

SEFTON SAFER COMMUNITIES PARTNERSHIP

DOMESTIC HOMICIDE REVIEW

Incorporating an

NHS INDEPENDENT INVESTIGATION [MENTAL HEALTH]

OVERVIEW REPORT POST QUALITY ASSURANCE PANEL

'Nina' and 'Jenny'

November 2017

Chair: David Hunter

Author: Paul Cheeseman

CONTENTS

SECTION

PAGE

1.	Introduction	3–4
2.	Establishing the Domestic Homicide Review	5–10
3.	Definitions	11
4.	Background: Nina, Jenny and Dean	12–15
5.	The Facts by Agency	16–28
6.	Analysis against the Terms of Reference	29–59
7.	Lessons Identified	60–63
8.	Conclusions	64–65
9.	Recommendations	66–69

Appendix A

Glossary

Appendix B

Definitions

Appendix C

Table 1: Events involving Dean

Appendix D

Table 2: Prisons where Dean was held

Appendix E

Panel Recommendations & Action Plans

Appendix F

Agency Recommendations & Action Plans

1. INTRODUCTION

- 1.1 On a day in the spring of 2015, a police officer from Merseyside Police found the body of Jenny at her home. She had been stabbed to death. The police had been alerted by a neighbour, who had not seen Jenny for a few days. A few hours later, the body of Nina, Jenny’s mother, was found at her home. She had been

asphyxiated. The suspect for both deaths was Dean (son and brother of Nina and Jenny respectively). Three days after the discovery of the victims' bodies, Dean was arrested on suspicion of their murders.

- 1.2 While Dean was in custody, he received a full mental health assessment. This determined that he was unfit for interview and detention. He was then transferred to a secure hospital for further assessment. He remains detained there for treatment under S3 of the Mental Health Act 1983. In January 2016, the Crown Prosecution Service, having considered expert medical opinion, decided that Dean should stand trial for the murders of his mother and sister. In June 2016 Dean appeared before a Crown court. He admitted the manslaughter of Nina and Jenny. He was sentenced to life imprisonment and will serve a minimum of twelve years and seven months with a hospital treatment order.
- 1.3 This case is about the homicide of Nina and her adult daughter Jenny. The perpetrator of the homicide was Dean. After the deaths of Nina and Jenny it became known that Nina had experienced domestic abuse from her daughter and her son. However, this was not known by agencies when she was alive, in spite of entreaties by friends to report her experiences. As far as the panel can ascertain, there was no knowledge of abuse occurring by those working in the supported accommodation Nina was living in at the time of her death. Dean was considered an attentive son.
- 1.4 This Domestic Homicide Review discovered that at the time of the deaths of his sister and mother, Dean had a substantial history of criminal offending for possessing drugs, burglary, damage and assault. He also had mental health needs that were identified within the prison system in 2010, although a formal diagnosis was not achieved until 2013. This was and remains a diagnosis of paranoid schizophrenia and personality disorder.
- 1.5 In the years preceding the deaths of his mother and sister, Dean had three periods in prison. The first was from 4 June 2010 to 28 January 2011; the second was from 9 March 2011 to 2 July 2014; and the third was from 11 December 2014 to 27 February 2015. It was in the former period that he was diagnosed with paranoid schizophrenia after being transferred to a secure hospital under Section 47/49 of the Mental Health Act 1983. Dean was discharged from the hospital back to prison on 16 January 2014 with a diagnosis of paranoid schizophrenia and personality disorder as evidenced in the psychiatrist's discharge report dated 14 January 2014. Following his discharge from prison in February 2015, Dean had no contact with mental health services owing to his not attending for a scheduled outpatient appointment. A second appointment date was offered, but the incident occurred before this.
- 1.6 In the context of the above, this report focuses on Dean's contacts with a number of agencies between 2010 and 2015 and whether there were opportunities to predict and prevent the incidents that occurred based on their knowledge of Dean.
- 1.7 The principal people referred to in this report are:

Person¹	Role	Relationship	Ethnicity
NINA (Less than 60 years)	Victim	Mother of Male One, Jenny and Dean	White British
JENNY (Less than 30 years)	Victim	Daughter of Nina and sister of Dean, half-brother of Male One	White British
DEAN (Less than 30 years)	Perpetrator	Son of Nina and brother of Jenny, half-brother of Male One	White British
MALE ONE	Son of Nina	Half-brother of Jenny and Dean	White British
FEMALE ONE	Survivor of domestic abuse	Alleged by Dean to be his partner	White British
NINA'S home	Address 1		
JENNY'S home	Address 2		

¹ The names are pseudonyms chosen by the family.

2. ESTABLISHING THE DOMESTIC HOMICIDE REVIEW (DHR)

2.1 Decision-making

- 2.1.1 Sefton Safer Communities Partnership (SSCP) decided on 24 April 2015 that the deaths of Nina and Jenny met the criteria for a Domestic Homicide Review 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 Domestic Homicide Review should be taken within one month of the homicide coming to the attention of the Community Safety Partnership and says that the review should be completed within a further six months.
- 2.1.3 The completion date for the review was set as 15 November 2015. This was later extended to 21 January 2016 to allow time for Dean's fitness to stand trial to be assessed and later to 31 August 2016 to cater for his trial. The panel was keen to involve the family and friends in the review and acceded to the police's request not to approach people until the conclusion of the criminal trial. The Home Office was kept informed.
- 2.1.4 It is important to say that the early learning from the review, in respect of the need to improve liaison between prison mental health services and community mental health services when prisoners are released, was acted on immediately².

2.2 DOMESTIC HOMICIDE REVIEW PANEL

- 2.2.1 David Hunter was appointed as the Independent Chair. He is an independent practitioner who has chaired and written previous Domestic Homicide Reviews, Child Serious Case Reviews and Multi-Agency Public Protection Reviews. He has never been employed by any of the agencies involved with this Domestic Homicide Review and was judged to have the experience and skills for the task. Paul Cheeseman, also an independent practitioner, supported David and authored the report with significant input from Maria Dineen as described in 2.2.2.
- 2.2.2 An NHS Independent Investigation should be undertaken when a homicide has been committed by a person who is, or has been, under the care of specialist mental health services in the six months prior to the event. These investigations are conducted under the Serious Incident Framework for England (2015) issued by NHS England on 27 March 2015. They normally do not commence until after the criminal case has been concluded. However, in this case, it was determined that the NHS Independent Investigation would be conducted in partnership with the Domestic Homicide Review so as to avoid unnecessary duplication of investigatory work, and to enable optimal multi-agency participation. Maria Dineen, an approved independent contractor for NHS England, was commissioned to attend panel meetings and to ensure that the mental health components of the Domestic Homicide Review met the standard required by NHS England.

² All information relating to referrals is now emailed to the appropriate community mental health team. Information was previously faxed, which gave the potential for information to be missed. Care coordinators are always invited in to the prison to assess those prisoners who have been referred to the community mental health team prior to their discharge.

2.2.3 Seven panel meetings were held, with good attendance by panel members. All panel members fully engaged in the process, thereby ensuring the issues were considered from several perspectives and disciplines. Between meetings additional work was undertaken via email, telephone and face-to-face meetings. The panel comprised:

Name	Job Title	Organisation
➤ Paul Cheeseman	Author	Independent
➤ Denis Cullen	Mersey Care NHS Trust ³	Social Care Strategic Lead
➤ Maria Dineen	Independent Practitioner commissioned by NHS England	Consequence UK Limited
➤ Robert Downs	Head of Health Care	HMP Manchester
➤ David Hunter	Chair	Independent
➤ Tracey Lloyd	District Manager	National Probation Service North West Division
➤ Janette Maxwell	Strategic Area Manager	Sefton Metropolitan Borough Council (SMBC) /Sefton Safer Communities Partnership
➤ John Middleton	Detective Chief Inspector	Merseyside Police
➤ Susan Norbury	Designated Nurse Safeguarding Adults CCG	NHS South Sefton Clinical Commissioning Group
➤ Diane Press	Head of Mental Health and Inpatient Unit	HMP Manchester
➤ Catherine Wardle	NHS Independent Investigation Lead	NHS England (North)
➤ Andrea Watts	Head of Communities	Sefton Safer Communities Partnership
➤ Gill Ward ⁴	Chief Executive	Sefton Women's and

³ Now Mersey Care NHS Foundation Trust.

⁴ Gill provided an additional level of independence and domestic abuse expertise.

		Children's Aid (SWACA)
➤	Bridgett Welch	Assistant Director of Nursing Safeguarding Lancashire Care NHS Foundation Trust

2.3 Agencies submitting Individual Management Reviews (IMRs)

2.3.1 The following agencies submitted IMRs:

- Merseyside Police
- Mersey Care NHS Trust
- Royal Liverpool and Broadgreen University NHS Trust
- Southport and Ormskirk Hospital NHS Trust
- Manchester Mental Health and Social Care Trust
- Your Housing Group
- The Spinney⁵
- Lancashire Care NHS Foundation Trust
- National Probation Service
- National Offender Management Service (NOMS)

2.3.2 Other agencies provided chronologies and relevant information when requested. When this material is used within the body of this report, it is attributed accordingly.

2.4 Notifications and involvement of families

2.4.1 David Hunter wrote in September 2015 to Nina's sister expressing sincere condolences for her loss, informing her of the review and inviting her to take part at an appropriate time. The letter, together with the Home Office leaflet explaining what a Domestic Homicide Review is and a leaflet from Advocacy After Fatal Domestic Abuse (AAFDA)⁶, was delivered by the police family liaison officer.

2.4.2 On 17 November 2015 David Hunter and the police family liaison officer met with members of Nina and Jenny's family. These included Nina's sister and Nina's two nieces and nephew. The purpose of the meeting was confined to explaining the process of the review and gathering some basic background information. Male One was expected but did not attend. At the request of the police, the meeting did not touch on evidential matters, as it was unknown whether the family would be required to give evidence in any trial. At this point (November 2015), it was judged inappropriate to see the victims' friends for the same reason.

2.4.3 The family were kept informed of the review's progress and understood they would have to wait until after the trial before contributing further. The family were

⁵ A medium-secure hospital providing services for people with mental health needs – www.partnershipsincare.co.uk.

⁶ A registered charity established in 2008 which provides advocacy and support to families of domestic homicides and contributes to educating and training professionals in the statutory and voluntary sectors.

provided with a copy of the draft report on 21 June 2016; however, they did not respond to several requests to see them. On 17 July 2016, the Chair asked the family liaison officer to intercede. At the time of the final panel meeting, on 18 August 2016, no response had been received from the family despite a number of letters, including two to Male One, and calls to various addresses. The panel decided that the submission of the report to the Community Safety Partnership Executive (NHS England North) and to the Home Office could not be delayed any longer. However, they did agree it was very important to try to re-establish contact with the family while these processes were underway. A copy of the report following the 18 August 2016 meeting was sent to Male One and another family member requesting a reply by 30 September 2016. The report was accepted by Sefton Safer Communities Partnership on 8 December 2016, and the family updated by way of letters.

