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Safeguarding Adult Review
DP

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Safeguarding Adult Review Report – DP

Preface

Plymouth Safeguarding Adults Board wishes to express sincere condolences to the family and friends of Mr Tanis Bhandari, and deepest sympathies to the surviving victims of the attack in which Mr Bhandari lost his life.

It is acknowledged that the circumstances that led to this Review had deeply affected many people, particularly the bereaved families and others directly impacted by the incident.

Redactions

Statutory guidance for Safeguarding Adults Boards states that reports should be published 'within the legal parameters about confidentiality'.

In publishing the findings from any review the Plymouth Safeguarding Adults Partnership has a responsibility to consider the legal rights of all individuals mentioned or closely connected to the case, as well as any potential risk to their physical or mental health or wellbeing.

Some medical, personal and third party information contained within this report has been redacted to ensure the board fulfils its legal responsibilities in respect of privacy, data protection and prevention of harm.

The report has been reviewed by an independent lawyer.

1.0 Introduction

1.1 During the early hours of 1st January 2015 DP and another male murdered TB and inflicted very serious injuries on other males in an unprovoked attack in which a knife and an axe were used. In the months prior to the murder DP was in contact with a range of agencies. After serving a term of imprisonment in a Young Offenders Institution (YOI) for carrying a machete, he was supervised on licence by the Community Rehabilitation Company (CRC). During this period his mental health began to deteriorate markedly and he was referred to the community mental health team (CMHT) by his GP. Following a mental health assessment, DP received treatment and was to be allocated a care co-ordinator. He was arrested and bailed by the police after being found in possession of meat cleavers in company with others. Shortly before the murder took place the CRC had concluded that they could no longer safely manage DP in the community and had initiated breach action as DP had failed to comply with the conditions of his licence.

1.2 Over the years since the murder of TB took place, several single agency reviews have been conducted which identified a range of improvements to professional practice. Plymouth Safeguarding Adults Board was aware of this review activity and commissioned a Safeguarding Adults Review (SAR) after receiving a referral from Devon and Cornwall Police in September 2017. The Safeguarding Adults Board commissioned the SAR in order to identify learning from how the range of agencies in contact with DP and his family in the months prior to the murder of TB, worked together to support DP and to safeguard him from harm including management of the risks he presented to himself and others.

1.3 A panel of senior managers from partner agencies oversaw this review and membership of this panel is shown in Appendix A. The methodology adopted for this review is also shown in Appendix A. It is unusual for a Safeguarding Adults Review to take place so many years after the time of the events under review. Largely as a result of the passage of time it has not proved possible to access all relevant records or obtain the views of practitioners involved in the case. However, the single agency reviews completed by Devon and Cornwall Police and Plymouth Community Healthcare (now known as Livewell Southwest) have been shared with this Safeguarding Adults Review. These single agency reviews took place much closer in time to the incident and involved interviews with practitioners when memories were relatively fresh.

1.4 David Mellor was commissioned to be the independent author of this report. He is a retired chief officer of police and former independent chair of a Safeguarding Adults Board. He has been the independent author of a number of Safeguarding Adults Reviews and other statutory reviews and has no connection to services in Plymouth.

2.0 Terms of Reference

2.1 The period covered by this Safeguarding Adults Review (SAR) is from September 2012, when DP reached adulthood, until 1st January 2015, when the murder of TB took place. Events which took place prior to September 2012 will be included if they appear to be relevant to the terms of reference for this SAR.

2.2 The specific areas of focus will be:

- How individual agencies followed agreed policies and procedures in working with DP and his family. How staff were supported to follow agreed policies and procedures.

- Were inter-agency processes and communication effective? Did each agency understand the role and duty of others? Were practitioners proactive in escalating concerns and providing effective challenge when appropriate?

- How agencies worked together in identifying and addressing concerns regarding DP's offending, mental health and welfare.

- How agencies assessed and managed the risks presented by DP.

- What supervision and management oversight was provided during the period under review?

- Identify good practice.

- Identify what changes have been introduced as a result of learning from this case including the outcome of any individual or multi-agency review activity generated by the case.

2.3 The family of TB contributed to this review and his parents suggested the following additional areas of focus:

- Could the death of the victim have been prevented if agencies had followed policies and shared information appropriately?

- Did agencies monitor DP's social media which demonstrated his interest in weapons?

- Why wasn't DP fitted with an electronic tag to ensure he complied with his licence conditions following his release from the Young Offenders Institution?

- Why wasn't breach action taken when DP failed to attend appointments with the CRC?

- Was DP's mental health assessed whilst he was serving his sentence in the Young Offender's Institution?

- How effective were the links between the National Probation Service, the Community Rehabilitation Company and the Police?

- How are escalating concerns about persons such as DP recognised and responded to?

3.0 Glossary

Care Programme Approach (CPA) - is a framework to assess the care and support needs of people with mental health problems, develop a care plan and provide the necessary support. A care coordinator monitors the care and support provided.

DASH (Domestic Abuse, Stalking and "Honour"-based violence) is a commonly accepted tool which was designed to help front line practitioners identify high risk cases of domestic abuse, stalking and 'honour'-based violence and to decide which cases should be referred to the Multi Agency Risk Assessment Conference (MARAC) and what other support might be required.

Dynamic Risk Assessment is the continuous process of identifying hazards, assessing risk, taking action to eliminate or reduce risk, monitoring and reviewing, in the rapidly changing circumstances of an operational incident.

Mental Capacity Act (MCA): The Mental Capacity Act 2005 came into force in 2007. It is designed to protect and empower those vulnerable people who may lack capacity to make certain decisions, due to the way their mind is affected by illness or disability, or the effects of drugs or alcohol. The MCA also supports those who have capacity and choose to plan for their future. The MCA applies to everyone working in social care, health and other sectors who is involved in the support and treatment of people aged 16 and over who live in England and Wales, and who are unable to make all or some decisions for themselves.

Multi-Agency Public Protection Arrangements (MAPPA) is the process through which various agencies such as the police, the Prison Service and Probation work together to protect the public by managing the risks posed by violent and sexual offenders living in the community.

The **Police National Computer** (**PNC**) is a computer database containing records of people and vehicles used extensively by law enforcement organisations across the United Kingdom.

The **Offender Assessment System (OASys)** is used by the National Probation Service and the Community Rehabilitation Company to assess the needs and risks of an offender. It is designed to assess how likely an offender is to re-offend; identify and classify offending-related needs; assess risk of serious harm, risks to the individual and other risks; inform the development of a plan to manage the risk of harm presented by the offender; link the assessment to the supervision or sentence plan; indicate the need for further specialist assessments and measure change during the period of supervision/sentence.

4.0 Synopsis

The sequence of events leading up to the murder of TB is complex and in this synopsis it will be necessary to describe these events in some detail. The following brief summary of these events has been prepared by way of an introduction:

24th December 2013 – DP arrested after punching another male. DP had been drinking and resisted arrest. Whilst in custody he disclosed mental health concerns. He was charged and refused bail by the police.
26th December 2013 – DP granted bail by Magistrates Court.
13th January 2014 – DP appeared at Magistrates Court to answer charges from the above incident and was sentenced to a Community Order for 12 months with an unpaid work requirement (UPW) of 150 hours.
9th May 2014 – DP alleged to have hit another male with a baseball bat. No complaints made and no further action by the police.
17th May 2014 – Probation decided to breach DP after he failed to attend a number of UPW appointments.
6th June 2014 – Magistrates Court considered the breach by DP of his Community Order and decided that it should continue unaltered. DP did not attend any further UPW appointments but no further breach action was taken.
7th June 2014 – DP stole alcohol from a shop. This was one of a series of thefts of alcohol from the same shop by DP over the following two months all of which were reported to the police.
13th June 2014 – DP was arrested by the police after being seen to brandish a machete in a public place. DP disclosed prior self-harm. He was bailed by the police to enable forensic examination of the machete which DP denied possessing.
15th July 2014 – DP attended the police station for a voluntary interview for stealing alcohol from the shop. One of these offences had been committed whilst on police bail but this was not noted at the time.
28th July 2014 – DP answered his police bail in respect of possession of the machete and was charged and bailed to court.

8th/9th August 2014 – DP continued to steal alcohol from the same shop and the police began investigating an incident at Saltash when DP and others threatened local residents.
13th August 2014 – DP attended Magistrates Court in respect of the machete offence and was bailed for a pre-sentence report to be prepared.
2nd September 2014 – DP was convicted of possession of a bladed article (the machete) and sentenced to 4 months youth custody. No pre-sentence report had been completed because DP did not attend the necessary Probation appointment.
31st October 2014 – DP was released from Portland Young Offenders Institution after serving two months. He was to be supervised in the community by the Community Rehabilitation Company (CRC) until 30th January 2015.
10th November 2014 – DP and another male broke into a sports and social club and stole alcohol. The police subsequently linked DP to the crime through DNA found on a hammer used to break into the club.
11th November 2014 – DP failed to attend an appointment with the CRC.
20th November 2014 – DP presented as mentally unwell when he next saw the CRC. He disclosed current and prior mental health concerns. The CRC arranged for DP to see his GP.
21st November 2014 – after not attending the GP appointment on 20th November, DP saw his GP who made an urgent referral to the community mental health team (CMHT). The CMHT conducted a triage assessment of DP the same day.
26th November 2014 – DP's case was discussed at CMHT multi-disciplinary meeting and referred to the Zone/Insight team (early intervention service for adults with mental health concerns).
2nd December 2014 – DP attempted serious self-harm and admitted to Hospital.
4th December 2014 – DP was discharged from hospital. On the same date the Insight team confirmed that DP was suitable for assessment which was arranged for 8th December 2014.
8th December 2014 – DP did not attend the Insight team assessment which was rearranged for 11th December.

9th December 2014 – DP attended an appointment with the CRC.
11th December 2014 – DP was assessed at home by the Insight team. An urgent appointment to see a Consultant Psychiatrist to discuss treatment options was arranged for 15th December.
15th December 2014 – DP and others were arrested by the police. DP was seen in possession of two meat cleavers. He and the other men were later bailed by the police to enable further enquiries to be carried out. The appointment with the Insight team was rearranged for 22nd December 2014.
22nd December 2014 – DP was seen at home by a Consultant Psychiatrist who offered treatment.
23rd December 2014 – the CRC decided that DP could no longer be safely supervised in the community and initiated breach action. This was listed for Court on 16th January 2015.
24th December 2014 – DP was telephoned by the Insight team to confirm he had commenced his treatment.
1st January 2015 – DP and his co-offender murdered TB.

4.1 DP was living with his family during the period covered by this Safeguarding Adults Review.

4.2 He had been supervised by the Youth Offending Team on two occasions and his involvement with that service had ended in June 2011. DP's involvement with the Youth Offending Team fell outside the time period addressed by this review. He was otherwise only known to universal services during his childhood.

4.3 During the late evening of 22nd November 2013 the police were called to a dispute between DP and his father at their home address. The police completed a Domestic Abuse, Stalking and 'Honour'-based violence (DASH) risk assessment which resulted in a 'standard' risk. DP temporarily went to stay in his adult sister's house in order to prevent further incident. DP was nineteen years of age at the time of this incident. (The DASH risk assessment checklist is a tried and tested method of assessing and understanding risk).

4.4 During the early hours of 24th December 2013 DP punched a male in the face near Plymouth City centre in what was described as an unprovoked attack. DP subsequently violently resisted arrest when the police were called. The police used a

Taser to subdue DP who tried to grab the device from the officer. He had been drinking and his violent behaviour continued after his arrest. In the custody suite he was physically and verbally aggressive. He was also seen to behave in an agitated manner. Whilst in custody, a medical practitioner conducted a health and mental health assessment during which DP disclosed self-harm in 2013.

4.5 He was later charged and refused bail in order to prevent further offences, prevent injury to others and to prevent harm to himself. He was placed before the next available court on 26th December 2013 which granted him bail.

4.6 DP appeared at Magistrates Court on 13th January 2014 and was found guilty of assault, battery and resisting arrest. A Probation Officer presented an oral report to the court. He was said to be unable to remember the events of the night on which the offences occurred and was reported to be 'disappointed with himself'. He was said to have some history of violence which was described as 'relatively minor'. DP was said to have monthly alcohol binges which he was reported to recognise he couldn't handle and accepted that he shouldn't drink so much. It was said that there were no known mental health issues.

4.7 DP was sentenced to a Community Order for twelve months (expiring on 12th January 2015) with an unpaid work requirement (UPW) of 150 hours. He was to be supervised by the then Devon and Cornwall Probation Trust. He would have been given an induction appointment and issued with work instructions. At this point he was assessed as of low risk of harm.

4.8 DP began attending his unpaid work placement and during February 2014 he was absent twice although both absences were judged to be 'acceptable' as on one occasion no work supervisor was available, and on the other occasion he was unwell.

4.9 During March 2014 an absence was deemed to be 'unacceptable' and DP was issued with a final warning. After two 'acceptable' absences during that month, there was a second 'unacceptable' absence in April which resulted in a decision to breach DP. The court was contacted and a date for a hearing arranged. However, the breach was later withdrawn after it was realised that the breach was an error as there had been no supervisor available on the date in question.

4.10 During the late evening of 9th May 2014 DP was amongst a group of five males who assaulted two other males after going to a house in Plymouth. DP was alleged to have hit one male with a baseball bat and punched another. The group of five men left the house after allegedly stealing a crate of beer. The injuries sustained by the victims amounted to bruising and what were described by the police as 'bumps'. Neither victim was willing to support a prosecution and the police took no further

action. DP was not arrested or interviewed and the Probation Service were not informed of DP's alleged involvement in this incident.

4.11 The following day (10th May 2014) DP was absent from UPW. He explained his absence by saying that he was required to attend a police station as there was a warrant for his arrest. After checking with the police, this absence was considered to be 'unacceptable'. DP would have been issued with a letter warning him that he was at risk of being returned to court if he failed to attend future appointments.

4.12 When DP attended UPW on 17th May 2014 his attitude was said to be 'bad'. It was decided to breach him, the court was contacted and a summons was issued for 6th June 2014. (It is worthy of note that DP said that his close family member was ill during this 17th May UPW attendance). There were two further 'unacceptable' absences during May for which no further action was taken as breach action had already been initiated.

4.13 On 1st June 2014 the thirty five Probation Trusts which delivered probation services across England and Wales ceased to exist, including Devon and Cornwall Probation Trust. From that date the National Probation Service was created to focus on work with offenders assessed as being of high risk of serious harm, sexual and violent offenders and to provide advice to courts on the sentencing of offenders. Most other work with low and medium risk of serious harm offenders was to be delivered by newly created Community Rehabilitation Companies. DP's case was allocated to the Dorset, Devon and Cornwall Community Rehabilitation Company (CRC) which was operated by parent company Working Links from 1st February 2015. (On 15th February 2019 Working Links went into administration. From that time Dorset, Devon and Cornwall CRC ceased to exist as an entity and became known as Dorset, Devon and Cornwall Probation Services and became part of Kent, Surrey and Sussex CRC, the parent company of which is Seetec).

4.14 On 6th June 2014 the Magistrates Court considered DP's breach of his UPW requirement and decided that the original Community Order should be allowed to continue. DP would have been given instructions to attend for work. The unpaid work team in the Devon and Cornwall Probation Trust had transferred to the CRC on 1st June 2014 and so they would have supervised DP's continuing UPW requirement, although DP failed to attend any further UPW sessions thereafter.

4.15 On 7th June 2014 DP failed to attend for UPW and during the same evening DP and another male became involved in a dispute with a female at the rear of a block of flats in which she was a resident. DP and the male had been drinking and are believed to have been causing a nuisance. The dispute escalated and DP and the male were alleged to have threatened to 'smash the female's face in' and burn her flat down before following her up the communal stairs to her flat whilst continuing to behave

aggressively towards her. The matter was reported to the police who investigated the matter with a Plymouth Community Homes (PCH) housing officer on 20th June 2014. (See Paragraph 4.19) Plymouth Community Homes is an independent social housing provider.

4.16 Later on the same evening DP stole two bottles of wine from a shop. He entered the shop as a customer, selected the bottles and left without making payment. The matter was reported to the police who interviewed DP on or around 15th July 2014 and reported him for summons. According to Police National Computer (PNC) records the case was discontinued on 8th October 2014.

4.17 During the late evening of 13th June 2014 DP was outside a public house when he was seen to brandish what was described as a samurai sword before concealing it down his trouser leg. The police were called and DP was arrested. The weapon was no longer in DP's possession but a machete was found nearby. DP had been drinking. Whilst in police custody DP disclosed past serious self-harm and a diagnosis of mental health (no indication of any diagnosis of mental health has been shared with this review). DP declined to see a health care practitioner whilst in police custody. He was interviewed in the presence of an appropriate adult (as a result of his disclosure of a mental health diagnosis) and denied possession of the machete. DP was later bailed by the police until 28th July 2014 to enable forensic examination of the machete to take place. A weapons warning marker was placed on DP's Unifi 'nominal record'. (Unifi is a database containing records of people who have come to police attention within the local police area).

4.18 Whilst in custody DP stated that he had a 'probation appointment' relating to a Community Order the following morning (14th June 2014). This was recorded in DP's custody record but there is no record of any police contact with the CRC at that time. The 'probation appointment' was an UPW session. The CRC recorded that he had failed to attend UPW as a result of being in police custody which was treated as an acceptable reason for his absence.

4.19 On 20th June 2014 a police officer and a PCH housing officer visited the flats where the 7th June 2014 dispute with the female resident had taken place (Paragraph 4.15). Enquiries established that DP and the other male had been visiting the partner of another female resident at the time of the incident. Following these enquiries, it was concluded that there was insufficient evidence to proceed with any offences and DP was not interviewed.

4.20 On 25th June 2014 DP was suspected of stealing alcohol from the shop from which he had previously stolen two bottles of wine on 7th June 2014. On this occasion DP entered the shop with his face covered but was recognised by staff and

told to leave. He then picked up a crate of beer and left the shop without offering payment.

