ROCHDALE SAFER COMMUNITIES PARTNERSHIP

DOMESTIC HOMICIDE REVIEW

OVERVIEW REPORT v 0.9

27.05.2015

Victim Female A

CONTENTS

1. INTRODUCTION

1.1 The principal people referred to in this report are:

Female Adult 1 (FA1)	<65 years	Victim	White British
Female Adult 2 (FA2)	<45 years	Daughter	White British
Female Adult 3 (FA3)	>50 years	Wife of MA4	White British
Male Adult 1 (MA1)	<50 years	Son (Perpetrator)	White British
Male Adult 2 (MA2)	>65 years	Partner of FA1	White British
Male Adult 3 (MA3)		Father of MA1	White British
Male Adult 4 (MA4)		Husband of FA3	White British
Detective Insp (DI1)		GMP (Retired)	White British
Mental Health Nurse (MHN1)		Pennine Health Care	White British

Address 1-Home of FA1

Address 2-Rented property occupied by MA1

1.2 At 23.56hrs on a Saturday in winter 2013 Greater Manchester Police (GMP) received a 999 call from a male stating that he had murdered someone at Address 1. After making enquiries to establish who resided at the address, police officers attended and found the property locked. After locating FA2, who had the keys for the property, they entered and found FA1 on the floor. She was not breathing and the officers noted a laceration to her neck and a knife nearby. An ambulance was called but she was pronounced dead by the attending paramedic at 01.14hrs the next day.

1.3 Checks on the property disclosed that MA1 also resided there and GMP circulated details of him to their patrols in an attempt to locate him. At 0201hrs a second call was received by GMP from a male claiming responsibility for the death of FA1. He then stated his intention to commit suicide. MA1 was located, arrested and taken into custody.

1.4 GMP commenced an investigation and the cause of FA1 death was established as multiple stab wounds. MA1 was charged with the murder of FA1. An inquest into the death of FA1 was opened and adjourned by HM Coroner Simon Nelson. The inquest will not be reopened given the findings of the criminal process.

1.5 MA1 appeared at Manchester Crown Court. He pleaded guilty to the manslaughter of FA1 on the grounds of diminished responsibility. The local newspaper reported that MA1 told interviewing detectives '*alarm bells started ringing*' when he discovered some ornaments went missing from his mother's attic. In an argument that followed, his mother threatened to *'report him to social services and a psychiatrist'*. Describing what happened next, MA1 reportedly said*: "I just went for her. I threw her down and got the knife and stabbed her. I was aware I'd just stabbed my mother and I didn't have any response to it."* He also claimed that he had been *'incredibly frightened'* of his mother and admitted that he had previously *'considered killing'* both his mother and father.

1.6 The court heard that he was suffering from a mental disorder as defined by the Mental Health Act 1983 as amended by the Mental Health Act 2007. The court made an order under S37 of this Act that MA1 be detained in hospital for medical treatment. The court also imposed a restriction order under S41 of the Act, the impact of which is that MA1 must remain in hospital until the order is lifted by the Secretary of State for Justice.

2. ESTABLISHING THE DOMESTIC HOMICIDE REVIEW [DHR]

2.1 Decision Making

2.1.1 Rochdale Safer Communities Partnership [RSCP] decided on 29.1.2014 that the death of Female A met the criteria for a DHR as defined in the Multi-Agency Statutory Guidance for the Conduct of Domestic Homicide Reviews August 2013 (the Guidance).

2.1.2 The Guidance states that a decision to hold a DHR should be taken within one month of the homicide coming to the attention of the Community Safety Partnership and says it should be completed within a further six months. The completion date was set as 8.09.2014.

2.2 DHR Panel

2.2.1 David Hunter was appointed as the Independent Chair and Author on 26.02.2014. He is an independent practitioner who has chaired and written previous DHRs, Child Serious Case Reviews and Multi Agency Public Protection Reviews. He has never been employed by any of the agencies involved with this DHR and was judged to have the experience and skills for the task. The first of four panel meetings was held on 27.02.2014. Attendance was good and all members freely contributed to the analysis, thereby ensuring the issues were considered from several perspectives and disciplines. Between meetings additional work was undertaken via e-mail and telephone.

The Panel comprised of:

- David Hunter — Review author and independent chair
- Ian Halliday — Rochdale Safer Communities Partnership (RSCP)

- Caroline McCann — Pennine Care NHS Foundation Trust (PCNHSFT)
- Jane Timson — Rochdale Met. Borough Council Adult Care Services
- Paul Cartwright — Victim Support (VS)
- Janice France — Greater Manchester Probation Trust (GMPT)
- Tim Cooke — Detective Sgt Greater Manchester Police (GMP)
- Paul Cheeseman — Assistant to the Independent Chair

2.3 Agencies Submitting Individual Management Reviews (IMRs)

2.3.1 The following agencies submitted IMRs.

- Greater Manchester Police
- Pennine Care NHS Foundation Trust

2.3.2 Rochdale Met. Borough Council Adult Care Services and Heywood, Middleton and Rochdale Clinical Commissioning Group submitted chronologies.

2.4 Notifications and Involvement of Families

2.4.1 David Hunter wrote to FA2, MA2, MA3, MA4 and FA 4 to explain the DHR process and determine whether they wanted to contribute. The victim's father [MA3] agreed to take part and an appointment was made which MA3 cancelled saying he did not want to contribute to the review. David Hunter also wrote to HM Coroner Simon Nelson informing him of the DHR and offering a briefing if needed.

2.4.2 David Hunter spoke with FA3 and MA4 [former friends of the offender] on the telephone and where appropriate their knowledge has been used within the report. The victim's partner [MA2] and her daughter [FA2] and husband agreed to meet with David Hunter and were seen on 03.09.2014.

2.4.3 They have clearly suffered a tragic experience in the loss of FA1 which is made far worse by the involvement of MA1 as the perpetrator. However they were eager to assist and acted with dignity and composure when describing their personal experiences and knowledge of MA1 which is incorporated within this report.

2.4.4 The family hold an honest belief from having observed MA1 over a number of years that he is mentally ill and has a complex personality disorder which is delusional and, they are convinced, is not treatable.

2.4.5 One issue the family were eager to raise with David Hunter, and to be reflected in this report, is their disappointment that none of the mental health assessments that have taken place so far, either in the events leading up to the death of FA1 nor following his arrest have involved input from the family. They recognise and

understand that MA1 has been difficult to engage and can also be someone who plays along with the system and can be very convincing. They believe their many years of experience of MA1 should have been used when these assessments were undertaken so that a much fuller and complete picture could be presented about his behaviour.

2.4.6 Another issue the family raised, although they recognise and understand that it is outside the scope of this DHR, is the fact that MA1 is now resident in premises which are very close to the family home. They believe his condition is not treatable and that MA1 presents a danger to themselves and others which is increased significantly by his proximity to them. While they have raised the issue with the relevant agencies they remain unhappy about the explanations provided and this issue will continue to have a significant impact on their feelings of safety.

2.4.7 Following the meeting with the family written feedback was received concerning the report emphasising the following points which have been condensed for brevity;

a) If professionals are going to make assumptions when deciding which route to take they should always assume worst case scenarios when assessing risk. Just because someone with clear mental health issues (even with no diagnosis) had not carried out things they said they would do does not mean that they never would;

b) Continuous and persistent refusal to engage with services and refusal to acknowledge there is an issue should also be identified as a risk factor. The fact MA1 continually considered himself removed from or above the rules of society presents a high risk to the public;

c) Some aspects of MA1 behaviour towards people he was close to went unreported because of fears that to do so would lead to him becoming more manipulative and thereby causing more upset and distress. If family members are included in assessments it would provide a safer environment for unreported experiences to be shared which would contribute to much more accurate assessments;

d) Concern there was an overemphasis on the needs of MA1 which included his criminal behaviour being ignored;

e) A sense that because agencies did not follow policies they allowed MA1 to manipulate the course of action to his own ends;

f) The importance of using a lack of engagement as a reason to proceed down a criminal route at a much earlier opportunity.

2.5 Terms of Reference

2.5.1 The purpose of a DHR is to;

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

- Identify clearly what those lessons are both within and between agencies, how and within what timescales they will be acted on, and what is expected to change as a result;
- Apply these lessons to service responses including changes to policies and procedures as appropriate;
- Prevent domestic violence, abuse and homicides and improve service responses for all domestic violence and abuse victims and their children through improved intra and inter-agency working.

(Multi-agency Statutory Guidance for the Conduct of Domestic Homicide Reviews [2013] Section 2 Paragraph 7)

2.5.2 Timeframe under Review

The DHR covers the period 01.03.2009 to the date of the homicide of FA1.

2.5.3 Case Specific Terms

I. How did your agency identify and assess the domestic abuse risk indicators in this case; and what cognisance did you take of MA1's mental health?

II. Were the risk levels you set appropriate and what did your agency do to keep them under review?

III. Was there sufficient focus on understanding MA1's behaviour towards FA1 and the other people he harassed and did your agency apply an appropriate mixture of sanctions (arrest/charge) and treatment interventions?

IV. What services did your agency provided for FA1 and MA1 and were they timely, proportionate and 'fit for purpose' in relation to the identified levels of risk?

V. How did your agency ascertain the wishes and feelings of FA1 and MA1 about their victimisation and offending and were their views taken into account when providing services or support?

VI. How effective was your agency in gathering and sharing relevant information and did you meet any resistance?

VII. How did your agency take account of any racial, cultural, linguistic, faith or other diversity issues, when completing assessments and providing services to FA1 and MA1?

VIII. Were single and multi-agency domestic abuse policies and procedures followed including the MARAC and MAPPA protocols, are the procedures embedded in practice and were any gaps identified?

IX. How effective was your agency's supervision and management of practitioners involved with the response to the needs of the victim and

perpetrator and did managers have effective oversight and control of the case?