- 2.4.4 As she is a survivor of domestic abuse, the panel felt it was important that the views of Female One were considered. Attempts to contact her have not been successful; these included a personal visit to her last known address by David Hunter and Paul Cheeseman. The occupant said a number of agencies had called there seeking the whereabouts of Female One. The occupant said they did not know where Female One was. Again, the panel felt the submission of the report should not be delayed, and they will continue to make attempts to trace Female One while the quality assurance processes are underway. Further attempts were unsuccessful.

2.5 Terms of Reference

2.5.1 The purpose of a Domestic Homicide Review is to:

- Establish what lessons are to be learned from the domestic homicide regarding the way in which local professionals and organisations work individually and together to safeguard victims;
- Identify clearly what those lessons are both within and between agencies, how and within what timescales they will be acted on, and what is expected to change as a result;
- Apply these lessons to service responses, including changes to policies and procedures as appropriate;
- 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 Time frame under Review

The Domestic Homicide Review covers the period 1 January 2010 until the date of the deaths of Nina and Jenny. The reason the former date was selected was because it was the date Dean first came to the attention of mental health professionals while in prison. Given the magnitude of the incident, it seemed reasonable to review the sequencing of events from this time, with detailed analysis occurring from 2013 to 2015.

2.5.3 Case-specific terms

Term 1

Review the mental health care, treatment and services provided to Dean by the NHS and other relevant agencies, identifying both areas of good practice and areas of concern for the period 1 January 2010 to the date of the homicides.

In analysing your agency's involvement, please pay specific attention to the following sub-terms.

Sub-terms

- 1.1** Determine whether professionals:
 - a.** recognised any domestic abuse indicators for the principals
 - b.** completed risk assessments [including self-harm] and risk management plans [RMPs] and managed them appropriately
 - c.** reviewed or amended RMPs in response to new or changing information
- 1.2** Were the services provided for the principals appropriate to the identified levels of risk?
- 1.3** Examine the effectiveness of Dean's mental health care plans, including the involvement of the service user and the family.
- 1.4** Review the application of the Mental Health Act for Dean in both the criminal justice system and health services.
- 1.5** Review the effectiveness of discharge planning and the application of appropriate aftercare for Dean.
- 1.6** Were single and multi-agency policies and procedures adhered to and effective in the management of this case?

Term 2

What knowledge did your agency have about domestic abuse between the principals? What risk assessments were undertaken and what actions were taken to ensure the safety of those at risk?

Term 3

What knowledge did the victim's family and friends have about domestic abuse within the family, and what did they do with it?

Term 4

If there were lapses in service provision to any of the principals, were there issues in relation to capacity or resources in your agency that impacted the ability to provide services to the principals and to work effectively with other agencies?

Term 5

Establish what lessons are to be learned regarding the way in which professionals and organisations work individually and together to safeguard future victims.

Term 6

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.

Term 7

Were equality and diversity issues – including ethnicity, culture, language, age, faith and disability – considered?

Term 8

Were issues with respect to safeguarding (adults) adequately assessed and acted upon?

Term 9

Determine through reasoned argument the extent to which the deaths of Nina and Jenny were either predictable or preventable, providing detailed rationale for the judgement.

Term 10

Provide a written report to the Home Office and NHS England North that includes measurable and sustainable outcome-focused recommendations.

3. DEFINITIONS

- 3.1 The Government definition of domestic violence (hereinafter referred to as domestic abuse) can be found at Appendix B.

4. BACKGROUND: NINA, JENNY AND DEAN

4.1 Nina

- 4.1.1 Nina was born on Merseyside. She was the youngest of nine children. Her parents are now deceased. Her family described Nina as caring, funny, generous, kind and very well liked. She had worked as a silver service waitress and a carer in a residential home.
- 4.1.2 At nineteen years of age, she gave birth to her eldest son, while living in the London area. Before he was a year old, Nina and her son returned to live with her parents. After this she had no contact with the father of her eldest son.
- 4.1.3 In 1983 she met and married her husband and went on to have two more children: Jenny and Dean. In 2008 Nina's husband died. She had been separated from him for some years before his death. Nina had not worked for several years.
- 4.1.4 A person made a statement after the murder of Nina and described herself as a good friend of Nina. She said they met two or three times a week. This friend said that in early 2014, she saw Nina had a black eye. Nina told this friend that Dean had hit her.
- 4.1.5 In October 2014 the same friend responded to a call from Nina and visited address one. She saw that Nina had extensive bruising to her shoulder and left chest area and was in a lot of pain. Initially Nina told this friend that she had fallen out of bed. When questioned further, she intimated that Dean had caused the injuries. This friend accompanied Nina to the hospital, where she was treated for a broken collar bone. Nina told the medical staff that she had fallen out of bed.
- 4.1.6 On a more recent occasion, the same friend witnessed Dean spit in Nina's face and then headbutt her before dragging her by the hair. This was because Nina refused to give Dean any money. On all these occasions, the friend encouraged Nina to report these matters, but she refused, saying it would make matters worse and she was terrified of Dean.

4.2 Jenny

- 4.2.1 Jenny's family described her as a very clever person who was top of the class at school, and a gifted musician who played the guitar and piano. Children loved her. The family said Jenny seemed to become withdrawn and had lived alone at address 2 for two years prior to her death. Nina visited her there regularly. She is described as having a warm relationship with Nina. The review panel heard that Jenny had mental health needs resulting in challenging behaviour towards her mother and others. Many of these incidents brought her into contact with the police who dealt with her formally and sympathetically. During some of the encounters she was found in possession of cannabis and on two occasions was arrested for breach of the peace. It is known from Merseyside Police records that on at least one occasion Jenny was the victim of domestic abuse perpetrated by Dean.

4.3 Dean

- 4.3.1 Dean had a troubled past both as an adult and as a child. Education records disclose that as far back as November 1997, when he was eight years of age, concerns were reported about Dean's progress at school. At the time he had been excluded from school for five days and was said to be at risk of permanent

exclusion. He was said to be aggressive, did not take part in lessons and did not mix with other children. Complaints had been received from parents that he was bullying other children.

- 4.3.2 Dean was then referred to Child and Adolescent Mental Health Services (CAMHS). There is a list of actions taken over the years he was in school to address his behaviour and improve his achievement. Aggressive and disruptive behaviour was a feature of his whole schooling history. Although he received special educational needs support, he was considered by his school to have been one of the most difficult children they had ever had to deal with. There was an appeal, by his parents, against the decision to class him as a pupil with special educational needs; a tribunal upheld Dean's classification.
- 4.3.3 Education records indicate that Dean's parents were often in dispute with the authorities over his schooling and decisions made in relation to his education. He had a very poor attendance record, and his parents were felt to be at fault. In December 2000 the education authority were granted an Education Supervision Order (ESO)⁷. However, Dean's father was said to be aggressive towards the Education Welfare Officer and communication broke down.
- 4.3.4 When Dean did attend school, he was reported to be a pupil who soon became distracted and would become defiant with staff, swearing and throwing objects at them. A core assessment was conducted on Dean by Children's Services, and this included recommendations that Dean attend a residential school and his parents a Youth Offending Team parenting course. On 29 August 2001 Nina told the Educational Welfare Supervisor (EWS) that when Dean couldn't get his own way, he had punched her in the stomach.
- 4.3.5 A feature of Dean's childhood and educational history is that Dean's mother did not attend meetings that had been arranged to discuss Dean's future. However, she is reported to have been keen to get him back to school.
- 4.3.6 By February 2005 Dean attended a training programme run by NACRO.⁸
- 4.3.7 Merseyside Police record that Dean had been arrested on a number of occasions and had fifteen convictions recorded against him. His Police National Computer record showed that he had warning signals for 'drugs', 'violence' and 'mental health issues' (suicidal tendencies). He served periods of imprisonment. While in custody, he developed a pattern of attacking custody, hospital and prison staff. Dean's history of offending during the period of this review is discussed in more detail at section 5.
- 4.3.8 Dean was a habitual user of cannabis and was suspected of using other illegal drugs. He had never worked, and it is believed his only relationship (which was a brief one) was with Female One. However, this woman denies they were ever in a relationship. As well as the three domestic abuse incidents Dean was involved in within the time frame of this review, Merseyside Police also recorded one incident

⁷ An Education Supervision Order is an order granted in the Family Proceedings Court requiring parents and their child to follow directions made in the Order and work alongside the Attendance Officer, as the Supervising Officer, to improve their child's school attendance.

⁸ A leading charity in England and Wales dedicated to making society safer by reducing offending.

of domestic abuse outside the time frame in which Female One was recorded as the victim and Dean the perpetrator. The incident was assessed as low risk.

- 4.3.9 The family of Nina and Jenny were unanimous in their views about Dean. They thought he was always a strange boy who was often destructive for no apparent reason. An example of this was how he would walk down a road and snap off car badges without warning. He was very difficult at school and did not attend very often. Dean always had anger issues.
- 4.3.10 The family said Nina was frightened of him. They evidenced this by saying that when Nina was at their house, Dean would telephone and demand her return. He could be heard screaming down the telephone at Nina. The family said Dean would take advantage of his mother's kind nature (taking money from her), but she could not see beyond the fact that he was her son, whom she loved.
- 4.3.11 One relative said they felt generally intimidated by Dean and uneasy in his company. The family did not believe Dean was mentally ill. They believed 'he was just an evil/bad person'.
- 4.3.12 However, the family accepted that if he had a diagnosis of mental illness, he might not be responsible for his actions. One relative said that if Dean did have a mental illness, then what happened was in some ways more of a tragedy, in that his mental illness should have been spotted and controlled with medication. In brief, it was more preventable. The family believed he should have been monitored when he came out of prison and made to attend appointments with mental health professionals. Dean met the criteria for S117 aftercare under the Mental Health Act. However, Dean was under no compulsion to attend appointments, and any engagement he had with mental health services would have been voluntary.
- 4.3.13 The family believed Dean was highly manipulative and felt he should not have been staying with Nina. Outside of mental illness, they felt his motive for causing the deaths was simply his 'evilness/badness'. They never knew him to have girlfriends.
- 4.3.14 The following family tribute appeared in a local newspaper:

'We are absolutely devastated following the loss of Nina and Jenny and are still trying to come to terms with what has happened to them both ...

Nina, who was a mother of three and grandmother of three, was a very outgoing and lovely person who wouldn't harm anyone. In fact, she only ever had nice things to say about people. She was so caring and would help anyone.

And Jenny was loved by her family and well-liked by her friends and neighbours. She was a fantastic aunty and was a cheeky, bubbly and outgoing person who loved her dog. They will both be greatly missed.'

Neighbours of Nina

- 4.3.15 The panel felt it would be helpful to seek the views of Nina's neighbours within the sheltered housing scheme. The physical design of such schemes, in which all properties are in one building with a shared lounge, means neighbours are much more likely to have personal contact than in a conventional address.

