Cornwall Adult Protection Committee

The Murder of Steven Hoskin

A Serious Case Review

Executive Summary

In memory of Steven Hoskin (15 February 1967- 6 July 2006)

'He was generous…he knew he had a learning disability…he tried to do as others do…he wanted friendships…he's at peace at last…now he can't be hurt any more'

Margaret C. Flynn
December 2007

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1. The Serious Case Review

1.1 On 31 August 2007 the Adult Protection Committee for Cornwall came to the decision that it was necessary to set up a Serious Case Review as the result of the murder of Steven Hoskin and to commission an independent person as its Chair. **The purpose of a Serious Case Review is:**

i) to establish whether there are lessons to be learned from the circumstances of the case about the way in which local professionals and agencies work together to safeguard vulnerable adults;
ii) to review of the effectiveness of procedures, both multi-agency and those of individual organizations;
iii) to inform and improve inter-agency practice;
iv) to improve practice by acting on learning;
v) to commission an overview report which brings together and analyzes the findings of the various reports from agencies in order to make recommendations for future action.

1.2 Margaret Flynn accepted the position of Chair of the Review, began work on 18 September 2007, and agreed to draft the Overview Report by 5 December 2007. The Review's terms of reference hinged on what is expected to change as a result of:

- establishing the effectiveness of procedures (both multi-agency and those of individual agencies) and the ways in which professionals worked together in the months preceding Steven Hoskin's murder; and
- considering ways in which inter-agency practice might be improved.

1.3 The Report is based on the *Individual Agency Management Reviews* undertaken by:

- Children's Social Care, Children, Young People and Families, Cornwall County Council;
- Cornwall and Isles of Scilly Primary Care Trust;
- Cornwall Partnership NHS Trust;
- Department of Adult Social Care, Cornwall County Council;
- Devon and Cornwall Constabulary;
- Multi-agency Adult Protection Unit;
- Ocean Housing Ltd;
- Youth Service, Children, Young People and Families, Cornwall County Council;
- Youth Offending Team, Children, Young People and Families, Cornwall County Council;

and on written information offered by the relatives of Sarah Bullock, Restormel Borough Council, South Western Ambulance Service NHS Trust, and Review Panel members.

2. The Murder of Steven Hoskin

2.1 The murder of Steven Hoskin was given extensive media coverage in August 2007 following the murder conviction of the two principal perpetrators, Darren Stewart (aged 29 years) and Sarah Bullock (aged 16 years), and the manslaughter conviction of Martin Pollard (aged 21 years). It has since been described as a *'disability hate crime'* (see CPS 2007; Disability Now 2007; and UKwatch 2007)) and links have been made with the deaths of others with learning disabilities with known support needs.

2.2 The facts of Steven's murder are stark. On 6 July 2006 his body was found at the base of the St. Austell railway viaduct. In addition to his bearing catastrophic injuries associated with falling 30 metres, a post-mortem examination confirmed that Steven had taken paracetamol tablets, had been drinking alcohol and had sustained recent injuries from cigarette burns. Further, he had neck bruises from having been hauled around his home by his own pet's dog-lead and the backs of his hands bore the marks of foot-prints.

2.3 At the trial it was reported that on the night of his murder, Steven had been found 'guilty' of being 'a paedophile.' While this claim was without foundation it was determined that Steven should die. Graffiti to this effect was written on a wall in Steven's bed-sit.

2.4 Steven's final hours were harrowing, not least as he was required to revise his view of himself from being Darren's 'friend' to being a 'paedophile' – reviled and morbidly different from other men. He returned home in the early evening, having been detained in a local store because of an accusation of shop-lifting (allegedly committed some days earlier). In addition to Darren, Sarah and Martin, four teenage boys were in his bed-sit, two of whom participated, in part, in his abuse, and reported witnessing:

(i) Darren and Sarah's escalating verbal and violent behaviour towards Steven. He was beaten about the head with a telephone charger, had his arm pushed up his back and was kicked, while held face-down on the floor. Two of the teenage boys also kicked Steven as they went to the toilet and as they left the flat;
(ii) the humiliations that Sarah imposed on Steven. She placed a dog-collar around his neck;
(iii) Steven being tied-up by Darren, Sarah and Martin and being imprisoned in his own home. His attempts to escape were thwarted and his mobile 'phone was taken from him when he tried to call for help.

2.5 Two of the teenage boys left early on in the evening with Martin (who later returned). They reported being scared of Darren and relieved when he unlocked the door of the bed-sit to let them go home. In statements to the Police, they described being *'disgusted'* by the humiliations imposed on Steven.

2.6 Against a backdrop of loud music, Steven repeatedly told Darren and Sarah that he was *'scared.'* His distress was ignored as Darren required him to adopt uncomfortable physical positions and Sarah pulled on the dog collar when he moved.

He was made to walk on his hands and knees and address them as 'Sir' and 'Madam.' Although, later on in the evening Steven's screams were heard, no one called the Police.

2.7 After the two remaining boys had left the bed-sit, Steven was coerced into swallowing a lethal dose of paracetamol tablets. He could not repel his persecutors. Steven's final minutes of consciousness were bleak in the extreme. Having been made to leave his home and walk to, and onto, the railway viaduct, accompanied by Darren, Sarah and Martin, Steven was forced over the safety rail. All his life, Steven had been terrified of heights. Sarah ensured that he would let-go by kicking his face and standing on his hands.

3. Pen Pictures of (1) Steven Hoskin, (2) Darren Stewart, (3) Sarah Bullock, (4) Martin Pollard and (5) two teenage boys

3.1 In assembling the following pen portraits, we are not seeking to offer complete case histories, but brief biographical information, and to describe the context, neither of which we know to be complete. Information about contacts with the NHS and the police is contained in the following pen portraits.

3.1.1 **(1) Steven Hoskin** was 39 years old. Born to a single woman who herself had a learning disability, Steven's learning disability became apparent in his early childhood. At 12 years of age he left a local primary school and became a weekly boarder at Pencalenick special school, returning to his mother (on the Lanhydrock Estate, outside Bodmin) at weekends. Steven did not read. After leaving school at 16, Steven was unable to secure employment and was admitted as an inpatient to Westheath House, an NHS 'Assessment and Treatment' unit for people with learning disabilities and mental health problems. Although he remained there for 14 months, the therapeutic purpose of his stay is unknown. While at Westheath House, Steven participated in youth training activities in the Bodmin area. This was an unhappy time for Steven as he was *'victimised by the other trainees.'*

3.1.2 Steven's life revolved around a small number of key relationships – his mother, the owner of the local farm and people at a coal merchant's where he helped from time to time, and, importantly, his dog Sue. He loved his rural life and he especially enjoyed taking his dog for walks in the local woods. Although Steven was a willing helper at the farm, his short attention span resulted in him *'downing tools' when he had had enough*. The general impression of social care personnel was that of *'a kind hearted, generous and understanding young man.'* He was very fond of music and would play it as loudly as possible, not understanding that this impinged on others. Steven was *'forever buying or swapping his 'hi fi' equipment.'* His main musical interest was in the sounds of the 1960s.

3.1.3 Over time Steven's relationship with his mother deteriorated and ultimately became characterised by conflict and violent outbursts. In September 2003, Steven was charged and convicted with common assault and he was subject to a Probation Order. An Adult Protection Plan confirmed that Steven's mother should move. Steven's difficult relationship with his mother was exacerbated by the death of his grandfather who had shared their family home. His work experience in Bodmin had

been distressing as he was teased and victimised. It confirmed his sense of being different and his isolation from others. Steven was bored and frustrated and, if unchecked, he spent his [welfare] benefit income on alcohol. When Steven secured a day service place, his attendance was poor as he preferred helping a local farmer. A Housing Homefinder Application stated, *'He is very vulnerable and can be taken advantage of due to the way he looks i.e. his learning disability.'*

3.1.4 Steven was assessed as having, *'substantial need'* according to the Fair Access to Care Criteria. It was planned that Steven should have weekly visits. This support was discontinued by Steven in August 2005. The records show that there were 11 actual visits to Steven when there should have been 18. There were two aborted visits.

