



DOMESTIC VIOLENCE HOMICIDE REVIEW

OVERVIEW REPORT

Into the death of
Patricia
in December 2015

Report Author
Gaynor Mears OBE, MA, BA (Hons), AASW, Dip SW

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Preface

The Tendring County Community Safety Partnership and the Domestic Homicide Review Panel would like to express their sincere condolences to the victim's sons, sister, and family members. Her loss due to this terrible crime has been extremely distressing and she is greatly missed by them all.

This Domestic Homicide Review (DHR) was commissioned by the Tendring Community Safety Partnership following notification of the homicide of a resident of the Tendring District Council area in December 2015 in circumstances which were agreed to fulfil the criteria of Section 9(3)(a) of the Domestic Violence, Crime and Victims Act 2004, namely the homicide appeared to be by a person to whom the victim was related, or with whom they had, or had been in an intimate relationship, or been a family member. The Home Office defines domestic violence as:

Any incident or pattern of incidents of controlling, coercive or threatening behaviour, violence or abuse between those aged 16 or over who are or have been intimate partners or family members regardless of gender or sexuality. This can encompass but is not limited to the following types of abuse: psychological, physical, sexual, financial, and emotional.

Controlling behaviour is: a range of acts designed to make a person subordinate and/or dependent by isolating them from sources of support, exploiting their resources and capacities for personal gain, depriving them of the means needed for independence, resistance and escape and regulating their everyday behaviour. Coercive behaviour is: an act or a pattern of acts of assault, threats, humiliation and intimidation or other abuse that is used to harm, punish, or frighten their victims.

However, as the Review progressed information provided to the Review Panel suggested that the victim in this case was not the partner, former partner, or a family member of the perpetrator. The perpetrator was sharing the victim's flat because she had offered him accommodation as he was homeless. The perpetrator himself confirmed that the relationship was not of an intimate nature. Nevertheless, the Panel felt there were relevant and useful lessons to be learnt, therefore a proportionate Review has taken place.

The independent chair and author would like to thank those who have contributed to this Review. The chair would also wish to express her appreciation for the time and thoughtful contributions made by members of the Review Panel and the Individual Management Review authors.

The key purpose for undertaking a Domestic Homicide Review (DHR) is to enable lessons to be learnt from homicides where a person is killed as a result of domestic violence. For these lessons to be learnt as widely and thoroughly as possible, professionals need to be able to fully understand what happened in each homicide, and most importantly, what needs to change in order to reduce the risk of such tragedies happening in the future.

The term domestic abuse will be used throughout this Review as it reflects the range of behaviours encapsulated within the above definition, and avoids the inclination to view domestic abuse in terms of physical assault only.

DOMESTIC HOMICIDE REVIEW

1. Introduction

- 1.1 This report of a domestic homicide review examines agency responses and support given to Patricia, a resident of the Tendring District Council area prior to the point of her death in December 2015. The review will consider agencies contact and involvement with her and the perpetrator of the crime from September 2013, the date when Patricia is thought to have met the perpetrator, and her death.
- 1.2 The key purpose for undertaking DHRs is to enable lessons to be learned from homicides where a person is killed as a result of domestic violence. In order for these lessons to be learned as widely and thoroughly as possible, professionals need to be able to understand fully what happened in each homicide, and most importantly, what needs to change in order to reduce the risk of such tragedies happening in the future.

Timescales

- 1.3 Following notification by the Police of the death the Tendring Community Safety Partnership (CSP) Chair met with the Police and Community Safety Department representatives on 22 January 2016 and made the decision that the circumstances known at that time reached the criteria to hold a Domestic Homicide Review (DHR). The Home Office was informed of the decision on 12 February 2016. The decision was discussed and ratified at a meeting of the CSP Responsible Authorities Group on 16 February 2016. Information gathering commenced, but the Review process was then adjourned until the completion of criminal proceedings. It was not possible to complete the Review within 6 months as set out in statutory guidance as criminal proceedings did not conclude until June 2016, after which the Review process recommenced. There were further delays in achieving information from relevant agencies. The Review was concluded on 20 March 2017.

Confidentiality

- 1.4 The findings of this review were held to be confidential, with information available only to participating officers/professionals and their line managers until the Review has been approved by the Home Office Quality Assurance Panel for publication.
- 1.5 To protect the identity of the victim, perpetrator, and their families and other parties to this Review the following pseudonyms have been used throughout this report:

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

Dissemination

- 1.6 The following will receive copies of this report for the purpose of strategic planning, appropriate action, and disseminating the contents to enable lessons to be learnt among their staff:

Chair & Partners, Tendring Community Safety Partnership
The Chair and Board, North East Essex Clinical Commissioning Group
The Chair and Board, North Essex Partnership University NHS Foundation Trust
(Mental Health)
Chief Executive, Colchester Hospital University Foundation NHS Trust
Chief Constable, Essex Police
Essex Police & Crime Commissioner
Medical Director for Primary Care, Care UK (provider of In Reach Service for
Chelmsford Prison)
Chief Officer, Anglian Community Enterprises
Chief Officer, Safer Places
The Independent Chair, Essex Safeguarding Adults Board
Director of Public Health and Wellbeing
Essex Domestic Abuse Coordinator
Chief Officer, Essex Probation Service
Chief Officer, Community Rehabilitation Company
Essex Crown Court and Magistrates Court
Essex Criminal Justice Board
NHS England for the Eastern Region
NHS England Commissioner for Prison Health Services

Summary

- 1.7 The circumstances leading to this Review are that in September 2015 the perpetrator Ian attended court from prison where he had been held on remand on charges of theft and assault. The assault charge was dropped and he was released from the court with a Suspended Sentence Order with no requirements. His release from court without returning to prison meant he had no accommodation arranged, no medication which he required for mental health problems, and no re-referral to mental health services for the continuation of his court mandated Mental Health Treatment Requirement.
- 1.8 After a short period of sleeping rough the perpetrator moved into Patricia's one bedroom flat where he slept on the sofa. There are indications that this was not Patricia's choice. Ian was known to Patricia as one of her friends who was deceased had been his partner. Patricia knew that Ian had been physically abusive to her friend.
- 1.9 Patricia suffered from long term depression and problems with alcohol; these difficulties could make her vulnerable on occasions. Ian also had longstanding mental ill-health (diagnosed with Unstable Personality Disorder) and he had a tendency to misuse illicit drugs.
- 1.10 In December 2015 Ian attacked Patricia which resulted in her death. He left the flat and went to a friend's accommodation and revealed what he had done, after which he took the friend to Patricia's flat to show him. The pair then returned to the friend's flat. Next morning the friend called the Police, and Ian was arrested and charged with Patricia's murder. At the time of the crime Ian was subject to supervision by the Community Rehabilitation Company, but he was in breach of

his order; he also had a period of time still to run before a previous Mental Health Treatment Requirement had been completed.

Terms of reference of the review

1.11 Statutory Guidance (Section 2) states 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.

Specific Terms of Reference for this 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 met the perpetrator. Agencies with relevant background information about the victim and 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 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.

Methodology

- 1.12 A scoping letter was sent to agencies in January 2016 requesting confirmation of contact with the victim and the perpetrator. 23 agencies were contacted, 10 confirmed contact, 1 of which was outside the timescale of the Review and the database did not record any involvement following a referral. There were 13 nil returns. Agencies confirming contact were asked to secure their files and to provide a chronology. Agencies chronologies were combined into a narrative chronology by the Review author. An appropriate proportion of this chronology relevant to the Review appears in section 3.
- 1.13 The Panel then decided which agencies needed to provide an Independent Management Review (IMR). A total of 9 IMRs were requested and provided. These were written by authors who were independent of direct involvement in the case or responsibility for the supervision of practitioners, with the exception of the Local Authority Housing Department IMR where the author confirmed that she had no contact with the victim or perpetrator, but she did supervise staff who did. The department's involvement during the period under detailed review was

relatively brief, but important and consisted of 2 visits to the office by the perpetrator and a completed Housing Benefit form, therefore the IMR was considered appropriate once additional questions were answered. The victim's GP IMR was provided by the victim's GP. The report was factual and clear, and the GP consulted the DHR author by telephone during the writing of the IMR to clarify aspects of the terms of reference which were outside their knowledge or field of expertise. Further support and guidance to the GP was given through telephone contacts together with a review and revision of the initial IMR by the Associate Named Nurse Safeguarding Children who was a DHR Panel member.

- 1.14 A Report answering specific questions was requested from the prison In-Reach mental health team provided by Care UK. Difficulties were experienced in obtaining this information from the service which delayed the report for a number of months. The chair went through the NHS England commissioner for criminal justice services and through their auspices was eventually able to gain a response from the team. A number of email and telephone exchanges took place to enable the Review to be informed regarding a critical period in the delivery of services and the process of the offender's release from prison.
- 1.15 The author held a briefing meeting with IMR authors and following IMR submissions after the criminal trial was concluded this was followed by a debrief. Practice procedures were reviewed and relevant staff were interviewed by IMR authors. The DHR Panel discussed the IMRs at their second Panel, and it was necessary to raise follow up questions with the authors and for some to revisit gaps in the terms of reference. The timeliness of this process was hampered by a change in staff in a key agency.
- 1.16 With the assistance of the Family Liaison Officer for the family the chair wrote to Patricia's son and sister including the Home Office leaflet for family members explaining the Review process. A meeting with Patricia's son and sister followed where the terms of reference were shared and agreed. It was also agreed that at their request contact would be with Patricia's son following the conclusion of the criminal proceedings.
- 1.17 The chair attended the final days of the criminal trial at which she was able to speak further with Patricia's son. Out of respect for the family's privacy information provided has been used in proportion to its relevance to the Review. The chair would like to acknowledge the impressive dignity and fortitude shown by Patricia's son during the trial. His mother would undoubtedly have been very proud of the way he conducted himself at this very difficult time, and particularly of the way in which he raised pertinent questions with the Police and the prosecuting counsel during the trial.
- 1.18 Unfortunately, attempts to re-establish contact with Patricia's son to share a copy of the final draft of the report were not successful despite a brief phone call to inform him that the report was ready for checking with him. The chair is saddened that the lessons learnt have not been able to be shared with him, but she understands that the time which has passed may make it painful to resurrect memories of such tragic events. Efforts are to be made to find a way of sending him a final approved copy if possible as he is no longer at his original address. Just before the report was received from Home Office Quality Assurance Panel with approval for publication, the chair was contacted by the victim's sister regarding its progress. A copy of the final report was therefore sent to her with an invitation to contact the chair with questions if she so wished.

- 1.19 An interview was undertaken with the perpetrator in the secure hospital in which he was held for the first part of his sentence. The interview was conducted by the chair and the Panel member who is head of safeguarding for the Mental Health Trust. Information gained during the interview has informed the Review.
- 1.20 A letter was written to the perpetrator's mother and this was followed by telephone contact when an appointment was arranged to meet. However, this meeting was cancelled and further contact to rearrange received no response. Limited background information from a Police statement taken from Ian's mother has therefore been accessed to inform the Review.
- 1.21 The chair wrote to the psychiatrists who undertook the assessments of the perpetrator for the court process to ask their consent to access their reports, and to cite relevant information to inform the Review. The chair is grateful to Consultant Forensic Psychiatrist Dr David Baird for kindly giving his consent.

Early Learning

- 1.22 As a result of the information gained from the chronology in the early stages of the Review process three key learning points were identified concerning the management of the perpetrator: No home visit had taken place to establish the appropriateness of his accommodation. Checks had not been made concerning an injunction forbidding contact with an ex-partner and their child. A violent assault described by the perpetrator which he said he had witnessed was not followed up and no reassessment of risk took place. As a result the chair sent a letter on 26 April 2016 to the head of operations for the Community Rehabilitation Company pointing out this learning. The chair received a letter of reply on 12 May 2016 confirming that the Serious Further Offence Review had also identified similar learning, and detailing the actions which had been taken via staff briefings to reinforce national service standards and expectations of staff. The IMR provided for the agency confirmed that the Serious Further Offence review had identified these learning points and the actions which were taken. However the Community Safety Partnership will wish to ensure that such learning is firmly embedded and thus the recommendations arising from this learning will feature in the Review action plan. The learning will be included in the later sections of this report.

Contributors to the Review

- 1.23 The agencies contributing to this Review and nature of their contribution are as follows:
- 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
 - General Practitioners for the perpetrator - medical notes only
 - 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

1.24 An IMR was not received from the perpetrator's GP practices with whom he had contact. Difficulty in being able to attain this was due in part to the changes in GP used by the perpetrator, the last of which was relatively brief, and the length of time in gaining records. Regular GP contact was also interrupted by periods in custody. However, after some months into the review his medical notes and summary care records were obtained, these were scrutinised and their contents have informed the Review. An attempt to achieve an IMR covering 3 GP practices would have involved an undue delay in the completion of the review, which given the other health information available to the review, was felt to be disproportionate to the information to be gained in this case. The medical records were accessed in the public interest, as at the time the information was needed the perpetrator was in a secure mental health hospital commencing treatment. As an IMR was not submitted from the perpetrator's GP scrutiny could not be given to the GP care by the 3 separate GP practices that were accessed by Ian in the period covering the scope of the review.

Review panel members

1.25 The Review Panel contained the following representation:

Name	Role	Organisation
Gaynor Mears	Independent Chair & Author	
Leanne Thornton	Community Safety Manager	Tendring District Council
Katie Castle	Manager Investigations	Essex Community Rehabilitation Company
Cathy Low	Housing Options Coordinator	Tendring District Council
Helen Edwardson	Safeguarding Adults Lead	Colchester Hospital University Foundation Trust
Lisa Poynter	Safeguarding Adults Lead	Anglian Community Enterprise
Tendayi Musundire	Head of Safeguarding	North Essex Partnership Mental Health Trust
Georgina Edwards	Associate Designated Nurse Safeguarding Children	North East Essex Clinical Commissioning Group
DI Caroline Venables	Public Protection	Essex Police (up to July 2016)
DI Janette Rawlingson	Major Incidents Review Unit	Essex Police (from December 2016)
Simon Chase	Safeguarding Lead	East of England Ambulance NHS Trust
Sophie Hickson	Review Administration & Panel minutes	Tendring District Council

There was no one available from the specialist domestic abuse sector able to attend the first Panel, and when this case was found not to fall under the definition of domestic abuse it was decided not to press for a representative from this sector due to pressures on staff time. The chair would have welcomed a representative from a suitable charity or service, however, capacity issues within the mental health voluntary sector made this difficult to achieve. The chair is however, confident that the Panel's standard of debate and member's willingness to probe, has enabled the key issues and learning to be drawn out from this Review in the hope that similar such crimes can be averted in future.

Chair & Author of the Review

- 1.26 The chair of this Review and author of this Overview Report is independent DHR chair and consultant Gaynor Mears OBE. The author holds a Masters Degree in Professional Child Care Practice (Child Protection) and an Advanced Award in Social Work in addition to a Diploma in Social Work qualification. The author has extensive experience of working in the domestic abuse field both in practice and at strategically, including roles at county and regional levels. Gaynor Mears has experience in undertaking previous Domestic Homicide Reviews, and research and evaluations into domestic abuse services and best practice. She has experience of working in crime reduction with Community Safety Partnerships, and across a wide variety of agencies and partnerships. Gaynor Mears is independent of, and has no connection with, any agencies in the Tendring Community Safety Partnership area other than in the capacity of chairing previous DHRs for the Partnership. She also has no connection with agencies in the county of Essex.

Parallel Reviews

- 1.27 A coroner's inquest was opened and adjourned. The inquest was closed following the completion of criminal proceedings.
- 1.28 A Serious Further Offence review was undertaken by the Community Rehabilitation Company and submitted to the National Offender Management Service. The agency's IMR was informed by this review.

