UTTLESFORD COMMUNITY SAFETY PARTNERSHIP

DOMESTIC HOMICIDE REVIEW

EXECUTIVE SUMMARY

Report into the deaths of Deborah and Michael

July 2015

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Date of Submitted Version: October 2017
Date of Final Version: October 2019

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1. Executive Summary

1.1 The Review Process

1.1.1 This summary outlines the process undertaken by Uttlesford Community Safety Partnership Domestic Homicide Review Panel in reviewing the homicides of Deborah and Michael who were residents in their area.

1.1.2 The following pseudonyms have been in used in this review for the victims and perpetrator (and other parties as appropriate) to protect their identities and those of their family members:

(a) Deborah, aged 54 at time of death, White British, mother of the perpetrator Ryan

(b) Michael, aged 60 at time of death, White British, friend of Deborah

(c) Ryan, aged 23 at the time of the homicides, White British, perpetrator of both homicides

1.1.3 Criminal proceedings were completed in May 2016 and the perpetrator was convicted of both Deborah's and Michael's homicides. He was given a life sentence with a minimum term of 32 years.

1.1.4 The process began when the Community Safety Partnership made the decision to hold a Domestic Homicide Review (DHR).

1.1.5 The completion of the Review was delayed for a number of reasons; it was approved for publication by the Home Office Quality Assurance Panel in July 2019.

1.2 Contributors to the Review

1.2.1 This review has followed the statutory guidance for DHRs (initially 2013 and subsequently taking account of the 2016 guidance) issued following the implementation of Section 9 of the *Domestic Violence Crime and Victims Act 2004*. On notification of the homicide agencies were asked to check for their involvement with any of the parties concerned and secure their records. A total of 28 agencies were contacted to check for involvement with the parties concerned with this review: seven agencies returned a nil contact; 17 agencies submitted Independent Management Reviews (IMRs) and chronologies; and four agencies chronologies only due to the brevity of their involvement. The chronologies were combined and a narrative chronology written by the Overview Report writer.

1.2.2 The following agencies and their contributions to this review are:

Agency	IMR and Chronology Received
ADAS (Alcohol and Drug Advisory Service)	Yes
East Hertfordshire Council, Housing Services	Yes
Essex County Council Connexions Service	Chronology and further information provided
Essex County Council Education Services	Yes

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Essex County Council Youth Offending Service	Yes
Essex Partnership NHS Foundation Trust (formerly the North Essex Partnership NHS Foundation Trust)	Yes
Essex Police	Yes
Essex Young People's Drug and Alcohol Service (now provided by The Children's Society)	Chronology and further information provided
Genesis Housing	Information provided
Her Majesty's Prison and Probation Service	Yes
Hertfordshire Constabulary	Yes
National Centre for Domestic Violence	Yes
National Probation Service	Yes
Northamptonshire Healthcare NHS Foundation Trust (Mental Health In-Reach Services at HMYOI Glen Parva and HMP Bedford)	Yes
Oxleas NHS Foundation Trust (Mental Health In-Reach Service at HMP Rochester)	Yes
Parsonage Surgery – General Practice for Michael	Yes
Princess Alexandra Hospital	Yes
Specialist Treatment and Recovery Service (STaRs, Community Drug and Alcohol Service)	Yes
Stansted Surgery – General Practice for Deborah and Ryan	Yes
Sussex Partnership NHS Foundation Trust (Primary Mental Health Care Service at HMP Ford Open Estate)	Incorrect request sent originally; corrected following Independent Mental Health Investigation, Trust reviewed the Overview Report and Executive Summary
Uttlesford District Council Environmental Health	Yes *Not included in Review as no relevant contact or learning*
Uttlesford District Council Housing Service	Information provided
Victim Support	Yes

1.2.3 In addition, the independent chair discussed the case with the domestic abuse leads for Essex County Council, who have a responsibility county-wide for developments in relation to domestic abuse services and overall responses, and are now responsible for county-wide coordination of DHRs.

1.2.4 *Independence and Quality of IMRs*: The IMRs were written by authors independent of case management or delivery of the service concerned. The above listed services had involvement with the victim of sufficient duration which required IMRs to be submitted. Most IMRs received were comprehensive and enabled the panel to analyse the contact with Deborah, Michael and Ryan and to produce the learning for this review. Where necessary further questions were sent to agencies and responses were received.

1.2.5 *Involvement of family*: Deborah's adult son and ex-partner (the brother and father of Ryan) met with the Independent Chair of the Review. They gave information about Deborah and

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Ryan, and about their experience of accessing services and seeking help. They reviewed a draft of the Overview Report and their feedback was incorporated. By request, they reviewed a summary update from the independent chair of changes made to the Overview Report, following which their comments were incorporated. The pseudonyms were checked with them. The independent chair contacted the family a final time to inform them that the review was completed, and had been handed to the Community Safety Partnership (CSP). The contact details for the CSP lead were provided, and an outline of what would happen next. The CSP lead was given the contact details for the family, who was tasked to contact the family prior to the review being published.

1.2.6 In addition, the independent chair spoke with the daughter of Michael on one occasion, and she gave information about Michael. She was contacted again later in the DHR to read the Overview Report; no response was received.

1.2.7 Ryan was written to twice to invite him to participate in the review; he did not respond. During the completion of the review, the independent chair was informed that Ryan had died in prison.

1.3 The Review Panel Members

1.3.1 The Review Panel were:

(a) Althea Cribb, DHR Chair and Report Author (Associate, Standing Together Against Domestic Violence)
(b) Allison Gardner, Safer Places
(c) Carol Rooney, Niche Health and Social Care Consulting (Mental Health Investigation Lead)
(d) Carolyn Smith, Essex Partnership NHS Foundation Trust (formerly the North Essex Partnership NHS Foundation Trust)
(e) Claire Bennett, East Hertfordshire Council Housing Services
(f) David Padgett, Victim Support
(g) Deborah Lambert, Essex Specialist Treatment and Recovery Service (STaRs, Community Drug and Alcohol Service) (replaced by Lidia Woods, November 2016)
(h) Fiona Gardiner, Uttlesford District Council Community Safety (replaced Martin Ford, March 2017)
(i) Frances Mason, National Probation Service (Essex)
(j) Gareth Clement, ADAS (Alcohol and Drug Advisory Service)
(k) Ian Cummings, Essex Police
(l) Jo Barclay, Essex County Council Education Services

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(m) Kate Harvey, National Probation Service (Hertfordshire)

(n) Lee-Ann Williams, Chelmsford Prison, Her Majesty's Prison and Probation Service

(o) Lidia Woods, Essex Specialist Treatment and Recovery Service (STaRs, Community Drug and Alcohol Service) (replaced Deborah Lambert, November 2016)

(p) Martin Ford, Uttlesford District Council Community Safety (replaced by Fiona Gardiner, March 2017)

(q) Mette Vognsen, NHS England

(r) Mohammed Shofiuzzaman, West Essex Clinical Commissioning Group

(s) Tina Snooks, Essex County Council Youth Offending Service

(t) Tracy Pemberton, Hertfordshire Constabulary

1.3.2 The following were connected with the Review Panel remotely, due to their distance from Uttlesford or minimal involvement:

(a) Kerry Clancy-Horner, Area Manager, The Children's Society

(b) Ben Tolley, Northamptonshire Healthcare NHS Foundation Trust (Mental Health In-Reach Services at HMYOI Glen Parva and HMP Bedford)

(c) Bryony Robertson, Oxleas NHS Foundation Trust (Mental Health In-Reach Service at HMP Rochester)

(d) Justine Rosser, Sussex Partnership NHS Foundation Trust (Mental Health In-Reach Service at HMP Ford)

(e) Michael O'Brien, Head of Commissioning Education, Essex County Council (with regard to Connexions)

(f) Timothy Samwell, HMP Rochester

1.3.3 *Independence and expertise*: Agency representatives were at an appropriate level and demonstrated an adequate level of knowledge in relation to domestic abuse and the individual and multi-agency responses required.