- 4.3.16 The DHR Chair and Author visited address one and met with the Housing Manager on the site. She had taken over responsibility for the complex from the previous manager, who was responsible when the homicides of Nina and Jenny occurred. The Housing Manager said she felt that approaching neighbours now would not produce any information that was not available to the police investigation. The Manager felt an approach now would cause extreme distress in the case of one neighbour, and in other cases was likely to upset residents, some of whom are vulnerable. This view was respected, and accordingly neighbours of Nina were not approached directly. Instead the panel has relied on the information provided by Your Housing Group within their IMR and by Merseyside Police as part of their homicide enquiry.
- 4.3.17 The Housing Manager who is now responsible for the complex has a good understanding of safeguarding issues and many years of experience working in the housing sector and with vulnerable persons. She told David Hunter and Paul Cheeseman that if she received information, or suspected, that domestic abuse was taking place, she would make a safeguarding alert herself to the local authority. The Housing Manager said she would not need to wait for approval from within her own organisation before taking this step, as she recognised any delay in making an alert could lead to harm or further harm to the victim. The Manager confirmed from the records she had available that a safeguarding alert had never been submitted in respect of Nina, nor did the record show any information which spoke of or hinted at Nina being a victim of domestic abuse.

5. THE FACTS BY AGENCY

5.1 Introduction

5.1.1 The agencies that submitted IMRs are dealt with in a narrative commentary for each of the victims and the perpetrator, which identifies the important points relative to the terms of reference. The main analysis of events appears in Section 6.

5.2 Nina

5.2.1 Nina took out a tenancy at address 1 on 24 April 2014. The property is owned and managed by Your Housing Group. Address 1 is a flat within a sheltered housing scheme designed to support independent living for people over fifty-five. Nina said she wanted to move there so that she could be closer to Jenny. Your Housing Group did not know that Nina had previously shared accommodation with Dean and did not know whether he had moved elsewhere or was homeless. At the time of the homicide, a manager was present at the accommodation for about eight hours a day, five days a week. It was not a live-in post.

5.2.2 As part of the tenancy agreement, a risk assessment⁹ was conducted to assess whether the tenant presented risks to themselves, other residents or staff. The section on risk lists examples that include domestic violence. The Your Housing Group IMR author states it is of particular note that this section was not completed as part of the interview and was left blank. There is not a conclusive answer as to why this section was not completed. The staff member who conducted the interview with Nina could not give a concrete reason. They expressed that they had probably made an assumption that Nina was not at risk of domestic abuse. She reported that she was single, as her partner had died and she was living alone. The IMR author believes an incomplete risk assessment at this point, or indeed at any point during Nina's tenancy, could be considered to be a missed opportunity to open up a dialogue regarding a history of domestic abuse.

5.2.3 Your Housing Group staff knew Dean visited his mother daily. Other residents made a number of complaints that, on occasions, Dean stayed overnight in address 1. These complaints included that Nina slept in other residents' flats so that Dean could stay in address 1. Your Housing Group believes that some of the residents jumped to conclusions and did not like Dean because he was young. Rumours apparently circulated that Dean had been 'locked up' and was a 'robber' and a 'burglar'.

5.2.4 Your Housing Group staff did not know that Nina vacated her room. They state there was no factual evidence for this, nor for whether Nina was forced to do this by Dean or, indeed, chose freely to have her son staying overnight at her address.

⁹ At the start of each tenancy, Your Housing Group completes an audit to check that the tenancy has been set up correctly. The audit also checks the name listed and that the document has been signed by all parties and is held on the system. Every Sheltered Housing Officer holds a 'Your Time' meeting (one to one) with each Scheme Manager every six weeks. In this meeting they discuss all aspects of the role and also do a sample check of paperwork and record this information on the document. In addition, every three months Sheltered Housing Managers carry out a full audit of all support plans for Your Housing Group regions and ensure all are up to date and everyone has a support plan, unless they have declined, in which case this is also noted. The Sheltered Housing Managers also hold the 'Your Time' meeting with the Sheltered Housing Officers every six weeks, in which they check progress and understanding and review any cases of safeguarding, anti-social behaviour and complaints. This feeds into the 'Your Time' meeting with the Head of Sheltered Housing.

The Housing Officer from Your Housing Group described sheltered housing as a scheme where independent living was encouraged and, although small amounts of support and daily welfare checks were provided, residents were encouraged to live independently and with privacy. He stated that there were no defined rules regarding how many times a relative or friend could stay in a sheltered housing scheme flat. There is no indication or evidence that residents within the scheme held suspicions or knew about domestic abuse within the family or of the injuries to Nina.

- 5.2.5 While we now know that Dean had a record of criminality, Your Housing Group staff found no evidence to support the claims of other residents. Discussions were held between Your Housing Group management and other residents. These concluded that Nina was not breaking the terms of her tenancy agreement and was doing nothing wrong. At the time of the complaints, the Your Housing Group Housing Officer for the site had sought advice from management and been assured there were no defined rules regarding how many times a relative or friend could stay in a sheltered housing scheme flat. It is now known that Nina told Merseyside Police that Dean lived in the flat with her. (See paragraph 6.1.78.)
- 5.2.6 Regular welfare contacts were made with Nina by the Scheme Manager in accordance with Your Housing Group policies¹⁰. The manager described Dean as always polite, although shy and difficult to engage in conversation. They saw no evidence Dean ever acted in a violent or threatening manner towards Nina, other residents or any of the Your Housing Group staff.
- 5.2.7 Your Housing Group staff said that Nina was 'happy, chirpy, bubbly' and that her flat was starting to 'take shape'. She spoke to staff at Your Housing Group about Dean in very positive terms, referring to him as 'my little baby, my little boy', 'misunderstood' and 'a lovely boy'. Staff saw no evidence there were any tensions between Nina and Dean.
- 5.2.8 The only indication staff saw that Nina's mood was low was during a routine older person assessment on 3 December 2014, when she said she had good days and bad days. She did not tell staff what caused these. A direct question regarding domestic abuse was not asked on this assessment either. The Your Housing Group IMR author states that a direct question regarding any potential history of domestic abuse should be part of the initial assessment and ongoing reassessment of the older person within a sheltered housing scheme. However, there is no evidence that Your Housing Group staff had any information in their possession to indicate Nina was at risk of harm from Dean.
- 5.2.9 Your Housing Group says its staff did not ask Nina a direct question on any occasion as to whether she had been a victim of domestic abuse. Factual information known to Your Housing Group personnel did not indicate that Nina was, or had ever been, at risk from Dean or that domestic abuse was a feature or had ever been a feature within her family unit. There were no indications of abuse between Nina and Dean during the period that Nina lived at the Your Housing Group sheltered housing scheme. Despite financial issues and a history of debt, there was no factual evidence that Nina was being financially abused by Dean or by anybody else. Nina was unemployed and in receipt of Housing Benefit and Employment and Support Allowance.

¹⁰ When Nina became a tenant, she said she would like daily contacts (otherwise known as welfare checks). The Scheme Manager made these wherever possible to check on Nina's welfare.

- 5.2.10 Jenny was never seen with Dean at address 1. She was only ever seen when visiting Nina, and Your Housing Group staff had no information regarding the dynamics between Dean and Jenny.
- 5.2.11 Staff from Your Housing Group recall a police officer visiting address 1 looking for Dean on 14 April 2015 (see paragraph 5.4.16). They were asked to inform the police if Dean arrived at the address. When Nina was told the police had been, she was described as being 'edgy' and said: 'Dean is an innocent boy. He has served his time and should be given a chance.'
- 5.2.12 The last contact that Nina had with Your Housing Group staff was two days before her body was found, when she asked the Scheme Manager if he would like a cup of tea. She said she would be going out early the next morning. On the same afternoon, Dean arrived at address 1 and the manager let him into the flat as Nina was out. Dean left at about 4pm looking relaxed and saying to the manager, 'Nice one, see you later.' This was the last contact between Dean and staff from Your Housing Group.
- 5.2.13 Nina attended Accident and Emergency at Aintree Hospital on two occasions. The first, on 1 January 2012, related to a road traffic collision. The second, on 28 October 2014¹¹, related to a shoulder injury. Nina said this was caused by a fall out of bed. She failed to attend follow-up appointments. In the light of what Merseyside Police learned during their enquiries (see paragraph 4.1.5), this injury may or may not have been caused by Dean assaulting his mother. He was not in prison at this time.
- 5.2.14 Nina had limited contact with her GP. The most relevant attendance was on 7 January 2015, when she presented with a fracture of the right clavicle. She told her GP that she 'couldn't remember how it happened'. Had agencies been aware of the abuse Nina was experiencing, then more detailed probing of the circumstances in which the injury was sustained would have been required. However, the level of enquiry was reasonable based on the lack of knowledge, at the time the assessment took place, about any abuse.
- 5.2.15 Merseyside Police had no contacts with Nina that are of relevance to this Domestic Homicide Review until she spoke to the officer investigating event 13 (Breach of Restraining Order, Appendix C) (see paragraph 5.4.18).

5.3 Jenny

- 5.3.1 There are eleven contacts recorded between Jenny and her GP. All of these have been explored, and only one is felt to be of relevance to this Domestic Homicide Review. On 9 September 2013 Jenny was diagnosed as having a 'soft tissue injury'. This may be related to her attendance on two occasions around this time at the Accident and Emergency Department of Royal Liverpool and Broadgreen University Hospital Trust (see paragraph 5.3.3).

¹¹ At this time Nina was probably living with Jenny at address two, as she did not take up residency at address one until 10 November 2014. Your Housing Group states there was no evidence or indication that Nina disclosed injuries of any nature to its staff before or during her tenancy. Your Housing Group staff were not suspicious of any injuries and, consequently, staff did not question Nina regarding personal injuries. The Sheltered Housing Officer and Scheme Manager reported that Nina was always happy and chirpy, very bubbly, anxious to please and anxious to help neighbours.

- 5.3.2 Jenny attended the Accident and Emergency Department of Royal Liverpool and Broadgreen University Hospital Trust on six occasions during the period of this review. These have been explored, and only three are considered relevant, as they relate to physical injury. These need to be considered by the panel, as Merseyside Police had previously recorded one occasion on which Jenny was the victim of domestic abuse at the hands of Dean, even though this fell outside the timescale of this review. On 3 May 2013 Jenny attended Accident and Emergency complaining of pain in her arm and said she had been assaulted. No details of the assault are documented, and there is nothing recorded for this event by Merseyside Police.
- 5.3.3 On 18 June 2013 and again on 20 June 2013 Jenny presented at the Accident and Emergency Department complaining of pain in the shoulder and arm. On the first occasion she left before being seen by a doctor. On the second occasion she blamed the pain on a fall and then said she had been assaulted. She would not give further details about this assault despite the doctor probing. Jenny then changed her explanation and said it was a chronic problem which had already been assessed as possibly needing surgery.
- 5.3.4 The panel believes the doctor's probing suggests they did not believe the history Jenny gave was complete. Jenny gave two explanations for this injury, and the panel believes the doctor was correct in probing further. The panel considered whether Dean might have been responsible for this injury. It believes this was not possible, as he was serving a custodial sentence at the time.
- 5.3.5 Jenny had a number of contacts with Merseyside Police during the timescale of this review. These have all been explored, and there is only one matter that requires comment. At the time of her death, Jenny had failed to attend court for a matter unrelated to this Domestic Homicide Review. The court had issued a warrant for her arrest. This warrant was never executed, as it was not passed to Merseyside Police for action to be taken. Therefore, Jenny was still wanted for non-appearance at court when she died. The panel does not believe this is a material factor that would have prevented her homicide.