2. The Facts

- 2.1 Patricia lived in a one bedroom flat in the Tendring District Council area and it was there that she was murdered by Ian. The post mortem concluded that Patricia died of stab wounds to the chest. She had suffered 13 to 14 stab wounds, and there were superficial wounds which the examiner considered evidence that she had been tortured.
- 2.2 Patricia had known Ian for approximately 2 years as he was once in a relationship with one of her friends called Vivienne who had died of a heart attack some months before when Ian was in prison for burglary. Patricia had taken Ian in when he was homeless in September 2015 after he had a short period in prison on charges of theft. He had been released straight from court without returning to prison, without accommodation organised, without his medication or a prescription, and without follow up organised with mental health services.
- 2.3 Ian was under the supervision of the Community Rehabilitation Company on his release as he had a remaining Mental Health Treatment Requirement to fulfil. On 22 September 2015 Ian's mother phoned the Community Rehabilitation Company to report that he was now living with a woman called Pat. Ian attended his offender manager appointments in September and October 2015, but then failed to attend. At the time of the fatal incident he was in breach for failing to report.
- 2.4 On the day of the murder in December 2015 Ian reported that he heard voices telling him to take Patricia's life. After the fatal incident Ian remained in the flat watching television for a while before attempting to dispose of Patricia's body in a wheelie bin. This failed and he covered her with a duvet in her bedroom and went

to visit a friend. He told the friend what he had done and returned to the flat with the friend where he proceeded to clean. The pair then left. After breakfast the next day Ian's friend contacted the Police to report what had happened. After a search of the local area Ian was arrested, charged with murder, and held in custody. He 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. Ian was sentenced 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.

Equality and Diversity

- 2.5 The Review has not identified any issues arising from the Equality Act 2010 in respect of Patricia or Ian. Although both suffered from long-term mental ill-health it is doubtful that any level of impairment used to define the meaning of 'disabled' under the Act in paragraph A5¹ of the Equality Act 2010 Guidance would be significant enough to have 'adverse effects which are substantial', long-term, and had long-term substantial adverse effects which were effected normal day-to-day activities. Both had access to services if they chose, and there is no evidence that services discriminated against them.

3. Chronology

The Victim's Background

- 3.1 Patricia had a long history of depression and problems with alcohol dependence. She received regular support from her GP; she was referred to specialist services for those conditions a number of times, but was unable to maintain appointments or sustain the treatment offered long term. She was prescribed medication for her depression. Patricia also received support from her family, but their help also proved unable to support her to recovery.
- 3.2 Patricia was known to North East Partnership Trust mental health services between 2008 and 2010 where she was assessed and offered services by NEEDAS (North East Essex Drug & Alcohol Service). Patricia was described as being alcohol dependent and as experiencing depression (which she attributed to the deaths of her parents). She had a long history prior to 2010 of alcohol misuse and being homeless. In 2010, mental health records include a Core Assessment which notes that Patricia was vulnerable to exploitation, was living in an unsuitable house of multiple occupancy and was experiencing physical attacks and financial exploitation. In 2010, Patricia was reported to have had 4 marriages and that 3 husbands were deceased as a consequence of alcohol-related illnesses. During the service's intervention at this time Patricia moved into her own one bedroom flat.
- 3.3 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

¹ Equality Act 2010 Guidance. '*Guidance on matters to be taken into account in determining questions relating to the definition of disability*'. Paragraph A5 pages 8/9
https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/85038/disability-definition.pdf Accessed 1.10.16

due to self harm, and she had an admission to the Accident and Emergency Department at Colchester hospital for a reported overdose. Patricia made frequent reports to the Police of thefts from her flat, particularly of her medication. Patricia's flat was in a house of multiple occupation and she was vulnerable to exploitation from others especially when she was intoxicated.

3. 4 In March and April 2010 Patricia was a victim of domestic abuse from her then partner in which 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 IMR found that no review of a risk assessment took place, an assessment of high risk was not made nor referral to MARAC². The IMR notes missed opportunities in the handling of the incident at that time. From May 2010 significant changes have taken place in Essex Police including mandatory domestic abuse and risk assessment training, and the units investigating 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. He was recorded on the Police PROtect database as a high risk perpetrator. The threats to kill were not pursued on the advice of the Crown Prosecution Service. The perpetrator's trial was not held until almost a year later in March 2011; Patricia attended court despite having contacted the Police in October 2010 to withdraw her statement. At the trial on the direction of the judge the perpetrator was found not guilty.

The Perpetrator's Background

3. 5 Ian had a very disrupted and difficult childhood. In interview for his psychiatric assessment by Dr Baird he described witnessing domestic abuse as a child, and seeing his mother self harm in front of him. He stated that his parents separated when he was 15 years old. Ian is the second youngest of four children in the family. He recalled having fits around the age of 5 years, but could not recall receiving any treatment for these. Ian attended mainstream primary school briefly before being excluded at 6 years old due to behavioural problems. He told Dr Baird that he was sent to a weekly state boarding school until the age of 16 years; he would return home at weekends. However, in her statement to the Police his mother reported that Ian had home tuition when first excluded from primary school and when that did not work he was sent to the boarding school.
3. 6 Ian's mother reported that this too failed after a few months and he was excluded again. She said she did not know the name of the school as Ian was collected in a taxi from home and taken to school. Ian described his behaviour at the school as very bad and he would keep disappearing and being violent. He reported to Dr Baird that he did not understand why he was there and he never settled.
3. 7 When he was 8 or 9 years old Ian's mother had a breakdown and he and his sibling were taken into the care of the local authority. Ian's mother's statement recalls that after a few weeks their father took them out of care, but returned them after a few months when he could not cope. Ian's own story to Dr Baird differs; he said he went into care after his parents separated when he was 15 years old and that he stayed with his mother and siblings until he was taken into care. He stated that he kept running away from foster care, but the residential home was better. Ian reported that after boarding school he attended College where he completed a one year course in bricklaying, electrical engineering and

² 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.

plumbing and obtained a Level 1 NVQ qualification. Ian has never been in paid employment; when not in prison he has been in receipt of benefits.

3. 8 Ian disclosed to Dr Baird that he was sexually abused by his father as a child. He said he was closer to his father than his mother, "but that was for sick reasons". At his interview in the secure hospital Ian said he was 12 or 13 years at the time of the abuse, but he did not want to talk about his experience either at this interview or with Dr Baird during his psychiatric assessment. As he was in care at this age this may not be his correct age at the time of the alleged abuse, however, it is not known if he had contact with his father during his time in care. Ian has refused a Police invitation to pursue an investigation into his allegations of abuse. Ian also alleged to Dr Baird that he was taken round men's houses with one of his siblings where "they did things...it was horrible."
3. 9 Ian has a criminal history including convictions as a youth which included time spend in a Youth Offending Institution. He has a total of 24 convictions for 46 offences. His first offence dates from 2002 when he was 12 years old; he was first convicted in November 2004 aged 14 years. His last conviction before the murder was on 21 September 2015 for theft. Ian's crimes were predominantly linked to acquisitive crime. In summary his convictions are:
- 2 x offences against property (2004)
 - 2 x offences against the person (2006-2007)
 - 3 x drug offences (2008-2009)
 - 12 x offences related to police/courts/prisons (2004-2015)
 - 26 x theft and kindred offences (2005-2015)
 - 1 x fraud and kindred offences (2015)
3. 10 In addition to these convictions there were two incidents of note which did not lead to charge or conviction. 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.
3. 11 On 16 March 2012 Ian was released from a 30 month Youth Offending Institution sentence. There was a condition on his licence that he was not to contact his previous partner or their child. He showed a copy of a Non-Molestation Order to his offender manager. At this point there was no mention of any serious mental health concerns recorded on the case management system.
3. 12 The second incident of relevance was a report from a victim with regard to an assault on her by her ex-partner Ian. This led to his arrest in Essex on 18 December 2012, following which he was interviewed and bailed with conditions. The custody record shows that he was examined by a health care professional due to markers on the Police National Computer (PNC) showing learning difficulties and self-harm. However, when being booked into custody Ian denied ever trying to previously self harm. It was recommended the he have an appropriate adult whilst in custody. This incident was classed as common assault no injury. Ian failed to report to the Police at the specified time in his bail conditions and he was arrested once more by Essex Police on behalf of Suffolk Constabulary on 23 April 2013. However, due to the nature of the crime and the time which had elapsed which took the matter past the 6 months limitation on

prosecution no further action was taken. The victim was given the necessary support during this process and was moved to sheltered accommodation in another town.

3. 13 Ian suffered from chronic back pain for many years for which he was prescribed pain killers which ranged from co-codamol, and tramadol, although these had been stopped by September 2015. He also had inhalers for asthma, and was prescribed olanzapine, an anti-psychotic medication. When not in prison Ian tended to have periods in temporary accommodation or would stay with friends, and this would involve moves of GP practice. Ian had a long history of using illicit substances including cannabis and cocaine.
3. 14 Dr Baird's psychiatric report for the court states that Ian has an IQ of 66. This score places his full scale IQ in the 'extremely low' range, falling at the first percentile (suggesting that 99% of his age-matched peers would perform better than him). A full scale IQ of between 50 to 69 is classified as mild mental retardation, which is a recognised condition within the World Health Organisation's International Classification of Diseases 10th Edition (ICD-10). Mental retardation is described in the ICD-10 as a condition of arrested or incomplete development of the mind, which is especially characterized by impairment of skills manifested during the developmental period, skills which contribute to the overall level of intelligence, i.e. cognitive, language, motor, and social abilities. Retardation can occur with or without any other mental or physical condition.

Chronology from 2013

3. 15 Ian was arrested on 14 April 2013 following an allegation of theft of two mobile phones from a man who had visited his girlfriend's flat. By this time he was 23 years old and had moved from Suffolk to Essex and formed a relationship with a woman called Vivienne who was approximately 45 years old. He suffered the effects of CS gas during the arrest indicating that he had resisted arrest. He was subject to a risk assessment when in custody and he 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 the matter. As a result of a PNC marker showing a mental age of 8 years it was recommended that an appropriate adult be used in interview. He was interviewed the next day, but the theft offence was not progressed due to insufficient evidence. He was charged with obstructing a constable in the execution of duty and bailed to the Magistrates Court. 13 days later he was arrested and transferred to Suffolk Police as mentioned previously at paragraph 3.12.
3. 16 The Police were involved in an investigation of an alleged theft of cash from Patricia's home on 14 May 2013. A male was arrested and remanded in custody.
3. 17 On 20 May 2013 Ian and his girlfriend Vivienne were implicated in the theft of supermarket vouchers from the communal letter box where they lived. Both denied the offence and CCTV was not of good enough quality to pursue a prosecution.
3. 18 On 25 June 2013 the Police attended Vivienne's flat (Ian's girlfriend) in response to the activation of a Police Temporary Alarm which had been previously installed as Vivienne had been assessed as a high risk victim of domestic abuse in a past relationship. The premises were flagged as being high risk for domestic violence. On arrival officers found that Vivienne had been subjected to an assault by Ian. It

was alleged that during an argument he grabbed her around the throat, pulled her to the floor, and then punched her in the face and kicked her in the ribs. Due to her injuries she was taken to hospital and a crime report was completed in relation to an offence of Actual Bodily Harm. Following treatment Vivienne made a witness statement in which her injuries were given as black eye, several broken ribs, and broken pelvis. Despite these injuries the crime was not revised to Grievous Bodily Harm. A Crime file question as to whether the victim was a repeat victim was answered 'no' inaccurately; Vivienne was known to be a repeat victim, hence she had a fitted alarm.

3. 19 Arrangements were made for her to stay with family out of the area. The Domestic Abuse Investigation Team (DAIT) were informed, the incident was graded as high risk. Attempts were made to locate Ian, but at that point he could not be found. A Domestic Abuse Investigation Team Safeguarding officer referred the matter to Adult Safeguarding, Victim Support Services, and MARAC. A safety plan was implemented. An officer approached the Crown Prosecution Service for charging advice, but was requested to bail pending medical evidence and a statement from another officer. Medical evidence was requested on 27 June 2013. The relevant officer has confirmed that emails were sent chasing the medical evidence, however these were not recorded on the investigation log. The officer has been given advice concerning the timely progressing of enquiries and recording all enquiries on the investigation log.
3. 20 After initially staying with a family member Vivienne return to her flat on 2 July 2013. A previous decision to remove the temporary alarm was revoked and Vivienne's address was flagged on the command and control system. She was also offered support from partner agencies and a review of her safety plan took place and further referral to MARAC and Social Care. Efforts continued to locate Ian. He was spoken to on the phone on 27 June 2013 and attempts made to persuade him to hand himself in which were refused. On 5 July Vivienne attended the Police station accompanied by a friend of Ian's and withdrew her statement to the Police. On 10 July the case was reviewed by supervisor 1 with the case officer. Vivienne's retraction was noted, but the decision was made that Ian still needed to be arrested.
3. 21 Vivienne's case was eventually heard at MARAC on 16 September. The Police IMR notes that the MARAC meeting was poorly attended with the only contributing agencies being the Police and the Criminal Justice Mental Health Team. Later that day Ian was eventually arrested at Vivienne's flat. He was discovered there following a phone call from Patricia who had gone to the flat to see her friend and seen Ian there. It is recorded that Ian disliked Patricia and told her to get out of the flat or he would kill her. This threat was discussed with Patricia by the Police, but she did not believe the threat was meant and she made no complaint to enable this to be followed up. The risk assessment for the threat to Patricia was assessed as medium risk. Ian was interviewed and denied the assault offence against Vivienne in June. Following consultation with the Crown Prosecution Service Ian was bailed to attend the Police station on 30 October 2013; two further statements were required, one regarding medical evidence and the other from the second officer who attended the initial report.
3. 22 On 20 October 2013 Ian's girlfriend Vivienne contacted the Police to report that he had arrived at her flat and forced her out. He was in breach of his bail conditions. After ensuring Vivienne's safety the Police went to the flat and arrested Ian. There were no assaults on this occasion and the assessment by the Domestic Abuse Safeguarding Team was medium risk. An alert was placed on Vivienne's address to treat calls as urgent. The Police assessed that despite bail

conditions Vivienne was still seeking contact with him. Police supervisor 2 reviewed Ian's bail, the investigation, and the original CPS advice; a remand in custody was initially sought. The enquiries requested by CPS particularly the medical evidence were still outstanding therefore the evidential picture had not changed. There was judged to be insufficient information to approach CPS again that day, therefore there was little alternative other than to re-bail Ian with the same conditions. He was to return to the Police station on the 30 October.

3. 23 The case was reviewed by supervisor 2 once more on 29 October 2013 and was found to not meet the full code test³ which would have to be applied in this case. The victim Vivienne had retracted her statement and given a plausible alternate explanation for her injuries, the statement also contradicted the first statement at times which could cast doubt on the reliability of the victim. There was no supporting evidence other than injuries noted by police and medical staff; no 999 tape, and a mutual friend of the couple (Ian's friend) would not provide a statement, but indicated to Police that the victim fell over, though this was not in evidential form it would still have to be disclosed. Vivienne was also known to the Police as was her dependence on alcohol. The suspect Ian, was noted to have only very minor previous for violence and had made no admissions. The supervisor recorded 'I do not feel there is a realistic prospect of a conviction', a decision to take no further action was made.
3. 24 Just over 2 months after the last call out the Police received a call from Patricia at 16:40hrs on 6 January 2014 stating that she had been at her friend Vivienne's house and had witnessed her friend's ex-partner Ian assaulting her. When the Police arrived Vivienne said Patricia and Ian had had an argument and she had left threatening to call the Police. No injuries were apparent and no offences were disclosed by Vivienne.
3. 25 On 7 February 2014 Ian was seen by Rehabilitation Services in connection with his back pain. It was recorded that he had had the back problem almost since birth and the pain disturbed his sleep. A history of asthma and schizophrenia was noted. Joining a back class was discussed, but Ian declined as he said he was not comfortable in groups due to his mental health condition. He missed two booked appointments with physiotherapy and was discharged from the service.
3. 26 Patricia contacted the Police via 999 on 18 February 2014 to report that Ian had taken her keys out of coat pocket, gone to her flat, and stolen £80 cash from her room and then returned the keys. This had happened when she was visiting a mutual friend. There were a number of significant delays in allocating and investigating the theft. It was not until 20 April 2014 when Ian was arrested on another matter that he was questioned about the burglary. However, there was insufficient evidence to proceed.
3. 27 Patricia's next contact with the Police was on 10 April 2014 when she reported that Ian and his girlfriend Vivienne had visited her flat and stolen her mobile phone and some sleeping tablets. The matter was dealt with over the phone. On 15 April, whilst Patricia was adamant that the items had been stolen, she reported that she had retrieved her phone and was no longer willing to pursue a complaint.