3.1.5 In total, Steven received three discrete episodes of care from the Cornwall Partnership Trust in total: an inpatient admission in 1983, a reassessment by Community Services in 1993 and a further reassessment in 2003. None of these were clearly terminated.

3.1.6 Prior to November 2005 Steven had an Out of Hours (OoHs) GP consultation in February 2005; a GP consultation in September 2005; and in October 2005 he attended a Minor Injury Unit. (The question marks included in Table 1 are direct quotations from the NHS logs).

Table 1: Health interventions for Steven from November 2005

November 2005	9th – consultation with GP 10th – consultation with nurse 16th – consultation with GP 23rd – fracture clinic appointment
December 2005	11th – to A&E via ambulance; 20th – consultation with OoHs GP service 21st – consultation with OoHs GP service
January 2006	10th – consultation with GP 15th to A&E via ambulance ? head injury
February 2006	13th to A&E via ambulance ? chest pains 28th – consultation with GP
March 2006	? – consultation with OoHs GP
April 2006	21st – consultation with GP 24th - attendance at MIU re alleged assault and chest pain
May 2006	16th – consultation with GP
June 2006	15th – consultation with GP

3.1.7 Table 1 confirms that Steven's health needs significantly increased when he discontinued contact with Adult Social Care and Darren and others were spending increasing periods of time in Steven's bed-sit, it appears that Steven became increasingly visible to NHS primary and secondary care services. The South Western Ambulance Service NHS Trust also records an emergency ambulance call-out in December 2005 and another in February 2006. In April 2006 Steven visited a Minor Injury Unit with chest pains and stated that he had been assaulted. This was not reported to the police.

3.1.8 The following Table shows that once Steven ceased to be supported by Adult Social Care he began to contact the police. It may be significant that a reference to Darren's pen portrait confirms that for Darren, the main perpetrator of the offence, police contact was also a very familiar response.

Table 2: Police interventions initiated by Steven from August 2005

August 2005	'Phone call alleging that R (one of Darren's girlfriends) has stolen money from his home
December 2005	'Phone call stating that front window had been broken
	'Phone call describing problems with local man
	'Phone call expressing concern for Darren's welfare. Darren had left 'depressed.'
	'Phone call stating that Darren had returned
January 2006	'Phone call stating that Darren was missing
February 2006	'Phone call stating that Darren had walked out having left a suicide note
March 2006	Steven attended St Austell Police Station as he was concerned about his mother.
May 2006	'Phone call stating that Darren and girlfriend Q were pestering him
	'Phone call about a threat from a local man
	'Phone call about a threat from a local man
June 2006	'Phone call stating that (another) local person had threatened him

3.1.9 During the period that Steven lived in St. Austell, it appears that his alcohol intake increased significantly. Also, on at least one occasion he took amphetamines with alcohol. Steven's excessive drinking was known to primary and secondary health care services as well as to the police.

3.1.10 It merits noting that during the escalation of events within Steven's bed-sit he preserved something that his persecutors could not have: his concern for his mother. In March 2006, Steven went to St Austell police station as he was worried about his mother's welfare. The police contacted his mother and were able to reassure Steven that, although she had been out when he had attempted to contact her by 'phone, she was safely home.

3.1.11 Finally, the allegations that Steven was *'a paedophile'* and *'a known sex offender'* cannot be proven. Steven had no convictions for sex offences and had not been subject to any police investigations yet Darren advanced these allegations to his girlfriends. A rumour-dynamic of this order is impossible to suppress and, as the final hours of Steven's life testify, it had chilling consequences.

3.2 **(2) Darren Stewart** was 30 years old when he was sentenced to 25 years for murdering Steven Hoskin. The chaotic contours of his early life in were defined by neglect, discord, assaults, truanting from school and thefts. He was a 'run-away' child who went on to live in an unknown number of care homes and secure services. He was sent to prison for arson and later was convicted of a street robbery. Darren's misuse of alcohol and amphetamines and being 'on the move' came to characterise

his adult life. Between 1998 and 2006 Darren had five children with three teenage partners, all of whom were vulnerable. These were volatile relationships.

3.2.1 Darren was convicted of arson in the house in which he lived with his first partner P (i.e. the first partner known to this Serious Case Review). On release from prison a Probation Service did an assessment of the risks he posed. Professionals came to be *'concerned for Darren…and for those in close contact with him because of his self-harm and because of his aggression to others.'* At a Review Child Protection Conference it was stated that Darren had a *borderline personality disorder.* Darren and his partner had two more children and concern for the welfare of his children was expressed by an array of professionals.

3.2.2 Darren had two phases of contact with Cornwall Partnership Trust. Four team members were involved in supervising contact with his children and in supporting his partner. As the Cornwall Partnership Trust noted, *this intensive multi-agency working by the specialist forensic team, which might be seen as ideal, did not prevent the serious harm of Darren's child, leading to a Serious Case Review*. As a result, Emergency Protection Orders were sought for the children. It was decided that insufficient evidence existed to proceed with any charge against Darren. He blamed P. The couple separated but the children remained on the Child Protection Register. A fire in their home, the cause of which was unknown, had triggered keen concern. The second phase of Darren's contact with Cornwall Partnership Trust began in January 2005. Darren gave at least six different addresses in Cornwall from this date and he began to use the *'c/o'* address at 8 Blowinghouse Close in January 2006. This phase was characterised by referrals followed by non-attendances, unplanned crisis attendances, 'overdoses,' arrests and detentions under the Mental Health Act. However, Darren's engagement with the service was poor.

3.2.3 Shortly after Darren met Q she became pregnant. They came to the attention of the police when Darren physically assaulted Q and she reported that Darren had locked her in a room and threatened her with a knife.

3.2.4 Another of Darren's partners, R, was 18 when she met Darren. Her first child had been removed by the Department of Children, Young People and Families. She became pregnant with Darren's baby.

3.2.5 Sarah Bullock was Darren's fourth partner. She was 15 years old when she met Darren.

3.2.6 The following Table confirms that Darren accessed the full range of NHS services to excess. (The question marks included in Table 3 are direct quotations from the NHS logs).

Table 3: Health interventions for Darren from January 2005

January 2005	2nd Ambulance Emergency Call Out 11th registered with GP and GP referral to Community Drugs and Alcohol Team (CDAT) 17th referral to Community Psychiatric Nurse (CPN) 21st GP consultation

February 2005	3rd Minor Injury Unit (MIU) attendance 8th Letter from CPN to GP re non attendance at assessment appointment 9th GP consultation and telephone call from GP to CPN 9th Ambulance Emergency Call Out 11th Out of Hours (OoHs) GP consultation 13th OoHs GP consultation 14th GP consultation 15th Ambulance Emergency Call Out 17th Seen by CPN 18th CPN telephone call to GP re risks to self/ others 18th OoHs consultation 19th OoHs advice sought by Police 19th Ambulance Emergency Call Out 24th letter to GP from Psychiatrist re non attendance 27th February – 8th March – admitted to Fletcher Ward 27th Letter from specialist registrar to GP re assessment in police custody
March 2005	4th MIU attendance (whilst in-patient) 7th Ambulance Emergency Call Out 7th A&E attendance at Derriford ? overdose 10th A&E attendance 11th Ambulance Emergency Call Out 14th Discharge letter to GP 18th Ambulance Emergency Call Out 19th – 22nd March – admitted to Fletcher Ward 23rd MIU attendance
April 2005	26th Letter from CPT to GP re diagnosis of Personality Disorder
May 2005	9th Threats of suicide to CPT 11th GP consultation – requesting referral to CPN 13th GP consultation 16th Letter to GP from Psychiatrist. No admission following arrest. Had been of no fixed abode for about 4 weeks 18th HV consultation 18th OoHs consultation 19th HV consultation 24th Referral to CPT 27th HV consultation 31st Letter re CMHT appointment
June 2005	13th Did not attend CPT appointment MIU attendance HV consultation 19th OOHs GP consultation 23rd Ambulance Emergency Call Out
July 2005	3rd Ambulance Emergency Call Out 3rd and 4th Ambulance and Police attended – ? taken to A&E 4th Ambulance Emergency Call Out (1213) 4th Ambulance Emergency Call Out (1532) 9th Ambulance Emergency Call Out 19th OoHs consultation
August 2005	1st GP consultation 2nd Ambulance Emergency Call Out 2nd MIU attendance 2nd OoHs consultation

