

Domestic Homicide Review

Joyce Jackson/2015

Executive Summary

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Commissioned by:
Kent Community Safety Partnership
Medway Community Safety Partnership

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1. The Review Process

- 1.1. This summary outlines the process undertaken by the Kent Community Safety Partnership domestic homicide review panel in reviewing the homicide of Joyce Jackson who was a resident in their area.
- 1.2. The following pseudonyms have been used in this review for the victim, perpetrators and others materially associated with the perpetrators to protect their identities and those of their family members:

Victim: Joyce Jackson
Perpetrator: David Rose
Perpetrator: Sean Rose
Perpetrator: Dean Rose
Mother of David, Sean and Dean Rose: Sandra Wilson
Girlfriend of Dean Rose: Kelly Cox.
Personal Advisor PA1
Personal Advisor PA2
Personal Advisor PA3
Neighbourhood Manager NHM1
Neighbourhood Manager NHM2
Neighbour N1
Neighbour N2
Social Worker SW1

- 1.3. Joyce was a white British female aged 54 years at the time of her death.

David is a white British male and was 23 years of age at the time of Joyce's death. In July 2016, David was convicted of murdering Joyce Jackson and received a life sentence with a 23 year tariff.

Sean is a white British male and was 20 years of age at the time of Joyce's death. In July 2016, Sean was convicted of murdering Joyce Jackson and received a life sentence with a 23 year tariff.

Dean is a white British male and was 19 years at the time of Joyce's death. In July 2016, Dean was convicted of murdering Joyce Jackson and received a life sentence with a 23 year tariff.

Sandra is a white British female and was aged 39 years at the time of Joyce's death. She is the mother of David, Sean and Dean by an estranged partner from whom she had separated several years prior to the events subject of this review.

Kelly is a white British female and was 18 years old at the time of Joyce's death, and was the girlfriend of Dean Rose.

- 1.4. Following the trial of the perpetrators, a referral was made to the Kent Safeguarding Children Board in respect of Dean Rose, who had been in the care of the local authority since 2013, and who was open to the KCC18+ service at the time of the assault on Joyce Jackson. In the past, the other

two brothers (David and Sean) had been under the care of Medway Social Services. It was decided this case did not meet the criteria for a Serious Case Review, but it was recommended a multiagency scrutiny of some type should take place.

As Joyce suffered from mental health issues a referral was then made to the Kent and Medway Adult Safeguarding Board which met on the 10th August 2016. It was decided that despite her history of mental health engagement, Joyce did not meet the definition of a 'vulnerable adult', and in consequence an adult safeguarding review was not commissioned. It was decided however the case did meet the criteria for a Domestic Homicide Review as the perpetrators were members of the same household as the victim¹.

A DHR Core Panel Meeting was deemed unnecessary as the main agencies were represented at the Adult Safeguarding Board meeting.

- 1.5. Agencies were asked to confirm whether they had contact with those named above and if so were asked to secure their files. In total 15 agencies were contacted and confirmed varying levels of involvement with these individuals.

2. Contributing Organisations

- 2.1. Each of the following agencies have completed IMR's, or shortened reports where indicated:

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

¹ Section 9 Domestic Violence, Crime and Victims Act 2004.

- 2.2. IMR authors are staff from the respective agencies, but were independent of any operational or supervisory involvement in this case. Each IMR has been signed off by a senior manager from the various organisations involved.
- 2.3. Joyce also attended a mental health support group called Speak Up, the manager of which has expressed an interest in this review. The Independent Chair has spoken with the manager of this organisation and the DHR process has been fully explained. Information provided by this group has been recorded by the Independent Chair and has been included in the Overview Report.

3. The Review Panel Members

- 3.1. The Review Panel consists of an Independent Chair and senior representatives of the organisations involved. It also includes a senior member of Kent County Council Community Safety Team. The members of the panel are:

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

- 3.2. Panel members hold senior positions in their organisations and had no contact or operational involvement with Joyce Jackson, the Rose Brother's or Kelly Cox. They met on three occasions during the course of this DHR.

4. The Independent Chairman and Author

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

5. Terms of Reference

Terms of reference were agreed by the DHR Panel following their meeting on 21st October 2016.

5.1. Background

At 12.45 hours on 17th November 2015, the South East Coast Ambulance Service attended Joyce's home address in response to a call from a 'friend' who was concerned for her welfare. Joyce was taken to hospital where she was found to be suffering from serious injuries including a fractured spine, ribs, a damaged pelvis and extensive bruising. Joyce was later admitted to Kings College Hospital in London, and on the 27th December 2015 she tragically died as a direct result of these injuries.