1.3.4 The Review Panel met a total of six times, with the first panel meeting in December 2015 and the final meeting in June 2017. The review was submitted to the Uttlesford CSP in October 2017.

1.3.5 The Chair of the Review wishes to thank everyone who contributed their time, patience and cooperation to this review.

1.4 Chair of the DHR and Author of the Overview Report

1.4.1 The Chair and Author of the Review is Althea Cribb, an Associate DHR Chair with Standing Together Against Domestic Violence (STADV). Althea has received Domestic Homicide Review Chair's training from STADV. Althea has chaired and authored eleven DHRs. Althea

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has ten years of experience working in the domestic violence and abuse sector, currently as a consultant supporting local strategic partnerships on their strategy and response to domestic violence and abuse.

1.4.2 Standing Together Against Domestic Violence (STADV) is a UK charity bringing communities together to end domestic abuse. We aim to see every area in the UK adopt the Coordinated Community Response (CCR). The CCR is based on the principle that no single agency or professional has a complete picture of the life of a domestic abuse survivor, but many will have insights that are crucial to their safety. It is paramount that agencies work together effectively and systematically to increase survivors' safety, hold perpetrators to account and ultimately prevent domestic homicides

1.4.3 *Independence*: Althea Cribb has no connection with Uttlesford Community Safety Partnership or any of the agencies involved in this case. Authors of IMRs are independent of line management of the service.

1.5 Terms of Reference for the Review

1.5.1 At the first meeting, the Review Panel shared brief information about agency contact with the individuals involved, and as a result, established that the time period to be reviewed would be from 1 January 2003 to the date of the homicide. Given the young age of the perpetrator, and the fact that one of the victims of the homicide was his mother, and that he was known to have started his drug use as a teenager, the Review Panel felt that this time period would capture the significant events. Agencies were asked to summarise any relevant contact they had had with Deborah, Michael or Ryan outside of these dates.

1.5.2 *Key Lines of Inquiry*: The Review Panel considered both the "generic issues" as set out in 2013 Guidance and identified and considered the following case specific issues: familial domestic abuse; drug and alcohol use; risk management and the Multi-Agency Risk Assessment Conference (MARAC); and mental health.

1.5.3 As a result, Safer Places were invited to be part of the review due to their expertise in domestic abuse even though they had not been previously aware of the individuals involved (in addition to the expertise of the panel in relation to the other issues).

1.5.4 *Parallel reviews*: In September 2016 NHS England commissioned an independent mental health investigation into Ryan's receipt of mental health care services. At that point the DHR was put on hold to await the findings, as it was agreed that Ryan's receipt of mental health care was a significant factor for the learning in the case. The investigation report was then delayed; a draft report was shared with the independent chair in May 2017, with the final report being shared in October 2017. The findings from the Investigation were then

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incorporated into the DHR. The report will be published at the same time as the DHR publication.

1.5.5 The National Probation Service carried out a Serious Further Offence Review. This was completed prior to the DHR starting, and all learning was therefore incorporated into the Overview Report.

1.6 Summary of Chronology

Background information

1.6.1 Deborah was aged 54 at the time of her death. She was not employed, but had worked for most of her life, latterly as a school dinner lady. She had two (adult) children, Ryan being the younger. She and Ryan's father had separated approximately nine years previously. Deborah's family (her other son and her ex-partner) described her as "*bubbly, very friendly … an extrovert*", that she was "*creative*" and loved cooking, and that she loved company. Deborah had always enjoyed drinking; it had always been a part of her life, but over time it had become "*worse and worse*". Her son felt that Ryan's behaviour (including breaking into Deborah's house, and causing disturbances) had an impact on Deborah's drinking; that she had always "*been a drinker*" but that dealing with Ryan's behaviour made it worse. The family were aware that Ryan posed some risk to them, and were concerned and fearful of what he could do. At one point Deborah's ex-partner told Deborah to "*put all the knives away*" but she wouldn't do that. They both stated that Ryan had never been violent towards Deborah. For them, the incident of the homicide was "*out of the blue*" – because Ryan had been "*behaving himself*" since coming out of prison, but also because he had never been violent towards Deborah before.

1.6.2 Deborah had contact with eight agencies involved with this Review.

1.6.3 Michael was aged 60 at the time of his death. Following the homicide, police established that Michael had multiple health problems, and had recently been treated for cancer. It is clear from the information gathered for this DHR that Deborah and Michael spent a great deal of time together, liked to drink alcohol together, and Deborah had recently been Michael's carer following his cancer treatment. The review could not establish whether they were in an intimate relationship or were friends. Michael had contact with three agencies (General Practice, Housing and the Hospital) during the Terms of Reference timeframe, and such contact as there was revealed no learning. Michael's daughter contributed to the review, although she has been estranged from Michael and had not had any contact with him since she was a child.

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1.6.4 Ryan was aged 23 at the time of the homicides. He was living with Deborah at the time following his release from prison three months earlier for grievous bodily harm against his father. Ryan's mental health issues and drug use formed much of the feedback from his family (brother and father). Ryan's brother stated that he felt part of the problem for Ryan was that "*drugs are too readily available*" and for Ryan it had started at a young age and that this should be tackled. Ryan's father and brother talked about the fact that Ryan would not engage with services, largely because from his perspective he was right and everyone else was wrong, and so he couldn't see why he needed the services. For the family, it was never clear how his drug use and mental health issues interacted: did the drug use cause the mental health issues, or was he "*self-medicating*" to deal with feeling the way he did?