4.21 On 15th July 2014 DP attended the police station voluntarily to be interviewed for both offences of theft of alcohol and was reported for summons. The 25th June 2014 offence (Paragraph 4.20) had been committed whilst on police bail but the officer who interviewed DP on 15th July 2014 was unaware of this fact. DP had voluntarily attended the police station. Had he been arrested his current bail situation would have been reviewed by the custody officer. However, had the interviewing officer searched DP's recent criminal history on Devon and Cornwall police systems, they would have become aware that DP had committed an offence whilst on police bail.

4.22 On 19th July 2014 DP failed to attend Unpaid Work (UPW) and the CRC sent him a warning letter. DP had failed to attend any UPW sessions since 17th May 2014 although two of the absences were as a result of illness, in respect of which a letter from his GP had been produced.

4.23 On 21st July 2014 DP smashed a window at the shop from which he had been stealing alcohol. He then left the scene before returning and taunting the shopkeeper. The incident was reported to the police and an investigation commenced.

4.24 On 28th July 2014 DP answered his police bail. The forensic examination of the machete recovered by the police on 13th June 2014 had linked the weapon to DP. He was charged with possessing an offensive weapon and bailed to appear at court on 13th August 2014.

4.25 During the evening of 8th August 2014 DP again stole alcohol from the same shop as previously. On this occasion he stole beer and kicked out at the shopkeeper who tried to prevent him leaving. The incident was reported to the police who obtained CCTV footage from the shop.

4.26 The following day (9th August 2014) DP was amongst a group of males who threatened residents in Saltash. DP was alleged to have threatened to smash a beer bottle over the head of a male and then exposed his buttocks to a female. The police were called and returned the group including DP to Plymouth. The police decided not to make arrests at that time and began obtaining statements from witnesses.

4.27 DP had been bailed to appear at the Magistrates Court on 13th August 2014 to answer the offensive weapon charge and was further bailed to return to the same court on 2nd September 2014. It is assumed that DP was bailed to enable the National Probation Service to prepare a pre-sentence report.

4.28 On 16th August 2014 failed to attend UPW. His had attended no UPW sessions since 17th May 2014 and the warning letter sent to him on 19th July 2014 appeared to have had no effect on his behaviour. The CRC wrote to DP on 20th August 2014 to advise him that they intended to commence breach proceedings although there is no record of any summons being taken out. DP continued to fail to attend UPW until his youth custody sentence was imposed. (See next Paragraph).

4.29 On 2nd September 2014 DP appeared at the Magistrates Court and a sentence of four months youth custody was imposed for possession of a bladed article (machete). He was sentenced without a pre-sentence report having failed to attend the interview with the National Probation Service which had been arranged for that purpose.

4.30 DP was initially held in Exeter Prison prior to transfer to Portland Young Offenders Institution. During screening he said he had no thoughts of self-harm. As DP had been sentenced without a pre-sentence report, the prison staff had little information relating to his history. However, there was a reference to DP having thoughts of serious self-harm one year previously. This reference is likely to have been obtained from court records or a police marker on the Police National Computer (PNC). When this was discussed with DP he said that this was 'rubbish' and he had no such thoughts. He was allocated an offender supervisor – to work with DP on his sentence plan and a personal officer – with whom he could raise any day to day concerns.

4.31 On 18th September 2014 DP was transferred to Portland Young Offenders institution (YOI) where he remained until his sentence was completed. He settled well and he received one behaviour warning for 'collecting' tobacco by going from cell to cell. This type of conduct is sanctioned because it often results in a delay in securing that area of the establishment. At that time Portland was assessed to be a 'fundamentally safe' jail (1). On 17th October 2014 he was provided with chaplaincy support after finding out his close family members illness has worsened. DP was described as 'worried' and 'under some strain' as a result of hearing this news. Resettlement support was also provided to DP. He intended to return to live with his parents. He said he had been unemployed at the time he received his sentence but had previously worked in a quarry. He added that he had five GCSEs and expressed an interest in building work and was provided with advice and support in respect of this. This support included help in obtaining a Construction Skills Certification Scheme (CSCS) card (CSCS cards provide proof that individuals working on construction sites have the required training and qualifications for the type of work they carry out) and a referral to an employment agency.

4.32 'Care First' the providers of healthcare in Portland YOI has advised the review that there were no concerns about DP's mental or psychological health whilst he was detained there.

4.33 Whilst DP was serving his sentence the police continued their enquiries into the various additional offences he was suspected of committing (Paragraphs 4.23, 4.25 and 4.26).

4.34 DP was released from Portland YOI on 31st October 2014. He was to be supervised by the Community Rehabilitation Company from that date until 30th January 2015.

4.35 DP's case was allocated to the CRC who met DP on 3rd November 2014. The CRC went through the terms of the supervision of his Youth Custody Licence. The objectives of this supervision were to protect the public, prevent re-offending and help him resettle successfully into the community. DP was advised that whilst under supervision he must be well behaved, not commit any offence and not do anything which could undermine the purposes of his supervision; keep in touch with the CRC in accordance with any instructions given; receive home visits from his supervising officer if required; permanently reside at an address approved by his supervising officer and obtain prior permission for any stay of one or more nights at a different address; undertake only work approved by his supervising officer and not travel outside the UK. DP was warned that if he failed to comply with any requirement of his supervision, he would be liable to be summoned to appear before a court which could order him to be detained for up to 30 days or impose a fine.

4.36 The CRC assessed DP as being of low risk of harm and he was given a further appointment on 11th November 2014. (DP's case had not been allocated to the CRC by the National Probation Service as a result of an error when DP was sentenced. At that point his sentence had been recorded as 'adult custody' rather than youth custody and the case record terminated as there was no requirement for supervision of adult offenders receiving a sentence of less than twelve months at that time. Fortunately, the CRC was prompted to contact Portland YOI in respect of DP's impending release because they had a record of his, as yet not fully completed, UPW requirement). The CRC then informed DP that he needed to attend an appointment with a UPW case manager. DP said that he had been advised by his solicitor that he did not have to complete the UPW requirement. The CRC advised DP to discuss this with the UPW case manager. No indication that DP met the UPW case manager has been provided to this review. In any event it was decided to suspend DP's UPW requirement on 21st November 2014 (Paragraph 4.49).

4.37 On 10th November 2014 DP and another male gained entry to a sports and social club by smashing a large ground floor window and stealing bottles of wine. The

police became aware that DP's DNA had been found on a hammer used in the burglary on 18th November 2014 (See Paragraph 4.39 below).

4.38 The following day (11th November 2014) DP failed to attend his scheduled appointment with the CRC who then contacted him to enquire why he had failed to attend. DP replied that he had been feeling unwell and was given a new appointment for 20th November 2014. On the same date DP's case was formally allocated to the CRC by the NPS.

4.39 On 18th November 2014 the police became aware that DP's DNA had been found at the scene of the burglary which took place on 10th November (Paragraph 4.37). There is no record of any consequent police enquiries until 2nd December 2014 by which time DP had been hospitalised (Paragraph 4.54).

Thursday 20th November 2014

4.40 On 20th November 2014 DP attended the rearranged appointment with the CRC. After being 'argumentative and difficult' whilst in the reception area he disclosed prior and current mental health concerns and previous incidents of serious self-harm. (The 2015 Plymouth Community Healthcare Root Cause Analysis Investigation report states that DP also disclosed to the CRC attempts of serious self-harm since leaving the YOI). He added that he had not had any of these thoughts recently but felt that 'things were getting out of control'. The CRC responded by contacting DP's GP practice and arranging an appointment for DP to attend the same afternoon. The CRC also telephoned DP's family to advise of the GP appointment. The CRC noted the illness of a close family member was considered to be a possible stressor for DP. The CRC also arranged for DP to attend a drop-in the next day at the Shekinah charity which provides support for people recovering from offending behaviour and mental ill health. The CRC felt that the drop-in would occupy DP's time and help him to find employment.

4.41 Later on 20th November 2014 DP's GP contacted the CRC to inform DP had failed to attend the GP appointment that had been arranged by the CRC. A further appointment was scheduled for the next day. The CRC rang DP, but spoke to his family who agreed to tell DP about the rearranged GP appointment.

4.42 During the afternoon of that day (20th November 2014) a Police Community Support Officer (PCSO) and a PCH Housing Officer visited DP's home address in connection with the thefts of alcohol which had taken place between 7th June and 8th August 2014, some or all of which were now being treated as anti-social behaviour. DP was not at home. PCH Housing followed up with a letter to DP dated 26th November 2014 setting out their concerns about his behaviour and offering to speak

with him directly. PCH Housing received no response to this letter and closed their anti-social behaviour file on DP.

Friday 21st November 2014

4.43 On 21st November 2014 DP visited his GP who was very concerned about his mental health. However, DP said that his thoughts had begun to settle. The GP felt that DP had reasonable insight, accepted that he needed help and had consented to an urgent referral to the community mental health team (CMHT). Whilst DP waited in a side room the GP spoke with the CMHT who agreed that an urgent mental health assessment was necessary and that he would contact DP directly to arrange this. The CMHT was given DP's mobile phone number for this purpose. The CMHT asked whether the GP would consider treatment for DP but the GP declined on the basis that this would be quite an unusual step for a GP to take prior to a secondary care assessment of the patient.

4.44 CMHT also recorded that the GP had informed them that DP had recently been released from prison for carrying a machete but did not appear to have any plans to harm others or himself. The CMHT recorded that the mobile phone number provided was a relative's phone. The GP also advised the CMHT that DP was involved with the CRC, who CMHT then telephoned.

4.45 The CRC had reassessed DP's risk of harm as medium and this was shared with the CMHT when the latter telephoned the CRC later that day. The CRC shared further information with the CMHT who concluded that the risks currently presented by DP were too high for a standard mental health assessment to be conducted. The CMHT was concerned with DP's presentation, had a history of carrying a weapon and there was a fear that he may currently have access to a weapon (the axe allegedly kept under his bed). The CMHT recommended that either the CRC or DP's GP needed to arrange for him to be assessed under Section 136 of the Mental Health Act. This would involve the police detaining DP and removing him to a place of safety where the assessment could be carried out with less risk.

4.46 The CRC then telephoned DP's GP who expressed some reservations about detaining DP under the Mental Health Act. However, it was agreed that the CRC would contact the police to request they consider detaining DP under the Mental Health Act. The GP said that he would share information from his earlier examination of DP with the police should they require it for the purposes of detaining him under the Mental Health Act.

4.47 The CRC telephoned the police call centre and explained the circumstances. The CRC was advised that Section 136 could only be used by the police when the person was in a public place and deemed by the police to be in immediate need of

care and control. DP was understood to have returned home and so Section 136 could not be considered at that time. Following the call from the CRC, the police submitted intelligence to the effect that DP had mental health problems, was believed to have access to an axe and that officers called to incidents at his home address should consider using protective equipment and deploying a 'double crewed' unit. A weapons marker was added to DP's Unifi nominal record including the information 'keeps an axe under his bed'.

4.48 The CRC then re-contacted the CMHT to advise that the police would not be able to detain DP under the Mental Health Act. The CMHT took the view that whilst it would be unsafe to attempt to assess DP at his home address, he could be offered a clinic appointment.

4.49 The CRC decided to suspend DP from his unpaid work requirement until his mental health assessment had been completed.

4.50 The CMHT made telephone contact with DP, who said that he had put the axe by his bed to keep himself safe but that he did not have it anymore. He said that he had earlier carried the machete to protect himself but he would not consider doing this again at this time 'due to prison'. He reported experiencing mental ill health. He said that he had been having these thoughts for over two years. He said he tried to stay in his room and 'did not want to be going out'. He disclosed that he attempted seriously harm himself but 'knew this does not work' and so he binge drank to stop the thoughts which helped him only in the short term but 'did not make him better'. After obtaining assurances from DP that he would not be carrying any weapons, he was offered and accepted a clinic appointment for a mental health triage assessment at 3pm that afternoon.

4.51 The triage assessment was completed that afternoon by the CMHT who described some uncertainty regarding the validity of DP's presentation. He was described as incongruent in that he was boastful regarding his situation at times. The CMHT expressed uncertainty regarding DP's needs as some aspects of his presentation did not appear to demonstrate valid mental health concerns. Risks were assessed and it was considered that these might increase when he was outside and around crowds. DP said that he had carried a machete since the age of eighteen. Due to DP's self-isolating behaviour, risks to others were considered most likely to be present when he visited the CRC or had to leave his house for any reason. DP was reported no have no weapons currently. He said he did not know where the axe was that he had kept by his bed although he thought it might be in the garden. There did not appear to be any reason to consider that he was at increased risk of serious self-harm. The outcome of the triage assessment was to be discussed with a consultant psychiatrist to consider any diagnosis and whether or not treatment would be helpful at that time. It was agreed that he would be safe that weekend (the

assessment was taking place on a Friday afternoon). DP consented to the CMHT sharing information with the CRC.

Monday 24th November 2014

4.52 On Monday 24th November 2014 the CMHT telephoned the CRC to advise of the outcome of the triage assessment. A discussion took place about the risks presented by DP. He was said to be spending most of the day in his bedroom with little or no risk to others. (The CRC recorded that 'going to his bedroom' was the 'safety plan'). The CMHT said that risks to others arose when he left his home to travel to meetings with the CRC for example. The CMHT advised that the triage assessment would be discussed at the next team meeting and that a referral to the Icebreak team may follow. In the CRC note of this telephone conversation it was recorded that the CMHT indicated that DP had described an inability to 'take responsibility' and that he had presented as void of emotions. The CRC also recorded that DP struggled to manage and explore his thoughts. Additionally, the CRC recorded that DP had told the CMHT that he had liked it at HMP Exeter because of the security staying in his cell provided. The CRC recorded that the CMHT would not prescribe medication or refer to the Icebreak team until DP had been assessed by a psychiatrist. The CRC recorded that the assessment could 'take months to complete'. (In the event DP was not referred to the Icebreak service as apparently suggested by the CPN. Icebreak works with 16-22 year olds who are experiencing personality disorder related symptoms. Had DP been referred to that service it is likely that there would have been a lengthy waiting list. DP was in fact referred to Insight which is an early intervention service for people aged 18+ who are experiencing their first episode of mental ill health. There was no waiting list for the Insight service at that time. The Plymouth Community Healthcare 2015 Root Cause Analysis Investigation report indicates that at the time of the triage assessment on Friday 21st November 2014, the plan had been to refer DP to the Insight service).

Tuesday 26th November 2014

4.53 On Tuesday 26th November 2014 DP was discussed at the CMHT multi-disciplinary team (MDT) meeting. His case was summarised during which he was said to have been previously known to CAMHS (this appears to have been incorrect). It was decided to refer DP to Insight to be seen by a consultant psychiatrist. Probation were to be informed of this outcome with DP's consent. The referral letter to Insight stated that DP's presentation was suggestive of emerging mental health and was copied to DP, his GP and the CRC. The CRC has advised this review that they did not receive a copy of the Insight referral letter.

Tuesday 2nd December 2014

4.54 Shortly before 1.00am on Tuesday 2nd December 2014 the police were called to an incident involving DP and taken to hospital. Police enquiries established that DP had had a verbal disagreement with his girlfriend following which he ran outside before attempting to seriously harm himself. DP was under the influence of alcohol and possibly drugs. The police completed a DASH risk assessment to establish the level of risk of domestic abuse DP presented to his girlfriend which disclosed a standard risk.

4.55 At around 1.40am DP arrived at Derriford Hospital emergency department (ED) where he was described as agitated. Assessments were undertaken and transferred from the hospital intensive care unit to a medical ward at 10.20pm on the evening of the same day.

Wednesday 3rd December 2014

4.56 By 1pm on Wednesday 3rd December 2014 DP was considered to be medically fit to be discharged from hospital but this could not take place until a mental health assessment had been carried out. At around 16:00 DP was seen by the Psychiatric Liaison Service. DP said that he had not intended to harm himself. DP claimed to have no history of any prior incidents of this kind or other forms of self-harm. He disclosed that he had experienced mental health concerns since two years earlier. He was deemed to have mental capacity to make decisions. DP was not considered to need inpatient admission as he did not present as acutely mentally unwell and was to receive psychiatric follow-up in the community and a referral to Insight 'counselling'. He was assessed as of minor risk of intentional self-harm and harm to others and property.

4.57 During that day DP's family telephoned the CRC to inform DP had attempted serious self-harm. The CRC asked DP's family to ask the hospital to send any relevant information to the CRC in the next couple of days.

4.58 The CRC considered whether DP's Youth Custody Licence should be returned to court for breach action. The issue of the risk DP presented to himself appeared to be the primary consideration at this time. It was decided to await the outcome of the planned mental health assessment of DP before further considering breach action.

4.59 Later the same day the Derriford Senior House Officer (SHO) telephoned the CMHT to express her disagreement with the outcome of the Psychiatric Liaison Team review of DP (Paragraph 4.56). She expressed a number of concerns about DP's mental health presentation and the inconsistent explanations he had given for the incident. The SHO was also concerned that DP had directed anger at a family

member. The SHO was also concerned about the level of support available to DP should he be discharged home and felt that there was justification for making use of the temporary holding power of Section 5(2) of the Mental Health Act. Section 5(2) provides for the detention of a person on a hospital ward for up to 72 hours to enable a Mental Health Act assessment to be conducted. At this point a duty manager became involved and confirmed that it was not standard practice at Derriford Hospital for an SHO to detain someone under Section 5 (2), although legal to do so, as this would usually be the responsibility of a registrar owing to the complexities of the Mental Health Act 1983. In the event Mental Health Act powers were not used.

Thursday 4th December 2014

4.60 During the morning of Thursday 4th December 2014 DP was discharged from hospital. He was noted to maintain eye contact and denied he would repeat the incident. He said he regretted his actions. Whilst DP had been noted to have thoughts the previous day, this no longer appeared to be the case on the day of discharge. Psychiatric follow up was to take place in the community and a discharge summary was sent to his GP.

4.61 On that date the referral to Insight from the CMHT (Paragraph 4.53) was considered at the Insight multi-disciplinary team (MDT) meeting and a decision made that DP was appropriate for assessment. There had been further telephone contact from the Derriford Hospital SHO that morning in which she had reiterated her concerns in respect of DP's presentation. By this time DP had been discharged from hospital, however noted the family were concerned and SHO had given them MIND and Mental Health Matters contact numbers. (It is not believed that DP's parents contacted either organisation for support). The Insight team assured the hospital SHO that a CMHT referral had been received in respect of DP and he was to be offered an initial assessment which would be arranged urgently.