	5th MIU attendance followed by GP consultation 6th Ambulance and Police attended 7th Ambulance Emergency Call Out 7th OoHs GP consultation 8th non attendance CPN appointment 10th admitted to RCH via A&E 11th Ambulance Emergency Call Out 18th Did not attend CPT appointment 23rd Ambulance Emergency Call Out ? date ? attended A&E
September 2005	3rd Letter to GP from A&E 30th Ambulance Emergency Call Out
October 2005	8th OoHs GP consultation [NB address given as 8 Blowinghouse Close] 9th Contacted surgery for GP appointment 11th OoHs GP consultation 12th non attendance GP appointment 16th Ambulance Emergency Call Out ? date ? attendance at A&E 21st Ambulance Emergency Call Out (02.10) 21st Ambulance Emergency Call Out (02.17) 21st Ambulance Emergency Call Out (14.00) 21st Letter to GP from A&E 30th OoHs consultation
November 2005	1st OoHs GP consultation 16th GP consultation 18th GP consultation
December 2005	20th OoHs GP consultation 25th OoHs GP consultation 28th OoHs GP consultation 29th GP consultation 29th patient wrote to GP asking GP to write to Ocean Housing
January 2006	3rd urgent referral by GP to CPT 10th CPT letter to patient 11th Telephone contact with GP – claims CPNs not willing to see him 19th Telephone contact with GP 24th Seen by CPT
February 2006	6th did not attend same day appointment with GP 8th telephone contact and appointment made for next day 8th OoHs consultation 9th GP consultation 9th Ambulance Emergency Call Out Ambulance and Police in attendance 10th Ambulance Emergency Call Out 10th A&E attendance taken by Police 11th A&E attendance – overdose 11th Letter to GP from Psychiatric Liaison Nurse
March 2006	12th OoHs GP consultation 20th GP consultation 31st did not attend GP appointment
April 2006	18th OoHs GP consultation 20th GP consultation 20th OoHs GP consultation

	24th OoHs GP consultation – advised to go to A&E 24th OoHs consultation – advised again to go to A&E 25th GP consultation
May 2006	2nd Letter to GP from Psychiatrist re assessment of patient at police station – no evidence of mental illness 4th GP consultation MIU attendance 19th non attendance of follow up hospital appointment 21st call to OoHs 21st second call to OoHs 21st third call to OoHs GP – advised to call ambulance 21st Ambulance Emergency Call Out 22nd Visit by GP 25th Did not attend CPT appointment
June 2006	9th Did not attend CPT appointment 16th OoHs GP consultation 21st GP consultation
July 2006	6th Ambulance Emergency Call Out 10th Admission to Derriford A&E 11th Appointment with Cornwall Partnership Trust

3.2.7 In summary, between January 2005 and Steven's murder on 6 July 2006, Darren made 7 visits to Minor Injury Units; and at least 8 to Accident and Emergency services. He consulted his GP on 15 occasions and the Out of Hours GP services on 21 occasions. In addition, he made 24 calls to the Ambulance Emergency Call Out, at least 8 of which were to Steven's bed-sit.

3.2.8 Darren's contacts with the police are as stark and as suggestive of his need for excitement and drama.

Table 4: Police interventions initiated by Darren since February 2005

February 2005	'Phone call stating that he had done something wrong and that he has mental health problems
April 2005	'Phone call stating he was suicidal
May 2005	'Phone call stating that he cannot cope any more…that train was coming
July 2005	'Phone call stating that he had taken an overdose
	'Phone call stating that he had received threats by text from ex-girlfriend Q
	'Phone call stating that Q had slapped him after an argument. In drink
	'Phone call stating he wished to make a complaint. [Re the earlier incident] the officers had believed Q and not him
	'Phone call stating that he was outside St Austell and Police Station and that his throat was closing due to having taken drugs
November 2005	'Phone call about three men who had tried to kick in his door [at 8 Blowinghouse Close]
December 2005	'Phone call stating that man was kicking on door
April 2006	'Phone call stating that Q was at his address [8 Blowinghouse Close] and had caused damage
May 2006	'Phone call stating that an aggressive male was outside

	trying to get him
	'Phone call to state that Q had been `assaulted by Steven`
July 2006	'Phone call stating that Steven was missing

3.2.9 Between December 2004 and 6 July 2006, there were 49 police contact logs in respect of Darren and his girlfriends. At least 12 hinged on Darren's potential violence and his fear of being subjected to violence; a further 12 concerned threatened and actual suicidal gestures; and 6 were nuisance calls associated with drinking alcohol. It should be noted that these figures are derived from contacts logged in Cornwall. It seems likely that there are contacts with emergency services elsewhere.

3.2.10 Although Darren's motivations were unknown, his very visible suicidal gestures were suggestive of a wish to be centre-stage and in the spotlight. However, the credibility of his threats to commit suicide was reduced by the frequency with which he made them. Looking back over Darren's life there appears to have been a marked tendency to *under-respond* to the gravity of his aggressive acts and no account appears to have been taken of the destabilizing factors of his alcohol and substance misuse. He had an uncanny gift for identifying those who were vulnerable and lonely (see Hare1993) and became violent when they sought to disengage from him.

3.3 **(3) Sarah Bullock** was 17 years old when she was sentenced to 10 years for murdering Steven Hoskin. She met Darren in the summer of 2005. She stopped going to college. The Youth Offending Team and children's social care services knew of her via a single121A notification from the police. In June 2006, a midwife contacted the Department of Children, Young People and Families to report that Sarah had run away with Darren and that she was living with Steven, *'a known sex offender.'* Sarah had a miscarriage a month before Steven's murder.

3.3.1 Sarah's supportive and abhorrent role in Steven's torture and murder does not appear to have been foreshadowed in what is known of her history. While sympathy and understanding are rarely extended to girls and women who break rules (see Kennedy 1992), it should be noted that all of Darren's young girlfriends became isolated from their customary activities and relationships (placing great strain on these) and were arguably flattered by his possessiveness which appeared to develop into total control. The toxic effects of alcohol and drugs are known to contribute to offending behaviour. Darren's substance misuse is likely to have influenced Sarah's own misuse which began when she met him.

3.4 **(4) Martin Pollard** was 21 years old when he was sentenced to 8 years imprisonment for the manslaughter of Steven Hoskin. At the time of the murder Martin was living in the family home. Although employed, Martin was on the fringes of criminal activities in St. Austell. Martin disclosed his role in Steven's murder, days after it had taken place, to a member of staff of Cornwall's Youth Service, Department of Children Young People and Families. As with Sarah, Martin's conduct was apparently not anticipated by his known history. Martin's substance misuse is likely to have played a part in his association with Darren and, ultimately, his witnessing of, and contributing to, the atrocities inflicted on Steven.

3.5 **(5) Teenage boys X and Z** were both 17 years old when they received a three year Supervision Order with an Intensive Supervision and Surveillance Programme and, respectively, a three year Community Punishment (100 hours) and Rehabilitation Order for falsely imprisoning and assaulting Steven Hoskin. They both left school at 16 and appeared without direction, although Z was in employment at the time of his arrest.

4. The 'Warnings' and Missed Opportunities for Intervention

4.1 There were weak and strong 'warning signals' that all was not well for Steven. None of these invoked the Adult Protection Procedure. As with all catastrophic events, the context has to be taken into account in understanding the chronology and the circumstances. The Serious Case Review Panel acknowledged that the origins and even solutions were foreshadowed in the facts of the murder and in the events leading up to this.

