REPORT OF THE INDEPENDENT INQUIRY TEAM

PRESENTED TO
BROMLEY HEALTH AUTHORITY
SOUTH EAST LONDON PROBATION SERVICE
LONDON BOROUGH OF BROMLEY - SOCIAL SERVICES & HOUSING

FOLLOWING A HOMICIDE BY
A SERVICE USER IN APRIL 1996

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Foreword

This inquiry follows others. There are new lessons from this inquiry but some from previous inquiries have not yet been fully learnt.

Why were a Probation Service's guidelines on risk assessment not in practice when other areas had achieved this?

Why, after five years, had a NHS Trust not fully implemented the Care Programme Approach? Why had a Health Authority not taken effective action to ensure implementation?

A false public perception is that people with a severe mental disorder such as schizophrenia are more likely to be violent and to kill than others. Homicides by people with severe mental illness are exceptional and people with such illnesses are more likely to be victims of violence rather than to inflict violence on others.

Research and some other inquiry reports have, however, identified another predisposing factor towards violence - previous physical, sexual or emotional abuse. Either the individual had been abused themselves or they had been abusive to others in the privacy of their own homes. As with mental illness, most people who have been abused in childhood do not later inflict violence on others. But some do - the link is there. Knowledge about such abuse is often not passed between agencies and is often not sought by those who need to know.

This inquiry shows the connection between past abuse and present violence and how things can go wrong. I hope this independent inquiry will help to raise both standards and understanding and add impetus to the action needed to combat domestic violence.

We set out our findings and make recommendations to a range of Authorities accountable to the public. They should respond.

Ken Dixon
Chair of the Independent Inquiry Team
April 1997

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INTRODUCTION

1. On 23 April 1996, Evan B. committed manslaughter. His victim was Susan B. his estranged wife.

2. In the preceding weeks he had been living in a probation hostel in Bromley, south east London, and he had been admitted and discharged from the psychiatric unit of a local hospital. For most of the time, however, he and his family had lived in Middlesbrough. The manslaughter took place in Manchester.

3. We were commissioned by Bromley Health Authority and Bromley Social Services, in conjunction with South East London Probation Service, to investigate all the circumstances relating to the care and treatment of Evan B by local mental health services in co-operation with criminal justice services; and to consider the adequacy and effectiveness of collaboration between various agencies. Our full Terms of Reference are shown in Appendix F of this Report. The authorities in Middlesbrough and Manchester were notified of our Inquiry and they undertook to co-operate fully with us.

4. It is our view that the social vulnerability of Evan B. and his family is representative of many people who have intermittent contact with GPs and psychiatrists, community nursing and social work practitioners including probation. There is a clear health dimension to this situation, but other significant contributory factors, particularly a history of domestic violence, add to the complexities and reinforce the need to take a holistic approach.

5. Health, criminal justice and social care agencies have responsibility for the assessment, care and treatment, and, where the courts have directed, the supervision of certain individuals. Risk-assessment and the management of risk, in order to protect the individual or others from harm, forms part of that responsibility. The services have a shared aim to reduce the incidence and prevalence of such violence, identify and support victims and develop appropriate services or interventions to reduce the risk of offending.

6. Half of women victims of homicide are killed by their "current or former spouse, cohabitant or lover"(1). Of all types of violence, repeat victimisation is most likely with domestic violence. Many women remain in danger even after they have left violent partners. Violence persists during or after separation in some cases, and may increase in severity at the time of separation. Studies have shown that in thirty per cent of the cases in which wives were killed by their husbands, the couple were no longer living together when the violence occurred (2).

7. Our investigation discloses one such tragic happening. There are few lessons from this inquiry which serve to inform social policy. There are a great many lessons which may help to put that policy into better practice.

BACKGROUND

8. Evan B. was born in 1954 in Middlesbrough, the third eldest of eleven siblings. He married Susan B. in March 1976. Their first son was born in 1976, their second in 1977 and their youngest son was born in 1980.

Criminal justice

9. Criminal records show that at the age of 8 years old, Evan B. committed a number of minor offences and that he was separated from his family and spent seven years at two Approved Schools a long distance from home. At the age of 15 he moved to independent living. In the next two years he committed offences of theft and burglary, was made the subject of a 2 year probation order, followed by a period in a detention centre (3 months), and then Borstal training (9 months). At the age of 19 he was convicted of robbery and wounding with intent and sentenced to 3 years imprisonment.

10. He met Susan, when she was aged 17, shortly after his release from prison, he being 21. During the first year of their relationship, Evan B. was convicted of an assault occasioning actual bodily harm (we do not know the circumstances), and he was made the subject of an 18 month probation order. The probation order was later extended to 2 years following a breach and an offence of handling stolen goods.

11. In November 1980, he was convicted of driving offences including excess alcohol and sentenced to 3 months imprisonment. In December 1980, he received a 12 month prison sentence for burglary and theft.

12. There were no further convictions until September 1986 when he was convicted for driving with excess alcohol and sentenced to a Community Service Order, the probation service being involved once more.

13. In November 1990, the first offence of criminal damage is recorded. He had smashed windows at a women's refuge where his wife had been staying. In January 1991, he was ordered by the magistrates court to pay compensation and he was sentenced to 3 months imprisonment suspended for 2 years.

Comment

Evan B's childhood was deprived. Half his early life was spent in custodial/institutional care. By his late 20s, his property offences ceased but two of the convictions involved physical violence. Two further criminal offences in 1980 and 1986 involved the excessive use of alcohol. Up to 1986, there is nothing particular in his criminal history to mark him out from many young male offenders.

The criminal damage offence in 1990 is the first which relates directly to his relationship with his wife and it coincides with the start of his admissions to psychiatric hospital.

The Probation services had extensive involvement with Evan B. (for supervision, prison welfare and community service) throughout the early 1970s and up to mid 1986. However, we understand records are not normally retained (even in summarised form) by the probation service for more than a few years if there is no further contact with the individual.

Evan B's recollection of his early childhood, as recorded by a prison medical officer (September 1996), is that he was constantly running away from home, truanting from school and shop lifting. His father would severely reprimand him - usually this took the form of beatings with a stick. He denied that he was unhappy at home,and said that his parents were "all right" and that his father only beat them if they were naughty. Whilst at Approved School he claimed that he would often get into trouble for wetting the bed and would be caned for this.

Health care

14. Records of Evan B's health care are available from 1969 when he was aged 15. Between then and 1980 he needed treatment for a skin complaint, back pain and nocturnal enuresis.

15. In August 1985 he was referred to his GP by a social worker from the Family Clinic because his wife had left him and he was "thought to be at risk". The family are described in the GP's letter as having "ongoing social problems" and Evan B. as being a heavy drinker, "probably a psychopath" with a criminal record. He complained of feeling tense and irritable and was drinking 15 pints a day (210 units/week. 28 units/week is generally considered the maximum compatible with long term health). His GP referred him to a psychiatrist at St. Luke's Hospital in Middlesbrough. Evan B. did not attend for two out-patient appointments in September and October 1985 and his GP was informed of this and that the hospital intended to take no further action.

16. Between then and 1990 he attended his GP mainly with muscular pains and an episode of feeling depressed in December 1990. A discharge summary from an overnight admission to St. Luke's Hospital, 9-10 December, recorded that he had taken an overdose and cut his wrist two weeks before. The morning after his admission he asked to be discharged and agreed to take medication and to attend out-patient follow up. There is no record that he did attend.

17. He took an overdose of paracetamol and ferrous sulphate on 2 March 1991 "because of problems in his marriage" which he refused to discuss further. He discharged himself from South Cleveland Hospital the following day before the effectiveness of treatment could be checked, saying that a reconciliation with his wife was underway. Before discharge he was

reviewed by the duty psychiatrist who found no evidence of a depressive illness and considered that he was no longer suicidal. He did not attend two out-patient appointments. At a health check in March 1991, he said that he was drinking only seven pints in two weeks (seven units a week) but complained of feeling depressed and an antidepressant was prescribed.

18. He was admitted to St. Luke's Hospital on 4 November 1991 having complained to his GP of feeling depressed and suicidal since his wife had left him two days previously. Having been referred as an emergency he arrived at the hospital seven hours later at midnight. 50 minutes later, he decided to leave but was detained under section 5(2) of the Mental Health Act 1983 and placed on constant observation. The next morning he was anxious but otherwise well and his detention was not continued. At 11.10 p.m. that night, he asked to discharge himself saying that his wife was returning from Edinburgh. His mental state was normal and he was allowed to leave.

19. Following a change of GP at a further health check in November 1993, he said he was teetotal and at another in January 1994 that he drank eight pints (16 units) a week. On 12 April 1994, he complained of feeling depressed after his wife had been raped. He was referred to St. Luke's Hospital and the Social Services Department was informed. It may be that this relates to an overnight admission to St. Luke's Hospital in February/March 1994 which is recalled by the consultant psychiatrist who knew Evan B. The records for this admission were not available during the Inquiry proceedings

Comment

Up to this point there is nothing about Evan B's health or health care to mark him out from the many thousands of other patients who consult psychiatrists. The picture of a man in a dysfunctional relationship with his partner, drinking too much and concealing this from his doctors, is common. His very rapid return to a normal mood from being suicidal suggests that his mood is influenced by alcohol, by immediate environmental stresses, e.g. court appearances, and by a personality marked by impulsiveness and an unstable mood. This treatment and referral to social services or for a specialist opinion appears appropriate.

Social Services support

20. Evan B's family first came to the attention of Cleveland Social Services in 1978. The records show that Susan B. presented herself with her 11 month old baby, having left Evan B. with their 2 year old son. She was alleging violence in the home and she stated she was in touch with a solicitor with a view to seeking an injunction to get her husband to move out. She was placed in sheltered temporary accommodation over the weekend. During this period, it is recorded that the family were supervised by the Probation Service. Evan B. and Susan B. were both known to the Probation Service and the former local authority Children's Department. Social Services received intermittent referrals. In April 1979 the

two sons names were placed on the 'at-risk' (child protection) register for suspected non-accidental injury. In July 1980, their third son was born, and Social Services allocated a social worker to support the family. In April 1981, following a suspected non-accidental injury, his name was also placed on the Register. Thereafter, there were regular child protection reviews involving many local agencies including the police.

21. In July 1983, care proceedings were instigated following evidence of non-accidental injury to one of the children which led to all three children being made the subject of a Supervision Order for 3 years to Cleveland Social Services. In July 1986, the Supervision Order expired and in April 1987, Social Services withdrew allocated support. However, intermittent referrals continued. For instance, in 1988 Susan B. was again taken to a women's refuge by the duty officer. In October 1990, Susan B. sought support saying that she had been beaten, and seeking Social Services assurance that contact with her husband would only be made through her solicitor.

22. In November 1990, the family were again allocated for Social Services support. Susan B. had left home, and Evan B. who had care of the children, was "feeling threatened". Social Services remained involved until February 1991. During 1994 there were intermittent referrals to Social Services, support with family housing difficulties and child protection concerns. Susan B. left the family home again at the end of 1994. In December 1994, the records show that she attended the Cleveland Social Services office stating that her reason for leaving her husband was his continuous violence towards her and the entry states:

> " last violent incident - husband had a knife to her throat threatening to kill her."

23. Social Services liaised with the police and made contact with the children and Evan B.

24. There are three volumes of files which contain records of support, monitoring and protective actions taken by Social Services and Susan B. It is evident that she had trust and confidence in Cleveland Social Services. There was an incident in 1983, when, with the assistance of Social Services, Susan B. was placed in a women's refuge for safety from her husband's violence. It is reported that Evan B. then made threatening calls, followed by a threat at the Social Services office to stab the social worker involved because she would not disclose Susan B's whereabouts. The records depict the trauma experienced by the worker.

Comment

There was family support work and child protection monitoring by Social Services during 7 years of Evan B's marriage, for the most part on a voluntary basis, and on-going support as required. Social Services concerns for the children centred on the differences between the parents, effects of domestic arguments followed by violence, and the inability of one parent to cope with all three children on their own. As the children grew older, the periods when Susan B. felt able to separate from her

husbands violence increased. Initially taking her young children with her, her later escapes left Evan B. with responsibility for their care.

Evan B. and his the family were well-known to local child health and other agencies. Much of that knowledge was pooled through child protection co-ordination arrangements, but early child protection reviews appear not to have included the family GP and certainly there is no reference to such child protection issues in Evan B's general practitioner records.

No court prosecution was instigated by the social worker or her Social Services Department against Evan B. in response to the serious incident of threatening behaviour towards the social worker (in 1983). Present day guidance on 'Violence to staff' in social work agencies usually recommends legal action. Such action can lead to the offender receiving a fuller multi agency assessment and review of their past behaviour to others, in order to assist full consideration of the interventions needed.

We have not sought to disclose full details contained in personal files of Susan B's accounts of the violence inflicted on her. However, we consider it is important to the understanding of subsequent events to highlight some of the information about the prevalence and characteristics of domestic violence in our society. We acknowledge the following findings from research:

Professor Jalna Hanmer, University of Bradford - findings based on the British Crime Survey 1992 :-

- **Violence against women by partners, ex partners and relatives is the most common form of physical, inter-personal crime.**
  1% of women said they had been a victim of domestic assault in 1991.

- **Of all types of violence, repeat victimisation is most likely with domestic violence.**
  Half of the women who reported domestic violence experienced more than one attack.

- **Most violence is perpetrated by men, and the concentration of violence against women by men is in domestic situations.**
  75% of women were assaulted by men, and in the domestic setting this proportion is higher.

- **Victims perceive domestic violence as serious but do not report it to the police or other agencies.**
  Only 1 in 5 domestic assaults mentioned by women was reported.

- **Women are likely to assume responsibility for attacks upon them.**
  25% of victims of domestic assaults felt they were responsible in some way for what happened, in comparison with 13% of victims of all violent incidents.

- **Women are likely to be related, or to have been previously related, to the assailant.**
  9 out of 10 assailants were either current or past husbands or partners.