It was established that David, Sean and Dean Rose had been residing at Joyce's address and, during the evening prior to her hospitalisation, for over six hours she had been systematically subjected to a vicious assault.

A Home Office forensic pathologist carried out a post-mortem examination on Joyce's body and concluded her death was caused by complications arising as a direct result of the blunt force injuries to the chest received during the assault.

It was established that Sandra Wilson had previously befriended Joyce and some months prior to her death had moved into her house. She was followed by her three sons who periodically began living at and visiting the address. At the time of Joyce's hospitalisation the three Rose Brothers, their mother (Sandra Wilson) and Dean Rose's girlfriend (Kelly Cox) were all residing at the house.

In accordance with Section 9 of the Domestic Violence, Crime and Victims Act 2004, it was agreed by the Core Panel that the criteria for a DHR had been met and on the 1st September 2016 the Chair of the Kent Community Safety partnership confirmed a DHR would be conducted.

The Chair of the Kent Community Safety Partnership ratified this (under the Kent and Medway CSP agreement to conduct DHR's jointly) and the Home Office was informed in accordance with established procedure.

5.2. The Purpose of a DHR

The generic purpose of a DHR is to:

- I. Establish what lessons are to be learned from the death of Joyce Jackson in terms of the way in which professionals and organisations work individually and together to safeguard victims.
- II. Identify what those lessons are both within and between organisations, how and within what timescales they will be acted on and what is expected to change.
- III. Apply these lessons to service responses for all domestic abuse victims and their children through intra and inter-organisation working.
- IV. Prevent domestic abuse homicide and improve service responses for all domestic abuse victims and their children through improved intra and inter-organisation working.

This is a somewhat unusual case in that Joyce was never specifically regarded as a victim of domestic abuse by the agencies involved. There were additional inter-related issues which have formed an important part of the review and which provide further learning opportunities.

5.3. The Focus of the DHR

To establish whether any of the organisations mentioned above had information which may have been relevant to the death of Joyce Jackson. Such contact may not have been specifically identified as domestic abuse, but none the less could have raised concerns over her vulnerability particularly at the hands of Sandra Wilson and her sons. If such concerns were not identified, the review was to consider why not, and how such abuse could be identified in future cases. If such concerns were identified, the review was to focus on whether each agency's response was in accordance with its own and multi-agency policies, protocols, and procedures in existence at the time. In particular, if abuse was identified, the review was to examine the method used to identify risk and any action plan put in place to reduce that risk. This review was to take into account current legislation and good practice. The review was also required to examine how information was recorded and what information was shared with other agencies.

Research conducted prior to the terms of reference being finalised suggested that Joyce was not formally classified by relevant agencies as 'a victim of domestic abuse', however she was suffering from mental health problems and prior to her hospitalisation there was evidence she was being

taken advantage of. This research also indicated that Joyce's house was being used for anti-social activity and that reports to the police suggested some of her property was being stolen or damaged by Sandra Wilson and her sons. In addition to the Police, officers from East Kent Housing attended Joyce's house shortly before her hospitalisation as did Dean Rose's social worker.

In addition to a scrutiny of the care and treatment of Joyce, the review was also required to assess how agencies interacted with the three Rose brothers particularly when they were subject to the involvement of both Medway and Kent Social Services. Specifically the review was to consider if there were any opportunities to identify them as a potential risk to Joyce or other vulnerable individuals. Similarly the review was to consider agency interaction with Sandra Wilson and any involvement she had with Joyce that could have compromised her safety.

Specifically the review was required to consider:

- The quality, scope and appropriateness of the physical and mental health care treatment, care planning, and risk assessments of Joyce.
- The appropriateness and management of Joyce's housing situation particularly following the arrival of Sandra Wilson and her sons.
- The quality, scope and appropriateness of agencies management of David, Sean and Dean Rose. This was to include an evaluation of relevant factors when they were subject of social services involvement and when they came into contact with law enforcement and the criminal justice system.
- The circumstances surrounding the arrival of Sandra Wilson into the life of Joyce and the degree of knowledge agencies had of this woman and the threat she may have posed to Joyce.
- Learning opportunities and recommendations to prevent similar such incidents occurring in the future.

5.4. DHR Methodology

Independent Management Reviews (IMR's) are submitted using the templates current at the time of completion. This review was based on IMR's provided by the agencies which had relevant contact with Joyce, David, Sean and Dean Rose, Sandra Wilson and Kelly Cox. Each IMR has been prepared by an appropriately skilled person who had no direct involvement with these individuals, and who was not an immediate line manager of any staff whose actions are, or may be, subject to review within the IMR. Each IMR includes a chronology, a genogram (if relevant), and analysis of the service provided by the agency submitting it. The IMR highlights both good and poor practice, and makes recommendations for the individual agency and, where relevant, for multi-agency working. The IMR includes issues such as the resourcing, workload, supervision, support, training and experience of the professionals involved.

