Mate Crime – Good Practice Guidance

Mate Crime Definition

When a person is harmed or taken advantage of by someone they thought was their friend.

What Mate Crime May Involve

1. Financial Abuse -

    - The perpetrator might demand or ask to be lent money and then not pay it back
    - The perpetrator might misuse or borrow and not return the property of a person
    - When the person has received their benefits and been shopping the perpetrator may visit and clear the cupboards of food and alcohol

2. Physical Abuse -

    - The person may be kicked, punched etc for the amusement of the perpetrator and others
    - The person may be seriously injured or ultimately the abuse may result in death

3. Emotional Abuse -

    - The perpetrator might manipulate or mislead the person
    - The perpetrator might make them feel worthless
    - The perpetrator might call them names
    - The perpetrator might groom the person for criminal offences

4. Sexual Abuse -

    - The person might be coerced into prostitution
    - The person might be sexually exploited by someone they think is their partner or friend
    - The person might be persuaded to perform sexual acts they do not feel comfortable with

Signs and Symptoms

- Unexplained injuries
- Bills not being paid/sudden loss of assets
- Weight loss
- Isolation from usual contacts

- Withdrawal from services
- Changes in behaviour or mood
- An overly critical or disrespectful friend

Vulnerable adults often do not recognise that they have been the subject of mate crime. The focus of enabling safety needs to be on encouraging an understanding for the individual of their right to make choices, but also their right to remain free from abuse.

Action to Take if Mate Crime is Identified

- Talk to the service user. What are their views and concerns?
- Appropriate action should be taken to ensure the safety of the victim
- If a crime is suspected, Police must be informed regardless of whether the victim is in agreement
- Consider whether the Safeguarding process should be started
- Information from other agencies should be sought
- If the victim receives Direct Payments and the money is being abused, seek advice from the Direct Payments Team e.g. would a 'managed account' be more suitable
- Investigate if the victim needs assistance with cancelling bank cards etc
- Offer assessments/support as appropriate

Preventative Action

- Consideration should be given as to whether the safeguarding process should be started when suspicions are raised rather than waiting for hard evidence
- People need to be enabled to feel they are part of the community
- Mate crime statistics need reporting (appropriate completion of AIS safeguarding module)
- More training needs to be given, including use of MCA, within all professional agencies
- Raising community awareness of Mate Crime
- Establishing Mate Crime Champions within a variety of agencies who will link with other professionals, service users, carers
- Posters/leaflets to be given to those participating in the Safer Places Scheme

Partnership Working

Consider involving other agencies –

- Hampshire Police
- HCC Accredited Community Safety Officers
- Hampshire Fire and Rescue Community Safety Officers

- Housing Officers
- Community Health Services

Ideas for Raising Awareness

- Talk to groups of people who live in sheltered housing, extra care housing, supported living
- Show Mate Crime DVD
- Hand out information
- Talk to voluntary groups, social clubs, charities
- Share case examples with colleagues
- Distribution of posters e.g. care homes, offices, GP surgeries, Safer Places

Research has highlighted common factors in Mate Crime and Hate Crime

- Disabled people may be reluctant to report the crimes as they fear they will not be believed.
- There have usually been previous incidents which become regular targeting.
- Incidents are likely to escalate in severity and frequency – so services should aim to intervene at an early stage.
- Perpetrators are often 'friends', carers, acquaintances or neighbours and victims may be reluctant to sever the relationship.
- There may be multiple perpetrators who encourage the main offender.
- Perpetrators might make false accusations that the victim is a paedophile or 'grass'.

Cruelty, degrading treatment and humiliation is often related to the person's disability.

Summary of Good Practice

- Prevent potential victims being the subject of mate crime
- Identify when a vulnerable adult is the victim of mate crime
- Take action when concerns are raised
- Minimise the escalation of the mate crime through a protection plan
- Identify the individual(s) responsible for the crime
- Raise awareness amongst the public and professionals of mate crime

Additionally, promote the ethos of –

- Enhancing social networks for vulnerable adults

- Developing positive friendships and relationships within the community so that vulnerable people do not feel so isolated and therefore are less likely to be a victim of mate crime.
- Raising self esteem and increased self confidence through advice and guidance so that vulnerable people feel more able to protect themselves from abuse.

And further Develop Professional Practice by –

- Accurate recording of mate crime occurrences.
- Inter-agency sharing of good practice and learning outcomes.
- Assisting victims to indentify for themselves when they have been the subject of mate crime and empowering them to take appropriate action wherever possible.
- Taking action on behalf of those adults unable to protect themselves.

Local case studies

1) **Concern Raised -** Two male perpetrators from the Portsmouth area befriended a vulnerable adult with learning difficulties. The perpetrators were well known to the police for violence and theft. In this case they were financially abusing the vulnerable adult who gave them money when asked. He felt he had no choice but to do this. Fortunately he told his care worker what was happening and the details were passed to the police.