1.6.5 Ryan had contact with 17 agencies involved with this review.

The Facts: Deborah

1.6.6 *Police*: Deborah's contact with agencies began with Essex Police, and between April 2010 and March 2012 police were called 14 times to her address for incidents involving Ryan. Additionally, Hertfordshire Police were called four times by Ryan's father to his own address while Ryan was living with him. At these incidents, Ryan was: removed from the premises or arrested in order to prevent breaches of the peace; arrested for drugs offences or criminal damage; on two occasions he was detained under the *Mental Health Act*; or no offences were recorded as a result of which no action was taken. On two occasions Ryan called police and on their attending no offences were disclosed. All of the incidents were flagged and responded to as domestic abuse with the exception of one incident in which Ryan was arrested for possession of illicit substances. A DV1[1] was completed with Deborah on nine occasions; she declined on two further occasions, and in one incident the completion or otherwise of a DV1 was not recorded. On the two occasions that Deborah declined to complete the DV1, a 'skeleton' DV1[2] was completed. Deborah was assessed as standard risk on three occasions (including one 'skeleton') and medium risk on three occasions (including one 'skeleton'). On one occasion she was identified as high risk and this was later downgraded to medium; she was identified as high risk on two occasions. On one occasion Deborah was given support by a specialist Domestic Abuse Liaison Officer including advice about gaining a non-molestation order (she contacted the National Centre

[1] Essex Police IMR describes this as a "*nationally recognised form to record all incidents of domestic abuse which includes a check list for staff, a question set to obtain relevant information from the victim and the DASH Risk Assessment together with advice to be provided to the victim.*" (Domestic Abuse, Stalking and Honour Based Violence (DASH 2009) Risk Identification Checklist: http://www.dashriskchecklist.co.uk)

[2] One in which the officer uses the information available to them to assess risk.

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for Domestic Violence for assistance with this but told police she could not progress as she was not entitled to legal aid). She was referred also to the Independent Domestic Violence Advisor (IDVA) (see Victim Support, below) and to MARAC (see below).

1.6.7 *Victim Support*: Victim Support attempted to contact Deborah once following an automated referral from Essex Police for an incident of domestic abuse by Ryan; a referral was also made to the IDVA service by Essex Police, and they attempted to contact her three times. They could not reach Deborah (her phone was switched off or went to voicemail) and so the case was closed. Essex Police were notified via email.

1.6.8 *Multi-Agency Risk Assessment Conference (MARAC)*: Deborah was referred to the MARAC by Essex Police following an incident involving Ryan in January 2012. Her case was heard in March 2012. Victim Support stated that Deborah's case was closed. Essex Police shared information about the January incident, and one further incident in March. Information was shared from Housing, Probation and NEP about Ryan. Actions were for Safer Places (a voluntary sector specialist domestic abuse provider covering west Essex) to post information about their service to Deborah; for Essex Police to carry out a welfare call; for information to be shared with Hertfordshire MARAC; and for NEP and Probation to "*update*" MARAC about Ryan. These actions were completed.

1.6.9 *General Practice*: Deborah attended her General Practice twice in January 2012 to seek help for stress, she was signposted to a voluntary sector service, who she did not contact. She next attended her General Practice in December 2012 to seek help again for stress, referring to Ryan and other issues, and also asking for help with regard to her alcohol use. She was signposted to community services, who she did not contact. Deborah attended her General Practice again in January and February 2013, and was then referred to the Community Mental Health Team. Deborah returned to her General Practice in January 2015 when she again asked for help with her alcohol use; she was signposted to a community service which she did not contact.

1.6.10 *Community Mental Health Team (CMHT), Community Drug and Alcohol Team (CDAT, now STaRS) and Alcohol and Drug Advisory Service (ADAS)*: Following the referral from her General Practice, Deborah had a joint assessment by CDAT and CMHT in March 2013. She was taken on by CDAT and discharged by CMHT. Deborah had a health assessment in September 2013 (as she had not attended a series of appointments until then; she was at that time attending a 'Preparation for Change' group). Deborah underwent inpatient detox in December 2013 following which she was referred to ADAS and discharged to her General Practice. Deborah had no contact with ADAS.

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1.6.11 *Princess Alexandra Hospital*: Deborah attended the hospital in 2014 with regard to a physical health issue in early 2015, in which her alcohol use was noted.

The Facts: Ryan

1.6.12 *Education*: Ryan attended secondary school from September 2003 to November 2007, at which time he was excluded due to his behaviour. He then attended the Integrated Support Service until summer 2008.

1.6.13 *Connexions (an advice, guidance and support service for young people)*: Ryan was in contact with this service from 2007 to 2009 for support with work and training opportunities, and again from July 2010 to March 2011 when he was assisted in a more intensive way with applying for work and then for benefits. Following a period of non-contact his case was closed in May 2012.

1.6.14 *General Practice*: Ryan attended his General Practice in January 2010 with regard to his mental health, and the General Practice referred him to the mental health service with concerns that Ryan may be exhibiting symptoms of psychosis (see NEP below). From then to April 2012 the General Practice received notifications from NEP about Ryan's care. Ryan attended twice in that time with physical health concerns and for support with applying for benefits. Ryan then had no contact until he re-registered with the same General Practice in April 2015 following his release from prison (see HMP below). He referred to his previous mental health history and that he had difficulty sleeping. He was treated for the latter and referred to North Essex Partnership University NHS Foundation Trust (NEP) in relation to the former, who notified the General Practice when Ryan was discharged in May 2015. Ryan last attended the General Practice in June 2015 for further help with insomnia.

1.6.15 *Essex Partnership University NHS Foundation Trust (EPUT[3])*: Ryan was referred into the mental health service by his General Practice in January/February 2010. Initially he was under the care of the Crisis Resolution and Home Treatment Team, who saw Ryan almost daily. He was treated with anti-psychotic medication, and his drug use was discussed as possibly causing the symptoms. He was discharged by that Team in March 2010 to another service in NEP: the Early Intervention in Psychosis (EIP) Team. He was under their care until entering prison for grievous bodily harm against his father in August 2012. He never attended the appointments made for him at the team's office (except one made at an alternative office); his interaction with the team was through home visits, which were carried out on average once a month. The purpose of these was to monitor Ryan's mental

[3] Ryan received services from North Essex Partnership University NHS Foundation Trust (NEP), which during the course of the Review merged with South Essex Partnership University NHS Foundation Trust to become EPUT

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state and compliance with medication, and to encourage and support him into work. Ryan's aggression towards Deborah and his father were noted, and a referral was made to family therapy; Ryan later cancelled the appointment. From August 2010 Ryan stopped being in contact directly with the EIP Team, who continued to engage with Ryan's father. From November 2010 Ryan was again engaged with the EIP Team, due to his father reporting significant concerns. He was then detained under Section 2 of the Mental Health Act on two occasions in a mental health inpatient unit. The second section ended in February 2011. Ryan was then in contact with a Care Coordinator in February and March 2011, following which his contact was sporadic, while his father remained in regular contact with the Team. It was recorded that home visits and contact would not be attempted as Ryan was not engaging with the Team. When Ryan's father was contacted in September 2011 he reported concerns for Ryan and a home visit was conducted. In January 2012 Ryan was assessed while in police custody following a domestic incident involving Deborah. Ryan agreed to meet with the Care Coordinator in February 2012 provided his drug use was not discussed. Two home visits took place; a plan was made to continue to support Ryan. He was not seen again by the EIP Team. Ryan's father remained in telephone contact with the EIP Team. He was discharged to the Mental Health In-Reach Team at HMP Bedford (see below). There are no records to suggest his Care Programme Approach, which structure his care, was transferred over. When Ryan was referred by his General Practice in April 2015 he was assessed over the phone by the Access and Assessment Team and then discharged as he declined the service.