³ The Full Code Test has two stages: (i) the evidential stage; followed by (ii) the public interest stage. See https://www.cps.gov.uk/publications/code_for_crown_prosecutors/codetest.html

3. 28 On 19 April 2014 Patricia made contact with the Police to report that her friend Vivienne had been assaulted by Ian and had a 1 cm cut above her left eye. It was the next day before her friend was located and a statement was taken, although this is noted as a negative statement. Officers noted the injury to her eye as reported by Patricia. Ian was arrested; as before he disclosed that he had been diagnosed with schizophrenia and personality disorder and an appropriate adult was present during his time in custody. He was interviewed and denied assault. He was also questioned about the burglary at Patricia's flat. Ian's girlfriend Vivienne was not willing to cooperate with a prosecution and both offences were recorded as no further action due to insufficient evidence.
3. 29 Ian saw his GP in Surgery 1 on 6 May 2014 when a review of his medication took place. His prescription at this time was diazepam 5mg, tramadol 50mg (for back pain), and venotolin. The plan from this appointment included referring him back to a psychiatrist regarding schizophrenia. It was noted that he had not attended 3 psychiatric appointments the previous year. The referral letter was sent on 13 May.
3. 30 The Police had two contacts in relation to Ian on 8 May 2014. Firstly the landlord of the flat where Ian and Vivienne lived made a complaint that they had diverted an electric pre-pay meter at the premises. Secondly, Police investigated a burglary of a flat and the selling of the property at a pawn brokers by Ian. The property was recovered and he was arrested on 19 May and charged with two offences. As before an appropriate adult was present.
3. 31 On 20 May 2014 Ian was assessed in the police station by the North Essex Partnership Criminal Justice Mental Health Team as a marker for schizophrenia was noted on his Police record. Ian reported that he and his 47 year old girlfriend were currently living in a friend's accommodation. The address on the referral is the same as Patricia's. It is possible that he and his girlfriend were evicted from their flat for the meter tampering mentioned above. Ian said his girlfriend was the only person he had ever trusted. He had not had contact with his family for quite some time; he did not want to discuss why, but said he had been abused. Ian stated that he had a child, but he did not know where the child was as he had no contact. He reported that he had been smoking 4-5 grams of cannabis per day in order to 'block out' his thoughts. He had also been stock piling his medication of tramadol and diazepam and taking over the prescribed amount; he also admitted taking some of his girlfriend's medication. Ian stated "I would rather be off my face or dead".
3. 32 At the time of this assessment Ian's case was closed to mental health services. He reported that he had recently been re-referred to the Community Mental Health Team by his GP, but he failed to attend as he did not realise what the appointments were for (Ian was probably referring to missed appointments in 2013, as he had only been referred again on 13 May 2014). Ian had previously been known to the prison In-Reach Team; he reported that he had been assessed numerous times by mental health professionals, been given a diagnosis and offered help, but had declined; he said he found it difficult to trust mental health professionals. Ian recalled being assessed for 28 days when he was 15 years old, but he could not remember where (this could indicate an admission for assessment under Section 2 of the Mental Health Act 1983). He reported that he had irregular sleep patterns, often waking at 3 or 4am and being unable to get back to sleep, and he did not have regular meals; he said his last proper meal had been a week ago and he had lost weight. During the assessment Ian stated that he had "serious shit going on in [his] head", and that he had recently witnessed his girlfriend being beaten up, but could not do anything about it as he

was "too scared". The assessment found Ian to have low mood and there was evidence that he lacked trust in others, coupled with low self-esteem and lack of self confidence. At one stage he ask his assessor whether he made them feel nervous; he stated that he often felt that he made others feel that way. Following assessment a 'prisoner warning' (relating to history of self harm) was activated and faxed to the prison In-Reach Team and SERCO.

- 3.33 On 21 May 2014 a 'suicide attempt with intent' was recorded on Ian's mental health service clinical record whilst he was remanded in prison custody. This did not require hospital treatment. On the same day a consultant psychiatrist wrote to Ian's GP at Surgery 1 thanking them for their referral and asking for further details of Ian's mental health problems to inform the most appropriate course of action to be taken. The consultant appeared unaware of the Criminal Justice Team assessment the previous day. This is explained in the mental health service IMR as probably due to the previous assessment not yet being recorded on the electronic record system.
- 3.34 On 22 May 2014 Police commenced an investigation into a further allegation of theft from Patricia's flat this time by a friend who it was alleged, had stolen £30 and taken some medication whilst visiting Patricia. However, Patricia reported to officers that her friend had returned the medication. There was no mention of the money and Patricia no longer wished to continue with a complaint.
- 3.35 Late in the evening on 13 August 2014 the Police investigated an allegation of assault raised by Vivienne that Patricia had slapped her around the face. However, officers found both women were extremely drunk and appointments were made for the victim to give a statement next day. A number of attempts were made to do this without success. Eventually on 9 September 2014 it was discovered that Vivienne had been taken to hospital the night before suffering from a heart attack. Sadly she did not recover; she died in hospital.
- 3.36 On the 5 November 2014 Ian appeared at Ipswich Crown Court for a dwelling burglary offence committed on 8 May 2014. A request was made for a pre-sentence report. He was remanded in custody to Chelmsford Prison and placed on the warning list for those at risk of self harm.
- 3.37 On 27 February 2015 Ian appeared at Southend Crown Court; the case was adjourned for an addendum report to be prepared to address whether he was suitable for a Mental Health Treatment Requirement. He was held in custody. On 23 March 2015 an email was sent to Mental Health Services to find out the outcome of the referral (dated 17 March 2015) to North Essex Partnership NHS Foundation Trust. The referral was to determine whether Ian was suitable for a Mental Health requirement as he was due in court again on 27 March 2015. An email was received from a community psychiatric nurse from the In-Reach Team in Chelmsford Prison confirming that a referral had been sent to the South Tendring Community Mental Health Team in the North Essex Partnership NHS Foundation Trust for consideration for mental health support. An email confirmed that the referral was complete and that Probation should be kept advised as to whether Ian fitted the criteria for care coordination.
- 3.38 On 12 March 2015 Patricia attended the Minor Injuries Unit and was found to have a fractured ankle. She reported falling down two stairs that morning after tripping over carpet. She was put in plaster below the knee and provided with crutches. Patricia had the plaster removed on 6 May 2015, but she failed to attend outpatient physiotherapy and exercise class appointments therefore she was discharged from the service on 1 September.

- 3.39 Ian was sentenced at Chelmsford Crown Court on 27 March 2015 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 Court Orders on 30 March 2015 from the National Probation Service.
- 3.40 On his release from court Ian appears to have attended GP Surgery 1 the same day (27 March 2015). His medical notes show that he saw a GP in Surgery 1 where it is noted that he informed the GP that he had been released from prison that day. He reported that he was started on olanzapine while in prison, but the GP had no record of this. It was noted that he needed analgesia which was discussed. Ian was advised that a discharge note from the prison doctor was required. The GP prescribed 100 capsules of tramadol 50mg. Ian's Summary Care Record was update and a New MED3 statement valid from 27 Mar 2015 to 1 Jun 2015 was issued confirming that he was not fit for work due to mental ill-health and back problems. On the 8 April 2015 a member of Surgery 1 staff spoke with a staff member at Chelmsford Prison regarding medication commenced whilst Ian was with them. A formal request for information was faxed as requested by the prison staff member.
- 3.41 Ian's offender manager 1 received a phone call from a mental health nurse from HMP Chelmsford In-Reach Team on 2 April 2015. She had been working with Ian whilst he was on remand. The nurse advised offender manager 1 that they would make a referral to the Access and Assessment Team at The Lakes in Colchester. The offender manager provided the address they had for Ian. Whilst in prison Ian had a diagnosis of Emotionally Unstable Personality Disorder confirmed.
- 3.42 On the 7 April 2015 Ian had his first appointment with offender manager 1. His address was confirmed as being with a friend until he could find his own accommodation. The offender manager spoke with the friend he was staying with and he 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 at Surgery 1 in the Tendring area, but they did not have information about his prescription for olanzapine⁴. Ian was advised by his offender manager to register with a GP in the town where he was currently staying with his friend; he registered with Surgery 2 on 15 April. During this appointment he informed his offender manager that he had a child with an ex-partner with whom he had no contact, and that there was an injunction in place. He also reported that he struggled with groups having been abused when younger. This appointment took place 6 days after allocation; as a consequence it was 1 day later than Service Level Measures prescribe. The chronology points out that the mention of his child should have prompted Social Care checks⁵ which are mandatory; these are not recorded on the database. No copy of the injunction was sought, and his report of abuse when younger was not followed up in subsequent sessions.
- 3.43 Ian's next planned visit with offender manager 1 took place on 14 April 2015. This was a three way meeting with a Thinking Skills Programme tutor. His friend with whom he was staying was also present. It was noted that his friend spoke

⁴ medication used in the treatment of schizophrenia.

⁵ As incidents resulting in the injunction took place in a neighbouring county it would have been essential to make checks in the relevant area. Checks with Essex Social Care would not have revealed a record.

for Ian a great deal and that the relationship should be monitored; however, the relationship between the two friends seemed genuinely warm.

3. 44 Ian's medical notes indicate that on 17 April he reported at GP Surgery 2 that he had run out of all his medication. He had been issued with 100 tramadol 21 days previously (1 or 2 tablets to be taken each day). This prescription should have lasted at least another 29 days taken as instructed. Ian saw a GP at Surgery 2 on 20 April 2015 where a history of schizophrenia and recent stay in prison is recorded. It was noted that he was making a new start in the area. On examination he presented as 'euthymic⁶ with good rapport and appropriate cognition'. The plan was to review in 1 month. His olanzapine prescription appears to have been confirmed by the prison as a prescription was issued for olanzapine 15mg tablets - 28 tablets - one daily, olanzapine 2.5mg tablets - 28 tablets - one daily, plus 100 tramadol 50mg capsules, 1 or 2 to be taken 3 times per day. A review of medication took place on 1 May 2015.
3. 45 At his next weekly meeting with his offender manager on 21 April 2015 alcohol was discussed; it was noted that Ian used to be an alcoholic. Ian said he used alcohol to alleviate stress and anxiety. He reported that he would be drinking more if it was not for his friend. Ian mentioned that he had been 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.
3. 46 On 24 April 2015 offender manager 1 telephoned the Access and Assessment Team and Psychosis Team. Ian was known to the East Specialist Psychosis Team between 24 April and 23 June 2015. It was confirmed that Ian had been referred to the Specialist Psychosis Team and would be under the care of a named community psychiatric nurse with whom Ian had his first appointment that day. After the appointment the nurse contacted Ian's offender manager and reported 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 Requirement in place and they needed to be advised of all appointments and if any were missed.
3. 47 On the 6 May 2015 Ian failed to attend an appointment at Surgery 2. The following day, 7 May Ian's medical notes show that he saw a different GP at the practice and it is recorded 'History: says olanzapine dose raised now, nothing documented'. A member of Surgery 2 staff was to call his mental health nurse to fax a letter regarding the increased dose. However, there is a scanned fax on the medical notes from Ian's community psychiatric nurse dated 29 April 2015, informing the practice of the increased dose. When Ian was seen at Surgery 2 on 13 May 2015 for medication review he reported 'feeling OK on increased dose of olanzapine' as per the Community Mental Health Team change in prescription. The change involved taking an extra 15mg tablet per day.

⁶ euthymic: pertaining to a normal mood in which the range of emotions is neither depressed nor highly elevated.

3. 48 During the next planned visit with offender manager 1 on 26 May 2015 Ian commented that he did not think he deserved to be alive. He related an incident with Vivienne: He describe how he was with Vivienne and the brother of the friend he was staying with. Vivienne had kissed his friend's brother when Ian was out of the room, and the brother told Ian and asked him what he should do about it; Ian told his offender manager that he told him to do whatever he wanted. Ian described how the brother then physically assaulted Vivienne for 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 brother 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 appointment 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. The Probation/Community Rehabilitation Company chronology notes that it is not recorded that offender manager 1 shared any of this concerning information with the Police. The explanation given is that Vivienne had died the previous year therefore there was no longer a complainant. The chronology notes that after sharing this information indicating 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 on 16 June 2015 at an office appointment with offender manager 1 he described everything as being fine. There was no further mention of the incident previously described.
3. 49 On 16 June 2015 Ian's medical notes show a repeat prescription was printed at Surgery 2. A further repeat prescription was printed on 6 July, however Ian was being held in custody in July therefore it is unclear whether this could have been collected. Ian later stated in custody that he had not taken his medication for some days.
3. 50 At 21:08hrs on 18 June 2015 the friend Ian had been staying with made contact with the Police to report that Ian had stolen electrical items from his house. He reported that he had located his belongings in a local pawn shop; the incident was 'crimed' over the phone.
3. 51 It is recorded that Patricia also contacted the Police to report this theft by Ian, she was reportedly the aunt of Ian's friend. At 23:49hrs on 18 June 2015 she called to report that Ian had come to her flat asking for food and to stay the night. Patricia reported that she had given him food, but refused to let him stay, he had punched her in the head knocking her to the floor and kicked her in the stomach. Patricia then informed the call taker that she had been punched in the face by Ian as she had tried to detain him, but he had now left the scene. It was noted that Patricia sounded confused and was not making sense; her descriptions were not consistent when repeated. It is possible that this could have been due to shock following the assault. The following day Patricia phoned the Police again and stated that Ian had threatened to kill her, and that he was pestering her as he had nowhere to stay. She also stated that Ian's partner had died earlier in the year and that he blamed her for her death. Officers despatched to interview Patricia after the first call were diverted due to a high risk missing person, and although the Police IMR states she was seen on the 22 June there is no record of this in the chronology and no details of the interview and whether any risk assessment was done.
3. 52 On the 19 June 2015 the Community Rehabilitation Company supervising Ian received a phone call from the friend with whom he had been staying. He reported that Ian had stolen his house keys and a television and assaulted his

aunt (Patricia). He said he did not feel safe staying there. The offender manager tried to confirm these details with the Police, but they would not share information. Offender manager 1 shared this information with the Mental Health Team and they both agreed they would phone the Police to share their concerns. There is no record of such phone call taking place.

