DOMESTIC VIOLENCE HOMICIDE REVIEW

Into the death of

Patricia
in December 2015

EXECUTIVE SUMMARY

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Report Completed: 20 March 2017

The Tendring Community Safety Partnership and the Domestic Homicide Review Panel wish to express their sincere condolences to the family and friends of the victim. Her life was not always easy, but she was a caring woman who often supported others at the expense of her own needs. She will be greatly missed by those who loved and cared about her.

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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 murder of a resident in who lived in the Tendring local authority area.

1.2 Following a Police investigation the perpetrator was arrested and charged with murder. At his criminal trial the perpetrator pleaded guilty to manslaughter on the grounds of diminished responsibility. After legal arguments and psychiatric reports were considered this plea was accepted by the trial judge. The perpetrator was sentenced in July 2016 to life imprisonment with a minimum term of 16 years to be served firstly in a secure hospital under the Mental Health Act, and when treatment is assessed as completed he is to be transferred to prison.

1.3 The Review process began when the Chair of the Tendring Community Safety Partnership (CSP) met with a representative from the Police and the local authority Community Safety Department on 22 January 2016 where the decision was taken that the circumstances of the case known at the time met the requirements to undertake a Domestic Homicide Review. The Home Office was informed of the decision on 12 February 2016. The decision was discussed and ratified by the CSP Responsible Authorities Group on 16 February 2016. The Review was concluded on 20 March 2017. This is over the statutory guidance timescale to complete a Review due to the criminal proceedings; and difficulties with gathering information from some agencies. The Review remained confidential until the Community Safety Partnership received approval for publication by the Home Office Quality Assurance Panel.

1.4 A total of 23 agencies were contacted and 10 responded confirming involvement with the individuals involved in this Review; 13 had no contact. Agencies participating in this case Review and the method of their contributions are:

- Essex Police - chronology and Individual Management Review (IMR)
- Suffolk Police - background information
- Colchester Hospital University Foundation Trust - chronology and IMR
- General Practitioner for the victim - chronology & IMR
- East of England Ambulance NHS Trust - chronology & IMR
- Anglian Community Enterprise (Minor Injuries Unit & Outpatients Physiotherapy) - chronology & IMR
- North Essex Partnership University NHS Foundation Trust (Mental Health Services) - chronology & IMR
- Tendring District Council, Housing Options Life Opportunities Department - chronology & IMR
- Community Rehabilitation Company - chronology & IMR

The Review chair is grateful for the contribution of a member of the victim's family.

1.5 To protect the identity and maintain the confidentiality of the victim, perpetrator, and their family members pseudonyms have been used throughout the Review. They are:

The victim: Patricia aged 57 years at the time of her death.

The perpetrator: Ian aged 26 years at the time of the offence.

The perpetrator's former partner and friend of Patricia: Vivienne

Both Patricia and Ian were of white British ethnicity

1.6 Purpose and Terms of Reference for the Review:

The purpose of the Review is to:

- Establish what lessons are to be learned from the domestic homicide regarding the way in which local professionals and organisations work individually and together to safeguard victims;

- Identify clearly what those lessons are both within and between agencies, how and within what timescales they will be acted on, and what is expected to change as a result;

- Apply these lessons to service responses including changes to policies and procedures as appropriate; and

- Prevent domestic violence homicide and improve service responses for all domestic violence victims and their children through improved intra and inter-agency working.

- To seek to establish whether the events leading to the homicide 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 the coroner and the criminal court.

Specific Terms of Reference for the Review:

1) To examine the events leading up to the fatal incident and the decisions made from September 2013 the date when the victim is thought to have meet the alleged perpetrator. Agencies with relevant background information about the victim and the perpetrator prior to this date are to provide a summary of that information.

2) In respect of the victim and the perpetrator all agencies are to describe and analyse: .

   a) what management or care plan did agencies have in place and how was it to be managed?
   b) what risk assessment process took place and was it regularly reviewed?
   c) was risk assessment thorough, in line with procedures, and informed by background history including that from other areas and other services assessment?
   d) was information provided by the perpetrator verified from other sources to check its validity.

3) What learning if any is there to be identified in the management of the offender? Is there any good practice relating to such cases that the Review should learn from?

4) Did any agency have an opportunity to inform the victim of the perpetrator's offending history? If so what was the outcome?

5) To examine whether communication and information sharing between agencies or within agencies was adequate and timely and in line with policies and procedures?

6) To examine whether there were any equality and diversity issues or other barriers to the victim or alleged perpetrator seeking help?

7) What was the impact of organisational change during the period under review and how did changes impact on:

   a) service's internal and external systems of operating.
   b) human and material resources.
   c) service's ability to understand and manage risk in the context of the service user group with whom they worked.

8) Each agency is asked to examine best practice in their specialist area and determine whether there are any changes to systems or ways of operating that can reduce the risk of a similar fatal incident taking place in future?

9) Over the period of time covered by this Review two criteria applied for assessing an adults' vulnerability. Up to March 2015 a 'vulnerable adult' was defined by the Department of Health 'No Secrets' 2000 guidance as:

> *"An adult (a person aged 18 years or over) who is or may be in need of community care services by reason of mental or other disability, age or illness; and who is or may be unable to take care of him or herself, or unable to protect him or herself against significant harm or serious exploitation."*

   Under the Care Act 2014 which was enacted in April 2015 the term 'an adult at risk' was adopted. An 'adult at risk' is considered in need of safeguarding services if she/he:

> *(a) has needs for care and support (whether or not the authority is meeting any of those needs),*
> *(b) is experiencing, or is at risk of, abuse or neglect, and*
> *(c) as a result of those needs is unable to protect himself or herself against the abuse or neglect or the risk of it.*

   Was the victim or perpetrator assessed or could they have been assessed as a 'vulnerable adult' pre 31 March 2015 or an 'adult at risk' post 1 April 2015? If not were the circumstances such that consideration should have been given to this risk assessment?

10) The chair will be responsible for making contact with family members to invite their contribution to the Review, to keep them informed of progress, and to share the Review's outcome.