- **Incidents are particularly likely to occur at the weekend and at night.**
  Most violence occurs between 6 p.m. and midnight.

- **Women experiencing domestic violence are most likely to be between 16-29 years old.**

- **Having children increases the risk of assault.**
  The British Crime Survey suggests that children increase the levels of financial and emotional stress, and that women intervene on behalf of children and are assaulted as a result. Professor Hanmer believes that another, more plausible, explanation is that women are more dependent on men when their children are under five years old. This dependence is usually financial, but may also be emotional, and is exacerbated by widely held views on family life. It is seen as less acceptable for women to leave men, whatever their behaviour, after children have been born.

EVENTS IN MIDDLESBROUGH IN THE PRECEDING MONTHS

25. We have depicted background knowledge held by the criminal justice services, health and social services about Evan B, individually and in a family context. What follows are events which led these agencies into closer liaison.

26. Shortly after Susan B. left at the end of 1994, Evan B. left the family home taking their youngest son with him, leaving their two elder sons in the tenancy - his sudden departure was marked only by a note but he did not inform them where he was going. He moved to an area outside Middlesbrough where he thought his wife might be staying. He traced her to her temporary accommodation.

27. On 5 January 1995 he was sentenced at Teesside Magistrates Court for criminal damage and ordered to pay compensation. On 9 January he appeared at Teesside Family Proceedings Court having made an application for a Residence Order in respect of his youngest son. He was seen by the Court Welfare Officer from Cleveland Probation Service. Susan B. did not attend court, and the matter was adjourned for a full welfare report. On 24 February 1995, Susan B. obtained an injunction order at Middlesbrough County Court to restrain Evan B. from using further violence upon her, from threatening, harassing or pestering her, and from entering or attempting to enter any property in which she resided. On 29 March 1995, Evan B. again appeared before Teesside Magistrates Court and was found guilty of common assault (against Susan B), threatening behaviour and criminal damage. He was ordered to pay compensation to Susan B., fined and bound over for 12 months.

28. On 28 April 1995, the court welfare officer filed a report on the family circumstances in the Family Proceedings Court.

29. **On 19 May 1995, following an interim family court hearing for the Residence Order, Evan B. physically assaulted his youngest son (age 14 years old). The two accounts and responses from Health and Social Services to this serious incident are as follows:**

Health Service response

30. On Friday, 19 May 1995, Evan B. was admitted to St. Luke's Hospital informally having been referred by the police following the assault on his son. The hospital discharge summary, which was completed by a Senior House Officer, states that Evan B. said he tried to murder his son by strangulation after a row, thinking his son looked like his wife. Evan B. also said his son was unconscious for 10 minutes and was left bleeding from the nose and face. The discharge summary reflects the history of his previous hospital admissions, records an inaccurate forensic history of "imprisonment twice for criminal damage", and that on admission he was looking depressed, that there was some suicidal ideation present and that "he was afraid of the death of his son". He was admitted under

close observation and no medication was prescribed. He stayed over the weekend. The summary states that:

> "There is apparently no charge by the police who asked to be informed when he leaves hospital. Social workers now involved in the case. The son came to visit him and the incident was not mentioned between them. There did not appear to be any evidence of mental illness and he can go if he wishes and as agreed the Police would be informed. No follow-up was arranged."

The discharge summary was addressed to his GP.

Social Services response

31. In the afternoon of Friday 19th May, Evan B's youngest son was found wandering around Middlesbrough in a very distressed state and was picked-up by the Police. The account given to the police was that Evan B. had contact that day with Susan B. and there had been an argument. Evan B. told his son to go home and when he later returned home he had a bottle of bleach and told his son to drink it. When he refused he punched his son in the face and tried to throttle him. The son had scratches and bruising around the eye and was distressed at the Police Station. He was unable to give the whereabouts of either parent. The Police referred the matter at 4.25 p.m. to Cleveland Social Services who treated the referral under child protection procedures. The son was immediately taken for medical examination but the cuts were seen to be superficial and there was no evidence that he drank any bleach.

32. Evan B.'s son refused Local Authority Care and was placed with a paternal uncle who gave assurances that he would keep him safe. On Monday 23 May 1995, the allocated social worker visited the uncle's house to interview the son but was informed he only stayed one night. Apparently, the following day he visited his father at St. Luke's and returned to the bed and breakfast accommodation where he had been living with his father. Meantime, Evan B. had taken his discharge from St. Luke's and his son chose to go with him. Evan B. and his son moved to Whitby/Scarborough and were not traced by the investigating social worker from Cleveland Social Services until 14 June 1995.

33. In a written statement to our Inquiry, the Social Services Manager of the Child Protection Investigation at this time stated that there was discussion between herself and a staff member on the ward at St. Luke's Hospital on 22 May and 23 May 1995. Her understanding was that Evan B. had requested admission to the ward over the weekend stating that he required help. The staff member told her that Evan B., in his opinion, was not psychiatrically ill and that he would be discharged on 23 May 1995. She was told that the son had spent most of the time on the ward with his father and at that time the situation was calm. Her perception of the health care response was that Evan B. was not psychiatrically ill but that he used St. Luke's "as a bolt hole in times of stress". She could not recall whether Social Services' opinion was sought as part of the clinical assessment,

and hospital staff appeared clear that as soon as he was seen by the Consultant, he would be discharged as there was no reason for him being on the ward.

Comment

If the account given by Evan B. is correct, then this was a major assault on a young person and, if prosecuted, could have led to a more serious charge (Grievous Bodily Harm) than Evan B. had faced before. It is especially worrying that Evan B. reported that he attacked his son because he looked like Susan B. Faced with a charge of a serious offence against a person and with a history of repeated hospital admissions, Evan B. might well at this stage have been assessed by a forensic psychiatrist. From the report written for the inquiry (and hence with the benefit of hindsight), the consultant psychiatrist who had responsibility for Evan B's health care was surprised by the police's decision not to charge him, but was influenced in deciding to allow self-discharge by Evan B's remorse and by a meeting in the ward between Evan B. and his son at which the attack was not mentioned. The notes for this admission are not available.

The police took initial and appropriate action in ensuring that the young person was safe and protected. Evan B's son, however, refused to make any complaint against his father of assault. It is possible that medical evidence of injuries was not considered substantial enough for prosecution by the police.

The child protection investigation commenced over a weekend when social service resources were limited to the Team Manager and emergency outside office hours duty social worker.

Neither the full history of domestic violence, nor Evan B's full criminal record appear to have been made available. In the absence of this information and in the absence of evidence of mental illness the decision to discharge Evan B from hospital was understandable. If the information had been available then it is possible that he might have been further detained in hospital to allow for an assessment by the forensic psychiatry service.

Contact with community mental health services in North Yorkshire

34. Whitby is in the area of North Yorkshire County Council Social Services. After several moves Evan B. approached Whitby Housing Department for temporary accommodation. On 14 June 1995, he was referred by a doctor from a medical centre to the Community Mental Health Team in Whitby. He was interviewed by a duty worker. He said that his son had previously been assaulted by a boy-friend of his wife, and that he had become angry following an altercation with his wife in May and taken it out on his son. He had been admitted to St. Luke's Hospital after the assault, and, following reconciliation with his son,

they had moved to different temporary addresses following further threats by his wife's boyfriend. He was concerned about his son's behaviour and that they had been arguing.

35. The duty worker recorded that during the interview, Evan B. was endeavouring to impress on him his concern for his son, and how they were both victims of circumstances (which the duty worker was not entirely convinced of). Following the interview the duty worker contacted the Consultant Psychiatrist at St. Luke's Hospital who knew Evan B. The record states that the consultant advised the duty worker that he considered that Evan B. was suffering from a personality disorder, that he could become aggressive when matters did not go his own way, that he had refused to stay in hospital and had changed address 19 times. The duty worker recorded the consultant as saying he felt that this man was endeavouring to use the system.

36. The duty worker also consulted a social worker in the mental health team who raised concern about the safety of the son. Cleveland Social Services were contacted and liaison was established with the child protection investigation social worker. A visit by the Cleveland social workers followed. Meantime, Evan B. was using a drop-in centre for homeless people in Whitby who were providing practical advice concerning education, benefits, housing etc. The duty worker advised them of Evan B's current circumstances.

Family and divorce proceedings

37. On 26 June 1995, Teesside Family Proceedings Court ordered an investigation report from Middlesbrough Social Services (pursuant to Section 37 of the Children Act 1989) to consider whether care proceedings should be brought. In August 1995, the son decided to live with Susan B. in Middlesbrough, and Evan B. indicated that he was withdrawing his application for a Residence Order and wanted no further involvement with Social Services. In October 1995, the S.37 Report was completed. The social worker told us that she gave Evan B. a copy to read just prior to the family court hearing. She told us " He wasn't aware that it would go so far back in history, because he had not made himself available for me to discuss it with him. He got quite angry and tore it up in front of me and flung it at me." Following the court hearing it is our understanding that support from Social Services and Education was offered to Susan B. and her son.

38. On 9 October 1995, Evan B. traced Susan B. and their son to temporary accommodation where he smashed windows, broke a door, and was arrested by the police. The following day, Susan B. instructed her solicitor to commence divorce proceedings and the solicitor made application within the divorce proceedings for an injunction to restrain Evan B. from using violence or threatening Susan B. with violence and to prevent him from harassing or pestering her further. On 27 October 1995, Susan B. attended her solicitor's office and informed him that Evan B. had been round to the Women's refuge where she was staying the previous evening. He advised her that she could take committal proceedings but she took the advice of a welfare worker from the refuge, and was transferred to a similar women's refuge in Manchester that day. **Susan B. and her son moved to Manchester on**

the 27 October 1995. Women's refuge staff contacted Cleveland Social Services shortly after. Given the notification that they had left the area, we were told by the social worker who had undertaken the investigation at that time, that she referred Susan B. and her 15 year old son to Manchester Social Services Department for follow-up support. However, we found no evidence to support this in the Cleveland social services files.

39. Evan B. appeared at Teesside Magistrates Court in October 1995 and was found guilty of criminal damage. The court ordered the Cleveland Probation Service to provide it with a pre-sentence report.

The Probation Officer's Pre-Sentence Report and Supervision Plan

40. 'National Standards for the Supervision of Offenders in the Community (1995)' state that the purpose of a Pre-Sentence Report for the Court is to provide a professional assessment of a person's offending behaviour and the action which can be taken to reduce re-offending. Reports should be prepared within a maximum of 15 working days (unless the Court requires otherwise) and a copy given to the offender.

41. The Cleveland probation officer who had responsibility for the preparation of the Pre-Sentence Report on Evan B. and the circumstances around the offence, liaised as follows:-

- direct access to records in the probation service which included those of the Family Court Welfare Officer;
- access to criminal records;
- telephone contact with the Middlesbrough Social Services Team Manager;
- telephone contact with the GP;
- telephone contact with Evan B's landlady;
- telephone contact with mental health staff attached to the Middlesbrough Custody Diversion Team;
- two interviews with Evan B;
- consultation with her line-manager.

42. The Cleveland probation officer proposed in her pre-sentence report that the magistrates court make Evan B. the subject of a 12 month Probation Order with a condition of residence for six months at a Probation Hostel in Middlesbrough. The aim of the Probation Order was stated as follows:

> a) Offer support to Evan B. that was constructive in tackling the causal factors of his offending so that he does not resort to inappropriate use of violence. I would envisage this would incorporate work on anger management and encourage the development of better coping strategies.
>
> b) Support him in issues related to health.
>
> c) Assist him in finding a more permanent solution to the problem of accommodation.

43. She asserted in the report that the condition to reside at the hostel "is paramount in helping the probation service achieve their aims in conjunction with Evan B." She told us she became aware that there was a long history of alleged domestic violence but other agencies were no longer involved with Evan B. She was concerned that this man needed some stability where they could monitor him and make some assessment of the risk he presented. She said that the whole relationship between him and his wife was complicated, and in her view clearly unresolved "because there was evidence to suggest he was not just phoning her, but she was phoning him. I had actually established at this stage that she had been up and spent Christmas." However, the probation officer also told us that she made no contact with Susan B. Evan B. told the probation officer "I want to start afresh" and she felt the best thing to do was "work with this man and make some ongoing assessment really of his needs." On 31 January 1996, the Magistrates Court adjourned to enable a 4 week assessment to take place and remanded Evan B. on bail with condition that he reside at the probation hostel.

Risk assessment during the period of bail.

44. Evan B. was admitted to the Probation Hostel in Middlesbrough on 31 January 1996. Following an induction the role of keyworker was explained to him, and the following day he had a session with the hostel member of staff who was his keyworker. The hostel records shows that during the session he sought home leave to spend time with his wife for a reconciliation attempt. He was advised that he needed to seek permission from the court and the implications of unauthorised leave were discussed at length. The key worker felt that his depression at the time could be a serious cause for concern, and liaised with the local custody diversion team (details of which are shown in Appendix C.)

45. Evan B. was interviewed at the hostel by a community psychiatric nurse (CPN) from the custody diversion team on 2 February 1996 (the probation records note the date as being the 5th) for an hour. The CPN had already obtained access to records from St. Luke's Hospital. The CPN's completed initial assessment form describes Evan B's symptoms as being low in mood, feels depressed, and that he felt his wife is messing him around by telephoning to arrange access visits to his son then calling off. Other entries are as follows:

Known primary diagnosis:	Personality disorder/reactive depression ?
History of Harm to others:	Tried to strangle son approx. May '95. No criminal proceedings
Current evidence of risk:	"If saw wife would kill her". Evidence that wife is returning to M/Bro. Wishes he could harm himself
Offences:	'95 criminal damage x 4 - fines
Probability of Harm to self:	none
Probability of Harm to others:	mild
Clients perception of support required:	Possible out-patient treatment with psychiatrist

Other relevant information: Has asked for a move from Middlesbrough.
Wants to be as far away from area as possible.

