RESTRICTED

Tendring County Community Safety Partnership

DOMESTIC VIOLENCE HOMICIDE REVIEW

EXECUTIVE SUMMARY

REPORT INTO THE DEATH OF:

Mrs F

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TENDRING DOMESTIC HOMICIDE REVIEW

EXECUTIVE SUMMARY

1 The Review Process:

1.1 This summary outlines the process undertaken by the Tendring Community Safety Partnership Domestic Homicide Review panel in reviewing the death of Mrs F a resident in their area.

1.2 Following a Police investigation and subsequent criminal trial Mrs F's son was convicted of her murder. He was sentenced to life imprisonment with a minimum tariff of 18 years.

1.3 The Review process began with a meeting called by the Chair of the Tendring Community Safety Partnership on 19 December 2012 where the decision was taken that the circumstances of the case met the requirements to undertake a Domestic Homicide Review. The Home Office was then notified of this decision as required by statute. The Review was concluded on 19 November 2013. This is over the statutory guidance timescale to complete a Review due to the criminal proceedings and a further delay in obtaining a key agency's Independent Management Review. The Review remained confidential until the Community Safety Partnership received approval for publication by the Home Office Quality Assurance Panel.

1.4 The Review has followed statutory guidance issued for the conduct of Domestic Homicide Reviews (DHR). A total of 11 agencies were contacted to check for any involvement with the parties concerned in this Review. There were 4 nil returns and 7 agencies confirmed involvement. Of the agencies confirming involvement with the victim or perpetrator all submitted a chronology of their contact except one. The one agency who did not contribute to the chronology formally was a voluntary sector service which had brief involvement with the victim. They provided dates and information relating to their contact which was considered a proportionate and appropriate contribution.

1.5 The Review chronology showed that at the time of the murder none of the agencies were involved with the perpetrator or the victim apart from the GP Practice which they both attended. Agencies involvement covered different periods over the time span investigated for the Review. Some of the accounts have more significance than others, but all contributions have assisted the Review.

1.6 The victim's most recent appointment prior to her death was with her GP; she was seen by the out of hour's doctor on 27 October and her GP on 29 October 2012. She also had a doctor's appointment booked for the day that she was discovered dead in her flat. The perpetrator's last contact with an agency was an overnight hospital admission for a physical ailment 2 days before the murder. The perpetrator's last contact with the Police was in December 2011, and a period of supervision and contact with Probation ended in July 2012. He was last seen by Mental Health services in September 2011 although he had significant contact with these services over the years covered by this Review. His last involvement with Open Road was in January 2009. The victim attended Open Road and MIND in January 2009 and the summer of 2011 respectively. Although these two agencies have limited relevance to the events which took place they provide context and insight into issues affecting the people involved in this Review. The only event requiring contact with the Police concerning the perpetrator and the victim was in March 2009

when he was arrested for criminal damage to her home. Previous domestic abuse was perpetrated on former partners.

Participating Agencies:

1.7 The following agencies were found to have contact with the victim and or the perpetrator and have therefore participated in this Review:

- Essex Constabulary - chronology and Independent Management Review (IMR).
- North East Essex Clinical Commissioning Group for GP Practice - chronology & IMR
- Colchester Hospital University Foundation Trust - chronology
- North Essex Partnership NHS Foundation Trust – chronology & IMR
- Open Road – chronology & IMR
- Colchester MIND – Information provided
- Colchester Walk in Centre - chronology

Family and a friend have also contributed to this Review

1.8 Purpose and Terms of Reference for the Review:

The purpose of the Review is to:

- Establish the facts that led to the death of Mrs F on 2 November 2012 and whether there are any lessons to be learned from the case about the way in which local professionals and agencies worked together to safeguard Mrs F.
- Identify what those lessons are, how they will be acted upon and what is expected to change as a result.
- Establish whether the agencies or inter agency responses were appropriate leading up to and at the time of the incident on 2 November 2012.
- Establish whether agencies have appropriate policies and procedures to respond to domestic abuse and to recommend any changes as a result of the review process.
- To seek to establish whether the events of 2 November 2012 could have been predicted or prevented.
- This Domestic Homicide Review is not an inquiry into how the victim died or who is culpable. That is a matter for coroners and criminal courts.

Terms of Reference for the Review:

1. To review the events and associated actions that occurred which relate to the victim Mrs F, and the alleged perpetrator Mr G, between 2003 and up to and including the 2 November 2012, the date of Mrs F's death.

2. Agencies with knowledge of the victim or perpetrator in the years preceding the timescale for detailed review should provide a brief summary of that involvement.

3. To review the quality and scope of action/s and services provided by the agencies defined in Section 9 of the Act which had involvement with Mrs F and Mr G. This to include any interaction with family members or friends which has relevance to the scope of this review as identified within agencies' records, Individual Management Reviews (IMR) or other information sources as deemed appropriate by the Independent Chair of the DHR.