Summary of Agencies Contact:

1.7 Agencies were asked to give a chronological account of their contact with Patricia and Ian prior to the homicide. A summary of that contact is given here.

1.8 Agency contact with Ian, the perpetrator began in his childhood which was very disrupted and difficult. In interview for his psychiatric assessment for the court he described witnessing domestic abuse as a child, and seeing his mother self harm. His parents eventually separated. Ian attended mainstream primary school briefly, but was excluded at 6 years old due to behavioural problems. Children's Services became involved and Ian and his siblings were eventually taken into the care of the local authority when he was 8 or 9 years old. At one point the Review Panel learnt that he and his siblings were taken out of care by his father, but when he could not cope they were returned. Ian later reported to a Mental Health practitioner and in his psychiatric assessment that he was sexually abused by his father. He has refused offers by the Police to pursue this.

1.9 Ian had periods of time in boarding school and a residential home until he left care at aged 18 years. He has a substantial criminal record; his first recorded offence was age 12 years. He spent 30 months in a Youth Offending Institution from which he was released in March 2010. A majority of Ian's offences are for theft, burglary, and handling stolen goods for which he has served a number of custodial sentences. He also has convictions for possession of drugs and common assault.

1.10 Prior to moving into the Tendring area Ian had two contacts with the Police in a neighbouring county which are of note. In March 2012 Ian was issued with a civil Non-Molestation Order with a power of arrest by his former partner to prevent him from intimidating or harassing her or her child. The order also prevented Ian from coming within 100 metres of his former partner's home or the child's school, and from sending abusive or threatening text messages. All communication was to be through solicitors. Police information suggests that Ian tried to locate his former partner and child, but there appears to have been no further contact or breach of the Order.

1.11 The second incident of relevance was a report in December 2012 by a victim that she had been assaulted by her ex-partner Ian. He was arrested, interviewed and bailed with conditions. In custody Ian was examined by a health care professional due to markers on the Police National Computer (PNC) showing learning difficulties and self-harm. An appropriate adult was arranged whilst he was in custody. This incident was classed as common assault no injury. Ian failed to report to the Police in line with his bail conditions and he was arrested. However, due to the 6 months limitation on prosecution for this crime no further action was taken. The victim was given the necessary support and was moved to sheltered accommodation in another town.

1.12 In 2013 Ian moved into the Tendring area; he was 23 years old. At some point that year he started a relationship with a 45 year old woman called Vivienne and moved into her flat. Vivienne was a friend of Patricia's and it is through this friendship that Patricia first came into contact with Ian.

1.13 Patricia suffered from a number of health difficulties in her life. She had a long history of depression and problems with alcohol dependence; these problems were also experienced by Vivienne. Patricia received regular support from her GP including medication for her depression and anxiety, and a number of referrals to specialist services for her mental health and dependence on alcohol. However, she was unable to maintain appointments or sustain the treatment offered long term. Patricia also

received support from her family, but their attempts to help also proved unable to support her to recovery.

1.14 A 2010 mental health Core Assessment noted that Patricia was vulnerable to exploitation, was living in an unsuitable house of multiple occupancy and was experiencing physical attacks and financial exploitation. Patricia had reported that she had had 4 marriages and that 3 husbands were deceased as a consequence of alcohol-related illnesses. During the mental health service's intervention Patricia moved into her own one bedroom flat.

1.15 Patricia was known to the Police and to her Local Authority Housing Department due to incidents of anti-social behaviour and minor offences, but she was more often the victim of theft, harassment and assault by others. Patricia attended her local Minor Injuries Unit for treatment on occasions including for minor wounds due to self harm, and she had an admission to an Accident and Emergency Department for a reported overdose. Patricia made frequent reports to the Police of thefts from her flat, particularly of her medication. On these occasions her GP routinely asked for confirmation that the thefts had been reported to the Police before issuing a replacement prescription. Patricia's flat was in a house of multiple occupation and such thefts reinforce that she was vulnerable to exploitation from others especially when she was intoxicated.

1.16 In March and April 2010 Patricia was a victim of domestic abuse from her then partner. She sustained broken ribs from the second incident; the perpetrator had also made threats to kill her. Although appropriate protective measures were taken, the Police report for this Review found there was no review of the risk assessment; an assessment of high risk was not made nor referral to MARAC[1]. From May 2010 there have been significant changes in Essex Police including mandatory domestic abuse and risk assessment training, and units to investigate domestic abuse have been restructured. The perpetrator of Patricia's abuse was arrested, charged with Actual Bodily Harm and threats to kill; he was bailed with conditions not to contact her, and was recorded on the Police database as a high risk perpetrator. The threats to kill were not pursued on the advice of the Crown Prosecution Service. Patricia attended the perpetrator's trial which was not until almost a year later in March 2011. He was found not guilty on the direction of the judge.

1.17 Shortly after arriving in the Tendring area Ian came to the notice of local Police in connection with thefts. He also tried to resist arrest on one occasion. On his arrest the Police National Computer alerted officers to his markers of self harm and he was subject to a risk assessment in custody. Ian indicated that he suffered from a personality disorder/schizophrenia. A medical assessment was conducted and his disclosure regarding schizophrenia was noted, however Ian was reluctant to discuss it. As a result of the PNC marker showing a mental age of 8yrs an appropriate adult was appointed as before. This process was consistently implemented each time Ian was arrested.

1.18 On 25 June 2013 the Police responded to the activation of a Police Temporary Alarm which had been previously installed in Vivienne's flat as she had been assessed as a high risk victim of domestic abuse in a past relationship. On arrival officers found that Vivienne had been subjected to an assault by Ian. It was alleged that during an argument he had grabbed her around the throat, pulled her to the floor, and then

[1] Multi-Agency Risk Assessment Conference (MARAC) - a multi-agency meeting to share information relating to high risk victims of domestic abuse, risk assess based on all known information, and put in place a safety plan to protect and reduce risk to the victim.

punched her in the face and kicked her in the ribs causing a black eye and cracked ribs. Due to her injuries she was taken to hospital and arrangements were made for her to stay with family out of the area. A referral was made to MARAC, a safety plan put in place, and medical evidence was requested.