Each agency has been required to include information held about Joyce, David, Sean and Dean Rose and Sandra Wilson from 1st January 2012 to 27th December 2015. Information preceding these dates which is deemed to be of relevance will also be included.

Any issues relevant to equality, such as disability, cultural and faith matters, have been considered by the authors of the IMR reports.

Agencies have been required to submit IMR's in accordance with agreed timescale following which they have been considered at a meeting of the DHR Panel. An overview report was then drafted by the Chair of the Panel and then considered at further meetings of the DHR Panel. A final, agreed version has been submitted to the Chair of the Kent Community Safety Partnership.

5.5. Specific Issues to be Addressed

In accordance with published guidance on domestic homicide reviews Terms of Reference required specific issues to be considered, and if relevant, addressed by each agency in their IMR:

- Were practitioners sensitive to the needs of Joyce, knowledgeable about potential indicators of domestic abuse and aware of what to do if they had concerns about a victim or perpetrator? Was it reasonable to expect them, given their level of training and knowledge, to fulfil these expectations?
- Did the agency have policies and procedures for the ACPO Domestic Abuse, Stalking and Harassment and Honour Based Violence (DASH) risk assessment and risk management for domestic abuse victims or perpetrators, and were those assessments correctly used in the case of Joyce (as applicable)? Did the agency have policies and procedures in place for dealing with concerns about domestic abuse? Were these assessment tools, procedures and policies professionally accepted as being effective?
- Did the agency comply with information sharing protocols?
- What were the key points or opportunities for assessment and decision making in this case? Do assessments and decisions appear to have been reached in an informed and professional way?
- Did actions or risk management plans fit with the assessment and decisions made? Were appropriate services offered or provided, or relevant enquiries made in the light of the assessments, given what was known or what should have been known at the time?

- Were procedures and practice sensitive to the ethnic, cultural, linguistic, religious and gender identity of Joyce (if these factors were relevant)? Was there consideration of vulnerability and disability (if relevant)?
- Were senior managers or other agencies and professionals involved at appropriate points?
- Are there ways of working effectively that could be passed on to other organisations or individuals?
- Are there lessons to be learned from this case relating to the way in which an agency or agencies worked to safeguard Joyce and promote her welfare, or the way it identified, assessed, and managed the risks posed by David, Sean and Dean Rose and Sandra Wilson. Are any such lessons case specific, or do they apply to systems, processes and policies? Where can practice be improved? Are there implications for ways of working, training, management, and supervision, or for working in partnership with other agencies and resources?
- How accessible were the services to Joyce (as applicable)?
- To what degree could the death of Joyce have been accurately predicted and prevented?

6. Summary Chronology

6.1. This section summarises the key facts from the background and combined chronology of agency interaction with Joyce Jackson, the Rose brothers and Sandra Wilson. It includes a summary of what was done and agreed. Although the relevant time scale for this review has been agreed as 1st January 2012 to the date of Joyce's death, some occurrences are referred to which pre-date this period as they bring some context into how these appalling events transpired.

6.2. Below is a summary of the background of each of these individuals.

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

For several years concerns had been raised by some of the organisations contributing to this review regarding Joyce's mental health, and her increasing dependency and abuse of prescribed medication. Joyce

alternated between receiving help from her GP and specialist mental health services. In addition to her dependency on prescribed drugs, she was also diagnosed as bipolar and suffering from depression.

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

Sandra Wilson was aged 39 years at the time of Joyce's death. She had three sons (David, Sean and Dean) by her estranged partner from whom she had separated several years prior to the events subject of this review. Sandra befriended Joyce sometime in 2012.

David Rose was 23 years of age at the time of Joyce's death. He was single, unemployed and had learning difficulties. He was supported by Medway Social Care Services both as a child, a care leaver and as a vulnerable adult. David has a number convictions, but other than for the murder of Joyce and an incident in 2006 when he was aged 16, none of these were for violent offending. The majority of his convictions were for theft and date from 2006 to 2016.

In 2010, David became 18 and at this time was residing in supported accommodation. In 2012, he went to live with his aunt in Thanet, but this relationship broke down due to his violence and drug taking. David had moved from Medway, but as a care leaver he still remained the responsibility of Medway Social Services. At some stage in 2015 he moved into Joyce's house with his mother (or at least became a regular visitor). By this time he ceased to be classified as a care leaver.