4.2 It is helpful to begin by broadly outlining what individuals in each agency *knew:*

- In 1983 Health and Social Care Learning Disability Services in Cornwall knew that **Steven** had a learning disability;
- In 1993 Cornwall Probation Service knew that *Darren* was a 'high risk;'
- In 1997-2003 the Cornwall Partnership Trust knew that *Darren* had a personality disorder;
- In 1997 Cornwall Probation Service knew that *Darren* had committed offences of robbery;
- In 2000-2006 Children's Services, NHS midwifery services and the Devon and Cornwall Constabulary knew that *Darren's* children and his girlfriends were potentially 'at risk;'
- In February 2005 NHS primary care services in St Austell knew that **Steven** had a learning *difficulty*;
- In April 2005 Ocean Housing Ltd. knew that **Steven** had a learning disability and that he was a vulnerable adult;
- In June 2005 the Community Care Assistant Service knew that another man (not *Darren*) was living in **Steven's** bed-sit;
- In July 2005 Ocean Housing Ltd. knew that youths were '*hanging around'* Steven's bed-sit;
- In July 2005 Ocean Housing Ltd. knew that **Steven** had a lodger;
- In August 2005 the Department of Children, Young People and Families knew that *Darren* was '*very dangerous;*
- In November 2005 police advised an Ocean Housing Officer not to visit **Steven's** bed-sit alone in view of *Darren's* presence;
- In November 2005 police knew that **Steven** had a learning *difficulty;* that a young girl was frequenting **Steven's** address and returning home apparently under the influence of drugs; and that *Darren* was dealing drugs from this address;
- In December 2005 Accident and Emergency services knew that **Steven** was drinking excessive quantities of alcohol;

- In December 2005 the Department of Children, Young People and Families knew that **Steven** had kicked *R* and *Darren* out of his home;
- In December 2005 Ocean Housing Ltd. and the police knew that **Steven's** front door had been damaged and that his front window had been broken;
- In January 2006 the South Western Ambulance Service NHS Trust knew that *Darren* was dangerous as they had a 'warning marker' against him and accordingly requested police attendance at all emergency calls;
- In April 2006 a Minor Injury Unit knew that **Steven** had been assaulted;
- In May 2006 primary care services knew that **Steven** was drinking alcohol to excess;
- In June 2006 the Department of Children, Young People and Families knew that young boys were frequenting **Steven's** bed-sit and misusing substances there;
- In the period during which **Steven** lived in St Austell, Cornwall's Youth Service, Department of Children, Young People and Families knew that he was associating with young people known to their service.

4.3 These points do not take account of disputed and unconfirmed messages from one agency to another.

4.4 The following table outlines the 'warnings' and missed opportunities for intervening and the responses of agencies arising from their contacts with Steven.

Table 5: 'Warnings,' missed opportunities for intervening and agencies' responses concerning Steven

'Warnings' and Missed Opportunities	**Agencies' Responses**
In **November 2003 Steven's** social worker wrote to the North Cornwall's District Housing Services, *'…Steven is used to living in an isolated rural situation and has expressed concern about his own ability to manage where others may be provocative or aggressive towards him…'* More generally in 2003-04 **Steven's** Care Plan indicated that he was '*used to a rural life…He is anxious about urban environment and close proximity to stress.'* However, the assessed risk that **Steven** posed to his mother led to her moving to sheltered accommodation because of her own support needs. Steven did not inherit his mother's tenancy. In March 2004 it was noted that, *'**Steven** has been befriended by an alcoholic…says she is girlfriend.'*	**Steven** was assisted by Adult Social Care to move to temporary accommodation in Newquay, where he had no connections. It was noted in a completed Housing Register Special Needs Form that when **Steven** was in temporary accommodation, *'he has been taken advantage of…he tends to be targeted and made fun of [He] is very vulnerable and is taken advantage of very easily…cannot read or write…can become aggressive when he has been drinking.'*
in **January 2005,** from Newquay, **Steven** sought his own accommodation in St Austell	Adult Social Care supported him in securing single-person accommodation.

In April 2005 Steven was allocated a bed-sit: 8 Blowinghouse Close owned by Ocean Housing Ltd., a Registered Social Landlord	Future support for **Steven's** tenancy was confirmed by Adult Social Care. All [welfare] benefit forms completed and all service providers contacted. A Home Help form was completed indicating that **Steven** was to have two hours of help each week with shopping, budgeting, correspondence and bills.
In **June 2005** a Community Care Assistant was concerned that a young man seemed to have moved into **Steven's** bed-sit and that he was taking decisions about what **Steven** should buy during their weekly shop	Community Care Assistant supervision note of **June 2005** states '*Steven has someone else staying at the flat. Social Work Assistant has been informed. To be monitored.'*
In **July 2005** an Ocean Housing Officer was alerted by neighbours that youths were *'hanging around'* 8 Blowinghouse Close	Ocean Housing Officer spoke to **Steven** who advised Officer that a lodger was living with him and sleeping on his settee. Officer advised about the implications of this. In **August 2005 Steven** and his lodger were given Homefinder Forms by the Housing Officer. They had indicated that they wished to transfer to larger accommodation together. In **October 2005** the Housing Officer told Restormel Borough Housing that **Steven** had a lodger
In **August 2005 Steven** cancelled his Community Care Assistant service	In **September 2005** Adult Social Care closed their active case work with **Steven** noting that he was '*likely to request services again when his living situation deteriorates'*
In **August 2005 Steven** 'phoned the police to inform them that *Q* (a girlfriend of *Darren's*) had stolen £60 from his bed-sit. '*Report of eight persons in the house when money taken.'*	Police attended…all persons searched…money not located
In **October 2005** *Darren* 'phoned the police to inform them that his girlfriend Q was missing from 8 Blowinghouse Close. Q returned	Police attended
In **October 2005 Steven** 'phoned the police stating that a man at 8 Blowinghouse Close was having a heart attack	Police did not attend. Ambulance attended
In **October 2005** *Darren's* (by now former) girlfriend *Q* rang her Leaving Care Social Worker. She disclosed that *'Big Steve… is a pervert towards young people. [Also] there is another woman staying…at the flat called Sarah who is with Darren and a 14 year old boy.* Q was believed to be *'living in a one bedroom flat owned by Steve.'*	
In **November 2005** *Q* 'phoned the police to report that *Darren* was 'missing from 8 Blowinghouse Close' that he was suicidal and had taken an overdose	Police located *Darren* and current girlfriend Sarah *'spoken to.'* Community Psychiatric Nurse to be notified

In **November 2005** the police received a 'phone call from *Sarah's* step father stating that *Darren* was dealing drugs from 8 Blowinghouse Close…the owner is **Steven**…*Sarah* is *Darren's* girlfriend and she is *'always coming home under the influence…'*	Police Management Report indicates that **Steven** *'had learning difficulties…Intelligence submitted reference Darren but does not appear to be linked to Steven.'*
In **November 2005** Ocean Housing Officer received an anonymous 'phone call from a man expressing concern about his daughter. She was frequenting 8 Blowinghouse Close and returning home under the apparent influence of drugs. Also advised that *Darren* was living at the address	Ocean Housing Officer rang the police on the same day. They advised her *'not to visit alone.'* The Housing Officer left a message with the Social Work Assistant. Social Work Assistant rang back the following day.
In **November 2005** *Darren* 'phoned the police. Three men had attended *'his address [i.e. 8 Blowinghouse Close] and tried to kick in the door.'*	Advice given over the 'phone. The Management Report states that *Darren* wanted this logged for information only as he did not want anyone attending
In **November 2005** *R* 'phoned the police to tell them that *Darren* had left 8 Blowinghouse Close following an argument. *R* was concerned that Darren might *'get into a fight.'*	
In **November 2005** Ocean Housing Officer visited **Steven's** bed-sit with a police officer. *Darren* and *Sarah* were present. They denied they were living there; in **late November 2005** *Q* 'phoned the police stating that *Sarah* and teenage boy were outside 8 Blowinghouse Close banging on the door	Ocean Housing Officer advised **Steven** about problems of overcrowding and the impact of having lodgers on his Housing Benefit; Police attended. All in order. No offences. Friends visiting Blowinghouse address
In **November – December 2005** *Sarah's* step father spoke to the Community Youth Affairs (Police) Officer about *Sarah's* circumstances	Community Youth Affairs (Police) Officer said would raise concerns with fellow officers
In **December 2005 Steven** was admitted to hospital for one night via A&E; A week later *R* informed her Leaving Care Social Worker that she was homeless as she and *Darren* had been *'kicked-out'* by **Steven**. They remained and two days later *R* told her Leaving Care Social Worker that **Steven** wants her, *'Darren and 'the others' out by tonight'*	Psychiatric Liaison Nurse wrote to **Steven's** GP; Advised to register as homeless
In **December 2005** *Darren* 'phoned the police as a neighbour was kicking on the door (of **Steven's** bed-sit)	