1.19 Attempts were made to locate Ian; he was spoken to on the phone, but refused to hand himself in to the Police. Vivienne returned to her flat on the 2 July 2013 and a review of her safety plan took place. On 10 July Vivienne attended the police station with a friend of Ian's and withdrew her statement to the Police. In the absence of medical evidence and a statement from a Police officer the Crown Prosecution Service threshold test was not reached and the case was made 'no further action' by the supervising Police officer Vivienne's case was eventually heard at a MARAC on 16 September (at this time the MARAC in Essex was experiencing difficulties in coping with the volume of cases. The system has since been restructured). Later that same day Ian was arrested at Vivienne's flat following a phone call to the Police by Patricia who had seen him there whilst visiting her friend. It is recorded that Ian disliked Patricia and he had told her to leave the flat or he would kill her. The Police discussed this threat with Patricia, but she did not believe the threat was meant and she made no complaint for this to be followed up. The risk assessment for this threat to Patricia was recorded as 'medium'.

1.20 Further incidents requiring Police involvement took place in October 2013 when Vivienne reported that Ian had forced her out of her flat. The incident was assessed as 'medium' risk. Ian was in breach of bail conditions and was arrested, but it was assessed that Vivienne was still seeking contact with him. No further action followed. In January 2014 Patricia called the Police to report witnessing an assault on Vivienne by Ian. On visiting Vivienne officers were told that Patricia and Ian had an argument and she had threaten to call the Police. No injuries were seen and no offence reported by Vivienne.

1.21 There are further incidents which illustrate the complexities of the relationship between Vivienne, Ian and Patricia. In February 2014 Patricia reported to the Police that Ian had stolen money from her room, and in April 2014 she reported that the couple had visited her and stolen her mobile phone and sleeping tablets. Five days later Patricia withdrew this complaint as she said she had retrieved her phone. On 19 April 2014 Patricia reported to the Police that Vivienne had been assault by Ian and she had a cut above her left eye. Ian was arrested and also questioned about the theft from Patricia's flat, however, there was insufficient evidence to proceed and Vivienne was not willing to make a statement regarding the assault. Patricia also reported a theft of cash and medication by a friend (not named) in May 2014 for which an investigation was started, however Patricia then reported that the medication had been returned and she discontinued the complaint.

1.22 Ian was arrested once more on 20 May 2014 due to a complaint from Vivienne's landlord that they had diverted the electric meter at the premises, and secondly for a burglary and selling the stolen property at a pawn shop. During custody Ian was assessed by the North Essex Partnership Criminal Justice Mental Health Team due to the Police markers of schizophrenia and self harm on his records. At this assessment Ian reported that he and his 47 year old girlfriend were living with a friend. The address given is Patricia's.

1.23 During the mental health assessment Ian reported that he had been abused in the past, that he had a child with whom he had no contact, and he smoked 4-5 grams of cannabis per day in order to 'block out' his thoughts. He also stated that he had been stockpiling his medication of tramadol and diazepam prescribed for back pain, and

taking over the prescribed amount in addition to some of his girlfriends medication. He said "I would rather be off my face or dead". Around this time Ian's GP at Surgery 1 made two referrals to mental health services for him, but he had failed to attend. He said he did not realise what the appointments were for. He had also failed to attend appointments made the previous year. Ian recalled numerous mental health assessments, but he had always turn down support offered as he found it difficult to trust mental health professionals. Ian reported poor sleep patterns, weight loss, and "serious shit going on in [his] head". He also stated that he had recently witnessed his girlfriend being beaten up, but could not do anything about it as he was "too scared". At one stage in the interview Ian asked his assessor whether he made them feel nervous; he stated that he often felt the he made others feel that way. After the assessment a 'prisoner warning' (relating to history of self harm) was faxed to the prison In-Reach Team which provides health services within the prison. On 21 May 2014 a 'suicide attempt with intent' was recorded on Ian's mental health service records.

1.24 The Police next had involvement with Patricia when they investigated an allegation by Vivienne that she had been slapped around the face by Patricia late at night on 13 August 2014. Officers attended and found both women were extremely drunk, therefore an appointment was arranged to see Vivienne for a statement the next day. A number of attempts were made to contact Vivienne without success. Eventually on 9 September 2014 it was discovered that Vivienne had been taken to hospital the previous night suffering from a heart attack. Sadly she did not recover; she died in hospital.

1.25 Ian appeared in court on 5 November 2014 for the burglary offence committed in May that year. He was remanded in custody for a pre-sentence report. He was next in court on 27 February 2015 when an addendum report was requested to assess whether he was suitable for a Mental Health Treatment Requirement; his suitability was confirmed by the North Essex Partnership Foundation Trust this and when Ian next appeared in the Crown Court on 27 March 2015 he was sentenced to a Suspended Sentence Order, 104 weeks custody suspended for 24 months with the following requirements of: 24 months Supervision; 24 months Mental Health Treatment Requirement, and Thinking Skills Programme Requirement. Essex Community Rehabilitation Company took ownership of Ian's Orders on 30 March 2015 from the National Probation Service.

1.26 Ian's offender manager received a phone call on 2 April 2015 from the nurse in the prison In-Reach Team who had been working with Ian whilst he was on remand. The nurse advised his offender manager that she would make a referral to the Access and Assessment Team at The Lakes in Colchester. Whilst in prison Ian had been diagnosed with Emotionally Unstable Personality Disorder.

1.27 On the 7 April 2015 Ian had his first appointment with his Community Rehabilitation Company offender manager. He was staying with a friend in another town until he could find his own accommodation. The offender manager spoke with the friend who appeared to be committed to helping Ian get back on his feet. Ian told his offender manager that he was diagnosed with schizophrenia, but he had been released from prison without a prescription. He was registered with a GP in the Tendring area, but they did not have information about his prescription for olanzapine[2]. Ian was advised to register with a GP where he was currently staying, he therefore registered with GP Surgery 2 in order to obtain his medication. During this appointment he informed his offender manager that he had a child with an ex-partner with whom he had no contact due to an injunction being in place. He also reported that he struggled with groups

[2] medication used in the treatment of schizophrenia.

having been abused when younger. The mention of his child should have prompted Social Care checks which are mandatory; these are not recorded as having taken place. No copy of the injunction was sought, and his report of abuse when younger was not followed up in subsequent sessions.