4. To examine the knowledge and training of staff involved in relation to the identification of indicators of domestic abuse and the application and use of appropriate risk assessment tools including:

- The DASH risk assessment checklist;
- Agencies own specialist risk assessment tools to assess risk posed by perpetrator and/or risk posed to victim;
- Knowledge and use of appropriate specialist domestic abuse services.

5. Examine the effectiveness of single and inter-agency communication and information sharing, both verbal and written.

6. To review the care and treatment of Mr G the perpetrator and son of the victim while in the care of the Mental Health Trust with specific attention to:

- The quality and scope of care provided by the Trust and associated support agencies.
- The quality and care planning process with specific attention to the implementation of the Care Programme Approach (CPA) and clinical risk assessment.
- The effectiveness of specific treatment strategies with particular attention to diagnosis and associated treatments and the application of the Mental Health Act, with particular attention to Mr G's diagnosis of Mixed Anxiety and Depressive State Cluster B Personality Disorder in July 2011.
- The communication regarding Mr G's diagnosis to other agencies and family members and the implications for his care and risk management.
- To assess the extent to which agencies relevant policies and procedures were followed, and whether these are up to date and fit for purpose in assisting staff to practice effectively where domestic abuse is present.

1.9 The overview report author was responsible for contacting family and friends of Mrs F and Mr G to invite their contribution to the DHR.

1.10 To protect the identity of family members the victim in this case will be referred to as Mrs F. The perpetrator, her son, is referred to as Mr G. Both were of white British ethnicity.

2 Key Issues Arising from the Review:

2.1 Mrs F has been described by family members as a loving, friendly person who was a great extrovert socially; however, this masked her long term health and family problems. She had experienced bouts of anxiety and depression for many years, and she also suffered from chronic pain from a degenerative illness. At the time of her death Mrs F was in her mid sixty's and Mr G her son was in his mid thirty's. Mrs F was in receipt of Disability Living Allowance and Attendance Allowance due to the effects of osteoarthritis, but she was not considered a 'vulnerable adult' as defined by the Department of Health as she had never been assessed for community care services. Nevertheless, in his summing up at the perpetrator's trial, the judge commented that the aggravating features of the case were that she was "vulnerable by virtue of her health".

2.2 Mrs F's health was adversely affected by her life experiences including her concerns for her adult children, the death of an adult son and her first husband from whom she was divorced, domestic abuse by her second husband, and most acutely, her constant worry about her youngest son Mr G. He had frequent involvement with the Police for incidents of affray, theft, driving offences, criminal damage, and harassment. Police were also

called to a total of 7 incidents of domestic abuse against former partners. A further worry to Mrs F was Mr G's recurrent overdose attempts, sometimes using her medication. He was a frequent attendee at Accident and Emergency Departments (A & E) with 16 visits for overdoses of medication; 9 for various physical illnesses; 16 for injuries plus 2 attendances at the Minor Injuries Unit many of which were due to altercations. She was both concerned and ashamed by his behaviour.

2.3 Mrs F accessed her GP services and nurses in the practice on a very regular basis due to her health problems and high levels of anxiety. She was in receipt of regular medication which included analgesics, tranquilisers, and sedatives to aid sleep. Between 2003 and 2012 the period covered by this Review Mrs F had a total of 207 visits to health professionals at her surgery. The Review findings indicate that Mrs F had ready access to services at her GP surgery, and in particular she appears to have had a trusting relationship with her GP. This was demonstrated by the candour of the disclosures she made to her doctor about the stresses and bereavements in her life, and in particular when in October 2007, January and September 2008, July and December 2010 she disclosed incidents of physical, verbal, and emotional abuse by her second husband. She also mentioned problems with her husband to a practice nurse. Whilst her physical needs and anxiety were attended to Mrs F was not given information or referred on to specialist domestic abuse agencies following these consultations. The Review enquiries revealed a lack of awareness, practice policy, and training concerning domestic abuse within the surgery team.

2.4 Mrs F attended the Women and Alcohol service run by the voluntary sector service Open Road between 29 April 2008 and 29 January 2009 as she wished to address her alcohol use. A close relative of Mrs F reported to the Review that achieving a reduction and cessation in her drinking made her feel much better about herself and boosted her self-esteem. Although during this period Mrs F was experiencing domestic abuse by her husband Open Road could find no record that she disclosed the abuse during her time with the service. The service has recently taken steps to improve its knowledge and practice concerning domestic abuse. Mrs F later attended five counselling sessions with the voluntary sector organisation MIND in the summer of 2011 by which time Mr G was living with her. They report receiving no disclosure of domestic abuse during her counselling sessions.

2.5 One of the assaults on Mrs F by her second husband in March 2010 resulted in the Police being called and he was arrested and cautioned for assault. Mrs F's husband was a shotgun certificate holder and as violence had been used the Police confiscated his shotguns and passed on information to their Firearms Licensing Department. This was good practice. It is not clear whether Mrs F was provided with information about sources of support following this incident, and there is no indication that she was contacted by Victim Support. Mrs F separated from her husband in December 2011 when she moved into a flat on her own and she proceeded with divorce proceedings.