5.4 Dean

- 5.4.1 Dean was known to a large number of agencies in the Merseyside area. This section considers each agency's contacts with Dean. The Domestic Homicide Review panel agreed that the most relevant information related to their review concerned Dean's mental health and section 5.5 covers those contacts.

Merseyside Police

- 5.4.2 Appendix C sets out the key events that Merseyside Police have recorded in respect of Dean. The most relevant of these are discussed in more detail in this section of the report. Between April 2010 and November 2014 Merseyside Police dealt with Dean on ten occasions. These included stop checks and arrests for possession of cannabis (events 1 and 2), burglary (event 6) and damage (event 8). While Dean was either remanded to prison or serving a sentence, he assaulted prison staff and health workers. This included spitting at an officer escorting him to court (event 4), breaking two of a prison officer's bones with an improvised weapon (event 7) and assaulting a health care worker (event 9).
- 5.4.3 Dean attended Accident and Emergency at Aintree Hospital stating he was suicidal. Before being assessed, he left the hospital and climbed a crane on a nearby building site (event 10, 23 November 2014). He was talked down by police

negotiators. He caused a total of £4,078 of damage to the crane and the windscreen on a police vehicle. He was detained by police under S136 of the Mental Health Act and taken back into the hospital for assessment. He was seen by a doctor and an Approved Mental Health Professional and did not meet the criteria for detention. An informal admission was not deemed appropriate and Dean was discharged into police custody. He was charged with damage and given conditional bail.

- 5.4.4 Merseyside Police received a call from Female One (event 11, 6 December 2014). She said she had been associated with Dean (not a relationship) for two days some months before. Female One said Dean was harassing her and her family and causing damage to her property. She said he was outside her house and threatening to burn it down. There was a suggestion that Dean was in possession of a firearm.
- 5.4.5 Armed officers attended and the family were found safe and well. Dean was circulated as wanted, and Merseyside Police carried out searches to find him. He was believed to be of no fixed abode at that time. A risk assessment was conducted in respect of Female One and she was assessed as being a 'gold'¹² victim (this indicated she was at high risk of harm). Female One's case was referred to the January 2015 Multi-Agency Risk Assessment Conference.¹³ Referrals were made to other support agencies, and Merseyside Police placed a marker on Female One's address. By the time of the Multi-Agency Risk Assessment Conference, Dean was already in custody, and no actions were raised in this case.
- 5.4.6 The panel asked the Mersey Care NHS Trust representative to establish what happened as a result of their staff's attendance at the Multi-Agency Risk Assessment Conference. An entry on Epex¹⁴ advises: 'Information shared at North Liverpool MARAC (Multi Agency Risk Assessment Conference). Please do not share with service user. For further information, please contact (name and telephone number of staff member).' The panel representative spoke to the staff member who attended. The staff member attending says about forty individuals were discussed at the meeting, including Dean. They have no notes on the discussion about Dean, and no actions were required of Mersey Care NHS Trust relating to Dean. The panel member concludes that, in the future, at the very least there should be a more explicit note stating 'no action required', and where there are actions, these should be noted on Epex with the caveat 'please do not share with service users'. There are entry codes on Epex that specifically relate to MARAC attendance. The panel specifically considered the way in which information is recorded at MARAC meetings and how agencies are expected to record this information (see paragraph 6.2.28).
- 5.4.7 Merseyside Police received a call concerning an assault in a shopping precinct (event 12, 10 December 2014). Female One was with her family, including three young children, when Dean approached them. He verbally abused Female One and then punched her to the side of her head. Merseyside Police officers attended and arrested Dean for this offence and the offences connected with event 11

¹² See Appendix A Glossary.

¹³ A Multi-Agency Risk Assessment Conference is a local, multi-agency victim-focused meeting where information is shared between different statutory and voluntary sector agencies on the highest-risk cases of domestic violence and abuse. A number of agencies were in attendance, including Merseyside Police, Mersey Care Trust, the National Probation Service and an Independent Domestic Violence Advocate.

¹⁴ The trust's electronic record-keeping system at the time.

[harassment]. A risk assessment was conducted and Female One remained a gold victim. Referrals were made to ICS Careline, Adult Social Services and an Independent Domestic Violence Advocate (IDVA).

- 5.4.8 While in the custody of Merseyside Police, Dean was assessed by the Criminal Justice Mental Health Team. While Dean said he had no mental health issues, this was not factually correct, as he had been diagnosed in 2013 with paranoid schizophrenia (see section 5.5 for an exploration of Dean's contact with mental health agencies). Merseyside Police put a care plan in place for the time he was in their custody. When interviewed, Dean denied the assault that day and stated Female One had 'made up' the circumstances.
- 5.4.9 Dean was charged with assaulting Female One and remanded in custody. There was felt to be insufficient evidence to substantiate a charge of threatening to commit damage. A request was made to the Crown Prosecution Service to apply for a restraining order at the conclusion of the case. On 30 January 2015 Dean appeared at the magistrates' court, where he pleaded guilty to the assault on Female One. He was sentenced to twenty-two weeks' imprisonment.
- 5.4.10 On 27 February 2015 Dean appeared at the magistrates' court and pleaded guilty to the damage to the police vehicle and crane (see event 10). Although he was sentenced to an additional eight weeks' imprisonment, because this was to run concurrently with the sentence he was already serving, he was released from prison. As requested the Crown Prosecution Service applied for, and obtained, a restraining order prohibiting Dean from approaching Female One.
- 5.4.11 Female One made a 999 call to Merseyside Police (event 13, 31 March 2015). She said Dean was trying to get into her home. Female One told the operator about the restraining order. Entries on the Merseyside Police command and control log (Storm¹⁵) showed there had been previous calls to the address and that Dean presented a high risk to Female One and her family. Police officers attended and searched the area for Dean, who had left prior to their arrival.
- 5.4.12 An initial risk assessment of Female One as a 'bronze'¹⁶ victim was later reassessed by the Family Crime Investigation Unit as 'gold'. Referrals were made to ICS Careline, Adult Social Services and the Independent Domestic Violence Advocate. Female One was not referred to a Multi-Agency Risk Assessment Conference, as she did not fall into the Coordinated Action Against Domestic Abuse (now Safelives) repeat referral criteria¹⁷. Investigation of the incident, which was recorded as a crime on the Merseyside Police Niche system, was passed to a uniformed patrol officer. An investigation plan regarding the breach of the restraining order was formulated and recorded on the Merseyside Police Niche system.
- 5.4.13 Dean was not arrested at the scene and he was not circulated as wanted on the Police National Computer. There is also no record that the CORVUS briefing system used by Merseyside Police was utilised to circulate Dean as wanted to officers who patrol the areas he frequented. Because he was not recorded on these systems as wanted, if police officers had attended another incident involving Dean, or carried out a check on him, they would not have been aware he was wanted.

¹⁵ Storm is Merseyside Police's computerised command and control system. A log is created as soon as a call is made to Merseyside Police. It is a chronological document on which important information is then recorded relating to that incident and subsequent events.

¹⁶ See Appendix A Glossary.

¹⁷ In Sefton not all gold victims are referred to a Multi-Agency Risk Assessment Conference.

- 5.4.14 On 5 April 2015 Dean was stopped in the street and searched by a patrolling police officer. A small amount of cannabis resin was found on him. Dean was issued with a street caution. The officer was aware of the incident on 31 March 2015 (event 13), because it was recorded on the Occurrence Enquiry Log (OEL) of Niche. The officer did not arrest Dean because Dean was not circulated as wanted for the offence. Dean told the officer he was living at address 2, the home of Jenny.
- 5.4.15 The officer investigating the breach of the restraining order was aware from the stop check carried out on 5 April 2015 of the address Dean gave and made arrangements to call at address 2 to trace Dean. On 10 April 2015 the investigating officer recorded that they had not had the opportunity to attend address 2 due to being engaged with other calls. The officer was then off duty for the next four days and stated they would try to arrest Dean when next on duty. The officer contacted Female One and told her about their plan. Female One said she had not seen or heard from Dean since event 13.
- 5.4.16 On 14 April 2015 the investigating officer visited address 2 and tried to speak to Jenny. She refused to answer the door. Nina arrived, told the officer who she was, and said that Jenny was not available to come to the door. Nina told the officer Dean was staying at her flat (address 1).
- 5.4.17 The investigating police officer then called at address 1. A staff member confirmed Dean was living there and allowed the officer access to the flat to search for him. He was not there. The investigating officer then placed intelligence onto the Niche system confirming Dean was living at address 1 and expressed concerns that vulnerable persons lived within this location. On 15 April 2015 a staff member from address 1 contacted the investigating police officer and told them Dean had been seen trying to get into the flat the previous evening and did not stay the night.
- 5.4.18 On a day in spring 2015 Merseyside Police received a call from a neighbour of Jenny who said Jenny's dog had been left outside address 2 for two days. The neighbour said Jenny had not been seen. Previous incidents at this address were checked and, due to the nature of these, enquiries were made with local hospitals. At 12.40am the following day Merseyside Police patrol visited address 2 and confirmed the premises were insecure. A check was carried out at address 1 to see if Nina had knowledge of Jenny's whereabouts. There was no reply.
- 5.4.19 At 1.35am police officers entered address 2 and found Jenny dead. She had stab wounds. At 3.51am police officers entered address 1 looking for Dean, who was now a suspect for the homicide of Jenny. They found the body of Nina in the flat. Measures were put in place to safeguard Female One.
- 5.4.20 Dean was circulated as wanted and enquiries found he had travelled to London two days earlier. Three days after the discovery of the bodies of Nina and Jenny he was arrested in London by officers from British Transport Police. While in custody with Merseyside Police he said he was not suffering from any mental health problems and was not taking any medication. A care plan was put in place and a mental health assessment took place. Dean was deemed unfit for detention and interview and was transferred under the Mental Health Act to a secure hospital.