1.28 Ian had weekly visits to his offender manager to fulfil the different elements of his orders. During an appointment on 21 April 2015 he reported experiencing hallucinations and voices telling him that people wanted to hurt him. Also, what he referred to as 'commandments' that he needed to follow otherwise he needed to hurt himself or others. Ian would not disclose what he was told to do because he said it was too bad. He added that he could only go out if his friend reassured him that voices and hallucinations were not real.

1.29 On 24 April 2015 Ian's offender manager telephoned the mental health service Access and Assessment Team and Psychosis Team. Ian was known to the East Specialist Psychosis Team between 24 April and 23 June 2015. He was under the care of a named community psychiatric nurse with whom Ian had his first appointment that day after which the nurse reported to Ian's offender manager that he had requested an increase in his anti-psychotic medication. The offender manager discussed risk with the nurse who did not think that Ian's condition was currently acute, therefore they did not believe it likely that he would act on any thoughts to harm himself or anyone else. The psychiatric nurse intended to see Ian fortnightly. Alcohol was discussed and the nurse reported that there were no indicators of alcohol use that day. The offender manager advised the nurse that there was a Mental Health Treatment Order Requirement in place and they needed to be advised of all appointments and if any were missed.

1.30 During a planned visit with his offender manager on 26 May 2015 Ian commented that he did not think he deserved to be alive. He related an incident where he was with his former partner Vivienne and the brother of his friend. Ian described that during the incident Vivienne had been brutally assaulted over a couple of hours. Ian told his offender manager that he just sat and watched as Vivienne was beaten, kicked, and punched and only stopped it when the assailant picked up a knife and said he was going to cut her throat (this appears to be the incident Ian reported witnessing during a mental health assessment on 20 May 2014). During this visit with his offender manager Ian also reported having some problems living with his friend. He said that when he was unable to sleep at night he looked at his friend and wanted to stab him. Disturbingly there is no record that the offender manager shared any of this concerning information regarding Vivienne's assault with the Police. The explanation given is that Vivienne had died the previous year therefore there was no longer a complainant. Despite the information shared in this session indicating a risk to himself and to others, Ian was not seen until 3 weeks later on 16 June 2015. Weekly supervision should have continued. Risk was not reducing. When Ian was seen next on 16 June 2015 at an office appointment with his offender manager he described everything as being fine. There was no further mention of the incident previously described.

1.31 Two days after his supervision session with his offender manager the friend he was staying with contacted the Police on 18 June 2015 to report that Ian had stolen items from his home and he had located them in a local pawn shop. The incident was 'crimed' over the phone and Ian was recorded as wanted in connection with the incident. At 23:49 hours that day Patricia also contacted the Police to report that Ian had come to her flat asking for food and to stay the night. Patricia stated that she had given him food, but refused to let him stay and he had punched her in the head knocking her to the floor and kicked her in the stomach. Patricia then told the call taker that she had been punched in the face by Ian as she tried to detain him, but he

had now left the scene. Patricia was noted to sound confused; she was not making sense and her descriptions were not consistent when repeated. Her alcohol use was well known, but her presentation might also have been due to shock. Patricia made another call the following day stating that Ian had threatened to kill her and he was pestering her as he had nowhere to stay. Patricia also reported that Ian's partner had died and he blamed her for the death. Officers despatched to interview Patricia after the first call were diverted due to a high risk missing person, and although the Police report for the Review states she was seen on the 22 June this is not logged in the Police chronology and there are no details of an interview and whether a risk assessment was done.

1.32 On the 19 June 2015 the friend Ian had stolen from phoned the Community Rehabilitation Company reporting that Ian had stolen his house keys and a television and assaulted his aunt (Patricia) and he no longer felt safe there. The offender manager called the Police and informed the call taker of Ian's mental health and his need for medication. The offender manager shared information with Ian's mental health nurse.

1.33 When Ian was arrested in connection with a burglary on 22 June 2015 the address he gave was Patricia's address; he said he was staying there whilst his care coordinator was arranging housing. He was not staying at Patricia's address at this time. The customary assessment by the Criminal Justice Mental Health team worker which took place on this arrest records the crime for which he is in custody as 'burglary-attempted'. There was no mention of the assault on Patricia. The assessment records 'no current thoughts of violence or aggression', but it is noted that he had a history of violent acts, and his care coordinator informed that Ian 'allegedly assaulted his friend the previous week'. It is not stated who the friend was or that it was a woman. It was recorded that according to his prison notes he may assault without notice. Ian also reported not taking his medication for the last 4 days, of hearing voices of a girl screaming and of an old man, in addition to visual hallucinations. These were not evident during the interview. He reported self harming 2 to 3 days before, but the wounds described were not visible. He threaten self harm if kept in custody. Ian was judged to have capacity and be fit for interview.

1.34 When interviewed regarding theft and the assault on Patricia Ian admitted the offence of theft, but denied the assault. He was charged with assault and theft, refused bail and put before the Magistrates Court on 23 June 2015 where a further assessment for the court was undertaken by a member of the Criminal Justice Mental Health Team. In this assessment Ian denied having self harm tendencies and admitted that he had not taken his medication for the last month. He also denied any suicidal intent. The court remanded Ian until a further hearing on 17 August.

1.35 The court outcome was relayed to the Community Rehabilitation Company by Ian's mental health nurse who had been notified of the court outcome by the member of the Criminal Justice Mental Health Team. The offender manager was informed that Ian would be picked up by the prison In-Reach Team and that on release he would benefit from working with the Non-Psychosis Team in the community as it was the community psychiatric nurse's opinion that his symptoms related to post trauma. Ian's offender manager did not disagree with this despite concerns about Ian's reports of hallucinations, but they did not challenge this diagnosis. The court result was entered onto the Delius database by the National Probation Service as required. An OASys[3] assessment was not reviewed.