Response from Services - The police then made a referral to the Accredited Community Safety Officers with a request for them to visit the victim. With the agreement of the victim, weekly well being visits were established. This resulted in the perpetrators withdrawing once they became aware that Police and ACSO's were involved. The vulnerable male was pleased that people in the community cared and he could share his problems with people he could trust.

2) **Concern Raised -** A group of vulnerable adults meet on a weekly basis in a Community Centre. Some of these people live in residential care settings and some of them live on their own. The manager of this group requested a presentation from the Accredited Community Safety Officers about Mate Crime as members of the group had experienced Mate Crime and doorstep crime

Response from Services - The ACSO's visited the Group and gave a talk was aimed at raising awareness of Mate Crime within the group. The service users are now familiar with the ACSO's through regular visits and trust them resulting in the fact that they will now share information/concerns.

3) **Concern Raised -** It was discovered that unexplained withdrawals had been taken from a service user's bank account and concerns were raised that she was

allegedly being financially abused by a member of her family. The concerns were highlighted through a safeguarding meeting.

Response by Services - The care manager was asked to approach the bank to gain further details on how the funds were being taken from the individual's bank account and to explore safeguards that could be put in place. The bank at this point advised the care manager that they could not share any personal details without the service user being present. However, they did strongly recommend that the care manager came back with the service user as soon as possible (implying there was reasons to be concerned). The care manager returned with the service user and was able to talk to the bank manager. Due to the service user having a hearing impairment and the need for loud speech to be used, the care manager requested a private room and this was provided. This allowed the service user to be fully involved in the consultation, to give permission for information to be shared and for safeguards to be put in place. As the service user did not use internet banking or her bank card to make payments, these facilities were stopped on her account. The bank also advised that they could work with the police to trace whose computer was being used and the PPU visited the service user with the care manager to discuss this. However, the service user declined to proceed with further police involvement. Nevertheless, the service user also gave permission for the care manager to contact the bank manager at regular intervals to check there had not been any unusual activity on the account and the bank manager also gave her direct line number to aid in this.

4) **Concern raised -** A service user with a learning and physical disability was befriended by a group of young people. They borrowed money off her and encouraged her to claim to her insurance company that her lap top was broken, whereas in fact they had sold it.

Response from Services - With assistance, the service user was able to distance herself from this group of young people and join alternative social groups. However, although she recognises that she was taken advantage of, she still misses this group of young people, saying that they made her feel 'attractive' and 'normal'.

5) **Concern Raised -** A physically disabled service user entered into an on-line relationship with a female prisoner in another part of the country, regularly sending her sums of money. They arranged that he would go to visit her over a bank holiday weekend. However, prison staff were given intelligence that in fact this prisoner had passed on details of where the service user would be staying and his home address. It was suspected that he might be the target of robbery and/or burglary.

Response from Services - A social worker visited the service user together with a Police Officer and explained the situation. The service user decided to still go ahead with the planned visit, but agreed for safeguards to be put in place. It

was arranged for an agreed limit to be placed on the amount of money that could be withdrawn from a cashpoint in any one day, he would use taxis when transferring between the station/ hotel and the hotel/prison rather than using public transport. The local Police Beat Officer also kept an eye on the property whilst the service user was away. The visit went ahead successfully and the service user continues, as an informed decision, to send the female prisoner regular sums of money.

Mate Crime - Learning from Serious Case Reviews

The murder of Gemma Hayter (2010)

- Gemma had a learning disability, but had no formal diagnosis, so specialist health and social care services were not always available to her.
- Gemma herself was reluctant to access services. There were questions about her capacity but it was felt that she was able to decide on what help she wanted.
- Gemma had suffered mate crime regularly over some time. She was found dead on a disused railway embankment. She was 27. She had been forced to drink urine from a beer can, beaten with a mop and stripped before being left for dead by people she regarded as her 'friends'.
- The Serious Case Review found no evidence that her death could have been predicted or prevented, however opportunities were missed to get a clearer picture of her situation and to have provided support that might have made her less likely to fall into the company of those people.
- No single agency had the whole picture. None of the agencies involved knew the details of her relationship with the five killers. There had been a lack of information sharing.

Gemma's background

- As a child Gemma was diagnosed with a learning disability, with differing reports about severity, and as being on the autistic spectrum. She went to a special school for her secondary education.
- At transition she was assessed as meeting eligibility for access to social care services (FACS), however after the age of 18 she was subsequently tested and found not to have a learning disability or Autistic Spectrum Disorder, she was subsequently deemed ineligible for secondary health and social care services on the grounds that she did not have a diagnosed learning disability.
- She had difficulty making friends and was at risk of being exploited. In 2004 age 21 she lived in supported housing.