X. Were there any issues in relation to capacity or resources within your agency or the Partnership that affected your ability to provide services to the victim and perpetrator or to work with other agencies?

3. DEFINITIONS

3.1 Domestic Violence

3.1.1 The Government definition of domestic violence against both men and women (agreed in 2004) is:

"Any incident of threatening behaviour, violence or abuse [psychological, physical, sexual, financial or emotional] between adults who are or have been intimate partners or family members, regardless of gender or sexuality"

3.1.2 The definition of domestic violence and abuse as amended by Home Office Circular 003/2013 came into force on 14.02.2013 is:

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

- psychological
- physical
- sexual
- financial
- emotional

Controlling behaviour is: a range of acts designed to make a person subordinate and/or dependent by isolating them from sources of support, exploiting their resources and capacities for personal gain, depriving them of the means needed for independence, resistance and escape and regulating their everyday behaviour.

Coercive behaviour is: an act or a pattern of acts of assault, threats, humiliation and intimidation or other abuse that is used to harm, punish, or frighten their victim.

3.1.3 Therefore, the experiences of FA1 fell within the various descriptions of domestic violence and abuse.

3.2 Risk Assessment Processes & Terms

3.2.1 Since 2002, GMP has placed a requirement on its officers to record a consistent and minimum set of data relating to domestic incidents. This set, known locally as '1-12', is recorded on the police incident log (FWINS) and includes details of names, relationships, circumstances etc. together with an assessment of risk.

3.2.2 In conjunction with '1-12' a list of established risk factors was also used, these are commonly referred to under the acronym SPECCSSVO. The completion of the risk assessment provided an opportunity for the officer dealing with the incident of domestic abuse to comment on the established, potentially aggravating risk factors. These included;

- **S**eparation or child contact issues
- **P**regnancy or new birth
- **E**scalation in violence
- **C**ultural awareness and isolation
- **S**talking
- **S**exual Assault
- **V**ulnerable adult – including mental health issues
- **O**ther factors

3.2.3 The completion of '1-12' and the SPECCSVO risk factors was replaced in GMP in 2011 by the Domestic Abuse, Stalking and Harassment and Honour Based Violence Risk Identification and Assessment form (DASH). This is an essential element to tackling domestic abuse. It provides the information that would influence whether or not to refer the victim to a Multi-Agency Risk Assessment Conference [MARAC]. All High risk cases go to MARAC.

3.2.4 There are three parts to the DASH risk assessment model:

1. Recording of information in accordance with DASH criteria by first response police staff;

2. The full risk assessment review by specialist domestic abuse staff. In GMP these officers are referred to as Public Protection Investigation Unit (PPIU);

3. Risk management and intervention plan by specialist domestic abuse staff.

3.2.5 In GMP all incidents relating to concern for the welfare of a child, young person, unborn child or vulnerable adult due to mental health or any other vulnerability or any incident where hate is a factor must include 8 specific pieces of information relating to the vulnerable person and circumstances of the incident. Specifically there is a requirement to undertake a risk assessment which is defined as;

- Low: Minor concerns, no offences, family may have additional needs which may benefit from the support of other services (CAF), e.g. truanting, minor ASB, shabby appearance, advice of specialist unsupervised vulnerable person etc.

- Medium: Child/adult currently safe but further support and assessment needed. Ensure PPIU aware for follow up and referral to social care/health e.g. an allegation of abuse from another family member who does not pose an immediate threat to the vulnerable person, and there are no immediate forensic/care issues or investigation involving violent/drug/firearm offences by parents or cares and children may be suffering as a result.

- High: Person in need of immediate protection from significant harm. Consider PPO. S136 Mental Health Act, re-housing, target hardening, Home Link Alarm, emergency duty team and consult CID/Public Protection Investigation Unit (PPIU) and S/V e.g. physical or sexual assault or serious neglect has occurred or person is likely to be abducted etc.

3.3 Mentally Disordered Offenders Panel in Rochdale (MDOP)

3.3.1 The MDOP in Rochdale (now known as the Mentally Vulnerable Offenders Panel (MVOP)) is a multi-agency panel which, during the period of these events, was chaired by a representative of Greater Manchester Probation Trust (GMPT) and sat every three weeks. Although the panel is not a statutory body, it is similar to many other multi agency groups in other areas established in the wake of Lord Bradley's review in 2009 into how the Criminal Justice System (CJS) deals with offenders with mental health problems. The Rochdale MDOP was established before this review.

3.3.2 No formal written policy documents outlining the aims, structure or decision making frame work of the MDOP in Rochdale at the time of these events has been provided to the author of this review. However it does appear from the IMRs submitted by agencies that formalised governance and membership arrangements were in place. The author understands that formalised policy documents are now being developed.

3.3.3 During the period covered by this review the MDOP met every three weeks with standing members from GMPT, the Mentally Disordered Offenders Team (MDO) (now the Criminal Justice Mental Health Team) and the police. The purpose of the MDOP is to facilitate multi-agency discussion of offences where it is considered that mental illness or mental disorder may have contributed to the offending behaviour. Panel members share information from gathering intelligence or from direct contact which informs their decision making. It is the remit of the panel to arrive at a recommendation that will result in a suitable pathway forward. This could be to recommend continuing along the CJS route or to that mental health services are accessed.

3.4 Vulnerable Adults No Secrets

3.4.1 The broad definition of a 'vulnerable adult' referred to in the 1997 Consultation Paper Who decides?* issued by the Lord Chancellor's Department, is a person:

"Who is or may be in need of community care services by reason of mental or other disability, age or illness; and who is or may be unable to take care of him or herself, or unable to protect him or herself against significant harm or exploitation".

A consensus has emerged identifying the following main different forms of abuse:

- physical abuse, including hitting, slapping, pushing, kicking, misuse of medication, restraint, or inappropriate sanctions;

- sexual abuse, including rape and sexual assault or sexual acts to which the vulnerable adult has not consented, or could not consent or was pressured into consenting;
- psychological abuse, including emotional abuse, threats of harm or abandonment, deprivation of contact, humiliation, blaming, controlling, intimidation, coercion, harassment, verbal abuse, isolation or withdrawal from services or supportive networks;
- financial or material abuse, including theft, fraud, exploitation, pressure in connection with wills, property or inheritance or financial transactions, or the misuse or misappropriation of property, possessions or benefits;
- neglect and acts of omission, including ignoring medical or physical care needs, failure to provide access to appropriate health, social care or educational services, the withholding of the necessities of life, such as medication, adequate nutrition and heating; and discriminatory abuse, including racist, sexist, that based on a person's disability, and other forms of harassment, slurs or similar treatment.

3.4.2 Incidents of abuse may be multiple, either to one person in a continuing relationship or service context or to more than one person at a time. This makes it important to look beyond the single incident or breach in standards to underlying dynamics and patterns of harm.

Source: Section 2 No Secrets Department of Health 2000

4. BACKGROUND: FEMALE A AND MALE A

Note: The information in this section is drawn from the IMRs, an interview with MA1 by Probation Officers and family members.

4.1 Female Adult 1

4.1.1 FA1 married MA3 in 1968 and they lived at Address 1 from 1969. They had two children, MA1 and FA2 and were separated in 1982 and divorced in 1984. FA1 met her partner MA2 around 1997 and, although they were in a relationship, they did not reside together. At the time of her death FA1 worked from Address 1 as a psychotherapist. FA1 was described by her family as being a respected member of her community, very independent and a talented artist.

4.2 Male Adult 1

4.2.1 MA1 was born and raised in the Greater Manchester area and was the eldest of two siblings. His parents separated when he was aged 16 and he continued to live with FA1. He was schooled to the age of 16 leaving with 6 O-Levels (grades A-D). He then went on to undertake a 3 year Course in Art at an art college followed by employment for a period of 1 year working in Manchester as a tarot card reader. He then went to Wales to pursue a fine Art degree over a 3 year period. However he left in the final year without completing the course due to the unfortunate deaths of two close friends who committed suicide.

4.2.2 Thereafter he went on to pursue stage acting and theatre as he acquired an equity card, a qualification held by professional performers that allowed him to seek out opportunities in background performing arts for TV serials. Due to the death of his ex-partners daughter following a spate of meningitis, he asserted that he lost interest in acting and became involved in literature and spiritual healing, undertaking various charitable related works. He returned to the North in 2007 and subsequently lived alone in private rented accommodation at Address 2 until early 12.2014 when he returned to live with FA1 at address 1.

4.2.3 Family members described MA1 as being a very complex person who they believed had been a significant user of cannabis from his teens as well as other drugs such as LSD. Although lay people and not medically qualified, they had observed his behaviour for many years and described him as having a *'disordered personality'*. They stated that he spent long periods alone and completely failed to engage with other people unless there was something he wanted. They also described him as being very articulate, well read and capable of playing along and *'circumventing the system'* to obtain his own way. They had been convinced for many years that he was delusional, mentally unwell and believe that MA1 does not have the necessary insight to appreciate this and consequently accept help.

4.2.4 The report author was given a number of examples of MA1's behaviour by those who knew him. One of these was when MA1 became convinced that Lord Lucan and some of his associates were plotting to kill him. This belief arose from an innocent mistake that had been made in relation to a few pence difference in some change he had been given from a local shop. It then grew into a complex, delusional and fixated belief.

4.3 Female Adult 1 and Male Adult 1 Relationship

4.3.1 Family members described FA1 as being very protective of MA1 and eager to ensure that his privacy was protected. He moved away from address 1 and his mother some years ago when he went to University in Wales. However he maintained contact with her and returned home to visit from time to time. When he was resident at address 1 he would continue to engage in strange behaviour, always wanting to make things his own. For example FA1 worked as a psychotherapist from that address. On occasions after a long days' work she would come downstairs and find that MA1 had eaten all the food in the house leaving nothing for her to eat. On other occasions incidents have been described of when MA1 would accuse clients of FA1, without any substance, of taking items of his property from the house, for example a mandolin he owned.