[3] Offender Assessment System (OASys) is used by probation and prison services across the country for assessing the risks and needs of an offender. It covers -Assess how likely an offender is to re-offend; Identify and classify offending-related needs; Assess risk of serious harm, risks to the individual and other risks;

1.36 During early September 2015 Patricia was in contact with the Police twice. Firstly, one night she reported that a man had knock on her door and when she asked who it was the man replied that he was Ian. She did not answer the door and so did not see the man. Patricia believed it to be Ian who had said he wanted to 'get her' and 'I will kill you for what you have put me through'. Patricia had been told by a friend that Ian wanted 'to get her'. A community support officer visited Patricia concerning this incident and she told him that the reason she called was to find out if Ian was still in prison. She was assured that he was. Two further calls were received from Patricia in mid September concerning the theft of medication and unknown people knocking on her door who appeared drunk. Officers attended and reported that Patricia was very intoxicated.

1.37 Between 2010 and 2015 Victim Support received 10 referrals from the Police for Patricia. None of their letters or phone calls were responded to by Patricia.

1.38 Ian appeared in the Crown Court on 21 September 2015 from Chelmsford Prison. The Probation report before the court was based on a fast delivery report and had not been informed by his full past criminal history, information from his current offender manager, or his mental health nurse. He received a Suspended Sentence Order with no requirements (although his Mental Health Treatment Requirement still had some months until completion). He was released straight from the court without returning to prison, therefore he had no medication with him and no opportunity had been available to arrange accommodation, benefits, or mental health service referral prior to release. The Probation duty court officer could not recall whether Ian's medication needs were checked. The duty court officer gave him an appointment with his offender manager for 5 days time in line with procedures. Ian was given a travel warrant, and was suppose to go to Colchester Probation for hostel accommodation, but in interview for this Review he stated he did not know how to get there so he took the bus he knew back to the Tendring area.

1.39 On the morning of 22 September 2015 a prison In-Reach Team nurse recorded that Ian had not returned to the prison from court the previous day. They made a call to his care coordinator in the Specialist Psychosis Team who stated that they had been contacted by Ian's probation officer (this was in fact the court duty probation officer) who informed him that Ian had been released from court. His care coordinator informed the mental health nurse that Ian had been discharged from the Specialist Psychosis Team due to the length of time he had been in prison, and the care coordinator had advised the probation officer to make a referral to the Access and Assessment Team. Contact details for the prison In-Reach team were given in case further information was required. The In-Reach Team nurse agreed to speak with the court probation officer to organise support.

1.40 Also on the 22 September Ian's mother phoned the Community Rehabilitation Company to inform them that he was now living with a woman called Pat. This is the first information this agency had that he was staying with Patricia. This information did not trigger a home visit to assess its suitability. Ian had visited GP Surgery 1 to obtain a prescription, but the practice had no discharge summary from the prison health team or a copy of his prescription. The GP practice contact the prison In-Reach Team and faxed a formal request for his prescription. Meanwhile Ian's offender manager reviewed his OASys record with his recent conviction, and contacted the In-Reach Team to try and resolve Ian's lack of prescription for his medication. This was

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Inform the development of a plan to manage the risk of harm presented by the offender; Link the assessment to the supervision or sentence plan; Indicate the need for further specialist assessments; Measure change during the period of supervision/sentence.

complicated by Ian not being registered with a GP in the area and having no identification. He was still registered with Surgery 2. The offender manager does not appear to have considered returning Ian to his previous GP Surgery 1 in the area, and he appears not to have said he had been there already. A prescription was eventually emailed to the offender manager to resolve this difficulty. It was also noted that Ian had no money and was banned from the night shelter.

1.41 Ian also attended the local authority Housing Department on 22 September 2015 enquiring about accommodation. He reported that that he was just out of prison. He supplied the name of his offender manager and the housing officer made a call to the Probation office. This was the correct office at the time as CRC and Probation had not yet separated in this area office. The offender manager was not available and a message was left for the housing officer to be called back. No call was received. Ian was asked to provide evidence of benefits which he did when he returned on 29 September. He was given information about a rent deposit scheme. In interview Ian denied being given this information; whether this was a misunderstanding on his part is not clear, but his offender manager notes record that this had been discussed. The Housing Department had no prior warning that Ian would be approaching them and would be homeless on release from prison. The fact that Ian's mother called the Community Rehabilitation Company to inform them that he was now living with a woman called Pat on the same day as this visit by Ian suggests he may have gone to stay with her straight from prison. Given Patricia's previous anxiety about his release from prison it is likely that this was not with her wholehearted agreement.

1.42 On 25 September 2015 Essex Police received intelligence that Ian was released from prison with a discharge address in Ipswich in Suffolk. This was incorrect as he was still in the Tendring area.

1.43 Ian kept his appointment at the Community Rehabilitation Company on 25 September 2105, but as his offender manager was absent that day he saw one of their colleagues. The session was spent organising benefits. The next planned visit with his offender manager took place on 19 October when Ian reported not feeling safe with Patricia as she had previously made allegations about him. The information did not trigger a further risk assessment or home visit. This was the last appointment Ian attended. No referral to mental health services had been made to continue his Mental Health Treatment Requirement. Efforts to contact Ian via a 'care of' address which was Patricia's, and her phone number met with no response.

1.44 On 2 December 2015 breach proceedings commenced with the relevant documentation sent by the Community Rehabilitation Company to the National Probation Service. The transfer was rejected by the National Probation Service as Ian had no fixed address via which he could be summoned. Patricia's 'care of' address used by his offender manager was not included in the information. Documentation was resent on 3 December and accepted by Probation on 4 December. The lack of 'care of' address meant when the hearing took place at court on 9 December 2015 Ian did not attend. A warrant without bail was issued at this hearing.