3. 53 Ian was arrested on 22 June 2015 in connection with an attempted burglary which had also taken place on the 18 June. The address he gave when taken into custody was Patricia's address (he was not in fact living there). As before Ian declared that he had mental health issues and he also said that he had tried to self harm in the past few days. A Custody Assessment was undertaken by the Criminal Justice Mental Health Team when Ian confirmed that he was staying with a female friend called Patricia whilst his care coordinator was arranging appropriate housing; he said his care coordinator was due at the next referral panel in a few days time. Ian was currently receiving care from the East Specialist Psychosis Team and had been due to attend an outpatient appointment that day. His current offender manager was noted. The crime for which Ian was in custody was noted as 'burglary - attempted'. No mention was made of the assault on Patricia in this section of the assessment. However when completing the section on aggression it is recorded 'no current thoughts of violence or aggression', but it was 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 that the friend was a woman. It was recorded that according to his prison notes he may assault without notice.
3. 54 During the assessment Ian stated that he had not taken his medication in the last 4 days as he did not have it with him. He reported the ongoing hearing of voices of a girl screaming and the voice of an old man, plus visual hallucinations, but these had not become worse whilst in custody. There were no outward signs that he was experiencing hallucinations or thought disorder during interview. Ian reported self harming 2 to 3 days previously by cutting his face and lip with a glass, however no visual evidence of this was noted. Ian advised that if kept in custody he may attempt to harm himself, but he denied any active plan to do so at the time. The assessor found that Ian was not complying with his medication which he maintained did not help with the visual or auditory hallucinations. The plan was to liaise with his care coordinator and the Criminal Justice Mental Health Team representative in court on 23 June, and inform Ian's GP. Copies of the Criminal Justice Team's assessments were sent to the GP in Surgery 2 where Ian was registered in the town where he previously lived with his friend; there was no opportunity for the GP to consider this in any care plan as he was now in custody and did not return to this GP. If remanded in custody Ian was to be referred to the prison In-Reach Team and a prisoner warning notice for suicide/self harm was to be completed. There were no concerns regarding Ian's capacity, therefore he was interviewed the Police about the attempted burglary and further interviewed in relation to the theft and the assault alleged by Patricia. He admitted the offence of theft, but denied the assault. He was charged with theft and assault, refused bail and put before the court.
3. 55 On 23 June 2015 Ian appeared at North East Essex Magistrates Court charged with 2 burglaries and 1 assault. He was seen in the custody area of the court by a Criminal Justice Mental Health Team community psychiatric nurse for a further assessment for the court. Records describe that Ian was somewhat guarded, and he refused to elaborate on his 'perceptual abnormalities'. However he was thought to engage reasonably well, although there were times when he made attempts to deceive. Examples of this were recorded as his denial of self-harm tendencies which were well documented in his notes, and Ian initially stated that

he had not taken his medication for approximately 5 days, but then later admitted this to be approximately one month. It is now known whether Ian collected his medication even though prescriptions were printed. He denied any suicidal intent at the time of the assessment and evidenced forward planning hoping to see his care co-ordinator in the near future and recommence medication if released from court that day. It was noted that it is likely that the risk of self-harm/suicide would increase if remanded/sentenced to a custodial setting therefore the relevant warnings will be activated should the court be minded to take this action.

3. 56 Risk factors identified in the assessment were summarised as; open to mental health services, but non-concordant with medication; socially isolated with limited support systems; self harm/suicide history - self harm by cutting; aggression - states arrested and charged with common assault. Ian was remanded in custody until a proposed hearing on 17 August 2015. The Criminal Justice Team CPN faxed a Prisoner Warning notice to Chelmsford prison regarding Ian's risk of self harm and providing contact details of his CPN. The prison In-Reach Team received copies of Criminal Justice Mental Health Team detailed assessments and the information was discussed at their daily team meeting held to discuss all new prisoners identified with mental health, self harm, or drug and alcohol concerns. Information was scanned into the SystemOne database, and Ian was seen for assessment by an In-Reach Team nurse.
3. 57 The court outcome was relayed to the Community Rehabilitation Company by Ian's CPN who had been notified of the court outcome by the Criminal Justice Team CPN. 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 his symptoms related to post trauma. Offender manager 1 did not disagree with this despite concerns about Ian's reports of hallucinations. The court result was entered onto the Delius database by the National Probation Service as required. An OASys⁷ assessment was not reviewed at this point. There is no evidence in the North Essex Partnership clinical notes that a referral was made later to the mental health service Access and Assessment team by the prison In-Reach service, or any other agency. This will be discussed in the analysis section of this report.
3. 58 At a court appearance at Chelmsford Crown Court on 29 July 2015 the assault charge against Ian was discontinued and the theft from a dwelling was adjourned.
3. 59 On 2 September 2015 the Police investigated an allegation by Patricia that whilst she was at home on 1 September 2015 between 21:00 and 22:00hrs there had been a knock at her door and she said when she asked who it was a male replied Ian. She did not answer the door and so did not see the man in person. She believed it to be Ian who then said he wanted to 'get her', and 'I will kill you after what you have put me through', but she was unsure whether he was out of prison (he had been remanded for the offences on 18 June described above). Patricia had been told by a friend that Ian wanted to 'get her'. A Police community support officer attended this incident and spoke to Patricia who told the officer the reason she called the Police was to find out if Ian was out of prison. Patricia said that Ian

⁷ 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; 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

was arrested for a theft and assault upon her and that the assault case was withdrawn after she did not go to court because she was suffering from agoraphobia. It was established that at the time of the incident Ian was still on remand in Chelmsford Prison, Patricia was informed of this and no further enquires were conducted. Patricia was interviewed further by the investigating officer and she told them that the alleged offender was someone she had never seen before and would not recognise again. Enquiries failed to identify the person responsible and the offence remained undetected.

3. 60 At 08:55 hrs on 11 September 2015 Essex Police commenced an investigation into theft of medication reported by Patricia. She alleged that an unknown suspect had removed her medication from her room. The person responsible could not be identified and the offence remains undetected. Later the same day at 23:52 hrs Patricia made a 999 call to the Police reporting that she had just been woken up by someone knocking on her door. She said she had looked through the kitchen window and seen 2 females and a male, all of whom looked drunk. Although she did not answer the door, she stated that she was now worried and requested police attendance. Officers attended and reported that Patricia was very intoxicated. They made a search of the area but found no trace of the persons involved.
3. 61 Between 2010 and 2015 Victim Support received 10 referrals from the Police relating to incidents they attended following contact with Patricia. None of their letters or phone calls resulted in a response by Patricia.

Events of Significance:

3. 62 Ian appeared at Chelmsford Crown Court on Tuesday 21 September 2015 from Chelmsford prison and received a Suspended Sentence Order with no requirements. He was provided with an appointment with the Essex Community Rehabilitation Company for the 25 September which was within 5 days in line with policies and procedures. The sentence imposed was based on a fast delivery report prepared by a court based probation officer. This report concluded:

That after interviewing Ian it was the officer's view that his current Order (a Suspended Sentence Order plus Mental Health Treatment Requirement and supervision) did address his current needs including his ongoing mental health problems, the deficiencies in regard to his thinking and behaviour, and his lack of victim empathy. He was judged to be complying with this Order to a comparatively better standard than previous years and engaging with his offender manager; although disappointment was expressed that he had chosen to offend again. The report suggested that the Suspended Sentence and Mental Health Treatment Requirement already in place continue. It was deemed imperative that any intervention continued to include his engagement with mental health services, and this was an area that needed to be monitored on a consistent basis, hence the need for the Order to continue. No record was found to indicate that the probation officer spoke to offender manager 1 or Ian's CPN when considering the report for the court.

3. 63 Sentencing Ian the judge said "You bit off the hand that was feeding you. You have a bad record of burglary. I am obliged to give you a custodial sentence which I will suspend. I will not activate this sentence (the Suspended Sentence Order imposed 27 March 2015), but will allow you to continue with all agencies that are helping you. I will fine you for this matter". Ian was fined £10.

3. 64 When interviewed in secure hospital Ian recalled that he was given an appointment by Probation to see his offender manager, and he was given a travel warrant by someone at the court. He said he was supposed to go to Probation in Colchester and he thought he was supposed to have accommodation there in a hostel, but he did not know how to get there so he took the bus he knew back to the Tendring area. Ian said he did not know Colchester very well, he had been taken there by a friend in a car before, and this is why he took the route he knew back to Tendring.
3. 65 Ian was released from the court that day. He had no medication or prescription from the prison with him. It had been noted on the court results that Ian had olanzapine medication, but it was not recorded whether he had medication with him or needed to see a doctor to have the medication prescribed. The court duty probation officer could not recall if he had the medication or not.
3. 66 At 09:54 on Tuesday 22 September 2015 a mental health nurse in the prison In-Reach Team recorded that Ian had not returned to the prison from court the previous day. A call was made to his care coordinator in the Specialist Psychosis Team and it is recorded that his care coordinator stated he 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. The care coordinator said he 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 North Essex Partnership Trust 72 hour report completed by Ian's care coordinator after Patricia's death records that the In-Reach Team mental health nurse agreed to have a conversation with the court probation officer to organise support.
3. 67 Also on 22 September 2015 Ian's mother phoned the Community Rehabilitation Company to inform them that he was now living with a woman called Pat. This was the first information the agency had that he was staying with Patricia.
3. 68 Ian 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 date of his next appointment with them on 25 September. The housing officer made a call to the appropriate Probation office. The offender manager was not available and a message was left asking for the housing officer to be called back. No return call was received. At this time CRC and Probation staff were still together in this area office; this was the correct location for the offender manager. However it is reported that temporary reception staff were having to be used during this period who did not have access to Delius the normal route for messages to be passed to staff; this may have disrupted the usual process. 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. 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.

3. 69 An OASys review was completed and updated following Ian's recent conviction and release from prison. Notably section 10 highlighted that Ian had been released from prison without medication and for that reason his current mental state was linked to risk of serious harm and risk of reoffending. On Wednesday 23 September Ian's offender manager 1 phoned the prison In-Reach Team. Ian was trying to get medication prescribed, but having difficulty in registering with a GP surgery as he had no form of identification. It was also stated that he was banned from the local night shelter and he had no money to travel anywhere. Offender manager 1 requested that a copy of his most recent prescription be emailed to help Ian register with a GP. This is recorded as being forwarded to obtain a copy of his prescription from the prison and to support him to obtaining a GP.
3. 70 On 25 September 2015 Essex Police received an intelligence report that Ian had been released from prison. His discharge address was recorded as an address in Ipswich. Research conducted by Essex Police identified Ian was recorded as a MAPPA⁸ subject on the PINS database but not monitored within the Essex area. Essex Police were only aware that Ian had returned to the Essex area following his arrest for murder. Background information from Suffolk Police did not show that Ian was subject to MAPPA arrangements.
3. 71 Ian attended the appointment to see offender manager 1 on 25 September 2015 as arranged at the court, but was seen by a colleague in offender manager 1's absence. The session was spent trying to sort out an Employment and Support Allowance claim⁹. A food bank voucher was provided. Also on this day he was seen in the Minor Injuries Unit with pain in his right foot. He was x-rayed 2 days later, the diagnosis was not classified. Physiotherapy appointments arranged in follow up during October were not kept by Ian and he was discharged. The next planned visit by Ian to his offender manager was due to be 1 October 2015, but he failed to attend. This is recorded as an acceptable absence because Ian could not be contacted and there was no further action. The IMR author found that no warning letter appeared to have been sent when a first instance warrant should have been considered.
3. 72 On 14 October 2015 records show that Ian's offender manager attempted to reach him by phoning Patricia's number, but the phone was switched off. This indicates that Ian had given Patricia's number as a means of contacting him. Ian arrived late for an appointment with his offender manager on 19 October 2015. The fact that he was registered with a GP and in receipt of repeat prescriptions was recorded in addition to his report that he was still hearing voices. His mental health treatment had still not been reinstated and no attempt to do this had been made. It is also recorded that the council had confirmed the availability of a rent deposit and had accepted the duty to house Ian. He was noted as being more confident in himself, however the IMR author notes that this was seen in a positive light; no consideration was given that this could have been over-confidence influenced by the voices speaking to him. Ian also reported not feeling safe with Patricia as she had previously made allegations about him.
3. 73 A further appointment was arranged by Ian's offender manager on 27 October 2015 which Ian failed to attend. This was recorded as an 'acceptable absence' with the reason of 'professional judgement' cited. In interview with the IMR author the offender manager explained that this was an additional appointment

⁸ Multi-Agency Public Protection Arrangements

⁹ Employment and Support Allowance (ESA) - a benefit for those who cannot work because of illness or disability.

arranged to provide support and monitor Ian's situation. It had been agreed at his last appointment that this would not be enforced given his financial/budgeting difficulties as it fell in a week between ESA payments making the cost of travel to the probation office difficult.

3. 74 Ian's next appointment with his offender manager was to be 4 November 2015, but he failed to attend. A timely enforcement letter was sent the next day, 5 November in line with breach procedures. The letter was sent care of Patricia's address with another appointment for 18 November. The appointment should have been arranged for the following week, not for 2 weeks time. Ian failed to attend the 18 November appointment. A breach letter was requested on 20 November, but this was not sent until the 23 November i.e. the third working day after request instead of within 2 days. A new appointment for 2 December was issued, which was once more in 2 weeks time; it should have been within one week.
3. 75 On 30 November 2015 Ian's offender manager tried to contact him via Patricia's telephone, but there was no answer as the phone was switched off.
3. 76 On 2 December 2015 there was a transfer of breach paperwork to the National Probation Service. This took place via Delius a national offender management system shared by the Community Rehabilitation Company and the National Probation Service whereby the details are added by the former and picked up by the latter agency. Thus the breach process was commenced. In this case the transfer was rejected by the National Probation Service as Ian had no fixed address via which he could be summoned and had 2 Suspended Sentence Orders, one of which was not mentioned. It appears that Patricia's 'care of' address used by his offender manager was not included in the breach documentation. The transfer of breach documentation was resent on 3 December and accepted by Probation on 4 December. As Probation did not have a 'care of' address for Ian no summons to court was sent to him, therefore when the breach hearing was taken place at court on 9 December 2015 Ian did not attend. A warrant without bail was issued at this hearing.
3. 77 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 last known address was identified as Patricia's address and this was updated on the Athena database. A letter was sent to this address notifying Ian 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 in relation to the breach was theft. They would not normally conduct research beyond this. The officer could not recall whether they may have interrogated the intelligence system. At the time of the assessment there was intelligence held indicating that Patricia was a high risk victim of domestic abuse, and that Ian was a high risk perpetrator. The officer stated that had Ian's warrant received a category A grading then his research may have been more extensive and identified this risk information and the progress of the warrant monitored and reviewed within the officer's department.

3. 78 A document entitled 'Court Issued Warrants Strategy' for the administration of arrest warrants with and without bail (2013) sets out that warrants are categorised either as A, B & C and should be executed within timelines approved by Association of Chief Police Officer (now National Police Chief Council) and endorsed by the Home Office and the Essex Criminal Justice Board (for further description of the warrant process see Appendix B). Ian's warrant was category B, based on his past criminal history. The timeframe within which a Category B warrant is executed is 21 days. The review period for this offence type is either 18 or 36 days depending on the circumstances of the original offence. Ian's warrant had been in place for less than half this time period. During the time span covered by this Review there were 673 outstanding warrants being administered by Essex Police.
3. 79 At the time of the murder, Ian was the subject of a suspended prison sentence imposed for dishonesty offences. These were imposed by the Chelmsford Crown Court in March and September 2015. He was in breach of this order and subject to a warrant for his arrest. At approximately 17:00 - 18:00hrs on Thursday 17th December 2015 the defendant Ian went to a friend's flat. The witness described the defendant as being wide eyed and 'buzzing'. The witness states; "[Ian] told me that he'd killed a woman he had been staying with. He told me that he had stabbed her around 14 times". The friend did not believe him and so Ian took him to the flat and he saw the scene for himself. Afterwards they returned to the witnesses flat. The witness and defendant then smoked cannabis, watched a film and had something to eat before going out together. Whilst they were out they parted company as the defendant wanted to go back to the scene of the murder to get rid of some evidence. The defendant stayed with the witness at his flat and the next morning they went out for breakfast, then returned home and had a short sleep. When the witness woke up he went to the police station to report what he had seen.
3. 80 On the first day of his trial for murder Ian admitted manslaughter by diminished responsibility. This was not accepted by the Crown Prosecution Service. However, following the evidence of medical experts who agreed that Ian was suffering from mild retardation and Personality Disorder, and legal arguments from counsel, the judge discontinued the trial and accepted Ian's original plea. He was told that had he not submitted an early guilty plea he would have been sentenced to 25 years. In light of his early plea Ian 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 when he would be transferred to prison to serve the rest of his sentence before being judged suitable for release.
3. 81 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".
3. 82 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 to 4 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.

4. Overview

Summary of information known to the agencies.