4.3.2 During late 2013 MA1 experienced problems with the shower at address 2. Again, family members say an example of what they believe to be his personality disorder was that, rather than raising the issue with the landlord, he simply stopped paying the rent. This led to MA1 being evicted from the property as a result of which he moved into address 1 on what was to be a temporary basis until after Christmas.

5. THE FACTS BY AGENCY

5.1 Introduction

5.1.1 The three agencies who submitted IMRs and chronologies are dealt with separately in a narrative commentary which identifies the important points relative to the terms of reference. The main analysis of events appears in Section 6.

5.2 GREATER MANCHESTER POLICE

Allegation of Sexual Abuse

5.2.1 In 2009 MA 1 made allegations that he was the victim of sexual abuse when he was a child. These were investigated by GMP and the alleged male perpetrator arrested. The offences were denied and no prosecution ensued. Appropriate safeguarding actions were taken by the local authority.

5.2.2 Between 03.2009 and 08.2009 MA1 wrote a number of letters to GMP including a book entitled 'Nest of Vipers' outlining sexual abuse and suggesting the involvement of the police in a conspiracy with a quasi-Masonic group called 'Ordo Templis Orientis'. As a result of these letters DI1 had contact with MA1 and formed a view that he was in need of psychiatric help.

5.2.3 On 27.08.2009 MA 1 was subject to a video interview but did not provide any evidence in relation to criminal offences. He was described as paranoid, rambling and on his own admission a heavy cannabis user. During this period, because of her concerns for MA1, DI1 sought advice from a member of the Mentally Disordered Offender Team and had a number of discussions with them over the following months in relation to his care.

5.2.4 DI1 continued to oversee the investigation into the allegations of abuse and followed a plan which included reviewing the evidence against the threshold and public interest tests. On 16.03.2010 a decision was made by DI1 that these tests had not been met and the matter was finalised as 'No Criminal Offences'.

5.2.5 On 02.10.2013 MA1 sent a letter to the police station for the attention of his local Child Protection Unit. The letter included a copy of his pe-sentence psychiatric report that included a reference to sexual abuse in his childhood. The letter also contained a complaint of illegal arrest and an attempt to section him under the Mental Health Act. These matters had previously been reported to the Independent Police Complaints Commission by MA1, investigated and the matters concluded. The police log indicated that no new information came to light and no further action was required.

Harassment of FA3 and MA4

5.2.6 On 14.01.2010 GMP received a request from another police force to issue MA1 with a harassment warning. This related to FA3 who had met MA1 while they were both students at a university and had previously been a family friend. An officer from GMP spoke to MA1 and issued the warning which he acknowledged he understood.

5.2.7 On 15.04.2010 MA1 left an answer phone text message on the landline of MA4 stating that *"What goes around comes around"*. On 17.04.2010 MA1 sent a letter to MA4 stating that he was free to contact him as the harassment warning only related to FA3. These matters were reported to the police by MA4 and recorded as a crime of harassment.

5.2.8 MA4 reported two further cases of harassment to GMP; on 22.06.2010 when he received a further letter from MA1 and on 03.08.2010 when his house sitter received telephone and text messages threatening to damage MA4's vehicle. He stated that he was very concerned MA1 may endanger his family and spoke about the lack of positive action. On 16.08.2010 an officer from GMP spoke to MA1 and warned him regarding any further contact with FA3 or MA4.

5.2.9 On 7.12.2010 the same officer from GMP updated the crime report relating to the harassment of MA4. The officer had become aware from another police force that MA1 had sent a weird poem to two pubs and a shop in the area in which FA3 and MA4 lived which were intended to cause them further harassment and distress. The officer arranged for statements to be obtained and noted that MA1 would need to be arrested as he had already received a warning from him.

5.2.10 On 09.03.2011 MA4 reported to GMP that he had received a further letter he believed had originated from MA1. On 23.03.2011 MA1 was interviewed in relation to the harassment of MA4 and FA3, admitted the offence and received a caution from a GMP Inspector.

5.2.11 On 09.09.2011 MA1 posted a letter to Monmouth Social Services who passed it to Gloucestershire Social Services alleging serious concern for the welfare of MA4 and FA3's daughter. The letter alleged FA3 was involved in abusive covenic witchcraft and enclosed in it were 30 pages of a *'soon to be published book'* believed to be the 'Nest of Vipers' referred to earlier.

5.2.12 Gloucestershire Social Services were apparently aware of MA1's behaviour but decided to take no action other than to warn MA4. On 23.09.2011 MA4 reported the matter to GMP as a case of harassment. There appears to have been some delay in the investigation of the matter as on 24.11.2011 FA3 sent an e mail to GMP expressing discontent at the lack of progress which included a copy of an e mail MA1 had sent to a third party. This included the comment;

"...once I have dispensed with MA4 and FA3....

5.2.13 The following day DI1 submitted an intelligence reporting requesting she be informed if MA1 was arrested, this included the following comment;

"When MA1 is arrested he will require an appropriate adult and dependant on how he presents to the officers a formal mental health assessment may also be required"

5.2.14 A number of updates were made the same day to the crime report concerning the harassment. These indicated that liaison had taken place between GMP and the

MDO team concerning an assessment of MA1. Specifically the update included an entry from a GMP Detective Sergeant that stated;

"The nominal does not have to engage with services and at this time services have no power to intervene. The most appropriate course of action is to continue with the criminal investigation and arrest the nominal. Once arrested if it is deemed that the nominal needs an assessment whilst in custody then this can be conducted by Medacs/Social Services".

5.2.15 While the professional view of this Detective Sergeant was that, in this case, arrest was the most appropriate way of engaging MA1 it is important to stress that in other cases there may be other options. For example, consideration could be given to involving an offender in a perpetrator programme. These are either mandatory, as part of a criminal justice sanction or voluntary, as part of a community based programme. However to be successful the community programme would require the offender to be willingly engaged which it seemed at this stage MA1 was not prepared to do hence the Detective Sergeant's judgment that he should be arrested.

5.2.16 As a result of a referral by DI1, the MDOP met on 15.12.2011 and discussed the harassment of MA4 and FA3. An action was raised to check/confirm the home address of MA1 and bring the case back to the panel on 12.01.2012.

5.2.17 On 22.12.2011 the PPI log was updated by a GMP Detective Sergeant which, amongst other things, included reference to an increase in telephone calls and voice mails to the PPIU over the last few weeks which was interpreted as a deterioration of MA1's mental state. It is noteworthy that the entry included a reference that MA1 had never been violent to himself or others.

5.2.18 The same day MA1 was arrested in relation to the harassment of MA4 and FA3 and after a mental health assessment was conducted he was bailed. On 13.01.2012 MA1 was interviewed by an officer from GMP and admitted sending letters and contacting MA4 and MA3 directly and indirectly causing them harassment. He was released without charge.

5.2.19 An entry on the GMP crime report dated 13.01.2012 states the MDOP made a decision not to pursue the harassment of MA4 and FA3 through the criminal justice system due to MA1's mental health status and that the mental health team should continue to work alongside him. It was noted that criminal proceedings could be resurrected in the event of further harassment. The victims, MA4 and FA3 together with Gloucestershire Police were apprised of the outcome. It should be noted that the MDO panel minutes referred to in the Pennine Health Care IMR/Chronology make no reference to a decision having been made concerning the harassment and simply state the harassment charge was discussed.

Domestic Incident and Police Contact with FA1

5.2.20 On 12.10.2010 FA1 reported that she had received abusive and threatening text messages from MA1 concerning an inheritance he believed he was due from her. The IMR submitted by GMP notes that the content of the messages included;

- He would 'do things' if he doesn't get the money;
- He would 'draw a circle' around her for everyone to see;
- He had 'not cut FA1's head off' (but there was no suggestion that he would do that or intended anyone to think that was the case);
- FA1 was partly responsible for him being abused as a child;
- FA1 should go away and stay with her paedophile friends;
- Request to attend Address 1 to do his laundry.

5.2.21 An officer from GMP visited FA1 and established that she was more concerned about MA1's mental health. The officer's view was that, although the text messages were odd and unpleasant they did not constitute a threat. The officer completed the 1-12 and SPECSSVO assessing the risk of MA1 causing serious harm to FA1 as 'medium'. They noted on the incident log that he was a vulnerable adult and needed support in relation to the sexual abuse issue or possibly a mental health assessment. Details of the incident were sent by the officer to the PPIU as they had identified that DI1 had prior involvement with MA1. The officer also made unsuccessful attempts to check on the welfare of MA1.

5.2.22 In response to the log and the officer's e mails a Public Protection Investigation log was generated which makes reference to the details of FA1 and MA1, a civil order, referral to vulnerable adult victim services and a medium risk assessment.

5.2.23 On 31.01.2011 DI1 submitted an intelligence report which stated that;

"MA1 suffers from mental health issues and has been seen by the MDO team...He does not present with sufficient issues to enforce treatment. He was a victim of sexual abuse when he was a baby which was investigated however there was insufficient evidence to proceed. MA corresponds by letter with both DI1 and a (named) MDO worker and his current letters show a slight fixation for both. Currently that is manageable and not a cause for major concern. Copies of all letters are placed within the PPIU. The current risk level is low however this will be monitored and raised if the situation should change"

5.2.24 On 28.01.2013 when a GMP officer was making enquiries to trace MA1 he spoke to FA1 at her address where he believed MA1 was residing. The officer noted she was constantly trying to defend MA1.

5.2.25 The only further contact FA1 appears to have had with GMP concerning MA1 was when she contacted them on 06.04.2013 stating that her son was due in court in relation to stalking and harassment charges. She complained that MA4 and FA3 had a website where they had posted an article that had also appeared in the Observer newspaper. The article made reference to their harassment by MA1. FA1 was advised to seek legal advice to establish if there were grounds for having the article removed.