Two days later **Steven** 'phoned the police stating that front window had been broken; a further two days later **Steven** 'phoned them to report problems with his neighbour	Police attended. Recorded as undetected; police attended (again) and could not locate neighbour. Gave advice to **Steven** and *Darren;* Ocean Housing repaired damage
In **December 2005** the police received an address check request for missing person *Q* (a former girlfriend of *Darren*). *Q* was in **Steven**'s bed-sit	Police attended. *Q* would not leave 8 Blowinghouse Close
Three days later **Steven** 'phoned the police to convey his concern for Darren who was depressed…later called to say *Darren* had returned	Police attended. All in order
In **January 2006 Steven** made a scene outside a take-away about poorly cooked food	Police attended. No offences disclosed
In **January 2006** *R* 'phoned her Leaving Care Social Worker to report that *Darren* had hit her and thrown a cup at her…she said that she was frightened of *Darren*…stated that she was living at 8 Blowinghouse Close with *Darren* and **Steven**	Advised to go to police if *Darren* threatened her. Police Management Report states, *'R and Darren have been living at 8 Blowinghouse Close with **Steven**…Darren is significant risk to females…R given accommodation by social services [i.e. Department of Children, Young People and Families] and property removed from 8 Blowinghouse Close…R discloses growing intimidation…turning into physical attacks*
In mid **January 2006** 'phone call from ambulance control to the police stating that they had been contacted by Darren at 8 Blowinghouse Close re **Steven's** possible head injuries. Request due to *'warning marker' against Darren for violence against ambulance*	Police and ambulance attended. **Steven** taken to hospital
In late **January 2006** Ocean Housing Officer visited **Steven** (*'unsure about presence of Darren and Sarah')* in response to a complaint from him about damage to his front door	Neighbours denied their role in the damage to property.
In late **January 2006, Steven** 'phoned the police to tell them that *Darren* was missing. He claimed that *Darren* was a friend and that he gave him a place to shower and sleep 2 or 3 times a week	Police attended. **Steven** was told that no action would be taken
In **February 2006** ambulance control 'phoned the police stating that a unit was attending 8 Blowinghouse Close. *Darren* was self harming by cutting his wrists. The following day **Steven** 'phoned the police stating that *Darren* had left a suicide note having taken tablets. He had stated his intention to jump off a	No concerns raised. Minor cuts *[Darren*] deemed to be of sound mind; *Darren* located by police and taken to hospital [where he was] kept overnight

cliff	
In mid **February 2006** *Darren* called for ambulance for **Steven.** Two days later a call from ambulance control to the police. Woman at 8 Blowinghouse Close coughing blood	Police attended with ambulance. **Steven** taken to hospital. Refused treatment…all units left
Two further days later **Steven** was visited by his Social Worker and his Social Work Assistant about whether it was necessary for him to be escorted when he met with his mother. [Contact with the police regarding this matter led to them informing the Social Worker about the two occasions in the week when there had been ambulance escorts to **Steven'**s flat]	They discussed **Steven's** supervised contact with his mother and recommended that it was no longer necessary for **Steven** to be escorted. The associated '*specialist assessment'* indicates that **Steven**, *'does enjoy drinking at home and we are aware that he also takes some illicit drugs.'*
In **April 2006** an Ocean Housing Officer visited **Steven** with a probationary Police Officer (who was on placement with Ocean Housing) to discuss change of probationary tenancy. *Sarah* and *Darren* were present and *Darren* admitted that he was living at the bed-sit; *Darren* rang the police to state that *Q* was at 8 Blowinghouse Close and had caused damage	**Steven** was advised that his probationary tenancy was being extended *'because there were some concerns over how he conducted his tenancy;'* Police attended*. Q* removed from address to prevent further problems
At the end of **April 2006, Steven** stopped receiving Housing Benefit and rent arrears began to accrue	
In early **May 2006, Steven** contacted his Social Work Assistant to ask for help completing a form (re housing). He said that he was having difficulty settling in St Austell and wanted a *'swap'* to be near his mother. On the same day he visited a local Adult Social Care Office asking for £20 for food and stated that he had been *'taken advantage of'*	Social Work Assistant liaised with the Care Manager, and **Steven** was given £20. No inquiries were made about who was exploiting **Steven**.
Three days after contacting Adult Social Care, **Steven** contacted the Police stating that *Darren* and *Sarah* were *'pestering'* him as they wanted to stay at his bed-sit. *Darren* had previously contacted the police to state that his girlfriend *Q* had been *'assaulted by Steven;'* all had been drinking	Police attended and sent all parties on their way…suitable advice given to **Steven** if others attended 8 Blowinghouse Close
In mid **May 2006** *Sarah* 'phoned the police stating that **Steven** and *Darren* had been assaulted; the alleged perpetrator contacted the police as	Police attended. All parties spoken to. No offences disclosed and suitable advice given

well and stated that *Darren* had threatened him with a knife	
The following day *Darren* 'phoned the police to report an *'aggressive'* male outside trying to get him	Police attended…ongoing dispute…advice given
Towards the end of **May 2006, Steven** 'phoned the police to report a neighbour who was threatening to burn his house down; days later, his neighbour threatened him with a knife	Police attended and spoke with **Steven** and neighbour. Advice given; Police attended. All parties spoken to. **Steven** in drink
In **June 2006, Steven '**phoned the police to report (another) neighbour who had threatened him, citing his loud music; a referral from Department of Children, Young People and Families to the Joint Consultancy Team arose from *Sarah's* midwife. *Sarah's* family were concerned that *Sarah's* boyfriend was known to the police, that they were staying with **Steven**, *'a known sex offender,'* and that young boys frequented the bed-sit	Police gave suitable advice; Police confirmed that **Steven** was *not* a Schedule One offender and determined that there should be a s.47 strategy meeting about the young boys. *'Strategy discussion:* *St. Austell Children Young People and Families and police – police to follow up.'*
Towards the end of **June 2006 Steven** 'phoned the police to inform them that he had been threatened with a knife when he went to get a DVD. Steven *'in drink'*	Police attended. All parties spoken to. Officer did not believe knife was used. Believed that **Steven** was *'trying to use this to get a house move.'*
In late **June 2006**, **Steven's** neighbour contacted Restormel Borough Council to complain about the noise emanating from **Steven's** bed-sit	A standard warning letter was issued to **Steven** from Restormel Borough Council and Ocean Housing Ltd. were informed
On **2 July 2006,** the Fire and Rescue Service contacted the police to inform them of a small shed fire at the rear of **Steven's** bed-sit	Police attended and spoke with **Steven**. '*Not crimed as arson*.' Ocean Housing Ltd. notified
On **3 July 2006,** neighbours sent a petition of 20 signatures to Ocean Housing Ltd. about the noise emanating from **Steven's** bed-sit; *Sarah's* step-father contacted Ocean Housing Ltd. to express concern for *Sarah's* welfare	
On **5 July 2006** a neighbour rang the police to inform them that the men from 8 Blowinghouse Close were burning bin bags from the shed; in the early evening **Steven** was recognised by the security officer of a large store regarding a shoplifting incident of 1 July when **Steven** had taken some lager. **Steven** admitted his involvement in the shoplifting and	No attendance deemed necessary; **Steven** was allowed to return home as he was willing to repay the price of the stolen goods…the police decided to interview him at a later date i.e. when he was sober.