- 4.1. Criminal justice agencies including the Police, Probation, Crown Prosecution Service, Community Rehabilitation Company, and the Courts were aware of Ian's offending history and his mental health problems. Whenever Ian was arrested the Police records highlighted that he had a propensity to self harm and he was noted to have a 'mental age of 8 years, as a consequence an appropriate adult was in attendance during his interviews, and mental health assessments were undertaken to assess risk and his suitability for interview. It is not known where and when the 'marker' for a mental age of 8 years arose. Neither his Probation nor Community Rehabilitation Company records make any such reference. Verbal reports from members of the prison In-Reach Team who knew Ian did not raise any concerns about his intellectual capacity. However, what is described as 'mild retardation' was identified in the psychiatric report following an assessment of Ian for the court. It is not totally clear from records that the extent of his capacity for managing the day to day functions of everyday life were fully understood across the agencies who had contact with him.
- 4.2. Ian's assaults on women did not result in charge or conviction, either due to lack of evidence to pursue a prosecution, or due to the withdrawal of the complainant's statements. As a consequence the Police were the agency most aware of the incidents of domestic abuse with which he was involved, although his Psychosis Team care coordinator was aware of the alleged assault on Patricia by Ian which was discontinued in court in June 2015. His offender manager failed to pursue enquiries about his previous history which led to a civil injunction forbidding him to have contact with his ex-partner and child and appears to have been unaware of his domestic abuse history.
- 4.3. The Police and Ian's GP were aware of some of his mental health issues; the Police knew he was at risk of self harm, and his GP referred him to Mental Health Services for schizophrenia, but he failed to attend three appointments for assessment in 2014 as he had in 2013. His life was often unsettled, punctuated by change of address, arrests, and periods in police or prison custody during these years which probably contributed in part to his failure to respond to appointments. Ian also appears not to have had a mobile telephone, there are various landline numbers recorded on his medical notes, and this caused difficulties for agencies trying to contact him. There are no notes to suggest that missed appointments were discussed with Ian by a GP. Between 2008-09 prison Mental Health Services were aware of his past childhood history and his long history of depression, suicide attempts, and self harm. At that time it is recorded that at the age of 18 years Ian had only spent 2 months of the previous 5 years out of prison for drug related offences and burglary.
- 4.4. It was in May 2014 when he was in Police custody that Ian had an assessment by the Criminal Justice Mental Health Team and this was shared with the prison In-Reach Team. The Magistrates Court were made aware of his mental health issues; he was made subject to a Mental Health Treatment Requirement and managed jointly by the Community Rehabilitation Company and the Mental Health Service Psychosis Team. In a second assessment in June 2015 whilst in

custody Ian had a diagnosis of Personality Disorder and at times he exhibited psychotic symptoms in the form of visual and auditory hallucinations. This and a previous assessment also identified that he was not taking his medication. Ian's CPN was of the opinion that he was suffering the effects of trauma and this was shared with his offender manager.

- 4.5. At the time of his last period of imprisonment from which he was released in September 2015 information was shared between the Probation court duty officer, community psychiatric nurse, and the prison In-Reach Team that a referral was needed to the Access and Assessment Team for Ian to receive long term support.
- 4.6. The Police, Probation, Community Rehabilitation Company, and the Court were aware that Ian was in breach of his suspended sentence conditions and that a warrant for his arrest had been issued on 9 December 2015.

The victim

- 4.7. Information regarding Patricia from the local Police described her as being a 'bit of a hermit', of being withdrawn, known to be on medication for depression and dependent on alcohol. Her life could be chaotic at times and she was a woman who 'attracted waifs and strays' into her flat when they had nowhere to go. This supports her family's description of Patricia, that although she had her problems, she was a kind hearted woman who would help anyone in need. Her kindness to others was acknowledge by the judge at the end of the perpetrator's trial.
- 4.8. There are many incidents reported to the Police which appear in the chronology which highlight how vulnerable Patricia was to harassment and intimidation by others, as well as being vulnerable to having her belongings stolen and being taken advantage of.
- 4.9. Patricia's mental ill-health and problems with alcohol were longstanding, and despite attempts by her family to encourage her to move closer to enable them to support her more effectively she was unable to take the necessary steps for this to happen. Her mental health issues and lifestyle increased her vulnerability and put her at particular risk; research has identified that those experiencing mental ill-health are at higher risk of experiencing domestic abuse, and women particularly are at greater risk.¹⁰
- 4.10. Alcohol misuse is also an added risk factor as it diminishes an individual's ability to be fully aware of their surroundings and to assess any risk or dangers in their environment or from others. A study by Alcohol Concern and AVA¹¹ of an initial sample of 39 Domestic Homicide Review reports found 27 (69%) featured varying levels of alcohol related harm. In 15 (38%) of the reports the victim was identified as experiencing problems with alcohol, with a possible two further reports where alcohol misuse was suspected.
- 4.11. It is evident from events in the chronology, that Patricia knew that Ian could be violent, both from her friend's experience at his hands and her own assault. She also appeared to be fearful of his release from prison. It is not unreasonable to

¹⁰ Trefillion K, Oram S, Feder G, Howard LM (2012) Experiences of Domestic Violence and Mental Disorders: A Systematic Review and Meta-Analysis.(page 9) PLoS ONE 7(12):Es1740.doi:10.1371/journal.pone.0051740

¹¹ Alcohol Concern & AVA (Against Violence & Abuse) '*Domestic abuse and change resistant drinkers: preventing and reducing the harm Learning lessons from Domestic Homicide Reviews*' Part of Alcohol Concern's Blue Light Project In partnership with AVA's Stella Project. page 11 June 2016

assume that the threat of violence from Ian gave him the ability to control Patricia and may have led to her being unable to stop him moving into her flat and taking money from her.

The perpetrator

- 4.12. It is the assessment of consultant forensic psychiatrist Dr Baird that Ian had "a very difficult and traumatic upbringing and his experience of emotional and sexual abuse has meant that he has developed an ability to 'protect' or 'detach' himself from negative emotions which in turn allows him to experience the suffering of others in a way that does not generate a normative emotional response. Such abuse may also have served to normalise the process of causing harm to others, and is likely to have taught him that violence is an acceptable response to strong emotions being triggered". From his background history outlined in this Review including sexual abuse as a child, it is rational to see how Dr Baird might come to such an assessment.
- 4.13. Ian's mother stated in her statement to the Police that he had not lived with her since the age of 8 or 9 years old when he was taken into care. Health records show that Ian was removed from the Looked After Child Register in 2008 when he would have been 18 years old. His mother stated that she had always known there was something wrong with Ian as he was a loner and had problems at school, but she only became aware of his mental health diagnosis when he was assessed in Chelmsford prison. His mother told the Police that she last saw Ian about 3 years ago at Christmas time. Since then they had only had telephone contact. He had no contact at all with his father. Given his disrupted childhood it would be reasonable to suggest that Ian also experienced attachment difficulties which would contribute to his psychological development and problems with relationships in adulthood. He also witnessed domestic abuse as a child and this too can have a disruptive effect on a child's development "as it increases feelings of insecurity and emotional distress".¹²
- 4.14. There are brief references in assessments that Ian 'has difficulty in managing his daily activities'. His mother stated that when Ian was last released from prison he had no support and no medication, she had to assist him to get registered at the doctors surgery as he was incapable of organising basic things for himself and needed assistance to fill in forms and keeping appointments. As an example of his limitations in one mental health assessment Ian stated that he did not understand what appointments with mental health services were for, hence he had not attended (paragraph 3.25).
- 4.15. Ian was assessed for the court as suffering from an abnormality of mental functioning at the material time [of the murder] which arose from recognised medical conditions, namely mild mental retardation and emotionally unstable and dependant personality disorder. Dr Baird found no evidence that these medical conditions substantially impaired Ian's ability to understand the nature of his conduct at the material time, however, it was his opinion that his ability to form a rational judgement and exercise self control was substantially impaired.
- 4.16. During interview with Ian in the secure hospital there was a real sense that he found coping 'in the outside world' difficult. He appeared to feel safer in the hospital, or previously in the hospital wings of prison, than he did 'outside'. His early experience of boarding school, and frequent terms of imprisonment have

¹² Howe D, Brandon M, Hinings D, Schofield G. (1999) *Attachment Theory, Child Maltreatment and Family Support* p249. MacMillan, Basingstoke.

perhaps institutionalised him and exacerbated his limited skills in managing his life in the 'outside world' and his ability to regulate his behaviour towards others.

5. Analysis

5.1 The analysis will examine the terms of reference for this Review. Where appropriate terms will be combined to provide the most relevant and easy to follow analysis.

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 met the perpetrator. Agencies with relevant background information about the victim and perpetrator prior to this date are to provide a summary of that information

5.2 This term of reference has been addressed by the provision of the background information and chronology sections in the Review.

5.3 The following section will combine terms of reference 2 and 5 due to their relevance and relationship to each other.

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.*

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

Services for Patricia:

5.4 The agencies predominantly involved with Patricia the victim during the period under review are the Police, and her GP. Patricia had some contact with Colchester Hospital and the local minor injuries unit, but her attendances were not associated to domestic abuse. At the time of her fractured ankle in March 2015 Patricia is thought to be living alone; her report of having a fall is consistent with her injury. Ian was in prison at that time. Patricia did not have a care plan as a result of her GP and Health agency contacts. Her engagement with mental health services was inconsistent and she was not assessed or seen after her discharge in 2010. Patricia was due to have a Care Programme Approach review following her re-referral in October 2013, but she did not keep her appointments and she was discharged in June 2014 due to non-attendance.

5.5 There was appropriate communication between the various health services and Patricia's GP which was in line with procedures. She was a regular attendee at her GP practice; between September 2013 and October 2015 she had contact with her surgery on 37 occasions. Some appointments were for sick notes, and at 4 consultations Patricia reported that her medication had been stolen and she

was seeking a repeat prescription. On these occasions the practice followed protocol, liaised with the Police, and asked Patricia to provide a Police incident number before giving a further prescription. This was good practice.

- 5.6 The Police IMR points out that the service does not have a system of management or care plans. The nearest equivalent would be safety plans to reduce risk to victims of domestic abuse. These are used by the Police themselves in some cases, and as a result of a MARAC referral where the Police are a contributing agency to the plan.
- 5.7 During a domestic abuse incident involving a previous partner in March 2010 Patricia had asked to speak to someone from the 'domestic team', but no record of this or a crime report was found. The Police IMR found that this incident could have resulted in more positive action. When she was assaulted again in April 2010 more positive action was taken; Patricia was assessed as high risk via a DASH risk assessment, however, there is no referral to MARAC recorded and therefore no MARAC safety plan. Actions taken were solely by the Police; markers were placed on their records system, the offender was arrested, charged, and released on conditional bail, although the case took almost a year to come to court and was then dismissed by the judge. There is no mention as to whether Patricia was supported by an Independent Domestic Violence Advocate (IDVA). Although the protective measures taken by the Police on this occasion appear to have been effective (her previous partner did not commit any further offences) the opportunity to offer Patricia a coordinated multi-agency plan of support was missed. The fact that Patricia was not referred to MARAC despite being assessed as 'high' risk means that procedures were not followed on this occasion and information was not shared with partner agencies.
- 5.8 There is no evidence to suggest that any risk assessment was carried out for Patricia following her report of assault by Ian when he came to her flat in June 2015 (see paragraph 3.44). She was a woman living on her own reporting being assaulted and having threats to kill made by Ian, and yet there appears to be no linking of him as a violent offender from Police callouts to his previous partner who was a high risk victim. Instead it is noted that Patricia sounded confused and was not making sense. This could have been due to concussion or shock. Or could it be that from her fairly frequent calls to the Police and Patricia's well known difficulties with alcohol, an assumption was made that she was drunk and therefore her report was unreliable? Whatever the reason the fact that she was not seen and risk assessed promptly was inadequate. Ian was still at liberty and could have returned and posed a threat to her again. Had a thorough background history of Ian's offending behaviour been checked, his past violence towards women, not just acquisitive crime, might have led to a different response. In addition to violence against Vivienne his former partner, Essex had a record that he had been violent to an ex-partner in Suffolk, for they had responded to a request for his arrest from Suffolk Police in December 2012.
- 5.9 When Ian assaulted his girlfriend Vivienne in June 2013, the incident was assessed as 'high' risk and a referral was made to MARAC. As part of a safety plan Vivienne was taken to stay with a family member where she remained until returning home the following month, and safety equipment was installed. It is not clear how much of Ian's previous history informed the action taken, and whether Vivienne was warned about his past as this was pre-Domestic Violence Disclosure Orders. It is disappointing that this incident, and the one that followed in October 2013 when Ian threw Vivienne out of her flat, resulted in no prosecution. Given the seriousness of the assault, the medical evidence which would have been available, and the fact that he was in breach of bail at the time of the second

incident, a victimless prosecution should have been vigorously pursued. The risk assessment on this occasion was 'medium', however, this was a second incident in under 6 months, and should have been viewed as an escalation in frequency of abuse and rated 'high'. The incident appears to have been judged in isolation. There is no evidence to suggest that Police risk assessments were informed by his previous criminal history and background from Suffolk Police regarding his previous partner and the existence of an injunction.

- 5.10 The Police IMR found that in addition to the absence of medical evidence to support a victimless prosecution following Vivienne's assault, an officer's statement was also missing, and this affected the Crown Prosecution Service's decision making.
- 5.11 The fact that Vivienne was accompanied to the Police by Ian's friend to make a withdrawal statement should also have indicated a high probability that she was coerced into that withdrawal. The Police IMR recognised that this should have been handled differently and a recommendation has been made as a result. Although this Review is not into Ian's treatment of Vivienne, this information is relevant for it brings to light Ian's capacity for violence towards women and his disregard for the law. It also highlights the gaps which occur in available information to share when such crimes do not reach prosecution.

Services Involved with Ian

- 5.12 Although only partially relevant to Patricia the incident of assault committed against her friend Vivienne by Ian in June 2013 is instructive for the insight it gives into his propensity for violence against women. There is a strong suggestion that Vivienne was coerced into withdrawing her statement by Ian backed up by his friend who attended the Police station with her to retract her statement. Hence this incident and investigation is worthy of comment.
- 5.13 The Police IMR considered that the case of Ian's assault on Vivienne in June 2013 could have been 'charge ready' when Ian was arrested on 16 September 2013 and that this would have enabled the Crown Prosecution Service to make a charging decision at that time. The missing components were an officer's statement and the medical evidence. Had these pieces of evidence been in place it may have made a more persuasive case for the Crown Prosecution Service to perhaps pursue a victimless prosecution. However, the IMR assessed that even with these components in place the case would have been unlikely to lead to a prosecution without the cooperation of the victim. There was good timely action taken in risk assessment and to protect the victim's environment i.e. safety planning, removal to a place of safety, alarm and flagging of address, but Ian's abusive history was not fully researched and he was not effectively held to account for his violent actions. The case against him for a late assault on Patricia in 2016 also went unprosecuted when it was adjourned by the court. Hence his violence towards women continued to go unchallenged. He was imprisoned for theft, but not for violence against women. The Police IMR and then further examination of the incident of assault against Vivienne found that the investigation could have been progressed more diligently, and recording of all the actions taken were not systematically recorded on the investigation log.
- 5.14 Whilst background is important to give context to this Review, the crucial period is from early 2015, therefore this section will concentrate on this timescale in respect of Services involved with Ian.