2.6 During his many contacts with Mental Health services Mr G had 2 full assessments by consultant Psychiatrists one in May 2004, and the other in June 2011 just before his court appearance for dangerous driving and other driving offences. Opportunities for further assessments were limited due to his tendency of not attending follow-up appointments arranged for him. He was prescribed anti-depressants and medication to help him sleep after his overdose attempts and he was advised about this excessive alcohol use. Binge drinking usually followed events which he found difficult to cope with and it was frequently a precursor to an overdose attempt. When he was assessed in 2004 after being admitted for smoke inhalation following a fire he caused in his mother's garage he was diagnosed with Adjustment Disorder with brief depressive reaction. This was thought to be due to the breakdown of his first marriage in 2003 and the loss of

contact with his children by court order because of his alcohol use, however, by this time he was already in another relationship and his girlfriend was pregnant.

2.7 Between March 2008 and January 2009 Mr G attended sessions at Open Road to address his drinking. He was not deemed to be a dependent drinker, but tended to binge drink. He had been recommended to attend the service by Mental Health professionals a number of times, but this was the only time he followed up the initial assessment by attending regularly. He completed 5 sessions with an Alcohol Adviser in the service, attended acupuncture sessions, and continued to see his keyworker on a regular basis until 27 January 2009 when he was discharged. During his time with the service he reported that his alcohol use decreased, and it is of note that he made no overdose attempts during this period.

2.8 Mr G had two marriages and a number of other relationships all of which were short lived due to his volatile and unpredictable behaviour and his excessive use of alcohol. In May and June of 2007 he is known to have lived in Coventry for he was seen in A & E there for overdose attempts. When he was not living with a partner Mr G had a period of time in a Shelter and occasions when he moved in with his mother and stepfather. On 26 February 2009 a month after Mr G finished his sessions at Open Road, Mrs F phoned the Police and reported that Mr G had stolen her husband's laptop and made threats to harm him. He pleaded guilty at court and was fined. The Criminal Justice Mental Health Team noted that he appeared 'slightly high' at this time. On 5 March 2009 Mrs F phoned the Police again to report that Mr G was smashing up the house. During a subsequent mental health assessment some months later Mr G disclosed that this incident followed an argument with his mother because she would not give him money to go on holiday. Mr G was arrested and also admitted to being in possession of a lock knife. He was sentenced on 15 April 2009 to 4 months imprisonment suspended for 12 months plus 100 hours unpaid work and 12 months supervision. This order was supervised by a London Probation services.

2.9 In the summer of 2009 Mr G lived in Harrow. His uncle gave him free use of his caravan and for a short time he had a girlfriend there. During his stay in Harrow Mr G was admitted as an inpatient to a Mental Health Unit due to overdose attempts between 23 to 27 July, 4 to 11 August, and 24 to September to 7 October 2009. He also registered with a local GP. He saw the GP for physical ailments and complained that his accommodation was not comfortable. During a mental health assessment in 2011 Mr G disclosed that he obtained admission to hospital in Harrow as he had nowhere to stay. This indicates a degree of insight and the ability to act in such a way as to be admitted to hospital for the purpose of gaining accommodation. The Mental Health Unit kept Mr G's GP updated on his condition and liaised with his girlfriend about his care, but this relationship was short lived. Mr G failed to attend further mental health appointments in Harrow.

2.10 On his return to Essex Mr G moved from a Shelter into a shared flat in December 2010. In January 2011 he struck up a friendship with a neighbour which then developed into a year long relationship. At first he was seen to be friendly and polite, but his behaviour became more unpredictable as time passed. He was responsible for significant damage to his shared flat; he stripped out pipes and the boiler and sold them, and he drew over the walls. On one occasion the Police came to interview him when he returned to his flat after his girlfriend had reported him missing and Mr G told them the flat had been burgled. After the Police left he admitted that he had done the damage.

2.11 On 11 March 2011 Mr G's girlfriend phoned the Police and reported that he had stolen her car, he had also taken some other possessions. A relative of Mrs F's also phoned their GP to report that he was 'as nutty as a fruitcake' and would need help if he was arrested. He was eventually arrested in Harrow and admitted to a Harrow Mental Health

hospital on 17 March 2011 under section (5)(2) of the Mental Health Act 1983, he was diagnosed with Personality Disorder Unspecified, but he absconded from the hospital on 19 March and returned to Essex. His girlfriend was reluctant to have him back with her, but was persuaded by a friend of Mr G's to help in the short-term, but on 20 March 2011 the Police were called once again as Mr G was 'going berserk' and had stolen his girlfriend's car again. A Police car chase ensued during which Mr G tried to ram a Police car. The chase end outside Mrs F's flat where Mr G was arrested for dangerous driving and other motoring offences.