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

Sean Rose was 20 years of age at the time of Joyce's death. He, like David, was single, unemployed and was supported by Medway Social Care Services. Sean has several convictions the majority of which were for theft. He has received prison sentences and indeed was released from prison shortly before the assault on Joyce. He also has a history of drug taking and alcohol abuse.

Sean Rose like his brothers led a very dysfunctional life as a child. He lived with his mother and later his father, and in 2004 became a looked after child (LAC) and was placed into foster care by Medway Children's Services. In 2006 he was temporarily returned home and by 2007 was back in foster care. At this time he was assessed as violent having assaulted his female foster carer. He was also assessed as a risk to himself and others

and also at risk of abuse and sexual exploitation. In 2007 he was assessed as having the emotional age of a 2 to 3 year old.

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

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

Dean had a troubled upbringing and until 2013 lived with his grandmother at which time she asked him to leave her home as he was beyond parental control; he was then accommodated by the Kent County Council. In August 2014, he turned 18 and was transferred to the 18 plus scheme.

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

- 6.3. In November 2012, the first reference to Sandra Wilson in relation to Joyce Jackson was recorded by the Police. On this occasion Joyce alleged Sandra had stolen property from her house. In 2013, the Police received further reports of domestic situations at Joyce's house involving Sandra and her sister, and in 2014 there was another allegation that Sandra had stolen Joyce's property. None of these allegations/reports resulted in charges or court appearances.
- 6.4. It was not until early 2015 that neighbour's began reporting to the Police and East Kent Housing (EKH) that anti-social behaviour was occurring at Joyce's house. Allegations were made of drug users frequenting the property and that people were taking advantage of Joyce. During this period Police and Housing Officers attended the house; again none of these allegations/reports resulted in charges or court appearances.

- 6.5. On 15th March 2015, it was agreed that Sandra could remain at the house and on 17th March 2015 the Police closed the case.
- 6.6. On 25th March 2015, Joyce reported to the Police that Sean Rose had stolen property from her house. It was also established at this time Sandra, Sean and another of the Rose brothers (Dean) were staying at Joyce's house. No charges ensued.
- 6.7. In April 2015, EKH received further complaints relating to Joyce's house specifically about the number of people frequenting the premises and the damage they were causing. Following a visit by a manager from EKH it was established Sandra was living at the house, but that her sons had been told to stop visiting. At this time the house and garden was described as neat and tidy.
- 6.8. On 18th June 2015, EKH closed the case as no further complaints had been received.
- 6.9. On 23rd July 2015, Dean informed his Personal Advisor from Kent Social Services (PA1) he had moved in with his mother at Joyce's address. Following this the PA visited the house and viewed the accommodation.
- 6.10. On 24th July 2015, a neighbour called Thanet District Council complaining about ASB in and around Joyce's house which resulted in a visit from an EKH Neighbourhood Manager. It was established Sandra was living at the house with the consent of Joyce. Both women stated they did not wish the Rose brothers to live at the house. At this time the Neighbourhood Manager had no concerns about the condition of the property.
- 6.11. On 2nd August 2015, Police attended Joyce's house in response to a call from neighbours complaining of excessive noise. The occupants were told to keep the noise down and no further action ensued. This was the last call the Police received to Joyce's address prior to her assault.
- 6.12. On 24th August 2015, EKH received a further telephone call from a neighbour complaining of rubbish at Joyce's property. A Neighbourhood Manager telephoned Joyce's house and Sandra answered stating she would remove the rubbish and said only she and Joyce were living at the property. A further visit took place by a Neighbourhood Manager who described Joyce's appearance as good as was the condition of the house.
- 6.13. On 28th August 2015, Dean's PA conducted his second visit to Joyce's house. He described the conditions in the house as not good, the brothers were taking 'legal highs' and were play fighting resulting in broken furniture. Joyce was seen but not spoken to by the PA.

- 6.14. On 17th September 2015, Sean was released from prison and went to live with his mother at Joyce's house. Following his release Sean's Personal Advisor (PA2) from Medway Social Services visited the house when Joyce informed her that neither Sean nor his mother were at home.
- 6.15. On 1st October 2015, neighbours contacted EKH to further complain of anti-social behaviour emanating from Joyce's house and one suggested she was being taken advantage of. The neighbours were asked to keep diary sheets and a full record was made, but no further action was taken by EKH.
- 6.16. On 9th October 2015, Sean's Personal Advisor met with Sean and Sandra at Joyce's house. Although Joyce was seen she was not spoken to and there was no comment made about her, or the state of her house.
- 6.17. On 23rd October 2015, Dean's Personal Advisor once again visited Joyce's house on a pre-planned visit. Joyce was not spoken to and he recorded there was no improvement in the general state of the house and that Sandra was still concerned over her sons taking drugs.
- 6.18. On 17th November 2017, the assault on Joyce Jackson took place resulting in the arrest and subsequent conviction of David, Sean and Dean Rose.