46. During the week, Evan B. had expressed his wish to live in a hostel outside Middlesbrough and it is recorded that he was feeling harassed by his wife's telephone calls. It appears that the Hostel Manager decided that this was an appropriate course of action and sought arrangements for transfer with the Probation Hostel in Beckenham, south-east London. On 12 February 1996, the probation officer with responsibility for the court report was advised of her colleague's intentions and interviewed him at the hostel. Evan.B told her his reason for wanting to move, namely that he believed his wife might move back to Middlesbrough, and that he felt he would harm her if she did. The probation officer heard him say in a whisper that he would kill her if she did move back, and she took the threat seriously. Later the same day, in consultation with her manager, she assessed the risks. The probation officer told us that at the time she expressed her reservations regarding the move, in that she considered the Middlesbrough hostel placement suitable for purposes of his supervision, support and the safety of his estranged wife. However, Evan B. was insistent that he needed to get away because he thought his wife was coming back to Middlesbrough and he thought he might harm her. The move appears to have been supported on the grounds that it was better for the probation service to facilitate his move, know where he was and monitor it than have him abscond. The probation officer's manager and the hostel manager were party to the decision.

The Cleveland Probation Officer completed a 'Risk Assessment Pro Forma' (which we reproduce as Appendix A) and a 'Risk Management Strategy'. The recorded risk assessment outcome was that Susan B. was regarded to be at high risk of serious physical injury from Evan B. Indeed, the perceived danger was that **physical contact between them could lead to serious injury or death to Susan B.**

The risk management strategy was as follows:

- **Maintain distance between Evan B and Susan B.**
- **If they were to become reconciled - notify police/Social Services Department sharing our concerns**
- **Share risk assessment/risk management with hostel in Kent.**

The proforma was signed and dated 12 February 1996, and a copy was date stamped as received by the probation hostel in Middlesbrough on 14 February 1996.

48. Evan B. transferred from Middlesbrough to the probation hostel in Bromley, south east London, on 15 February 1996. (N.B. the postal address is in Kent, and Middlesbrough staff referred to the Beckenham Probation Hostel as being in Kent).

Comment

The Middlesbrough probation officer achieved effective liaison with the relevant agencies in the time available for preparation of the pre-sentence report, and attempted to balance different perspectives from health, social care and family court welfare colleagues and to reconcile Evan B's denial of violence towards his wife.

The proposed supervision plan in the pre-sentence report was appropriately focused. Indeed, this was the first occasion, if not opportunity, for any of the agencies so far involved, in the probation officer's words, **"to work with this man and make some ongoing assessment really of his needs."**

The reports and actions of both the family court welfare officer and probation officer were consistent with Practice Guidelines on Domestic Violence issued by Cleveland Probation Service (dated 29 March 1995), and the risk assessment proforma was in accordance with Practice Guidelines (dated 31 August 1995).

It is evident that in taking Evan B's threat seriously, and giving proper weight to a number of risk factors, the Cleveland Probation Officer gave an accurate prediction of the risk he posed to his estranged wife.

The decision to support Evan B's request to transfer away from Middlesbrough had regard to his strong motivation to distance himself from his estranged wife. There was a fine balance of judgement and the decision was appropriate. In view of this decision, following his initial and limited assessment (and prior to the probation officer's risk assessment), the CPN had no reason to consider a care plan nor invoke the skills of the full multi-disciplinary mental health team.

REFERRAL AND ADMISSION TO PROBATION HOSTEL IN BROMLEY

Introduction The Role of Approved Probation Hostels

49. National Standards for the Supervision of Offenders in the Community (1995) define the purpose of approved hostels as "to provide an enhanced level of supervision to enable certain bailees and offenders to remain under supervision in the community". National Standards go on to say:

> "Approved hostels should be reserved for those who require this enhanced supervision and are not meant simply as accommodation. They should provide a supportive and structured environment within which their residents can be supervised effectively. But it should be clearly understood that approved hostels are **not secure** and so, unlike Prison Service establishments, cannot provide the same degree of protection from the risks posed by the most serious offenders."

Hostel staff should develop a regime in agreement with their committee and the Probation Service locally. This should be set out in a published statement of aims and objectives which should seek to:

- ensure that the requirements of the court are met;
- promote a responsible and law-abiding lifestyle and respect for others;
- create and maintain a constructive relationship between the hostel's staff and its residents;
- facilitate the work of the Probation Service and other agencies aimed at reducing the risk that hostel residents will offend or re-offend in future;
- assist hostel residents to keep or find employment and to develop their employment skills;
- encourage and enable hostel residents to use the facilities available in the local community and to develop their ability to become self-reliant in doing so;
- enable hostel residents to move on successfully to other appropriate accommodation at the end of their period of residence;
- establish and maintain good relations with neighbours and the community in general.

50. The same National Standards state that whenever an individual is placed on a Probation Order "an assessment of the risk posed by the offender should be made. This should consider the risk to the public of re-offending or of causing serious harm (and its likely nature)". This also applies to Probation Orders made with a condition of residence in approved hostels.

51. The Criminal Justice Act 1991 had promulgated a dual approach - effective community supervision for those who did not pose a threat to the community and a greater focus on public protection for those who presented a significant potential risk to the public. From

1993 there has been an expectation that the management of risk should play an increasingly important part in Probation Service practice. The Home Office Inspectorate of Probation reporting in September 1995 expected all Probation Committees to have in place a policy on public protection and guidelines for staff practice. At this time Services were at different stages of implementing policies to meet these requirements. Of the Services from whom evidence was taken in the course of this Inquiry, Cleveland had introduced a policy in August 1995 and that of South East London Probation Service is dated August 1996, i.e. was not in place at the time of Evan B's stay in Beckenham.

Referral to Beckenham Hostel and admission

52. The Beckenham Probation Hostel is a service provided by the South East London Probation Service. It is accommodated in a large Edwardian looking house which blends with neighbouring properties. It is situated on a main public transport route with numerous shops, voluntary and public services in the immediate locality. At the time of our visit in January 1997, service users spoke appreciatively about its facilities and supportive role in their lives. At the time of Evan.B's stay it was staffed by a Manager, four Assistant Managers, and a large number of part-time care assistants. The staff work rotas to ensure that the hostel in staffed 24 hours of each day.

53. The hostel caters for 20 men over the age of 17, referred by Probation Officers or by the courts for periods of either bail assessment or supervision when subject to a Probation Order or license following a prison sentence. Local practice, which reflects Home Office guidelines, is that all referrals to the hostel should be accepted unless there is good reason not to. Referrals are taken by non-professionally qualified staff who are instructed, if in doubt, to consult with the manager. The referral form asks for "Problem areas", but does not ask for any assessment of potential risk to other people by the person making the referral. At the time of Evan B's referral, the worker taking the information was an inexperienced member of staff with no background in residential work.

54. Evan B. was accepted on the basis of a referral from the Cleveland Probation Hostel on 8 February. The Pre-Sentence Report prepared for the earlier court hearing on 31 January was faxed to the hostel on the same day. Within the next few days details of Evan B's previous convictions and hostel 'Part C' case note entries from Cleveland up to the date of referral were also forwarded. These were in the possession of Beckenham hostel at the time of Evan B's arrival there on 15 February. Staff at the Beckenham hostel say they never received any written Risk Assessment from colleagues in Middlesbrough. In terms of written material, therefore, they were working to the earlier, more tentative, assessment made in the Pre Sentence Report.

55. The Cleveland probation officer told us that she had sent her risk assessment to the Middlesbrough hostel in expectation that it would be passed from there to the Beckenham Hostel. She also told us that she thought her office had sent a copy direct to Beckenham

but commented that this was the first occasion when the subject of a risk assessment was transferring outside the probation area.

Comment

Given the importance for effective supervision of ensuring all relevant information has been brought together, greater clarity regarding responsibility for transmitting documents when service users are transferred between probation service areas is clearly required. The fact that the Beckenham Probation Hostel did not receive a copy of the written risk assessment was a serious omission.

56. Evan B. spent the next four weeks at the Beckenham hostel, subject to a period of bail assessment. During that period he appears to have settled well and the staff did not have any cause for concern regarding his behaviour. However, we note that on 5 March he was reported as being very drunk after arrival of his Giro. He registered with a local GP and the hostel was informed that he was treated with antidepressants. The bail assessment report prepared by the Beckenham Hostel Manager supported the making of a probation order with a six-month condition of residence at the hostel, with a view to helping Evan B. rebuild his life in the Bromley area.

Comment

Although the manager of the hostel talked to the Probation Officer in Cleveland who had prepared the Pre Sentence Report, there appears to have been acceptance by the hostel staff that the geographical separation had removed any serious threat of violence by Evan B. to his wife.

The Inquiry Team considered that opportunities were missed at this stage. Staff at the hostel failed to gather together during the assessment period all the information relevant to supervising Evan B.. This was not helped by the absence of the Risk Assessment Pro Forma from Cleveland, but it was also partly the result of their own intake systems and lack of procedures for undertaking a thorough assessment. The information required by the hostel at Beckenham before admission was significantly less than that asked for at the Cleveland hostel. Some of the gaps in information would have become apparent if questions had been more systematically asked.

Period under supervision in the hostel

57. Evan B. returned to the Beckenham hostel on 15 March, subject to an 18-month Probation Order with a condition of residence for six months. At that hostel a Probation Order is normally held by the Probation Officer working in the hostel. Evan B. had expressed himself as being unhappy with having that particular supervising officer (a man) and then asked the manager (a woman) for her to be his Probation Officer. She eventually agreed to this. Within the hostel each resident would also be allocated one of the Assistant

Managers as a key worker. The four full-time Assistant Managers within the hostel were all experienced residential workers, though not qualified Probation Officers. The expectations of the Assistant Manager keyworker in that setting were to devote particular attention to allocated residents, deal with practical issues with which they needed help and spend time discussing problems in more depth, if appropriate. They would be expected to bring any difficulties to the Manager during staff supervision.

58. The Manager and the Assistant Manager keyworker saw Evan B. frequently, in part because of his demanding behaviour. However, neither appears to have undertaken any structured work with him. Under National Standards a supervision plan should be drawn up for every offender who is made subject to a Probation Order within 10 working days of the making of the Order. The aim of the supervision plan is to set out the purpose and desired outcomes of the supervision of that particular offender and to draw up an individual programme which addresses problems identified. It should include an assessment of potential risk to other people and a plan for minimising that risk. This plan should be agreed with the offender and reviewed every three months. In Evan B's instance no supervision plan was drawn up. This compounded the lack of detailed assessment.

59. This is not to imply that the staff at the hostel did not seek to help Evan B. Our interview with staff at the hostel indicated a very high level of caring and contact with residents. This was confirmed by Evan B. who commented :-

> "The staff in the Probation Office at Beckenham were totally brilliant and helped me to settle in and settle down and seek employment .... but what they failed to do was to talk about the reason I was there and the depression I was suffering."

60. The extent to which Evan B. could have responded to more structured interventions is, of course, an open question. Comment from his keyworker sums up perceptions from various workers :-

> "I didn't have many lengthy discussions with Evan B. due to him not particularly wanting that. Lots of communication, but short and sweet really: very hard to engage on a long, lengthy sort of one-to-one basis".

61. During the weeks following sentence, Evan B. was found by staff to be increasingly demanding. Some time during this period, Evan B. received a letter from his wife with a forwarding address in Manchester, saying if he wanted to see his youngest son, to let her know when they could come down and see him. He showed this letter to the manager and allowed her to take a copy of it, which was placed on file.

Comment

It is our view that had a clear supervision plan including risk assessment been agreed, which referred back to the Pre-Sentence Report, in particular to the need to

help Evan B. address his anger, it might have helped staff within the hostel to retain a focus on the issues which had led to the making of the Order. Instead, it seems to the Inquiry Team that the probation staff were increasingly preoccupied solely with the difficulties of managing Evan B's behaviour within the hostel.

Actions leading to admission to Hospital

62. Although Evan B. was recorded in the hostel log as having been drunk on several occasions (e.g. 5, 14 and 22 March) a serious problem did not arise until 23 March when he was taken to see the duty GP at his surgery having been abusive to hostel staff. On that day he was seen as being very depressed in the hostel. There is an entry in the hostel record which notes Evan B. as saying to the doctor that "the only person he wanted to harm was himself, and not, as he had said in the hostel many times, his estranged wife". Evan B. continued drinking all day. He was becoming too difficult for staff to manage, including refusing to take the medication he had been prescribed and threatening suicide. The police were called, by which time he had disappeared but was located in a pub and was brought back to the hostel. The staff thought that he needed to be "sectioned" but the police explained that they had no authority to remove him from the hostel to hospital (i.e. without assessment by health and social services). After considerable difficulties at the hostel, the emergency doctor was called. Although the doctor and Hostel Manager told him the admission to hospital was in his best interests, he was insistent that the Hostel Manager make the decision for him, "If you tell me I must go, I will." She resisted his demands and he eventually agreed to go into hospital.

63. There is no evidence that Evan B. was accompanied to the hospital by a member of staff from the hostel. Information regarding Evan B. was passed by telephone conversation from the Hostel Manager to the admitting doctor on the night of the admission.

Comment

The actions by the hostel staff would seem to demonstrate a lack of familiarity with the provisions of the Mental Health Act 1983 and with the role of an Approved Social Worker who could have been contacted. Misunderstanding may have arisen from advice given by the GP on the morning of the 23 March 1995 to call the Police if Evan B. became aggressive.

PRIMARY HEALTH CARE IN BROMLEY

GP Involvement

64. Evan B. first came into contact with health services in Bromley when he registered with a new general medical practitioner (GP) on 16 February 1996, following his move from Middlesbrough to Beckenham. The primary care notes record that previously he had been living in Middlesbrough, that he was on bail and awaiting a court appearance on 14 March. He told the doctor that he had faced three charges of criminal damage in the last year centred round disputes with his wife. He denied any misuse of alcohol or drugs and during a routine health promotion assessment said that he drank, on average, the equivalent of five pints of beer (10 units) each week. Evan B. reported nothing of note in his previous history of physical illness.