1.6.16 *Essex Young People's Drug and Alcohol Service*: Ryan was referred to this service by the Youth Offending Service in May 2010. A worker met with Ryan at that point; there were no further records on the system of contact with Ryan, but there were contacts recorded by the Youth Offending Service and NEP EIP Team that the worker had engaged with Ryan who had reduced his drug use. Ryan's case was closed in August 2010 following a home visit.

1.6.17 *Police*: In addition to the domestic abuse incidents reported by Deborah and Ryan's father, Essex Police had 12 contacts with Ryan over a number of drug and other offences such as theft and assault; three led to criminal justice outcomes. The earliest of these was in 2005 when Ryan was aged 13. In 2007 he was given a warning that led to Ryan being in contact with the Youth Offending Service (see below). In early 2009 he was convicted of a drug offence and given an absolute discharge at court. Later in 2009 he was convicted of assault and given a Referral Order to the Youth Offending Service (see below). Ryan was in contact with Hertfordshire Constabulary four times from December 2011 to August 2012;

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these were all related to domestic incidents, including assault, from Ryan towards his father. The first two incidents led to no further action; the third incident (assault) led to a fine; and final incident in August 2012 led to Ryan's imprisonment until April 2015 for grievous bodily harm against his father.

1.6.18 *Youth Offending Service (YOS)*: YOS were in contact with Ryan twice in 2008 as he completed victim empathy work to meet the requirements of the Final Warning issued for offences of handling stolen goods and assault. Ryan was again engaged with YOS following pleading guilty for assault in November 2009; the Referral Order began in January 2010. The order was suspended in February 2010 due to Ryan's mental health and recommenced in April 2010. Ryan completed the Order, having fulfilled the requirements in, August 2010.

1.6.19 *Her Majesty's Prison Service (HMP) / National Offender Management Service (NOMS)*: Ryan was in custody from his arrest in August 2012 for grievous bodily harm against his father, through to his sentencing in June 2013 and then to his release following the serving of that sentence in April 2015. During that time he was held in six different prisons and moved eleven times. Ryan was moved to the Open Estate due to his progression through his sentence and-categorisation to Category D (eligible for 'open' conditions[4]). Two months later he was transferred back to closed conditions due to having no completed Offender Assessment System (OASys) (see Probation below). Due to mis-recording by Probation (see below), Ryan's sentencing planning meeting did not take plus until August 2014, at which point there was insufficient time for him to complete the requirements of Thinking Skills Programme; victim empathy work; Anger Reduction programme. When released from prison in April 2015, Ryan was then under licence with Probation (see below). His release address was Deborah's home, although he did not initially return there.

1.6.20 *Mental Health In-Reach Services (in prisons)*: Ryan was in contact with Mental Health In-Reach Teams in three different prisons: from August 2012 to March 2013, and in January/February 2015. The records submitted to the Review do not always link together so a full picture throughout Ryan's time in prison has been difficult to establish. In the earliest period, he was assessed and prescribed anti-psychotic medication in December 2012, this had ended by March 2013 (there are no records as to why). In one prison, he was seen twice by the health service and did not disclose any mental health issues or history. Ryan was not engaged with a Mental Health In-Reach Team again until January

[4] Category D prisons ('open conditions') are for those male prisoners considered to pose a low risk in relation to security, and protection of the public; the prisons usually have less obvious forms of security, for example less fencing or high walls; prisoners might be able to control when they go in and out of their cells.

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2015 when he was assessed as having no current mental health issues and was discharged.

1.6.21 *National Probation Service*[5]: Ryan had two periods of contact with probation. One was from October 2011 to April 2012, when Ryan was given a six-month Community Order for criminal damage at Deborah's house. Ryan attended monthly supervision meetings with the probation officer, with the following objectives: victim awareness; housing; agency involvement in respect of drugs and mental health (Ryan's lack of engagement and motivation were noted with regard to this last objective). Accommodation options were pursued with and for Ryan; and the officer engaged with Ryan over his drug use. Victim empathy was carried out. There was regular liaison with the NEP EIP Team. At the end of the Order Ryan was considered to be "*more stable*" and was noted to be receiving benefits. Ryan was next in contact with probation when they completed a pre-sentence report for Ryan in June 2013 prior to his sentencing for the grievous bodily harm against his father committed in August 2012. The report found that Ryan posed a medium risk of harm to a known adult (his father); lacked victim empathy; that the psychiatric report did not identify any symptoms of psychosis or mood disorder; and that Ryan's serious risk of harm to a known adult was unlikely to reduce unless he addressed his drug use, intense family conflict, very limited victim awareness, and beliefs that supported the use of violence. The risk assessment was added to the OASys system[6] incorrectly as high, when it should have been medium. The outcome of this was that: the prison believed Ryan to be high risk and therefore the responsibility for sentence planning was with probation; and probation believed him to be medium risk and therefore the responsibility for sentence planning was with the prison. As a result, sentence planning did not take place until 14 months into Ryan's sentence, in August 2014. At the sentence planning, and a subsequent assessment in December 2014, Ryan's accommodation was discussed as he could not return to live with his father, and Deborah had said to probation that Ryan could not live with her. Ryan's licence conditions were to: comply with any requirements specified by his supervising officer for the purpose of ensuring that Ryan addressed his substance misuse; and not to enter his father's address without the prior approval of his supervising officer. Ryan met with the probation officer weekly following his release in April 2015. Accommodation was

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[5] Ryan's contact with Probation began prior to the creation of the National Probation Service and Community Rehabilitation Companies. His first contact was with the then Essex Probation Trust. His second contact was with the then Hertfordshire Probation Trust, which became the National Probation Service (for Hertfordshire) during his time with them. The name 'Probation' is used to refer to all organisations.

[6] Probation assessment tool that provides a consistent framework to offender managers in assessing an individual's risk of serious harm and likelihood of re-offending

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the main focus: Deborah and Ryan's father were paying for Ryan to stay in a hotel but this was not sustainable. Probation felt that Ryan was "*putting obstacles in the way of realistic housing options*", for example refusing certain offers due to his mental health, but not seeking help for this. Ryan's sentence planning objectives remained the same (see prison section above) but he was not referred to any programmes or a drug support service. In May 2015 the probation officer approved Ryan's request to live with his mother. In June 2015 Ryan's supervision appointments were reduced to monthly, and his last one, in which no concerns were noted, was at the end of June 2015.

1.6.22 *Housing*: Ryan applied to Uttlesford District Council for support with housing in November 2011; he was referred to a supported housing project run by Genesis Housing, who assessed Ryan as not suitable. Ryan sought help from East Hertfordshire Council housing service in April 2012; he was given information about available services and he then applied to go on the housing register where he remained until his conviction for the two homicides.