7. Key Issues

- 7.1. Two key issues have been considered in progressing this DHR:
- I. The way in which organisations have interacted with Joyce (individually or in conjunction with other agencies) and specifically how they have identified and addressed her vulnerabilities.
 - II. The way in which organisations (individually or in conjunction with other agencies) have engaged and managed Sandra Wilson and her three sons particularly in terms of how they represented a threat to Joyce.
- 7.2. Although badged as a DHR, the content of this report deals with a number of interrelated issues:
- Domestic Abuse as it relates specifically to perpetrators 'living in the same household' as the victim.
 - Mental health
 - Child Protection
 - Leaving Care
 - Mate Crime
 - Offender Management

8. Conclusion

- 8.1. In reaching conclusions consideration has been given to areas that could have provided agencies with an opportunity to identify Joyce's vulnerability, and in consequence trigger safeguarding activity:
 - Risk assessment of the Rose brother's and their mother i.e. the threat they represented to Joyce and others.
 - Risk assessment of Joyce as an individual and her vulnerability to abuse and exploitation.
 - Management of incidents and activity occurring at Joyce's council owned property.
- 8.2. As with so many of these reviews if one considers the case in the round, and with the benefit of hindsight, it seems the profound danger to Joyce could have been identified prior to her assault/murder. It is not suggested the appalling circumstances which lead to Joyce's death could have been predicted, however had the information referred to in this report been shared between agencies then perhaps more robust risk assessments would have ensued, and measures taken to address and improve her safeguarding.
- 8.3. Much of this review centres on activities at Joyce's home address and whether or not Sandra Wilson and her sons should have been living or visiting the house. It should be pointed out that at the time of the assault, Joyce was deemed to have mental capacity and expressed a desire to have Sandra Wilson living with her. It should also be recognised that Sandra Wilson and her three sons were adults and there was no legal restriction as to where they should live.
- 8.4. There was evidence available to most of the agencies that Sandra Wilson's sons were living or frequenting Joyce's house and they could have represented a risk to her. Had these risks been recognised and agencies began working proactively together then steps could have been taken to ensure Sandra and her sons lived elsewhere, and more advice given and measures taken to help safeguard Joyce from these and other individuals who may have sought to exploit her as a vulnerable person. It should be recognised that unsuccessful attempts were made to discuss alternative housing arrangements with the brothers.
- 8.5. Having considered the background of these brother's and indeed their mother, it would seem quite obvious they were not a healthy addition to Joyce's home and quality of life.
- 8.6. There was evidence that Sandra Wilson was increasingly exploiting Joyce by using her house for her own dysfunctional activities. Sandra's lifestyle either directly or indirectly resulted in Joyce's home becoming a magnet in attracting individuals and activity that was disruptive, illegal and most certainly harmful to this vulnerable woman. Once in the premises little could be done to force or persuade Sandra to live in alternative accommodation. Sandra seems to have first befriended Joyce in 2012 and only moved in

with her when she failed to find appropriate accommodation. There is evidence that agencies endeavoured to help her in this task, but were largely unsuccessful. In the final analysis there was no order or restriction on Sandra Wilson to prevent her living with Joyce.

- 8.7. The Rose Brothers were all adults but were, or had been, subject to care leaving activity by Kent or Medway Children's Social Services. It can be seen that efforts were made to help them make this transition which included finding them accommodation. Despite this, all three came together in Joyce's house each having profound problems, which included establishing a suitable place in which they could live. Whilst they were in care or when they were subject of a statutory/court order, restrictions could have been imposed as to where they lived, but this was not the case at the time Joyce was attacked. In essence if given permission by the occupant/house owner they could have lived where ever they wanted.
- 8.8. In the case of Dean he was still part of the Kent Specialist Children's Service 18 plus scheme and was allocated a Personal Advisor (PA1), who visited him shortly before he and his brothers attacked Joyce. This PA undoubtedly had an opportunity to identify a potential threat to Joyce particularly when undertaking these home visits. This PA was focussed on supporting Dean and failed to consider any threat he may have posed to others, including Joyce. The expression 'professional curiosity' has been used frequently throughout the review process and is highly applicable to this case. Professionals understandably have a primary responsibility to the agency they represent, and in the case of PA1 this was to offer support to Dean as part of the 18 plus scheme. Front line staff however must extend their activities beyond their specific job description and exercise 'curiosity' to identify vulnerable/ abused individuals who do not fall within that primary role.
- 8.9. Sean Rose had been classified as representing a high risk to himself and others and thus must have been a potential risk to Joyce. In June 2015, he was sent to prison and during this time was visited by his Personal Advisor under the Medway 18 plus arrangements. It was established upon release he would reside with his mother at Joyce's address. There appears to have been no risk assessment in relation to the suitability of this address, and in particular no reference to the potential vulnerability of Joyce. It should be pointed out that no risk assessment took place either by the PA or the Community Rehabilitation Company (CRC) and no consideration was given to the appropriateness of the address as he was not identified as high risk upon his release. Had such a risk been identified, further efforts could have been undertaken to provide Sean with alternative accommodation. Whilst his PA seems to have agreed that Sean could live with his mother at Joyce's house, information was not shared with either EKH or the CRC/probation provider: EKH have made it clear that permission for Sean or indeed any of the sons to live at this address would never have been granted as it was only a two bedroomed house, and thus too small.