4.62 Some difficulty was experienced in contacting DP to arrange the assessment appointment. Contact was made with DP's GP and the CRC to assist and DP was offered an assessment on 8th December 2014. During the conversation, verbal consent to share information was obtained from DP.

4.63 The police had considered arresting DP following his admission to hospital in respect of the outstanding offences set out earlier in this report but it was decided to visit him in hospital and arrange for him to voluntarily attend a police station on 13th December 2014 for these matters to be dealt with.

Monday 8th December 2014

4.64 On Monday 8th December 2014 DP did not attend his initial assessment appointment at Insight. His family was contacted by telephone and stated that DP was unwell. When asked how DP was mentally, the family replied that was 'calm' and that he was 'OK if he was at home'. An alternative appointment date of 16th December 2014 was offered. DP's family was asked if she would be able to accompany DP to the appointment. DP's family was advised of support that could be accessed if DP's mental health deteriorated during the period prior to the rearranged appointment.

4.65 The Insight team leader intervened to bring forward the rearranged appointment to 11th December 2014 out of concern about the length of time between the missed appointment and the rearranged appointment, given DP's presentation and risk. This new appointment was to take place at DP's home. His family was contacted by telephone and accepted the appointment on behalf of DP.

Tuesday 9th December 2014

4.66 On 9th December 2014 DP attended an appointment with the CRC. He described feeling mentally unwell and had struggled to attend the appointment. DP discussed the incident of the 2nd December (See Paragraph 4.54) which he said had happened after drinking alcohol. The CRC concluded that DP understood that some of his thoughts were not real and he was able to rationalise them. He was also said to understand that he could not carry weapons when feeling scared as this would result in him being returned to prison. He also disclosed that he was playing 'Call of Duty' on an X-box for several hours each day. Any focussed work with DP had been suspended until the CRC was made aware of the contents of the forthcoming mental health assessment. A hospital 'sick note' had been received by the CRC which did not disclose the reason for DP's admission to Derriford hospital. It is understood that the next CRC appointment was arranged to take place at DP's home on 17th December 2014 but this was subsequently cancelled (See Paragraph 4.86).

Thursday 11th December 2014

4.67 On Thursday 11th December 2014 the initial mental health assessment took place at DP's home. His family was present for some of the assessment. DP said he found it difficult to express how he was feeling. He appeared withdrawn and anxious. He began to describe some of the mental health symptoms he was experiencing. These thoughts appeared to have been affecting him for the past two years. He said that they caused him distress and led to him attempting to seriously harm himself after drinking a 'case of beer', although he was said to minimise this event. He provided an offending history. He said he used alcohol to manage his distress. He said he was managing himself by avoiding contact with others and spending time in his bedroom. When asked whether he felt safe, he reiterated that he was managing

his distress by staying in his bedroom and had no clear intent to seriously harm himself at this time. He added that he could not guarantee his safety if he left the house.

4.68 The support which the Insight team could offer was discussed with him and he was said to accept the opportunity to engage with the service. The agreed plan was for DP to continue to remain in the family home. He would continue to isolate himself and not go out. An urgent appointment with a psychiatrist was to be arranged to discuss treatment options.

4.69 An appointment was later arranged for DP to see the consultant psychiatrist at 1.15pm on Monday 15th December 2014 at DP's home. This was communicated to DP's family by telephone.

Saturday 13th December 2014

4.70 DP attended a police station voluntarily as previously arranged (Paragraph 4.64) and he was interviewed about four prior alleged offences. He made no comments during the interview and was reported for consideration of prosecution.

Monday 15th December 2014

4.71 At 1.10am on Monday 15th December 2014 there was a disturbance in the Stonehouse area of Plymouth. The incident involved seven males who formed two separate groups. Four men, including DP, were in one of the groups. The two groups were in dispute with one another and their actions were captured on CCTV cameras operated by Plymouth City Council. The footage showed DP brandishing two meat cleavers and lunging towards a member of the other group. One of the males in the other group was armed with a wooden meat hammer which he threw at DP before running away. When the police attended the males ran from the scene apart from one of the males who was injured. Most of the males were arrested shortly afterwards. DP was arrested later that morning. Prior to DP's arrest the critical incident manager (police inspector) requested the completion of a firearms assessment in order to assess the risks involved in arresting him. The risks identified were to DP himself, members of the household in which he resided and the arresting officers. No risks were identified to other individuals or the community. The arrest of DP was made without incident although the deployment of a Taser had been authorised.

4.72 Witnesses were traced who described different males being in possession of weapons. When the seven suspects were interviewed only two of them provided an account of what had taken place. DP said he had no memory of events, due to the amount of alcohol he had consumed, but accepted that his behaviour was

inappropriate and would have caused people to fear for their safety. DP also acknowledged that he had been involved in another incident during the same night in which four males ran off from a taxi without making payment. He said he was willing to repay the fare and indicated that his family would give him the money.

4.73 Whilst in police custody DP was seen by a medical health practitioner who identified no 'acute' medical issues. The medical health practitioner discussed DP with the Liaison and Diversion nurse who contacted Insight that day (The Liaison and Diversion service identifies people with mental health, learning disability, substance misuse or other vulnerabilities who come into contact with the criminal justice system and assesses and refers identified individuals to appropriate treatment or support services). The Liaison and Diversion nurse was aware that DP had been due to be seen by the consultant psychiatrist at his home at 1.15pm that day. DP was still in custody and so the Liaison and Diversion nurse asked whether the consultant psychiatrist would wish to conduct the planned assessment at the police station rather than at DP's home.

4.74 The consultant psychiatrist declined to assess DP at the police station on the basis that this was not a conducive location in which to undertake an assessment and treatment review, may undermine DP's trust in the Insight service if he perceived they were connected to the police and there was the potential for confusion as an assessment whilst in custody would be examining somewhat different issues to the planned assessment of DP in his own home.

4.75 Because DP was unable to attend the 1.15pm Insight appointment a letter was sent to his GP advising of this fact.

4.76 There is no record of any mental health assessment of DP taking place whilst in custody. It was stated that Insight had been informed of his arrest and had been asked to arrange to see DP in the community as soon as possible. Based on the medical examination of DP whilst in custody there was said to be no indication of a need for a Mental Health Act assessment. DP was said to have no thoughts of self-harm and he said he was happy to engage with Insight.

4.77 A police gatekeeping officer (usually a Sergeant who is trained to review evidential material and make certain charging decisions and grant police bail) assessed the investigation and decided that all the suspects should be released on bail for further investigations to be carried out. Further statements needed to be taken together with an analysis of phones removed from the suspects, including DP. Late in the evening of Monday 15th December 2014, DP was bailed to attend Charles Cross Police Station at 5pm on 9th February 2015. Although DP's PNC record was checked at the time his period of police detention was initially authorised, the handover documentation did not include any details of PNC checks for any of the

detainees including DP. However, DP's Youth Custody Licence conditions were not held on his PNC record.

4.78 The wooden meat hammer had been recovered following a search of the area in which DP and the other males were first observed on CCTV. However, the two large meat cleavers were not recovered despite searches of DP's home address and that of one of the other suspects.

4.79 A Serious Further Offence (SFO) review conducted by the Probation Service following the murder of TB, established that there was a handwritten note in CRC case notes relating to DP's arrest for affray. The note, which also stated that he had been in possession of two meat cleavers and that he had been bailed, was written on 15th December 2014. The SFO Review concluded that although the note was recorded as having been written on 15th December 2014, the CRC did not become aware of the details of the new offences until 23rd December 2014. It is not known which agency communicated these brief details of DP's arrest to the CRC on 15th December 2014. There is no record of the police, the Liaison and Diversion Nurse or the Insight team contacting the CRC on that date. However, the Insight team contacted the CRC the following day (Paragraph 4.82) although any such contact was not recorded by the CRC. It seems possible that the handwritten note recorded by the CRC and dated 15th December 2014 may have related to the 16th December 2014 telephone call from the Insight team.

Tuesday 16th December 2014

4.80 On Tuesday 16th December 2014 the Liaison and Diversion nurse from the police station telephoned the Insight team to advise that DP had been released from custody. Details about DP's arrest were said to still be unclear and so the Insight team asked the nurse to find out further information.

4.81 Later that day the Insight team telephoned DP's family. They said that DP was in bed and that the police had kept his phone. DP was offered an appointment with the Insight team for the following day. DP was to ring back to confirm that he would be attending the appointment. Brief telephone contact was made with DP later in the day during which he confirmed that he would attend the appointment the following day.

4.82 The Insight team telephoned the CRC. A message was left for the CRC to contact the Insight team to discuss DP's support plan (This contact does not appear to have been recorded by the CRC).

Wednesday 17th December 2014

4.83 On Wednesday 17th December 2014 the Liaison and Diversion nurse at the police station re-contacted the Insight team to advise that DP had been arrested for affray on 15th December after being found with a meat cleaver. No other details had been obtained.

4.84 DP failed to attend the rescheduled Insight appointment that day. Telephone contact was later made with his family who said he had toothache and described him as quiet and subdued. The Insight team then rearranged the appointment for Monday 22nd December at DP's home address.

4.85 A further 'did not attend' letter was sent to DP's GP.

4.86 On the same date the CRC reconsidered the home visit to DP that was due to undertake. Given the information received about 'weapons in the house', it was decided not to conduct a home visit. It was suggested that arrangements could be made for DP to be transported to CRC appointments by taxi and that the supervision of his licence could be conducted by telephone. It was agreed the CRC could continue to hold DP's case but with Probation Officer oversight.

Sunday 21st December 2014

4.87 The police gatekeeper was still awaiting the necessary paperwork to inform a charging decision in respect of the burglary to which DP had been connected by DNA (Paragraph 4.39).

Monday 22nd December 2014

4.88 On Monday 22nd December 2014 the CRC telephoned the Insight team and the latter advised that a home visit was to be made that day to assess DP's mental wellbeing at his home address. The Insight team said they were aware of DP's 15th December 2014 arrest in possession of a meat cleaver and went on to ask for any further information about weapons. The CRC advised that it had been decided that a home visit to DP was 'too risky' due to mental health concerns and potential weapons to protect himself. The CRC requested that Insight update them with any information relating to risk and the outcome of the mental health assessment. The information arising from this discussion was passed on to the CRC management.

4.89 Later that day DP was seen at his home address by the consultant psychiatrist and the Insight team leader. DP talked about the incident which led to his most recent arrest. He said he had been drinking heavily with a friend prior to going out but could not explain why he went to the location where the incident occurred. He was said to continue to find it difficult to talk about how he felt. His mental health and treatment options were discussed and he agreed to commence treatment,

initially for two weeks. His family was present whilst the treatment plan was discussed.

4.90 It was planned to telephone DP on Wednesday 24th December 2014 to check whether he had started his treatment and offer telephone support over the Christmas period. DP had accepted the offer of a care co-ordinator and an appointment to facilitate this was to be made in the New Year. The following day a letter was sent to DP's GP advising of the commencement of treatment.

Tuesday 23rd December 2014

4.91 On Tuesday 23rd December 2014 the CRC telephoned the Insight care co-ordinator to obtain more information about the circumstances of DP's arrest. The CRC was advised that DP had been arrested at home and bailed for affray after being found with a meat cleaver in a public place. The CRC was also advised that the Insight team had carried out a further assessment and 'had decided to offer DP more support over the Christmas period'. She was informed that DP had been prescribed treatment but CRC case records state that the details of the treatment could not be shared with the CRC. Insight's record of the conversation differs in that no mention is made of support over the Christmas period and it is stated that the details of DP's treatment was shared with the CRC.

4.92 Later that morning the CRC contacted the police, via the police call centre, to obtain further information about the arrest of DP. The CRC informed the police that DP was currently being supervised on a Youth Justice Licence. The police provided what is recorded as an 'outline of the situation' and the date to which DP had been bailed.

4.93 The CRC discussed that due to the new offences for which DP had been arrested, he could not be managed in the community. Following liaison with a NPS legal proceedings officer, the breach of DP's licence was listed for Court on 16th January 2015.

4.94 According to the Serious Further Offence Review the CRC completed the Offender Assessment System (OASys) assessment in respect of DP. This should have been completed within ten days of first contact with DP following release i.e. by 17th November 2014. However, it has been established that no OASys assessment was ever begun for DP and the Serious Further Offence Review was in error on this point.

Wednesday 24th December 2014

4.95 On Wednesday 24th December 2014 the Insight team spoke briefly with DP by telephone. DP confirmed he had started his treatment and had not experienced any ill effects. The Insight team had earlier spoken to DP's family by telephone and had been provided with details of Out of Hours support if required over the Christmas period. No contact was subsequently made with the Out of Hours service by, or on behalf of DP.

4.96 On the same date the CRC case records show that the risk classification for DP had been reduced from medium to low risk. It is assumed that this was the result of an error in recording.

Tuesday 30th December 2014

4.97 On Tuesday 30th December 2014 the CRC attempted to contact DP by telephone but was unsuccessful. No further action was taken in respect of this lack of response by DP as steps had already been initiated to breach DP. A further appointment for DP to be seen by the CRC was planned for 8th January 2015.

Thursday 1st January 2015

4.98 At 1.36am on Thursday 1st January 2015 the police were called to an incident in which DP and another male had made an unprovoked attack on a number of other males. Armed with knives and an axe, DP and the other male fatally stabbed one person and inflicted very serious injuries on others.

5.0 Contribution of DP, his family and the family of the victims

5.1 DP was keen to contribute to this review and was interviewed by the independent author in the prison where he is serving his life sentence.

5.2 He described an incident which took place in secondary school which he felt had had quite a profound impact on his life. [redacted]

5.3 [redacted]

5.4 He recalled beginning to feel and think differently. [redacted] Despite his families prompting, he didn't seek help. He said he became 'afraid to go out' which may have prevented him going to see his GP. He said he 'suffered for about two years on the quiet'.

5.5 He said he had begun smoking cannabis towards the end of his school days but during the period after he found out that a close family member was unwell, he began using 'bubble' to cope with mental ill health. 'Bubble' is one of a number of slang names for Mephedrone which is a powerful stimulant and is part of a group of drugs which are closely related to amphetamines. (The Insight team was unaware that DP was using any substances other than alcohol at the time treatment was prescribed. The Insight team has advised that both Mephedrone and cannabis have the potential to impact on mental health and increase vulnerability to experiencing mental ill health. The team also advises that in theory neither drug should have a direct interaction with the prescribed treatment).

5.6 He said he eventually began going out more but said he 'got in with the wrong crowd'. After seeing a friend 'stabbed in the chest' he decided to carry a machete but was caught by the police and was sent to the Young Offenders Institution. He said that Portland was an 'easy gaol' and that he was happy to be in a cell all the time and not 'around people'.

5.7 Following his release, he said he began feeling depressed. At this time he described himself as living 'like a recluse'. He said he began 'sniffing bubble every day' which he said helped him to feel better. DP said he took on a caring role for his close family member at that time which consisted of cleaning the house, washing the dishes and looking after his extended family when they came to stay, or visiting the family.

5.8 He confirmed that he developed an irrational fear following an incident and kept an axe in his bed in order to protect himself. He said he had been upset to read about this incident in the media as he felt that the manner in which the incident had been reported suggested a genuine threat to him when this was not the case.

5.9 He tried to seriously harm himself and recalled later 'waking up' in hospital. He recalled becoming very angry and 'lashing out' at nursing staff when they attempted to cut away the tracksuit he was wearing.

5.10 Turning to his contact with probation services, he said he 'hardly used to turn up' for the unpaid work requirement of the community order imposed on him in January 2014, adding that when he did turn up he often asked to go back home.

[redacted]

5.11 He recalled being arrested by the police for causing an affray. He said that he felt it was worth being arrested in order to 'save a girl' who he and his friends believed was being abused and needed their immediate help. He said he had no intention of using the weapons he had with him. He explained that he felt that if people knew he was carrying weapons they wouldn't come near him. Thus carrying weapons helped him deal with his fear of being attacked. He said he posted pictures of himself with weapons on social media so that would 'stop it all', but he now realised that this ended up making matters worse for him.

5.12 [redacted]

5.13 He said that the treatment he was prescribed by the Insight Service made him feel 'weird' and made his thoughts worse, adding that he had also been prescribed the same medication whilst serving his current sentence and this had had the effect on him of making him think that 'everyone was out to get him' and caused him to be reluctant to leave his cell.

5.14 [redacted]

5.15 DP's family and a close friend of the family contributed to this review. DP's close family member died in 2017 and it became clear that they had played a significant role in supporting DP when he experienced difficulties in his life. [redacted]

5.16 [redacted]

5.17 [redacted]

5.18 [redacted]

5.19 [redacted]

5.20 The family said that DP became a carer of a close family member following his release from Portland Young Offenders Institution. [redacted]

5.21 [redacted]

5.22 The parents of TB were invited to contribute to this review. [redacted]

5.23 [redacted]

5.24 [redacted]

5.25 [redacted]

[redacted]

[redacted]

5.26 [redacted] An update on progress against the further actions implemented by HM Prisons and Probation is included in this review.

5.27 [redacted]

5.28 [redacted]

5.29 [redacted]

5.30 There is much learning for agencies arising from the experiences of TB's family following his murder. Additionally, the persistence of the family in seeking answers to questions they had about the manner in which agencies in contact with DP had shared information and generally worked together is highly commendable. Their criticisms of aspects of the response to the death of TB are outside the scope of this Safeguarding Adults Review and so it is recommended that these concerns are brought to the attention of the agencies concerned separately.

5.31 The independent author separately revisited the parents of TB and took them through a late draft of this report. Both parents expressed complete satisfaction with the SAR report with the exception of the response to mother's query in relation to why DP was not subject to a Home Detention Curfew (see Paragraphs 6.79 – 6.81). Both parents fully supported the findings and recommendations of the SAR report.

6.0 Analysis

6.1 In this section of the report each of the terms of reference questions will be considered in turn. Where the question is one which was asked by the family of the victim, this will be indicated.

How individual agencies followed agreed policies and procedures in working with DP and his family. How staff were supported to follow agreed policies and procedures. How agencies worked together in identifying and addressing concerns regarding DP's offending, mental health and welfare.