1.7 Conclusion

1.7.1 Information gathered for this DHR indicates that Deborah was a victim of domestic abuse from Ryan. The disclosures concerned verbal abuse and aggression, economic abuse, threats of violence and sexual violence, and damage to her property. This could be seen as a pattern of coercive control tactics by Ryan to keep Deborah in fear of what he may do if she stopped supporting him. For the family, it felt that Ryan's unstable mental health drove much of his behaviour. It is not possible for this DHR to draw a conclusion on this, or how Deborah experienced at the time, but it was clear from the information provided to the DHR that she was in fear of what he could do.

1.7.2 From the point of his release from prison in April 2015, to the homicide, Ryan was not a cause for concern to any of the agencies with which he was involved. He received ongoing support from his parents, culminating in Deborah allowing him to live with her, despite the fact that she did not want him to, because of his previous behaviour.

1.7.3 That Ryan could be violent was known by police (Essex and Hertfordshire), probation and NEP; but NEP's substantive contact with Ryan had ended in 2012, and probation's contact with Ryan was reduced to monthly supervision at the time he moved in with Deborah – and relied on Ryan self-reporting any issues, which he did not do.

1.7.4 Deborah and Ryan's family, in their feedback to this DHR, indicated that the homicide came *'out of the blue'* in the context of a period of time when Ryan's behaviour had not caused any concern, and he and Deborah appeared to be getting on well.

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1.7.5 The family were aware of Deborah's friendship/relationship with Michael, but there was no indication that he was at risk from Ryan.

1.7.6 Ryan did pose a clear and recognised risk to his family members, primarily Deborah and his father. There were actions which, if taken, could have reduced the possibility of Ryan being in a position to attack Deborah and Michael, which were:

(a) More proactive management of Ryan's risk and support needs by probation, including referrals to drug and alcohol services, mental health service, and relevant offender programmes (a precursor to this would have been ensuring that his licence conditions were more specific, as outlined in his sentence plan). With the service referrals, there are indications in Ryan's history that he might not have engaged: but they should have been made, and Ryan worked with in a motivational way to improve his engagement. Combined with information gathering from other agencies to inform the understanding of Ryan's risks, this could have enabled a more comprehensive risk management plan around Ryan. This should have included explicit recognition of, and response to, Ryan as a domestic abuse perpetrator. Ryan's lack of engagement was a risk factor.

(b) Pursuit of alternative housing for Ryan: Deborah clearly felt pressured to have Ryan live with her; and it was not a safe option, given his history of aggression, violence and abuse against both parents. Probation should have explored this background, and spoken with Deborah. Probation faced difficulties in accessing housing advice and suitable accommodation for all offenders, and this was a particular problem with Ryan as there were options he would not consider (see further discussion below, 4.2.4). Adequate understanding was not shown of the pressure felt by Deborah to care for Ryan and not leave him homeless; this responsibility should not have fallen to her.

(c) Deborah should have received support that responded to her holistically, in a way that was led by her needs and what she felt she needed, rather than categorising her according to service-led labels (whether this was 'alcoholic', 'mental health' or 'domestic abuse victim'). This needed to recognise the pattern of abuse and violence she was experiencing from Ryan. This could have been done by the services she was engaged with, or by a new one that they could have referred her to, such as Safer Places. This support could have led to Deborah having the strength to manage her relationship with Ryan, in such a way that led to her not having to accept him living with her.

1.7.7 Ultimately, Ryan is responsible for the homicides. A theme throughout his engagement with agencies was a failure to take responsibility for his actions. Deborah, or agencies, could not make him do this or take that responsibility for his behaviour on.

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1.8 Lessons to be Learned (Key issues arising from the review)

1.8.1 *Identification, naming and understanding of domestic abuse and coercive control*

(a) STaRS, Essex Police, Hertfordshire Constabulary, Probation (Hertfordshire and Essex) and NEP all had information about domestic abuse perpetrated by Ryan against Deborah and his father. Deborah's General Practitioner did not know but had a number of opportunities to enquire with Deborah that could have led to a disclosure. A recommendation (1) is made for the Clinical Commissioning Group to improve General Practice's engagement with the MARAC process.

(b) STaRS and NEP did not explore with Deborah what she was experiencing from Ryan, and did not name the disclosures provided as domestic abuse, using instead terms such as 'difficult relationship', 'anger' and 'aggression', or 'family conflict'. Essex Police and Hertfordshire Constabulary did specifically identify the incidents as domestic abuse, and acted according to their procedure for this type of incident. Officers did not respond to the ongoing nature of Deborah's experiences. Instead of seeing the pattern of abusive behaviours Deborah (and Ryan's father) experienced from Ryan, they dealt with each incident as a new episode (with a new risk assessment each time), and did not see or review the whole situation, and assess the risk Ryan posed from that perspective. A recommendation (4) is made.

(c) Deborah was not seen as a whole person, with many different needs, in relation to a situation, and relationship, that she was managing on a day-to-day basis. The Essex Police DALO offered emotional support but this was short-term; referrals to other services could have followed. The General Practice, CDAT and ADAS could have worked better together to ensure Deborah's needs were met; a recommendation (2) is made.

(d) Probation (Hertfordshire) were fully aware of Ryan's abuse against his father, as their involvement with him was as a result of Ryan's serious assault against him. While their actions to assess and manage Ryan's potential risk to his father were appropriate, this was not extended to Deborah, and she was not seen as being at equal risk from Ryan.

(e) The Review Panel discussed the fact that, because the domestic abuse Ryan perpetrated was against his parents it was not necessarily within some people's understanding of 'domestic abuse', which is sometimes assumed to only occur from an individual to their intimate partner/ex-partner. While the Government definition of domestic abuse (including before it was amended in March 2013) has always including 'family members', awareness, and labelling, of such situations is not as widespread.

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(f) There was also discussion around the appropriateness of standard responses to domestic abuse being applied to situations of family-based abuse such as this. This was identified by probation (Essex) in that the officer working with Ryan used victim empathy work rather than domestic abuse specific interventions, as the latter are targeted at male perpetrators of abuse against female intimate partners.

(g) The DASH-2009 risk identification checklist is recognised rightly as a useful tool in identifying the risk a victim faces from a perpetrator. It is an evidence-based tool, developed through a review of domestic homicides and the identification of common factors prior to those homicides. The majority of domestic homicides involve a male killing his female partner/ex-partner[7] and therefore the results of any such review would be skewed towards this situation. Key questions in the DASH-2009 such as those around pregnancy and child contact were not relevant in this case, and those around separation must be viewed differently in a case where the victim is the mother of the perpetrator and potentially feels an additional responsibility, even guilt, for his behaviour and his wellbeing due to societal expectations of parents and particularly mothers[8]. This may have led to an inaccurate identification of risk.

(h) The DASH should be used wherever possible with identified victims of domestic abuse; but more work is needed to understand the particular risk factors that are relevant in family-based domestic abuse, and specifically from this case, how it interacts with the perpetrator's mental health and drug use.

(i) More awareness and understanding is required, locally and nationally, around familial abuse. A recommendation (5) is made for the Home Office to build on the recent DHR Key Findings report to utilise more DHR reports to develop an understanding of the risk factors relating to familial abuse.