- 8.10. David Rose was the elder of the three brothers and like them was a care leaver and for a time was helped by the Medway 18 Plus/ Leaving Care Team. David unlike his brothers was referred to Medway Adult Services because of his learning disability and was subsequently aided by the 0-25 Disability Team. The Medway Council Housing Service deemed David to have made himself intentionally homeless. Despite their previous efforts the Disability Team were unable to help him, and following an assessment of his mental capacity the case was closed. This was in accordance with recognised procedures.
- 8.11. As stated the three brothers all had profound problems after leaving care including the issue of where they should live. Over a period of time, individual members of staff from the two local authorities were assigned to each of the brothers, but they seemed to work independently of each other. Similarly information sharing between Children's Services, Probation, housing providers and the Police could have been better, particularly in relation to identifying the risks these individuals posed to Joyce.
- 8.12. This case appears to fall under the heading of 'mate crime'. This is a relatively new expression, but is a useful classification, which could trigger a greater awareness of agencies to vulnerable people who are befriended and exploited by individuals such as Sandra Wilson and her three sons. It is quite clear that Joyce was seen as an 'easy touch' with her possessions being stolen and her house used for inappropriate and anti-social activity, however she was never identified as the victim of 'mate crime'. Kent Police have now embraced the concept of 'mate crime' and have introduced it into their training programmes. During the course of this review, with the exception of the Police and KMPT, IMR's have not referred to 'mate crime' as such, however it should be incorporated into these organisations policy and practice regimes and included in training programmes.
- 8.13. In considering Joyce's vulnerability, if one excludes Sandra Wilson and her sons from the equation, then a pattern of peaks and troughs emerge in relation to her mental and physical health. There were times when she presented as deeply disturbed whereas on other occasions she appeared well and able to adequately take care of herself. At the time of the assault there were no particular concerns raised by her GP, and she was not then receiving any specialist mental health support. What is apparent is that Joyce on occasions was masking (either deliberately or unintentionally) the reality of her situation. It would appear Joyce had been 'self-neglecting' and was making herself more vulnerable. In such cases professionals should not rely on a person's self-appraisal, but take evidence from other individuals or agencies. There was some degree of collaboration, but in the main, professionals described her improved condition without taking a wider view only basing their assessment on how she presented at a particular time.
- 8.14. In reaching conclusions one must also take regard of the house in which Joyce lived and the potential it represented for agencies to identify her vulnerability, and to take into consideration safeguarding issues. As can be seen, there were several calls neighbours made about Joyce's house,

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

- 8.15. As part of the review process the Independent Chair in reaching conclusions has taken into consideration the views of Joyce's immediate neighbours. One neighbour described the arrival of Sandra Wilson and particularly the Rose Brothers and how they caused him immense distress, which in turn had a detrimental effect on his health. He described the house being occupied by up to eight people who kept his family awake with shouting, banging and generally disruptive behaviour. He described these individuals as intimidating who could not be reasoned with. Although the Rose brothers were at the heart of the problem, they acted as a magnet for other undesirable individuals who neighbours referred to as 'drug abusers'. Not only was the neighbour concerned for his own sake but he feared for the safety and wellbeing of Joyce at the hands of those living in her house. Prior to the arrival of Sandra Wilson and her sons the area was peaceful and the neighbour had no concerns for Joyce's safety. The neighbour had no doubt that Joyce was being taken advantage of by Sandra Wilson and her sons.
- 8.16. The neighbour's main concern was that the organisations involved did not communicate with each other either internally or externally and the situation called for a coordinated response. The neighbour's views have formed an integral part of this review and their concerns have been echoed from information contained in the IMR's particularly in relation to the lack of co-ordinated agency activity.
- 8.17. There were some examples of collaboration with other agencies, but this was sporadic. Such cases do call for a coordinated multiagency approach rather than dealing with each incident in isolation. Achieving this is easier said than done given the number of cases and the resources available. The use of local Community Safety Units such as the one hosted by Thanet District Council, is seen as perhaps an existing method of achieving this.
- 8.18. The Police received a number of calls relating to Joyce's address, usually from neighbours complaining of anti-social behaviour. The complainants were generally treated as the victim and those in Joyce's house as the perpetrators. Officers could have also identified Joyce as a victim had they

looked more closely into the circumstances. To deal with such cases in this manner requires knowledge and background intelligence both from previous police attendance to the address and information from partner agencies.