6.2 Partner agencies primarily began working together in respect of DP when they became aware of a serious deterioration in his mental health from 20th November 2014. However, on the basis of his self-reporting DP had been experiencing symptoms of mental health during the preceding two years. It appears that carrying, or having access to weapons helped him to feel safe due to these symptoms.

6.3 There may have been opportunities for DP or his family to seek help earlier. The first opportunity for any agency to refer DP for support arose when DP was arrested on 24th December 2013. Whilst in custody DP disclosed current and prior mental health concerns. It is not known whether the police considered a referral to mental health services at this point. Had the Liaison and Diversion nurse service been in place at that time it seems likely that a referral would have been made. The lack of any referral following arrest was exacerbated by the omission from the oral report prepared by the Probation Officer to inform sentencing in January 2014 of any of the concerns about DP's mental health arising from his December 2013 arrest.

6.4 When DP was sentenced to imprisonment in September 2014 no pre-sentence report was available to the court as DP had failed to attend the interview arranged for this purpose. Had the court not chosen to sentence DP without the report, his prior mental health concerns may have been referred to as well as the potential impact on his wellbeing of his close family member's illness.

6.5 However, once DP began presenting as mentally unwell from 20th November 2014, several agencies worked effectively together for a period. The CRC promptly arranged an appointment with his GP, then quickly arranged another GP appointment when he failed to attend the first one. DP's GP immediately referred DP for a triage mental health assessment by the community mental health team which took place the same day. Two working days later the community mental health team referred DP to the Insight team for assessment by a consultant

psychiatrist. The CRC was updated on the action taken by the community mental health team.

6.6 The referral to Insight from the community mental health team could have been considered at their weekly MDT meeting a week earlier than it was, had referrals been managed more proactively at that time. The letter of referral from the community mental health team had been sent by post but also entered onto the SystmOne electronic system to which the Insight team also had access. Had the community mental health team telephoned the Insight team to advise them that the letter was available for them to view electronically on SystmOne, the referral could have been considered a week earlier. Had this happened, there may have been a possibility of scheduling an intervention before the incident of attempted serious self-harm on 2nd December 2014 and treatment could have been commenced earlier.

6.7 However, once the community mental health team referral was considered by the Insight MDT on 4th December 2014 an assessment appointment was arranged promptly and the important intervention by the Derriford Hospital SHO added to the sense of urgency.

6.8 When DP failed to attend the appointment for assessment by the consultant psychiatrist on 8th December 2014 a replacement appointment was promptly offered and then brought forward to 11th December 2014. This took place at DP's home. After DP agreed to accept support from the Insight team a further appointment was promptly arranged for 15th December 2014 to consider medication options. DP was unable to attend this appointment because of his arrest on the same date for the alleged affray. The consultant psychiatrist declined the request to see DP whilst in police custody on 15th December 2014 because the police station was not considered to be a conducive location in which to undertake an assessment and treatment review, could undermine DP's trust in the Insight service if he perceived they were connected to the police and there was the potential for confusion as an assessment whilst in custody would be examining somewhat different issues to the planned assessment of DP in his own home (Paragraph 4.74). Although seeing DP whilst in custody would have enabled the treatment review to take place, and any prescribed treatment to commence, a week earlier than it subsequently did, the grounds for declining the examination in police custody were defensible.

6.9 Partnership working began to diminish in effectiveness from this point onwards. The police were unaware that the CRC were supervising DP on licence. The offences for which DP was arrested on 15th December 2014 justified the initiation of court proceedings for breaching his licence conditions but this action was delayed until 23rd December 2014 when CRC became aware of his arrest.

6.10 The consultant psychiatrist saw DP at his home address on 22nd December 2014 and prescribed treatment and a follow up telephone call by the Insight team two days later established that DP had begun the treatment with no adverse effects (In his contribution to this review DP said that the medication affected him adversely – Paragraph 5.13). However, the planned telephone contact with DP over the Christmas/ New Year holiday period did not take place promptly with no contact attempted until after the murder had taken place. The CRC appears to have been under the incorrect impression that the Insight team intended to provide more intensive support to DP over the holiday period than was actually the case. The CRC did not carry out the required formal assessment of DP which had been delayed to await the outcome of his mental health assessment and made one unsuccessful attempt to telephone DP over the holiday period.

6.11 Partner agencies experienced difficulties in engaging with DP. His attendance at appointments was unreliable. There were concerns about the safety of practitioners in visiting him at his home address to conduct assessments or supervise his licence. Concerns for public safety led to the suspension of his Unpaid Work requirement. Whilst this was a defensible decision on public safety grounds, it meant that there was less supervision of him.

6.12 Agencies were over reliant on self-reporting by DP who sometimes minimised his self-harming behaviour and provided little information about his offending behaviour and what motivated it. Agencies were also heavily reliant on contacting DP's family for information, including the reasons why he had not attended appointments. The family's assurances that DP was rarely leaving his bedroom appear to have been accepted at face value and may have provided a level of reassurance which may not have been justified. Practitioners do not appear to have considered the dilemma facing the family in being prepared to work with mental health services whilst also wanting to keep DP out of further trouble.

6.13 DP's GP had no further contact with him after referring him to the community mental health team on 21st November 2014. Several letters were sent to the GP practice after that date to advise of his admission and discharge from Derriford Hospital, his non-attendance at appointments with Insight and the details of treatment prescribed by the consultant psychiatrist on 22nd December 2014. DP's GP practice takes the view that apart from remaining accessible and responsive to any emergent issues, there was no clear, specific role for primary care during that period.

6.14 DP had an unhealthy relationship with alcohol. He had been drinking when he resisted arrest and threatened custody staff with violence on 24th December 2013 (Paragraph 4.4). When he appeared at court following this arrest, the oral report presented by the Probation Officer stated that DP had monthly alcohol binges which

he acknowledged he could not handle and accepted that he should drink less (Paragraph 4.6). He had been drinking prior to his arrest in possession of a machete on 13th June 2014 (Paragraph 4.17) and his arrest having been seen in possession of machetes on 15th December 2014 (Paragraph 4.89). He disclosed to the community mental health team that he binge drank to stop the thoughts which helped him only in the short term but 'did not make him better' (Paragraph 4.50). He told both the CRC and the Insight team that he attempted serious self-harm after drinking alcohol (Paragraph 4.66 and 4.67). He repeatedly stole alcohol from a shop and later a sports and social club.

6.15 DP's alcohol abuse seems to have disinhibited DP and contributed to a loss of control and increased impulsiveness which may have elevated the risk he presented to others. Following his arrest in December 2013 and thereafter on several occasions, there were opportunities to refer DP for help with his abuse of alcohol but no practitioner appears to have considered this as an option.

6.16 No agency considered an adult safeguarding referral in respect of DP. The period on which this SAR focusses preceded the Care Act 2014. The safeguarding duty set out in the act (2) seems unlikely to have applied to DP. Whilst he had care and support needs and he was at risk of abuse from himself (self-harm), he was receiving support from the Insight team, which was the appropriate service for him to be referred to. The pre-Care Act definition of a 'vulnerable adult' set out in *No Secrets* (3) which is 'in need of community care services by reason of mental or other disability, age or illness; and who is or may be unable to take care of him or herself, or unable to protect him or herself against significant harm or exploitation', could have applied to DP but as stated he was receiving appropriate support from the correct service.

How agencies assessed and managed the risks presented by DP.
How are escalating concerns about persons such as DP recognised and responded to? (TB Family Question)

6.17 At no time was DP ever assessed as being of high risk of harm to others. In the risk assessments carried out prior to agencies becoming aware that his mental health was deteriorating on 20th November 2014, he was perceived to be of low risk of harm. Thereafter his risk to self and/or others was never assessed to be higher than medium.

6.18 With the benefit of hindsight, the risks presented by DP to himself and others can be seen to have escalated over the twelve months prior to the murder of TB:

- DP began arming himself with very dangerous weapons (Paragraphs 4.10 (baseball bat), 4.17 (machete), 4.37 (hammer), 4.43 (axe), 4.71 (two large meat cleavers) and 4.98 (knifes and an axe).

- He attacked others without provocation (Paragraphs 4.4, 4.10 and 4.98.

- He violently resisted arrest (Paragraph 4.4) and 'lashed out' at officers whilst in police custody (also Paragraph 4.4).

- He made threats of extreme violence (Paragraphs 4.4, 4.15 and 4.26).

- The police twice deployed Tasers when arresting DP (Paragraphs 4.4 and 4.71).

- DP attempted serious self-harm (Paragraph 4.54).

- DP threatened serious self-harm (Paragraph 4.4).

- DP disclosed previous self-harm (Paragraphs 4.4, 4.17, 4.40 and 4.61).

- He misused alcohol (Paragraphs 4.6, 4.50, 4.54, 4.73 and 4.98).

- He repeatedly and blatantly stole alcohol (Paragraphs 4.10, 4.16, 4.20, 4.22, 4.24, 4.37) and if challenged used or threatened violence.

6.19 Examining the twelve month period prior to the murder of TB chronologically, there appear to be a number of points at which the risks he presented to others began to escalate. From May 2014 DP began to be involved in using weapons to inflict violence (Paragraph 4.10) or carrying weapons (Paragraph 4.17). Absences and a 'bad attitude' at his UPW placement in April and May 2014 led to him being breached by the then Probation Trust. It was at this time that there was the first indication that concerns about his close family member's health could be affecting his behaviour.

6.20 During July and August 2014, his thefts of alcohol became more brazen and were accompanied by threats and violence and he was amongst a group of males who threatened a group of local residents with violence. The two month sentence he served primarily at Portland Young Offenders Institution appears to have been a stable period although he was noted to be under strain when he received news that his mother's cancer had worsened. However, whilst serving this sentence he appeared to distance himself from concerns about his mental health, describing thoughts of serious self-harm attributed to him at the time of an earlier arrest as 'rubbish' (Paragraph 4.28).

6.21 However, the risks he presented to others increased significantly following his release from Portland YOI when his pre-existing misuse of alcohol and tendency to carry weapons was accompanied by deteriorating mental health. He said he had kept an axe under his bed because of fears that his father intended to kill him. He also carried a hammer whilst breaking into a bar around this time. He made a serious attempt to hang himself in early December 2014 after a dispute with a girlfriend. Again, he was under the influence of drink and possibly drugs. And the combination of alcohol, weapons and aggression towards others were again present in the incident for which he and six other males were arrested on 15th December 2014.

6.22 When the Community Rehabilitation Company (CRC) began to supervise DP following his release from Portland at the end of October 2014 they were largely unaware of the risks DP may present to himself and others. This was due to a number of factors:

- In January 2014 the oral pre-sentencing report completed in respect of DP had not considered the concerns about DP's mental health which had arisen at the time of his arrest or explored family functioning.

- In September 2014 he had been sentenced without a pre-sentence report having failed to attend the interview arranged for that purpose.

- The lack of a pre-sentence report left Portland Young Offenders Institution without a reliable information source to inform the work they did with DP during his brief sentence.

- The police were proceeding very slowly with their investigations of the various crimes DP was suspected of committing prior to DP beginning his sentence at Portland, including an offence committed whilst he was on bail. At the time there appeared to be no mechanism for the sharing of information about offending behaviour between the police and the CRC. Whilst formal information sharing arrangements existed in respect of the Multi Agency Public Protection Arrangements (MAPPA) process, these were likely to be with the NPS rather than the CRC because MAPPA was concerned primarily with managing the offenders who had been assessed as presenting the highest risk. The review has been advised that the revised Police and Criminal Evidence Act 1984 (PACE), Code G which was implemented in November 2012, demanded more detailed consideration by arresting officers of the necessity to arrest than had previously been the case. Since that time increased emphasis has been placed on the use of alternatives to arrest, such as the use of street bail and, specifically from an interview perspective, the use of voluntary interviews under caution (4).

6.23 In exercising their responsibility for supervising DP's licence, under which he was required to be 'well behaved', 'not commit any offence' or 'do anything which could undermine the purposes of his supervision', the CRC found themselves to be largely reliant on DP's self-reporting which was not conducive to safeguarding DP or indeed the public. However, the CRC should have been aware of DP's extremely poor record of engagement with the Unpaid Work element of his Community Order. Breach action was taken against DP for failures to attend UPW (Paragraph 4.14) but this appeared to have no effect on his subsequent compliance as he attended no UPW sessions from 17th May until his youth custody sentence was imposed on 2nd September 2014. Further breach action appears to have been considered by the CRC in August 2014 but may not have been pursued in light of the youth custody sentence imposed early the following month.

6.24 Once the CRC became aware of DP's deteriorating mental health including his disclosure of previous self-harm, the CRC moved swiftly to refer him to his GP which led to a prompt triage mental health assessment. At this stage the CRC should have completed a full assessment of offender needs and risks as well as a sentence and risk management plan using the electronic Offender Assessment System (OASys). The OASys assessment should be completed within ten working days of first contact. However, the CRC newly appointed member of staff (DP's case being one of several low risk cases allocated to her on the first day in post) and was not due to receive the necessary training in how to complete OASys until 21st November 2014. However, the delay in receiving the necessary training did not appear to be a significant issue as CRC agreed that the assessment could be delayed until DP's mental health assessment had been completed. This appeared to be a defensible decision given that gaining clarity about DP's mental health would help to inform any assessment of needs and risks, although the CRC had no control over the timescales for the assessment of DP's mental health.

6.25 In the event no OASys assessment was ever completed by the CRC. The Previously mentioned SFO review concluded that a OASYs assessment had been completed but with a number of omissions. In fact, it has recently come to light that the OASys had been opened, automatically populated with information to assist the officer in completing the assessment, but had never actually been started. This meant that the CRC was assessing and managing the risks presented by DP without the support of the tool designed for that purpose. However, the SFO review found that the notes contained within the CRC log of contact with DP appeared to indicate that the focus of planning was on helping DP access the mental health assessment and treatment he needed which the SFO reviewer concluded to be the correct priority for any plan.

6.26 However, concerns about the risks that DP may present to the public limited the ability of the CRC to fully supervise DP. DP's UPW requirement was suspended on public safety grounds on 22nd November 2014. On 17th December 2014 it was decided to rule out the planned CRC home visit to DP on staff safety grounds. These were defensible decisions but appeared to be taken without consideration of whether a joint home visit with the police was a viable option. This could also have opened up lines of communication between the CRC and the police in respect of DP. The author of the CRC individual agency report says that there was no mechanism for such a joint home visit to happen.

6.27 Once the CRC became aware of DP's 15th December 2014 arrest, it was concluded that DP had breached the terms of his Youth Justice licence and this breach was listed for court. However, this process did not begin until 23rd December 2014 which meant that the CRC, would continue to supervise his licence until breach action was taken by the court on 16th January 2015. The CRC retained a duty to supervise DP after the decision to breach him had been taken, but it unclear what the CRC plan was for supervising DP during this period. The last time he was seen by the CRC was when DP attended his appointment on 9th December 2014. The next appointment was the home visit on 17th December 2014 which was cancelled on safety grounds. Thereafter unsuccessful attempts were made to contact DP by telephone on 30th December 2014 and a further appointment was planned for 8th January 2015 which would have been a month after the last appointment DP attended. There is no indication that the decision to breach DP or the arrangements for supervising his licence in the interim period prior to the breach hearing were shared with any other partner agency. This could have been of particular value to the Insight team as it may have affected their assessment of DP's risk and the content of his treatment plan.

6.28 The decision to breach DP could have been made earlier than 23rd December 2014. CRC case notes in respect of DP include a handwritten note relating to his arrest on 15th December 2014 (Paragraph 4.79). The handwritten note is dated 15th December 2014 but it is not known which agency informed the CRC of DP's arrest. As previously stated, it seems possible that the handwritten note may have been a response to the contact from the Insight team the following day of which the CRC has no record. Had the information in the handwritten note been promptly shared with the CRC it seems certain that the decision to breach DP would have been taken without delay.

6.29 The question of whether DP's breach of his Youth Justice licence could have been enforced by the issue of a warrant for his arrest has been discussed with the CRC. They have advised this review that a warrant would only be considered where the address of the service user was unknown or the service user presented an immediate risk. The officer who conducted the SFO Review also investigated why a

warrant had not been considered but was informed by the NPS that they would not have supported this on the basis that DP's location was known. However, had the 'immediate risk' route to seeking a warrant been considered, the CRC was not in a strong position to fully articulate the risks DP presented as no OASys assessment had been completed.

6.30 However, the Safeguarding Adults Review has been advised by Michael Spurr, the Chief Executive of HM Prisons and Probation, who also examined some aspects of this case (Paragraph 5.7) that the CRC 'should have considered applying for an arrest warrant to expedite the breach hearing when the police arrested and bailed DP for further offences and he subsequently failed to report to his offender manager'. It is thought that the 'failure to report' Mr. Spurr refers to may relate to the lack of response by DP to CRC attempts to telephone him on 30th December 2014 (Paragraph 4.97).

6.31 As previously stated the police granted DP bail after his arrest on 15th December 2014. DP had been arrested on suspicion of affray and booked into custody at 11.47am. When interviewed DP admitted to being the person with the meat cleavers in the CCTV footage. He said he had drunk 8-9 cans of lager and could not remember going to Stonehouse or how he got there. However, one of the other suspects stated that four of the males, including DP, had seen information posted on Facebook which led them to believe that a 'young girl' was being forced into doing acts of a sexual nature, so he and the other males went to Stonehouse to give the person responsible a 'beating'.

6.32 At 9.43pm on 15th December 2014 a Detective Sergeant authorised the police bail of DP. The entry on the custody record stated:

'This is one of seven detainees for an affray. We are not in a position to make a charging decision in relation to all of the suspects at this time. There are outstanding statements and phone work which needs to be done in relation to the build-up to the affray and possible further offences committed. I authorise that the detained person is bailed to allow further enquiries to take place.'

6.33 In authorising bail for DP, the Detective Sergeant was unaware he was subject to CRC supervision of a Youth Justice licence. This Safeguarding Adults Review has been advised by Michael Spurr that 'the releasing establishment (Portland Young Offenders Institution) should have informed the police (the Metropolitan Police PNC Bureau) so that this information could be uploaded to PNC. Unfortunately, this did not happen. The failure was that of a particular prison rather than a systemic failure. There was, and is, a Prison service Instruction regarding the sharing of licences with both the PNC and the local police – and is a long standing practice'.