- 5.15 The hospital services and Anglian Community Enterprise (ACE) Minor Injuries involved in this Review were of an acute nature therefore a care plan was not necessary for the treatment required. Appropriate follow up appointments were made for Ian, although these were not always attended and some were 'open appointments' where attendance was discretionary; the patient may attend if they need further advice. Letters written to a GP informing them that Ian had missed a fracture clinic and physiotherapy appointment in October 2015 was sent to GP Surgery 1. This indicates that Ian did not inform the hospital that his GP had changed and/or that this information was not checked with him. A Trust wide email reminding all staff to check GP details on admission and prior to the discharge of a patient was sent on 6 March 2017, therefore a recommendation which would have been made concerning the checking of addresses will not be made as action has already been taken.
- 5.16 Each time Ian was arrested and held in custody he consistently stated that he had self harmed recently and had mental health problems. Appropriate action was taken to mitigate risk of self harm. The Criminal Justice Mental Health Team conducted risk assessments which were shared with the custody officer and then with the prison In-Reach Team which provides mental health support services within the prison. A copy of their assessments were also sent to Ian's GP at the time. One of the custody assessments on 22 June 2015 contained the information 'may assault without notice according to prison notes', and 'history of violent acts'. It also noted information from Ian's care coordinator that he had allegedly assaulted a friend the previous week. Apart from Police domestic abuse incidents this is the most significant recording of Ian's tendency towards violence in recent records.
- 5.17 There is evidence of correspondence and reports being shared with Ian's GPs from community health services including the Criminal Justice Mental Health Team assessments whose assessments were scanned onto Ian's GP notes. Communication with prison health services were less smooth; Ian's GP Surgery 1 had to contact the prison direct for confirmation of the medication he had been prescribed as no discharge summary was sent by the prison. This delayed issuing Ian with a prescription for his anti-psychotic medication on his release from prison. This will be covered later. There is no evidence that the Criminal Justice Mental Health Team assessments are shared with Probation or the Community Rehabilitation Company, even though their content would be helpful to inform offender manager plans and risk assessments and he was on a Mental Health Treatment Requirement.
- 5.18 Ian's GP electronic notes have no record of his Mental Health Treatment Requirement which, given that this concerned Ian's mental health and he was under the care programme approach, seems a surprising omission as it denies a GP information concerning an important aspect of their patient's treatment. Ian had been with the same GP practice between 2013 when he came to the Tendring area and 2014 when he went into prison. After one visit to GP Surgery 1 after release he then moved to GP Surgery 2 in April 2015 to access his prescriptions in the new town to which he had moved. GP Surgery 2 received copies of the Criminal Justice Mental Health Team assessments, but had no knowledge of the Mental Health Treatment Requirement. The Summary Care record recorded by GP Surgery 1 states 'notes not printed as patient is with a System One Surgery'. Medical records were sent to the Health Authority on 24 April. GP Surgery 2 Summary Care record shows Ian's medical notes were received on 1 May 2015. Ian was only with Surgery 2 between April and June 2015 when he was held in custody once more.

- 5.19 Ian moved GP again to Surgery 3 when released from custody in September 2015; Lloyd George notes¹³ did not arrive at this GP practice by the time he was arrested and held in custody in December 2015, therefore even if details of the Mental Health Treatment Requirement had been shared, Ian's last GP had not received his health records and this information would have remained unknown. However, if a GP practice using SystemOne had received and recorded notification of his Mental Health Treatment Requirement, this would have been visible to any subsequent practices which also used System One. In addition to GPs being unaware of the Mental Health Treatment Requirement, no re-referral had been made to mental health services after his release from prison, therefore GP Surgery 3 would not have had communication from that service to confirm Ian's mental health diagnosis.
- 5.20 Ian first came to the notice of Essex Probation and mental health services provided by the North Essex Partnership Trust following his appearance at Southend Crown Court on 27 February 2015, when he was assessed as suitable for a Mental Health Treatment Requirement and he met the criteria for care coordination. So began the joint working between criminal justice agencies and mental health services.
- 5.21 Essex Community Rehabilitation Company took ownership of Ian's Suspended Sentence Order from the National Probation Service on 30 March 2015. 3 days later his offender manager 1 received a phone call from the mental health nurse in the prison In-Reach Team where he had been held on remand to say that they would make a referral to the Access and Assessment Team in Colchester. Offender manager 1 provided the address they had for Ian. Considering that Ian had already been assessed as meeting the requirements to receive services from mental health services under a Mental Health Treatment Requirement a process which requires a further referral appears to be unnecessarily bureaucratic. The added referral process appears to have caused a delay between the sentence requirement put in place by the court on 27 March and the Mental Health Treatment Requirement being implemented as Ian was not seen by a mental health nurse until 24 April. A more efficient and streamlined system would be welcome.
- 5.22 Ian's initial appointment with offender manager 1 took place 6 days after allocation, 1 day later than prescribed. During this appointment Ian mentioned his child and an injunction. The offender manager should have sought a copy of the injunction, but did not. Ian also talked of being abused; this should have been explored further in subsequent appointments, but was not. He also reported that he had been released from prison the previous week without a prescription for olanzapine. This medication had commenced in prison and whereas Ian could obtain a repeat prescription for his other medication previously prescribed by his GP on the day of his release, for the olanzapine his doctor had to call the prison and fax a request for information before a prescription. The prison In-Reach Team were using paper prescriptions at the time, they now use electronic prescribing. Whether this facilitates a smoother transition from prison to community is not known. Ian eventually received this medication on 20 April 2015 after he had registered with another GP in the town where he was staying with his friend. The change of living location and GP meant that Ian was leaving a practice who knew him; he had been a patient there since mid 2013.
- 5.23 Offender manager 1 completed a sentence plan within 6 weeks of allocation as required by service level measures at that time. The Community Rehabilitation

¹³ "Lloyd George envelopes" are where most primary care paper health records in England are stored.

Company IMR found that a Self Assessment Questionnaire had been completed pre-sentence in November 2014, but this was not revisited by offender manager 1 when completing the initial sentence plan, although the issues were still relevant. Ian identified mental health as the key issue for which he wanted support and this was prioritised by offender manager 1.

- 5.24 The level of mental health input was judged to be satisfactory at the beginning of his sentence and there was a good level of communication between the community psychiatric nurse (CPN) who was Ian's care coordinator and his offender manager. The importance of being notified of any missed appointments or not complying with his Treatment Requirement was appropriately conveyed by offender manager 1 and how this would be managed was clearly defined in the sentence plan. However, in practice offender manager 1 did not record the dates when Ian attended appointments with his CPN nor any other mental health services. In interview offender manager 1 suggested that they were confident they would have been informed by his CPN had Ian not attended his appointments. The IMR author was of the view that for clarity, and to ensure progress can be monitored, it is necessary to record all attendances against specific requirements on the case management recording system. Good recording also means that in the absence of an offender manager another member of staff can fulfil that role knowledgeably and effectively.
- 5.25 The Company Rehabilitation Community IMR assessed the sentence plan to have identified factors which would inhibit change and these factors informed the Risk Management Plan and the risk management actions required. Although the objectives were mainly around rehabilitation it was evident that failure to comply would bring breach action and the serving of a prison sentence. The sentence plan objectives included addressing mental health issues, drug and alcohol misuse, thinking skills and lifestyle. Both criminogenic needs and ongoing risks were addressed, and work on the plan started promptly.
- 5.26 Offender manager 1 completed an OASys risk assessment within 6 weeks of Ian's sentence. This including assessing risk to others for which Ian was assessed as presenting a medium risk of serious harm to the public and low in all other categories. This assessment followed an in-depth induction appointment, liaison with the mental health team, a 3-way meeting with the interventions team manager, and information contained within the Pre-sentence assessment. The assessment also included a risk of harm screening which prompts a full risk of harm analysis. However the IMR judged this to fall short in that not all available information had been considered or additional assessments completed. No checks had been undertaken by the Probation Pre-sentence Report author nor offender manager 1 with the Police or Children's Social Care. This was not in line with procedures. These checks are mandatory as outlined in the minimum standards and domestic abuse Practice Instructions. In interview offender manager 1 said they were satisfied that Ian was not in an intimate relationship and that he was not having contact with his ex-partner or child, therefore they did not consider contacting the Police or Social Care and were not aware that checks were required on all cases. The absence of these checks was identified as early learning in a DHR Panel held on 18 April 2016, and as a result the Community Rehabilitation Company has undertaken staff briefings in each of their Local Management Centres.
- 5.27 Essex Community Rehabilitation Company and National Probation have an additional risk assessment called the Spousal Assault Risk Assessment (SARA) which Domestic Abuse Practice Instruction clearly outlines should be completed where there is a risk of domestic abuse. SARA was not completed with Ian by

either the probation officer who completed the Pre-sentence Report or the Community Rehabilitation Company responsible officers because they failed to identify the previous domestic abuse of his ex-partner, or the risk of further abuse to future partners. His offender manager had not read previous assessments. Police enquiries may have identified Ian's involvement in domestic abuse incidents against Vivienne even though these did not reach prosecution. The lack of SARA assessment also meant that Ian's attitude to women and relationships was not assessed.

- 5.28 The risk assessments undertaken were not adequately informed by Ian's background history as previous assessments had not been read. The Community Rehabilitation Company IMR found that a previous assessment recorded that the Youth Offending Service had concerns about Ian's obsessive behaviour towards his ex-partner, and they were sufficiently concerned that they recorded that Ian had the potential to imprison her and their child. Intelligence also suggested that Ian had assaulted a previous landlady. If this information had been read and shared with his CPN both agencies could have made different risk assessments and been more cautious in how they managed the risk Ian posed. For example the Community Rehabilitation Company IMR suggests that Ian's use of Patricia's address might have been rejected as unsuitable and work to find him more appropriate accommodation expedited. The Review author would go further and suggest that as Patricia had been a victim of assault by Ian before, and she lived in a one bedroom flat, the address should definitely have been rejected immediately it became known and Ian re-housed as a matter of urgency.
- 5.29 One of the most disturbing disclosures made by Ian to his offender manager was on 26 May 2015 when he reported an incident where he said he had witnessed an attack on his then partner who had died the previous September. What is equally disturbing is that the offender manager did not inform the Police. Ian had also reported at that same appointment that he had thoughts of wanting to stab his friend. There is no evidence that this was shared with his CPN and Ian was not seen again for 3 weeks by his offender manager, nor was he seen by mental health. These reports were not followed up with Ian at a later date. The content of the appointment should have resulted in a discussion with Ian's CPN and a review of both agencies risk assessments.
- 5.30 Ian's mental health care plan was to find him housing through the joint referral panel, set up benefits, and to monitor his mental state to prevent reoffending and being returned to prison. He was visited by his CPN in the town he moved to when living with his friend. When interviewed Ian stated that he had a good relationship with his CPN, but this and Community Rehabilitation Company supervision was not enough to prevent him reoffending again. His housing situation was not resolved before he returned to custody on 22 June 2015. He had been out of prison just under 3 months. The mental health care plan was not shared with the Community Rehabilitation Company despite the Mental Health Treatment Requirement being part of Ian's sentence. The Community Rehabilitation Company IMR believes it would be good practice to incorporate the care plan into the OASys sentence plan. The Review author supports this change in practice not only to improve information sharing, but it could also lead to improved coordination between the services by encouraging joint work to achieve the care plan objectives.
- 5.31 Essex Community Rehabilitation Company expects any changes in circumstances, change in risk, or completion of a requirement to result in a review of the risk assessment and sentence plan. Where there are no identified changes the OASys assessment must be reviewed at a minimum of 6 monthly. In this case the

OASys was reviewed on 24 September 2015 following Ian's further conviction for theft. Whilst this was within the 6 months review period it would have been reasonable to assume that a risk assessment would have been reviewed before this point, especially due to Ian's disclosure of thoughts of stabbing his friend, witnessing the assault on his ex-partner, increase in auditory hallucinations, and importantly, his arrest for theft and assaulting Patricia in June 2015. Crown Prosecution Service documents confirmed that Patricia was the victim of his assault. It was a significant shortcoming that his risk to others was not reviewed.

- 5.32 The Community Rehabilitation Company IMR could find no record to indicate when they became aware that Ian knew Patricia, however a psychiatric report prepared on 12 February 2015 mentioned Ian visiting Patricia in May 2014 after he committed a burglary and was wanted by the Police. This report suggested that Patricia called the authorities to alert them to his whereabouts, although it does not appear in the Police chronology that Ian was arrested at Patricia's address for this offence.
- 5.33 A further cause for concern regarding information sharing arises at the time of Ian's theft from his friend and the assault on Patricia. The friend phoned offender manager 1 to inform them that Ian had stolen from him and assaulted his aunt. He also said he did not feel safe staying there. Offender manager 1 shared this information with Ian's CPN and tried to confirm the details with the Police. However, offender manager 1 recorded that the Police would not share the information and noted that they and the CPN would call the Police to express their concern. There is no record of a follow up call to the Police. Further scrutiny of Police records concerning this exchange between offender manager 1 and the Police call taker show that offender manager was providing information about Ian for Police enquiries, rather than requesting information. It is unclear why offender manager 1 recorded the call as a refusal by the Police to give information. The issue of Police contacting Probation or Community Rehabilitation Company regarding offences committed by offenders they supervise has arisen in previous DHRs in Essex. It can often be at the time of a court appearance that an offender manager first becomes aware of an arrest rather than at the time of the arrest for an offence.
- 5.34 A key period in this Review is Ian's attendance at court from prison on 21 September 2015 and the days which followed, for the trail of events brought him to Patricia's flat.
- 5.35 Ian was released from the court without returning to the prison. He had no medication and no prescription with him from the prison. Following his remand in custody in June 2015 Ian's case was closed to the Specialist Psychosis Team and his CPN and transferred to the prison In-Reach Team; this team was unaware at the time that Ian was subject to a Mental Health Treatment Requirement. The In-Reach Team who monitored his mental health and his medication have explained that the prison Pharmacy do not receive lists of offenders attending court the next day until 5pm daily, by this time the pharmacist has left for the day. Therefore arranging for medication is not possible. Also they do not know who will be released from court or who will return to custody. As part of their risk assessment process offenders are assessed as to who can safely be in possession of their own medication and those who cannot. Those scoring above 18 would not be given their own medication. Ian scored 14, but he would still not have been given medication when going to court due to the risk of an offender overdosing at court. The In-Reach Team do not give medication to offenders attending court on the assumption that they will be released from court and there is no protocol or contingency plan for this to happen. The normal procedure is designed for when

an offender is released from prison when they will be given a weeks' supply of medication and a letter to take to their GP.

- 5.36 On the day of the court when Ian was released it was the responsibility of the duty probation officer at the court to deal with the offender. There are records that this officer contacted Ian's CPN with the information that he was about to be released. The duty probation officer was informed that they would need to refer Ian to the Access and Assessment Team as he was no longer an open case to the CPN in light of his diagnosis of Unstable Personality Disorder. The duty probation officer was aware of Ian's mental health issues, but could not recall whether he had medication with him or not. No contact was made with his offender manager for information. An appointment was booked for Ian by the duty officer with the Community Rehabilitation Company for 5 days time in line with policy. Ian was directed to go to Colchester Probation offices and given a travel warrant by the prison transport organisation. As previously mentioned Ian reported that he was unsure how to get to Colchester, so he took the route he knew back to the Tendring area. At this stage he had no medication, no appointment for mental health services, and no accommodation.
- 5.37 On the morning of the 22 September the prison In-Reach Team became aware that Ian had not returned from court to the prison. A nurse in the team phoned Ian's CPN to inform them that he had not returned and was told that the duty court probation officer had confirmed Ian's release from court the previous day. The CPN confirmed Ian's discharge from the Specialist Psychosis Team due to the length of time he had been in prison (3 months). The CPN reported that they had advised the duty probation officer to make a referral to the Access and Assessment Team. The nurse left contact details in case further information was required. The CPN's notes record that the nurse agreed to have a conversation with the duty probation officer to organise support. There are no records that this took place.
- 5.38 In-Reach Team records show that Ian's offender manager called the Team the following day, 23 September, reporting that Ian was trying to get his medication prescribed, but was having difficulty registering with a GP as he had no identification. The offender manager informed the nurse that Ian was banned from the local night shelter (no reason given) and he had no money to travel elsewhere. The nurse emailed a copy of his prescription as requested. There appears to have been no discussion about ongoing mental health support and a referral. Ian had previously been registered with a GP in the area for almost 2 years before transferring GP when he lived with his friend in another town. Community Rehabilitation Company notes indicate that his offender manager was trying to support him to obtain a GP. Why he was not supported to go back to Surgery 1 where he was known is unclear; his offender manager could have faxed confirmation of his identity to the practice if required. Ian ended up registering with a new GP at GP Surgery 3 near to Patricia's address where he was seen for his medication on 24 September 2015.
- 5.39 The Mental Health Trust records show that no referral was made to the Access and Assessment Team to re-establish Ian's Mental Health Treatment Requirement and his engagement with the service. Despite his offender manager identifying his mental health issues as a risk factor they did not make the referral, neither had the court duty probation officer as advised by the CPN, nor did the prison In-Reach Team make a referral. In effect Ian had slipped through the mental health service net due to this inaction.