National Probation Service

- 5.4.21 In 2011 Dean was considered to be a Prolific and Priority Offender (PPO)¹⁸ and was managed using a multi-agency approach involving Merseyside Police, substance misuse services and the (former) Merseyside Probation Trust (now part of the National Probation Service). It was recognised that Dean had issues with substance misuse, and he was made subject to specific licence conditions that required him to engage with local substance misuse services to access support for his dependency issues when released from custody.
- 5.4.22 Dean's ongoing substance misuse in custody and the community was a constant feature of his sentence planning. Regular meetings took place between those supervising Dean and the partner agencies and information was shared. The probation officers supervising Dean were fully aware of his mental health issues, which directly linked to his offending behaviour and subsequent risk level. These were detailed in OASys (the Offender Assessment System) in the Delius contact records for Dean.
- 5.4.23 Dean was referred into Multi-Agency Public Protection Arrangements¹⁹ prior to the expiration of his prison sentence in 2014. The purpose of the referral was to consider registering him for Multi-Agency Public Protection Arrangements management. Dean was managed as a Multi-Agency Public Protection Arrangements Level 2, Category 3 offender²⁰. When Multi-Agency Public Protection Arrangements met on 12 August 2014, HMP Manchester attended and their contribution was noted to be valuable. However, the Chair of that meeting recalls that a mental health representative did not attend this meeting. This meant there was a gap in information from relevant agencies. (See paragraphs 6.1.68 to 6.1.92 for a full exploration of the MAPPA process.)
- 5.4.24 Dean was deregistered from Multi-Agency Public Protection Arrangements on 27 August 2014, as it was judged he no longer required management under the arrangements.
- 5.4.25 Dean spent the majority of the time he was involved with Merseyside Probation Trust in custody. His case was discussed monthly. While he was in the community, work was done with Dean to address his offending behaviour and his substance misuse. However, the IMR author draws attention to the fact there are some gaps in how his mental health issues were managed (see section 5.5 for a full description of Dean's mental health treatment). The fact Dean was moved between prison establishments on eleven occasions made continued input by Merseyside Probation Trust problematic. Dean's frequent moves while in prison and the impact this had upon his mental health treatment are considered further at section 5.5.

¹⁸ PPO is a term used to describe someone who is responsible for committing a large amount of crime in a particular area. They are identified from arrests, convictions and intelligence, and then a multi-agency approach is adopted to try to reduce their offending. The task of the police is to catch and convict PPOs, while probation's focus is to resettle and rehabilitate them.

¹⁹ The Criminal Justice Act 2003 provides for the establishment of Multi-Agency Public Protection Arrangements (MAPPA) in each of the forty-two criminal justice areas in England and Wales. They require local criminal justice agencies and other bodies dealing with offenders to work in partnership in dealing with those offenders in order to protect the public from violent and sexual offenders.

²⁰ There are different levels at which offenders are managed and categories into which offenders are placed. Level 2 is active multi-agency management. A category 3 offender is dangerous: a person cautioned or convicted for an offence which indicates they are capable of causing serious harm and which requires a multi-agency approach.

- 5.4.26 As well as Multi-Agency Public Protection Arrangements, Dean's case was also considered by Sefton Multi-Agency Response to Guns and Gangs (MARGG)²¹ on 9 April 2014. At this time, he was in prison after being recalled (event 8, Appendix C). The notes of the meeting state that while imprisoned, Dean had been assessed as posing a high risk of harm to both staff and the public; he had issues with his mental health and had spent time in a secure mental health unit during his sentence. It was noted that it would be important that Dean linked in with mental health services and took his correct medication. At the time of the meeting, Dean had twelve previous convictions and was being managed at Multi-Agency Public Protection Arrangements Level 2. An action was raised in the meeting for the Probation Service representative to assist Dean with a housing application on his release.
- 5.4.27 Minutes of the MARGG meeting held on 7 May 2014 show that Dean refused to engage with the Probation Service while in custody and said he did not want anyone to know where he was when released. He stated a preference to be rehoused in Leeds.

NHS England Cheshire and Merseyside (GP)

- 5.4.28 There are three relevant contacts on Dean's GP records. On 23 July 2014 there is a reference to 'Dean having come out of prison after 14 months due to burglary, now living with mother' and 'h/o personality disorder with psychosis'. On 13 October 2014 there is a record that Dean was non-compliant with medication, that he had a personality disorder/psychosis and that a referral was faxed to the Maple Unit on 17 October 2014. A discharge letter was sent by HMP Manchester to Dean's GP. However, they would not have received a discharge summary from the Spinney, as Dean was a prisoner at the time of his confinement at the Spinney. On 1 July 2014 HMP Manchester sent a summary of Dean's health to his GP. It included his diagnosis of paranoid schizophrenia.

Royal Liverpool and Broadgreen University Hospital

- 5.4.29 On 30 January 2010 Dean attended the Emergency Department of Royal Liverpool and Broadgreen University Hospital. He said he had been assaulted by strangers, who used sticks and walking sticks to hit him over the head, chest and back. He had contusions and lacerations and had a pneumothorax which required a chest drain. He was admitted for this and discharged on 3 February 2010.

Aintree Hospital

- 5.4.30 As outlined at paragraph 5.4.3, on 23 November 2014 Dean attended Accident and Emergency at Aintree Hospital. Following the incident with the crane, he was detained by officers from Merseyside Police under S136 of the Mental Health Act. He was seen by an Approved Mental Health Professional and did not meet the criteria for detention. An informal admission was not deemed appropriate and Dean was discharged into police custody. The circumstances of this assessment are considered in more detail at paragraphs 6.1.24 to 6.1.30.

²¹ Guns and gangs were reported as one of the main issues for Sefton in 2011–12. The CSP responded to this through Operation Disarm and the Multi-Agency Response to Guns and Gangs (MARGG) group. MARGG is an operational group that shares information about gun crime nominals, known associates and those on the periphery. A series of appropriate actions are developed in response. Source: Sefton CSP Strategic Intelligence Assessment 2012–13.

5.5 Overview of mental health agencies' contact with Dean²²

5.5.1 Between 2010 and the time of the index offence in 2015, Dean had contact with specialist mental health services in the following locations and with the following mental health providers:

- HMP Liverpool (Mersey Care NHS Trust);
- Mersey Care NHS Trust (when not in prison);
- The Spinney (private medium-secure hospital provider);
- HMP Manchester (Manchester Mental Health and Social Care NHS Trust);
- HMP Liverpool, HMP Holme House.

Furthermore, Dean's Care Programme Approach²³ document, completed by the Spinney in October 2013, revealed that prior to 2010, and up to his admission to the Spinney, Dean had been in 'at least 12 different establishments. These included various HMP's and HMP YOI's.'

5.5.2 In 2010 Dean first came into contact with mental health services when he was referred to the Criminal Justice Liaison Team while at Bootle Magistrates' Court. This followed a referral from G4S staff, who reported he was talking to himself in his cell and that he was aggressive to police during arrest and detention in custody.

5.5.3 At this time Dean had a notable forensic history, but one comprising relatively low-level crime in the context of the lifestyle choices he was making and the criminal world he appeared to be inhabiting. At this early stage, there was nothing that would have alerted a professional to him being a homicide risk. A pertinent extract from the records made by the assessing professional at Bootle Magistrates' Court is:

'Gave the impression that he wanted me to believe he had mental illness. Referred to himself as Schizo and mental and made a number of leading statements which would indicate he wanted to purport the image of someone experiencing major mental illness. However, he was not able to give content or detail to these statements.'

5.5.4 Dean was offered a referral to drug and alcohol services, which he refused. There were no indications at this time that he required ongoing mental health input.

5.5.5 In January 2011 Dean received a custodial sentence and went to HMP Liverpool. Within two to three weeks of his admission, he was referred to the Scott Clinic (an NHS-managed medium-secure facility) as a consequence of his paranoid and psychotic behaviours. Consequently, Dean was assessed by a forensic training grade forensic psychiatrist and commenced on antipsychotic medication, and the plan was to review him in two weeks. The working diagnosis at this time was paranoid schizophrenia.

²² Sections 5.5 and 6.1 were researched and written by Maria Dineen as part of her investigation conducted under guidance issued by the Department of Health (NHS England Serious Incident Framework, March 2015).

²³ The Care Programme Approach (CPA) is a way that services are assessed, planned, coordinated and reviewed for someone with mental health problems or a range of related complex needs. www.nhs.uk.

- 5.5.6 Before his reassessment could occur, he was transferred to HMP Hull and HMP Forest Bank. At these locations, it seems Dean was seen by another three psychiatrists, but he was moved before a firm diagnosis could be made.
- 5.5.7 In January 2013 Dean was again residing in HMP Liverpool, and a referral was made for him to be assessed by the mental health in-reach team. As happened in 2011, Dean was transferred to another prison facility before assessment could take place. Dean was released on licence from HMP Oakwood some seven to eight weeks later, on 25 February 2013.
- 5.5.8 Dean was recalled to prison in June 2013 (for damage to a bail hostel, event 8, Appendix C) as a consequence of being in breach of his licence conditions. Fortunately, in the April of that year, the Governor at HMP Liverpool is reported as saying that Dean 'should serve his sentence here until he has been assessed properly by a psychiatrist and prescribed correct medication'. Dean was admitted to the HCC (Health Care Centre).
- 5.5.9 Within three days of his arrival in HMP Liverpool, Dean was assessed by a consultant in forensic psychiatry from Ashworth Hospital. Dean was recommenced on antipsychotic medication as a consequence. At a subsequent review two weeks later, the same consultant in forensic psychiatry noted:
- 'Despite him being off drugs for 2 weeks (as he is in prison) he has exhibited psychotic symptoms and appears thought disordered. There seems to be an on-going psychotic illness probably of Schizophrenic type which is further compounded by drug dependence.'
- 5.5.10 At around this time, the in-reach team noted that Dean's relationship with officers working within HMP Liverpool had irretrievably broken down. Then on 14 June 2013 he was assessed by another consultant in forensic psychiatry as an urgent assessment. This was due to concerns regarding Dean's mental state.
- 5.5.11 The SystmOne²⁴ records show that Dean attempted to electrocute himself by putting his tongue on an electric socket. The SystmOne records also show that staff reported a history of destructive behaviours in the cells and that this clinical assessment resulted in consideration of the need for assessment and management in a medium-secure hospital facility. The need for this was confirmed and agreed and Dean was transferred to the Spinney (a private medium-secure unit) on 4 July 2013 under section 47/49 of the Mental Health Act. He was not transferred to the local NHS medium-secure facility owing to non-availability of beds.
- 5.5.12 The Care Programme Approach document completed by the Spinney on 3 October 2013 stated under a heading 'My Diagnosis': 'Dean has a diagnosis of Paranoid Schizophrenia typified by persecutory paranoid delusions and hallucinatory experiences. It would seem that he has been mentally unwell for two and a half years. He has been intermittently compliant with medication and has taken a large amount of cannabis in the form of Skunk.'
- 5.5.13 Dean's main risks at the time of admission to the Spinney were identified as:
- Violence including assault with improvised weapons

²⁴ SystmOne is a complete clinical system which enables health and care organisations to deliver truly integrated patient care. It is not used by all NHS or care organisations, but it is the dominant system for prison healthcare and primary care in England. <http://www.tpp-uk.com/>.