6.34 However, the police review of their handling of DP's case, conducted in 2016, found that Portland Young Offenders Institution did not routinely send details of prisoners released on licence to the PNC Bureau and that continued to be the case at the time of the 2016 review; if sent to the Metropolitan Police PNC Bureau and uploaded onto PNC, the entry on a person's PNC record could be missed by staff subsequently viewing the PNC record and not all relevant details of the licence were readily available to staff viewing it; and in Devon and Cornwall the Unifi interface with the PNC did not extract the licence information available on PNC so even if the licence information was present on PNC, it would not be visible to Devon and Cornwall officers viewing a PNC record via the Unifi interface. (However, it would have been possible for officers to view the licence information, had it been present on PNC, by performing a standalone PNC search on a separate computer system). The Safeguarding Adults Review has not been made aware of any policy or practice by which licence information is, or was, shared directly with local police forces as stated by Mr. Spurr (See Paragraph above).

6.35 Focussing on the investigation of the incident for which DP and the other six suspects had been arrested, the decision to grant DP bail was defensible. It would take some time to piece together what had happened and clarify the conduct of each suspect. Phones had been seized. It would take time to analyse the relevant content. The offence of affray requires proof that people were fearful of their personal safety and so witness statements would be required. Thus, the police would be in a much stronger position to charge the suspects after enquiries had been made.

6.36 However, focussing on DP individually, as opposed to the incident, the decision to bail him appears less defensible. DP's PNC record did not inform the decision to bail DP which was unfortunate. Had DN's PNC record been reviewed prior to the bail decision being made, the following information was 'knowable' to the Detective Sergeant:

- He had been released from Portland Young Offenders Institution on 31st October 2014 (less than seven weeks earlier) for a similar offence of carrying a machete.

- He committed several offences after being granted police bail on 13th June 2014 for the machete offence (Paragraphs 4.20, 4.22, 4.25 and 4.26). However, an unintended consequence of the necessity principle which had been applied to arrests since November 2012 was that the investigation and finalisation of these offences was proceeding very slowly.

- He had committed a burglary in which he had used a hammer on 10th November 2014 to which he had been linked by DNA four days later.

- A weapons marker had been added to DP's Unifi nominal on 21st November 2014 including the information 'keeps an axe under his bed'.

- There were concerns about DP's mental health. He was known to be receiving care from Insight mental health services and he had made an attempt serious self-harm on 2nd December 2014 (less than two weeks earlier). (This information was not on PNC but was known to custody staff and the Liaison and Diversion nurse).

- He had previously been denied bail by the police 'to prevent injury to others and harm to himself' (Paragraph 4.5).

- Neither of the meat cleavers had been recovered, although DP's house had been searched at the time of his arrest.

6.37 However, focussing on the group of suspected offenders, rather than DP as an individual may have been influenced by the fact that a key element in proving an offence of affray in which two or more persons are involved is the conduct of the persons, *taken together*.

6.38 Had DP been denied bail and charged and placed before the next available Court it is not known what decision the Court would have made. It is unclear whether the fact that DP was currently being supervised on licence by the CRC would have been brought to the attention of the court as the police were unaware of this fact. However, the CRC would have been notified of any such court appearance by DP which may have enabled an earlier review of whether to commence breach action by the CRC.

6.39 Primary and secondary health services also played key roles in assessing and managing the risks presented by DP. His GP saw him on 21st November 2014 and made an immediate referral to the community mental health team. The GP felt thoughts had begun to settle and considered that DP did not have any plans to harm himself or others.

6.40 The community mental health team decided that an urgent triage mental health assessment was necessary but on the basis of the information provided by the GP and CRC, initially concluded that the risks presented by DP were too high for a standard mental health assessment to be conducted, and began to actively consider whether DP could be detained under the Mental Health Act. Unfortunately, the advice of an Approved Mental Health Practitioner was not sought at this point. After the possibility of the detaining DP under Section 136 of the Mental Health Act had been explored and ruled out by the police, the community mental health team contacted DP by telephone, and after obtaining assurances from him that he would

not be carrying any weapons, he was offered a clinic appointment for the triage assessment which took place on the same day that the GP had made the referral. A lack of congruence in DP's presentation was noted by the CMHT who carried out the assessment. He disclosed that he had carried a machete since the age of eighteen although he was reported to have no weapons currently. His self-isolating behaviour was noted which led the CMHT to conclude that he was most likely to present risks to others when he left the house for any reason including visiting the CRC.

6.41 A very positive feature of this case was effective working between the community mental health team, the Insight team and the CRC. (Unfortunately, this appeared to diminish somewhat from the point at which DP was arrested on 15th December 2014). The community mental health team advised the CRC of the outcome of the triage mental health assessment of DP. From the conversation between these agencies on 24th November 2014 (Paragraph 4.52) it appears that DP's stated self-seclusion and the positive care from his family were perceived to be giving him provided mental health services with a fairly high degree of assurance that any risks DP presented to himself and/or others could be safely managed.

6.42 The community mental health team promptly referred DP to the Insight team to enable him to be seen by a consultant psychiatrist. There was then an avoidable delay of one week in DP's case being considered at the Insight team's weekly MDT. During this intervening period DP was admitted to hospital after attempting serious self-harm. When assessed by the psychiatric liaison team in Derriford Hospital, DP significantly minimised this and the assessment concluded that he presented a minor risk of intentional self-harm, harm to others and property. It appears that the psychiatric liaison relied largely on self-reporting of DP's serious self-harm and may not have adequately reviewed his medical records which would have disclosed an earlier attempt of serious self-harm. There was a difference of view of DP's presentation between the psychiatric liaison team and the Derriford Hospital SHO (Paragraph 4.59). On the basis of the information had elicited from DP and his family, including inconsistent explanations for the attempted serious self-harm, the SHO formed the view that DP should be detained in hospital for a Mental Health Act assessment to be conducted. The issue was escalated to a (non-clinical) duty manager who confirmed the hospital policy that junior doctors such as the SHO were not allowed to use Mental Health Act powers to detain a patient for up to 72 hours. It is unfortunate that the difference of view was resolved in this manner as the psychiatric liaison assessment of DP was less than comprehensive whilst the SHO had managed to obtain a fuller, and more concerning, picture of DP. A different outcome, including the possibility of repeating the psychiatric liaison assessment of DP and involving the SHO in that assessment, may have led to a more thorough professional assessment which could have made different recommendations around ongoing care and assessment.

6.43 After DP did not attend his initial assessment appointment with the Insight team, an alternative date was offered which was wisely brought forward given DP's presentation and risk. This assessment took place at DP's home on 11th December 2014. The plan was for DP to continue to remain in the family home where his family were described as supportive of him. DP said that he could not guarantee his safety if he left the house. Clearly this was a flaw in the safety plan which appears to have gone unaddressed. Another potential flaw was the capacity of DP's family to contribute to the safety plan. As previously noted a close family member was seriously ill. Research has shown that mental health practitioners sometimes over-estimate the abilities of parents or carers to help keep their children safe and protect them from the risk of self-harm (5). Additionally, there appeared to be very little consideration of the risks to DP's family in caring for their son, except by the Derriford Hospital SHO who expressed concern about their ability to cope with him. DP had stated that he kept an axe under his bed, which suggested that DP could present a threat to his family whilst experiencing a mental health episode. Furthermore, it appears that DP may not have been completely open with his family about his mental health problems (Paragraph 4.68).

6.44 An urgent appointment to discuss treatment options was disrupted by DP's 15th December 2014 arrest and the Insight consultant psychiatrist decided against seeing DP whilst he was detained in custody on grounds which were defensible (See Paragraph 6.8). In any event a new appointment to discuss medication options was provided which DP did not attend. The missed appointment was rearranged and DP was seen by the consultant psychiatrist on Monday 22nd December 2014 and medication prescribed. There appeared to be no consideration of whether the self-seclusion safety plan remained viable given DP's arrest a week earlier and it being the time of year when there would be considerable temptation to leave his home to meet friends and drink alcohol.

6.45 The Insight team had assessed DP's risk of serious self-harm on the 16th December 2014 by the completion of the STORM assessment tool. The assessment noted that DP had recently made a serious attempt to harm himself, that he was experiencing adverse life events (close family member's ill health), emerging mental health symptoms and expressing high levels of distress. A care programme approach (CPA) risk assessment was completed on 24th December 2014 and identified DP's risk of serious self-harm and the risk of him carrying a bladed weapon in public. The risk assessments noted that further information was needed in respect of DP's offending behaviour and that this information was being sought. The risks were identified as needing to be 'pulled through' into DP's care plan. His care plan had not yet been completed due to difficulties in engaging DP in the process and his short period of engagement with the Insight team.

6.46 DP was to be allocated a care co-ordinator early in the New Year. Further telephone contact was made on 24th December 2014 to check that he had started his treatment and was not experiencing any adverse effects. However, the plan for the Christmas/New year period envisaged a single telephone contact with DP which had not taken place prior to the murder of TB on 1st January 2015.

6.47 DP was being supported by the correct team at the time of the murder but the majority of the recorded contact was with his mother. The Insight team's interventions with DP commenced only a short time prior to the murder and were adversely affected by missed appointments.

6.48 There were three points during the period in which serious concerns about DP's presentation began to emerge when a multi-agency meeting of practitioners was justified. These were the point at which DP's mental health began to deteriorate on 20th November 2014 when the CRC, the GP, the community mental health team and the police were in contact with each other. The second opportunity arose when DP was admitted to Derriford Hospital following an attempt of serious self-harm. At that point the Insight team, the hospital, the CRC and the police were all involved. Finally, DP's arrest on 15th December 2015 was the point at which the dynamic changed completely. The CRC concluded that they could no longer safely supervise DP in the community, the Insight safety plan was no longer tenable and the fears of agencies that DP might carry weapons in a public place whilst drunk and experiencing paranoia had been realised. No agency appears to have proposed a meeting on any of these occasions. The practitioner learning event organised to inform this review supported greater use of multi-agency adult safeguarding meetings of professionals whilst emphasising the need for such meetings to be organised and run in the most time efficient manner.

6.49 It is worthy of mention that on the only occasion on which an assessment of DP's mental capacity was carried out, when he was deemed to have mental capacity by the hospital psychiatric liaison team on 3rd December 2014 (Paragraph 4.54), the assessment did not appear to be decision specific.

Did the Xmas /New Year period impact of agencies involvement with DP?

6.50 The final time that DP was seen by a practitioner prior to the murder of TB was on Monday 22nd December 2014 when the consultant psychiatrist and Insight team leader visited him at his home address.

6.51 The final telephone contact with DP took place on Wednesday 24th December 2014 when the Insight team leader enquired whether he had started his treatment.

6.52 The following two days (Christmas Day and Boxing Day) were public holidays. The weekend followed on from these public holidays. There were then three working days (Monday 29th, Tuesday 30th and Wednesday 31st December 2014) prior to the murder. During this period (Tuesday 30th December), the CRC made an unsuccessful attempt to contact DP by telephone. The Insight team had planned to contact DP by telephone over the holiday period but this contact had not been made prior to the murder.

6.53 The Christmas/New Year period is a time during which agencies operate with lower staffing levels as a result of the three public holidays and much higher levels of staff annual leave.

6.54 The Christmas/New Year period was an interval in the management of DP during which there was a much reduced level of contact with him. However, the necessary assessment and treatment review had been accomplished by the Insight team although the short time DP had been receiving treatment meant that it was unlikely to yet be fully effective. The CRC had concluded that he could no longer be supervised on licence within the community and steps to initiate breach action had commenced. However, DP had not been seen by the CRC since 9th December 2014 and it is unclear how the CRC planned to manage DP until the date breach proceedings were listed for court on 16th January 2015.

6.55 The arrival of the Christmas/New Year period probably increased the risks that DP presented to self and others as practitioner contact with him would be reduced and the likelihood that he would drink alcohol was increased. However, the holiday period was a much less significant factor than DP's arrest on 15th December 2014 and the response of agencies to that arrest and the increased risks arising from the behaviour which led to that arrest.

Were inter-agency processes and communication effective?
How effective were the links between Probation/CRC and the police? (TB Family Question)

6.56 The processes for assessing DP's needs and risks and referring him for support have been addressed earlier in this report.

6.57 Communication between agencies was often prompt and effective particularly communication between the CRC, the GP practice, the community mental health team and the Insight team. The CRC and the Insight team played prominent roles in the effective communication which took place. The Derriford Hospital SHO also communicated effectively when she contacted the Insight team to stress the urgency of DP's referral.

6.58 However, as DP's presentation became increasingly concerning and addressing his needs and managing his risks became more complex, communication between agencies became more challenging. For example, the Plymouth Community HealthCare Root Cause Analysis Investigation Report found that the Insight team did not become aware that DP had been engaging in para-suicidal acts which he apparently disclosed to the CRC. The challenges in exchanging information fully and accurately was exacerbated by DP's presentation and behaviour. He frequently missed appointments which had to be hurriedly rearranged, he sometimes had understandable difficulty in articulating what he was experiencing and feeling, there were times when what he disclosed to practitioners was not entirely congruent with his presentation and there were also times when he minimised events, particularly his attempted serious self-harm on December 2nd 2014.

6.59 The Plymouth Community HealthCare Root Cause Analysis Investigation Report observed that the Insight team had delayed making a request for DP's forensic history due to the incorrect assumption that their effective liaison with the Community Rehabilitation Company would provide them with a route to access this information.

6.60 Communication between the police and the CRC was not entirely effective. The CRC had no method of contacting the police other than via the police contact centre where call handlers provided an effective generic response, although these contacts did not result in information being placed on DP's local police records to highlight his involvement with the Community Rehabilitation Company. Additionally, it would have been more helpful if the CRC could have had access to a colleague in the police who had an appreciation of offender management.

6.61 The author of the Devon and Cornwall Police individual agency report observed that formal information sharing between the police and probation was consistent with the requirements of the Crime and Disorder Act 1998 which places a duty on relevant authorities to share information to reduce crime and disorder. Information sharing had been further increased through the introduction of weekly arrest requests and the development of the Police Central Safeguarding team. However, the author felt that proactive sharing of information by the police in order to address the risks posed by offenders was less organised. The National Police Chiefs Council/ National Offender Management Service and Community Rehabilitation Companies (CRC) information sharing agreement largely deals with the supplying of police information to probation services at the request of the latter. However, the agreement does state that where the police are aware of information which is relevant to assessing the risks posed by an offender and are aware of probation involvement in the case, they should share information where it is necessary and proportionate.

6.62 The Liaison and Diversion nurse provided a valuable communication link from police custody to the Insight team following DP's arrest on 15th December 2014. However, Insight were unable to review the notes made in her assessment as these were not recorded on Plymouth Community Health's information system. It appears that the Liaison and Diversion nurse was more accustomed to sharing information with other agencies within the health economy (such as Insight) rather than other criminal justice agencies (such as the CRC). As previously stated communication between the police and the CRC following this arrest was dependent on the police being aware that DP was being supervised on licence. This information should have been available to the police custody officers via PNC but because of criminal justice system failures referred to earlier in the report, this was not the case.

Did each agency understand the role and duty of others?

6.63 As DP's needs escalated, a range of agencies became involved in his care and management. There were many examples of a lack of appreciation and understanding of the role and duties of partner agencies which may have impacted on the overall effectiveness of the multi-agency response. Importantly there was also a lack of appreciation of the limitations on the actions partner agencies could take.

6.64 Understanding the application of the Mental Health Act proved to be a particular difficulty. When the community mental health team not unreasonably raised safety concerns about conducting a triage assessment of DP on 21st November 2014, neither the CMHT nor the GP considered seeking the advice of an Approved Mental Health Professional (AMHP) at that time. Instead the CRC was asked to contact the police to request them to detain DP under Section 136 of the Mental Health Act which was not an appropriate course of action in the circumstances. Section 135 (1) of the Mental Health Act could have been considered as an alternative to Section 136. Section 135(1) provides for the removal of a person from a dwelling if it is considered they have a mental disorder and that they may be in need of care and attention for this. However, an Advanced Mental Health Practitioner attended the learning event organised to inform this review and helpfully explained the role to colleagues from a range of disciplines. Further, went on to advise that in order to make use of Section 135 (1), the AMHP must first obtain a warrant from a Magistrates Court.

6.65 It may be pertinent to note that a 2018 CQC briefing on AMHP services found a recurring theme relating to the lack of integration and joint working with other agencies (6).

6.66 As previously stated there was also some lack of clarity over the local policy for utilising Section 5(2) of the Mental Health Act to detain a patient on a hospital ward for assessment.

6.67 The very well attended learning event organised to inform this review provided an excellent opportunity for colleagues from a wide range of agencies to explore each other's roles and how they might work together more effectively to safeguard adults and protect the public. The view was strongly expressed that obtaining a better understanding of the roles of partner agencies was an important issue in its own right and it was unwise to assume that sufficient knowledge of partner agency roles was something which developed organically through multi-agency working.

What supervision and management oversight was provided during the period under review? Were practitioners proactive in escalating concerns and providing effective challenge when appropriate?

6.68 The conclusion reached by the SFO reviewer in regard to management oversight was that it was consistent with the CRC Policy and in line with expectations. The newly appointed CRC worker found a much more challenging case to manage than was anticipated but appeared to be readily able to seek guidance from management. The only challenge to the positive conclusion reached by the SFO reviewer was in the absence of any OASys assessment of DP which, it is understood, would have been of value to inform the breach process.

6.69 The Insight team leader played a proactive role in trying to ensure that DP was promptly assessed and subject to a medical review.

6.70 Actions taken to escalate the concerns which began to arise have been addressed earlier in the report. Professional challenge was not conspicuous in this case, with the exception of the Derriford Hospital SHO who challenged the outcome of the psychiatric assessment of DP and promptly communicated her concerns to the Insight team. However, had any of the opportunities to hold multi-agency meetings/discussions been taken (Paragraph 6.48), there would have been greater opportunity for professional challenge.