1.45 The warrant was sent by the court to the Police the same day and Ian's warrant was categorised as category B in line with his offence. A wanted/missing person report was entered on to the Police National Computer, thus making the existence of the warrant known to all officers and staff. Ian's last known address was identified as Patricia's address and this was updated on the Athena database. Ian was sent a letter to this address notifying him that he was wanted on warrant and advising him to attend a police station. In line with procedures in place at the time the warrant was sent via Athena to the North Pacesetter Team for assessment; no officers were involved in outside enquiries in this team. On 11 December 2015 an entry was placed

on the Pacesetter Team system by a police officer stating 'unable to send warrant for allocation, email sent to area inspector with details of warrant. No THR (Threat Harm Risk) identified'. The officer involved in the assessment cannot recollect the specific case; they stated that they made the assessment of the warrant according to the original offence, which was in relation to the breach was theft. They would not normally conduct research beyond this.

1.46 The warrant was outstanding at the time of the fatal incident, but it was still within the timeframe for action within 'Court Issued Warrants Strategy' and the administration of arrest warrants with and without bail (2013) procedures. The 'Court Issued Warrants Strategy' is undated and the accompanying schedule dates from 2004.

1.47 Witness statements made during Police enquiries suggest that Ian had been coercing Patricia into giving him money. One witness reported that Patricia had been taken to a cash point and Ian made her give him money out of her bank account. One witness reported that he had been told by his wife that she had seen Patricia with a big black eye 3 to4 weeks before her death. Friends had expressed concern to Patricia about having Ian living in her flat, but she said she felt bad for him as he was sleeping rough since coming out of prison, and she could not see him sleeping on the streets.

1.48 In his summing up at the trial the judge said "Nobody could have felt anything but shock and revulsion of the killing committed by you". The judge continued "This was a sickening murder of a kind hearted and generous woman, and it was her kind nature and generosity which could not let her see you living on the street… you repaid that generosity and kindness by killing her. Her son and sister have been left devastated".

1.49 Ian was told by the judge that had he not submitted an early guilty plea he would have been sentenced to 25 years. In light of his early plea he was sentenced to life imprisonment with a minimum term of 16 years. The judge was satisfied that he was suffering from a mental disorder and imposed a Section 41 Restriction Order under the Mental Health Act 1983 whereby he would be held in a secure mental health hospital to receive treatment until such time as this was complete. He would then be transferred to prison to serve the rest of his sentence before being judged suitable for release.

2 Key Issues Arising from the Review:

2.1 This Review emphasises the importance of adopting a more investigative approach to information gathering and the validating of reports in the management of offenders. This includes the need to read previous assessments and to make checks with the Police and safeguarding to inform risk assessments, and management and care plans, as well as making home visits.

2.2 Ian was a well known offender due to his long offending history and was under Community Rehabilitation Company (CRC) supervision at the time of the murder. A previous DHR recommendation (Tendring DHR 2013) identified a need for Police systems to flag offenders who are managed by Probation (and now also CRC) to ensure that information on incidents and arrests of offenders are passed to their offender manager. This has not happened. The reason for this is that there are no database systems to facilitate such a process across the country which would be needed to account for offender's moving across authority, county, or metropolitan service borders.

2.3 Whether an offender is in an intimate relationship or not, a previous history of domestic abuse needs to be taken into account and included in risk assessments. In this case no such assessment was undertaken and the perpetrator's attitude towards

women in particular was not assessed. Where a specialist domestic abuse risk assessment exists this needs to be used to establish risk to future partners or others, particularly women.

2.4 There was a concentration on risk to Ian himself rather than the risk he posed to others. Whilst being supportive and empathetic are commendable qualities when working to achieve engagement with an offender or service user, the risks to others should never be subsumed or ignored by that role. Practitioners need to be helpfully challenged and supported in management supervision to prevent the loss of this focus, particularly on victims.

2.5 The practice of releasing offenders straight from court when they have previously been held in custody and in receipt of health services and prescribed medication in prison needs to be reviewed. Ian's unplanned release from court meant he was homeless and without his medication which helped to alleviate his mental health symptoms. Had he had accommodation organised prior to release he would not have moved into Patricia's flat. It is understandable that Ian could not be prescribed medication to take with him to his court appearance, the In-Reach Team and the system of prescribing from the prison Pharmacy and the receipt of court lists do not facilitate this, and there are safety considerations with regard to a prisoner having prescribed medication at court. This emphasises the need for release to be planned in such cases.

2.6 Ian was not referred to mental health services on release from prison as he should have been. Whether the court duty probation officer was the correct person to be expected to do this is debatable. A clearer referral pathway between prison and community services is needed. The practice of discharging a patient from mental health services when they go into custody and are supported by the prison In-Reach Team is a barrier to delivering a seamless service of support and monitoring of progress, especially when a Mental Health Treatment Requirement is in place which needs to be complied with. It is possible that the break in mental health support might have contributed to a deterioration in Ian's mental health and his compliance with his medication. Such gaps in treatment need to be avoided.

2.7 In common with many Reviews gaps in information sharing were identified. Even small omissions such as an address to which a summons can be sent can have serious ramifications.

2.8 Following his release, and up to the time of Patricia's death, the only agency involved with Ian was the Community Rehabilitation Company apart from the GP he briefly consulted for prescriptions. He was late for one Community Rehabilitation Company appointment and failed to attend 4 appointments suggesting that he was disengaging. He was eventually breached, and at Chelmsford Crown Court a warrant without bail was requested and granted on 9 December 2015. Ian was not in court as his offender manager had omitted details of his 'care of' address in the breach information provided to Probation. He was therefore not at court as he was unaware of the court hearing, thus he was not able to be detained that day. Information regarding the warrant was sent by the court to the Police where it was recorded on the system. However, there is no record of active steps being taken to execute the warrant which was outstanding at the time Ian killed Patricia.

2.9 The importance of background history and intelligence is not just an issue for offender management. Its importance is equally key in Police assessments, be that for assessing categories of warrant or actions to pursue in investigations.