Harassment of DI1 and MHN1

5.2.26 Since her initial involvement with MA1 in 2009, DI1 had been contacted by him on a number of occasions both in person, by way of letter, book, text, telephone and voicemail. The update to the PPI log on 22.12.2011 indicated the volume of these increased and they appear to have been directed at DI1. Consequently on 23.12.2011 an officer from GMP issued MA1 with a harassment warning letter in relation to his continued contact with DI1.

5.2.27 When the MDOP met on 12.01.2012 it noted that MA1 had made a complaint against DI1 following his arrest and that he continued to send abusive letters, some of which included sexual content, and harass DI1.

5.2.28 On 22.05.2012 a meeting of professionals, including officers from GMP, was convened as a direct result of DI1 and MHN1 receiving an increasing number of text messages and letters from MA1. On 2nd July DI1 updated the PPI log with the following entry;

"Information received from MHN1. MA1 will not be subject to an assessment. This has been decided by a psychiatrist. The action is to offer MA1 support by MHN1. No further texts have been received by DI1. A visit has been completed by a police constable and PPIU staff to check on MA1's welfare and at this stage he is safe and well. This PPI to be closed until any further action prompts it's reopening i.e. messages or other concerns. Mental Health services remain lead. No further role for PPIU at this stage. This PPI to be finalised ending any further action required. Mental Health services remain lead agency"

5.2.29 On 14.11.2012 and 16.11.2012 MA1 sent D1 further text messages stating;

"It is illegal to impose psychiatric reviews on civilians in custody unless they have been convicted or sectioned. Your request for MA1 to be assessed was illegal...Police and Social Services have been acting illegally for decades. Now it's your turn to be driven into a breakdown you pathetic Nazi psychopath. You're going to court".

5.2.30 On 16.11.2012 MHN1 received seven text messages from MA1 which amounted to harassment and consequently these and the messages directed to DI1 were recorded by GMP as crimes.

5.2.31 MA1 was invited to his local police station on 23.11.2012 and interviewed under caution. After admitting both offences he was reported for summons. On 10.12.2012 MA attended the police station and left a letter regarding DI1. The precise contents of this letter are not recorded in the IMR. Although the log notes that no further PPIU action was necessary, as a result of its receipt a referral was made to the Initial Access Team (IAT) of mental health services requesting a further intervention with MA1.

5.2.32 On 23.03.2013 MA1 sent text messages to the mobile telephone of DI1 who, by this time, had retired from GMP. The text stated that MA1 may take his own life and that of his father. An incident log marked concern for welfare was raised and

MA1 was visited by an officer from GMP. MA1 gave reassurances to the officer that he was not violent and did not know the whereabouts of his father. He explained that he had been taking some medication for tendonitis that took the lid off his predisposition to negativity.

5.2.33 The police log was endorsed with a comment that there was no information or intelligence to indicate MA1 has actually been violent towards anyone in the past. Further entries on the log stated that MA1 refused any voluntary mental health assessment because of his deep distrust of the police, mental health and social services although he would like to receive counselling to assist in the future. The officer completing the log indicated that he had provided MA1 with the telephone number for MIND and had advised him to attend his GP surgery for alternative medication.

5.2.34 The attending officer completed the required 8 point report relating to concern for the welfare of a vulnerable adult. This included a risk assessment which the officer recorded as 'low'. The officer also referred the matter to PPIU and a log was generated indicating that consent had been given to share information and a referral sent to the IAT. The officer included the following rationale;

"(MA1) has previously come to the attention of police and mental health services. He has had a mental health assessment whilst in custody in the past and was considered fit for release. He has refused to engage with mental health services in the past and on speaking with him this appears to be due to his mistrust of the (locally) based services. Although there have been concerns for his own welfare in the past he has never actually harmed himself and never harmed anyone else. He would benefit from assistance from other services from outside (the local) area and as already noted would like to engage in counselling".

5.2.35 On 24.07.2013 MA1 attended court and pleaded guilty to pursuing a course of action that amounted to the harassment of DI1 and MHN1. He received a community order, an unpaid work requirement, and costs of £85, a restraining order and a victim surcharge of £60.

Final contact by MA1 with GMP

5.2.36 MA1's final recorded contact with GMP prior to his arrest for murder was on 30.11.2013 when he reported that he was being intimidated by his landlord who he said had had sent him a letter asking him to leave by that date. At the time of calling he said the landlord and others had arrived at his address and he felt intimidated. Five minutes after the initial call MA1 rang GMP again stating the issue had been resolved and that he had not been threatened and the police were no longer required. The police log was endorsed with a comment that this was a civil matter and MA1 would speak to Citizens Advice Bureau.

5.2.37 Enquiries with the letting agents provided an explanation that the visit was in connection with a final move out inspection. When they attended with the landlord they found MA1 was still living at the flat and had not in fact moved out. In response to MA1 they stated they were not attempting to intimidate him and were there to gain possession. A short time after this date FA1 visited the agents and

offered to contribute 50% towards clearing the arears which the agents agreed to. It was shortly after this happened they learnt of the homicide of FA1.

5.2.38 Although the agent never witnessed any threats from MA1 he describes his behaviour as very strange and received a number of e mails from MA1 which he says are very peculiar. For example a fire extinguisher went missing from the flat and MA1 accused the agents of breaking in and stealing it

5.2.39 It is now known that MA1 left that property on or shortly after that date and moved into his mother's house at address 1. It is highly likely that this move was the catalyst that led to the tragic death of FA1.

5.3 PENNINE CARE NHS FOUNDATION TRUST [MENTAL HEALTH]

5.3.1 The first recorded contact with MA1 during the period under review came after his case was brought to the Rochdale MDOP in 08.2009 as a 'cause for concern'. This was as a result of the police investigation into allegations of sexual abuse. MA1 would not consent to a psychiatric referral and at the time there were no grounds to enforce one. Two further informal, apparently unsuccessful, contacts were made in 02.2010 with MA1 in an attempt to engage him.

5.3.2 Although no minutes can be found, the next involvement with MA1 was when his case came before the MDOP in 11.2011. At this time MA1 was subject to an investigation by GMP into the harassment of MA4 and FA3 and, although the matters had not yet been recorded as a crime, by this time he was also harassing MHN1 and DI1 with multiple texts and letters.

5.3.3 MHN1 and a colleague recall the panel recommended a warning under the harassment act. However the police IMR and chronology indicates that the agreed course of action was to continue with the criminal investigation which is what actually occurred. Later that month MHN1 and a colleague made an unsuccessful attempt to visit MA1 due to GMP having provided incorrect address details.

5.3.4 MA1's case was again discussed at the MDOP on 15.12.2011 when the harassment of MA4 and FA3 was discussed as well as the letters and e mails relating to witchcraft. At this stage MHN1 advised that a mental health assessment should be considered if MA1 was arrested.

5.3.5 On 23.12.2011 MA1 was arrested and while in custody a mental health assessment was conducted by two approved doctors and a member of the mental health team. The conclusion reached was that MA1 did not meet the criteria for detention and no mental disorder was identified.

5.3.6 On 05.01.2012, MHN1 and a social worker conducted a home visit with MA1 and an assessment was conducted using the Trust's approved documentation (PAD). The assessment described troubled presentation and delusional beliefs and that MA1 attributed his issues as stemming from having being a victim of childhood sexual abuse.

5.3.7 A risk assessment was completed which found, amongst other things; no previous harm to self; lives alone and is unemployed increasing vulnerability and risk of deliberate self-harm; no previous incidents of harm to others or current intent; no

history of using violence or carrying weapons; history of harassment noted; no issues of self-neglect or being vulnerable to exploitation. When formulating the risk it was identified that it was difficult to assess any link between mental illness and harassment behaviour and that MA1 had denied such a link. The assessment did not identify any significant concerns regarding risk although it did include references to a risk of harassment to police, probation, mental health services and past acquaintances. The notes to the visit record that the plan is to attempt to engage MA1 to enable a better assessment.

5.3.8 The MDOP met on 12.01.2012 at which time the harassment was discussed as well as the abusive letters which MA1 was sending to DI1. The IMR author comments that, although the minutes suggest potential theories behind MA1's presentation this did not equate to a diagnosis. No reference is made in the chronology to the MDOP proposing any course of action in relation to the harassment charge. However a comprehensive note on the GMP crime report dated 13.01.2012 records that the MDOP had jointly decided not to pursue the harassment issue through the criminal justice system.

5.3.9 On 26.01.2012 MHN1 conducted a further home visit with MA1 to discuss what mental health services could offer, however MA1 appeared unwilling to accept this as he did not feel he had a mental disorder. Minutes from the MDOP on 02.02.2012 noted that contact with DI1 and all correspondence had stopped.

5.3.10 On 07.02.2012 the case notes record that a Detective Chief Inspector (DCI) from GMP and MHN1 visited MA1 at home. Here MA1 was told that the charges of harassment would be dropped and the complaint by him against DI1 would go no further. Although the meeting is described as amicable MA1 maintained there was a conspiracy against him. MHN1 then attempted to arrange a follow up appointment with MA1, which was not successful during which time he sent numerous texts to MHN1 denying he was mentally ill.

5.3.11 MHN1 eventually met with MA1 in a cafe on 22.02.2012 where he disclosed that he had sent letters of a threatening nature to the police in Welshpool. The MDOP minutes of 23.02.2012 record this contact and a planned visit to him by the police.

5.3.12 During 02.2012 and 03.2012 the case notes record attempts by MHN1 to contact MA1 in person and by telephone. These were not successful although MA1 continued to send abusive texts. MA1's case was discussed by the MDOP on 15.03.2012 and again on 05.04.2012 at which time it was agreed to take no further action and the case was closed by the panel.