Why wasn't breach action taken when DP failed to attend appointments with the CRC? (TB Family Question)

6.71 Breach action was taken when DP failed to attend Unpaid Work (UPW) and the Court decided that the Community Order should continue unchanged (Paragraph 4.14). Further breach action appears to have been justified after DP continued to disregard the UPW element of his Community Order. Indeed, the CRC advised DP that they intended to take breach action in August 2014 but they didn't follow through on this possibly because his court appearance for carrying a machete was imminent (Paragraph 4.28).

6.72 Following his release from Portland YOI, DP failed to attend one appointment with the CRC on 11th November 2014 and this was rearranged for 20th November 2014. He said that he had been feeling unwell (Paragraph 4.38). It would not have been reasonable to have breached DP at this point.

Did agencies monitor DP's social media which demonstrated his interest in weapons? (TB Family Question)

6.73 The family of TB were very concerned that a short time before the murder, DP and his co-offender posted images of themselves with meat cleavers on Facebook. The family asked if any of the agencies involved with DP had been monitoring his use of social media.

6.74 In 2014 Devon and Cornwall Probation Trust had a social media policy which applied to staff usage only. Currently the CRC does not have a social media policy relating to service users. They also advise that they would not have the capacity to resource such a policy for the number of medium and low risk offenders they supervise. The CRC added the monitoring of social media would predominantly be reserved for the sex offenders managed by the National Probation Service.

6.75 The police have advised the review that any monitoring of social media has to be legal, proportionate and necessary. Their policy on 'open source investigation', including social media, allows officers to conduct overt online research without authorisation for a specific identified and necessary purpose. All such investigation must be done openly and overtly and not conceal their identity as a police officer. Any form of repeated viewing or monitoring of an account would require the necessary surveillance authority. The principles set out in the police policy are also likely to apply to partner agencies.

6.76 To have become aware of the images DP and his co-offender posted on social media a short time before the murder of TB and then to have initiated action to check on DP and his co-offender, would have required a proactive approach to the monitoring of social media allied to the capability of responding very quickly to any images which caused concern. As stated the monitoring of DP's account would have required surveillance authority and a fast response to images of concern would not be realistic in most circumstances.

The organisational context during the period under review

6.77 The supervision of DP took place during a period when the Probation Service was experiencing profound change in structure, ownership and design as part of the Transforming Rehabilitation Programme. The former Probation Trusts were split into the public owned National Probation Service (NPS) and the privately owned

Community Rehabilitation Companies (CRC), with staff being distributed between the two new organisations.

6.78 Additionally a substantial number of new procedures and processes had been put in place between the National Probation Service and the Community Rehabilitation Companies to ensure appropriate allocation of offenders to the respective organisations. These procedures were new to the staff from both organisations who initially struggled with the methodology and tools provided. Many of the new procedures were introduced at short notice. As Her Majesty's Inspector of Probation, who published several reports on the challenges involved in implementing the Transforming Rehabilitation programme, observed 'The splitting of one organisation into two separate organisations is bound to create process, communication and information sharing challenges that did not previously exist.' (7)

6.79 The author of the CRC individual management report describes a huge amount of turmoil in the organisation at the time of the separation. Staff morale was very low, with some presenting in a state of bereavement with high levels of stress and anxiety due to the split in organisations and the process of people being allocated to the two new organisations. There was a great deal of uncertainty over jobs, roles, locations and how the new owners of this CRC, Working Links was going to operate the service.

6.80 There was confusion and misunderstanding about the interface between NPS and CRC and how service users moved between both organisations. In DP's case, the increase in the level of risk he presented may have justified escalation to the NPS.

Why wasn't DP fitted with an electronic tag to ensure he complied with his licence conditions following his release from the Young Offenders Institution? (Family)

6.81 The CRC has advised this Safeguarding Adults Review that an electronic tag is not used for licence releases unless under Home Detention Curfew (HDC) and no application was made for this in respect of DP.

6.82 The current HM Prison and Probation Service Home Detention Curfew Policy Framework (8) states that in order to maintain public confidence in the scheme, certain offenders are presumed unsuitable for release on HDC. These offenders are statutorily eligible to be considered for HDC but are, as a matter of policy, presumed unsuitable for the scheme in the absence of exceptional circumstances. Anyone serving a sentence for possession of an offensive weapon is presumed unsuitable because of the risks associated with this type of offence. This would have excluded DP from a Home Detention Curfew unless exceptional circumstances had applied.

6.83 [redacted]

Was DP's mental health assessed whilst he was serving his sentence in the Young Offender's Institution? (TB Family Question)

6.84 As stated earlier in this report, Care First, the providers of healthcare in Portland YOI has advised the review that there were no concerns about DP's mental or psychological health whilst he was detained in Portland YOI (Paragraph 4.30).

Identify what changes have been introduced as a result of learning from this case including the outcome of any individual or multi-agency review activity generated by the case.

6.85 The aforementioned Devon and Cornwall Police Review (September 2016) identified the following recommendations. Action taken to implement the recommendations is shown in italics:

Recommendation 1: The process of prisons informing the Metropolitan Police PNC Bureau of prisoners released on licence. Prisons nationwide are adopting different criteria for sending, or not sending, prisoner licence details to the PNC Bureau. Until all prisoner licence details are sent to the PNC Bureau, there is every chance that incidents similar to this case will recur.

Action: *DP was released from prison on 31 October 2015 on a 3 month Notice of Supervision. The releasing establishment should have informed the police so that this information could be uploaded to the PNC. Unfortunately, this did not happen. The failure was that of a particular prison rather than a systemic failure. There was, and is, a Prison Service Instruction regarding the sharing of licences with both the PNC and the local police - and this is a long-standing practice. HM Prisons and Probation Service (HMPPS) have instructed all prisons to share licences with the PNC Bureau via dedicated e-mail addresses, and in 2017 an audit found that prisons were compliant and had eliminated all other modes of communication, although there was more to do to strengthen recording. A new Licence Management System (LMS) is due to replace the current system whereby the prisons generate licences. This will have a range of benefits, including a more efficient means of sharing comprehensive information with the PNC Bureau and local police. HMPPS are due to issue an updated Instruction in early 2019 to support the release of the LMS which will include up-to-date contact details to ensure the prison from which the offender is*

released uses the correct addresses. HMPPS continue to monitor correct e-mail addresses are being used by both prisons and the PNC Bureau (Letter from Michael Spurr dated 12th November 2018).

Recommendation 2: The manner in which licence and supervision information is presented on PNC. Licence information should be in a readily identifiable and accessible format on PNC so that it is obvious to the person viewing the record. The fallibility of a custody system interface which does not extract relevant data from PNC. The Unifi system interface does not extract the 'CU' screen information from PNC. Licence information should be recorded on that 'CU' screen. This needs to be changed with immediate effect and all forces should check the interface used to ensure the CU screen is being extracted by it from PNC.

Actions:

- *A pseudo marker has been created on the police Unifi custody system showing on the nominal screen as 'released supervised'. This marker highlights to a custody officer that the individual has a probation supervision requirement and that further information is held on PNC which is required to be checked in full. This has been created as the Unifi Custody system does not download all PNC pages including the 'CU' page where probation supervision material is held.*

- *Sharepoint Prison licence database has been created where the full licence of prisoners released to the police area are available for all police officers and staff to access.*

- *Contact with police custody staff, detectives and a training sergeant has highlighted that although the above processes have been implemented they are not fully embedded in the knowledge of officers. Custody staff are not currently seeking information regarding probation licences nor do they understand the relevance of the technical change made to the Unifi custody system created as a response to the failings in this case to indicate a PNC check of the 'CU' page where offender supervision details are held. Steps have been put in place to improve the awareness of custody staff and current 24 hrs contact details for probation services have been provided to the police so that direct contact can be made to probation officers.*

6.86 The Plymouth HealthCare Root Cause Analysis Investigation Report (May 2015) made the following recommendations (Progress achieved in italics):

Recommendation 1: That the referral process from CMHT considers best use of SystmOne in order to expedite referrals to other teams

Action: *An internal review was held and an action plan identified. It sets out work carried out with the referral pathways between community and acute hospital settings. It also identifies that after MDT meetings that raise concerns about individuals, staff should make calls to partners instead of waiting for mail to inform decisions. The Insight team now check system daily for referrals and teams referring in are encouraged to call the team to discuss the referral.*

Recommendation 2: That the insight team consider their allocation process for contacting service users during people's annual leave in order that calls are not missed.

Action: *Systems are in place to ensure that service users are adequately supported during periods when their designated worker may be on leave in order that reasonable contact is maintained by other allocated team members in context to identified needs and any known risks.*

Recommendation 3: That the Insight team consider gaining offending information on referral despite involvement with probation services.

Action: *The standard operating policy (SOP) for the service has been updated to include the following reference to offending behaviour:*

'When a referral to the service identifies offending behaviour, the team will assertively follow-up on the initial information, to seek clarification and additional information. Equally, if additional risk is identified by the Insight team, this information will be shared with the referrer and other relevant agencies.'

Recommendation 4: That there is a review of the pathway at Derriford for obtaining mental health act assessments and improvements made to actively seeking information from colleagues and available information on System One.

The Root Cause Analysis investigation report was shared with University Hospital Plymouth NHS Trust Mental Health Act Lead for information, learning and action.

Recommendation 5: That findings are shared with managers at Derriford regarding dispute resolution.

The Root Cause Analysis investigation report was shared with University Hospital Plymouth NHS Trust Mental Health Act Lead for information, learning and action.

Recommendation 6: That the liaison and diversion service is enabled to access 'write' access and training for Plymouth patients on SystmOne.

The University Hospital Plymouth NHS Trust Liaison and Diversion team have access to SystmOne including the ability to read and input data.

6.87 The Community Rehabilitation Company Serious Further Offence Review (March 2015) made the following recommendations (Progress achieved in italics):

Recommendation 1: Ensure that cases are allocated and case details are recorded accurately throughout the supervision period.

Action: *The current process is managed through a centralised hub. A Practice Instruction 'Case Allocation and Transfers' was developed and disseminated to all staff in 2015.*

Recommendation 2: Core training for new case managers to be prioritised to ensure it takes place as soon as possible after the person has come into post. The team manager to address how to provide support to staff that are new in role until the formal core training has been completed.

Action: *The Probation Support Officer development programme was introduced in 2016 for all new PSO's and existing PSO's. This is a practical course covering all aspects of work, with written assignments and assessment of practice. Unfortunately, this has not been offered since then but planned to be rolled out again in October 2019.*

Recommendation 3: Develop guidance for all team managers on the allocation of appropriate cases to new staff and level of training required to hold specific types of cases and appropriate oversight of their work.

Action: *A Practice Instruction was developed and disseminated for all managers on Management Oversight and OASys countersigning, this was launched via a training event for managers.*

Recommendation 4: Monitor completion of formal risk assessments and risk reviews through individual staff supervision and the CRC's staff observation policy.

Action: *The countersigning process in in place for all new staff. A suite of performance information was made available to all managers and staff on timely completions of assessments which is reviewed weekly across Devon and Cornwall. Staff receive regular supervision which feedback case audits for quality and assessment including the need for any risk reviews. There has been limited observations due to capacity, managers prioritise observations on new members of staff.*

Recommendation 5: Agree a protocol with the police public protection team regarding access to intelligence and escalation of concerns.

Action: *In respect of CRC access to information held on police systems, Dorset, Devon and Cornwall CRC are working with the Police and have implemented a small pilot to test new processes* (Letter from Michael Spurr dated 12th December 2018).

'Direct Access' is a proposed process where by a new information sharing agreement between police and probation has been drawn up which will place computers with police Unifi access with in probation and CRC offices. Probation officers will be able to gain direct access to the Devon and Cornwall police Unifi records of individuals under their supervision and gain details of the investigating officers and the circumstance of any incidents. The system is set up so that when records of those nominals of interest to a probation or CRC officer are updated in some way an email will be sent alerting the probation officer of the record update and prompting them to check the record for full detail. The Probation officers will have to contact police officers with knowledge of the case to gain a full understanding of the situation. It is understood that this development is close to completion but that computer hardware is awaiting supply.

Recommendation 6: Ensure that identified learning is shared via the Safeguarding Adults Board.

Action: *Plymouth Safeguarding Adults Board commissioned this Safeguarding Adults Review.*

6.88 The SFO review also raised the issue of the use of warrants by probation staff. Michael Spurr has advised this Safeguarding Adults Review that the CRC should have considered applying for an arrest warrant to expedite the breach hearing when the police arrested and bailed DP for further offences. HM Prison and Probation Service has revised the advice to probation staff about the application to the court for a Warrant Not Backed by Bail (WNBBB) and re-issued Practice Instruction 06/2014 in December 2017 to reflect the guidance. The revised Instruction clarifies and strengthens the guidance to staff about the considerations to be applied when considering the need to apply for a WNBBB. Specifically, the Instruction states that 'an assessment should include consideration of intelligence gathering and the attempts made to re-contact and re-engage the offender' (Letter from Michael Spurr dated 12th November 2018).

6.89 Whilst not specifically arising from the SFO Review, the National Probation Service has also made improvements in two relevant areas of practice:

- All breaches must be discussed with a manager and effort made to look at what can be put in place to engage the offender and increase motivation and compliance as well as looking at obstacles to undertaking the order.

- A Young Adult team has been formed across Plymouth and Cornwall which includes the Youth Offending Team NPS offender managers, the intention being to better understand and work with offenders aged 18-25.

6.90 Additionally, Dorset, Devon and Cornwall CRC has advised this review that a specific process regarding allocation between CRC and NPS has been embedded within an administration hub and is monitored closely. There are in place monthly interface meetings between NPS and CRC managers both at operational and senior management level to discuss cases of concern and any allocation issues. These meetings are also used to discuss potential risk escalations.

6.91 The CRC has also recently run a series of mandatory training events on sentence plans and assessments followed up by audits of assessments. There were some issues identified with how safeguarding is addressed within assessments which is being taken forward by managers with their teams. The CRC has recently implemented a case audit programme and all staff are observed at least once each year.

6.92 In relation to timeliness of assessments, CRC performance has improved and is closely monitored both internally and by the Ministry of Justice. Devon and Cornwall Local Delivery Units achieved 98.63% completion of all assessments within the timescale with Plymouth achieving 99.18% completion.

Could the death of the victim have been prevented if agencies had followed policies and shared information appropriately? (TB Family Question)

6.93 DP and his co-offender are personally responsible for the murder of TB and the very serious injuries they inflicted on others on 1st January 2015.

6.94 However, the question asked by TB's family is entirely appropriate given that DP had care and support needs relating to his mental health which were being addressed by the Insight team, he was being supervised on licence by the Community Rehabilitation Company and had been repeatedly coming to the attention of the police as a result of his offending behaviour.

6.95 As stated earlier the behaviour which led to DP's arrest on 15th December 2014 demonstrated that he presented escalating risks to others as a result of his repeated carrying of weapons, mental health concerns, alcohol abuse, disregard for the conditions of his licence and the difficulties agencies experienced in sustaining consistent engagement with him.

6.96 Had bail been refused on 15th December 2014 and DP placed before a Magistrates Court, it is not known what decision they would have reached. They may or may not have granted him bail, and if they had granted him bail, may have imposed conditions which may have restricted his movements had he complied with those conditions.

6.97 The Community Rehabilitation Company correctly decided to initiate breach action but this was delayed because the system by which they would have expected to be promptly notified of DP's arrest on 15th December 2014 failed. They could have more actively considered obtaining a warrant for the arrest of DP. Had they done so, and had it been possible to execute the warrant before 1st January 2015, then DP would have been placed before the Magistrates Court which would have been asked to revoke his Youth Custody Licence and return him to prison (Young Offenders Institution).

6.98 Insight's safety plan for DP depended in part on self-seclusion. Following the events which led to DP's arrest on 15th December 2014, this was no longer a viable safety plan but the plan was not reconsidered. This review has been advised that alternatives to self-seclusion included assertively inviting DP to present at the agency premises, although this option carried a risk to the public, arranging home visits, although this would have required more than one worker for each visit, and considering whether other family members could have been involved in working with the Insight team to support DP.

6.99 There was little contact with DP and his family over the Christmas/New Year period and the risks of him drinking to excess over the holiday period could have been given greater consideration.

6.100 By the time of the murder of TB, DP presented significant risks to himself and others although he had recently commenced treatment which was intended to stabilise his condition but the full effects of this may not have been felt by the time of the murder.

6.101 The risks DP presented to others were not being addressed effectively at the time of the murder because the arrangements for supervising him on licence in the community were no longer sufficient and his safety plan was predicated to an extent on self-secluding behaviour with which he was no longer compliant. However, although DP had displayed no compunction about using and threatening violence during the previous twelve months, the level of violence inflicted on the victim and others on 1st January 2015 was of a far greater severity than his previous behaviour would have led the practitioners in contact with him to reasonably anticipate.

Good practice

6.102 There were examples of very good practice in this case:

- When DP first presented as mentally unwell to the CRC on 20th November 2014, they responded by arranging a GP appointment for the same day and rearranging this for the following day when DP did not attend. The CRC also promptly arranged for DP to attend a drop-in the next day at a charity which provides support for people recovering from offending behaviour and mental ill health (Paragraph 4.40)

- DP's GP promptly referred him to the community mental health team.

- On 2nd December 2014 the police, assisted by members of the public, prevented DP's death following an attempt of serious self-harm. (Paragraph 4.54)

- On 4th December 2014 the Derriford Hospital SHO contacted the Insight team to reiterate her concerns about DP's presentation in order that urgent consideration would be given to DP's referral to Insight (Paragraph 4.61).

- On 8th December 2014 the Insight team leader intervened to bring forward DP's rearranged appointment to 11th December 2014 out of concern about the length of time between the missed appointment and the rearranged appointment, given DP's presentation and risk (Paragraph 4.66).

7.0 Finding and Recommendations

7.1 During the early hours of New Year's Day 2015 a group of friends were subjected to an unprovoked attack by DP and another male who had armed themselves with knives and an axe. During the violent assault TB was killed and some of his friends suffered very severe injuries.