- 5.40 When he was released earlier in the year the In-Reach Team had made the referral direct from the prison on 2 April 2015. It is debatable whether a probation officer based on duty covering courtrooms is the best person to take on this responsibility. The most logical pathway to referral in such circumstance would be for onward transfer from one health service to another such as between the prison In-Reach Team and the Access and Assessment Team. It is also questionable whether the closure and need for re-referral of a case involving an offender with a known history of mental health problems who also has a Mental Health Treatment Requirement is the most efficient and effective means of managing and supporting such patients. Where a patient goes into custody for relatively short periods of time a process whereby the case can be put 'on review' or 'on hold' would be more efficient and save administration and practitioners time. It could also give the patient the benefit of consistency of service. This option was discussed at length by the Panel and advice from the Mental Health Trust representative identified potential hazards of patients being missed by taking a different route into the service, or a change in their needs not being identified effectively. Thus after discussion the safest route was judged to be through the Access and Assessment Team, but with a clear pathway which would fast track offenders being released from custody. A recommendation was therefore developed to reflect this in addition to the need for a clear pathway to aid the understanding of agencies working with offenders with mental ill-health .
- 5.41 Ian's mother had phoned the Community Rehabilitation Company on 22 September to report that he was now living with a woman called Patricia. Why she did this is unknown. It was one of the main questions the author would have asked had she agreed to an interview. Unfortunately no connection was made that Patricia was the victim of an alleged assault by Ian, and no home visit took place to undertake checks. This was a serious oversight. The need for home visits to assess the suitability of an offender's address has been a recommendation in previous DHRs in Essex, one of which was in the Tendring area (DHR 2013).
- 5.42 Although Patricia is described as someone who took in 'waifs and strays' she had been assaulted by Ian, therefore it is legitimate to question whether she willingly took him in on his release from prison, or did she do this under duress due to coercion. The Community Rehabilitation Company IMR found the quality of the reviewed OASys risk reassessment which took place 2 days later on 24 September 2015 could have been improved as there was little update or analysis regarding the relationship between Ian and the victim Patricia, there had been no home visit or input from the mental health team since his contact with them ended on his arrest in June 2015. Therefore critical pieces of information and analysis were missing. The risk assessment centred on his lack of medication following release from prison and for that reason linked his current mental health with risk of serious harm and risk of reoffending without assessing the risk he posed to those around him. The concerns around Ian's mental health make it all the more surprising that a mental health referral did not take place, especially as this meant his Mental Health Treatment Requirement which still had time to run, was not being implemented.
- 5.43 The lack of accommodation is also key. Ian left prison and the court with no accommodation organised, although admittedly this was hampered by his unplanned release from court. He may have been offered a hostel if he had attended Colchester Probation offices on the day of his release, but he failed to go there. Ian did attend the local authority Housing Department on the 22 September and he provided the name of his offender manager to the housing officer. The Probation office was called to obtain confirmation of his offence

history from his offender manager. They were not available; a message was left for the housing officer to be called back, but no call was received, and no further call was made by a housing officer in follow up. Ian was asked to return with proof of his benefits. This he did on 29 September and was offered help with a rent deposit and advised of the night shelter where he could stay whilst looking for properties. During interview Ian said he was not offered a rent deposit, however the availability of the rent deposit was recorded on his offender manager case records. Whether this was a misunderstanding on Ian's part is unclear, but he then appears to have gone to stay with Patricia. The Housing Department received no information and no prior warning that Ian would be homeless on release, or that he would be approaching them as homeless.

- 5.44 There was a further failure to undertake a home visit when on 19 October 2015 Ian told his offender manager that he did not feel safe with Patricia as she had previously made allegations against him. This should also have expedited securing independent accommodations for Ian to remove him from this situation.
- 5.45 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 unaware of the court hearing. 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.
- 5.46 During the early part of Ian's supervision by the Community Rehabilitation Company a good level of communication developed between offender manager 1 and his CPN which enabled them to check out what Ian told them independently. The friend he lived with on his release in March 2015 also provided a source of information at certain points. In the opinion of the Community Rehabilitation Company IMR author whilst this was good practice there were many occasions when Ian was given the benefit of the doubt without any attempt to verify his own reports. For example the alleged assault on Patricia which was discontinued should have led to further discussion with the Police so that the circumstances could be assessed for any potential for future incidents and for Ian's risk assessment to be revised.
- 5.47 The Panel were genuinely shocked that no attempt was made to verify Ian's disclosure of witnessing his then partner being seriously assaulted even though she had died some time after the alleged incident of a heart attack. The Community Rehabilitation Company IMR also highlighted that neither the offender manager, the psychiatrist who prepared the Pre-sentence court report, nor the CPN felt it pertinent to discuss the disclosure with the Police.
- 5.48 There are also occasions when Ian was giving addresses, including to the Police, which he was not in fact living at and which were not checked for validity. This included Patricia's address at times.
- 5.49 Information provided to mental health services by Ian was verified with known information shared previously by his GP, the Criminal Justice Mental Health Team, and the Police.

5.50 The fact that Ian had a warrant out for his arrest at the time he killed Patricia having failed to comply with the conditions of his Suspended Sentence Order at first glance appear concerning. However, policies and procedures in place at the time via the Court Issued Warrants Strategy were followed, and the category applied to the warrant also comply with those policies and procedures. The matter of the execution of the warrant in this case was referred to the Police Professional Standards Department. After reviewing the actions taken they too found that procedures had been followed. It is accepted that Ian's personal situation (high risk domestic abuse perpetrator) was an aggravating factor, but when looking at the duties of the area inspector sent the warrant and the procedures in place at the time, the Professional Standards Department do not feel that any officer's conduct requires formal investigation.

5.51 There have been a number of changes in the administration of the warrant system which has resulted in a reduction in the number of warrants now handled by the Police. However the numbers are still significant. The 'Court Issued Warrants Strategy' was found to be undated and the accompanying schedule dates from 2004. This is in urgent need of review. It would be helpful if this DHR and its learning could be taken into account during this review.

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?

5.52 A key learning is the need for risk assessments to be informed by all available sources of information and intelligence. There were aspects of good practice where the offender manager had made links to risk of serious harm throughout which had been taken forward into the Risk Management Plan and the sentence plan, but this was let down by the lack of checks with Police and Children's Services.

5.53 The risk management plan for Ian would have been better informed if the additional SARA which good practice dictates should have been done, had taken place. Good practice would also have been for the offender manager to ensure that all previous history and assessments were read. As the CRC IMR points out whilst it is acceptable practice to adopt a previous assessment, its accuracy needs to be assured. The IMR states 'The theory that past behaviour is the best predictor of future behaviour should not be overlooked'. Thus past history is vitally important.

5.54 A further observation regarding good practice in the risk management of this offender includes the early liaison with mental health providers and the support offered to Ian to encourage his engagement with treatment. It is disappointing that his engagement did not prevent him reoffending.

5.55 In a further area of good practice the offender manager recognised the importance of developing a good relationship with Ian and mental health services. His mental health symptoms such as high levels of anxiety meant that the Thinking Skills Programme was adapted to be 3 way meetings with the treatment manager to accommodate this. The offender manager's recording was good, as was sentence planning and objective setting which was linked to risk of serious harm. However, there was one occasion where the wording used in recording was

misleading, giving the impression that information had not been shared when in fact it had not been requested.

- 5.56 The Community Rehabilitation Company IMR author recognises the benefit of hindsight, and the positive aspects of being empathetic and supportive with the offender, but felt the offender manager lost sight of the victims or potential victims with whom he came into contact. There was a reluctance to probe Ian about his relationships for fear that this would worsen his mental health symptoms. The lesson here is never to lose sight of risk to victims or potential victims above all else.
- 5.57 Practitioners charged with supervising complex cases such as Ian, need knowledgeable supervision from their managers to ensure their decisions are valid, and to ensure that perspectives on risk do not become affected by the support component of practice at the expense of risk management of the offender.
- 5.58 There is a lesson to be learnt concerning the management of Mental Health Treatment Requirements and the need to record all dates of appointments and progress which should be recorded on Delius (the CRC database). Not only is this important for a Court Order, but it also enables a colleague to pick up the case in the absence of the offender manager.
- 5.59 Enforcement action was not taken in a timely manner when Ian failed to attend appointments and did not conform to Enforcement Practice Instructions. In the opinion of the Community Rehabilitation Company IMR author there were 2 failures which should have resulted in breach action, but the offender manager was so keen to help Ian he was given the benefit of the doubt; the possibility that this decline in engagement might indicate a decline in behaviour, mental health and possible increased risk was overlooked. The management of this situation was further diminished by the failure to take an investigative approach to find out what was happening, or to consider an alternative meeting place if he could not get to the office. Most importantly no home visit was considered. A home visit is considered good practice especially where an address has changed, as it had in Ian's case. A home visit should have taken place.
- 5.60 It is difficult not to hypothesise whether, if independent supported accommodation had been found in those early weeks, Ian might have managed his life a little better and strengthened his engagement with the Community Rehabilitation Company and mental health services. He would also not have had cause to move in with Patricia.
- 5.61 Given his childhood background and history of abuse it is surprising that his mental health history does not appear to have included longer term therapeutic interventions to deal with the effects. Just before he reoffended his CPN assessed that Ian was suffering from Post Trauma. Learning from this case suggests that an offender who has suffered childhood abuse, separation, and periods in care should have the appropriate therapy built into their plans.

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

- 5.62 Patricia was not formally told of Ian's previous offending history by criminal justice agencies. However, as she knew of his relationship with her friend Vivienne and the violence he inflicted on her, and indeed Patricia reported some of those incidents to the Police, she was well aware that he could be violent. Patricia also

knew he was capable of theft since she herself reported that he had stolen from her, and stolen from the friend he stayed with. In addition she reported to the Police that Ian had assaulted her in June 2015.

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

5.63 There were no equality and diversity issues which prevented Patricia receiving or being offered services. Nevertheless, her problems with alcohol and depression continued to put her at risk, and her alcohol use formed a barrier at times in that her accounts of events were sometimes contradictory or confused which affected the ability of complaints to be taken through the criminal justice system. Of note is her report of being assaulted by Ian in June 2015 (paragraph 3.48) where it is recorded that her descriptions were inconsistent and she sounded confused. Patricia's problems with alcohol were well known due to her frequent contact; it would be an understandable human reaction to put her confusion down to alcohol, but she could have been suffering from shock, hence the confused state, rather than been confused due to alcohol. Her problems also formed a barrier to her ability to accept the help that was being attempted by her family to get her to move away from the area nearer to family support.

5.64 Ian also had services offered which were appropriate for his needs and no access was affected by equality and diversity issues. There is evidence in this review that services adapted to his needs, for example in delivering the Thinking Skills Programme in a 3 way meeting instead of a group setting which would have had a negative impact on his mental health. On another occasion he said did not feel comfortable with 2 male mental health workers as a result of the abuse he reported at the hands of his father and this was noted.

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.

5.65 Essex Probation became two organisations in 2014. Essex Community Rehabilitation Company became responsible for managing low and medium risk offenders, whilst National Probation Service retained the management of high and very high risk cases, they also retained court work, including all pre-sentence assessments and reports. National Probation court officers prepare case allocation documents including risk of serious harm screening. Cases determined to be low or medium risk are transferred to CRC. This means the initial assessment prepared by Probation court officers are crucial to ensuring appropriate allocation. As a consequence post sentence assessments prepared by the Community Rehabilitation Company offender managers are usually based on the assessment completed by Probation. As mentioned previously, whilst this is acceptable practice it is important to ensure that assessments are accurate and grounded in evidence before Essex Community Rehabilitation Company accepts transfer cases or replicates a previous assessment.

5.66 The Review Panel were concerned that perhaps the number of duty probation officers in the court were not sufficient to cover all the operational court rooms in the Crown Court at the time Ian was released straight from custody in September 2015. Panel discussed whether this could have contributed to shortcomings in ensuring that Ian had arrangements made for obtaining medication, a mental

health referral being made, and that he was adequately appraised of the actions he needed to take after leaving court. The National Probation Service (NPS) is responsible for all court reports and court work and, as such, they have performance targets that require them to allocate a case (to NPS or CRC) within 48 hours of the offender being sentenced. This was done in Ian's case. A key part of this target involves NPS seeing the offender after sentence to ensure that they know where they need to be i.e. attend appointment with CRC or NPS. If when the court officer sees the offender they present with mental health/health problems that require an immediate response the officer will speak to criminal justice mental health colleagues based in court, or will advise the CRC of any concerns for the CRC (or NPS) to follow-up. Ian's mental health issues and need for a prescription for anti-psychotic medication were not adequately covered before he left court. In a few cases offenders who have been sentenced and told to await instructions from a probation officer leave court and they have to be sent their reporting instructions to the address they have given in court. Ian did not go to hostel accommodation, therefore had he been sent instructions they would not have been received. A senior level Probation officer has reported to the Review author that in the period of time since the start of this Review the court probation officer role has evolved in order to meet its targets and the needs of the court for reports and assessments. The restructure in how courts are covered is believed to improve the service they deliver. However, if an offender chooses to ignore instructions on leaving court there is little court officers can do.

- 5.67 During 2014 and the early part of 2015, which included the period of this Review, Essex Community Rehabilitation Company went through a period of transition with 6 Local Delivery Units becoming 4 Local Management Centres (LMC) and the development of 2 Neighbourhood Centres in those areas without an LMC. To implement this new operating model staff were moved to ensure adequate staffing numbers in each of the LMCs. As with any transition of this scale there have been unforeseen problems; including technical issues, such as a lack of telecommunications in certain areas, one area being Colchester which covers the Tendring area.
- 5.68 To facilitate this transition there has been a caseload reallocation involving many service users being allocated to a different offender manager. However in the case of Ian, he was allocated to offender manager 1 from the start of his Suspended Sentence Order and remained so throughout the sentence up to and past the point when Patricia was killed. Offender manager 1 has since left the Essex Community Rehabilitation Company.
- 5.69 The prison In-Reach Team changed provider on 1 April 2015 from the North East Partnership Foundation Trust (NEPFT) to Care UK. As of that date the NEPFT database was closed, therefore any information that was held by NEPFT was not available to Care UK unless the Team made contact with them via telephone. Such loss of data and history can cause disruption to the service and support able to be given to patients. The Review understands that the prison In-Reach Team would have access to the Health database System One. One member of staff from NEPFT was transferred to Care UK and remains in the In-Reach Team and this has mitigated some of the disruption which might otherwise have been caused, however they were unaware that Ian had a Mental Health Treatment Requirement. In the closing stages of this Review the Panel learnt that the provider of In-Reach Team services in the prison is to change once more, which again gives rise to issues of continuity of records and care for those in prison custody.

- 5.70 North Essex Partnership Foundation Trust IMR found no evidence that their periods of organisation change impacted on the care of Patricia or Ian when they were providing a service to them.
- 5.71 The Police in Essex have undergone what their IMR describes as an immense change in relation to its approach to domestic abuse. However, during the period of this Review there was stability and clear direction in the Police approach. The impact of the introduction of the Athena database to Essex Police as a whole was significant, but the impact on the recording and management of domestic abuse less so.
- 5.72 During the reporting period the biggest impact for Essex Police was the introduction of the Central Referral Unit in 2012 and specialist Domestic Abuse Investigation Teams in 2014. This enabled Essex Police to focus these resources towards protecting victims of domestic abuse in addition to other vulnerable adults.
- 5.73 With the advent of the Athena database in April 2015 Essex Police reports improvements to the way in which risk is managed, especially in relation to victims of domestic abuse. Information in relation to domestic abuse incidents is recorded, along with other incidents, on the Athena database and is readily available 24/7 to all authorised staff, including front line officers attending incident. In addition this information is now available in real time to all forces who have adopted the Athena system.
- 5.74 Concerning the shortcomings in the investigation log during the enquiry into the assault on Ian's then partner, Vivienne, the Review has been informed by a senior Police officer that more thorough recording and review practices have been introduced into the area's Investigations Department since November 2016. The officer is confident that this practice improvement will prevent similar shortcomings happening again. A recommendation has been made concerning recording and timeliness of investigations

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?

