Learning from the death of Lee Irving

Newcastle Safeguarding Adults Board
“Ensuring Newcastle is an increasingly safe city for adults at risk.”
Lee’s Life

• Lee had a statement of Special Educational Need from age 4 and was diagnosed with a Learning Disability at the age of 16.

• Often rejected the diagnosis of a Learning Disability

• Lee was keen to make friends and to attain a sense of belonging within a social circle.

• By 2014 it was reported that Lee was being exploited by those he lived with.

• Lee was found dead on 6 June 2015. Post mortem examination shows that Lee had suffered extensive injuries which had occurred over a period of weeks leading up to his death.
What could have been better?

1. Mental Capacity Assessments
   • Defining the decision to be assessed – ability v’s capacity.
   • Best Interest decisions and the need to realise when urgent action is required.

2. Multi-agency working
   • Professionals worked well but could have worked more cohesively and shared a collective responsibility.

3. Using the Safeguarding Adults Process
   • Whilst work was being done to manage risk, safeguarding adults procedures were not always being used.
What went well?

1. “All agencies involved with Lee Irving recognised his disability and tried hard to deliver a service in difficult circumstances.”

2. Engagement and commitment
   - Examples of good practice in engagement with Lee, this included.
   - Inviting Lee to attend meetings.
   - Extensive contact with Lee and his family.

3. Person Centred
   - Evidence of a person centred approach throughout contact with Lee.
   - Clear that Lee’s views were at the centre of decision making.
### Recommendations

<table>
<thead>
<tr>
<th>Transition</th>
<th>Partnership</th>
<th>Thresholds</th>
<th>Mental Capacity Act (2005)</th>
<th>Engagement</th>
<th>Training</th>
<th>Social Media</th>
</tr>
</thead>
</table>

- Lee’s family described the way in which professionals were able to respond to Lee as an adult as difficult to understand.
- “Protection that children’s legislation affords is replaced by legislation applicable to adults which inevitably means there needs to be a higher regard for an adult’s autonomy and involvement in decision making.”
National Picture

Factors

Previous Incidents

Opportunist Criminal Offending

Cruelty Humiliation Sustained Attacks

False accusations

Perpetrators as “friends”

Escalation
Mate Crime and Safeguarding Adults

Problems with the use of the term “mate crime”

• Potential to make it sound less serious
• Not reported if threshold for crime not met
• Importance of safeguarding, early intervention and prevention.
“New approaches are needed that enhance social capitol, in particular in helping people with learning disabilities to create relationships, ties and bonds within their communities. Practitioners working in housing, police, care and support, local authorities, schools and voluntary organisations have a key role in developing and delivering these community-based approaches. There is also a wider social responsibility. As people are challenged by today’s self-actualising culture to stretch their professional and emotional boundaries, so they must also be challenged to step out of their comfort zones, to reach out and stand up for their fellow citizens – people with learning disabilities who need friendship, kindness and respect – not just the well meaning support of professionals.”

• Lemos and Crane – Loneliness and Cruelty (2012)
Key messages for VCS

• Recognise and report abuse of this nature
• Abuse does not need to be a crime to be reported via safeguarding adults procedures
• Clear understanding of the Mental Capacity Act and its application
• There are circumstances when the adult at risk’s consent has to be overridden
• Follow best practice approaches when engagement with a person is difficult or challenging
• VCS likely to play an important role in combatting loneliness and social isolation