- Psychologically driven threats/assaults
 - Threats
 - Frequent periods in segregation
 - Persistent damage to property
 - Suicidal thoughts and self-harm (cutting)
 - Poor treatment compliance
 - Serial acquisitive offending
 - Possible gang links and victimisation
 - Persistent ill discipline
 - Substance misuse
 - Poor social stability
- 5.5.14 Dean remained at the Spinney for a period of six months before being transferred to HMP Manchester on 20 January 2014. At the time of his transfer, Dean was under Section 117 aftercare and also the Care Programme Approach (paragraph 6.1.39 explains S117, and paragraph 5.5.1 discusses the Care Programme Approach). While this did not require any different care to that which he received in HMP Manchester, as he was provided with monthly consultant follow-up, it did mean that strict procedural conditions applied when the time came for his discharge from HMP Manchester back to mainstream mental health services in Liverpool.
- 5.5.15 This transfer of care commenced on 18 June 2014 and Dean was discharged from HMP Manchester on 2 July 2014. At this point his case management became the responsibility of Mersey Care NHS Trust. Between 2 July 2014 and his attendance at Aintree Hospital on 22 November 2014 (the crane incident), Dean had no contact with his designated community mental health team, and despite being offered a number of outpatient appointments, he attended none.
- 5.5.16 On the night of 22/23 November 2014 (the crane incident), Dean was detained by Merseyside Police under Section 136 of the Mental Health Act and assessed under the Act at Aintree Hospital. The outcome of this assessment was that Dean was not displaying any signs of mental illness at the time and required no ongoing follow-up by mental health services (see paragraph 5.4.13).
- 5.5.17 There was no further contact between services provided by Mersey Care NHS Trust and Dean until 27 February 2015, when his solicitor opportunistically asked the Criminal Justice Liaison Team to assess Dean at Liverpool Magistrates' Court, where he was waiting to be sentenced. A Criminal Justice Liaison Nurse did meet with Dean, but did not have time for a full assessment and arranged for him to be sent an outpatient appointment for a more complete assessment by his community mental health team. This appointment was booked for 18 March 2015. Dean did not attend for this.
- 5.5.18 Dean was offered another appointment for 29 May 2015, by which time he had been arrested for the unlawful killing of Nina and Jenny.

6. ANALYSIS AGAINST THE TERMS OF REFERENCE

Each term appears in **bold** and is examined separately. Commentary is made using the material in the IMRs and the Domestic Homicide Review Panel's debates. Some material would fit into more than one term, and where that happens a best-fit approach has been taken.

6.1 Term 1

Review the mental health care, treatment and services provided to Dean by the NHS and other relevant agencies, identifying both areas of good practice and areas of concern for the period 1 January 2010 to 15 April 2015.

Good practice

6.1.1 Prior to Dean's discharge from HMP Manchester [2 July 2014] to Mersey Care NHS Trust, the care and treatment he received met the standards expected. An area of particular note was the sustained efforts the visiting psychiatrists made in HMP Liverpool prior to Dean's transfer to the Spinney to assess him in:

- 2010;
- 2011; and
- 2013.

It is also acknowledged that the in-reach team in HMP Liverpool made sustained efforts not just in relation to Dean's care and treatment, but also to oversee and coordinate the input from the visiting psychiatrists and Dean's subsequent transfer to the Spinney.

6.1.2 At the time of his sentencing in February 2015, there was another aspect of practice that requires noting here. When Dean's solicitor asked for him to be seen by the Criminal Justice Liaison Team nurse on duty, although already fully committed with scheduled assessments in the cells that day, the nurse made the time to meet with Dean and was sufficiently concerned to make a recommendation for follow-up in the community for him. The timeliness of the subsequent appointment offered was reasonable on the basis of what the staff understood about Dean at the time. However, it is notable that the practitioners involved openly acknowledge that had they been aware of his diagnosis and previous admission to the Spinney, they would have tried to achieve an earlier follow-up date for Dean.

Determine whether professionals:

a. Recognised any domestic abuse indicators for the principals

6.1.3 There were no indicators available to the mental health services²⁵ (in prison or within the civilian community) that Dean posed a risk of domestic abuse. All mental health providers were aware that Dean posed risks, most predominantly to prison

²⁵ However, Dean did pose a high risk of causing harm to others (see paragraph 6.1.6). Health agencies now make general enquiries about the risk a person may cause domestic abuse.

officers and other staff and also to the physical integrity of his cell. There was no evidence available at the time his care and treatment was provided, or even now after the death of his sister and mother, that Dean ever posed a homicide risk to others. The most likely predictable course for Dean was continued low-level criminality and substance misuse.

- 6.1.4 The role of other agencies, outside the mental health and prison areas, in the recognition of domestic abuse indicators is considered at section 6.2.

Determine whether professionals:

b. Completed risk assessments [including self-harm] and risk management plans [RMPs] and managed them appropriately

2010 to July 2013

- 6.1.5 Between 2010 and Dean's admission to the Spinney on 4 July 2013, his mental health care and treatment was confined to his episodes as a prisoner. In this environment risk assessment is central to the safe management of the service and the prisoners. There has been no information forthcoming, or reviewed, that suggests that staff were anything but aware of the risks that Dean posed within the prison environment and took appropriate measures to manage these risks. From a clinical perspective, and in spite of the challenges posed by Dean being moved around the prison system, professionals working in HMP Liverpool mental health in-reach were diligent in determining that Dean required specialist assessment and secured this via the forensic psychiatry service. This intervention led to Dean's transfer to the Spinney medium-secure unit in 2013 for detailed assessment and instigation of an appropriate treatment regime for him.

4 July 2013 to 20 January 2014 – Dean's period of time at the Spinney

- 6.1.6 In October 2013, the Care Programme Approach document compiled by the Spinney identified Dean as:

- High risk of harm to others
- Low risk of harm to self
- Low risk of suicide
- High risk of unauthorised leave
- High risk of substance misuse
- Low risk of self-neglect
- Low risk of being victimised
- Low risk of 'case specific' risks

- 6.1.7 The risk assessment specifically identifies that Dean's violent behaviour has mostly occurred with prisons and seems to have been driven by:

'his paranoid thoughts that he would be harmed by gang members and prison officers. There is also some evidence of him behaving violently in order to achieve his goal of being placed in segregation where he felt safer and also of him reacting aggressively when his needs cannot be met immediately.'

6.1.8 The initial assessment also identified that Dean demonstrated 'poor emotional control as he acted aggressively when feeling angry.'

6.1.9 Notably this October 2013 Care Programme Approach document stated that Dean had a diagnosis of paranoid schizophrenia and went on to say:

'There appears to be a functional link between Dean's mental illness and his risk of violence. He has also reported hearing a male voice, which told him to hurt people and also reported that he has heard a voice telling him to kill people. The extent to which (Dean) has acted on these hallucinations is unclear.'

6.1.10 A report three months later, in January 2014, identified that Dean had presented with 'extremely challenging behaviour throughout his admission within medium secure services' and that he had been able to access controlled items including lighters and mobile telephones, which represented a breach of security. In spite of an extensive search and investigation, the Spinney was not able to determine how Dean managed to secure access to these items. However, the report seemed to suggest that Dean had hidden the lighter internally, which demonstrated the lengths he was prepared to go to get his own way.

6.1.11 On 16 January 2014 there was a Section 117 discharge planning meeting for Dean regarding his transfer from the Spinney back into the prison population. This document identified Dean's risks as:

- Violence, including assault with improvised weapons
- Psychotically driven threats/assaults
- Threats
- Frequent periods on segregation
- Persistent damage to property
- Suicidal thoughts and self-harm (cutting)
- Poor treatment compliance
- Serial acquisitive offending
- Possible gang links and victimisation
- Persistent ill discipline
- Substance misuse
- Poor social stability
- Unauthorised leave

6.1.12 In terms of substance misuse and relapse, Dean was noted to have stated that he fully intended to re-engage in drug-taking. Relapse indicators for Dean were identified as:

- Paranoid and increased agitation
- Would include reports of suicidal thoughts and self-harm
- Psychotically driven threats/assaults
- Non-compliance with medication

Relapse indicators would warrant a medication review and screening for the use of illicit substances.

6.1.13 This section 117 discharge plan also said Dean:

'can escalate very easily by just being told the word "no". He becomes verbally abusive and a lot of this is racial abuse. He will throw items that are close to him at members of staff. He will threaten members of staff with violence. He will continue to escalate and disrupt the ward environment.'

20 January 2014 to 2 July 2014 – Dean's period of time at HMP Manchester

- 6.1.14 HMP Manchester reports that all risk assessments and risk management plans were completed and managed appropriately. Where there were changes in risk identified, or new information was received, risk management plans were reviewed and amended as required. A review of Dean's SystemOne records shows that his disruptive behaviour continued in HMP Manchester as it had in HMP Liverpool.

2 July 2014 to 22 November 2014 – Dean's care and management by Mersey Care NHS Trust in the community

- 6.1.15 The mental health service responsible for delivering care and treatment to Dean was not able to make contact with him. This – coupled with the fact that Mersey Care NHS Trust staff did not display the professional curiosity that would have been expected when the incomplete fax (see 6.1.25 and 6.1.63) was received, and that the community mental health staff did not read the clinical summary data received from HMP Manchester and scanned onto the trust's electronic record-keeping system – meant that the staff were situationally unaware of Dean's risk profile. It also meant that no risk assessment was performed on or with Dean between leaving the Spinney and 2015, which is the time period in which he was referred to Mersey Care NHS Trust's general adult mental health service.
- 6.1.16 This situation resulted in Dean not being on the Care Programme Approach, and consequently not 'open to Epex', which meant that staff who subsequently had contact with Dean, or were contacted about Dean, were working with incomplete information and again were risk unaware and situationally compromised. Out of contact with mental health services, Dean was at a predictable and significant risk of relapse and consequently posed a predictable high risk of serious harm to others. Based on his known past behaviours, it is not possible to say that this included the risk of homicide.
- 6.1.17 Optimal practice would have been for a risk assessment to have been conducted in his absence, and there is no reason to believe this would not have happened had he been placed on a Care Programme Approach and thus remained open to services. The opportunity for further risk assessment would have also presented itself had Dean attended for any one of his outpatient appointments, which he did not. Indeed, it is inconceivable that a risk assessment would not have been performed under these circumstances.
- 6.1.18 The whole question of why he was not on a Care Programme Approach after his transfer from HMP Manchester to Mersey Care NHS Trust in 2013 is a significant issue in Dean's case management between prison and community mental health services.