5.3.13 The DCI mentioned at para 5.3.9 then made contact with MHN1 on 17.04.2012 expressing concerns that the police continued to receive complaints from MA1. On 22.05.2012 a meeting of professionals was convened which included the police, MHN1, the Pennine Care [Mental Health] IMR author and a colleague. Here a number of options and potential pathways were discussed. However the limiting factor in all of these was MA1's refusal to engage unless there was some means of compulsory enforcement which was unlikely as he did not meet the criteria for detention. A review of MA1's case notes by a psychiatrist was suggested.

5.3.14 The case notes record that a discussion with the area consultant took place later that month. However due to the unwillingness to engage by MA1 it was felt that input could not be imposed. Any assessment of mental health needs would most likely be achieved in a formal setting such as following arrest; a community mental health assessment would be unlikely to result in admission.

5.3.15 Although there is some confusion between the police notes and those of mental health over the date this took place, a joint visit was made to the address of MA1 involving members of the vulnerable adults team and the police PPIU. A conversation took place on the doorstep during which MA1 described feeling persecuted by groups of people including the police. He agreed to stop contacting DI1 and declined the offer of mental health input. During this visit MA1 stated that while he continued to write his book, he had no plans to self-harm and the writing of the book was identified as a protective factor in reducing such a risk.

5.3.16 MA1's case was again considered by the MDOP on 28.06.2012 when concerns were raised following threats to kill himself or harm others. The minutes indicate a joint visit was conducted by the police and mental health team (although it is unclear as to the date of this visit). The minutes also indicate MA1 suggested he would engage with the community mental health team and that a letter would be sent offering such an input. However it was subsequently decided not to send this letter as it was felt such a move might exacerbate his feelings of persecution. The MDOP minutes then record that the case was closed to the panel.

5.3.17 On 09.08.2012 the MDOP received a re-referral concerning harassment offences committed by MA1. The panel were informed that MA1's harassment of a police officer had escalated and that he had written a letter of complaint to adult care services. Case notes from 06.08.2012 also refer to a letter MA1 had written to social services accusing them of invading his privacy and making references to paedophiles in the area. It was agreed that a plan would be discussed with the community mental health team for an assessment however this did not take place due to MA1's lack of consent to engage with services.

5.3.18 The MDOP minutes of 30.08.2012 record that the police have had no further contact with MA1 and consequently no further action is required by the panel and the case is closed both by them, and the MDO team due to his lack of engagement. This was the last occasion on which MA1 was the subject of MDOP discussions. However, as outlined earlier, the harassment of MHN1 and DI1 resumed as a result of which MA1 was prosecuted.

5.3.19 It is noteworthy that, despite being the victim of this harassment MHN1 continued to maintain an interest in MA1's welfare. As he was the victim he could not undertake the role of mental health liaison, consequently he arranged for this to be carried out by another member of the team and suggested this would be an opportunity to obtain a psychiatric assessment. Following a discussion between a member of the mental health team and his legal advisor such an assessment did take place on 01.05.2013. Although the author of the IMR has not had sight of the report they believe it did not diagnose a mental disorder.

5.4 GPs (Heywood, Middleton and Rochdale Clinical Commissioning Group)

5.4.1 MA1 had very limited contact with GPs. He made visits on 28.02.2012 and 30.03.2012 for acute reaction to stress. On the first visit this is noted as being due to a couple of on-going conflicts; one in relation to him giving evidence against a relative for being involved in drug dealing with heroin and one in which the police are 'hassling him' over allegations he has made that the people he previously knew in North Wales are, or were, involved in paedophile activities. The second visit contains a reference to MA1 setting up a new business.

5.4.2 There is no detail in the notes to describe what symptoms MA1 had and it appears he was not prescribed any treatment. There is nothing in the IMR or chronology from GMP to suggest that MA1 was involved in giving evidence against a family member in connection with drug dealing. The GP notes make no reference to any suggested mental health issues.

5.4.3 FA1 made a number of visits to her GP during the period of the review. On 9.11.2010 she mentioned to her GP that she thought her son needed a mental health assessment but would not seek help himself although she recognised he could not be forced to undergo one.

5.4.4 During a visit on 05.01.2011 she complained of feeling tired due to stress with her son and again on 13.03.2012 she again complained of tiredness and discussed receiving abusive texts from her son. Finally on 03.12.2013 during a visit she mentioned her son was increasing her stress at home and discussed that he was an undiagnosed Asperger's sufferer and was going to be evicted. There is no reference any referrals were made or treatment prescribed for these issues.

6. ANALYSIS AGAINST THE TERMS OF REFERENCE

Each term appears in ***bold italics*** and is examined separately. Commentary is made using the material in the IMRs and the DHR Panel's debates. Some material would fit into more than one terms and where that happens a best fit approach has been taken. A summary table of agencies significant events associated with MA1 is attached at Appendix 'A' and helps illustrate the breadth of professional involvement.

6.1 *How did agencies identify and assess the domestic abuse risk indicators in this case; and what cognisance did they take of MA 1's mental health?*

6.1.1 During the period under review there was only one reported incident involving MA1 which fell within the definition of domestic abuse as outlined at paragraph 3.1.2. This event occurred on 12.10.2010 when FA1 reported abusive and threatening text messages from MA1. The attending officer established that FA1 was in fact more concerned about the mental health of MA1 than the text messages which the officer viewed and formed an opinion were odd and unpleasant in nature but did not constitute a threat. The officer correctly identified and assessed the incident as

one of domestic abuse given the nature of the threats revolved around the issue of an inheritance and therefore fell into the category of *'controlling, coercive or threatening behaviour.....encompass(ing) abuse (that is) financial..emotional..'*

6.1.2 The officer completed the GMP 1-12 form and also the SPECSSVO list of aggravating risk factors and assessed the level of risk as medium. In addition they endorsed the incident log with the following comment;

"...it would be of benefit for the (divisional) vulnerable adult unit to contact MA1 as he is clearly in need of some form of support whether in relation to coming to terms with the abuse he has suffered or possibly for a MN (mental health) assessment"

6.1.3 The risk identified by the officer attending this incident was reviewed the following day by specialist officers within the local PPIU who did not amend the initial risk level. The police Public Protection Incident log makes reference to a referral to vulnerable adult victim support. However, due to computer legacy issues, no further details are available to establish whether this referral took place and, if so, what action it resulted in.

6.1.4 The chronology produced by Pennine Care and Rochdale Adult Care does not make any specific references to the receipt of a referral from the police relating to this incident. However, the MDO were already aware of MA1 and had engaged with him, albeit at that time the assessment was that he was *"not demonstrating a threshold such that he could be considered a danger to himself or others"*.

6.1.5 It is a matter of conjecture whether the information concerning this incident would have put MA1 beyond the threshold of being a *'danger to others'* and therefore trigger intervention by mental health. This seems unlikely given that FA1's motive for reporting the incident seemed to have been driven by concern for MA1's health and the officer attending did not consider the messages MA1 had sent constituted a crime. Without those ingredients MA1 could not be arrested and therefore compelled to undergo a mental health assessment while in custody.

6.1.6 Further evidence of FA1's concern for MA1's mental health around this time can be inferred from the visit she made to her GP on 09.11.2010 during which time she told them that she thought MA1 needed a mental health assessment. FA1 did not appear to make any mention to her GP at that time of the threats from MA1.

6.1.7 Although not reported as domestic abuse incidents, FA1's visits to her GP in 2011, 2012 and 2013 do contain references to MA1 causing her stress and the receipt of abusive text messages.

6.1.8 While there were no other reported domestic abuse incidents, agencies in fact considered the risks MA1 might pose on three further occasions. The first of these was on 05.01.2012 when, following a mental health assessment while he was in custody, MA1 was visited at home by MHN1. The Pennine Care Trust Approved Documentation (PAD) was used to complete a risk assessment (outlined at paragraph 5.4.5). The assessment was comprehensive and covered the domains of

risk of self-harm/suicide, risk of harm/violence, risk of self-neglect and risk of exploitation/vulnerability.

6.1.9 Although this was the only formal risk assessment completed by mental health services, they tried to engage with MA1 on many other occasions (see Appendix A). On these occasions they continued to assess his mental health and found that he was not suffering from mental illness and neither did they make a formal diagnosis of mental disorder. It is noteworthy that when MA1 was seen in prison following his arrest and charge for murder he was seen by a Consultant Psychiatrist. In notes sent to the CJMHT and GP they also state that no formal mental disorder has been identified although long standing psychodynamic difficulties have been.

6.1.10 As well as the formal risk assessment conducted by an officer from GMP on 12.10.2010 further reference to the risk posed by MA1 was made by DI1 when submitting an intelligence report on 31.01.2011. This was in response to the sending of letters to DI1 and a named MDO worker. The report concluded that the letters showed a slight fixation although this was manageable and not a major cause for concern. The risk was recorded as low and would be monitored.

6.1.11 On 23.03.2013, following MA1 sending text messages to DI1, an officer attended and spoke with him. The officer identified that MA1 was a vulnerable adult and completed the required 8 point reporting and risk assessment which recorded the risk as low. As well as recording the risk the officer also referred the matter to PPIU with a recommendation for engagement with counselling for MA1 (see paragraph 5.3.39). The PPIU log makes reference to a referral to the Integrated Adults Team and the chronology provided by Adult Care Services Team records the receipt of this request from the PPIU on 25.03.2013.

6.1.12 In turn the Adult Care Services Team forwarded a letter to MA1's GP on 11.04.2013 informing them that concerns had been raised regarding his mental health. An entry on the GP Chronology for that day records an *'admin letter to social services'* with no further detail as to what the letter contained or the action that resulted. It would appear the receipt of the letter from Adult Care Services Team has been incorrectly recorded as the dispatch of a letter from the GP.

6.1.13 In addition to the formal recording and reviewing of risk set out above it was clear from the chronologies and IMRs submitted by GMP and Pennine Care NHS Trust that police officers and health professionals recognised that MA1 was vulnerable and constantly considered his welfare and the risks to, and by him. Indeed, as will be mentioned elsewhere, there was almost an over emphasis on MA1 as a vulnerable adult when a firmer stance could have been taken in relation to his criminal behaviour.