told store staff that he did not want *Sarah* involved in the shoplifting offence because *'Darren would not be happy… In the past Darren has pinned me to the settee and slapped me for no reason…I don't want to go to the flat straight away because of what Darren might do.'* Store staff referred to **Steven** as *'agitated'* and *'shaken'* when the conversation hinged on his home. Police arrived at 7.10 pm…**Steven** smelled of alcohol and his speech was slurred. When asked who accompanied him he told them 'Sarah Burke' and explained that she was staying with him and *Darren* at 8 Blowinghouse Close. **Steven** said, *'Don't tell them I gave you their names otherwise they won't be very happy about this.'* An officer described **Steven** as *'very nervous'* about the others knowing what he had said	

4.5 These sets of events and responses reveal an incomplete picture of Steven's circumstances before his murder. Within weeks of becoming a tenant, Steven's bed-sit was not his own. Once Darren and his girlfriends moved in, and young people began to *'hang around'* there, Steven literally had nowhere within his own home to which he could retreat – his bed-sit was a single room with a small bathroom. The presence of others accelerated the erosion of his freedoms. Neighbours associated Darren's arrival with persistently loud music. Prior to this, Steven's bed-sit was not associated with noise nuisance. Table 5 conveys a little of the drama of living in what became a multi-occupancy room with Darren, girlfriends and teenagers keen to sample, *inter alia*, underage drinking. Also, it confirms that Steven was unequal to protecting himself from Darren's influence. Even though he did not have an instinct for a mutually-rewarding friendship, he knew in December 2005 and May 2006 that he had to leave St Austell and create some adaptive distance between himself, Darren and his associates.

4.6 Tables 3 and 4 should be considered alongside the above table. It will be recalled that Darren was an excessive user of all NHS services and further, that he did not hesitate to call the police and threaten to kill himself. A master of interpersonal power, he compelled the obedience of those weaker than himself with violence and threats of violence (e.g. Person 2002). Layer onto this the traffic of girlfriends, some of whom resided in Steven's bed-sit, and other anchorless teenagers, and we glimpse something of Steven's circumstances.

5. The Overarching Lessons Learned

5.1 Even the initial meeting of the Serious Case Review Panel confirmed there was no lack of information about Steven and his circumstances and that with better inter-

agency working, Steven Hoskin would have been spared the destructive impacts of unrestrained physical, financial and emotional abuse in his own home. While this knowledge cannot change, erase or soften what happened to Steven, it was an impetus for Cornwall Adult Protection Committee and its partner agencies to analyse what went so badly wrong. As uncomfortable as this process has been, it leads to learning, i.e. our purpose has not been one of judgement but of correction and improvement (Dixon 1999).

5.2 All agencies have legal responsibilities not only to prevent harm being caused by their own agents, but to safeguard vulnerable people against the harmful actions of third parties. What is striking about the responses of services to Steven's circumstances is that each agency focused on single issues within their own sectional remits and did not make the connections deemed necessary for the protection of vulnerable adults and proposed by *No Secrets* (Home Office/ Department of Health 2000).

5.3 Failure to take reasonable and appropriate 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 protection 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. In order to conform to their obligations under human rights law, agencies have to be proactive in undertaking risk assessments (e.g. Monahan *et al* 2001) to ensure that preventive action is taken wherever practicable.

5.4 Steven's visits to primary care increased when he discontinued his Community Care Assistant support i.e. at a time when he was losing control in his own life. Significantly too, his contact with the police commenced once he had discontinued his Community Care Assistant support. The Disability Rights Commission (2005) confirmed that the health of people with learning disabilities is likely to be worse than that of other people, (even before taking into account specific health needs or disability related barriers to accessing health care), as they are *likely to live in poverty..*and are exceptionally *socially excluded.*

5.5 Steven's visits to NHS primary and secondary care, most of which were unaccompanied, were atypical, given that adults with learning disabilities tend to *under-use* health services. If primary and secondary healthcare personnel had been attuned to Steven's learning disability, arguably his visits could have been regarded as 'alerts.' A physical assault is a traumatic event and yet Steven went home alone from a Minor Injury Unit. Furthermore, Steven's alcohol abuse did not evoke the necessary 'alert' from any external to healthcare personnel. Although primary and secondary care personnel knew that Steven was drinking to excess, no decisive action ensued. He was not a patient who could, or should, have been expected to initiate contact with drug and alcohol services.

5.6 Steven became a heavy user of emergency services and Darren was a prolific and intensive user of emergency services. The emergency services did not appear to regard themselves as potential 'alerters' or even as the recipients of direct and indirect requests for assistance. In contrast, Steven visited Adult Social Care on only

two occasions in May 2006 and Darren visited the Department of Children's Social Care, on five occasions in 2006.

5.7 Steven Hoskin's murder has occasioned sorrow and distress among the families of those who were associated with the events surrounding it and among the many professionals who had a duty of care to him. Many lives have been transformed as information has emerged regarding the slow build-up of catastrophic events in 8 Blowinghouse Close. Steven's family are supporting Steven's mother, who still mourns the fact and circumstances of her son's murder. As Sarah's step-father, who had sought to engage the interest of several agencies, noted, *'as you can see, trying to follow the correct channels in this country seems to be a consistent dead-end.'*

5.8 The Serious Case Review considered the 'filters' through which information was received and addressed by individual agency personnel. Not all staff receiving and collecting information made it available to others in their organisations or, as importantly, to partner organisations. Individual agencies did not have access to what other parts of their organisation and other agencies knew. Each held a piece or pieces of a jig saw puzzle without any sense of the picture they were creating, or indeed the timeframe within which the puzzle had to be completed. Communication is an interactive process. Information senders need to know that their information has been received and should confirm to what use it has been put. It is not enough to send or 'leave' a message. This leads to the error of assuming that information that has been passed on or shared will be 'known' by recipients. This error prevailed in Cornwall.

5.9 The anti-social behaviour associated with Steven's bed-sit after Darren and associates had moved in did not come to the attention of the Crime and Disorder Reduction Partnership which should bring together a number of key agencies. In fact, the police, the Department of Children, Young People and Families as well as Ocean Housing Ltd. were separately aware of the presence of young people in the bed-sit or *'hanging around'* the address and of the damage to the property and yet no collective action was taken beyond repairing the property.

- Police attendances at Steven's bed-sit;
- 'missing person' checks;
- a complaint to Ocean Housing about the presence of young people outside the address and, subsequently, noise levels emanating from the address;
- the local authority's records of short term and permanent exclusions from schools;
- Restormel Borough Council's records of environmental enforcement action regarding noise levels;
- NHS ambulance trusts' records of emergency calls;
- records of presentations at Accident and Emergency Departments; and
- the Fire and Rescue Services' records of emergency calls

provide valuable intelligence (see Audit Commission 2006) and yet no crime reduction activity was initiated. This is all the more remarkable, given the amount of time and resources taken up in responding to individual calls, complaints and expressions of concern with respect to 8 Blowinghouse Close.

5.10 Bullying and victimisation among children and young people, including sexual bullying, remain areas in which we may have school-level policies, but which appear

apparently devoid of effective strategic interventions. The consequences of these extend far beyond individual suffering. How young people occupy themselves when they are not at home or at school has to move up the political agenda. Young people were bit-part players in Steven's torture. Two left, two contributed, but none of them reported what they had witnessed to the police. Steven's torture seems to reflect unthinking and imitative behaviour by unguided and inexperienced young people. Steven's attendance at services from the Department of Children, Young People and Families, alongside young people with whom he associated, should have raised questions, particularly given work by MENCAP (re bullying) which confirms that groups of young people are not renowned for their compassion towards adults with learning disabilities. Necessarily, the Department of Children, Young People and Adults have to 'look out' for young people. They must be alert to the possibility that the same young people may be harming those more vulnerable than themselves.