- 5.75 Essex Community Rehabilitation Company has a statutory responsibility to manage service users in the community. They have the opportunity to approve or reject an address where the risk is too high for the individual to remain. Practice Instructions outline the minimum expectations in relation to home visits and this should be adhered to, but was not in this case. Home visits can provide valuable information on a person's personal circumstances. Essex Community Rehabilitation Company need to ensure that it embraces home visits as an essential part of practice in offender and risk management. The richness of information gained during home visits can contribute to managing risk and the reduction of fatal incidents in future.
- 5.76 Risk assessment and risk management are areas in which Essex Community Rehabilitation Company should specialise and to do this practitioners need to adopt and maintain an investigative approach. Promoting this good practice is being taken forward in a series of briefings to all offender managers.
- 5.77 Accommodation was a key issue in this case as it is for many people being released from prison. The Housing Department IMR described a new project begun in late 2015, which it was hoped would prove to be good practice in

reducing homelessness for ex-offenders. This project became operational at the in late 2015. In partnership with two other local Councils, Tendring District Council put in a joint bid for funding to enable housing support to be given to prisoners upon their release. The contract was put out to tender and awarded to Anglia Care Trust to support and monitor ex-offenders to find accommodation upon release. The service was to provide an intensive brokerage service to the clients who are often less eager to engage with services. Anglia Care Trust had a fund for providing deposits and rent in advance, and all allocations of money in advance of a tenancy were approved by the local authorities to ensure sustainability for the ex-offenders. Just as this Review was being completed it was learnt that funding to continue this project in 2017 has not been found. Rough data approaching the end of the project contract appears to suggest that the target number of ex-offenders supported will be met and the expenditure per client supported into housing and not returning to prison will be cost effective.

5.78 The Police IMR and further inquiries identified a need to review the warrant policy and procedures. This has been covered in paragraph 5.51. Working practices arising from recording on investigation logs has also been mentioned previously. However, within a recent Essex domestic homicide IMR an HMIC inspection report¹⁴ was highlighted where it was recommended that officers and staff are reminded of the content of the Essex Police Domestic Abuse Action Plan 2014/2015 (still current). In particular the following:

- When signing off domestic abuse incidents supervisors are to bear in mind the training they have received which focused specifically on safeguarding and referrals to partner agencies, as well as perpetrator and vulnerable case referrals. (January 2015)

* NB As this has already formed a recommendation in another Essex DHR they will not be included as recommendations in this Review.

9. 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?

5.79 During a period of engagement with North Essex Partnership Trust mental health services in 2010 Patricia had a Core Assessment which noted that she was vulnerable to exploitation and was living in an unsuitable house of multiple occupation. She was experiencing physical attacks and financial exploitation. The Mental Health IMR identified robust assessment and planning at this time which saw Patricia's accommodation change. Whilst the mental health IMR confirmed that Patricia was identified as a vulnerable adult in 2010 no other agency that had contact with her in more recent times such as the Police, formally identified her as such.

5.80 The Anglia Community Enterprise (ACE) IMR covering the Minor Injuries Unit and out-patient physiotherapy in common with other agencies were unaware of any connection between Patricia and Ian. Therefore no question of abuse arose. Assessments indicated that Patricia displayed symptoms for which consideration should have been given to undertaking a risk assessment in accordance with the Department of Health (2000) definition of a vulnerable adult. For example her fall, and her use of alcohol. It is also considered due to past history and information gained during a consultation post April 2015 when the Care Act 2014

¹⁴ Everyone's business: Improving the police response to domestic abuse

was implemented, that a risk assessment should have been undertaken in relation to the definition of an adult at risk. Opportunities to explore these matters further with Patricia to enable a fully informed overview and assessment of her situation, and her own estimation of risk and needs, went unnoticed by the practitioners. With the hindsight available from information available within this Review, there was more information available to external agencies that was unknown in ACE records which could have informed and strengthened analysis of her needs. However, this information was not available at the time and it is probable that information from external non-Health agencies would not be available in similar circumstances today.

- 5.81 Both women with whom Ian came into close contact were vulnerable. His former partner Vivienne was a friend of Patricia's and she too had problems with alcohol. Despite his assertion that she was the only woman he ever trusted, Ian was violent towards Vivienne, but he was not successfully prosecuted for the serious assault he inflicted upon her. A question arises; did the lifestyle of Patricia and Vivienne subconsciously affect the way offences against them were dealt with? There is no evidence that either Patricia or Vivienne were referred as vulnerable via Safeguarding Adults procedures.
- 5.82 It is arguable that Patricia was in need of 'care and support', 'at risk of abuse or neglect' and was at times 'unable to protect herself' the criteria listed for 'adult at risk' in the Care Act 2014. However she also appeared on occasions to be capable of taking steps to protect herself, for example by calling the Police or seeking medical help when needed. Nevertheless, there were definitely times when others took advantage when she was under the influence of alcohol and at such times she was at risk of exploitation and at risk of harm. However, Patricia had mental capacity, as defined by the Mental Capacity Act and thus she had a right to make decisions, whether those were in her own interests or not.
- 5.83 Ian had been in the care of the local authority as a child, he had been known to the Youth Offending Service in addition to Probation as an adult, and he was accessing mental health services. It was not clear from Community Rehabilitation Company records whether there had been a consistent diagnosis at the point of the fatal offence; Ian disclosed hearing voices, he spoke of feeling unsafe, and disclosed abuse at the hands of his father as a child. Essex Community Rehabilitation Company has a vulnerable adults Performance Indicator which outlines that where a practitioner considers that a referral is appropriate and necessary, the Single Assessment Process Form should be completed. In the view of the IMR author consideration could have been given to a referral in Ian's case.

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.

- 5.84 The chair's fulfilment of this term of reference is outlined in the methodology of this report.

6. Conclusions

- 6.1 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 relating to the perpetrator which

included information about his past violence, including domestic violence and abuse to women, in addition to his considerable acquisitive crime record. His history was not researched, was not taken into account in agency risk assessments, and actions taken when they should have been. 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 were not 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 him. There was a significant lack of professional curiosity and investigative practice.

- 6.2 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.
- 6.3 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 mental health treatment and medication which are being met by prison health services.
- 6.4 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 or safe accommodation.
- 6.5 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 health needs and management of his behaviour was inadequate and going unchallenged.
- 6.6 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.

Lessons Learnt

- 6.7 This Review emphasises the importance of adopting a more investigative approach to information gathering and validating reports. This includes the need to read previous assessments and to make checks with the Police and Safeguarding agencies to inform risk assessments, management and care plans, as well as making home visits.
- 6.8 Ian was a well known offender due to his long offending history and he was under Community Rehabilitation Company (CRC) supervision at the time of the murder. However, when Ian was arrested his offender manager only found out when he was in court. 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 promptly 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 county or metropolitan service borders.
- 6.9 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.
- 6.10 There was a concentration on risk to Ian himself rather than the risk he posed to others. His violent offences were ignored. 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 within that role. Practitioners need to be helpfully challenged and supported in management supervision to prevent the loss of this focus, particularly a focus on victims.
- 6.11 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 had reason to move into Patricia's flat.
- 6.12 It is understandable that Ian could not be prescribed medication to take with him to his court appearance; there are safety considerations with regard to a prisoner having prescribed medication at court. The prison In-Reach Team receipt of court lists and the operational times of the prison Pharmacy also contribute to the difficulties of ensuring continuity of medication in such circumstances. This emphasises the need for release to be planned in such cases.
- 6.13 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 in addition to timely communication with GPs to ensure that they have knowledge of any patients with a Mental Health Treatment Requirement, and medication prescribed in prison. 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.

- 6.14 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.
- 6.15 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.
- 6.16 Both Patricia and 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 pain¹⁵. Women who experience domestic violence are 15 times more likely to use alcohol and 9 times more likely to use drugs than women who have not been abused¹⁶. Mental illness also increases a woman's vulnerability and 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 disorders¹⁷. These additional risks faced by victims such as Patricia and Vivienne need to be considered by all agencies when undertaking assessments of need and risk.

Recommendations

- 6.17 Domestic Homicide Review 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.

¹⁵ Humphreys C, Thiara R, Regan L. (2005) *Domestic Violence & Substance Misuse, Overlapping issues in separate services*. London, Stella Project

¹⁶ Barron J (2004) *Struggle to Survive*. Bristol, Women's Aid Publications

¹⁷ 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

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.

6.18 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.

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

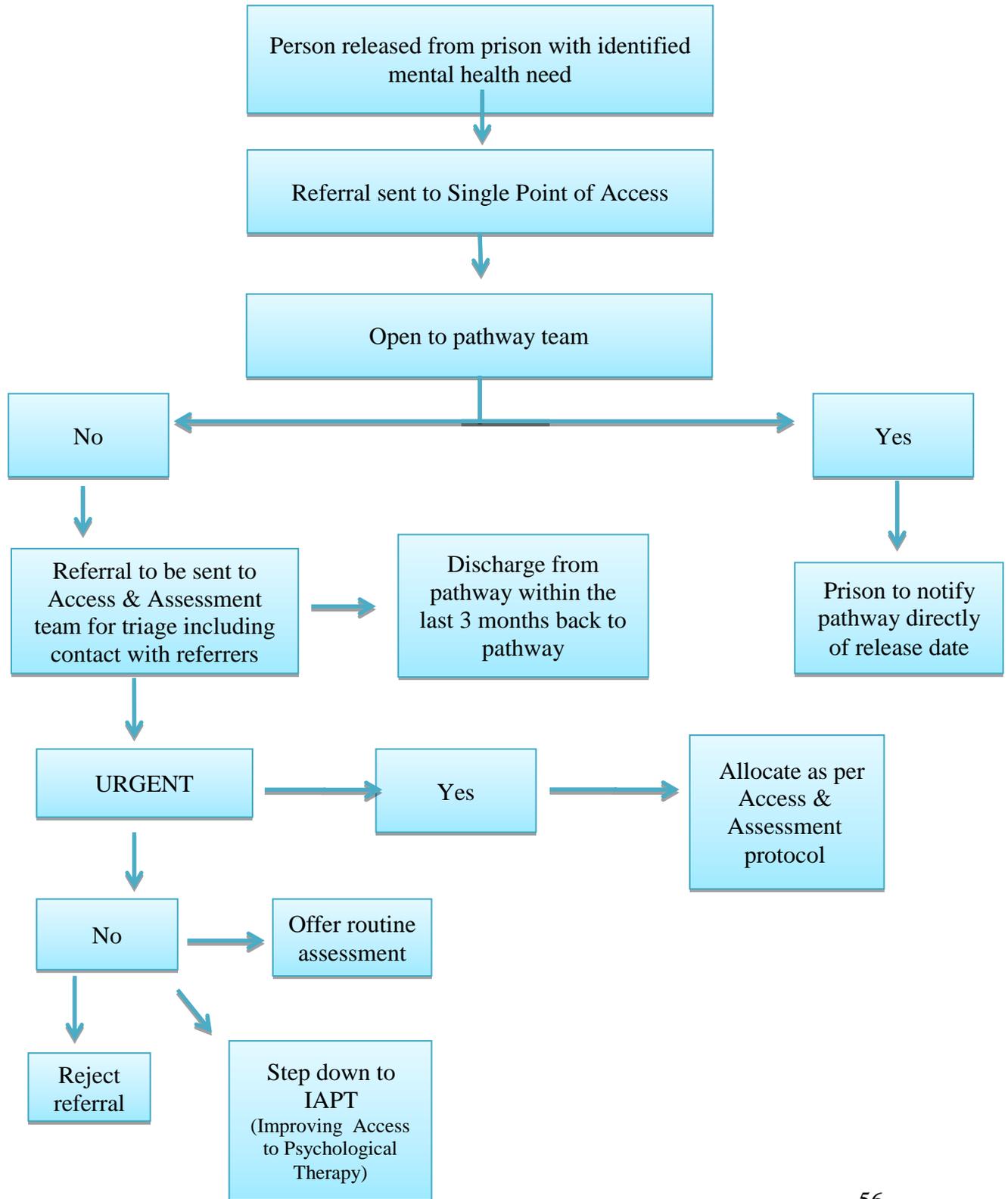
Recommendation 26:

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.

Process for Adult released from prison who was under care of North Essex Partnership mental health services immediately prior to detention in prison. Discharged from services due to Imprisonment.



WARRANT PROCESS & PROCEDURES

Essex Police have a Warrants Department which is sited in Colchester but serves the whole of the County of Essex. Until early 2016 the department carried out the administration of all warrant types with many warrants being executed by Civilian Warrants Officers depending on the risk assessment.

Since 2016 Essex Police have ceased to administer and execute warrants in relation to non-payment of fines warrants on behalf of the Courts and a private contractor is now employed by the Courts for this area of business. The result is that Essex Police no longer employ Warrants Officers within the organisation. Prior to the change, Essex Police administered around 100-150 warrants per week but since the change this has dropped considerably to around 40-50. At the time this review made its enquiries there were 673 outstanding warrants being administered by Essex Police.

Essex Police practice in relation to warrants is currently based on a document entitled 'Court Issued Warrants Strategy' for the administration of arrest warrants with and without bail (2013). The document sets out that warrants are categorised either as A, B & C and should be executed within timelines approved by ACPO (now NPCC) and endorsed by the Home Office and the Essex Criminal Justice Board. Category A is intended for the most serious offences and offenders, Category B is intended for other 'crime' matters and Category C for warrants issued for non-crime matters and any Fail to attend/bench warrant issued with bail.

The strategy document is accompanied by a table, set out in a memorandum, which specifies the categories which should be applied to warrants and sets specific time scales for their execution and target dates for review. It states that Category A warrants should be executed within 14 days, a Category B within 21 days and a Category C within 28 days.

The memorandum details, inter alia, that a warrant issued without bail in relation to the breach of a Court Order where the original offence was one of theft should be graded as Category B. The review period for this offence type is either 18 or 36 days depending on the circumstances of the original offence.



Home Office

Public Protection Unit
2 Marsham Street
London
SW1P 4DF

T: 020 7035 4848
www.gov.uk/homeoffice

Leanne Thornton
Community Safety Manager
Tending Community Safety Partnership

9 October 2017

Dear Ms Thornton,

Thank you for submitting the Domestic Homicide Review report for Tending to the Home Office Quality Assurance (QA) Panel. The report was considered at the QA Panel meeting on 23 August 2017. I very much regret the delay in providing the Panel's feedback.

The QA Panel would like to thank you for conducting this review and for providing them with the final report. The Panel concluded this was a skilfully conducted, fearless and probing review which has identified local as well as national lessons and which have been clearly articulated in the action plan.

There were, however, some aspects of the report which the Panel felt may benefit from further analysis, or be revised, which you will wish to consider:

- The Panel believed there was no organisation represented on the review panel from the charitable sector and reiterated the importance of ensuring that a panel's composition should be sufficiently configured to bring in statutory and voluntary agencies as well as relevant expertise in relation to the particular circumstances of the case;
- You may wish to explain why the perpetrator's GP did not provide an IMR (paragraph 1.24);
- The Panel recommended that the important finding set out in paragraph 5.45 in the overview report should also feature in the executive summary;



The Panel does not need to review another version of the report, but I would be grateful if you could include our letter as an appendix to the report. I would be grateful if you could email us at DHREnquiries@homeoffice.gsi.gov.uk and provide us with the URL to the report when it is published.

The QA Panel felt it would be helpful to routinely sight Police and Crime Commissioners on DHRs in their local area. I am, accordingly, copying this letter to the PCC for information.

Yours sincerely

Hannah Buckley

Acting Chair of the Home Office DHR Quality Assurance Panel