The purpose of this Safeguarding Adults Review

7.2 The focus of this Safeguarding Adults Review is on DP as an adult who, in the period leading up to the murder of TB, had care and support needs. He had mental health needs which had led his GP to make an urgent referral to community mental health services less than six weeks prior to the murder. After a triage assessment he was referred to the Insight team which is an early intervention service for adults experiencing their first episode of mental health. This team had assessed his needs, prescribed treatment and a care co-ordinator was to be put in place following the Christmas/New Year period. DP was also being supervised by the Community Rehabilitation Company on a Youth Custody Licence following his release from Portland Young Offenders Institution two months prior to the murder. The Community Rehabilitation Company had been formed six months earlier and was responsible for supervising medium and low risk offenders. After DP's arrest with others for carrying weapons on 15th December 2014, the Community Rehabilitation Company decided that DP could no longer be safely supervised in the community and had initiated Court action to breach him. During the year prior to the murder, DP had come to the notice of the police on many other occasions.

7.3 A key principle of adult safeguarding is prevention, in that it is better to take action before harm occurs. In this case DP presented risks to himself and to others. He made an attempt to seriously harm himself a month before the murder. He had also attempted serious self-harm two years previously. He appeared to be adversely affected by a close family member's serious illness. He also presented risks to others. He drank alcohol to excess and behaved violently when drunk. He also drank to quieten his thoughts. He said he had been carrying weapons for up to two years 'for his own safety'. The police arrested him for carrying a machete in a public place in June 2014 for which he was sentenced to four months imprisonment, of which he served two, in Portland Young Offenders Institution. Following his release, he again began carrying weapons, self-reportedly keeping an axe under his bed out of an irrational fear and, as stated, was arrested with others after being seen to carry meat cleavers in a public place on 15th December 2014.

7.4 The purpose of this Safeguarding Adults Review is to identify what can be learned about how the various agencies, with which DP was in contact in the months prior to the murder, worked individually and collectively to meet his mental health

needs and to prevent him harming himself and others. The purpose of the Safeguarding Adults Review is not to re-investigate the crime or apportion blame to any agency or individual. The purpose is to identify learning from this case in order to improve single and multi-agency practice in an effort to prevent future tragedies.

7.5 Over the intervening years since the murder of TB, several single agency or single sector reviews have been carried out by Devon and Cornwall police, Plymouth Community HealthCare (now known as Livewell Southwest) the Community Rehabilitation Company (which conducted a Serious Further Offence Review) and HM Prisons and Probation. Each of these reviews identified valuable learning which has led to improvements in policies and systems. However, the Safeguarding Adults Review provided the first opportunity to focus on how the individual agencies worked together.

The supervision of DP by the Community Rehabilitation Company

7.6 Turning first of all to the Community Rehabilitation Company, DP's case was allocated to a newly appointed CRC member of staff to supervise his Youth Custody Licence. It was an appropriate case for the officer to supervise because at that point DP was considered to present a low risk. However, the Community Rehabilitation Company had a less than complete picture of the risk that DP presented because an oral report prepared by the Probation Service when DP appeared in court in January 2014 omitted reference to the mental health issues disclosed by DP at the time of the arrest which had precipitated the court appearance. Additionally, when DP was sentenced to imprisonment for carrying a machete in September 2014, no pre-sentence report was available to the court because DP had not attended the appointment with a Probation Officer arranged for that purpose.

7.7 When DP began presenting as mentally unwell the CRC worked very effectively with his GP and the community mental health team to facilitate a triage assessment which led to his referral to the Insight team. The CRC delayed conducting a formal assessment of DP, including a risk assessment, in order to await the outcome of his assessment by the Insight team. Delaying the formal assessment was a correct decision but, in the event, no formal assessment of DP actually took place. However, the CRC used DP's case notes as a means of recording decisions and risk assessments. As the risk which DP presented escalated, decisions were taken to suspend the unpaid work element of his licence in the interests of public safety and cancel a planned home visit on officer safety grounds. The unintended consequence of these defensible decisions was that DP was seen less frequently and the last time he attended an appointment with the CRC was on 9th December 2014.

The system for notifying the police of the releases on licence

7.8 There was a crucial delay in taking the decision to breach DP and initiate the process to do so because the system which should have ensured the police promptly notified the Community Rehabilitation Company of his arrest failed comprehensively. Portland Young Offenders Institution had not notified the Police National Computer (PNC) Bureau of DP's release on licence so the police were unaware that he was being supervised by the Community Rehabilitation Company. However, had Portland YOI notified the PNC Bureau, and had the details of the licence been entered on the PNC, it would not have been visible to the police as their computer interface would not have extracted the information from PNC. Additionally, communication between the Community Rehabilitation Company and the police was generally ineffective at that time. The CRC's only communication route into the police was to telephone the police contact centre and on the occasions the CRC rang the police in respect of DP, the fact that he was being supervised by the Community Rehabilitation Company was not recorded on his local file as it should have been.

7.9 This Safeguarding Adults Review has been advised that the system by which prisons and young offenders' institutions notify the PNC Bureau of the release of offenders on licence has been strengthened and when audited, found to be working effectively. The Safeguarding Adults Review has also been advised that the police interface with the PNC is now configured in such a way as to enable custody staff to note that an arrestee is subject to licence. However, this review has also been advised that custody staff awareness of the availability and potential value of licence information requires further effort.

7.10 It is therefore recommended that Plymouth Safeguarding Adults Board seek assurance from Devon and Cornwall Police that all relevant staff are aware of how to access licence information from the PNC, appreciate the potential value of this information and the need to promptly notify the arrest to the National Probation Service or Community Rehabilitation Company, depending on which service is supervising the offender. The Board may also wish to seek assurance that these issues are fully addressed in the training of new staff. The Board may also wish to request Devon and Cornwall Police to ensure that notifications of arrests to the National Probation Service/Community Rehabilitation Service are being made when they are required and are being made without delay.

Recommendation 1

That Devon and Cornwall Police ensure that all relevant staff are aware of how to access licence information from the PNC, appreciate the potential value of this information and the need to promptly notify any relevant arrest to the National Probation Service or Community Rehabilitation Company,

depending on which service is supervising the offender. That Devon and Cornwall Police ensure that these issues are fully addressed in the training of new staff.

Recommendation 2

That Devon and Cornwall Police ensure that the notifications of arrests to the National Probation Service/Community Rehabilitation Service are being made when they are required and are being made without delay.

7.11 The system failures which prevented the police from being aware that DP had been released on licence from a custodial sentence and was being supervised by the Community Rehabilitation Company at the time of his arrest on 15th December 2014 seem unlikely to have been limited to Devon and Cornwall. It will therefore be of benefit to share the learning from this Safeguarding Adults Review with the Metropolitan Police PNC Bureau and every police service in England and Wales so that they are able to ensure the effectiveness of systems for notifying prison releases on licence, uploading this information onto PNC and ensuring that relevant staff can access this information on PNC and are aware of the need to access and use this information appropriately.

Recommendation 3

That Plymouth Safeguarding Adults Board share the learning from this Safeguarding Adults Review with the Metropolitan Police PNC Bureau and every police service in England and Wales so that they are able to ensure the effectiveness of systems for notifying prison releases on licence, uploading this information onto PNC and ensuring that relevant staff can access this information on PNC and are aware of the need to access and use this information appropriately.

Information sharing between the police and probation

7.12 As previously stated communication and information sharing between the police and the Community Rehabilitation Company was generally ineffective in the period during which the latter service was supervising DP. This Safeguarding Adults Review has been advised that arrangements for improving information sharing between the police and National Probation Service/Community Rehabilitation Company are at an advanced stage. The proposed process, entitled 'Direct Access', entails placing computers with police Unifi access within National Probation and CRC offices. Probation officers will be able to gain direct access to the Devon and Cornwall police Unifi records of individuals under their supervision and gain details

of the investigating officers and the circumstance of any incidents. This is a very welcome step.

7.13 The Safeguarding Adults Board may wish to seek assurance that the 'Direct Access' system has been successfully implemented and that anticipated information sharing gains have been achieved.

Recommendation 4

That Devon and Cornwall Police, the National Probation Service and Dorset, Devon and Cornwall Community Rehabilitation Company ensure that the 'Direct Access' system is successfully implemented and that anticipated information sharing gains in respect of offenders supervised by the National Probation Service/Community Rehabilitation Company are realised.

Warrants to expedite breach hearings

7.14 During the period DP was supervised by the Community Rehabilitation Company the risks he presented escalated to the point at which it was considered to be no longer safe to supervise him in the community. When it was decided to breach DP the Community Rehabilitation Company should have considered applying for an arrest warrant to expedite the breach hearing. This Safeguarding Adults Review has been advised that HM Prisons and Probation Service has issued an instruction which has clarified and strengthened guidance to probation staff in respect of application to court for a warrant (Paragraph 6.86).

7.15 The Safeguarding Adults Board may wish to obtain assurance from the National Probation Service and the Dorset, Devon and Cornwall Community Rehabilitation Company that warrants are sought in order to expedite breach proceedings when appropriate.

Recommendation 5

That the National Probation Service and the Dorset and Devon and Cornwall Community Rehabilitation Company ensure that warrants are sought in order to expedite breach proceedings when appropriate.

The supervision of young adult offenders

7.16 Supervising DP's youth custody licence proved to be extremely challenging for the Community Rehabilitation Company. Although the number of young adults

involved in the criminal justice system, who are typically men, has fallen in recent years (9), young adults still account for a significant and disproportionate volume of criminal justice caseloads (10). Young adults have the highest reconviction rates of any group in that 75% are reconvicted within two years of release from prison (11). Young adults also have the highest breach rates of adults serving community sentences (12). The National Probation Service has established a local Young Adult Team to supervise offenders between the age of 18 and 25. This case discloses that whilst the supervision of young adult offenders is the responsibility of the NPS and the CRC, partner agencies also play important roles. Therefore, the Safeguarding Adults Board may wish to seek assurance in respect of the overall effectiveness of the supervision of younger offenders such as DP by the National Probation Service and Dorset, Devon and Cornwall Community Rehabilitation Company.

Recommendation 6

That the National Probation Service and Dorset, Devon and Cornwall Community Rehabilitation Company ensure the overall effectiveness of the supervision of younger adult offenders aged 18-25 years, with particular reference to reconviction and breach of community order rates.

Police bail and PNC records

7.17 When DP was released on bail by the police on 15th December 2014, none of the information recorded about DP on PNC was considered as part of that decision. The information not considered included his recent release from Portland Young Offenders Institution for a similar offence (carrying a machete), the fact that he had a history of committing offences whilst on bail, that he had committed a recent burglary in which a hammer had been used and that there was a warning marker on his file relating to the carrying of an axe. Whilst it is unfair to second guess decisions, it seems possible that had DP's PNC record been consulted, a different decision may have been taken. Additionally, it is in the public interest for relevant and readily available information to be considered when taking such a decision.

7.18 The granting of police bail has changed markedly since December 2014. Since the implementation of the Policing and Crime Act 2017 there had been a presumption of release without police bail in almost all cases unless strict criteria around necessity and proportionality are met. However, the Safeguarding Adults Board may wish to obtain assurance that in order to inform a decision to grant police bail to a suspected offender, the police will always review the suspect's PNC record.

Recommendation 7

That Devon and Cornwall Police ensure that, in order to inform any decision to grant bail to a suspected offender or release them under investigation, the police will always consider wider public safety including a review of the suspect's PNC record.

'Necessity to arrest' principle

7.19 DP came into frequent contact with the police during the year prior to the murder of TB but many of the offences he committed were dealt with less than promptly and there were occasions when the police did not recognise that DP had committed offences whilst on bail. The Safeguarding Adults Review has been advised that the less than rigorous police response to DP's repeated offending may have been an unintended consequence of 'necessity to arrest' guidance implemented across the police service of England and Wales in November 2012. Under this Association of Chief Police Officers (ACPO) guidance there is increased emphasis on alternatives to arrest such as arranging for suspects to voluntarily attend police stations for interview. Amongst the justification for this change were the desire to avoid unnecessary arrests of suspects such as teachers and school staff facing allegations and the need to find efficiencies and make savings as a result of austerity.

7.20 However, the ACPO guidance stressed the importance of avoiding unintended consequences such as officers becoming fearful of exercising lawful powers and coming to see a decision not to arrest as the default position. On the evidence presented to this Safeguarding Adults Review, there is some indication that ACPO's fears may have been realised. DP committed several offences whilst on bail following his arrest for carrying a machete in June 2014 during which time he attended the police station for a voluntary interview without any check being carried out on PNC which would have established that he was on police bail. One of the criteria for officers to consider when deciding whether to arrest or not is whether the suspect is on bail.

7.21 The Safeguarding Adults Board may wish to seek assurance from the police that they adopt a balanced approach to complying with the 'necessity to arrest' principle, that a suspect's PNC record will inform arrest decisions and that public protection considerations will always inform decisions to arrest or not.

Recommendation 8

That Devon and Cornwall Police ensures that they adopt a balanced approach to complying with the 'necessity to arrest' principle, that a suspect's PNC

record always informs arrest decisions and that public protection considerations will always inform decisions to arrest or not.

Mental Health Act advice

7.22 DP was referred promptly to the community mental health team by his GP on 21st November 2014 but when the community mental health team expressed the view that DP may need to be detained under the Mental Health Act in order to safely assess his needs, neither the GP nor the community mental health team considered seeking the advice and assistance of an Approved Mental Health Professional (AMHP).

7.23 The Safeguarding Adults Board may wish to seek assurance that the advice and support that Approved Mental Health Professionals can provide is well understood by practitioners from any of the disciplines they could be called upon to support.

Recommendation 9

That Plymouth Safeguarding Adults Board seeks assurance that the advice and support that Approved Mental Health Professionals (AMHP) can provide is well understood by practitioners from any of the disciplines they could be called upon to support.

Assessment of the risks presented by DP

7.24 Criminal justice services (the Police, the Community Rehabilitation Company and the National Probation Service) and mental health services (the Community Mental Health Team and the Insight Team) each attempted to assess the risk that DP presented to himself and others. This was an extremely challenging task from 20th November 2014 onwards as the risks DP presented began to escalate markedly. Staff were involved in a process of 'dynamic risk assessment' which became a more or less continuous process as circumstances changed quite rapidly.

7.25 Effective communication between the CRC, the CMHT, Insight and the SHO from Derriford Hospital resulted in the prompt sharing of risk information which assisted each agency to review and update their assessment of risk. However, agencies struggled to keep pace with the escalating risks and at the time of the murder their risk assessments were not fully completed or documented.

7.26 The lessons arising from this review about risk assessment are as follows:

- the assessment of risk needs to be as holistic as possible.

- individual agency risk assessments need to be informed by risk information from partner agencies.
- agencies may need to be equipped to adopt a 'dynamic risk management' approach when circumstances change quite rapidly.
- risk management plans should be reviewed when circumstances change.

7.27 Agencies proved to be quite effective in addressing the first three bullet points but were less effective in respect of the fourth bullet point.

7.28 Recommendations follow on reviewing safety plans and obtaining offending history which are intended to enhance risk management. In addition, it may be of value for a key focus of any dissemination of learning from this Safeguarding Adults Review to be 'dynamic risk management'.

Review of safety Plans

7.29 Both the community mental health team and the Insight team adopted safety plans for DP which relied upon him secluding himself in his bedroom and being supported by his family to remain safe. They also relied too heavily on information provided by his family to monitor DP's needs and the risks he presented to himself and others. Self-seclusion was no longer a viable element of the safety plan following DP's arrest on 15th December 2014. A close family member was known to be seriously ill which may have affected the family's capacity to contribute to the safety plan. Indeed, in his contribution to this review, DP stated that he was caring for his close family member at that time. Little information appeared to have been obtained about the capabilities of the family. The seriously ill close family member regarded as a reliable source of information about DP's current presentation and little consideration appeared to have been given to the dilemma facing the family in wanting to work with mental health services whilst also desiring to keep her son out of trouble. Additionally, there appeared to be no consideration of the safety of DP's family, DP had disclosed that he had been keeping an axe under his bed.

7.30 The Safeguarding Adults Board may wish to seek assurance from Livewell Southwest (Community Mental Health Team) and the Zone (Insight Team) that safety plans for patients being supported in the community are reviewed when circumstances change and that the capacity of family members to contribute to the safety plan is assessed and support provided to family members where necessary.

Recommendation 10

That Livewell Southwest (Community Mental Health Team) and the Zone (Insight Team) ensure that safety plans for patients being supported in the community are reviewed when circumstances change.

Recommendation 11

That Livewell Southwest (Community Mental Health Team) and the Zone (Insight Team) ensure that the capacity of family members to contribute to the safety plan is assessed and support provided to family members where necessary.

Offending history of referrals to mental health services

7.31 The Insight team largely relied on DP for self-reporting of his offending history. This Safeguarding Adults Review has been advised that the Insight team has developed a standard operating policy to ensure that they assertively follow up to gather the patients offending history where offending behaviour is a factor in the patient's presentation. The Safeguarding Adults Board may wish to obtain assurance from the Zone that the Standard Operating Policy is working effectively to enable them to obtain offending history of patients where relevant.

Recommendation 12

That the Zone ensures that their Standard Operating Policy is working effectively to enable them to obtain the offending history of patients where relevant.

Multi-agency meetings

7.32 As stated in Paragraph 6.48, there were occasions when holding multi-agency meetings of practitioners may have enabled agencies to gain a fuller understanding of the risks presented by DP. The practitioner learning event organised to inform this review supported greater use of multi-agency meetings of practitioners whilst emphasising the need for such meetings to be organised and run in the most time efficient manner. It is therefore recommended that Plymouth Safeguarding Adults Board promotes the holding of multi-agency meetings of practitioners when there would be benefit in doing so to safeguard adults from harm and/or to protect the public.

Recommendation 13

That Plymouth Safeguarding Adults Board promotes the holding of multi-agency meetings of practitioners when there would be benefit in doing so to safeguard adults from harm and/or to protect the public.

Awareness of partner agency roles and responsibilities

7.33 There are many examples from the review of this case where agencies were insufficiently informed about the roles, responsibilities and limitations on action of partner agencies. For example, the Insight team made an assumption that because they were in contact with the Community Rehabilitation Company in respect of DP, they would not need to seek information about his offending history from the police. The community mental health team requested the CRC to request the police to detain DP under Section 136 of the Mental Health Act when he was no longer known to be in a public place. The GP and the community mental health team did not consider seeking the advice of the AMHP. These and many other examples were explored at the very well attended learning event to inform this Safeguarding Adults Review.