2.12 Mr G was initially held in custody. He was then electronically tagged and released on bail until his court case. Each time Mr G was held in custody following involvement with the Police he made them aware of his previous overdose attempts and arrangements were made for him to be medically assessed and checked at regular intervals. In 2 previous custodies he had been taken by Police for medical treatment due to punching the cell door or complaining of a physical ailment. During this period of custody he was found with his sweatshirt around his neck, observations were increased but this was not considered a serious attempt on his life. The Criminal Justice Mental Health Team assessed Mr G on 21 March 2011 and he reported that he lived in Harrow with his mother. This was untrue; Mrs F had never lived in Harrow. He presented as chaotic and anxious, and a Prison Warning Notice was completed advising that he was at possible risk of self harm. Mr G was released on bail on 15 April 2011.

2.13 Between his release on bail and his trial Mr G had an assessment by a forensic Psychiatrist to ascertain his fitness to plead. He was found to have no evidence of psychosis and his mental illness did not warrant treatment under the Mental Health Act. The Psychiatrist judged that he would benefit from drug and psychological treatments for depression, anxiety, and to address his personality issues. It was considered that his acting irresponsibly would increase at times of distress, but he was able to understand his actions were against the law. He showed partial insight into his behaviour, but he showed little remorse for putting others at risk. He was considered fit to plead.

2.14 In his period of bail leading up to his trial in July 2011 Mr G lived with his mother Mrs F. With the support of her GP and the Pharmacist she was trying to reduce some of her medication, however her anxiety levels increased and at an appointment on 26 May 2011 with the Pharmacist she was in a 'terrible state' as her son was out of prison and threatening suicide. Mrs F also admitted that she had given some of her medication to her son. She was strongly advised not to do this and told that her son must see the doctor himself for medication.

2.15 On 18 June 2011 Mr G was admitted by ambulance to A & E having taken an overdose of his medication, and on 28 June he arrived unaccompanied in A & E having taken an overdose of paracetamol. He was thought to be anxious about his approaching trial. Mr G was assessed by a consultant Psychiatrist with his mother present and a diagnosis of Mixed Anxiety and Depressive States and Cluster B Personality Disorder was given. Mr G failed to attend a follow up appointment with the Crisis Resolution and Home Treatment Team. The consultant reported this and the diagnosis to Mr G's GP. During assessment it is noted that Mr G was to continue attending Open Road, however, he was not attending the service at this time. His attendance at Open Road finished in January 2009.

2.16 On 11 July 2011 Mr G's first wife contacted the Police stating that he was outside her house and he was not suppose to know where she lived. She stated that she had not seen him for a number of years and she was scared. The Police met her at her mother's house, but no offences were disclosed. Mr G was advised to leave and not return. The

incident was assessed as 'standard' risk and information was shared with Children's Services as there were children in the household.

2.17 Mr G was found guilty of dangerous driving and other driving offences on 13 July 2011. He was sentenced to a 24 month Community Order with supervision and a requirement to undertake a 'thinking skills' course. The Probation Offender Manager undertaking his assessment judged him to be medium risk to the public and staff, including the Police, and low risk to 'known adults'. His full criminal history including his history of domestic abuse to past partners was not known to inform this assessment; therefore no Probation SARA[1] assessment was undertaken. Similarly, although the Offender Manager was aware of Mr G's mental health issues and diagnosis, and had spoken to the Psychiatrist who was overseeing Mr G's care in the community, no full mental health history and his record of overdose attempts was shared. The Psychiatrist was clear that Mr G's mental health did not absolve him of responsibility for his offending behaviour, although Mr G himself attributed his behaviour to his mental health problems. The Offender Manager considered his actions were also the result of attention seeking behaviour and poor problem solving skills. Alcohol was noted as a contributing factor in his offending.

2.18 During his time under the supervision of Probation Mr G was living with his mother in her one bedroom flat. This meant accommodation was cramped and he slept in the living room, although Mrs F sometimes gave up her bed for him. At the beginning he was to be assessed for independent accommodation, but he had previous tenancy issues. He also reported that he was his mother's carer and had related benefits; as a result he withdrew from the job seeking process. In March 2012 he informed his supervising Offender Manager that they had moved to a ground floor flat which was more suitable for his mother's needs. This was untrue; his mother's flat was on the first floor and she did not move at any time. However, in the absence of a home visit the Offender Manager gained the impression that Mrs F had mobility problems and they had no knowledge of the extent of her ill-health or that she was taking medication for anxiety which was being exacerbated by Mr G virtually taking over her flat. For example a relative informed the Review that Mr G determined which television programmes were watched, he had a girlfriend to stay, and Mrs F was not allowed to put her pictures on the wall only his.

2.19 Whilst under Probation supervision Mr G had good attendance at the Thinking Skills Programme and sessions with his supervising Offender Manager. At one stage he expressed a wish to regain contact with his children, but then changed his mind. The reason for his lack of contact was not explored. He had a mental health assessment in September 2011 and was discharged to the care of his GP. This information was not shared with Probation. On 1 November 2011 Mr G told the Offender Manager that he wanted to stop his medication, and he was advised to consult his GP. Mr G informed his supervisor on 8 December that he was no longer taking his medication. It would appear that he did not consult his GP for at the beginning of January 2012 his surgery noticed that he had not requested a repeat prescription, and he was asked to attend the surgery to see his GP. The Offender Manager did not follow up this matter with Mr G's GP or Psychiatrist although disengagement from Mental Health services or from his medication were key elements of his management plan.