(j) In Essex a 2016 Thematic Review found that agencies needed to "*consider a strengthened response to tackling domestic abuse in family related cases*". Some action in relation to General Practices has begun. The Central Southend Essex and Thurrock (SET) Domestic Abuse Team disseminate learnings and recommendations to the SET Domestic Abuse Joint Commissioning Group and the Domestic Abuse Board (both of which are multi-agency) and to the wider remit of partners through

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[7] http://web.ons.gov.uk/ons/dcp171778_432410.pdf: of all female victims 44% were killed by a partner/ex-partner and 17% by a family member; of all male victims 6% were killed by a partner/ex-partner; 14% by a family member.

[8] Home Office (2015) *Information Guide: Adolescent to Parent Violence and Abuse (APVA)*

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dissemination seminars to share the learnings and recommendations. Five DHR learning seminars have been delivered across SET in 2017.

1.8.2 *Responses to co-existing mental health, drug/alcohol and domestic abuse*

(a) It is well known that mental health, drug/alcohol use and domestic abuse often co-exist, and the overlapping and interlinking issues can present particular challenges to services and families[9]. The perpetrator may present mental health and/or drug use as the reason, or excuse, for their abusive behaviours, and a focus by agencies on those issues can mask ongoing abusive behaviours and their impact on victims. Victims also at times blame the abuse on the perpetrator's substance misuse, as a way of trying to 'make sense' of their experiences from a loved one[10].

(b) Mental health has been shown to be a feature in a significant number of domestic homicides in which an adult son has killed his parent, often mother[11]. Relevant to this case, the research demonstrated that this is an additional risk factor when combined with substance misuse and previous criminality by the perpetrator.

(c) Deborah misused alcohol, which has been identified as a way in which victims of domestic abuse 'self-medicate' in an attempt to manage their feelings in the face of a distressing situation[12].

(d) Despite both Deborah and Ryan disclosing issues with both mental health and substance misuse, agencies focused on just one of those issues, thereby not addressing them holistically as individuals with many factors impacting on their wellbeing, safety and needs.

- STaRS focused exclusively on detox for Deborah, as did her General Practitioner. This effectively left Deborah unsupported in relation to her mental health and her issues with Ryan and his abuse.
- The NEP records mention Ryan's drug use sporadically but there was no evidence of direct, sustained engagement with him on this, or records of staff considering how his drug use and mental health issues interacted. The absence of a mental health diagnosis was a part of this. NEP's exclusive focus on Ryan's mental health led to missed opportunities to respond to the domestic abuse he was responsible for.

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[9] AVA Stella Project (2016) *Complicated Matters: A Toolkit Addressing Domestic and Sexual Violence, Substance Use and Mental Ill-Health*

[10] Galvani, S. (2010) *Supporting families affected by substance use and domestic violence: Research report* p46

[11] op. cit. Home Office (2016) and Sharp-Jeffs, N. and Kelly, L. (2016)

[12] Humphreys, C., Thiara, R. and Regan, L (2005) *Domestic Violence and Substance Use: Overlapping Issues in Separate Services?* Home Office / Greater London Authority

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(e) The reality for many service users is that they will present with mental health issues and drug and/or alcohol issues together; while it may not be possible to fully assess someone's mental health in the midst of their addiction or reliance on drugs or alcohol, to attempt to address an individual's problematic substance misuse in isolation from the other issues they are trying to manage is neither likely to succeed nor does it recognise the complexities of many people's day-to-day lives. The reality for Deborah was that, once she had processed through detox, there was no reassessment of her mental health needs and they remained unaddressed – and ultimately, as we know from her attendance at her General Practice, her alcohol use again became a problem for her.

(f) A recommendation (6) is made for the relevant agencies to review their practice in relation to dual diagnosis to ensure it reflects policy.

(g) The Essex DHR Thematic Review led to the following action, which has been completed: "*Revise working protocols across the substance misuse system (including new risk assessments) to ensure victims and perpetrators are identified and proactively engaged.*" In addition, an action is in progress to ensure domestic abuse is clearly featured within the developed mental health strategy.

(h) An outstanding issue identified by this review is that Ryan's sentence plan requirements (which were unable to be met during his time in prison) were not added to his licence requirements. As this practice appears to vary between individual prisons, a national recommendation (3) is made for NOMS to take action to address this. The SET Domestic Abuse Partnership lead is currently in discussion with the Essex Partnership Trust to take this work forward with an aim to align strategies where possible.

1.8.3 *Responses to families supporting someone with a substance misuse / mental health issue*

(a) The family expressed to the DHR the feeling that, throughout the period of Ryan's engagement with NEP, they were not supported as they would have liked to have been. This could have taken the form of advice and guidance on how to respond to or manage Ryan's behaviour, and a more concerted approach from NEP on engaging Ryan in services. In reviewing the chronology from NEP, the impression is given that Ryan's 'disengagement' from services was not consistent and there were times when he stated he was "*happy*" for interventions to continue, yet they were not.

(b) Information from Deborah and from Ryan's father was at times given a lot of weight (as outlined in the NEP section) and at other times not enough. It was clear to practitioners that they were both heavily involved in Ryan's care and were not in a

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position to permanently remove themselves from that, even if at times they may have wanted to. Despite the fact that Ryan declined consent for information to be shared with his parents (which NEP adhered to) NEP could have more thoroughly involved them in Ryan's care through the joint meetings with Ryan present, fully taking on board their concerns over Ryan's behaviour and acting on those concerns (in the context of professional assessment of Ryan); and through offering them additional support for themselves.

(c) That they didn't likely left Deborah feeling unsupported in her day-to-day management of Ryan and her relationship with him. Her occasions of contact with agencies gave some impression of this, for example she told Essex Police that the abuse from Ryan was a "*regular occurrence*". Practitioners failed to see Deborah as a whole person, with needs of her own that, even if they couldn't meet directly, they could have recognised and ensured appropriate referrals took place.

(d) NEP offered Ryan's father a carer's assessment; he passed this to Deborah (presumably as Ryan was living there at the time) and it was noted that she declined this assessment. It may be that Deborah did not view herself as a 'carer'; many people don't. A more open conversation about Deborah's needs could have led to an offer of referral or support, where the closed nature of offering just a carers assessment did not. A recommendation (7) is made.

(e) The family were also dissatisfied with the response from Essex Police; in reviewing these interactions, there were incidents in which the responses could have been improved, but the missing piece was in taking the opportunity of the MARAC to review the situation as a whole – to look at all of the incidents, the different issues faced by Deborah, Ryan and the family – and address those issues holistically through the proactive offering of support from an appropriate agency (e.g. IDVA, or another). Instead the MARAC appeared to achieve little.

(f) As a result of all of this, Deborah and the family felt unsupported. There were many agencies that could have offered support to Deborah and the family in dealing with the day-to-day reality of living with Ryan, either themselves or through referral to another agency. A recommendation (8) is made.