7.34 When disseminating the learning from this Safeguarding Adults Review, the Safeguarding Adults Board may wish to take the opportunity to highlight information about the respective roles of the range of agencies involved in the case.

Recommendation 14

When disseminating the learning from this Safeguarding Adults Review, Plymouth Safeguarding Adults Board may wish to take the opportunity to highlight information about the respective roles of the range of agencies involved in the case.

[redacted]

7.35 [redacted]

[redacted]

7.36 [redacted]

Recommendation 15

That Plymouth Safeguarding Adults Board brings the feedback from TB's family in respect of aspects of the response to his death to the attention of the agencies concerned.

[redacted]

7.37 [redacted]

7.38 [redacted]

8.0 Single Agency Recommendations

8.1 Devon and Cornwall Police

Custody Officer licence condition awareness and direct information sharing:

- Highlight Unifi pseudo marker and define the need to check PNC and 'Sharepoint'
- Improve direct contact with probation services when individuals are in custody.
- Highlight the SharePoint prison licence system and ensure its use.
- Gain direct contact details for probation services and embed these in to custody centre knowledge.

Direct access:

- Probation services to gain alters when police update a supervised persons record
- Probation officers to have access to police Unifi system to gain detail of incidents and officers dealing
- Information Sharing Protocol (already completed)

Use of Unifi warning markers probation conditions / probation interest:

- Markers to be added to relevant nominals screens when;
  Licence condition is added to SharePoint
  Intelligence / information suggests that probation are involved with an individual and this is confirmed.
  Direction that police staff have a duty to share information that could reduce crime and disorder with probation as per policy D313.

8.2 Dorset, Devon and Cornwall Community Rehabilitation Company

1. To improve the understanding of CRC staff in relation to Mental Health/Safeguarding Adult processes in Plymouth, in particular how to escalate concerns

2. To improve the timely sharing of information with the CRC by Devon and Cornwall Police

3. Monitoring the impact of recent workshops on initial sentence plan (ISP) quality through supervision and case audits.

8.3 Livewell Southwest

Livewell Southwest reiterated historic recommendations 2, 3, 4 and 5 from the 2015 Plymouth Community HealthCare Root Cause Analysis Investigation Report (Paragraph 6.84). Livewell Southwest made no new recommendations.

8.4 Mayflower Group Practice

No recommendations

8.5 National Probation Service

1. All court report writers to attend awareness raising workshop in respect of Young Adults and links with Youth Offender Teams

2. Young Adult single point of contact (SPOC) from court team to attend local delivery unit (LDU) Young Adult team meetings which include Youth Offending Team NPS offender managers.

3. Ensure all oral and full court reports have a quality OASYs undertaken.

8.6 The Zone

1. The Zone ensures that checks should be routinely undertaken into the forensic history of people who are known to have previous offending behaviour.

2. The Zone ensures that any outstanding actions required for clients when their care coordinator is on leave are allocated and completed within an appropriate time frame.

8.7 University Hospitals Plymouth Hospitals NHS Trust

No recommendations

9.0 References

(1) Retrieved from https://www.justiceinspectorates.gov.uk/hmiprisons/wp-content/uploads/sites/4/2017/09/Portland-Web-2017.pdf

(2) Retrieved from https://www.gov.uk/government/publications/care-act-statutory-guidance/care-and-support-statutory-guidance#safeguarding-1

(3) Retrieved from https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/194272/No_secrets__guidance_on_developing_and_implementing_multi-agency_policies_and_procedures_to_protect_vulnerable_adults_from_abuse.pdf

(4) Retrieved from http://library.college.police.uk/docs/APPREF/ACPO-Position-Statement-Necessity-to-Arrest.pdf

(5) NSPCC. (2017). CAMHS: learning from case reviews. Summary of risk factors and learning for improved practice for child and adolescent mental health services.

(6) Retrieved from https://www.cqc.org.uk/sites/default/files/20180326_mha_amhpbriefing.pdf

(7) Retrieved from https://www.justiceinspectorates.gov.uk/hmiprobation/wp-content/uploads/sites/5/2015/05/Transforming-Rehabilitation2-report.pdf

(8) Retrieved from https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/790670/home-detention-curfew-pf.pdf

(9) Retrieved from https://publications.parliament.uk/pa/cm201617/cmselect/cmjust/169/169.pdf

(10) ibid

(11) ibid

(12) ibid

10. Appendix A

Membership of the SAR Panel and the process by which the SAR was completed.

A panel of senior managers from partner agencies, chaired by an independent chair, oversaw this review and membership of this panel is shown below:

- Team Manager (Adult Safeguarding and Deprivation of Liberty Safeguards), Plymouth City Council (Chair)
- Strategic Safeguarding Lead (Adults) Plymouth City Council.
- Chief Executive, The Zone/Insight Team.
- Integrated Safeguarding Manager for Children and Adults, Livewell Southwest.
- Assistant Chief Officer, Dorset, Devon and Cornwall Community Rehabilitation Company.
- Senior Probation Officer National Probation Service.
- Detective Sergeant, Devon and Cornwall Police
- Mental Capacity Act and Deprivation of Liberty Safeguards Lead Practitioner, North, Eastern and Western Devon NHS Clinical Commissioning Group.
- Named Nurse Safeguarding Adults, University Hospitals Plymouth NHS Trust
- Safeguarding Administrator, Plymouth City Council
- David Mellor, Independent Author.

It was decided to adopt a broadly systems approach to conducting this SAR. The systems approach helps identify which factors in the work environment support good practice, and which create unsafe conditions in which unsatisfactory safeguarding practice is more likely. This approach supports an analysis that goes beyond identifying *what* happened to explain *why* it did so – recognising that actions or decisions will usually have seemed sensible at the time they were taken. It is a collaborative approach to case reviews in that those directly involved in the case are centrally and actively involved in the analysis and development of recommendations.

The following previously completed single agency or single sector reviews were shared with the SAR:

- Devon and Cornwall Police Investigation Report.
- Devon and Cornwall Police Investigation Report (Complaint against Police).
- Plymouth Community HealthCare Root Cause Analysis Investigation Report.

The Serious Further Offence (SFO) review completed by Dorset, Devon and Cornwall Community Rehabilitation Company has not been shared with the Safeguarding Adults Review. However, the Dorset, Devon and Cornwall Community Rehabilitation Company chronology was derived from the SFO review (A SFO is completed when specified further offences are committed by people who are under probation supervision).

Chronologies which described and analysed relevant contacts with DP and his family were completed by the following agencies:

- Devon and Cornwall Police
- Dorset, Devon and Cornwall Community Rehabilitation Company
- Livewell Southwest (Community Mental Health Team)
- Mayflower Medical Group (GP practice)
- National Probation Service
- The Zone, Plymouth (Insight Team)
- University Hospitals Plymouth NHS Trust

A learning event took place to inform the Safeguarding Adults Review and validate the review's findings and recommendations. This was a very well attended event by practitioners from a wide range of relevant local agencies. Practitioners who had been involved in DP's case were not invited to participate in the learning event because several had moved on to other roles over the intervening years. [redacted]

11. Appendix B

Safeguarding Adult Review Recommendations (Agency updates in italics)

Recommendation 1. That Devon and Cornwall Police ensure that all relevant staff are aware of how to access licence information from the PNC, appreciate the potential value of this information and the need to promptly notify any relevant arrest to the relevant National Probation Service or Community Rehabilitation Company supervising the offender. That Devon and Cornwall Police ensure that these issues are fully addressed in the training of new staff.

Devon & Cornwall Police provide PNC training within an officer's basic training. The training and notification requirements for officers and staff to check PNC is covered in more detail under recommendation 7.

In addition, Devon & Cornwall Police have issued internal guidance to all officers and staff providing instruction on accessing licence information from the PNC. This has been reiterated in the internal Vulnerability Matters bulletin that goes to all officers and staff undertaking investigation. The bulletin goes on to outline the need for officers and staff to consider a PNC check at the earliest available opportunity for both detainees in custody and also for those suspected of a crime.

A Prison Licence page has been added to the force intranet site, where officers and staff can access full license conditions and details for the relevant probation staff member. We have also introduced the Direct Access programme (detailed in recommendation 2) which has allowed access to police IT systems for probation services. These two new introductions to police processes have aided information sharing between colleagues and partner agencies.

Recommendation 2. That Devon and Cornwall Police ensure that the notifications of arrests to the relevant National Probation Service or Community Rehabilitation Company supervising the offender are being made, when they are required and without delay.

Devon & Cornwall Police; please refer to the update provided in recommendation 4 below

Recommendation 3. That Plymouth Safeguarding Adults Board shares the learning from this Safeguarding Adults Review with the Metropolitan Police PNC Bureau and every police service in England and Wales so that they are able to ensure the effectiveness of systems for notifying prison releases on licence, uploading this information onto PNC and ensuring that relevant staff can access this information on PNC and are aware of the need to access and use this information appropriately.

The Plymouth Safeguarding Adults Board has communicated with the Metropolitan Police Service (MPS) PNC Bureau in advance of publication and provided the following update.

The MPS PNC Bureau now aim to get prison licences updated onto PNC within 24 hours of the licence details being sent to us by HMPPS. As HMPPS move towards implementing

their new IT system, it is anticipated that prison licences will be sent to us approximately two weeks ahead of the prisoners release dates, which will then enable to the licences details to be updated ahead of release.

Recommendation 4. That Devon and Cornwall Police, the NPS and CRC ensure that the 'Direct Access' system is successfully implemented and that anticipated information sharing gains, in respect of offenders supervised by the NPS and the CRC, are realised.

Devon & Cornwall Police; prior to the commissioning of the Serious Adult Review, Devon & Cornwall Police reviewed information sharing protocols between police and the probation services, (National Probation Service (NPS) and Community Rehabilitation Company (CRC)) which identified clear gaps in information sharing.

The Direct Access programme was initiated in 2017 in order to ensure enhanced and timely information sharing protocols were established, without imposing excessive demand on Police, NPS and CRC resources.

It was agreed that information regarding any police contact with statutory offenders should be shared in order to support meaningful management of statutory offenders, informed decision making and timely assessment of threat, risk and harm.

When the programme began, a limited number of vetted probation staff took part in a two day training course to enable them to be given direct access to police IT systems, which provides all contact data held by the police. Across the peninsula there are now fourteen NPS and nine CRC probation staff vetted and trained who can directly access the relevant police systems.

As part of the programme, a daily Probation Report is automatically generated with relevant details of police incidents and recent intelligence for every statutory offender who has had some form of police contact in the previous 24 hours. This automated report allows probation staff to access the information via a secure network.
It is for each NPS or CRC office to implement their own practices.

NPS; appropriate administration staff have been trained and use police consoles as NPS staff are co-located with Police Public Protection Unit. NPS will track use and determine effectiveness.

CRC; a number of staff have been trained and have access via police terminals. The CRC have also purchased licences to allow access to police systems via a web based secure link and this is in the process of being implemented.

Recommendation 5. That the National Probation Service and the Community Rehabilitation Company ensure that warrants are sought in order to expedite breach proceedings when appropriate.

NPS; where the decision is to breach a case, it will be listed at court and if the person doesn't attend a warrant can be issued. Where the person is assessed as high risk, we

would apply to the court for a warrant in the first instance and bypass the listing stage. The evidence is that both CRC and NPS use this process where appropriate.

CRC; all staff are aware that a warrant can be requested where there is evidence of escalating risk concerns.

Recommendation 6. That the National Probation Service and Community Rehabilitation Company ensure the overall effectiveness of the supervision of younger adult offenders aged 18-25 years, with particular reference to reconviction and breach of community order rates.

NPS; is responsible for allocating cases transferring from the Youth Offending Service (YOS),18-25 year olds appearing in Court and those being released on licence from custody. However if they are low or medium risk and are not subject to Multi Agency Public Protection Arrangements (MAPPA),they are allocated to the CRC who are responsible for their supervision. The NPS locally in Plymouth plans to re-establish the NPS young adult offenders unit. This will establish strong links to the local Youth Offending Team, relevant services and groups such as care experienced young people, to improve the NPS response.

CRC; are allocated and supervise 18-25 year olds who are assessed as low and medium risk of harm. There is an agreed national transition arrangement between Youth Offending Service (YOS) and the CRC to ensure effective supervision and we have strong long links with YOS at a local level.

Recommendation 7. That Devon and Cornwall Police ensure that, in order to inform any decision to grant bail to a suspected offender or release them under investigation, the police will consider wider public safety including a review of the suspect's PNC record.

Custody Sergeants undergo comprehensive training which takes five weeks and covers all the requirements to do PNC checks and to use this information when considering the release of a detainee.

They are also trained extensively in the application of the law around bail and risk assessments on the release of a detainee; which includes public and victim safety. Custody officers are tested through work place assessments which are required to prove their competency. This also includes scrutiny over their considerations when releasing a detainee.

Devon and Cornwall Police follow national guidance issued by the College of Policing, known as Authorised Professional Practice. This is a living document, shared with all UK forces and is updated by the College of Policing when there are lessons to be learned from incidents involving detainees. The training team at Devon and Cornwall Police are constantly updating the training packages based on this document to ensure they are teaching best practice.

One of the reviews, as part of this case, highlighted that not all the information on PNC is uploaded into the police custody IT system. Therefore force training now emphasises that an additional PNC check should be undertaken on the main system to see if there is any further information that would impact either, looking after a detainee or their release plan.

We have improved the way we check PNC to ensure we always have the full information. Previously custody Sergeants accessed PNC via our local IT system, Unifi. This method of access meant that officers could only see the front screen and limited information sufficient to check we had the correct person. However accessing PNC direct through a separate gateway outside of Unifi, which all officers now have, ensures the full PNC information including back screen information can be accessed to fully inform risk assessment and decision making.

To prompt staff to access this PNC information directly we have introduced the pseudo markers on the system. These markers are automatically generated on Unifi by data from the prison service. Our training ensures staff see these Unifi pseudo markers as prompts to access PNC directly to pick up all the information.

Recommendation 8. That Devon and Cornwall Police ensures that they adopt a balanced approach to complying with the 'necessity to arrest' principle, that a suspect's PNC record always informs arrest decisions and that public protection considerations will always inform decisions to arrest or not.

Devon & Cornwall Police have expanded on the recommendation contained in the review and has reminded staff that there is a necessity to review all available systems, including PNC and licence conditions at the earliest available opportunity. This is relevant both for suspects of crimes and in some cases victims, as not every case will meet the necessity criteria for arrest.

Early checking of systems allows for effective management of risk harm and threat, allows for multi-agency information sharing and for victims signposting and support. The internal investigation standards website translates the College of Policing Authorised Professional Practice into guides and guidance, which includes a section on suspect management; in particular risk, harm and threat.

In addition, an internal message has been shared with all officers and staff reminding them not to rely only on one system when carrying out checks into those involved in crimes and incidents. The message provides guidance to colleagues on other systems to utilise and what their responsibilities are. Furthermore, a secondary note has been included in the Vulnerability matters bulletin, which has been shared with all officers and staff involved in crime and investigation.

Recommendation 9. That Plymouth Safeguarding Adults Board Partners provide assurance that their agency or organisation takes the advice and support that Approved Mental Health Professionals can provide and that this is well understood by practitioners from any of the disciplines they could be called upon to support.

The Plymouth Safeguarding Adults Board will, as part of the ongoing follow up of recommendations request this assurance.

Recommendation 10. That Livewell Southwest (Community Mental Health Teams) and the Zone ensure that safety plans for patients being supported in the community are reviewed when circumstances change.

Livewell Southwest; will be including the relevant actions in the quarterly Safeguarding report presented to the operational performance meeting with further presentation to the Board Committee for assurance of development of the operational actions. Significant changes in practice have already been implemented with the investment in mental health services since the incident. Livewell Southwest transformation team is currently working to achieve a successful tender for Mental Health services and these actions will be provided so they are accommodated in the remobilisation of adult services going forward.

The Zone; as part of Care Programme Approach (CPA), care plans/safety plans are reviewed on a regular basis and at least every 6 months. This requirement is monitored externally to the team. Importantly, risk plans/care plans/safety plans are updated/reviewed when risk changes or circumstances change.

Recommendation 11. That Livewell Southwest (Community Mental Health Teams) and the Zone ensure that the capacity of family members to contribute to the safety plan is assessed and support provided to family members where necessary.

Livewell Southwest; will be reviewing the support currently provided to family members involved in the risk management of their family members' safety plans.

The Zone; the involvement of family and carers in contributing to care planning/safety planning is integral to the work of the Zone/Insight, though capacity and consent requires us naturally to be primarily mindful of the needs and wishes of the client with regard to the involvement of family and/or carers.

Recommendation 12. That the Zone ensures that their Standard Operating Policy is working effectively to enable them to obtain the offending history of patients where relevant.

The Zone; adhere to an updated standard operating policy and thus proactively obtain the offending history of clients open to their service, accessed via the safeguarding team at Livewell Southwest. To date there have been no reported instances / incidences where the policy has been breached leading to a negative outcome.

Recommendation 13. That Plymouth Safeguarding Adults Board Partners provide assurance that their agency or organisation promotes holding multi-agency meetings of practitioners when there would be benefit in doing so to safeguard adults and/or to protect the public.

The Plymouth Safeguarding Adults Board will, as part of the ongoing follow up of recommendations request this assurance.

Recommendation 14. When disseminating the learning from this Safeguarding Adults Review, Plymouth Safeguarding Adults Board takes the opportunity to highlight information about the respective roles of the range of agencies involved in the case.

The Plymouth Safeguarding Adults Board will, as part of the ongoing follow up of recommendations seek this opportunity.

Recommendation 15. That Plymouth Safeguarding Adults Board brings the feedback from TB's family in respect of aspects of the response to his death to the attention of the agencies concerned.

The Plymouth Safeguarding Adult Board has brought to the attention of all relevant agencies the feedback provided by the family of TB as part of this review.

Going forward, the Safeguarding Adult Review sub-group of the Plymouth Safeguarding Adults Board, with the oversight of a senior manager from a member agency, will develop and monitor partner agencies responses to the recommendations to ensure traction and that the learning is embedded into practice. Progress against the recommendations will be shared with those involved and reported to the Board.