5.11 Taking an overall view of Steven's life, once he had left his mother's home, there is little that is reassuring in terms of public policy. *Valuing People* (2001) identified *Independence* as a *key principle* and helpfully confirmed that:
While people's individual needs will differ, the starting presumption should be one of independence, rather than dependence, with public services providing the support needed to maximize this. ***Independence in this context does not mean doing everything unaided****.* (p23) (emphasis added)

5.12 A classification of *learning disability* should imply support needs throughout the life course, most particularly for those who are without protective social networks, day to day routines and/ or the geographical proximity of families who are able and willing to assist. As with all those who share this classification, there was more to Steven than the uniquely powerful term of *learning disability*. It is descriptively crude and ignores people's substantial diversities. Steven wanted friends. He did not see that the friendship he had so prized was starkly exploitative, devoid of reciprocity and instrumental in obstructing his relationships with those who would have safeguarded him.

5.13 It is essential that health and social care services review the implications of acceding to people's 'choice' if the latter is not to be construed as abandonment (e.g. Flynn, Keywood and Fovargue 2003). Steven's 'choice' to terminate contact with Adult Social Care was not investigated or explored with him, or other key agencies involved in his care, even though such choices may compound a person's vulnerability; may be made on the basis of inadequate or inappropriate information; or result from the exercise of inappropriate coercion from third parties. Steven's murder has confirmed that the choices of adults with learning disabilities in relation to their health care decision-making (Flynn, Keywood and Fovargue, 2003) can be transposed to social care as follows:

- *`the process of determining that people are making 'choices' is frequently neither specific nor very explicitly discussed;*
- *the discourse of 'rights' and the ideology of 'normalisation' are often implicated in the guise of people's 'choices';*
- *the 'choices' are often not discussed with people's GPs, members of Primary Care Teams, support personnel in routine contact;*
- *the fatal complications of 'choices' are not always considered'.*

(based on Keywood et al 1999, p47)

5.14 *Valuing People* (2001) defines 'choice' as follows:
`*Like other people, people with learning disabilities want a real say in where they live, what work they should do and who looks after them. But for too many people with learning disabilities, these are currently unattainable goals. We believe that everyone should be able to make choices. This includes people with severe and profound disabilities who, with the right help and support, can make important choices and express preferences about their day to day lives'.* (p24)

5.15 In a section headed' *Protecting Vulnerable Adults*,' *Valuing People* states:

`*People with learning disabilities are entitled to at least the same level of support and intervention from abuse and harm as other citizens. This needs to be provided in a way that respects their own choices and decisions'.* (p 93)

5.16 The definition of choice in *Valuing People* sets no boundaries on people's choices and neither does it make a distinction between life-transforming choices such as moving home, moving in with a partner or such lesser life-transforming, though important, choices as *'tea or coffee?'* While no service, whether health or social care, which support adults with learning disabilities advertises its aims in terms of '*admit no restraints...adopt an attitude of non-interference...promote unfettered independence'* (Keywood *et al* 1999), effectively, this is what happens when 'choice' is advanced as a rationale for setting aside a duty of care and/or discontinuing a service. The police reported Steven's circumstances in the months preceding his murder as follows:
`*Steven Hoskin had lost all control of his own life within his home. He had no say, choice or control over who stayed or visited the flat. He had no voice or influence over what happened within the premises. Darren Stewart had recognised the clear vulnerability of Steven Hoskin and had 'moved in' on him…he recognised the opportunity for accommodation and removed from Steven Hoskin the little ability he had to make his own choices and decisions. Darren Stewart was fully aware of Steven's vulnerability and learning difficulties and took advantage of those facts to control both Steven and the premises'.*

5.17 It follows that it is not possible to underestimate the influence of competent assistance offered to adults with learning disabilities living alone – the routine availability of known people; the basic decency that they can and do model; their talent for doing things with, and not merely for, people. This needs endorsing for what it is, *concerned vigilance* (see Grant and Ramcharan 2007) and essential protection. At its best it is attentive, affirming and valuing, and it must be long term.

6. Conclusions

6.1 At every stage following Steven's departure from his family home, from the comparative safety of his rural community, to Newquay and then to St Austell, all Serious Case Review contributors could have been potential rescuers, but every part of the service system had significant failures in this role.

6.2 Emergency services feature large in this Serious Case Review. It forcibly brings the commissioners and providers of health services and the police to the foreground. They were Darren's first port of call and, perhaps under his influence, they became Steven's as well. Steven's murder presses the case for ever–greater investment in partnership working in safeguarding adults (Perkins et al., 2007). This cannot be regarded as the sole responsibility of Adult Social Care.

6.3 The term *'disability hate crime'* fails to recognise the duration of Steven's contact with his persecutors; the counterfeit friendship; the background to Steven's perilous disclosures to Darren; the joyless enslavement; or the motivations of all of his persecutors. Steven's murder has profound implications for the support of vulnerable adults in our communities. It challenges the 'principle', or dogma, of 'choice' for adults who are apparently 'able;' it unstitches some certainties about communities – their capacity to 'look out' for others, their familiarity and permanence; and it requires us to question why the ever- tightening eligibility criteria of services are rendering very vulnerable men and women so unprotected. The fact that individuals in all agencies knew that Steven was a vulnerable adult did not prevent his torture and murder.

6.4 Serious Case Review colleagues have been willing to explain and amplify the weaknesses of their own agencies. This does not imply that these agencies are without merits or strengths or that they are wholly culpable, but is intended to convey their acknowledgement of their individual and collective under-performance, and what has to change in the light of the magnitude of cruelty experienced by Steven.

7. Review Recommendations:

7.1 The following recommendations for improvement are at three levels: ***system wide adult protection***; ***agency; and individual***.

7.2 System wide recommendations:

7.2.1 **1. The Chair of the Cornwall Adult Protection Committee raises with the Department of Health the need for all local authorities to be required to set up an Adult Protection Committee.** The safeguarding systems for children and adults are poles apart in terms of profile, performance and working in partnership. Getting child protection practice right is a key performance concern for local authorities but safeguarding adults is a poor relation in terms of profile, funding and resources. Currently**,** paragraph 3.4 of *No Secrets* only requires that *'…agencies may consider there are merits in establishing a multi-agency management committee (adult*

protection) which is a standing committee of lead officers.' This contrasts starkly with the requirements set out in the Children Act 2004 that each local authority with responsibility for social services must establish Local Safeguarding Children's Boards.

7.2.2 **2. The Chair of the Cornwall Adult Protection Committee raises with the Department of Health the need for a statutory duty to *cooperate* with Serious Case Reviews.** Although the critical role of primary care is well established in addressing the physical and mental sequelae of abuse (BMA 2007), this text makes no reference to the lead agency role of local authorities in England and Wales in respect of the connection with safeguarding vulnerable adults (i.e. ADSS 2005), yet it is important to remember that the obligations to respect the confidentiality and privacy of vulnerable adults apply similarly in health and social care domains. This means that the obligation is not absolute and may be over-ridden when disclosure is necessary to protect a person from the risk of harm. A person termed a vulnerable adult is regarded as being at such a risk and so information sharing, insofar as it is necessary to safeguard against that risk, is required. It was not until three-quarters of the way through the Review that the Primary Care Trust could access Steven's patient records, so unpractised is the process of scrutiny of patient records with respect to Serious Case Reviews. Delays in information-sharing highlight the lack of familiarity with the process of Serious Case Reviews with respect to vulnerable adults (as compared to the processes for protecting children).

7.2.3 **3. The Chair of the Cornwall Adult Protection Committee raises with the central government the need, where appropriate, for Serious Case Reviews to have access to court transcriptions without charge**. It was only three-quarters of the way through the Review process, that the Chair learned certain facts which had been revealed during the trial which again illustrated his prolific and intensive use of emergency services.

