Practice review report: **Steven Hoskin murder**

These case studies are intended to raise issues in a practical application; bringing together the critical factors, particularity around multi-agency working. They will help to contextualise risk factors and raise questions about prevention within situations of known abuse, neglect and harm. They have been summarised to assist in this process, but more information is available in the actual review reports.

Context and background of review

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.

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' and links have been made with the deaths of others with learning disabilities with known support needs.

Circumstances of, and challenges faced by, the individual

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'.

What happened?

Steven was placed in a bedsit by adult social care in April 2005. He was allocated two hours of help each week but he chose to cancel the service in August, and by September, the council closed his case.

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.

Why it happened?

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 had an extensive and prolific use of emergency services frequently appearing in accident and emergency departments yet this did not trigger any suspicions.

Report recommendations

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.

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 Cornwall Adult Protection Committee 27 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.

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.

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.

These are not the full set of recommendations.

Citation www.cornwall.gov.uk/media/3633936/Steven-Hoskin-Serious-Case-Review-Exec-Summary.pdf