65. The GP did not have access to the primary care notes from Cleveland until they arrived in Bromley on 25 April 1996.

66. He told the GP that he had been depressed for four years, and had had two admissions in Middlesbrough for overdoses and having cut his wrists. He reported that he was currently taking an antidepressant and a hypnotic. This medication appears to have been started by a previous general practitioner when Evan B. was resident in the Middlesbrough Probation hostel. A prescription record exists dated 12 February 1996 and it is clear from the Bromley GP's referral letter to the catchment area Consultant Psychiatrist that Evan B. had reported that he had been on this medication for "the past month". If the anti-depressant was going to relieve Evan B.'s depression, then some improvement would be expected in the course of a month's treatment, and in the absence of such change, the GP made the decision to add another antidepressant and to substitute a different hypnotic. In view of Evan B's account of poor appetite and upper abdominal tenderness, the GP also prescribed a treatment for gastro-intestinal tract problems.

67. The GP made a diagnosis of severe depressive illness and referred Evan B. in a letter dated 19 February to the Consultant Psychiatrist for advice on further management. An appointment for 25 March was sent to Evan B. but at the request of the GP an earlier appointment was arranged for 14 March and sent to Evan B. on 4 March. However, Evan B. said he would not be in Bromley on 14 March (in fact he was due to attend a court hearing in Teesside that day) and so the original appointment was reinstated. Evan B. kept subsequent appointments with the GP on 23 February when the dose of the new anti-depressant was increased, and on 8 March when the dose was again adjusted. At that time, Evan B. was still complaining of depression, anxiety and poor appetite. By 18 March he reported feeling somewhat better and his treatment was continued.

68. On Saturday 23 March, he was seen as an emergency by another partner in the GP practice. At interview, he was calm and coherent but anxious as already discussed in the previous chapter. He said that his medication was not helping and the dose of tranquilizer

was increased. The hostel staff were advised to contact the police if he became aggressive or abusive again. His appointment to see the Senior Registrar on Monday 25 March still stood. He spent the latter part of the 23rd drinking. His account to us of that day was that he was feeling very depressed. He had spoken to his wife and son, he and a friend bought bottles of cider and sat in the park "just getting drunk". On returning to the hostel, the police were called and then the emergency doctor. The emergency doctor (a general practitioner) visited an hour after being called, found him depressed and suicidal, noted that he had not been taking his medication and that he was willing to accept informal admission. Evan B. was eventually persuaded to go to Farnborough Hospital early in the morning of 24 March.

Comment

Evan B. was very rapidly linked into the local health service and an appointment was made for him to see a psychiatrist at an early stage.

The system for the transfer of GP records is appallingly slow. We consider it desirable for all GPs providing services to residents in Probation Hostels to invoke emergency transfer procedures when seeking previous records.

ADMISSION TO HOSPITAL IN BROMLEY

Introduction - The Care Programme Approach, supervision registers and discharge planning

69. The Care Programme Approach (CPA) aims to ensure that the needs of mentally disordered people referred to the specialist mental health service are assessed, a plan established to meet these needs, a key worker appointed to monitor the implementation of the plan and arrangements for review of the plan agreed. It is regarded by the Government as the principal instrument through which consistent high quality care can be delivered to people with mental disorder referred to the specialist mental health service. The CPA is supported by central guidance issued in 1994 on discharge planning which includes a section on the need for a methodology of risk assessment and on the establishment by 1 April 1994 of registers of patients who present a significant risk of seriously harming themselves or others or of self-neglect (supervision registers).

The CPA and discharge guidance offer benefits to patients by ensuring that there is a formal structure for assessing their needs and managing their care. It also benefits the clinicians by providing a framework to ensure that their assessments are comprehensive and their decisions are clearly recorded. Supervision registers allow attention to be focused on those most at risk. Instructions to implement CPA in all mental health provider units by 1 April 1991 were issued in 1990. Supervision registers were to be established by 1 April 1994 and the guidance on discharge was issued in May 1994.

The Portnalls Unit Farnborough Hospital

70. Evan B. was admitted to the Portnalls Unit, a psychiatric unit of Farnborough Hospital. The Portnalls Unit is located in a large complex of buildings which make up the hospital. It is on a site which is due for closure, the fabric is old, and the environs reflect this. We visited the Unit in January 1997 to see the admission wards where Evan B. had been a patient - Avon I ward (a lockable reception ward) and Medway II ward (an open ward). We found the physical conditions unwelcoming. Walls were bare (i.e. no pictures or information leaflet displays) in the corridors, the public reception area and in communal areas. The unit conveyed all the physical features of a Cinderella service.

71. We were provided with reports of visits by members of Bromley Community Health Council on 1 March 1996, and an unannounced visit by Mental Health Act Commission members on 23 March 1996 - these being on or about the time Evan B. was an in-patient. In the written responses on behalf of Ravensbourne NHS Trust, which, until recently, had been the responsible service provider, there is acknowledgment that the overall environs needed improvement.

72. In March 1996, Avon I ward (15 beds) had 4 nursing staff per day shift, and at night there were 3 staff on duty per shift plus the 'bleep-holder nurse' who is supernumerary. The

staffing ratio of qualified to unqualified nursing staff was 60:40. Medway II ward (20 beds) had 2 qualified, to 1 unqualified staff per shift. One of the qualified nurses is required to attend the multi-disciplinary 'ward-round' held on the ward with an unqualified member of staff frequently employed to provide cover. This staffing level for an acute mental health service is, in our opinion, low and it is difficult to see how a high quality service can be maintained. The Bromley Health Authority Mental Health Strategy (1993) directs additional funding towards the development of community services, but does not address acute in-patient admission needs.

73. The Consultant Psychiatrist with responsibility for adult patients from the catchment of the probation hostel had been employed for 14 years in the Bromley health services. His Senior Registrar, the doctor primarily involved in Evan B's care, had nearly completed his psychiatric training and had previously worked in Bromley mental health services. On the evidence presented to us, he had received no proper induction by Ravensbourne NHS Trust.

Admission and assessment

75. Evan B. was assessed on the Portnalls Unit by the duty doctor, a Senior House Officer (SHO). The SHO records that the hostel staff told him that Evan B. had been depressed and threatening to kill his wife. However, it is clear that the limited history of his offending "at least three incidents of criminal damage" came from Evan B. and was not supplied by the hostel staff. Informal admission was agreed pending assessment by the full clinical team the following day and medication - a major tranquilliser - prescribed. In the early hours of the morning, Evan B. wanted to leave hospital and the SHO detained him under Section 5(2) of the Mental Health Act 1983 (i.e. a doctor's holding power up to 72 hours) and signed section 5(2) papers. He was noted to be at risk of absconding. In the morning, an admission assessment and nursing plan were drawn up by the staff nurse. The risk of absconding was reassessed after discussion with the SHO and it was agreed that the risk would be lessened if Evan B. were allowed out with an escort. Evan B. was told that if he absconded the police would be informed and he might well be remanded in custody.

Comment

The notes both by the Senior House Officer and by the Staff Nurse on that night are full and much better than one might expect at that time of the morning. The SHO's notes cover five pages. The use of section 5(2) of the Mental Health Act 1983 was appropriate. A note should have been made in the clinical record when he completed section 5(2), but since the forms are kept within the notes, this is a minor lapse.

76. Nursing notes report that throughout 24 March he continued to talk about wanting to kill his wife and himself, though later in the same interview he said he did not want to harm anybody. He admitted to only three convictions for criminal damage but when pressed agreed that he drank 10-14 cans of strong lager a day if he had the money. He said he had

a low level of tolerance and tended to smash things up. An individual care plan was completed by the Staff Nurse with stated objectives and plans for minimising the risk of absconding and of improving his appetite.

77. The next morning, 25 March, he was seen by the Senior Registrar for review of his legal status. He told the Registrar that although he wished to die, he had no suicidal plans or ruminations. He worried that he would go up to Manchester and "bother his wife (further criminal damage)". He said that he was willing to stay in hospital and to comply with treatment. His legal detention was not extended. There is no record of any discussion of his previous threats to kill his wife. He was reviewed again by the Senior Registrar at the ward round on 26 March. His continuing depression was noted and it was recorded that he was talking less about his feelings about his wife.

Comment

There is no record that, during the assessment of the need for continued detention, there was any discussion of the threats that Evan B. had been making against his wife, although these are recorded in the nursing notes. In evidence to us, the Senior Registrar said that he had considered risk to others when assessing the need for extended detention. He had concluded that there was no significant risk since he believed, on the account given by Evan B. that he had no conviction for injury or violence. The Senior Registrar was aware of the attack on his son but, because Evan B. had not been charged nor detained in hospital, took this to be a "temporary aberration". These misunderstandings emphasise the importance of obtaining objective information and not relying solely on the account of a patient. A full list of Evan B.'s previous convictions was held by the probation hostel.

The Senior Registrar also appears to have misunderstood the Mental Health Act 1983 since he told us that expressed willingness by Evan B. to stay in hospital was sufficient and meant that compulsory powers could not be used.

78. Between 26 March and the ward round on 29 March, Evan B. was clearly more settled and the ward round noted that he had "negotiated" his discharge for 1 April. There is a conflict of evidence regarding the Consultant Psychiatrist's attendance at this ward round. The Ward Round Book records his apologies and one of the nurses present maintains he was not there. However, the consultant insists that he was present. We were not able to resolve this conflict and it is unlikely that the consultant's presence or absence made a difference to the decision to discharge Evan B. The Consultant had no previous knowledge of Evan B, whereas the experienced Senior Registrar had assessed him on two separate occasions before the discharge conference. The tranquilliser prescribed while he was in hospital was to be discontinued on discharge, the antidepressant continued and the community psychiatric nurse (CPN) was to be asked to follow Evan B. up. There is uncertainty about when this referral was made. His discharge was agreed with the hostel and arrangements for his aftercare discussed by the then acting deputy nurse manager. He was discharged on

1 April. There is no record that he was seen by a doctor on the day of discharge as required by the Trust's 1993 guidance on discharge if there had been any doubt about his fitness for discharge.

Comment

During Evan B's stay in hospital there was no meeting with the probation hostel staff though there were discussions on the telephone. There is no evidence that staff from the hostel visited Evan B. during his stay though residents from the hostel did.

79. Evan B. took his discharge proforma to his GP the day after his discharge. A discharge summary was completed on 18 April 1995. The agreed discharge plan was to attend for an outpatient appointment and to be visited by the community psychiatric nurse.

THE HEALTH AND SOCIAL CARE EPISODE

The Named Nurse

80. The concept of the named nurse has been part of the Patient's Charter standards since 1991. The Charter standard is that "*you should have a named qualified nurse who will be responsible for your nursing care*" (Dept. of Health 1991). This approach to nursing care was in answer to the trend away from task allocation to a new approach which treats patients as individuals and recognise they benefit from a personal relationship with their nurse. These developments have been led by the nursing profession and as a direct result of the growing awareness of the rights of the patient as a consumer.

81. This initiative formally locates responsibility for an individual patient's care with a named nurse who retains responsibility for and assures continuity of care particularly after care arrangements on discharge from hospital. Sometimes this approach is known as primary nursing and ensures a qualified nurse is responsible for making an assessment, outlines a plan of care, monitors, evaluates and reviews that plan in conjunction with other members of the team.

82. A nursing plan was available for Evan B. whilst he was in hospital and therefore there was an assumption that an allocation to a named nurse was made. It was unclear from the records and talking to staff who his named nurse was and therefore responsibility to assure continuity of care was also unclear. What we do know is that Evan B. was said to prefer female staff and therefore the allocation was made to the qualified female nurse. However, she had two days off shortly after he was admitted and made the assumption that the male nurse who took the allocation when Evan B. was admitted to Medway II was the named nurse. Neither did Evan B. know who his named nurse was.

83. When the Inquiry Team visited the ward, we were given a document which is given to patients explaining the named nurse concept. However, this document is not dated and therefore the Inquiry Team could not be sure that it was in use at the time that Evan B. was a patient or in fact given to him. It was difficult to ascertain that any senior member of the nursing staff reviewed the nursing care plan or carried out a systematic approach to clinical supervision to ensure there was a named nurse and that that person understood their function and responsibility in the discharge plan.

84. The Inquiry Team were also certain that no nurse took responsibility at the time of his discharge for following through the discharge plan and coordinating the CPN Service as agreed on the ward round (to refer to a community psychiatric nurse for follow up in the hostel and an outpatient appointment). Evan B. was discharged on 1 April, but the referral form to the community psychiatric nurse was dated 10 April and did not appear to be received in the CPN office until 24 May 1996. This is despite a CPN being present on the ward round at which Evan B's discharge was discussed and agreed with him.

85. The role of the CPN on the ward round was not very clear and could have been instrumental in ensuring a line of communication between the hostel and the continuing mental health services.

Sharing of Information and Discharge Planning

86. Accurate information about past events is crucial in assessing the risk a patient presents, determining their needs and planning their future care. So far as information about his past health is concerned it is not possible to determine when some important bits of information were available to the mental health team. Although considerable information was available in the GP record, old records do not follow the patient quickly unless specially requested, and Evan B.'s did not arrive with the Bromley GP until 25 April, two days after the death of Susan B. The GP's referral letter to the Consultant Psychiatrist of 19 February mentions the two previous admissions to St. Luke's Hospital but these notes were not requested until 21 March. There is no record of when they arrived, though the Senior Registrar believes they were available before Evan B's discharge.

87. According to the then acting deputy nurse manager and the senior registrar, they knew about the assault on his son, but since Evan B. had not been charged nor been detained in hospital and it had not caused a break in his relationship with his son, the senior registrar decided it was a "temporary aberration". He reported that he had asked the hostel "whether he had committed any violent acts" but recalls no information being offered other than what he knew already about the incident with Evan B's son. So far as his recent convictions for criminal damage were concerned, the clinical team's view was that since the court had determined that residence in a probation hostel was appropriate and he was being supervised there, then the risks could not be high.

88. It seems clear that the clinicians at Bromley did not have access to Evan B.'s criminal record nor to his pre-sentence report dated 30 January, and particularly did not see the risk assessment (12 February) made by the Cleveland Probation Officer, and there was no risk assessment from the Beckenham Hostel staff.