- 8.19. In addition to calls from neighbours, the Police investigated allegations made by Joyce of theft of her property by Sandra Wilson and her sons. These complaints generally resulted in Joyce being reluctant to support a prosecution. The allegations were generally treated in isolation, but if looked at collectively gave a clear indication that Joyce was the target of 'mate crime'. Comments regarding Joyce's reluctance to support formal action against Sandra Wilson or her sons should not be construed as blaming her for becoming a victim.
- 8.20. As with other agencies, the attending police officers did not exercise their 'professional curiosity' in relation to Joyce, and had they done so, her vulnerability may have been identified.
- 8.21. Police policies and working practice in relation to Domestic Abuse are robust and appropriate, however Joyce was never classified as the victim of domestic abuse. This was the result of applied legislation not including perpetrators who merely live in the same house. However, there were elements of mate crime present and it is important that front line officers are aware of this type of offending. Once it has been identified it should be dealt with in a similar way to domestic abuse and indeed, in many cases, it could be classified as such, particularly if the perpetrators are residing in the same household as the victim. It is for this reason mate crime will be incorporated into police policy, and training will be delivered accordingly.
- 8.22. Joyce's siblings were clearly very concerned for her wellbeing, and prior to the arrival of Sandra Wilson and her sons into her life, her sister and brothers took an active role in managing her physical and mental condition. Joyce's willingness to accept Sandra Wilson as her friend and, to some extent her protector, resulted in her family members being marginalised in terms of her medical and safeguarding needs. When a vulnerable person's life is invaded in such a way it should be of no surprise that members of that person's family are alienated in such a way.
- 8.23. The Author would like to extend his condolences to Joyce's family members and thank them for the assistance they have given in conducting this review.

9. Lessons Learnt

1. In the main, organisations contributing to this DHR have in place appropriate policies and defined working practice relating to domestic abuse. These procedures involve well established risk assessment tools and contain guidance on joint working and information sharing protocols. In this case Joyce was never identified as the victim of 'domestic abuse' as defined by legislation, and as such none of these organisations put these policies into practice. Even if Joyce's general ill treatment by the Rose Brother's had been recognised, it is still possible she would not have been classified as a victim of domestic abuse, and these procedures would not have been implemented. Agencies are unlikely to define a situation as domestic abuse if the victim is only living in the same household rather than being related to or the intimate partner of the perpetrator.
2. This report makes a great deal of reference to 'mate crime' and this case fits into this category of offending. 'Mate crime' may also fit the definition of domestic abuse, but this need not always be so as the perpetrator may not always live in the same household as the victim. This case would indicate that 'mate crime' should generally be dealt with in the same way as domestic abuse with defined policies and risk assessments being established by each of the agencies. Whilst the Kent Police have now introduced guidance on 'mate crime' this does not seem to be the case with other agencies with the exception of KMPT and Kent Adult Services.
3. Professionals visiting Joyce's house failed to identify her vulnerability at the hands of Sandra Wilson and her three sons. They were focussed on their own field of activity, but should have extended their observations to include the ambient condition of the house, and the vulnerability and safeguarding of its occupants. This throughout the review process has been referred to as 'professional curiosity'.
4. Calls made to Joyce's house by agencies were often dealt with in isolation with no account being taken of previous events or intelligence. It is important such cases are managed as a progressive and chronic situation rather than a reaction to each call as a single issue. Such an approach, where relevant, should also involve multi-agency activity with information being exchanged between organisations.
5. Agencies that respond to calls relating to Anti-Social Behaviour should make appropriate enquiries to establish who are the victims and who are the perpetrators. In this case only the complainants were regarded as the victims, but it would seem Joyce and potentially Sandra were also victims, but living in the same house as those responsible.
6. In addition to the abuse perpetrated by the Rose Brother's, it would seem Joyce was self-neglecting by failing to take care of her own needs. Professionals often took Joyce's own self-assessment at face value and did not seek information from other sources when identifying her needs and potential vulnerability.