2.20 On 14 December 2011 the Police received a call from Mr G's former girlfriend from whom he had stolen a car twice. She was receiving unwanted texts and phone calls from him. Mr G was arrested on 16 December and following interview he was cautioned for harassment and released. This arrest was not shared with Probation as they and the Police currently have no system for flagging offenders supervised by Probation or for

[1] Spousal Assault Risk Assessment: a clinical checklist used by Probation to assess perpetrators of domestic abuse.

Probation to notify the Police of an offender who is supervised by them. This was raised as an early leaning point at the beginning of the Review.

2.21 Mr G was perceived to be progressing well on his order and, as during the period of support by Open Road in 2008, he had no overdose attempts while he was receiving the attention Probation. An application was made to the court on 16 July 2012 to revoke his order early and this was granted. At his last appointment with his supervisor on 23 July he reported that he was caring for his mother full time.

2.22 A contribution to the Review by one of Mrs F's close relatives provides an insight into the difficulties Mrs F was facing by having Mr G living with her. She was lower in mood and felt that her flat no longer belong to her. She often visited her relative and would frequently be reluctant to go home because he was there or he would have his girlfriend in the flat with him. Mrs F felt unable to challenge him because he would become verbally abusive, stomp around the flat, or threaten to go out and get drunk; she then worried that he would get into trouble with the Police. Mrs F also supported him financially, usually buying him clothes and giving him money to go out.

2.23 At some point in the middle of October 2012 Mrs F discovered that her son Mr G had been using her bank cards and stealing from her. She asked for his key to the flat and told Mr G to leave. Mrs F's relative stated that she was traumatised by the discovery of her son's behaviour and extremely upset; she was thought to be contemplating removing him from her will. It is thought Mr G went to live with his girlfriend, however, at some point Mrs F's relative reports that a neighbour saw him using a ladder to try and enter his mother's flat and she let him in to prevent him disturbing her neighbours. Mrs F loved her son even though his behaviour caused her great anxiety and shame and she would not report his actions to the Police. Relatives describe Mr G as having been spoilt as a child and if he did not get his own way he would become abusive.

2.24 At the beginning of November 2012 Mrs F's relative became concerned that she had not heard from Mrs F nor had she attended a doctor's appointment and she called the Police. The Police forced entry to Mrs F's flat and found her body in the bedroom. Mr G was also in the room. He was arrested, charged with murder, and held in custody until his trial.

2.25 In summary key Issues arising from the Review are:

- Information sharing between Probation, Police and Mental Health.
- Agencies reliance on Mr G's self reports of his situation and progress without corroboration from other sources.
- Lack of assessment of Mrs F's situation, her needs, and affect of having her son living with her.
- A number of agencies had Safeguarding policies, but inadequate policies and processes for domestic abuse.

3 Conclusions:

3.1 Based on what individual agencies knew at the time it is unlikely that they could have predicted that Mr G would murder his mother. Had all their information been brought together there would have been a greater chance that risks would have been assessed differently, actions may have changed, and Mr G's circumstances might have altered leading to a different outcome. For example if Mrs F had had an assessment in her own

right as a carer, and the accommodation and her ill health had meant Mr G was moved to his own accommodation he would not have been in the location to kill his mother. If Mrs F had had specialist support she may have had help with a safety plan and an injunction to protect her from further abuse and intimidation from her son. There are many 'what ifs'. However, the unpredictable and impulsive behaviour of Mr G which is evident from the Review, coupled with the fact that his mother had recently told him to leave her flat, and his tendency to be abusive when he could not get his own way, probably meant Mrs F's murder at his hands was not preventable.

Lessons to be Drawn from the Case.

3.2 Systems issues

3.3 Mr G's many suicide attempts, his binge drinking, and risky offending behaviour, plus his personality traits focussed agencies attention on him and away from the risks he posed to others. As is the case in so many Reviews crucial information was not shared about his domestic abuse history or his mental health history which in effect skewed the effectiveness of any risk assessment. Why does this happen?

3.4 Undoubtedly differences in organisational culture play a part and information sharing is affected by agencies policies governing consent, internal communication structures, databases, and inter-agency information sharing policies, or the lack of them. In cases involving criminal behaviour legislation is not a barrier to sharing information, particularly when to do so is believed to protect the welfare of others as well as the person involved. Whether it is a complete history of someone's criminal record or mental health interventions, a new offence whist under supervision, or a seemingly small piece of information such as where someone is living at a given time, or are they taking their medication. Each set of facts is crucial to completing the jigsaw of what is going on in a sometimes chaotic vulnerable person's life which places them at risk and those around them. The absence of a complete picture results in a domino effect; one flawed decision made after another, however unintentional.