Implementation of CPA discharge guidance and the supervision register in Ravensbourne NHS Trust

89. It is clear that the clinicians in the mental health service at Ravensbourne Trust did not favour the Care Programme Approach. This was a view widely held among psychiatrists at the time of CPA's first introduction. Many have since come to appreciate its worth, though rightly resenting the often unnecessary bureaucracy that sometimes accompanies CPA. The Consultant Psychiatrist in evidence to us said that he regarded it with "some scepticism" and produced articles from *The Lancet* in support of his contention. Despite the CPA being mandatory throughout the mental health service nationally since April 1991, it was still, according to the Bromley Mental Health User's Group audit, in the process of implementation in Ravensbourne in early 1996. An audit of casenotes between

February and May 1996 shows that in March 1996, of the patients whose assessment by the mental health service was complete and who had been accepted for treatment, only 53 per cent recorded a CPA level, 61 per cent recorded an initial assessment, 54 per cent identified a key-worker, 68 per cent recorded a care plan and 68 per cent arrangements for reassessment.

90. A Ravensbourne Trust CPA pack, undated, had marked "CPA for in-patients [?to be developed later]". Towards the end of our collection of evidence, we were given a CPA Pack by the Trust dated 9 April 1996, including guidelines for CPA with in-patients and a full set of related forms. It seems from these that implementation of the discharge guidance and of the supervision register (both required to be implemented in 1994) awaited incorporation in the 1996 CPA Pack. It is not clear whether the system described in the 9 April pack was in fact in operation at the end of March. However, if it were not, the Trust's 1993 policy document on discharge and its procedure document for the mental health directorate on discharge from in-patient status would have been in operation in March 1996.

Comment

These 1993 procedures seem to have been followed in outline. A discharge form was completed but a community key-worker was not identified, the details of the after-care plan as set out in the notes of the ward round at which discharge was agreed are limited to a note of medication, a note that the CPN was to be asked to follow up Evan B. and the note of an out-patient appointment.

91. If CPA and the discharge guidance had been implemented at an earlier date along the lines of the 1996 CPA pack, then Evan B. should have received a more structured assessment both of his needs and of any potential risk that he might pose to other people. He might have had a more detailed plan for his care after leaving hospital though the degree of detail would have depended on the decision as to what level of CPA was appropriate in his case. The Consultant Psychiatrist in his evidence to us said that he regarded Evan B. as being at level 2.

92. *"Building Bridges"*, issued in 1995, gives guidance on the three levels of CPA:

- **Minimal CPA** "would apply to patients who have limited disability or health care needs arising from their illness and have low support needs which are likely to remain stable. They will often need regular attention from only one practitioner ...".

- **More complex CPA** is for the patient "who needs a medium level of support ... This may be because the person is likely to need more than one type of service, or because their needs are less likely to remain stable".

- **Full, multi-disciplinary CPA** is for those who are "suffering from severe social dysfunction, whose needs are likely to be highly volatile or who represent a significant risk".

93. These definitions in *Building Bridges* are significantly different from those in the Ravensbourne 1996 CPA pack where level 1 CPA is for those who do not have long term or complex mental health needs and do not require longer term aftercare. Level 3 is for those at risk and who should be considered for the supervision register.

Comment

By either the definitions in Building Bridges or in the CPA Pack, the Consultant Psychiatrist's assessment that Evan B. was at CPA Level 2 seems correct, rather than the finding of the internal inquiry undertaken by the Ravensbourne NHS Trust, that he was at Level 1. Since Evan B. had had mental health care intermittently since at least 1985, it is unlikely that he did not have long term mental health needs. More than one agency was already involved. Moreover, if better information had been available to the clinical team it is very likely that Evan B. would have been found to need entry on the supervision register. In our view, it is unfortunate that Ravensbourne's current CPA pack has definitions different from those promulgated nationally. Linking the need for care at Level 3 with risk is of questionable benefit.

Risk assessment and risk management

94. The internal inquiry says that a risk assessment was conducted before discharge and we accept this. Since it is not documented in the notes, it is not possible to evaluate the extent and quality of the assessment. However, the information available to the clinical team was so limited that an accurate risk assessment (always a very difficult task) was well nigh impossible.

Comment

The "Guidance on discharge of mentally disordered people and their continuing care in the community" issued by the Department of Health in 1994 in its section on "Assessing potentially violent patients" says that " assessing the risk of a patient acting in an aggressive or violent way at some time in the future is at best an inexact science. But there are some ways in which uncertainty may be reduced". First among these it lists making sure relevant information is available, citing as relevant sources inter alia police and probation officers. Since "Nothing predicts behaviour like behaviour" it is particularly important to know about the past history of risk-taking and dangerous behaviour. Much of this important information was not available to the mental health services in Ravensbourne, though Evan B's previous convictions and the Cleveland pre-sentence report were at the Beckenham probation

hostel. Staff at the hostel do not seem to have considered sending this information to the mental health team, who, in turn, do not seem to have considered asking if more information was available.

Evidence about previous behaviour and offending existed and some was held locally. If this information and especially the Cleveland Probation Officer's accurate risk assessment and the elements of her risk management plan had been available to the Ravensbourne team, a different assessment of risk might have resulted and provoked at an earlier stage the move to seek advice from the forensic psychiatric service. The discharge guidance emphasises the need to seek expert help in difficult cases, but the information available to the clinical team made it unlikely that they would identify Evan B as such a case. Indeed the later referral to the local forensic consultant psychiatrist was because of difficult behaviour in the hostel rather than on account of possible dangerousness.

The role of the Trust

95. Ravensbourne NHS Trust was, at the time, responsible to the commissioning health authority, Bromley Health, for the delivery of a service in line with central requirements. Since the CPA is the "cornerstone of the Government's mental health policy" there has understandably been considerable concern to ensure that it is being implemented. The Trust's Chief Executive in evidence to us said that implementation of CPA "was not uniform across all areas of the organisation" and that responsibility for "driving the CPA forward" had been allocated to the then Medical Director. The Chief Executive and the Trust board received regular reports. The Chief Executive described CPA as being "like the 30 mph speed limit" which we understood to mean that whatever was required some clinicians observed CPA and others did not. Whether the Trust was fully aware of the concerns of clinical staff about the implementation of CPA and of its limited use was not clear. It is clear that until very recently the Trust had not ensured the full implementation of CPA and had not, as have most other Trusts, overcome the initial scepticism of their clinicians.

96. Since 1994 mental health Trusts have been required to submit quarterly returns on CPA and other mental health service activity. It is clear from the returns for the "Quarter 1 1996/97" and Quarters 2 and 3 that significant misunderstandings exist, since while at Q1 all patients of the service are listed as subject to CPA (which must be correct in theory), at Q2 and Q3 the question is left unanswered.

The role of the Health Authority

97. The Head of Commissioning for Mental Health Services at Bromley Health who had been in post for eight months told us of "considerable concern over the last twelve months about the quality and extent to which it (CPA) has influenced the way in which patients are

treated". This concern had played its part in the decision to go out to tender for the management of mental health services in Bromley.

98. On the basis of their tender, the Oxleas NHS Trust was commissioned by Bromley Health Authority to provide mental health services in Bromley with effect from 1 April 1997.

Liaison over hospital discharge

99. Prior to Evan B's hospital discharge, the probation hostel manager made further enquiries through colleagues in Cleveland, both in the Probation Office and then the Custody Diversion Team about the possibility of getting access to previous medical records. She told us that she believed there was something psychiatrically wrong with him, more than depression, and she knew there had been a previous hospital admission. As a result of this, the Custody Diversion Team notes were made available to her. She saw from these records that Evan B. had previously been classified as suffering from a personality disorder. From this point the manager assumed that, in her words,

> "the hospital wouldn't keep him in because they know that a personality disorder is untreatable, so what treatment can they give?"

100. Evan B. had visited the hostel on 29 March without the knowledge of the hospital staff. He was persuaded by hostel staff to return to the hospital, and did so reluctantly as he did not feel the hospital was doing any good. When the Inquiry Team met Evan B. he told us what his days were like in hospital :-

> "I was just given my medication in the morning and at night, and I was just sitting in the room talking to other patients. It was not a friendly atmosphere. That was all I used to do all day. I was not even eating. I had about two discussions with the doctor. The first was to discuss my depression and what was the cause of it and everything, and the second one was to discuss what I was going to do when I got out. The psychiatrist arranged for someone to come to the hostel, and I was signed as an out-patient ."

101. Various members of staff at the hostel spoke to staff at the hospital in the course of that week, but they do not appear to have sought to attend the ward round at which his hospital discharge was agreed, nor was an invitation offered. The hostel knew that CPN support was supposed to be available, as well as out-patient follow-up from the psychiatrist. Neither was seen as really meeting the needs of the hostel. In the words of the Hostel Manager :

> " I wanted Evan in hospital. Anything less than that would not have been enough because he was so difficult to manage."

102. On the day that Evan B. was due to be discharged, the hostel manager spoke to the ward nurse who told her that if she felt the health services arrangements were insufficient, that

she could contact a social worker from the local community team. A name of a social worker from Bromley Social Services was given, and the hostel manager recalled that this social worker had been helpful to her in the past in respect of another resident. The hostel manager telephoned, but was informed the social worker was on a day's leave. She recorded her intention to ring the following day but in the event took no further action.

Comment

It is difficult to see what incentive there was for Evan B. to remain in hospital. The physical environment was unattractive, there were intermittent conversations with nursing staff, other patients and some residents from the probation hostel who visited him but little else. An entry from the psychiatrist in the clinical notes states:

> ***Patient has come to the conclusion he cannot stay in hospital anymore. Bored. Negotiated discharge on 1.4.96 if hostel agree.***

The feelings of the hostel staff are not untypical of those expressed on occasion by carers of people with mental health needs. The hospital provided a short respite, the individual's condition had stabilised, but the burden of care had been passed back and nothing had fundamentally changed.

The Hostel Manager was satisfied with the links with the hospital and the service they received, but this seems to us to reflect a low level of expectation regarding joint working. We noted in particular that telephone contact was seen as adequate and there was no expectation of attendance at the discharge conference. There was little optimism that involvement of health professionals might assist probation staff in their ongoing management of Evan B.

Did Social Services have a role to perform ?

103. There were many occasions when Bromley Social Services might have been involved, for example:

- on 23 March - a referral to an Approved Social Worker (ASW) could have been made for assessment of the mental health crisis at the hostel, and support and advice to probation staff (who were in the dual roles of professional colleagues and carers). In the event the probation staff did not appreciate what the role of an ASW is, and the emergency duty GP made direct arrangement for hospital admission ;

- an ASW assessment referral could have been made when Evan B. was being held in hospital under Section 5(2) of the Mental Health Act 1983;

- as part of the multi-disciplinary meeting ('ward round') held on 29 March to discuss Evan B's discharge. A senior care manager from Bromley Social Services was attached to the

Consultant Psychiatrist and his clinical team and attended the 'ward round'. However, no one referred Evan B. to her neither did she seek a referral. The Ravenbourne Trust's Care Programme Approach (which had been agreed with Bromley Social Services) was not being used and therefore she was not systematically involved in his care. The consultant's view was that since the Probation Service were actively involved, Social Services involvement was superfluous;

- as part of the after-care support arrangements following hospital discharge. The probation hostel manager did not pursue this option.

104. Joint assessment is a matter of good practice between doctors and social workers who have specialist training in mental health work, particularly in response to mental health crises. The importance of social assessment, in addition to medical assessment, is embodied in the Mental Health Act 1983. The principle is not confined to compulsory measures. The ASW is trained in what information and knowledge to seek for purposes of the social assessment, including risk assessment, and the importance of obtaining knowledge from people who know the individual.

105. People experiencing a mental health crisis have multi-faceted needs. A crisis is when a person or their carers feel unable to cope with the distress or behaviour of the individual which is attributable to their mental and emotional state, and their personal and social situation - all of which interact. Such crises are best dealt with on a multi-disciplinary basis involving mental health services (health, social services, primary health care and other appropriate agencies). Social workers attached to ward based teams can play an important role but are often involved too late.

106. It is our view that Bromley Social Services should have been involved with the assessment, care and treatment of Evan B. That involvement would have enhanced the range of options considered and the skills applied in problem solving. It would have supported probation staff in appreciating the importance of making available full information and may have led the hostel manager to seek a social history, rather than psychiatric history, from her Cleveland colleague.

107. In the context of specialist work with people with mental health needs, both the Care Programme Approach and Care Management reflect the professional inter-dependency between Health and Social Services. The service manager for mental health services from Bromley Social Services was able to give us some valuable insights into the shortcomings and culture for change which was being managed in Bromley. She had been in post one year, but had previously worked in Bromley as an ASW. In her view there was a lot to work with in Bromley, but services are very uncoordinated and disconnected. "It is not a criticism, it is an observation. It is how services have evolved." As an example, she spoke of Social Services' own need to establish working arrangements with the Probation Service - the fact that the Probation Service was not included in her induction programme, that there was a court diversion scheme based on the medium secure hospital unit which

her workers did not know existed, and the fact that no-one had established a contact with the probation hostel .

108. In relation to the effect of Government reforms, she said, "You need social work skills to do a very good assessment of the needs of someone with mental health problems. Somehow it has been sold as devaluing and a lowering of standards to be termed a care manager rather than a social worker, but I do not agree with that at all. I promote care management as the way forward." It was evident to us that Bromley Social Services were engaged in a programme of service improvements for people with mental health needs, and they were welcoming the opportunity to work with the new health service provider for mental health services in Bromley.

The influence of user attitude and behaviour in service delivery

109. It was known from the outset by probation staff in Beckenham that Evan B. had a history of domestic violence, and Bromley mental health practitioners knew of his threats to his wife. Other than that, there was limited knowledge of his background. On their first contact with him, he presented in a state of mental distress and depression. Some staff had formed a view, based on his attitude and behaviour and known encounters, that he would most likely attract vulnerable women and was probably quite dangerous for them. Both male and female professionals experienced his attempts to control and manipulate situations.