1.8.4 *Individuals under mental health care in the community who enter prison*

(a) This review struggled to gain a complete picture of Ryan's engagement with mental health services during his time in prison from August 2012 to April 2015. This period was felt to be important because, prior to his imprisonment he had been under the

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care of NEP for nearly three years; yet on his release he was under no mental health service.

(b) Pre-trial Ryan was held in two prisons, and moved between them (for court hearings) three times.

(c) Having been sentenced, Ryan was held in five prisons until his release, and was moved seven times. His longest time between moves was five and a half months; his shortest was twelve days. The reasons for his moves have been outlined in the HMP section (see 3.24).

(d) Pre-trial Ryan was assessed by two Mental Health In-Reach Teams (in HMP Bedford and HMYOI Glen Parva, see 3.25). Following sentence he was assessed by one (in HMP Rochester, see 3.27) and by one Primary Mental Health Team (HMP Ford, see 3.25). On three occasions (in HMP Blundeston, HMP Rochester and HMP Ford) no concerns were noted. Ryan frequently told medical staff in the prisons that he had no history of mental health issues.

(e) This situation is drawn out by the Independent Mental Health Investigation, which concludes that a significant factor was the apparent closing of the Care Programme Approach (CPA) that Ryan had been under with NEP. Ryan was discharged by NEP to the Mental Health In Reach Team at HMP Bedford in January 2013, and although it was not recorded, it can be assumed that he was also discharged from the CPA. There are no references to a CPA by the Mental Health In Reach Teams or Primary Mental Health Teams Ryan was in contact with.

(f) NEP expected Ryan to come back into their care following his release; but (the Independent Mental Health Investigation concludes) without a CPA in place, it was not possible for there to be any continuity to Ryan's care. Each mental health service made their own assessment of Ryan's care, at times without any information as to his history other than what Ryan himself disclosed. The Investigation states that NEP's Discharge Policy does not cover situations in which an individual's care is transferred to prison; we do not know if this is the case in the other Trust's delivering services in prisons but this review has enough information to conclude that the transfer of care between prisons is inconsistent.

(g) A recommendation (9) is therefore made for the Trusts involved in this case to amend their Discharge policies in light of this learning. A national recommendation (10) is also made for NHS England to share this learning.

1.8.5 *Housing for offenders*

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(a) A recurring discussion for the Review Panel was that of Ryan's accommodation; this reflected the emphasis placed on this issue by Ryan and probation following Ryan's release from prison in April 2015. The actions taken, and what was missed, by the probation officer from April 2015 onwards are outlined in the NPS section.

(b) NPS highlighted the difficulties they have in trying to find appropriate accommodation for offenders post release; this has been exacerbated since the Transforming Rehabilitation split into NPS and Community Rehabilitation Companies, in which the housing link remained with CRCs, increasing the difficulties NPS faced. NPS have no direct access to housing resources, and rely on local authority housing departments for support.

(c) HM Inspectorate of Probation published a review of Transforming Rehabilitation (May 2016) that found "*over two-thirds of offenders released from prison had not received enough help pre-release in relation to accommodation, employment or finances*"[13].

(d) These difficulties were echoed by YOS, who also find that accommodation for young offenders becomes a dominant and distracting feature of supervision.

(e) NPS have informed the DHR that this issue has been raised regionally and nationally. Locally, Hertfordshire NPS have met with the local Heads of Housing Departments to try to improve their contribution to MAPPA. This resulted in the allocation of one Head of Housing to the MAPPA, plus an option of additional funding contribution to support high risk offenders into private rented accommodation on release. The discussions are ongoing.

(f) Additionally, the issue of offender accommodation remains one of the main significant risks for both MAPPA Strategic Management board risk register and the NPS Divisional risk register: it is an issue NPS cannot address alone, and partnership working with Housing support and advice services, and Housing providers, are essential.

(g) The independent chair spoke with the Reducing Reoffending Coordinator for the Essex Police and Crime Commissioner, and the following information was provided on developments in Essex to address this issue, including the engagement of the Essex Housing Officers Group with the Crime Reduction Strategy, and a new 'Trailblazers' pilot of mentors with specialisms including offenders to support practitioners working to prevent homelessness.

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[13] http://www.justiceinspectorates.gov.uk/hmiprobation/wp-content/uploads/sites/5/2016/05/Transforming-Rehabilitation-5.pdf

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(h) The Review also heard that Through the Gate resettlement services began nationally in 2015 (shortly after Ryan was released from prison), with the aim of improving the resettlement process for prisoners being released, including helping prisoners to find accommodation, as well as employment, training or education, and help with managing their finances, benefits and debt.

(i) A recommendation (11) is made for Hertfordshire MAPPA Strategic Board.

1.8.6 *Responsibility of agencies in finalising referrals*

(a) The police made a second referral to MARAC after the incident of 7 March 2012. The MARAC team did not receive this, and the referring officer did not follow it up. The incident was discussed at the MARAC meeting on 13 March 2012, and it may have been felt by the MARAC team that one meeting was sufficient. But it was the responsibility of the referring officer, having made that referral, to follow up and ensure that it got through; and to record this, and any decision-making in relation to this.

(b) The Victim Support IDVA service emailed the Domestic Abuse Liaison Officer informing them that the IDVA had not been able to make contact with Deborah. No follow up was made to ensure that this email had been received and acted upon in relation to ensuring Deborah was safe and her needs being met. Joint working should have been considered to establish contact with Deborah.

(c) This was particularly notable at the MARAC meeting referred to above, in which the IDVA service had recorded Deborah's case as 'closed': the MARAC meeting was the opportunity to attempt to engage with her again, and the MARAC Chair and other agencies could have challenged the IDVA service over their lack of engagement with Deborah. Given the skills that IDVAs have in supporting people in Deborah's situation, and their role as the independent advocate for that person, it is very unfortunate that Deborah never got to know about the IDVA service, or what they could offer her.

(d) STaRS made a referral for Deborah to ADAS, so that she received ongoing support following detox and case closure. No checks were made to ensure that Deborah had engaged with ADAS and yet STaRS closed Deborah's case, thereby leaving her unsupported. Deborah's General Practitioner was requested to make ongoing prescriptions; with Deborah not engaged in a support service, there was no way to ensure that Deborah continued to collect these prescriptions, which we now know she did not.

(e) These examples suggest that for some agencies, a 'referral' is seen as the end of their involvement. This should not be the case. An agency holds responsibility for an individual until such time as they are satisfied that the agency referred to has taken on

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the care of that individual. This did not happen in these cases, leaving Deborah unsupported and, in the case of (b) and (c), unaware that the IDVA service existed and could help her.

(f) A recommendation (12) is made.

1.8.7 *Clients who do not engage with a service*

(a) Both Deborah and Ryan appeared to struggle to fully engage with support services. This varied at different times and in relation to different agencies. In particular in drug and alcohol services (in this case STaRS, ADAS and EYPDAS), domestic abuse services (Victim Support) and mental health services (NEP), engagement with clients is an ongoing challenge. The nature of the problem that leads individuals to be in need of these support services is often the very reason they find it hard to sustain engagement.

