted of 'causing or allowing the death of a vulnerable adult.' Accordingly, while the decision of the court is not to be questioned, for the purposes of this review and the lessons learned it is still considered appropriate to view the death of Lee Irving as directly connected if not motivated by his disability and vulnerability.

3.3 The case of Lee Irving was complex and he was difficult to help. It was always known that he had a Learning Disability and as he reached his teenage years his family found it increasingly difficult to cope with him. While a number of statutory agencies knew the extent of his disability his physical capability and his determination to make his own decisions belied his true disability and gave the false impression of capacity to some agencies.

In addition, his non-attendance at many of his numerous appointments with agencies meant that they saw only snapshots of his life rather than a complete picture.

Notwithstanding agencies never gave up on Lee and over the years were proactive and creative in trying to get him to engage with them even when his contact with them was sporadic.

3.4 There were, however, weaknesses in the multi-agency support to Lee Irving and they deserve attention and reflection in the recommendations of this review.
The transition from childhood to adulthood was, in the view of Lee's family, disjointed with inadequate recognition of his true capacity. The legal options that children's services have under current legislation are no longer applicable once a child reaches the age of 18 regardless of their ability. Protection that children's legislation affords is replaced by legislation applicable to adults which inevitably means there needs to be a higher regard for an adult's autonomy and involvement in decision making. In some circumstances this can result in less

consultation with family but whenever possible families' views should be sought and respected.

While individual agencies tried to engage with Lee there was not a co-ordinated information sharing, response to the presenting issues and a lack of professional challenge.

The powers and legal requirements of the Mental Capacity Act (2005) were not understood by all agencies. Consequently, the powers of the Act (such as consideration of referral to the Court of Protection) were not fully considered.

Lee's reluctance/inability to engage with services meant his care was badly interrupted but this behaviour was not always interpreted as a symptom of his disability.

3.5 In conclusion many individuals and agencies tried hard to engage with Lee Irving. His family struggled over years to protect him from harm. He was difficult to help and while lacking the capacity to make some decisions in his own interest he seemed determined to exercise his own autonomy which sometimes placed him at risk.

Whether any of these changes would have saved the life of Lee Irving will never be known.

3.6 The case of Lee Irving, like other reported disability hate crimes, highlights wider issues about community safety for adults who may be vulnerable to disability based harassment, hate and exploitation.

This case once again highlights a subculture that prevails in certain groups where alcohol and drug misuse is endemic, where bullying, violence and crime is normal and where there is a general lack of respect for others.

3.7 The co-operation with this review has been outstanding, the Single Agency Reviews were completed to a high standard and the participation of Lee Irving's family has been both helpful and positive. In particular, the multi-agency training events were useful and contributed much to the review. These events should be seen as best practice and considered in any future Safeguarding Adults Case Review.

Recommendations

1. **Transitions between Children's and Adults Services**

The transition from Children's to Adults Services took place in 2008 and cannot be associated with the circumstances surrounding his untimely death. Nevertheless, Lee's transition has been viewed by his family as a major and negative change in his life.

It is recognised that legal requirements direct agencies and that in any case much has changed and improved in the transition process since 2008.

Nevertheless, it is recommended that the Newcastle Safeguarding Adults Board examine again the transition process to ensure as smooth and integrated a process as possible. In particular, whenever possible the family of the vulnerable person should be informed and consulted about the care of their family member notwithstanding legal requirements and the 'Adult' status of the subject.

2. **Partnership – Theory and Practice**

It is recommended that the Newcastle Safeguarding Adults Board examine the realities of Partnership working with particular emphasis on joint decision making, the inclusion of all relevant agencies and the consideration of legal options. These issues may be addressed by training or reinforcing guidelines.

3. **Safeguarding Adults Alerts**

It is recommended that the Newcastle Safeguarding Adults Board examine their guidelines concerning the management of Safeguarding Alerts to ensure that they are individually scrutinised and that the cumulative effect of a number of alerts is seen as an escalation of risk to be separately considered as a priority.

4. **The Mental Capacity Act**

It is recommended that the Newcastle Safeguarding Adults Board consider the application and legal requirements of the Mental Capacity Act. It is a powerful piece of legislation placing responsibility on all agencies but it is complex and requires detailed knowledge. To facilitate this, it is further recommended that a Senior Mental Capacity Act "Champion" is appointed in all statutory agencies so as to ensure ownership and a high degree of familiarity and compliance.

5. **Managing (Did not attend) failure to attend appointments**

It is recommended that the Newcastle Safeguarding Adults Board address partner agencies response to clients who regularly do not attend appointments. While it is costly and frustrating and often leads to a cessation of service, in the case of Lee Irving it was symptomatic of his disability. Agencies and the partnership should consider non-attendance on a case by case basis and jointly agree actions to respond to this issue.

6. **Training**

Newcastle Safeguarding Adults Board has a well-developed training programme which has been regularly updated and widely attended. Most of the staff who worked with Lee Irving had attended training specifically addressing disability hate crime yet some did not recognise it when they met it.

It is recommended that training is once again refreshed, using experience of this case as a case study.

7. Social Media

Latterly the only way to track Lee's chaotic lifestyle was via social media, as he regularly used Facebook and other sites to communicate with associates and family. While children's services regularly use social media to communicate with clients, this is less common in agencies who deliver services to adults. It is recommended that consideration be given to improving agencies familiarity and use of social media so as to improve service delivery.

8. Recommendations for Single Agency Reviews

As part of this review agencies submitted detailed Single Agency Reviews including recommendations for improving their own service. These recommendations were of a high standard and should be implemented by the relevant agencies.

Tom Wood
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