110. We make the following observations:

- The standard practice in the Beckenham probation hostel for supervision to be allocated to the probation officer in the hostel was not followed because he was male. Evan B. insisted that he wanted to deal with the Hostel Manager, who was female. This was agreed to, and had serious implications for her day to day work. She told us:

  > "He was a very manipulative person. He liked and wanted to deal with me. In fact I can remember a point where I would open my office door, and I would think 'Oh, goodness, that guy is sitting there staring at me again', and it was driving me crazy at one point. A relentless barrage of attention really. Nothing aggressive. It didn't feel dangerous. I think later on I came to feel uncomfortable, more and more uncomfortable in that way, but it was very pathetic and manipulative at that stage. His behaviour very much changed after the making of the probation order, which is very typical in probation hostels. The honeymoon is over once the order is made."

- Both the hostel manager and the female probation officer, who had interviewed Evan B. during the preparation of the Pre-Sentence Report, recalled discussing how manipulative he was with women, how uncomfortable he made them feel, that "he was very much into women", "a general feeling of unease".

- The usual practice in the Portnalls Unit was to allocate a 'named nurse' to patients, as described earlier in our Report. A male staff nurse told us:

> "I was in charge of the ward. Naturally, I should have taken him as my patient. Because he said no, he could not communicate with male staff and preferred female staff, that is probably why I changed to a female member of staff. I remember he told me he had three or four criminal records, one was when he smashed up his wife's place. Rather than asking all the questions on the first day, I did not press him, but because he did not want me after that I did not get the chance to get down to the nitty gritty. After that, whenever I was in charge of the ward, I made sure he was allocated a female nurse. We had a very good female nursing assistant who was very experienced. I allocated her."

A female nurse, who at the time was acting deputy head nurse for the ward where Evan B. was admitted, told us

> "No. I didn't become his named nurse. I don't know how it evolved. He was allocated a male nurse as his named nurse. He did at that stage say to one of the home care assistants that he had difficulty communicating with males and preferred females. At that time I think the whole question was that Evan. B. was quite manipulative and could be intimidating. The feeling among staff was that he might find it easier to intimidate a female member of staff, and we weren't sure about his reasons for requesting a female rather than a male. I don't know when, but in the next day he demanded a female primary nurse. My intention was that if problems continued and he could not build up a relationship with a male primary nurse, then a female would take over and that would probably be myself."

- The hospital discharge summary completed by the male psychiatrist states:

> "Tended to monopolise staff. Rapidly made social relationships with some female patients, expressing affection towards them. Demanded a female primary nurse because "I can't communicate with men"."

111. This behaviour was seen to be characteristic of his personality disorder and emotional instability. There was limited opportunity to examine it in a fuller context, and consequentially, no-one challenged his attitudes and behaviour towards women.

112. The implications for vulnerable female service users, and for female professionals working with male service users who abuse women need greater recognition. Probation hostels and hospitals, by their very purpose and commitment, receive and work with a mix of people in need, in group settings, where the ethos is not to exclude or reject because of past behaviour. Good practice should ensure that when exceptions are made to the normal allocation of professional roles at the service user's request on the basis of gender, and this is agreed, the implications are carefully considered. We regard it as extremely important in

these circumstances that good supervision is available to the female worker which focuses on the possible attempts by the service user to manipulate and dominate, and supports the worker in recognising and dealing with this. There was no evidence of such supervision in either the health or probation services in Bromley.

113. The Patient's Charter (Mental Health Services), issued in January 1997, addresses the need for single sex wards in psychiatric hospitals, but recognises that in some cases, particularly emergencies, a hospital may not be able to provide single sex accommodation. Health staff need to be particularly sensitive to the personal needs and fears of vulnerable women patients in mixed settings.

LEAVE OF ABSENCE FROM THE PROBATION HOSTEL AND BREACH PROCEEDINGS

Leave of absence

114. Evan B. returned to the hostel on 1 April. He knew that a CPN would visit him, and that he had an out-patient appointment. He told us

> "Even I made arrangements for myself to try to better the situation by seeing that everytime that I had money, the staff in the hostel would take charge of it so that I could not go drinking".

115. For the following week he was much calmer and seen as causing no problems within the hostel.

116. Around 7 or 8 April, he approached the manager and asked for permission to visit his son in Manchester. All the staff in the hostel were well aware that Evan B. was missing his son. There is no contemporaneous record of how the decision was made. The manager states that she talked in detail with Evan B. about whether he intended also to visit his wife and says that he was quite definite he would not do so. She had been unable to verify the address where he said he was going to stay as they had no phone. Her assumption appears to have been that he would be visiting his elder sons who lived in Middlesbrough, and that the younger son would go round to see them. The geographical distance between the elder sons in Middlesbrough and the wife and youngest son in Manchester had not registered with her. In practice, Evan B. was given a travel warrant to visit his youngest son in Manchester without any checks having been made on the suitability of the arrangements.

Comment

The Approved Hostels Handbook gives authority to hostel managers to grant leave of absence from the hostel for up to five days. There is no specific guidance on how this should be exercised and there were no local guidelines. Leave of absence would often be used to enable residents to make plans prior to discharge or to allow them to retain links with family in other areas, so the decision to grant leave was not in itself surprising.

However, in this instance, the hostel staff had been made aware of the risks of contact between Evan B. and Susan B. through telephone conversation with the Cleveland Probation Officer. Either at the time of making the request or immediately before his admission to hospital, Evan B. had shown to the manager a letter in which his wife was proposing that she and their son come down to visit him. The letter clearly indicated that the youngest son was living with the wife in Manchester. The Pre-Sentence Report also referred to his wife and son having moved to Manchester.

In these circumstances, permission to go should not have been granted and alternative arrangements for Evan B. to meet his son should have been considered. Had a fuller assessment been made at the time of admission to the hostel, the continuing strength of Evan B's desire to see his wife and the risks that this presented might have been recognised and have prompted more extensive enquiries to be made.

The probation hostel staff were aware that there were divorce proceedings. The Family court welfare officer could have been consulted over the implications. Susan B. had kept the court welfare officer informed of her changes of address.

There were no practice guidelines on Domestic Violence which may have helped raise staff awareness levels (Appendix B. shows an extract from guidance issued by another probation service.)

117. Evan B. left the hostel for Manchester on 12 April. On the same day the hostel received complaints from a woman friend of his in the Middlesbrough area that Evan B. and his wife had been making abusing and threatening phone calls to her. Shortly after 5pm the following day, one of the assistant managers of the hostel received a phone call from Evan B. saying that he was at home, his wife was asleep on the sofa and he wanted to kill her. The assistant manager advised him to get out and get on a train back to the hostel. The same assistant hostel manager alerted the local police and, though them, the Manchester police who traced the whereabouts of Mr and Mrs B, but were assured by both Mr and Mrs B. that there was no problem and Evan B. denied making the phone call. The police, therefore, took no further action. The assistant manager who took the phone call knew Evan B. well and had had no doubts that it was he who made the phone call. According to the assistant hostel manager, the police refused to disclose to him the address where they had traced Mr. and Mrs. B. Evan B. returned to the hostel as scheduled on the evening of 14 April.

118. The hostel manager and the hostel probation officer saw Evan B. jointly on the morning of 15 April. Records indicate that they challenged him about his behaviour over the weekend, pointing out to him how much anxiety his behaviour had caused. Evan B.'s response was that he would not tell them in future. He also requested a transfer to a probation hostel in Manchester.

119. Evan B. was due to see the Senior Registrar for an out-patient appointment on the same afternoon. In the light of the concerns following that weekend, the manager decided to write to the Senior Registrar updating him on events since Evan B. had left the hospital. The manager concludes her letter by stating:

"We feel his behaviour is beyond our capability of managing. As he is one month into an 18-month Probation Order with a six months condition of residence here, we are committed to finding any solution possible in order to contain him. Can you help?"

120. Evan B. was seen at out-patients on 15 April. At that interview he was not depressed and was "extremely well presented". He left precipitately because the senior registrar would not intervene on his behalf with his request for a hostel transfer. A further appointment was to be sent to him for 29 April. After consultation with the Consultant Psychiatrist a referral was made to the local forensic psychiatrist seeking his advice on Evan B's management in the hostel.

Comment

The staff at the hostel had been sufficiently concerned by Evan B's behaviour to have wanted urgent psychiatric support. However, they appear to have seen his threat to his wife over the weekend as yet another in the long line of threats that he had made but not translated into action and to have interpreted this as behaviour designed to alarm other people rather than as a serious immediate threat to Susan B.

Referral for Forensic Psychiatric Assessment might have been helpful in formulating a plan for supervision, but events were moving too fast for this to have been likely to have made a significant difference and both Probation and Health were left in a position of trying to deal with somebody who posed serious problems.

If the account of the police response to the assistant hostel manager is correct, their refusal to disclose Susan B's address is an important issue. The probation hostel staff would have had good reason for seeking to establish contact with her and ascertain for themselves her experience of the incident in order to reassess the risk Evan B. posed.

Breach proceedings

121. From 16 April, Evan B. made it clear that he wished to leave the hostel and move to Manchester. Abortive enquiries were made of Probation hostels in the Manchester area, though it was thought unlikely that any would accept him in the light of the behavioral difficulties he had presented. He was told by the hostel manager that they would not sanction a return to the Manchester area. When Manchester Probation contacted hostel staff as a result of a telephone enquiry from Evan B. the Probation Officer informed them that they were trying not to let Evan B. leave the hostel. On 17 April, Evan B. did leave, despite having been warned that he would be in breach of his Probation Order.

122. On 18 April, the Probation Officer at the Beckenham hostel was contacted by a duty social worker in Middlesbrough, who had heard from Susan B. The social worker had seen Susan B. that morning and she had heard that Evan B. was now in Manchester. She was afraid to

return home and told the social worker that she feared for her life. The social worker wanted to know if Evan B. was in Manchester and what his legal position was. The Probation Officer told him the hostel's intentions concerning breach, and that he thought Evan B. was in Manchester but did not know for sure.

123. The hostel were again contacted by Manchester Probation as a result of Evan B. phoning them from the Manchester area requesting help with accommodation. The hostel Probation Officer agreed with Manchester Probation that as Evan B. had now left, it was appropriate that he should be encouraged to report to Probation in Manchester. The hostel Probation Officer was advised that Evan B. would be told to make contact with the Homeless Offenders Unit. Following a subsequent telephone conversation with a member of staff at the Homeless Offenders Unit, the Probation Officer noted:

> "I gave her some background and faxed PSR, MG16 (previous convictions), psychiatric assessment and recent correspondence. I also advised the PO of our intention to breach."

124. In the afternoon of 18 April, Evan B. phoned the hostel and spoke to the Probation Officer. He was drunk at the time but appeared to be saying he wished to make contact with Manchester Probation. He was told to report to the Homeless Offenders Unit. At the request of Evan B., the Probation Officer also spoke to Susan B. who was with him, as Evan B. wanted her reassured about his legal position. Susan B. was thought to be drunk as well and communication was difficult but the Probation Officer had no reason to think that she was concerned about her safety at that time.

125. The Probation Officer at the hostel believed that the later conversation between himself and Evan B. confused the picture. The question remains whether it would have been appropriate to inform the Manchester police. The hostel staff say this was considered but felt not to be appropriate, partly in the light of the telephone conversation with Susan B. and the lack of immediate threat which would enable the police to act, and partly because of the events of the previous weekend, from which it was thought it was unlikely the police would treat any information very seriously.

Comment

The assurance given by the police on 13 April that Susan B. was safe and uninjured was based on an interview when Evan B. was present part of the time and both were intoxicated. Similarly the brief telephone conversation between the hostel probation officer and Susan B. took place when so far as the probation officer could tell she had been drinking. It is not clear whether any assessment of the situation was therefore made on either occasion, nor whether consideration was given to the balance of power within the relationship between Mr. and Mrs. B. When Susan B. made contact with the Middlesborough duty social worker on 18 April, she was by herself and expressed fear for her life. In the absence of any immediate threat, it is

often difficult for workers to decide whether to alert the Police, but in the light of the above contradictory information, the inquiry team consider the hostel staff should have either alerted Greater Manchester Police or contacted Manchester Social Services Department (as envisaged in the risk-management strategy produced by the Middlesbrough probation officer).

126. As Evan B. had been absent from the hostel overnight, breach proceedings were begun. At this stage it was recognised that the Probation Order had not been received from Teesside. This was requested but when it was received it was wrongly made out and had to be returned for amendment as breach proceedings could not proceed without this. In practice, therefore, there was a week's delay before the court Probation Officer in Bromley was able to make an application for a warrant.

127. The breach warrant was eventually issued (unknowingly) after Susan B. had been killed.

Comment

This highlights the importance for a Probation hostel to have its documentation available and accurate so that breach proceedings can be instituted quickly. Had a warrant been issued as a matter of great urgency, theoretically Evan B. could have been arrested in Manchester during the week beginning 22 April. Whether, in practice, it would have been executed with such speed is open to question.

An arrest for breach of probation would have lead to Evan B. appearing before the court and would have afforded the opportunity to reassess the support and control he needed in the light of up-to-date information regarding the relationship between him and his wife.

The role of the Probation Committee and Probation Management

128. The probation committee for South East London Probation Service is responsible for the policy of the hostel and an Assistant Chief Probation Officer carries delegated responsibilities. In evidence to us, the Assistant Chief Officer confirmed that there was no risk policy and guidance for staff in operation at the time of Evan B.'s stay in the Beckenham hostel but their Practice Guidelines on Supervision of Probation Orders did require an assessment of risk. We asked about operational policy on the exchange of information with other agencies and he told us that there were specific circumstances, particularly in relation to child protection procedures which are clearly documented, where there would be exchange with Social Services and Police. He went on to say:

> "That does not extend to any other groups of individuals. There is a normal expectation of confidentiality of information, but where there is an obvious risk of an offence being committed then that confidentiality would be subsumed by the risk that

might be posed to an individual or the community at large. But we do not have any specific guidance on procedures in that specific area of exchange of information".