3.5 Best practice point 5 of Department of Health Guidance instructs us that risk management requires an organisational strategy as well as efforts by the individual practitioner. Best practice also urges that agencies should have clear information policies in place; a vital part of an organisational strategy for managing risk, but an information sharing policy must be straightforward for practitioners to be clear about the function of sharing information. For example if a policy states that information is shared on a 'needs to know' basis the policy should be clear about what this means to adequately advise and support the practitioner trying to implement it; preferably giving case examples. Department of Health best practice states that "If someone other than the service user is at risk, advice must be sought from the police public protection team or multi-agency public protection arrangements (MAPPA) so that an appropriate public protection plan can be activated. The rationale for any disclosure without consent, e.g. to prevent harm, should be clearly documented"[2]. This is fine as far as it goes, but in this case the crucial information missing between Mental Health, Police, Probation and GP would probably not have felt important enough to warrant such a step as calling the Police.

[2] Page 21 Best Practice in Managing Risk: *Principles and evidence for best practice in the assessment and management of risk to self and others in mental health services* Department of Health, National Risk Management Programme 2007.

3.6 When the offender in the case was supervised by the Probation service between July 2011 and July 2012 he was arrested in December 2011 and cautioned for harassment of a former partner. The Police were not aware that he was under the supervision of Probation and therefore did not inform Probation of this incident. Probation does not have a process to inform the Police of offenders who are supervised and the Police do not have a process for flagging offenders who are supervised on their systems. The offender was thought to be progressing well by his Offender Manager, to the extent that an application was made to the court and his supervision order was revoked a year early. It is almost impossible to imagine that had his harassment of his former partner and subsequent arrest been known this would not have happened, and a different approach to his management could have resulted. The incident would also have shown him in a different light, and could have resulted in him being seen as someone with obsessive and controlling tendencies. However, the missing intelligence about his offending, and his mental health history resulted in Mr G being discharged from his order a year early, and inadequate monitoring of his alcohol use, disengagement from mental health services, and ceasing his medication despite the importance of these elements in his sentence plan. It is to be hoped that negotiations underway to include Probation within the Police Central Referral Hub will result in a mechanism to improve information sharing in domestic abuse cases, for whilst the Police and Probation share information well concerning high risk offenders under MAPPA or MARAC procedures, it is doubtful that Mrs F would have been assessed as at high risk based on the information known at the time.

3.7 Although the safeguarding adults policy for the county does mention domestic abuse on two occasions, there are no specific guidelines on how to risk assess using the DASH checklist, safety plan with victims, or an appropriate referral pathway to guide practitioners' actions. Most of the agencies taking part in this review had adult and safeguarding policies and procedures, but no specific domestic abuse policies. There was a sense that the adult safeguarding policy covered all that was needed. However, the high risks attached to domestic abuse cases warrants separate procedures. Whether this is as an addendum to existing adult and children's safeguarding policies and procedures or a stand alone document is for agencies to decide. Without clear policies and procedures systems will not work safely and effectively. The Royal College of General Practitioners has developed guidance to assist GPs with drafting their own procedures for staff to follow. It has been developed in collaboration with IRIS, and CAADA as mentioned in paragraph 5.43.

3.8 Probation has a policy of only conducting home visits if an offender is assessed as high risk of serious harm or there are safeguarding issues. Neither of these factors applied to Mr G based on the information known by Probation at the time of his supervision. However, if more had been known about Mrs F and her relationship with her son and the accommodation issues which existed, perhaps safeguarding concerns might have been identified. Only a home visit would have enabled this type of assessment. Offender Managers are being encouraged to apply professional judgement in relation to when a home visit is required, and an emphasis is being put on safeguarding issues. Essex Probation has noted the need for a more investigative approach in their management of offenders and has already started disseminating findings via staff briefings.

Practice

3.9 Mr G had a long history of mental ill-health and alcohol misuse which would have benefited from a more coordinated approach. Patients with personality disorders and substance misuse problems can be challenging to manage and support, this makes inter-agency collaboration all the more important as failure to communicate can contribute to

drop out and patients can be lost from services[3]. Mr G tended to boomerang from service to service and crisis to crisis, and some of these incidents had a direct and detrimental impact on his mother's health and ability to cope, but this was not known to agencies apart from her GP and other health professionals in the surgery. The only time Mr G appears to be mentally stable is when he is receiving regular sustained support and supervision over a longer period of time i.e. from Probation and Open Road. Best practice within the Care Programme Approach is for one identified worker to be the 'Care Co-ordinator'[4]. There is no indication that this happened in Mr G's case.

3.10 There appeared to be a great deal of reliance on self reporting by Mr G in gathering information for his assessments and on his progress in various aspects of his life. But unless these reports are corroborated by information from colleagues in other agencies, or family members or partners, self reports cannot be safely relied upon for the continuing risk assessment of a service user or offender. A more investigative approach would be helpful. This is a further justification for following best practice and working in a multi-agency, multi-disciplinary manner with a care coordinator providing a centralised resource for information and management of care through multi-agency CPA case meetings.