6.1.14 The review panel believes this stemmed from a genuinely held belief that MA1's perceived vulnerability meant the focus of attention should be on diversion as opposed to criminalising his behaviour. The problem for professionals from all services was that MA1 was not diagnosed as suffering from mental-illness nor a mental disorder. Without such a diagnosis, and in the absence of MA1's repeated refusal to engage voluntarily, there were no alternative pathways to divert him elsewhere.

6.2 *Were the risk levels set appropriate and what did agencies do to keep them under review?*

6.2.1 An important feature of MA1's involvement with the police and other agencies is that he does not appear to have ever used violence or weapons towards them or anyone else. None of the three formally documented risk assessments completed by agencies make any reference to such a risk and it seems there were no grounds for regarding MA1 as violent.

6.2.2 While, until he committed the homicide, MA1 did not display any behaviour that was violent he did make threats that contained direct or inferred references to violence. One of these was the incident involving FA1 on 12.10.2010 when he referred to *'doing things'* and *'not cut FA1s head off'*. While in the context of what is now known about MA1s actions those comments might well have a different significance, it is clear that the police officer attending at the time did not have any supporting evidence from which to believe these comments amounted to the very serious offence of threats to kill.

6.2.3 Nonetheless the officer remained concerned about MA1s mental condition and the panel believe their assessment of the risk as medium and the referral of MA1 through the vulnerable adult team was the correct course of action given the information then available. The subsequent endorsement of that risk level the following day by specialist officers in the PPIU reinforces the soundness of that decision.

6.2.4 The second occasion MA1 made a threat was on 23.03.2013 when he sent text messages to DI1's phone (then retired) that he may take his own and his father's life. Again those comments need to be looked at in the context of what was then known about MA1. The risk assessment states;

"Although there have been concerns for his own welfare in the past he has never actually harmed himself and never harmed anyone else..."

Based upon the information the officer had available to them and the conversation with MA1 the panel believe that the decision by the officer to request a referral to adult mental health services was the appropriate course of action to take.

6.2.5 The risk assessment documented by mental health services was the PAD completed on 05.01.2012. While comprehensive it did not identify any history of violence or carrying of weapons and no risk of domestic violence at that time. Although it was not repeated or formally reviewed it is clear that mental health services continued to try and remain engaged with MA1 either directly or through consideration of his case at the MDOP.

6.2.6 In respect of reviews of risk, Appendix 'A' provides a clear demonstration of the breadth of agency engagement with, for example, the MDOP or a professionals meeting discussing MA1 on at least 14 different occasions over almost 4 years. Each of those meetings was an opportunity to consider any changes to MA1's risk levels. While it was clear that he posed a risk of psychological harm to staff, and this was eventually addressed through his appearance at court, there is no indication that any risk or increased risk of domestic abuse was identified.

6.3 *Was there sufficient focus on understanding MA 1's behaviour towards FA 1 and the other people he harassed and did agencies apply an appropriate mixture of sanctions (arrest/charge) and treatment interventions?*

6.3.1 There was only one opportunity presented to GMP to assess MA1's behaviour towards FA1 and this related to the incident on 12.10.2010 when the victim alleged she had received threatening text messages. The complaint was investigated and the officer correctly followed the force policy in respect of domestic violence including the completion of a risk assessment. They also made attempts to trace MA1 to check on his welfare.

6.3.2 While the call received from FA1 related to text messages it is clear from the officer's conversation with her that she was more concerned about MA1's mental health. The panel believe that the referral by the officer to the PPIU for additional support demonstrated an understanding of FA1 and MA1's needs.

6.3.3 The panel have considered the information provided within the GP Chronology for FA1 in relation to comments she made on 13.03.2012 that she was receiving abusive texts from MA1. The panel has not seen any information to indicate these disclosures presented any risks to FA1. They believe her comments to the GP were of a routine and every day nature, within the context of a conversation between patient and GP about 'feeling tired'. There is no evidence to suggest the GP should have followed these up and FA1 was offered counselling which she declined.

6.3.4 In relation to mental health services the IMR author believes MDOP had little if any information available to it in respect of MA1's behaviour towards FA1. There is no indication from the chronologies that the panel ever discussed the incident on 12.10.2010 nor that information about it was shared with them by the police as they did not consider the matter required a criminal investigation and closed this incident with the referral to vulnerable adult victim support.

6.3.5 In relation to the harassment of MA4 and FA3 the police IMR author believes the sanctions applied to MA1 were progressive in nature. He received harassment warnings in relation to FA3 and then, when he switched his attention to MA4, he received a separate but additional harassment warning. Following this MA1 pursued his conduct through third parties for which he received a police caution on 24.03.2011.

6.3.6 The next step in this progressive process should have been consideration of a prosecution in respect of MA1's harassment of MA4 and FA3 which continued after the administration of this caution. The MDOP considered the harassment of MA4 and FA3 when it met on 15.12.2011. The minutes of that meeting state;

"Address details were checked and MA1 has been visited by MDO team and therapeutic options are being considered. He may have an underlying psychotic illness (not specified). He has now issued a complaint against DI1 following his arrest. He continues to send abusive letters (sexual content) and harass DI1".

6.3.7 The update to the crime report following the meeting states;

"....The case was brought before the local Mentally Disordered Offenders (MDOP) Panel. The case was discussed amongst the professionals who form the panel and it was jointly decided not to pursue the matter through the criminal justice system due to MA1's current mental health status (status unspecified). However it was agreed that MA1 should continue working alongside the mental health team (MHN1) who could monitor him and help him get well. Decision was to take no further criminal action against MA1 but should MA4/FA3 family receive any further contact from him in the future, then this matter could be resurrected and criminal proceedings considered. The victims (MA4 and FA3) and Gloucestershire police were fully apprised of the outcome"

6.3.8 The concern for MA1's welfare is clear from this minute and from many other notes that appear in agencies records. In this instance the care for MA1 and the desire for him to 'get well' appear to be the reason why a criminal justice avenue was not pursued. While this panel is not critical of such a desire it does believe there was a missed opportunity to continue along the scale of escalation in terms of tackling what was clear criminal conduct. The aims of supporting MA 1 and prosecuting him were not mutually exclusive, rather the opposite. Formal involvement with the criminal justice system may have brought an element of compulsion into assisting a person in need of expert help. MA 1 was someone likely to have benefitted from non-negotiable support.

6.3.9 MA1 is a man who knows how to circumvent systems and this is clear from the letter he sent on 17.04.2010 to MA4 stating the warning he had just received only applied to FA3. In addition to what the panel knew about the harassment of MA4 and FA3 on 12.01.2012 it also had information to hand concerning the harassment of DI1. Although MA1 had received a formal harassment warning this review panel believes that information, taken together with the harassment of MA4 and FA3, could have added weight to the need for an earlier prosecution.

6.3.10 Despite being warned about his harassment of DI1, MA1 continued with his course of conduct towards her. Panel minutes and case notes from 04.2012 show continuing text messages to the police and a note in the PPI journal from 22.05.2012 states, amongst other things;

"Actions agreed.... harassment to be pursued criminally (MA1 had already received a warning)..."

6.3.11 Despite that decision there was no immediate recourse to the criminal justice route. Subsequent panel minutes and case notes indicate MA1's behaviour in relation to his harassment of DI1 appeared to stop then recommence. For example he was referred to the panel on 09.08.2012 in relation to these matters but prosecution does not appear to have been considered. On 30.08.2012 the MDOP noted the police had received no further contact from him and therefore the case was closed.

6.3.12 It was only when his behaviour escalated in 11.2012, by which time he was also directing offensive texts at MHN1, that affirmative criminal justice action was commenced which resulted in his conviction for harassment on 24.07.2013. Again, while this panel makes no criticism of the desire to address MA1's welfare as a priority, it believes there were earlier opportunities to prosecute MA1 which may well have been more effective in addressing his criminal behaviour. In coming to

that view the panel recognises that, following his conviction, there were no further incidents of harassment of police or mental health staff.

6.4 *What services did agencies provide for FA 1 and MA 1 and were they timely, proportionate and 'fit for purpose' in relation to the identified levels of risk?*

6.4.1 There were a large number of contacts between MA1 and agencies particularly GMP and mental health services which are set out in Appendix 1 and the most significant ones described in some detail by agency in section 5. There were fewer contacts between agencies and FA1.

6.4.2 GMP's first recorded contact with both MA1 and FA1 related to allegations of sexual abuse. It is clear they conducted an extensive and searching investigation into these matters which included interviewing both MA1 and FA1 and providing extensive support to them through the process. It was a result of this first contact that officers from GMP then became closely involved, along with mental health services, continuing to recognise that MA1 was vulnerable and at risk and encouraging his engagement with services.

6.4.3 In respect of the incident on 12.10.2010, when MA1 sent abusive text messages to FA1, it is clear that the service provided by GMP met the standard of service expected for such an incident. Similarly when MA1 threatened to take his own life on 23.03.2013 the response by GMP was correct.

6.4.4 Throughout the rest of the time period of this review there are a large number of other contacts recorded concerning, MA1. It is clear to the panel that in all of these the welfare of MA1 has been a priority for GMP.