129. On the question of liaison arrangements with the health services, he told us that those were well established on the forensic side, particularly with the local medium secure hospital unit, and there had been a history of well-established liaison with consultant psychiatrists.

AGENCY RESPONSES IN MANCHESTER

Introduction : Domestic Violence Policies in Manchester

130. Following a Home Office Circular (60/90) to all Chief Officers of Police, expressing the concern of other agencies, the public and the police themselves over the incidences of domestic violence, Greater Manchester Police responded by setting up Domestic Violence Units on its 11 divisions staffed by "trained and experienced" officers. Greater Manchester Police produced its policy on domestic violence and action to be taken by officers attending incidents of physical attack, as follows:

(I) to protect the victim and any children from further attack;

(ii) to take firm and positive action against the assailant and where a power of arrest exists, either under the criminal law or under a Court injunction, the offender should generally be arrested;

(iii) where there is sufficient evidence to justify a prosecution, the emphasis should be on bringing the assailant before Court. However, this does not preclude utilising the Force cautioning policy in exceptional circumstances;

(iv) the officer will NOT immediately seek to effect conciliation between the victim and assailant, particularly in circumstances which may leave the victim or the family at risk of continued attack or abuse;

It is acknowledged that on occasions the assailant may in fact be a female and this should not detract the officer from fulfilling his responsibilities under criminal law.

131. We note that the term "physical attack" precludes emotional abuse or threatening behaviour.

132. There are no multi-agency forums in North (covering the area of Susan B's last address) or South Manchester at present. The Police Domestic Violence Units have links with Social Services, Housing Women's Aid, Probation and Victim Support on a divisional basis.

133. In 1995, the Home Office issued an Inter-Agency Circular "Domestic Violence - Don't Stand For It'. It seeks to encourage local statutory and voluntary agencies to co-ordinate responses to domestic violence in a manner which is both consistent and well informed - to develop good local policy and practice.

134. Both the Greater Manchester Police and Probation Services interface with a number of local authorities. Manchester Council has a city-wide inter Departmental Domestic Violence Steering Group which is led by their Housing Department. This forum has been developing policy and practice guidance to which Manchester Social Services contribute.

At the time of our inquiry we were provided with a copy of Manchester Social Services Domestic Violence Policy document, but we noted that the production of this document was subsequent to the homicide.

Manchester Social Services

135. On 27 October 1995, Susan B. and her youngest son moved from the Middlesbrough area to a women's refuge in Manchester. After four days in the Manchester Refuge she was asked to leave because of her son's disruptive behaviour and, apparently Susan presented herself to the Manchester Housing Department's Homeless Person's Unit. On 30 October 1995 she was transferred with her son to accommodation for homeless families provided by Manchester's Housing Department. On 31 October 1995, Susan B. was referred to the Manchester Social Services by a caseworker in the Homeless Families Section of the Housing Department for the allocation of a social worker. The letter of referral states:

> "Susan B. has come to Manchester to escape domestic violence from her ex-partner, Evan B. She was transferred from another Women's Aid Refuge. She was asked to leave because of her son's disruptive behaviour and was admitted to (address) on 30 October.
>
> Susan B. and her son are the subject of on-going social services involvement in Middlesbrough. Her social worker is (name) who can be contacted on (phone no.) Social Services have been involved in initiating court action against Evan B. because of his violence towards Susan B. and their youngest son. The son was on the 'at risk' register until two years ago.
>
> Susan B. is having great difficulty coping at the moment and has requested the allocation of a social worker. I've told her that I will make a referral to yourselves and advised her about the duty social worker service in the meantime."

136. On 1 November 1995 Susan B. telephoned the Social Work Team and asked for help in moving her clothes from the Refuge. We do not know what the response was to this request but it appears that the social worker enquired about concerns regarding her son, and advised her to contact the Social Work team if she needed any further help in this matter.

137. On 2 and 3 November 1995 respectively, Manchester Housing Department contacted Middlesbrough Social Services Department to confirm that Susan B was the subject of domestic violence for the purpose of processing her application for priority housing. In the course of giving evidence to our Inquiry, the social worker in Middlesbrough was asked whether, following Susan B.'s departure to Manchester, there was any liaison between her and Manchester Social Services or the Refuge in Manchester. The social worker told us: "I think that I sent them a copy of one of the reports. I know that I confirmed with the person I spoke to that Mrs. B was terrified of Mr. B". It would seem that this conversation

took place either on 2 or 3 November with a member of staff from the Housing Department.

138. On 6 November 1995, a further referral in respect of Susan B. and her son was made to Manchester Social Services by telephone by a primary health care worker, at the temporary accommodation where she was staying. The referral form states:

> "Received telephone call from Nurse (name) expressing concerns re Susan B. & son. Susan has approached Nurse (name) - very concerned regarding son and his behaviour. Family have fled domestic violence in Middlesbrough due to partner Evan B's abuse. Susan is not coping well in present situation."

139. The referral form was completed by an information and advice worker and passed to the Homeless Families Social Work team who considered the referral at their allocation meeting on 7 November 1995. A decision was made to take no further action on the referral. We understand that the basis for this decision was that the referral was perceived to be concerned with the son and his behaviour and it represented a lower priority when compared with other cases presenting at that time (e.g. children on the child protection register or subject to a court order). He was not regarded as being at risk as he was geographically separated from the perpetrator of domestic violence.

140. Manchester Housing Department considered that Susan B. was homeless and of priority need on the basis of her history of domestic violence. On 2 February 1995 Susan B. and her son moved to an address in Blackley, Manchester. In about the middle of February 1996, Susan B. and her son moved again, this time into the home of a man in Cheetham, Manchester, with whom Susan B. had formed a relationship. Susan B. and her son moved again, in mid-March, into the home of another man at a different address in the Cheetham district.

141. On 18 April, Susan B. who was visiting her elder sons in Middlesbrough for a few days, contacted Middlesbrough Social Services Department and expressed her concerns that Evan B. had moved to Manchester. She said that she was afraid to return home and feared for her life. The duty social worker contacted the probation hostel in Beckenham. Following the call, it would seem that he had difficulty in re-establishing contact with Susan B. There does not appear to have been any communication between Middlesbrough and Manchester Social Services at this time.

Comment

Susan B. was referred to Manchester Social Services on at least two occasions at the beginning of November 1995, almost six months before her death. Both referrals mentioned domestic violence by Evan B. The first referral form also recorded the name and telephone no. of the social worker who had been involved with Susan and her son in Middlesbrough. Despite this, no further information seems to have been

sought by Manchester Social Services from Middlesbrough regarding the family's background, nor does it seem that all the information obtained by Manchester Housing Department on the history of domestic violence was sought by the Social Work Team. No attempt was made to interview Susan B. or her son in order to obtain a fuller assessment of their needs prior to the meeting on 7 November 1995 when the decision was made not to allocate a social worker.

In written evidence to our Inquiry, the Assistant Director of Social Services with responsibility for the Social Work Team stated that no referral from Middlesbrough was sought "due to the fact that the referrals were focussed on the son and his behaviour and not the risk of ongoing domestic violence."

Greater Manchester Probation Service

142. Evan B. first contacted the Greater Manchester Probation Service on 16 April 1996, shortly after returning to the Beckenham Hostel following his authorised weekend visit to Manchester. To the knowledge of the Hostel probation officer, Evan B. telephoned a duty probation officer in Manchester and informed him that he was going to leave the Hostel the following day and move to Manchester. Evan B. was advised by the duty probation officer to contact the senior probation officer for the Cheetham area (the Cheetham SPO), we infer as a result of having informed the duty probation officer of his intention to move to the Cheetham district of Manchester, which was of course where Susan B. was living.

143. The Cheetham SPO was in fact unavailable when Evan B. telephoned to speak to him. However, he returned Mr. B.'s call and spoke to the Hostel probation officer who confirmed that Evan B. intended to move to Manchester but that the Hostel staff did not support the move and would institute proceedings against Evan B. for breach of his probation order if in fact he did leave the Hostel. The Cheetham SPO indicated that Manchester Probation Service was not in a position to provide Evan B. with accommodation but that Evan B. could apply to the Magistrates Court to have the conditions of residence at the Hostel revoked and to have the probation order transferred so that he could report to a probation officer in Manchester. The Hostel probation officer agreed to report the contents of this conversation back to Evan B.

144. On 17 April 1996, Evan B. left the Beckenham Probation Hostel at 9.25 am and travelled to Manchester.

145. On 18 April 1996, Evan B. now in Manchester, telephoned the Cheetham SPO from a public house and said that he had arrived and that he was reporting to the officer in accordance with the requirements of his probation order. Evan B. was asked for an address but he did not give one, although he did give the telephone number of the public house he was in where he said he could be contacted.

146. After speaking to Evan B. the Cheetham SPO telephoned the Manchester Homeless Offenders Unit who confirmed that they were prepared to "caretake" Evan B., i.e. to give him housing advice and to keep in contact with him. The Cheetham SPO telephoned the Beckenham Hostel probation officer and informed him of his conversation with Evan B. and the offer of the Homeless Offenders Unit to "caretake" Evan B. The Cheetham SPO also telephoned Evan B. back at the public house and supplied him with the address of and directions to the offenders unit, and the name of the duty probation officer to whom he should report.

147. Later on 18 April 1996, the Homeless Offenders Unit also telephoned the Beckenham Hostel probation officer and obtained further information regarding Evan B., including: details of the probation order he was subject to; confirmation that he had not been convicted of any sexual offences; that he had not been violent to Hostel staff; and details of his recent admission to a psychiatric unit because of fears of self harm. The HOU were also informed that Evan B.'s behaviour could be manipulative and difficult.

148. Thereafter, Evan B. did not have any further contact with the Probation Service or Homeless Offenders Unit in Manchester until after the death of Susan B.

Comment

The involvement of the Greater Manchester Probation Service with Evan B. before the death of his wife was brief and peripheral. Given the circumstances of Evan B.'s departure from the Hostel, it is difficult to see any way in which the Manchester Probation Service or their Homeless Offenders Unit could have become or been any more involved with Evan B.

However, there was a conflict in the evidence we received from the Beckenham Hostel probation officer and the staff from the Greater Manchester Probation Service and Homeless Offenders Unit as to the nature and extent of the background information regarding Evan B. which was passed from the Hostel to the Greater Manchester Probation Service.

According to the Beckenham Hostel probation officer, he informed the Cheetham Senior Probation Officer, during the course of their telephone conversation on 16 April 1996, of the threats Evan B. had made to harm his wife during his authorised weekend visit to Manchester. The Cheetham SPO denies that he was told anything about the threats of violence by Evan B. to his wife.

The Homeless Offenders Unit in Manchester states that the list of previous convictions sent by the Beckenham Hostel was never received

We do not intend to make a finding of fact as to whether such information was or was not sent or received. We are of the view that as a matter of good practice the

following basic information should have been sent to the Cheetham SPO and the Manchester HOU by the Beckenham Hostel probation officer:

a copy of the Pre-Sentence Report and a list of Evan B's previous convictions;

details of his probation order;

a copy of a risk assessment (which should have been completed by the Hostel staff and identified the risk of harm to Susan B);

a copy of Evan B's supervision plan (which should have been completed by the Hostel staff);

Susan B's last known address in Manchester.

However, even if all of the foregoing information had been passed to the Manchester Probation Services, it is unlikely that the involvement of the Manchester Probation Services with Evan B. would have been any different. Until Evan B. made further contact with them, they were not in a position to do anything further to assist him. We are of the view that the responsibility for informing the Manchester police that Evan B. was in the area, was in breach of his probation order and was at risk of harming his wife, lay squarely with the Hostel staff who knew so much more about Evan B. than the Manchester Probation Services.

This is the second instance during our inquiry where we have found that the Probation Services have no means of verification for the transmission and receipt of important information between areas. A simple "Please confirm receipt of Fax" message, together with an instruction to file the response, would have solved the problem.

Manchester Police

149. The Manchester Police were first involved with Evan B. during his authorised visit to Manchester over the weekend 13/14 April 1996. Two police constables attended the address given to them by the Beckenham hostel and found the house to be empty. On leaving the premises they were approached by Susan B's son who said that his mother was asleep and gave the address of another house in Cheetham. The police visited this property where they saw Mr. and Mrs B. , both of whom were very drunk. Susan B. denied that Evan B. had threatened her and suggested that someone else had made the phone call to make trouble, but she refused to say whom she thought had made the call. Having ascertained that Susan B. was uninjured, the police left the premises.

150. According to a statement by the son, he telephoned the police at Susan B's request on 23 April 1996 some time after 4.15 PM, after Evan B. had thrown a tobacco tin at his wife's head during an argument between them. He telephoned the police from a public call box

and then went round to the house of a friend of his mother's who lived nearby. It is not clear from the documentation whether the police responded to this call.

151. Later the same day at about 7.10 PM, two police constables attended the address where Susan B. had been living in response to a report of alleged theft and breach of bail conditions. We believe that it was Susan B. who contacted the police on this occasion. They found Susan B. and a female friend of hers in the house in a very drunken state. Susan B. reported that Evan B. had visited the house earlier in the evening, and had stolen her purse with £50 in it. She also claimed that he was in breach of bail conditions but after questioning Susan B. further, the police constables were in fact under the impression that Susan B. was referring to the conditions attached to a lapsed injunction which she had obtained against her husband. She was advised to contact her solicitor when she was sober. The police constables left the premises at 7: 25PM, just a few hours before Susan B. died.

Comment

Had the Manchester Police known (a) that Evan B. was in breach of his probation order, and (b) that there was a real risk that he would harm his wife, they might have intervened by taking steps to locate and arrest Evan B., or offered to accompany Susan B. to safe alternative accommodation.

As previously stated it is often difficult for workers to decide whether to call the police but we are of the view that upon Evan B's departure from the Hostel, the staff at the Hostel should have contacted the Manchester Police and passed on the following information:

- ***that Evan B. was in breach of his probation order;***
- ***an assessment of the risk that Evan B. presented to his wife;***
- ***Susan B's last known address in Manchester.***

Of course no-one knows whether if this information had been passed to the police it would have made any difference to the eventual outcome, but it is possible that it could have done.