3.11 It is recognised that the use of alcohol increases general impulsivity in the way people act. When this is coupled with the traits present in personality disorders which Mr G exhibited such as a lack of concern, regret, or remorse about other peoples' distress; irresponsibility and disregard for normal social behaviour; little ability to tolerate frustration and to control anger; a lack of guilt and not learning from their mistakes, extra rigor is needed in agency's assessments. To reinforce this recent analysis of homicides where the perpetrator had mental ill health found that 74% of mental health patients who committed homicides had a history of alcohol misuse, and unsatisfactory assessments prior to homicide were associated with a diagnosis of personality disorder or alcohol misuse[5]. This needs to be taken into account when agencies are assessing service users with duel diagnosis, and in multi-agency training.

3.12 A further and very important component of best practice which was omitted in this case was not collaborative working with the patient, but with Mr G's carer. Neither his mother Mrs F, nor any partner was assessed or offered support or information. Again guidance recommends that, with service user consent, there is a need to consult with carers or family members concerning the service user's diagnosis and ensure that carers have an assessment of their needs and are given information about sources of support for themselves. There should also be an assessment of risk of violence to a family member or spouse, especially as they are the group which research shows are more at risk of homicide by patients suffering from mental ill health.[6] This is particularly the case where the impact of anti-social behaviour, offending, and drug or alcohol misuse is present.

3.13 Practice in handling the domestic abuse disclosures by Mrs F within her GP surgery indicates that there is considerable room for improvement in how patients are supported on these occasions. If patients disclosing domestic abuse leave their surgery without follow up support of any kind there is a risk that they will feel disbelieved and never

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[3] Banerjee S, Clancy C, Crome I (eds) (2002) *Co-existing Problems of Mental Disorder and Substance Misuse (dual diagnosis) An Information Manual* . The Royal College of Psychiatrists' Research Unit

[4] ibid

[5] The National Confidential Inquiry into Suicide and Homicide by People with Mental Illness Annual Report , Manchester University.July 2013 http://www.bbmh.manchester.ac.uk/cmhr/centreforsuicideprevention/nci/reports/AnnualReport2013_UK.pdf Accessed 30.10.13

[6] ibid

disclose again and the abuse will continue and escalate. There is substantial physical and psychiatric morbidity associated with domestic violence, as a consequence victims use of health services is increased compared to those who are not abused and this brings with it substantial healthcare costs, with direct medical and mental healthcare costs of approximating £1,730 million per annum in the UK[7]. GP's and their staff have significant demands on their time, but the findings from Professor Feder's evaluation of IRIS which was mentioned in paragraph 5.14 found that once a victim had the support they needed to recover from their abuse their visits to their GP fell considerably. The IRIS identification and training project is worthy of consideration for improving practice in GP surgeries.

3.14 Whereas the Southend Essex and Thurrock Safeguarding Adult Policy contains domestic violence guidelines in the context of safeguarding adults processes, a more practitioner friendly source of information would be helpful to describe the steps to take for dealing with disclosure of domestic abuse. A clear pathway diagram, the DASH checklist, MARAC referral process, steps to take and further sources of support would usefully be contained within a separate handbook for ease of access. The current pathway diagram within the Safeguarding Adult Policy (page 27) could contain a trigger point for undertaking a DASH risk assessment with a victim where a family member or partner is suspected of abuse and the domestic abuse pathway could be followed at that point.

Training

3.15 A further learning point from the Review is the patchiness of training in domestic abuse and risk management, and knowledge of specialist services. In common with many practices the GP surgery lacked knowledge and training in domestic abuse. There was also found to be inadequate record keeping concerning who had received training in areas such as safeguarding. The lack of training in domestic abuse showed itself most starkly when Mrs F disclosed domestic abuse at the hands of her husband. The fact that she disclosed the abuse showed a sense of trust and confidence in her GP, but the response fell short of best practice. Had Mrs F been referred on to her local Women's Aid for specialist advice, whilst there is no guarantee that she would have accepted their support, she would have received expert advice which could have helped her leave the abusive relationship safely and faster, and she may have been helped to recognise abusive behaviours including those of her son sooner and had the support to act safely to remove him from her flat.

3.16 Training in domestic abuse awareness and risk assessment often concentrates on risk to the victim and identifying those risks. Apart from Probation who work with offenders there is frequently a gap in agencies ability to recognise a potential perpetrator of abuse and how to act when they do. None of the agencies in this Review considered any of Mr G's behaviours and mental ill health in terms of risk to others, apart from his previous history of aggression towards professionals. Their lack of knowledge about his criminal history did not prompt anyone to think of him in terms of a perpetrator of domestic abuse, particularly against his mother, even though he was arrested for criminal damage of her home in the past. Nor did his personality disorder or alcohol use seem to feature in assessing his risk to others apart from professionals.

[7] Trevillion K, Oram S, Feder G, Howard LM (2012) Experiences of Domestic Violence and Mental Disorders: A Systematic Review and Meta-Analysis. PLoS ONE 7(12): e51740. doi:10.1371/journal.pone.0051740

4 Recommendations:

4.1 The following recommendations stem from the lessons learned during this Review and from Independent Management Reviews. There were some recommendations made in agency IMRs which were specific to their internal processes and had no bearing on the agency's response to domestic abuse i.e. recommendations concerning the prescription of medication. Such recommendations will be taken forward by the appropriate internal mechanisms for that service and will not be included here.