Determine whether professionals:

- c) Reviewed or amended risk management plans in response to new or changing information**

- 6.1.19 Throughout his contact with mental health services in and out of prison, there is little doubt that when in the secure confines of prison and the Spinney, Dean's risk behaviours were reviewed and managed in line with the relevant policies and procedures.
- 6.1.20 The most pertinent assessment of risk, and transfer of risk information, was the point of Dean's discharge from HMP Manchester in July 2014 back to Mersey Care NHS Trust and a civilian population.
- 6.1.21 As highlighted above, Mersey Care NHS Trust were not as informed about Dean's risks as they ought to have been, and the community mental health team in Mersey Care NHS Trust were not able to secure a face-to-face or a telephone meeting with Dean, so they had no opportunity to conduct any risk assessment or create a risk management plan in conjunction with him.
- 6.1.22 There were other points of contact between Mersey Care NHS Trust professionals and Dean, notably during his Mental Health Act assessment and in his dealings with the criminal liaison justice team. Consideration was given to risk and assessment at all of these points of contact, but because almost all relevant information regarding risk would have been on SystmOne (an electronic records system utilised by most prison healthcare providers)²⁶, the healthcare professionals employed by Mersey Care NHS Trust were not able to access this information.
- 6.1.23 Furthermore, there was no mental health attendance at any of the three Multi-Agency Public Protection Arrangements²⁷ meetings.
- 6.1.24 The invitation to attend the Multi-Agency Public Protection Arrangements meeting on 27 August 2014 pre-dated Dean's discharge from HMP Manchester and occurred seven days after Dean had been referred to the Acute Care Team. There is no evidence that the minutes of any of the meetings were shared with mental health professionals.
- 6.1.25 A further factor contributing to the lack of expected follow-up of Dean by Mersey Care NHS Trust was an incomplete transfer of information between Manchester Mental Health and Social Care NHS Trust, and Mersey Care NHS Trust. Manchester Mental Health and Social Care Trust faxed comprehensive information to Mersey Care NHS Trust, but not all of the faxed information arrived. An assumption was made by the receiving team that further information would follow, but no assertive follow-up of this was instituted. Consequently, Mersey Care Trust never took receipt of a complete information package from Manchester Mental Health and Social Care Trust. The lack of complete information was a significant contributory factor in Mersey Care NHS Trust's lack of awareness of Dean's needs, including the need to be on CPA. Both NHS trusts agreed that the primary responsibility for this

²⁶ In most circumstances SystmOne is only available to clinical staff within prison environments. In certain circumstances access can be granted to external agencies subject to there being an identified need. As an example, as the psychiatrists who work within HMP Manchester are all employed by Ashworth High Secure Hospital, SystmOne has been installed at Ashworth. At the time Dean was in receipt of care from Mersey Care NHS Trust, staff did not have access to SystmOne records. It is not within the authority of the trust to enable this to have occurred.

²⁷ See Appendix F for an extract from the Multi-Agency Public Protection Arrangements guidance document that explains how CPA relates to Multi-Agency Public Protection Arrangements.

information loss rests with Mersey Care NHS Trust. Owing to changes in practice instituted in Mersey Care Trust and Manchester Mental Health and Social Care Trust, it is very unlikely that such a critical loss of information would occur again.

Term 1.2

Were the services provided for the principals appropriate to the identified levels of risk?

- 6.1.26 The only 'principal' mental health services were in contact with was Dean. At face value, one can say that while Dean was within the prison system and at the Spinney, the levels of service provided to him were very good. He received a more than reasonable level of attention from the prison in-reach teams in HMP Liverpool and HMP Manchester, including the follow-up he received from the visiting consultant psychiatrists. However, having reviewed Dean's journey through the prison system, it is clear that prior to his being admitted to the Spinney under Section 47/49 of the Mental Health Act, and then again following his disposal via a custodial sentence in December 2014, he appeared to be arbitrarily moved around the prison system, thus denying him the level of mental health supervision, assessment and treatment he required.
- 6.1.27 That this occurred is not a reflection on the mental health services involved; rather, it appears representative of what the panel understands is established custom and practice within the prison system of 'sharing the load' with prisoners known to be challenging to manage, as Dean was. The panel felt that from the perspective of achieving a good level of mental health management, including effective medication management and stabilisation of an individual such as Dean (who had a diagnosis of paranoid schizophrenia and a personality disorder characterised by manipulative behaviour), this custom and practice of sharing the load of a disruptive prisoner is less than ideal. It is not in the best interests of effective mental health management in the prison system, because it presents a barrier to achieving an effective mental health assessment of the prisoner, and instituting effective treatment. In this case, what impact earlier diagnosis and treatment would have had for Dean cannot be determined.

Term 1.3

Examine the effectiveness of Dean's mental health care plans, including the involvement of the service user and the family.

- 6.1.28 The period of time where the content and delivery of care plans for Dean was of most relevance to this case is following his discharge from HMP Manchester to Mersey Care NHS Trust. Because Dean had no effective contact with the services provided by Mersey Care NHS Trust between July 2014 and the date of the incident, he did not have a care plan. The substantive contact he did have, on 22 November 2014 and 23 November 2014 [the crane incident], resulted in a recommendation that no ongoing mental health care was required, as he was displaying no signs of mental illness, including no signs of psychosis. This decision was made following an assessment of Dean under the Mental Health Act in Aintree Hospital.
- 6.1.29 With regard to family contact, bar the two attempts to engage with Dean via unannounced visits to his home, there was no reason for the mental health service

to have made direct contact with Dean's family. It is now known that the family firmly believes that Dean was faking mental illness.

Term 1.4

Review the application of the Mental Health Act for Dean in both the criminal justice system and health services.

- 6.1.30 Dean was assessed under the Mental Health Act on two occasions between 2010 and 2015. The first assessment, in June 2013, led to his transfer to the Spinney medium-secure unit on 4 July 2013 under Section 47/49 of the Act. This meant that he came under the care and management responsibility of a specialist forensic service. The utilisation of the Mental Health Act was appropriate, and Dean was correctly transferred to a care environment necessary to conduct a detailed assessment of his presentation.
- 6.1.31 The second occasion the Mental Health Act was utilised was on 23 November 2014. This followed Dean self-presenting at Aintree Hospital but then leaving it before he could undergo an assessment by the Psychiatric Liaison Team. Police were alerted because staff were concerned about Dean's mental state and his wellbeing. Dean did re-present at A&E of his own accord and again left the premises before an assessment could take place. He then climbed a crane outside the hospital, staying up there for a considerable period of time, refusing to come down unless Female One was brought to see him. This behaviour mirrors that witnessed in prison when Dean did not get what he wanted. An entry on the police log instructs that she was not to be contacted at that stage. Later into the incident, he made further demands that she attend in order to tell him in person what she had told him over the telephone. This would indicate that the reason he climbed the crane was to manipulate a face-to-face contact with Female One. This did not happen and she did not attend the scene. While on the crane Dean broke off bits of the crane and hurled them to the ground, causing damage to nearby parked police vehicles.
- 6.1.32 Once Dean did come down from the crane, which he did of his own accord, he was assessed by the on-call trainee psychiatrist, the equivalent of registrar grade and an approved mental health practitioner²⁸.
- 6.1.33 The record of the Mental Health Act assessment has been reviewed, and the Forensic Consultant currently responsible for Dean's management found no fault with the actual assessment of Dean. The assessment is well documented and the documentation demonstrates a thorough process. However, a concern was raised about the conclusions formed by the assessing psychiatrist and the documented plan for Dean.

The assessing clinician concluded:

'[Dean] has historically been thought to suffer with a psychotic illness but I could elicit no evidence of any psychotic symptoms on assessing him today and would be sceptical about this diagnosis.'

The clinician's documented plan set out the following points:

²⁸ Mental health specialists (known as the Crisis Team) are based in Aintree Hospital's Accident and Emergency department. The staff are employed by Mersey Care. The consultant who saw Dean would have had access to the Mersey Care records. Clinicians employed by Aintree Hospital cannot access Mersey Care records to obtain a mental health background. This has to be done via the Crisis Team. There have been previous requests for senior clinicians at Aintree to be able to access Mersey Care records.

- Dean discharged from Section 136;
- No follow-up indicated by mental health services;
- Recommendation to stop medication of Risperidone and Procyclidine as no clinical indication at that time;
- GP to refer to Inclusion Matters for some counselling to address anger management issues – he is keen to access counselling.

6.1.34 The trainee psychiatrist talked through what influenced his decision-making with one of the panel members. It became clear that had this professional known of the complexity of Dean’s history, he would not have formed the conclusions he had. In fact, with the benefit of hindsight, he can see how on the basis of a single assessment it was unwise to be as definitive in his documented opinion as he was.

6.1.35 At the time the assessment was conducted, the trainee was unaware of the detailed assessments by the Consultant Forensic Psychiatrist undertaken in HMP Liverpool and also those involved in Dean’s episode of care at the Spinney. As far as he could recall, the trainee did access the information that was quickly available to him on Mersey Care NHS Trust’s electronic record-keeping system – Epex. However, he did not locate information that triggered any sense of concern about Dean or that ought to have been followed up by a community mental health team. He did not have access to SystmOne, the electronic system that held the most informative information about Dean.

6.1.36 This trainee was categorical that, had he been aware of Dean’s past history and the extent of Dean’s history of contact with mental health services within the prison system, he would not have made the recommendations he did. Furthermore, had Dean been ‘open to Epex’, i.e. registered as actively being managed by a community mental health team (which he would have been had he been on a Care Programme Approach, as he ought to have been), the trainee would also have acted differently. In this circumstance he would have made contact with Dean’s community mental health team, apprised them of the events of 22 and 23 November 2014, and made a recommendation for early follow-up of Dean.

6.1.37 The issue of secondary mental health services not having access to SystmOne records is a persistent feature of Dean’s care pathway and a contributory factor to decisions being made and opinions being formed by mainstream mental health services that might not otherwise have been made or formed.

Term 1.5

Review the effectiveness of discharge planning and the application of appropriate aftercare for Dean.

6.1.38 There were a number of points of discharge in Dean’s care pathway between 2010 and 2015. Those of most relevance to this investigation were:

- Dean’s discharge from the Spinney to HMP Manchester;
- Dean’s discharge from HMP Manchester to Mersey Care NHS Trust.

The transfer from the Spinney to HMP Manchester

6.1.39 At the time this discharge took place, Dean was subject to something referred to as Section 117 aftercare. The website MIND ('for a better mental health') provides the following explanation about Section 117 aftercare:

'Section 117 imposes a duty on health and social services to provide aftercare services to certain patients who have been detained under the Mental Health Act.

Section 117 states that aftercare services must be provided to patients who have been detained in hospital:

- For treatment under Section 3
 - Under a hospital order pursuant to Section 37 (with or without a restriction order)
- Or
- Following transfer from prison under Section 47 or 48.

This also includes patients on authorised leave from hospital and patients who were previously detained under Section 3 but who stayed in hospital after discharge from section.

It also includes people who are living in the community subject to a community treatment order and restricted patients who have been conditionally discharged.' (<http://www.mind.org.uk/information-support/legal-rights/aftercare-under-section-117-of-the-mental-health-act/>)

6.1.40 On 16 January 2014 a Section 117 discharge planning meeting was arranged by adult social care and convened at the Spinney. In attendance were Dean's:

- Responsible clinician;
- Senior OT, Forensic Psychologist;
- Social Worker;
- HMP Manchester representation;
- Staff Nurse.

6.1.41 In the case of patients admitted under Sections 47/49 of the Mental Health Act 1983, the nearest relative is the Ministry of Justice, who are not invited to CPA meetings.