Subsequent events

152Evan B. made contact with the Samaritans telephone counselling service. In accordance with the Samaritans Code On Caller Confidentiality, the information contained in the statements provided to the police was only done so with the express consent of Evan B. From Police evidence to our Inquiry, we see that on 23 April 1996, Evan B. telephoned the Samaritans office in Oxford Street, Manchester. Evan B. telephoned the Samaritans again at 9.40 PM. At 9.59 PM Evan B. made a third telephone call to the Samaritans. He asked if he could come to the Samaritans office. He was told he could and was given the address and told that the Samaritans would pay his taxi fare. At about 11pm Evan B. arrived at the

Samaritans offices. Two female Samaritan workers spoke to Evan B. in an interview room and after a period of time persuaded him to contact the police. The police arrived and Evan B. agreed to accompany them to the police station provided that the two female Samaritan workers also went with him which they agreed to.

153. At approx. 12.25am Evan B. accompanied by two police officers and the two Samaritans arrived at the police station. Evan B. was left in an interview room with the two Samaritans who tried to ascertain the whereabouts of Susan B.'s body. Evan B. refused to divulge this and eventually the Samaritan workers explained that they could not offer Mr. B. any further support and that they had to leave which they duly did.

154. **At around 6.30 am on 24 April, 1996**, Evan B. accompanied by his legal representative took the police to a place in the Cheetham Hill area of Manchester, where **they found the body of Susan B.**

High Court Sentence

155. Evan B. pleaded guilty to the manslaughter of his wife at the High Court of Justice, Manchester on 1 August 1996. On 12 November 1996, the Hon. Mr. Justice McKinnon, in passing sentence, said:

> "It is perfectly clear that you treated her with considerable violence on this occasion in April this year when you and her were both in drink. The cause of death was pressure to her neck. There were bruises round her neck strongly suggestive of manual strangulation, but she could well have died as a result of a nervous reflex whereby pressure on the neck causes the heart to stop beating, hence the prosecution's acceptance of your plea of manslaughter. .....there is nothing mentally wrong with you although it is said you suffer from severe grief and reactive depression."

Evan B was sentenced to five years imprisonment.

156. Prior to his sentence, Evan B was interviewed by the prison medical Officer on 25 September 1996. The medical officer reports that Evan B admitted during this interview that for the first 5 years of his marriage he beat his wife, but stated that for the last 10 - 15 years of their relationship he had never beaten her.

157. Susan B's actions to protect herself, and the records of the agencies she had contact with, speak for her.

INTERNAL INQUIRIES AND SUPPORT TO THE VICTIM'S FAMILY

158. According to the medical notes, the Consultant Psychiatrist responsible for Evan B's health care at Farnborough Hospital, was made aware of this tragic incident by the probation hostel manager. However, we learnt that this information was not passed onto anyone else in the Trust. An assumption was made by the consultant that there was no requirement to set up an internal inquiry. The incident did not come to the attention of the senior staff in the Trust and consequently the Health Authority until some time in July 1996. This action or lack of action was in spite of the HSG circular 94(27) which clearly sets out the requirements for an internal inquiry as well as an external inquiry in the case of a homicide.

159. *Building Bridges* (Dept. of Health 1995) also recommends that a local audit of serious incidents is conducted. At least a full clinical audit should have been undertaken to ensure two things: a) identification of clinical procedural deficiencies, and b) support to those members of staff who require it.

160. The Trust did eventually carry out an investigation to which we had access. This investigation relied on written evidence only and sought the views of the health professionals and the probation staff involved in Evan B.'s care. The conclusions made by the internal inquiry have resulted in recommendations for the review of discharge procedures particularly documentation, pre-discharge assessment and the CPN referral system.

161. The Probation Service had a responsibility to inform the Home Office of any serious incident (Probation Circular No. 41/1995). This document spells out the instances which require reporting and the content of the report. The circular requires that the Home Office should be informed as soon as the defendant is charged in the first instance by fax, in writing or telephone. A management review should then be carried out and the findings written in a report. This report should cover:

- the nature of the offence;
- previous convictions;
- details of the offence with which the defendant is now charged;
- history of Probation involvement;
- details of further action to be taken as a result of the management review.

162. The South East London Probation Service notification to the Home Office contained merely a factual account - it did not state the need for any further action.

163. A further Probation Circular (79/1996) dated 17 December 1996, on Serious Incidents, has been issued. It restates the purpose of notification and gives guidance on management reviews which should be assessed by the local services to see if lessons can be learned about how procedures/practice might be improved.

164. Given that the care of Evan B. was shared between the Probation Service and the local mental health services, it seems extraordinary that there was no joint follow-up to examine what happened and how best the services could link together. We note that the Bromley Health Authority's Annual Report 1995/96 states that Criminal Justice Agencies featured prominently in a consultation exercise on the needs of mentally disordered offenders, and that a multi-agency strategy group is to be developed.

165. From the records and the interviews, the Independent Inquiry Team could find no evidence that the Ravensbourne NHS Trust attempted to locate the family of Evan and Susan B. to offer support or put them in touch with an independent source of support. This was despite the fact that there were three sons, one of whom was living with his mother at the time of her death and who had the ordeal of identifying her body. The attempt to make contact with the family by Bromley Health Authority was unsuccessful.

166. Other Inquiry after Homicide reports which have been published have drawn attention to the support needs of people affected by serious and fatal incidents and made recommendations. We note that Ravensbourne NHS Trust had subsequently introduced a policy for dealing with serious untoward incidents. **However, such a policy, following an internal audit, should include a decision to include other agencies involved in the service delivery. Findings should then be conveyed to other members of the service as part of an on-going training programme. All staff involved should be given the opportunity to make a statement and be given the offer of support by an external organisation if necessary. This should continue through the internal inquiry, any criminal proceedings and an external independent inquiry. The Chief Executive of the health authority or a named officer, should seek to ensure that adequate support is available to the patient's and victim's family, and others who may have witnessed the incident, and that they are kept informed of the actions taken.**

167. The inquiry team were pleased to learn that as a consequence of the younger son returning to Middlesbrough to live with one of his brothers, they were receiving help from the local Victim Support and Middlesbrough Social Services.

CONCLUSIONS

168. In recent years, the development of partnerships between health and social services in the delivery of mental health services has been accorded high priority. The complexities of the relationship between primary health care and specialist psychiatric services, and between child care and adult care in social services, and their interface with people with mental health needs, is currently the subject of national debate in response to the Secretary of State for Health's consultation paper (3). Those complexities are illustrated in this Inquiry. This Inquiry has also shown the difficulties which need to be overcome at the interface with other statutory authorities, in this instance, the probation service.

169. The one common agreement is that multi-disciplinary working is the best way forward. This approach requires authorities to understand the complexities involved in multi-agency collaboration. Co-ordination has to be supported by agreed structures and protocols on information exchange to facilitate it, coupled with on-going work to familarise staff with changing roles and skills of colleagues in other agencies. None of these structures were in place between the Health, Probation and Social Services in Bromley.

170. **Our main criticism is that the Health Authority, the Probation Committee, and Ravensbourne NHS Trust, and their executive management, failed to ensure that they had in place operational policies which promoted joint working and facilitated multi-disciplinary assessment, risk assessment and risk management reflecting recent national policy developments.** Policy implementation has to be managed. It cannot be left to practitioners to get on with. The announcement of new policies will always raise public expectation, and the time needed to translate policy into practice is not always appreciated. However, when those policies are intended to bring better protection and improvement in services directed towards socially vulnerable members of our community, management has to give account of what priority and commitment it has given.

171. In outcome, no joint and comprehensive assessment by probation, health and social services of Evan B's needs and risk was undertaken in Bromley, and more structured interventions were not devised. Concerns about how best to manage his behaviour diverted attention from the risk he posed to Susan B. Crisis management followed in consequence.

172. The issues involved in attempting to undertake effective work with people whose attitude and behaviour is so deeply entrenched are well known. Re-Education programmes for men who perpetrate violent acts against their women partners are being set up throughout the UK, notably within the criminal justices services. The research (4) suggests that programmes using cognitive behavioural principles may make a positive contribution towards a reduction in violence against women in the home. A pre-requisite is that men are willing and able to be motivated to change. Whether Evan B. can change is unknown by us.

Would a local co-ordinated response on domestic violence have helped prevent the homicide ?

173. When Susan B. moved to Manchester she was vulnerable and outside the area where she had lived most of her life, where she had contacts and where she was known. The domestic violence policy from police, probation and social services in Manchester, which we have seen, primarily aim to make explicit each service's role and response to notification of domestic violence and to develop good practices against a backdrop of evidence derived from research. It is evident to us from their submissions to this Inquiry that each of these agencies aspired to closer inter-agency working arrangements. However, the necessary structures and communication systems to foster multi-agency co-ordination, needs assessment and protection at operational level were not in place. This situation was compounded by the fact that agencies in Middlesbrough and Bromley failed to effectively communicate the on-going risk Evan B. posed to Susan B. We hope that the findings from this Inquiry will add impetus for all agencies to develop co-ordination to tackle domestic violence both within and across geographical boundaries.

The process of risk assessment

174. This inquiry has shown that information about abuse in the home, so often under-reported and so unlikely to appear on previous conviction records, needs to be integrated in the process of risk assessment and risk management. Such a process begins with an assessment which views the person in the context of their family, household and life experiences. To be effective, time has to be afforded for information gathering, for consultation with colleagues from other professional disciplines, and carers. Where a joint assessment is undertaken with other agencies, there has to be a clarity of purpose and understanding of different agencies responsibilities.

References

(1) Criminal Statistics for England and Wales, Home Office 1995 - female victims of homicide aged 16 and over.
(2) Summary of research findings on Incidence and Prevalence of Domestic Violence compiled by Professor Jalna Hanmer, Violence, Abuse and Gender Relations Research Unit, University of Bradford and presented to conferences held by Social Services Inspectorate, Department of Health, in March 1995.
(3) "Developing Partnerships in Mental Health", Secretary of State for Health, CM 3555, February 1997.
(4) "Re-Education Programmes for Violent Men - An Evaluation", Home Office Research Findings No.46, Dobash R, et al October 1996.

RECOMMENDATIONS

Evan B. and the sons of the family, on behalf of their deceased mother, consented to us having access to personal files in order that others may learn the lessons. Their needs provided a context for us to investigate the public services' response. The services involved and not the family are the focus. **We ask that the wishes of Susan B's sons to have their family's identity remain anonymous be respected by everyone.**

1. **We recommend that Bromley Health Authority direct the new health service provider for local mental health services, Oxleas NHS Trust, to complete arrangements for the implementation of the Care Programme Approach (1991) and Hospital Discharge Guidance (1994) as a matter of urgency.**

2. **We recommend that Bromley Health Authority make available funding to improve the conditions of the Portnalls Unit, Farnborough Hospital, or to relocate the service to new premises, so that the standards for the health care of people experiencing acute mental distress meet the requirements for "high quality service provision" in accordance with Bromley Health Authority's own stated aims (Mental Health Strategy 1993).**

3. **We recommend that Bromley Health Authority and the South East London Probation Service, in conjunction with Bromley Social Services, develop working relationships between mental health services and probation services using the published document 'A Guidance Document Aimed At Promoting Effective Working Between Health and Probation Services'(1995) as their framework.**

4. **We recommend that the South East London Probation Service produce and disseminate practice guidelines on domestic violence, supported by learning opportunities, for all their staff as a matter of priority.**

5. **We recommend that the South East London Probation Service review their procedures and information requirements for admission of offenders to the Beckenham hostel.**

6. **We recommend that health service managers in Bromley ensure that staff are attentive to the needs of vulnerable women service users who may be vulnerable to abusing men.**

7. **We recommend that the local authorities responsible for police, probation and social services in Manchester give detailed consideration and a joint response to the findings of this inquiry, in particular, in relation to management and allocation of referrals and inter-agency communications.**

8. **We recommend that GPs seek medical records through emergency procedures for all residents in probation hostels.**

9. **We recommend that when exceptions are made to the normal allocation of professional roles at the service user's request on the basis of gender and this is agreed, the implications are considered and appropriate support and supervision is given to staff.**

10. **We recommend that Probation Services:**
    (a) review the information including risk assessment which needs to be transmitted from one area to another; and
    (b) their communication procedures.

11. **We recommend that Probation Services, in conjunction with the Home Office consider a policy for the retention of records when there is a history of violence.**

12. **We recommend that the Department of Health give consideration to obtaining agreement nationally on definitions of the differing levels of the Care Programme Approach, not least to avoid confusion if mental health service users move from one area to another.**

13. **We recommend that local health, social services and criminal justice agencies have in place joint policies on the exchange of confidential personal information for purposes of multi-disciplinary risk assessment and management, in the interests of the safety of the individual and/or the public.**

14. **We recommend that the current working group on supervising difficult offenders in the community, set up by the Criminal Justice Consultative Council to develop a common Core Document for information sharing, include information on domestic violence.**

15. **We recommend that the statutory mental health services (Health and Social Services):**
    (a) develop operational policy and practice guidance on domestic violence, supported by learning opportunities, for all staff; and
    (b) participate in inter-agency co-ordination fora on domestic violence in local areas.

16. **We recommend that Probation Services should ensure their guidelines on risk assessment and management include domestic violence.**

17. **We recommend that the Social Services Inspectorate of the Department of Health, H.M. Inspectorate for Probation Services, and the National Health Service Executive, monitor the development of services for users who have experienced or inflicted domestic violence and a) disseminate examples of good practice, and b) include their findings in their annual reports.**

18. **We recommend that the central government Inter-Agency Circular 'Domestic Violence - Don't Stand For It' (1995) be re-issued as a joint circular from the Home Office and the Department of Health in standard format to local health authorities, local authority social services departments and criminal justice authorities, drawing attention to the findings of this Inquiry.**