7. Social Services perform a crucial role in assisting care leavers move into adulthood and independent living. As can be seen throughout this report assisting care leavers in finding suitable accommodation is a vital part of that role and some efforts were indeed made to find the Rose Brother's appropriate housing. Having said that, professionals must also take account of potential risks to the person with whom the care leaver is to reside. In this case there was much emphasis on providing the brother's with accommodation and little or no recognition that they may have a detrimental effect to Joyce's welfare and safeguarding.
8. Whilst the main responsibility of managing a person leaving care falls to Social Services, this case demonstrates decision making should involve the sharing of information from a variety of sources and agencies; in this case the Probation providers (NPS and CRC), Youth Offending Service, Police and East Kent Housing. This activity should commence prior to the care leaver reaching the age of 18 years.
9. This case demonstrates the need to risk assess the accommodation to which a prisoner is to reside upon release from HMP. There was no risk assessment and no objection by Sean Rose's Personal Advisor that he should reside with his mother at Joyce's house.
10. This case demonstrates the need for EKH (and other agencies where relevant) to undertake unannounced visits when dealing with cases of potential abuse, ASB or allegations of 'mate crime'.

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

10. Recommendations

1. **Front line officers or staff who, as part of their job description, visit premises or interact with members of the public, have the opportunity to identify potential victims of 'Mate Crime' or Domestic Abuse. Officers and staff should be encouraged to exercise 'professional curiosity' and follow up on indications of an abusive relationship or safeguarding issues that relate to a person who may not be the primary focus of their work.** *Police, EKH, Thanet Council, Kent and Medway Social Services, KMPT, SECamb, NPS, CRC, Kent YOS.*
2. **Where there are complaints of Anti-Social Behaviour, it is important to establish who is the victim, who is the perpetrator and whether they are vulnerable and in need of assessment.** *Kent Police, East Kent Housing, Thanet District Council*
3. **The concept of 'Mate Crime' or the harming of vulnerable persons in abusive relationships by offenders who set out or take the opportunity to abuse a victim, should be incorporated into agencies policies and working practice, and staff should be trained**

accordingly. This type of offending should be treated in a similar way to Domestic Abuse e.g. structured risk assessment, information sharing protocols, victim safeguarding plans etc. *Police, EKH, Thanet Council, Kent and Medway Social Services, KMPT*

4. **Housing providers should undertake a risk assessment when they are aware that someone has moved into a property with a potentially vulnerable tenant.** *East Kent Housing, Thanet District Council*
5. **To facilitate information exchange, East Kent Housing to attend formal and minuted Tasking and Coordinating Meetings held by the Thanet Community Safety Unit.** *East Kent Housing, Thanet District Council, Thanet CSU*
6. **To provide each GP practice with an up to date adult safeguarding policy that reflects national and local guidance and best practice to guide and support staff in responding to victim and perpetrators of domestic abuse and self-neglect.** *Kent and Medway CCG's/NHS England.*
7. **In exercising their responsibility in assisting young adults leaving care, Social Services should endeavour to ensure such individuals are registered with a GP, (none of the Rose Brothers were registered with a GP at the time they attacked Joyce).** *Kent and Medway social Services*
8. **Agencies should recognise that an individual's safety and wellbeing may be, in whole or in part, compromised by self-neglect rather than abuse inflicted by a third person. Agencies should ensure that published guidance on self-neglect is both delivered in training and conformed to as outlined in the Kent and Medway Adult Safeguarding Board Policy.** *All agencies*
9. **Social Services have a responsibility to assist young adults leaving care, which will include helping them find suitable accommodation in which to live. In addition to establishing the accommodation is suitable for the care leaver, a risk assessment should also take place intended to identify safeguarding issues in relation to the existing occupants.** *Kent Social Services, Medway Social Services*
10. **In considering the appropriateness of accommodation for persons leaving prison or detention centres, agencies involved should use their own risk assessment processes to determine the suitability of the premises in respect of the vulnerability of existing occupants. Information from risk assessments should be shared with other agencies.** *Social Services, NPS, YOS, Housing Providers*
11. **When adult offenders have been previously subject to youth offending supervision, liaison must take place with the previous allocated YOT worker/s in order to gather information to inform risk assessment and risk management.** *NPS, YOS*

12. **When offenders subject to statutory supervision are related, professionals with offender management responsibility must work collaboratively in order to build a holistic view of the family to inform the assessment and management of risk. (NPS, YOS)**
13. **This review and its recommendations should be brought to the attention of the Kent and Medway Adult Safeguarding Board. In so doing the Board and its member organisations may be able to provide guidance and a degree of consistency to those charged with implementing recommendations particularly relating to the use of professional curiosity, mate crime and self neglect.’ Kent and Medway Adult Safeguarding Board**

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