2.10 Both Patricia and the perpetrators former partner Vivienne, had problems with alcohol, which may have resulted in them being seen as unreliable witnesses, but they

deserved the same level of protection if not more, than someone able to articulate their experiences to an expected high standard. Patricia also suffered from depression and anxiety and had been a victim of domestic abuse in the past. Research consistently shows that women's use of alcohol can be as a consequence of experiencing domestic abuse, with alcohol often used to self-medicate to dull the effects of physical abuse and/or emotional pain[4]. Women who experience domestic violence are 15 times more likely to use alcohol and 9 times more likely to use drugs than women that have not been abused[5]. Mental illness also increases a woman's risk of being abused. Research has found a higher risk of experiencing partner violence among women with depressive disorders, anxiety disorders, and Post Traumatic Stress Disorder compared to women without mental disorders[6]. These additional risks faced by women such as Patricia and Vivienne need to be considered by all agencies.

3 Conclusions:

3. 1 Avoiding hindsight, and from the information known to the key agencies who were managing the perpetrator and supporting him with his mental health issues, Patricia's murder was not predictable by agencies. The main contributory factor to this was the lack of background history which included information about past violence, including domestic violence, in addition to his considerable acquisitive crime record. This was not researched, and was not taken into account in agency risk assessments. When Ian did express thoughts of harm to another person, or when he was charged with assaulting Patricia, this was not followed up and risk levels changed. Crucially, there was no home visit to Patricia's flat to check the appropriateness of Ian living there, and no connection was made that she was a victim of a previous assault by Ian. There was a significant lack of professional curiosity and investigative practice.

3. 2 However, Patricia's death could have been prevented if crucial actions had taken place, particularly at the time of Ian's sudden release from custody by the court in September 2015 and the months which followed.

3. 3 Releasing Ian straight from court meant no preparation had taken place for his release including arrangement of accommodation, benefits, mental health service referral and his medication. Courts should be aware of the consequences of sudden unplanned releases from custody, especially where an offender has needs for treatment and medication which are being met by prison health services.

3. 4 The fact that he was homeless following release resulted in Ian moving in with Patricia which had a direct relevance to her death. Had he had his own accommodation arranged he would not have been living in her flat, and had a home visit taken place and Patricia identified as Ian's previous victim of assault, it would have been clear that living with Patricia in her one bedroom flat was not suitable accommodation.

3. 5 The failure to re-establish mental health services to fulfil the conditions of his Mental Health Treatment Requirement and Ian's engagement with support was also significant. The monitoring of his mental health could have acted as a preventative measure. It appears from his failure to attend appointments with his offender manager in October and November 2015 that he was disengaging, and his mental

[4] Humphreys C, Thiara R, Regan L. (2005) *Domestic Violence & Substance Misuse, Overlapping issues in separate services. London, Stella Project*
[5] Barron J (2004) *Struggle to Survive.* Bristol, Women's Aid Publications
[6] 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

health needs and management of his behaviour was inadequate and going unchallenged.

3. 6 Ian's breach of his order went unchecked and unchallenged for too long, and the warrant granted in December shortly before he killed Patricia was a final preventative step which should have seen him arrested and back in custody. This did not happen. Had Ian been arrested at that time he would have been in prison and Patricia would not have been killed. Ian's breach of his Order went unchecked and unchallenged for too long. No 'care of' address was provided to which a summons to court could be sent, therefore Ian was probably unaware that he should have been in court to learn that he was to be returned to custody. Had he been in court he could have been apprehended immediately and returned to custody easily. The warrant granted in December 2015 shortly before he killed Patricia was a final preventative step which should have seen him arrested promptly and back in custody. This did not happen; his warrant was not categorised at a level to require the fastest execution as his offence did not meet the relevant criteria. Intelligence which would have shown him to be a high risk domestic abuse offender was not checked; his criminal history was for acquisitive crime, his history of violent assaults were not considered as they were not prosecuted. Had he been arrested promptly Ian would have been in prison and Patricia might not have been killed. However, warrant procedures of the time were complied with and the time for reviewing his warrant had not yet been met. A series of small omissions in systems and procedures, which in themselves appear insignificant, had a devastating outcome for Patricia and her family.

4 Recommendations

4.1. DHR Statutory Guidance instructs that recommendations should be realistic and achievable, however before going on to the recommendations the Panel wish to highlight two areas of concern for which they would have wished to make a recommendation, but realise they would be difficult to achieve either within the current legislation, or which an agency cannot realistically achieve within resources available at this time. The issues are:

1. Health colleagues on the Panel have highlighted the difficulty Health professionals face when considering whether an adult may be at risk since they do not have access to all the health records that may exist for the patient. Professionals may, therefore, often only have a small part of the picture concerning the patient they are assessing. Confidentiality and patient health records that are held on different IT systems can limit information sharing and may not support professionals to consider all known risks to the patient. However, professionals are encouraged to liaise across services.

2. The perpetrator had a very difficult and traumatic start in life. It is outside the remit of this Review to focus on this aspect of his history and previous DHRs where perpetrators have had similar childhood experiences have highlighted the long-term impact of all forms of abuse on children which has not been sufficiently addressed at that time. Nevertheless, the Panel wished to emphasise the importance of access to effective psychological and mental health services for children and young people who have suffered childhood trauma and abuse. This is not just to address their future wellbeing, but also to reduce the risk of harm to others which have arisen in this and comparable cases.

4.2. The following recommendations arise from IMRs, lessons learnt from the Review and Panel discussions. Timescales for their achievement are set out in the Review Action Plan.

National:

The Home Office

Recommendation 1:
The learning from this and previous Reviews confirms that information on arrests of persons already supervised by Probation (CRC or NPS) is not routinely shared by Police because it is difficult for Police to ascertain where a person is being supervised. There is no single or national platform for communication between agencies. The Home Office may therefore wish to consider a review of how information is shared between Police and probation service providers to ensure that all known risks are shared and breaches of existing Orders are quickly acted upon for the protection of the public.