- Her tenancy broke down in 2006, and she was felt to be aggressive and un co-operative. She was referred to mental health services and was assessed in 2007/2008 as having a Conduct Disorder. Her CPN tried to refer her to Adults Services unsuccessfully, the CPN closed the case.
- Her lifestyle was becoming chaotic and she had involvements with the police.
- A police safeguarding referral to Adults Services resulted in the police being advised to contact the mental health services. However no safeguarding meeting was held and there was no on-going input from the mental health services.
- Gemma moved to another tenancy (Aug 2008) and received tenancy support funded via Supporting People.
- There was evidence of increasing self neglect, debts, chaotic life style and reluctance to engage with services. She had no job or day services opportunities. The 'friends' she spent time with were involved in petty crimes and drug and alcohol abuse.

<u>The Perpetrators – two couples and a single man</u>

- One of the women had known Gemma for 18 months prior to her murder
- All perpetrators were between the ages of 17 and 21
- DN (male) was known to Youth Justice and Probation for violent crimes and anti social behaviour, also known to mental health and subs misuse services though no diagnosed mental illness.
- CB (female) was violent, bullying and also the victim of domestic abuse, she lived with DN, and had a previous conviction of common assault.
- JL (female) known to police as a perpetrator and victim of crime
- JB (male) partner to JL, involved in drug use, known to police, in breach of his court order, not known to be violent.
- DE (male) had been convicted of 9 offences.

<u>Gemma's murder in August 2010</u>

- 7 August – Gemma was drinking with the 5 perpetrators and caused a situation which the 5 felt had spoilt the evening.
- 8 August – the group drinking and smoking cannabis, Gemma joined them in the early evening and was subject to serious and prolonged assaults over a period of 4 hours including violence leading to a broken nose and being forced to drink urine from a can – the perpetrators link their behaviour to the allegation (unsubstantiated) that Gemma owed money to CB .
- 9 August – in the early hours the group walked her to a disused railway line, Gemma was physically assaulted, stabbed and beaten to death.

Key findings

- "No evidence that Gemma's murder could have been predicted or prevented but if she had received and accepted better support, …she may have been less likely to fall into the company of people who presented her with serious risks".
- The statutory agencies were not aware of Gemma's involvement with the 5 perpetrators or that they were a risk to vulnerable adults.
- There was clear evidence that Gemma was vulnerable to the risk of abuse and vulnerable to mate crime.
- No single agency had a full picture of what was happening.
- There were missed opportunities for initiating safeguarding procedures or other interventions.

Lessons learned

- Right to assessment - Learning disability services should not have said Gemma was ineligible for services based solely on the fact that she did not have a diagnosis of LD – there should have been reference to FACS risk/needs led assessment. In Hampshire we have a Policy related to Vulnerable Adults (policy number… and link) which confirms our statutory obligation to assess the needs of any adult in need of assessment, irrespective of whether they have a diagnosis or fall clearly into a specific care group.
- Managing situations where service users dis-engage - there was no evidence of risk assessments being undertaken to inform the decision to close, instead there was over reliance on client dis-engagement/choice as reason for closure.
- Practitioners need more guidance on working with 'difficult to engage' service users – using assertive outreach approaches.
- It was assumed that Gemma had capacity to make key decisions, but no assessment of mental capacity undertaken. Professionals focussed on Gemma's 'right to choose' over their common law 'duty of care'.
- Low level safeguarding alerts did not always trigger full investigations – there is a need to recognise risk indicated by patterns of low level concerns.

The murder of Stephen Hoskins (2006)

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. On

the night of his murder, Steven had been found 'guilty' by the three people who murdered him of being 'a paedophile.' While this claim was without foundation it was determined by the perpetrators as the reason why Steven should die.

Steven Hoskin'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 a special school, returning to his mother at weekends. Steven did not read. After leaving school at 16, Steven was unable to secure employment and was admitted as an inpatient to an NHS 'Assessment and Treatment' unit for people with learning disabilities and mental health problems. 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. 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.

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. 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. He was seen a number of times by his GP and at A&E. 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. Steven also made increasing number of calls to the police during this period. His alcohol intake increased.

The Perpetrators – DS (male) aged 30 years old, SB (girlfriend to DS) aged 17, and MP (male) aged 21. DS 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. His misuse of alcohol and amphetamines and being 'on the move' came to characterise his adult life. Between 1998 and 2006 DS had five children with three teenage partners, all of whom were vulnerable. These were volatile relationships. At a Review Child Protection Conference it was stated that DS had a borderline personality disorder. He had a history of overdoses, arrests and detentions under the Mental Health Act.

Lessons learned

Poor inter agency communication

Not all staff receiving and collecting information made it available to others in their organisations or, as importantly, to partner organisations. 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.

Support to people with a learning disability who are socially isolated

A diagnosis 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. 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.

Dis-engagement with services

- 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.
- The process of determining that people are making 'choices' is frequently neither specific nor very explicitly discussed; sound assessment of mental capacity is required – to understand whether the choice to dis-engage was an informed one.

Known risk factors

- Patterns of low level concerns should be responded to before behaviours escalate.
- People living alone may be more vulnerable, particularly when the adult is associating with peers where the subculture has normalised drug misuse, crime, violence and mate crime.