6.4.5 Similarly in respect of mental health services these were fit for purpose and as the IMR author points out reflect the flexible criteria of the Criminal Justice Mental Health Team (CJMHMT). While the attempts by mental health professionals to engage MA1 are admirable, the author of the IMR makes a very relevant point when stating;

"As MA1 did not have a diagnosed mental illness nor did he have a mental disorder it can be suggested in hindsight that the attempts made to engage him were over and above what should have been offered and if he had been dealt with by the criminal justice system at an earlier point that this would have been more appropriate. However the author believes that all agencies who had contact with MA1 felt that his emotional distress and perceived vulnerability resulted in them attempting to support him despite him not neatly fitting the criteria for services. The motivation to engage MA1 appears to stem from services wanting to reduce risks posed to himself rather than others"

6.5 *How did your agency ascertain the wishes and feelings of FA 1 and MA 1 about their victimisation and offending and were their views taken into account when providing services or support?*

6.5.1 In relation to contact with FA1, the only relevant instances during the period of the review were with GMP and her GP. The former have already been covered in some

detail earlier in this report. As far as GMP are concerned it is clear they gave consideration to her feelings, for example in relation to the issues of sexual abuse and by not pursuing the offensive text messages from MA1 as harassment and instead referring MA1 in respect of mental health concerns. It is evident from the notes the attending officer recorded that he recognised FA1's feelings towards her son where motivated by a concern for his mental welfare rather than punitive action for the texts and this was reflected in their subsequent actions.

6.5.3 As far as MA1 is concerned GMP clearly gave a great deal of consideration to his feelings as is apparent from the many contacts they had with him when they dealt with him in a sympathetic and caring way with his welfare always assuming a high priority. For example, when the officer attended on 23.03.2013 in response to MA1's threats to harm himself and his father the officer took into account the fact MA1 did not trust local service providers and therefore requested a referral to counselling out of area.

6.5.4 Similarly mental health services always appear to have demonstrated a caring and compassionate approach to MA1 taking his views into account when offering support. For example, trying to engage MA1 on 'neutral ground' in a cafe so as to gain his trust. In completing her IMR for mental health services the author makes specific mention of the fact that, despite being the victim of abusive texts, MHN1 ensured that another member of his team provided the court liaison support for MA1 which facilitated an independent psychiatric report.

6.6 *How effective was your agency in gathering and sharing relevant information and did you meet any resistance?*

6.6.1 There are no significant issues of concern in relation to communications and sharing of information between agencies. Working relationships between police, probation and mental health services via the MDOP appeared to work well. The IMR author for mental services highlights the joint meetings between senior police officers and MHN1 and the sharing of information as an example of good practice.

6.6.2 One issue of note at this point relates to the lack of a timely response to MA4 and FA3 complaints of harassment which resulted in them complaining to GMP. These concerns are recognised by the author of the GMP IMR and the panel believes that their resolution rests with the force.

6.7 *How did agencies take account of any racial, cultural, linguistic, faith or other diversity issues, when completing assessments and providing services to the FA 1 and MA 1.*

6.7.1 None of the issues above acted as barriers to engagement or the provision of services. Rather the most significant barrier was MA1 himself who showed an unwillingness to accept support which could have enabled more in depth assessment and the lack of any formal diagnosis.

6.8 *Were single and multi-agency domestic abuse policies and procedures followed including the MARAC and MAPPA protocols, are the procedures embedded in practice and were any gaps identified?*

6.8.1 Only one instance of domestic abuse was identified and this has been covered in depth elsewhere and it is clear that the policies and procedures then in place were followed and the appropriate levels of service provided. The level of risk and circumstances did not necessitate activating the MARAC or MAPPA protocols.

6.8.2 The MDOP was the multi-agency forum which provided the framework for discussion and action planning and this forum appears to have been effective for bringing professionals together to share information. However the IMR author acknowledges that the minutes of these meetings do not accurately reflect the discussions. This has hindered her capacity to provide an accurate chronology. This has been acknowledged prior to this incident and the minutes are now recorded differently to better reflect the panel's decision making. In addition formal written policies are now being developed in relation to the operation of the MDOP.

6.8.3 There was no evidence that specific contact was made by agencies with Greater Manchester Probation Trust (GMPT) requesting help with MA1. Until MA1 appeared in court on 23.07.2013 no criminal sanctions were recorded against him hence there would be no requirement for GMPT to have contact with MA1. However GMPT had knowledge of MA1 and contributed to the problem solving process as, at that time, the multi-agency MDOP was chaired by a representative of GMPT and sat every three weeks.

6.9 *How effective was the supervision and management of practitioners who responded to the victims and perpetrators needs and did managers have oversight and control of the case?*

6.9.1 All agencies appear to have maintained a reasonable level of oversight of practitioners dealing with MA1. In relation to mental health services there was direct contact with MA1 by a manager in one meeting and through correspondence with him in response to letters of complaint he sent to the local authority. This manager shared the same concerns as practitioners that, despite MA1 not meeting the criteria for services input, it was beneficial to attempt to engage him in order to further assess him.

6.9.2 In respect of GMP they also provided effective supervision and management of MA1 as DI1 was the head of the local Public Protection Investigation Unit until such time as she retired. In addition a Detective Chief Inspector also became involved and visited MA1 on at least one occasion jointly with mental health services. The panel makes no criticism of DI1's close involvement and personal commitment to MA1's case. However this involvement did seem to result in her becoming the target of unacceptable harassment from MA1 for a significant period of time which the panel believes was too long and could have been avoided by swifter recourse to a criminal justice pathway.

6.10 *Were there any issues in relation to capacity or resources within your agency or the Partnership that affected your ability to provide services to the victim and perpetrator or to work with other agencies?*

6.10.1 Neither the agencies, nor this panel, have identified any resource or capacity issues that affected their ability to provide services.

7. LESSONS IDENTIFIED

7.1 No agency identified any lessons in their IMRs. The DHR panel found this to be unusual and spent a considerable amount of time discussing this issue and whether any opportunities for learning had been overlooked. They concluded there were no obvious or serious individual gaps for agencies which impacted upon the predictability or preventability of FA1's sad death. However they did feel there were some collective lessons to learn for those agencies who comprise the MDOP (now MVOP).

i. Narrative:

MA1 had a number of contacts with agencies and his behaviour over the period of the DHR review escalated to the point at which he committed specific offences of harassment against victims that included agency staff. He failed to engage adequately with statutory mental health agencies and consequently failed to address and correct his own behaviour. Opportunities were not taken early enough to address his behaviour through a criminal justice intervention which may have corrected his behaviour.

Lesson:

Not recognising the appropriate time to escalate action against MA1 to prosecution in respect of his continuing harassment of agencies staff, enabled his harassment to continue unfettered.

ii. Narrative:

During the time of this review MA1 was assessed on two occasions and found not to be suffering from a mental disorder. However he would have benefited from support to address his behaviour although it is clear he did not believe he needed such support and positively resisted attempts to provide it. There is evidence that this resistance to engage may have been because he had a distrust of agencies or did not believe he was in need of help. In the absence of a mental disorder there was no agency framework within which MA1 could be compelled to receive support. Neither does it appear there was a framework provided by voluntary or third sector agencies that could fill this gap. As statutory agencies continue to operate within an environment in which financial and other resources are challenged it is unlikely they will have the capacity to commission additional services for clients such as MA1; particularly when they are unwilling to voluntarily engage with statutory agencies.

Lesson:

Despite the difficulties of trying to provide help to clients such as MA1 professionals will need to recognise there will always be a cohort of individuals such as MA1 who cannot be compelled to engage with agencies and for whom it is simply not practical to commission a service. These clients must not be allowed to fall through the gap and agencies and professionals

need to explore opportunities to work with voluntary and third sector organisations. As none statutory bodies these organisations may be able to gain the trust of, and engage with clients like MA1 in ways that statutory agencies cannot.

8. CONCLUSIONS

8.1 Although MA1 became well known to agencies because of his irrational and unpleasant letters, phone calls, text message and general behaviour there was no evidence before he killed FA1 that he was suffering from a mental disorder.

8.2 Although he had threatened to kill himself and his father, and the content of the text messages to his mother were threatening, he had never used violence towards his family, members of any agency or a third party. Neither had he carried or used weapons. Although agencies treated him on occasions as vulnerable, he had capacity, lived independently and was not actually vulnerable in terms of the 'No Secrets' definition. He was therefore never seen as dangerous but more a nuisance.

8.3 The difficulty for agencies was that their professional instincts seem to have been first and foremost to try and find a solution that would make MA1 'better' when such a solution, if it existed, could only be implemented with the active cooperation of MA1. However it is apparent that MA1 consistently refused to cooperate. Despite this, professionals continued to believe that the pathway to pursue was one of voluntary assessment and engagement.

8.4 In the early days MA1's offending was addressed by an escalation of punitive measures up to the point at which he received a police caution. The next step in that chain should have been prosecution. However it seems to this panel that because agencies became too focussed upon making MA1 'well' they became almost too tolerant of his behaviour and missed a very real opportunity to implement an earlier prosecution.

8.5 One of the difficulties for agencies in circumstances such as this, when there is no diagnosis of mental disorder, is the lack of a suitable service to support people in MA1's position. Consequently, as appears to have happened in this case, there is a danger that professionals intervene beyond their remit in an attempt to solve a problem.

8.6 In reaching these conclusions it should also be borne in mind that, other than FA1 who sadly lost her life, there were other victims who had expectations and on whom there was a need for a closer focus. MA4 and FA3 had been the subject of sustained and deliberate harassment from MA1. While they were made aware of the MDOP decision this panel questions whether sufficient weight was given to their position as victims when reaching the decision not to prosecute.

8.7 The panel discussed at length the very obvious anomaly; that MA1 was formally assessed on two occasions and was not diagnosed as mentally disordered yet went on to kill FA1 following which he was diagnosed as mentally disordered and is now

detained in hospital. The family raised similar issues and had substantial doubts about the accuracy of the post homicide assessments and diagnosis believing that MA1 has a delusional disorder that is not treatable.

8.8 The panel have carefully considered what may have caused this change and whether there were any gaps in the sharing of information by agencies with health professionals which could have led to the difference in diagnosis. They are satisfied there is no evidence of any such gaps. The panel recognises that assessments of mental health are subjective and based upon the presentation of an individual and facts concerning their behaviour.

8.9 The panel concludes there were no facts about MA1's behaviour that were known or available that could have indicated to those carrying out the mental health assessments that his behaviour would escalate so dramatically. The panel also recognise there were differences in the circumstances in which the mental health diagnosis were conducted that might explain the different conclusions that were reached.