(b) This has been recognised in research looking at alcohol use and domestic abuse in published Domestic Homicide Reviews[14]:

"*The more crucial question in relation to identifying change resistant drinkers is whether the client had difficulty in maintaining engagement with specialist alcohol services. Again, this project found a distinct pattern:*

- *In six of the eight cases (75%) where the perpetrator was referred to specialist alcohol services the perpetrator had a pattern of non-engagement.*
- *In eight of the ten (80%) relevant cases the victim had a pattern of non-engagement with specialist services.*

This pattern is not surprising. At any one time the vast majority of problem drinkers are not engaged in services or even a process of change. Public Health England has suggested that at any one time 75% of dependent drinkers are not engaged with services.

What the DHR reports highlight, however, is a lack of general understanding of how perpetrating or experiencing domestic abuse may be a factor in someone being a change resistant drinker, i.e. struggling to engage with or benefit from an alcohol treatment service."

(c) Agencies have a duty to do all they can to facilitate and encourage engagement, including identifying possible barriers to that engagement and working to remove them, within the limitations of their service delivery. The Blue Light Project has

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[14] Alcohol Concern and AVA (2016) *Domestic Abuse and Change Resistant Drinkers: Preventing and Reducing Harm – Learning Lessons from Domestic Homicide Reviews*

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identified ways in which alcohol agencies can support those people identified as 'change resistant' or 'reluctant to engage': https://www.alcoholconcern.org.uk/blue-light-project

(d) STaRS were proactive in pursuing Deborah and over time offered many opportunities for her to engage, and eventually she felt able to. As outlined in the previous section, neither ADAS nor Victim Support were proactive in ensuring that Deborah was offered a service, but with new ways of providing services this issue has been resolved.

(e) Despite Ryan stating he did not want to engage with NEP on 2011-12, they kept his case open; but, as outlined above, there was little evidence of ongoing proactive attempts to engage him, but an apparent acceptance of his lack of engagement.

(f) A recommendation (13) is made.

1.9 Recommendations from the review

The recommendations below should be acted on through the development of an action plan, with progress reported on to the Uttlesford CSP within six months of the Review being approved by the Partnership. Review Panel agencies to report on the progress of their IMR recommendations to the Uttlesford Community Safety Partnership within the same timeframe.

1.9.1 **Recommendation 1** (see 1.8.1.b)

West Essex Clinical Commissioning Group to ensure that training is made available to General Practices on identifying domestic abuse and risk to ensure that they are equipped to refer appropriately to the MARAC; to have reference to the materials available through the IRIS project[15] to support this. To report to the Uttlesford CSP on the actions taken.

1.9.2 **Recommendation 2** (see 1.8.1.c)

West Essex Clinical Commissioning Group to work with Essex Partnership University NHS Foundation Trust, STaRS, ADAS and other commissioned drug and alcohol and mental health services to establish a procedure for joint working with General Practices to ensure that individuals receive support in a coordinated way. To report to the Uttlesford CSP on the actions taken.

1.9.3 **Recommendation 3** (see 1.8.2.h)

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[15] Identification and Referral to Improve Safety: http://www.irisdomesticviolence.org.uk/iris/

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Her Majesty's Prison and Probation Service (HMPPS) to take action to ensure all prisons have adequate structures in place to communicate with the National Probation Service prior to an offender being released to ensure that licence conditions reflect sentence plans.

1.9.4 **Recommendation 4** (see 1.8.1.b)

Essex Police, Hertfordshire Constabulary, Essex Partnership University NHS Foundation Trust and STaRS to review their domestic abuse training and materials to ensure that practitioners understand domestic abuse as a pattern of coercive and controlling behaviours, not as a single incident. For local commissioned domestic abuse specialist services to be involved to support this understanding. To report to the Uttlesford CSP and the Essex Southend and Thurrock Domestic Abuse Strategic Board on the actions taken.

1.9.5 **Recommendation 5** (see 1.8.1.i)

Home Office to utilise DHR findings to develop and share nationally an in-depth understanding of the risk factors relating to familial abuse.

1.9.6 **Recommendation 6** (see 1.8.2.f)

STaRS and Essex Partnership University NHS Foundation Trust to review their dual diagnosis approach in light of the learning in this DHR, for example through a dip sample audit of cases, to ensure that policy is reflected in practice; and to ensure that, where a person presents with substance misuse and mental health issues, that both are addressed before a person is discharged. To take appropriate action where necessary and feed back to the Uttlesford CSP.

1.9.7 **Recommendation 7** (see 1.8.3.d)

The Essex Adult Safeguarding Board to review, and amend where necessary, multi-agency policy and training to address the learning from this review concerning support offered for families with caring responsibilities, specifically: conversations with those who have caring responsibilities should not be limited to offering carer's assessments, and must be open, non-judgemental and avoid labelling someone as 'a carer', to allow individuals and families to express their needs and wishes, and be directed to appropriate support.

1.9.8 **Recommendation 8** (see 1.8.3.f)

The Essex Southend and Thurrock Domestic Abuse Strategic Board to share with all members the learning in this DHR in relation to the need for agencies to engage with individuals holistically: and for agencies to integrate this into training to ensure that all of an individual's issues and needs are identified, and appropriate referrals are made where necessary.

1.9.9 **Recommendation 9** (see 1.8.4.g)

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The mental health NHS Trusts named in this report to amend their Discharge Policies to ensure that they set out clearly the procedure for when a patient under their care is transferred into prison (or into a different prison), and that these procedures take into account the learning from this review.

1.9.10 **Recommendation 10** (see 1.8.4.g)

That NHS England share nationally the learning from this review, as addressed by recommendation 13, and encourage all mental health Trusts to ensure their Discharge Policies adequately address cases where patients transfer into or between prisons.

1.9.11 **Recommendation 11** (see 1.8.5.i)

Hertfordshire MAPPA Strategic Management Board to work with the Local Authorities to ensure that housing departments and housing associations are adequately represented at and engaged with MAPPA and that a position of flexibility in relation to housing options for offenders is taken to support the management of risk.

1.9.12 **Recommendation 12** (see 1.8.6.f)

The Essex Southend and Thurrock Domestic Abuse Strategic Board to direct all members to review their onward referral processes in light of the learning in this DHR, and make changes where necessary to ensure that referrals are: recorded where possible; followed up to ensure they have been received; and appropriate action taken if referral has not been received / accepted. For member agencies to feedback to the Strategic Board on this.

1.9.13 **Recommendation 13** (see 1.8.7.f)

STaRS, Essex Partnership University NHS Foundation Trust, ADAS and Victim Support to review their approach and response to people who ‘don’t engage’ in the service, in light of the learning identified in this DHR, to ensure barriers to people’s engagement are identified and acted upon, and that motivational work is done that aims to improve engagement. To take appropriate action where necessary and feed back to the Uttlesford CSP. For the learning from these agency reviews to be shared through the Essex Southend and Thurrock Domestic Abuse Strategic Board.

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