National level:

4.2 That NHS England supports the introduction of IRIS within GP practices by building into its contractual and performance management arrangements a requirement that practices should implement the Identification and Referral to Improve Safety (IRIS) system in coordination with Independent Domestic Abuse Advocacy Services.

County level:

4.3 1. Information sharing protocols between agencies should be reviewed to ensure that they are effective in empowering practitioners to share information across disciplines and agencies for the purpose of gathering an offender's full criminal and mental health history to inform comprehensive risk assessments. Practitioners should take an investigative approach and offenders self reports should be corroborated by reference to additional sources.

4.4 2. Safeguarding policies should be reviewed to ensure that domestic abuse has an explicit pathway which includes the DASH risk assessment checklist, MARAC referral process, and options for support and actions, so that practitioners have ease of access to clear guidance about the steps to take and processes. This could be as an addendum to existing policies, but preferably a standalone document or handbook.

4.5 3. Domestic abuse training content should be reviewed to ensure that it includes a module on the indicators and identification of perpetrators including criminogenic typologies for high risk perpetrators, additional risk factors such as mental ill health, personality disorders, substance misuse, and risk assessment.

4.6 4. A process should be put in place between the Police and Probation that results in offenders supervised by Probation being flagged on Police systems for the duration of their supervision, and that a notification of any incidents involving a Police intervention with a supervised offender is emailed to Probation to enable their Offender Managers to be alerted. The notification should take place whether an offender is involved in an incident which results in a non-crime, a caution, or a crime. The process should aim to be put in place by April 2014.

4.7 5. Essex Probation will remind staff to use professional judgement in making home visits, which are not confined to cases assessed as high risk, particularly where an offender has caring responsibilities either for children or a vulnerable adult.

4.8 6. All GP practices should develop a robust domestic abuse policy and protocols within X months of the publication of this Review which clearly outline the responsibilities of staff to understand and respond to the needs of domestic abuse victims. The policies and protocols should be mindful of the Home Office definition of domestic abuse which was

amended in March 2013[8] to include individuals of 16 years and over, and the inclusion of coercive control in the description of abuse. Policies and protocols should include:

(a) A domestic abuse care pathway as recommended by the Royal College of General Practitioners, IRIS, and CAADA: this can be found at http://www.rcgp.org.uk/clinical-and-research/clinical-resources/domestic-violence.aspx

(b) The identification of a key individual within the practice who will have additional training and be able to act as more specialist support for other staff.

(c) Where an individual is regularly accompanied by a partner, relative or carer a policy should be put in place setting a clear expectation that opportunities will be made available to see individuals alone in a safe and confidential setting. Advice and guidance on how to achieve this should be included.

(d) GPs would find it useful to access the Royal College of General Practitioners e-learning course for guidance and practice advice regarding domestic violence. This is available on the Royal College's website at: http://elearning.rcgp.org.uk (enter domestic violence in the search for courses window).

4.9 **7.** GPs should review their safeguarding adults and children strategies to ensure a standardised approach. The strategies should reflect the requirements of the Essex Safeguarding Adults Board and be in line with the Southend, Essex & Thurrock Safeguarding Guidelines. A lead practitioner for safeguarding should be identified who will have a governance and co-ordinating role, overseeing and recording training requirements and attendance, and ensuring that staff managing safeguarding issues receive formal supervision. The level of training provided will be determined by the responsibilities of the post holder as per the Southend, Essex and Thurrock Guidelines.

4.10 **8.** At the time of writing NICE are in the process of developing guidance to support the prevention and reduction of domestic violence which is due to be published in February 2014. It is recommended that Clinical Commissioning Groups, Hospital and Mental Health Trusts take forward NICE recommendations with its membership at that point.

4.11 **9.** The Mental Health Trust should ensure that appropriate procedures are in place to implement NICE guidelines[9] so that practitioners are clear that where the consent of the person diagnosed is obtained, their family or carer should be consulted, have a carer's assessment if appropriate, and be provided with information about local support groups. This should be done at the time of diagnosis or as soon as practicable following diagnosis.

4.12 **10.** The Mental Health Trust should review the Care Programme Approach to ensure that it is effectively coordinating the needs of its service users and the agencies supporting them by:

(a) That robust auditing of CPA is implemented where Consultants act as the care coordinator.

(b) Ensure that relevant agencies such as Probation and others are invited to CPA case meetings when they are held concerning their service users.

[8] www.gov.uk/domestic-violence-and-abuse

[9] NICE Clinical Guidelines 78 Borderline Personality Disorder: Treatment and management. Issued January 2009

4.13 **11.** That the Community Safety Partnership writes to the Chief Executive of MIND to request that they review their safeguarding policy to strengthen their policies and training around domestic violence, and is signposted to the appropriate lead in the Safeguarding Essex Board.