8.10 The first and most obvious difference is that the recent assessments for the purpose of sentencing were conducted after a dramatic and known escalation in the behaviour of MA1; from non-violent harassment to killing with a knife. The other difference is that mental health diagnosis needs a period of time for an assessment to take place.

8.11 On the most recent occasion MA1 has been detained in custody pending trial, health professionals have had an extended period of time in which to assess him. Conversely on the earlier occasions MA1 was assessed these took place over a much shorter period which could be measured in hours rather than weeks or months. Because MA1 would not cooperate neither was it possible to work with him over an extended period and professionals had a much more limited envelope in which to reach a conclusion as to whether he was mentally disordered.

8.12 The panel therefore concludes that, while the anomaly remains, there are a number of rational reasons as to why the assessments of mental disorder may have differed so markedly.

8.13 The DHR author has also carefully considered the feelings of the family in respect of MA1's mental health assessments and their belief they should have been involved in these assessments (see paragraph 2.4.5). The author shared their views with the panel member representing Pennine Care NHS Trust and asked for an opinion in relation to the involvement of family members in relation to mental health assessments.

8.14 Their professional view is that in the case of MA1, and in all practice in general healthcare, there is only an obligation to consult the nearest relative when seeking to detain somebody under S3 of the Mental Health Act. Patient confidentially is only breached on a need to know basis and would require a significant risk issue to prompt this. MA1 was not fully engaged with any service and was extremely guarded concerning his personal and private life. The DHR panel discussed at length and concluded there was not the perceived level of dangerousness which

would have prompted agencies to seek information from his family without his consent.

8.15 The psychiatric report prepared for the court relating to the harassment charge relied upon MA1 self-reporting and it is not the purpose of such reports or assessments to undertake investigative work. If police officers had felt there were grounds to be concerned about his level of risk then they would potentially have had a remit to seek information from the family.

8.16 However mental health teams can listen to family's concerns and views and incorporate them into their formulation of an individual and it is recognised that family members are most often the best placed to advise. Practitioners are able to do this without breaching confidentiality as they do not relay patient information back to family. It would still however have been unlikely in MA1's case, or the majority of community cases such as this (i.e. single person, no active relationship contacts) for any practitioner to have the legal grounds or the jurisdiction to seek out third party information particularly without consent.

8.17 The author understands there are professional and legal issues which do not always make it possible to share mental health assessments in many cases with family members. However he still believes the family's idea of exploring opportunities for closer engagement with them does have merit.

9. PREDICTABILITY/PREVENTABILITY

9.1 Only one contact between GMP, and FA1 concerned domestic abuse and this occurred some three years before she became a victim at the hands of MA1. The risk assessment that was completed therefore has little relevance in reaching a view as to whether his actions in killing FA1 on 14th December 2013 were predictable.

9.2 As discussed earlier on in this report, while MA1 had multiple contacts with agencies, he had never used violence or weapons and other than the incident above had never been considered to present a threat to FA1. Indeed, once he had appeared in court on 23.07.2013 his level of offending behaviour stopped. Although he continued to have contact with agencies these were much fewer in number and none of them related to him harassing or threatening victims. Consequently during the period between conviction and his arrest for murder there were no opportunities or reasons why agencies should carry out an assessment of risk in relation to MA1 and FA1.

9.3 Based upon the reported admissions made in interview it would seem that the catalyst for the death of FA1 was MA1's move out of rented accommodation and back into address 1 on, or soon after, 03.12.2013. A series of events then occurred within the house between FA1 and MA1 that culminated in him killing her on 14.12.2013.

9.4 While FA1 told her GP that MA1 was being evicted, and this was increasing her stress levels, there was no indication from that consultation that MA1 presented a

risk to FA1. None of the agencies already engaged with MA1 during that period were aware of the fact MA1 was moving into address 1 nor of the significance this would have on the relationship between him and MA1. Consequently agencies did not have the opportunity to assess any risk this move had created.

9.5 The panel therefore conclude that when MA1 killed FA1 it could not reasonably have been predicted nor prevented.

10. RECOMMENDATIONS

10.1 The DHR Recommendations appear below and in the Action Plan.

i. Rochdale MDOP (now MVOP) reviews its policies so as to ensure the appropriate balance is achieved between the mental health and/or other needs of an offender and the point at which their behaviour ceases to be capable of being managed outside the criminal justice system;

ii. Rochdale MDOP (now MVOP) explore opportunities to work with voluntary and third sector organisations that can provide support and services to those with mental vulnerabilities and with whom statutory agencies do not have the capacity or grounds to engage or clients are reluctant to engage with.

iii. Rochdale MVOP panel to amend its practice and criteria to reflect the GMPs guidance in order to operate as the Mentally Vulnerable Offenders Panel (MVOP)

iv. That Rochdale Safer Communities Partnership commission research through their partners in health to determine whether the involvement of family members in mental health assessments would be helpful.

v. In order to help practitioners understand MA1's behaviour when he committed this offence it will be helpful at the appropriate stage to provide the institution where he is detained and receiving treatment with a copy of this report.

Appendix A

Table of Significant Events

Date	Allegation Made	Arrested or Interviewed	Warning Caution or Prosecuted	Risk Assessed	Discussed by MDOP or Professionals	Engaged by MH Team	MH Assessment	Welfare Check
August 2009					✓	✓		
14/1/10	✓FA3		✓HW					
Feb 2010						✓		
30/4/10	✓FA3							
22/6/10	✓MA4							
3/8/10	✓MA4							
16/8/10			✓HW					
12/10/10	✓FA1			✓ Police				
7/12/10	✓MA4							
31/1/11				✓ Police				
9/3/11	✓MA4							
24/3/11		✓	✓ Caution					
23/9/11	✓MA4							
24/11/11	✓FA3				✓			

Date	Allegation Made	Arrested or Interviewed	Warning Caution or Prosecuted	Risk Assessed	Discussed by MDOP or Professionals	Engaged by MH Team	MH Assessment	Welfare Check
15/12/11					✓			
22/12/11		✓			✓		✓	
23/12/11	✓DI1		✓HW					
5/1/12				✓ MH		✓	✓PAD	
12/1/12					✓			
13/1/12		✓						
2/2/12					✓			
7/2/12						✓& police		
22/2/12						✓		
23/2/12					✓			
15/3/12					✓			
5/4/12	✓ Police Wales				✓			
23/4/12								✓Police & Vul. Adults
22/5/12					✓			
28/6/12					✓			
2/7/12?								✓PPIU
19/7/12					✓			

Date	Allegation Made	Arrested or Interviewed	Warning Caution or Prosecuted	Risk Assessed	Discussed by MDOP or Professionals	Engaged by MH Team	MH Assessment	Welfare Check
9/8/12					✓			
30/8/12					✓			
14/11/12	✓DI1							
15/11/12	✓ MHN1							
23/11/12		✓	✓ Pros.					
23/3/13				✓ Police				✓Police
1/5/13?							✓By Defence	
23/7/13			✓ Court					
14 & 15/12/13	✓ Murder		✓ Arrest					

End of v0.8

Appendix 'B'

Action Plan

Panel Recommendations						
Recommendation	**Scope (Local, Regional, National)**	**Action to Take**	**Lead Agency**	**Key Milestones Achieved in Reaching Recommendation**	**Target Date**	**Date of Completion & Outcome**
<u>One</u> Rochdale MDOP (now MVOP) reviews its policies so as to ensure the appropriate balance is achieved between the mental health and/or other needs of an offender and the point at which their behaviour ceases to be capable of being managed outside the criminal justice system.	Local	MVOP Chair to oversee undertaking of review of policies by the Panel and implement any revisions considered to be necessary	Rochdale CSP / MVOP Chair	1. Review of policies timetabled and undertaken 2. Findings considered and any necessary revisions implemented	March 2015	
<u>Two</u> Rochdale MDOP (now MVOP) explore opportunities to work with voluntary and third sector organisations that can provide support and services to those with mental vulnerabilities and with whom statutory agencies do not have the capacity or grounds to engage or clients are reluctant to engage with.	Local	MVOP Chair to explore potential and capacity within third sector for suitable organisations to engage with and provide support to those with mental vulnerabilities for	Rochdale CSP / MVOP Chair	1. Scoping of third sector potential carried out 2. Engagement with identified agencies to develop potential opportunities 3.Where such opportunities exist, further work undertaken to develop	September 2015	

		whom engagement with statutory services is difficult to achieve		commissioning arrangements		
Three Rochdale MVOP panel to amend its practice and criteria to reflect the GMPs guidance in order to operate as the Mentally Vulnerable Offenders Panel (MVOP)	Local	MVOP Chair to oversee amendment of criteria and operating practices	Rochdale CSP / MVOP Chair	1. Practice and criteria review timetabled and undertaken 2. Findings embedded into MVOP operating practice and revised criteria agreed and implemented	March 2015	
Four That Rochdale Safer Communities Partnership commission research through their partners in health to determine whether the involvement of family members in mental health assessments would be helpful.		1.Rochdale Council Community Safety Unit request that research be undertaken 2.Pennine Care NHS Trust carry out research and report findings back to Rochdale Safer Communities Partnership	Rochdale Council / Pennine Care NHS Trust	1. Request submitted to Pennine Care 2.Terms of reference, timescales and methodology agreed 3.Draft report of findings produced 4.Final report approved and findings shared with all relevant partners	March 2015	

Five In order to help practitioners understand MA1's behaviour when he committed this offence it will be helpful at the appropriate stage to provide the institution where he is detained and receiving treatments with a copy of this report.	Local	Final report and findings to be made available to named institution	Rochdale Council / Community Rehabilitation Company	1. Copy of report issued to relevant Offender Management contact within CRC 2. Report delivered to relevant institution and findings shared with appropriate officers	November 2014	