Regional:

NHS England Midlands & East (East)

Recommendation 2:
That the specification for the provision of prison healthcare services includes the requirement for the service provider to have in place a clear care pathway for service users who are to be released from prison with a diagnosis of a mental health condition which ensures referral to Community Mental Health Services prior to release to ensure there is no delay in receiving care and treatment following release. The pathway should include:

(a) A fast track referral system agreed with Community Mental Health Services for those with a diagnosis of mental illness or a Mental Health Treatment Requirement which has been imposed by the courts.

(b) Where a prisoner is released straight from custody by the courts the prison healthcare service on notification of this event should take responsibility for any referral to the Community Mental Health Services as soon as possible and liaise with Probation or other supervisory agency.

(c) The referral pathway should be shared with the necessary agencies including Probation and other offender management agencies.

Recommendation 3:
NHSE Midlands & East (East) should share the learning from this case with GP practices across Midlands & East (East) to highlight what a Mental Health Treatment Requirement is and why a court imposes it. This should outline that notification from Probation or the Community Rehabilitation Company, or Community Mental Health Services is to ensure that GP practices are aware their patient is receiving mental health services, and that this information must be recorded on the patients' health records. If they have concerns about their patient's mental health, they should liaise promptly with their patient's mental health worker. This learning should highlight that where a mental health service user has refused to share this information with their GP, the practice would not receive notification and may therefore be unaware of the order.

County

Essex Criminal Justice Board

Recommendation 4:
A review should take place into the system of releasing an offender from prison custody from court without accommodation and/or a prescription for existing

medication being arranged, especially where the person being released has been in receipt of prison health services and prescribed medication for mental illness or disorder.

Local

Essex Adult Safeguarding Board

Recommendation 5:
The Adult Safeguarding Board should disseminate the learning from this Review via their newsletter and website for practitioners.

Essex Community Rehabilitation Company

Recommendation 6:
Responsible officers must ensure that they draw on previous risk assessments and historic information to inform current risk assessments.

Recommendation 7:
Police intelligence checks and children's safeguarding checks must be completed as soon as possible after sentence and the outcome of these enquiries documented on the Delius database and OASys assessment.

Recommendation 8:
Where an issue is linked to Risk of Serious Harm, this needs to be outlined in the Risk Management Plan with specific actions identified.

Recommendation 9:
Responsible Officers must record attendances and failures against Court requirements on Delius to ensure progress is monitored and enforcement action taken as required.
Recommendation 10:
Responsible Officers must adopt an investigative approach to the management of service users, demonstrating professional curiosity which is an essential skill in offender management.

Recommendation 11:
Responsible Officers must adhere to the minimum standards in relation to home visits and reviewing risk assessments following any change in accommodation or circumstances.

Recommendation 12:
Whether an offender is in an intimate relationship or not at the time of assessment, where there is a history of domestic abuse/ violence a SARA must be undertaken to inform risk.

Recommendation 13:
Supervising managers should ensure that appropriate guidance and challenge is given in supervision sessions to ensure sight is not lost of the victims of crime, and that risk assessments contain thorough risk assessments to others which are regularly reviewed.

Recommendation 14:
Where a 'care of' address has been used for correspondence the Responsible Officer needs to ensure that this is recorded on the case management system and the National Probation Service made aware of the address on the breach documentation.

National Probation Essex

Recommendation 15:
Reports for the court should be informed by information from an offender's current offender manager where relevant, and any other professional involved in their care and/or supervision, in addition to a full criminal history.

Recommendation 16:
An offender's cognitive and intellectual abilities should be taken into account to establish that they fully understand the instructions given to them and the actions they need to take prior to release.

North Essex Partnership Foundation NHS Trust (Mental Health Services)
& NHS England East Region

Recommendation 17:
With the consent of the service user, where they are subject to a court mandated Mental Health Treatment Requirement their GP should be informed and provided with the contact details of the mental health service member of staff responsible for their patient's care. GPs should be given information explaining Mental Health Treatment Requirements.

Essex Community Rehabilitation Company & Essex Partnership Foundation NHS Trust (Mental Health Services)

Recommendation 18:
That Essex Community Rehabilitation Company and Essex Partnership Foundation NHS Trust providers of Mental Health Services, should ensure that a secure process is established whereby an offender's mental health care plan and risk management plan is shared between the staff responsible for the management of the offender with the joint goal of coordinating work to achieve both plan's outcomes.

North Essex Partnership Foundation NHS Trust (Mental Health Services)

Recommendation 19:
The Trust should confirm that the new format of their records enables clinicians to gain an overview of a patients full history and care.

Recommendation 20:
That the Trust develop a care pathway for patients who are released from prison with a diagnosis of a mental health condition to ensure there is no delay in receiving care and treatment, and that there is a fast track system for those with a diagnosis or a Mental Health Treatment Requirement which has been imposed by the courts.

Recommendation 21:
The Trust should review its policy of discharging offenders who go into custody from their service with a view to achieving a seamless service back into the service when custody ends.

Anglia Community Enterprises

Recommendation 22:.
To review ACE staff's access to the Summary Care Record to enable them to be alerted to patients' known vulnerabilities.

Recommendation 23:
A section should be added to the generic referral form to enable early recognition of safeguarding concerns and any reasonable adjustments required.

Recommendation 24:
A three monthly audit of patient records should be developed and undertaken over a period of twelve months to monitor compliance with the use of and effectiveness of the safeguarding adults' template. Findings of the audit should be used to identify further quality improvement opportunities.

Recommendation 25:
A three monthly audit of patient records should be developed and undertaken over a period of twelve months to monitor compliance with the holistic assessment template. Findings of the audit should be used to identify further quality improvement opportunities.

Essex Police

Recommendation 26:
It is recommended that performance feedback is given to the case officer regarding the timely progression of the investigation (for the incident on 25.06.2013) the accurate recording of enquiries in the investigation log, and performance advice is provided to their supervisor who should have ensured a timely investigation being conducted by their officer.

Recommendation 27:
In light of the age of the documents entitled Court Issued Warrants Strategy (undated) and the accompanying schedule dated 2004, and more importantly, in light of the circumstances and learning from this case, this DHR considers that a review of the Policy in relation to warrants is carried out as a matter of urgency.