7.2.4 **4.The Chair of the Cornwall Adult Protection Committee raises with the Department of Health the need for clear risk criteria and 'thresholds' needed with respect to safeguarding vulnerable adults corresponding to those for the protection of children**. If clear 'thresholds' are set out, such as, for example: any more than three presentations to A&E/Minor Injury Unit (MIU) services by a vulnerable adult within a period of three months; or any vulnerable adult who presents to A&E/MIU services having been assaulted/ having taken an excess of drugs and/ or alcohol, then, the vulnerable adults concerned should *always* be referred to Adult Protection services and the Department of Adult Social Care. Although all the agencies working with Steven knew that he had a learning disability, or learning *difficulty*, they did not appear to regard him as a vulnerable man. Steven disclosed in disguised ways the fact that he was distressed (e.g. *I can't settle in St Austell;* through his escalating drinking); and in explicit ways, the fact that he was subject to abuse (e.g. *I have no money;* unpaid rent; and through his increased contact with the NHS and the police). None of these facts triggered an adult protection 'alert' or the partnership working that is so critical to safeguarding vulnerable adults.

7.2.5 **5. The Chair of the Cornwall Adult Protection Committee raises with the Home Office the need for Police Domestic Violence services not to be limited to**

adults only. The current situation does not take account of young women and men under the age of 18 who reside with violent partners but who may not be protected by child protection procedures.

7.2.6 **6.The Chair of the Cornwall Adult Protection Committee raises with the Department of Health that any life-transforming decisions (or 'choices') by a known vulnerable adult – such as discontinuing a support service - should result in assessments of a person's *decision-making capacity***. A person's refusal to receive care and welfare support has legal force when: it is made by a person with capacity; it is premised on appropriate information about the consequences of disengagement; and it is made free from duress. Minimally, Steven's 'choice' should have prompted a dialogue in order to ascertain the circumstances surrounding his decision, the factors that prompted the decision to discontinue his social care support, and to consider whether a more effective working relationship with Steven could be created.

7.2.7 **7.The Chair of the Cornwall Adult Protection Committee raises with the Department of Health that the shift to self-directed care for vulnerable adults living alone (e.g. Direct Payments Recipients and those receiving Individual Budgets), should always be accompanied by the monitoring of their personal safety**. To be vulnerable is to be in circumstances defined by the continuous possibility of harm or threat (e.g. Flynn 2005). *'No Secrets'* makes it clear that monitoring safety is a multi agency responsibility. The key to protecting and safeguarding vulnerable adults is sharing information, so any professional - who comes into contact with a vulnerable adult should be able to determine immediately if, and when, other agencies are involved and has a duty to share concerns. There were no such consequences arising from the numerous instances when Steven and Darren came to the notice of NHS services or the police.

7.2.8 **8. The Chair of the Cornwall Adult Protection Committee raises with the Home Office the need for improved national guidance regarding people with a criminal offence history being diverted to the mental health services**. Recourse to the Mental Health Act as a means of 'diverting' mentally disordered offenders into health services does not mean that criminal justice agencies should relinquish their involvement in addressing the offending behaviour of people like Darren Stewart (see Laing,1999; Greenberg and Haines, 2003).

7.2.9 **9. The Chair of the Cornwall Adult Protection Committee raises with the Department of Health the true extent of the restriction of access to services for vulnerable people, in the light of the anticipated review of *Valuing People*.** Living in communities signals neither acceptance nor the inevitability of respectful friendships. Steven was bullied and victimised as a young man and was pained by the teasing he invoked. It made him acutely conscious of being different from other men. Flynn (1989) confirmed that adults with learning disabilities living in their own tenancies were vulnerable to victimisation, most particularly in localities of 'hard to let' tenancies; that these men and woman were wary and scared of young people; and that most experienced loneliness and isolation. Departments of Adult Social Care cannot be expected to 'look out' for all citizens with learning disabilities without the resources to do so. *Fair Access to Care* criteria are known to be rendering more

and more vulnerable adults ineligible for ongoing support.

7.3 Agency recommendations:

7.3.1 **10. Intelligence regarding 'warning markers' against individuals should be shared within the NHS and externally with services in direct contact with vulnerable adults e.g. Adult Social Care.** There is no evidence that services in regular contact with Darren were aware of the ambulance services' *'warning marker'* that he was dangerous and that they were seeking police attendance when he made emergency calls. The police informed Ocean Housing Ltd. of Darren's dangerousness in November 2005, simply because an Ocean Housing Officer shared information with them about alleged substance misuse at 8 Blowinghouse Close.

7.3.2 **11. All agencies associated with Serious Case Reviews should invest in processes which systematically investigate the events leading to the Review**. In this case, it was helpful to the Review that Cornwall County Council had commissioned an *Internal Management Review* of its services. This ran concurrently with the Serious Case Review. The *Internal Management Review* uncovered facts that would otherwise not have been known to the Serious Case Review.

7.3.3 **12. In parallel with the work of the National Confidential Inquiry Team, the Strategic Health Authority should commission a Homicide Inquiry and seek to determine: a) why Multi-Agency Public Protection Arrangements** (**MAPPAs) were not employed;** and **b) the reasons for the failure to engage with the fact of domestic violence, as experienced by Darren's girlfriends and children.** The statutory arrangements for limiting re-offending by sex and violent offenders were not employed with respect to Darren Stewart after 2000. Although Darren's pregnant girlfriends were not spared assaults during their pregnancies, domestic violence services did not feature in the assistance they were offered (with the exception of girl friend R, who was assisted to move to a women's refuge).

7.3.4 **13. The Director of Adult Social Care and the Chief Executive of the Primary Health Care Trust should develop a joint understanding of the expenditure necessary to support vulnerable adults in the community**. It is disquieting that Steven might not have received a service in Cornwall in 2007-2008. In 2006-2007 the relative spend per head of population by Cornwall County Council for learning disability social care services was £38, compared to an average across 34 shire counties of £56. Thus Cornwall County Council had *the lowest spend per head of population* for any shire county.

7.3.5 **14.Devon and Cornwall Constabulary and the Primary Care Trust should adopt the Department of Health term, *learning disability* to limit the scope for any potential ambiguity about a person's long term support needs and status as a vulnerable adult.** The words we use matter a great deal. It is striking that the Devon and Cornwall Constabulary and Primary Care Services knew Steven as a man with *learning difficulty.* The Department of Health adopted the term *learning disability* in 1992, not least to set aside the term 'mental handicap.' The merit of *learning disability* is that it suggests enduring, i.e. life-long, support needs. In contrast,

professionals may assume that a *'learning difficulty,'* may manifest as a slight set-back such as illiteracy.

7.3.6 **15. The Department of Children, Young People and Families and the Devon and Cornwall Constabulary should collaborate in determining a shared approach to concerns regarding young people who associate with dangerous men and engage in underage sex.** While Children's Services were effective in protecting Darren's children, it appears that a different standard of evidence was applied to the circumstances of the young girls, who legally were children too, with whom Darren had sex. What would have happened if *all* of Darren's girlfriends had been in the care of the local authority? Had Children's Services properly assessed the living circumstances of Darren's girlfriends, they would have learned that Steven was a man with support needs himself.

7.3.7 **16. The Local Medical Committee should become party to Cornwall's Adult Protection Committee.** The task of safeguarding vulnerable adults has to secure the engagement of General Practitioners.

7.4 Individual:

7.4.1 17. Sarah's parents should be separately invited by
- **the Department of Children, Young People and Families,**
- **Ocean Housing Ltd.; and**
- **Devon and Cornwall Constabulary**

to engage with and comment on the recommendations and action planning of these agencies. They should also be offered support to contribute to such work. The written account of Sarah's parents' unheeded efforts to engage the interest of the Police, Ocean Housing Ltd. and the Department of Children, Young People and Families into Sarah's circumstances confirms how this continues to distress them.

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