6.1.42 The purpose of the meeting was to discuss the transfer of care from the Spinney to Manchester Mental Health's in-reach team at HMP Manchester and Dean's ongoing treatment needs. In addition to his medication needs, it was identified that Dean needed:

- To participate in an emotional regulation programme;
- Ongoing psychological work around substance misuse and insight into his illness;
- Ongoing counselling and therapy;
- Group therapies to target violence and identified antisocial conducts.

6.1.43 The expected standard of practice required for individuals managed under the Mental Health Act was delivered by the Spinney.

The transfer from HMP Manchester to Mersey Care NHS Trust

- 6.1.44 Dean was discharged from HMP Manchester back into the community and into the care responsibility of Mersey Care NHS Trust on 2 July 2014.
- 6.1.45 The usual process for this is to commence the planning process as soon as possible, working with an inmate's pre-existing care coordinator. In this case there was no pre-existing care coordinator, as Dean became Care Programme Approach eligible within the term of his prison sentence. Furthermore, and unusually, Dean did not know where he wanted to reside on his release. He had made a decision to reside in Leeds, but he changed this to Liverpool approximately three weeks before his release date, thus shortening, considerably, the planning and preparation time available to the mental health services involved in the transfer process.
- 6.1.46 The below information sets out the process that took place. On 4 June 2014 the SystmOne records show that the in-reach team at HMP Manchester started to consider and prepare for Dean's discharge back into the community from 3 June 2014. The record of 4 June 2014 says:
- 'Discuss in MDT (multi-disciplinary team) meeting with regard to arranging community follow up upon release. All present agreed that it was appropriate and safe to close the ACCT (Assessment, Care in Custody and Teamwork) document. Post closure interview planned for one week's time. Remain on caseload for monitoring and support. I have agreed with Dean that I will see him again tomorrow and envisage a high level of support over the next few weeks running up to his release. Care plan updated.'
- 6.1.47 Dean's SystmOne record for 9 June 2014 says:
- 'Contacted Liverpool Criminal Justice Liaison [part of Mersey Care NHS Trust] with regard to preparing for Dean's release in July. Confirmed by staff that he is known to their service and requested to confirm request in an e-mail, which I have done.'
- 6.1.48 On the same day, HMP Manchester was advised by the Criminal Justice Liaison Team that the team would not be involved in the transfer of services to the Leeds area (the area Dean was saying he wanted to be released to). This was reasonable. HMP Manchester therefore made contact with mental health services in Leeds to try to find out which service would be taking over care responsibility for Dean.
- 6.1.49 On 13 June 2014 the SystmOne records reveal that Dean had told his Community Psychiatric Nurse at HMP Manchester that he no longer wanted to relocate to Leeds, as he had fallen out with his aunt. The family is adamant that Dean does not have an aunt in Leeds. The address he now wanted to be released to was his mother's address. At this stage there were only nineteen days to Dean's release date.
- 6.1.50 On 17 June 2014 HMP Manchester again made contact with Mersey Care NHS Trust. HMP Manchester was advised to refer Dean via the Acute Care Team single point of access. The records state that the HMP Manchester staff member involved:
- 'contacted the above fax number to check its authenticity and received a return call from ... [the] Secretary to [the consultant psychiatrist]. She confirmed that this was the correct number to fax a referral letter to and requested that I do a letter with as much information and detail as possible.'

- 6.1.51 On 18 June 2014 at 3.49pm the detailed letter of referral with supporting clinical information taken from the clinical summaries written by Dean's visiting consultant psychiatrists was faxed to Mersey Care NHS Trust to the fax number agreed.
- 6.1.52 On 19 June 2014 at 10.33am HMP Manchester proactively confirmed with Mersey Care NHS Trust that they had received the faxed information. Positive confirmation of receipt was given.
- 6.1.53 On the same day, HMP Manchester also spoke with Liverpool Probation Service, which made contact with HMP Manchester because it wanted to be sure that Dean was going to be followed up by mental health services on release from HMP Manchester.
- 6.1.54 On 24 June 2014 HMP Manchester again contacted the Acute Care Team single point of access. The SystemOne record says:
- 'They confirmed that the referral had been received and discussed. Because Dean currently is not registered with a GP his case is going to be taken and overseen by the CMHT manager (community mental health team, part of Mersey Care NHS Trust). They stated that there was no more information required by them at this time. I informed them that I had been contacted by ... Liverpool Probation Office and had given ... their contact details.'
- 6.1.55 On 25 June 2014 the SystemOne record says:
- 'I informed him that his community referral had been confirmed by the single point of access team and that they would be following him up and continuing with support in the community. A colleague from the secondary mental health team will confirm with them that he has been released. Dean states that he continues to concur with his Risperidone medication. I made Dean aware that he has a review booked with [the visiting consultant psychiatrist] prior to release.'
- 6.1.56 On 27 June 2014 HMP Manchester informed the Spinney that Dean was soon to be released back into the community. On 1 July 2014 the visiting consultant psychiatrist to HMP Manchester documented that:
- 'I informed Dean that a referral had been made to a single point of access Community Mental Health Team at Liverpool and advised him to attend for appointments.'
- Observation of the panel**
- 6.1.57 At the time Dean's ongoing mental health management was passed from HMP Manchester to Mersey Care NHS Trust, he was on Section 117 aftercare and thus met the criteria for the Care Programme Approach. Care Programme Approach applies regardless of the care setting, including in prison. The NHS Plan 2000 said that:
- 'From 2004, no Prisoner with a serious mental illness will leave prison without a care plan and a Care Co-ordinator.'

- 6.1.58 In this case, although the discharging CPN faxed a comprehensive package of information to Mersey Care NHS Trust, she did not provide Dean's care plan. Furthermore, the good practice expectation that there would have been a face-to-face S117 discharge and care planning meeting between the discharging and receiving care teams was not fulfilled.
- 6.1.59 The previously mentioned indecisiveness by Dean regarding the location of his residency on release reduced the time available for the planning of Dean's discharge from between six and eight weeks to three weeks. Other complicating factors were:
- Dean became Section 117 and Care Programme Approach eligible in prison and therefore did not have a care coordinator already assigned to him in Mersey Care NHS Trust;
 - Dean would ordinarily have been discharged from the Spinney back to HMP Liverpool, as this was the prison that invoked his detention on the Mental Health Act in 2013. However, because of the challenges experienced with Dean in HMP Liverpool and his paranoia about HMP Liverpool, clinically it was considered preferable for him to be discharged to the nearest receiving prison, which was HMP Manchester. This created a break in the continuity of his care, as he was 'unknown' by the staff at HMP Manchester.
- 6.1.60 Nevertheless, an attempt to achieve a face-to-face handover and discharge meeting ought to have been made. It is accepted that no attempt to arrange a face-to-face meeting was initiated by Manchester Mental Health or Mersey Care NHS Trust. The CPN managing the transfer of care from HMP Manchester:
- Wrote a comprehensive letter to the Acute Access Team at Mersey Care NHS Trust and faxed this to the secretary to the consultant responsible for the single point of access team, having first ascertained the correct fax number to use;
 - Phoned Mersey Care NHS Trust for assurance that the fax had arrived and was assured that it had;
 - Phoned Mersey Care NHS Trust again a week later to ascertain whether they needed any further information, at which point she was advised that they did not.
- 6.1.61 All of these actions were reasonable actions to take, but they were no substitute for either a clinician-to-clinician telephone call or a clinician-to-clinician face-to-face meeting, either of which would have avoided the information loss that occurred.
- 6.1.62 Manchester Mental Health and Social Care Trust in HMP Manchester fully accept that this would have been optimal practice and report that what happened with Dean is unusual in their experience (from him becoming Care Programme Approach eligible through to the delay in knowing where he was going to reside). The managers for the prison mental health service reported that it is their normal expectation that face-to-face meetings take place with a full and complete exchange of information, including care plans. Since this transfer episode, the mental health team in HMP Manchester no longer transfer clinical information by fax, but use secure email via the nhs.net system. The technical fax problems (described below) that occurred in Dean's case are therefore unlikely to recur.

6.1.63 Mersey Care NHS Trust supports the perspective of HMP Manchester. Furthermore, Mersey Care NHS Trust also reflected on their contribution to the less than optimal handover and reported that:

- The fax header sheet they received was blank save the HMP Manchester header (the header sheet sent clearly said who it was for, the number of pages included, etc.).
- They received only eight sheets of faxed data from HMP Manchester, and these comprised the clinical summaries made by the visiting psychiatrists who had attended to assess and prescribe the management plan for Dean (ten sheets were faxed from HMP Manchester).
- No one from the Access Team followed up with HMP Manchester the clearly incomplete fax assuming that more information was to follow. This was an error in judgement on the part of the staff involved.
- When the consultant responsible for reviewing all referrals came to Dean's referrals, he set it aside because it was incomplete, focusing his attention on those referrals he could attend to.
- The detailed clinical summaries provided were scanned onto the trust's electronic records system (Epex). As a consequence of internal conversations and a facilitated round-table meeting, it appears that no one read them, or if they did, the significance of the information contained therein was missed in relation to the complexity of Dean's diagnosis and his need to be managed on a Care Programme Approach.
- The community mental health team to whom Dean's referral was passed seems to have worked on the basis that if the Acute Care Access Team did not raise any concerns or highlight issues relating to a mental health service user, then there were no issues for them to be cognisant of. It was not their practice to interrogate the available information for themselves. Staff would have depended at the time upon the information received from the Acute Care Team as being pertinent and accurate. However, once the referral is received and allocated, a fully comprehensive assessment and care plan is then completed in line with the Care Programme Approach framework²⁹. This may well highlight additional factors not identified within the initial assessment.
- The GP referral to Mersey Care NHS Trust on 23 July 2014 highlights:
 - That Dean has been in prison for 14/12³⁰ and was discharged 'a couple of weeks ago'
 - That his diagnosis was personality disorder with psychosis
 - Dean's medication

6.1.64 The GP referral letter also says: 'He [Dean] obviously needs continual care in the community and specialist input.' The GP letter makes clear that Dean's GP would like him to be sent an appointment. This appointment was sent. There was no reference to paranoid schizophrenia in this letter. However, it has been established that information in the discharge medical letter provided to the GP from the prison system was not the easiest to work with and did not make data access easy. The formulation of these documents would benefit from a wholesale redesign to minimise loss of important data.

²⁹ While this is the process that should have happened, it is not what happened on this occasion. Had things gone as they should, the comprehensive assessment would have taken place – providing that Dean attended.

³⁰ Shorthand for 14 months.

- The second GP referral of 15 October 2014, which was received by South Sefton CMHT on 17 October 2014, stated:
 - Dean is noted to be expressing profound anxiety and episodes of ideation of self-harm;
 - Dean is finding it increasingly difficult to leave his home;
 - Discharged from prison in July '14 after 14/12³¹;
 - Ministry of Justice Report is enclosed;
 - Medication has been recommenced Risperidone 2mg BD and Procyclidine 5mg.

6.1.65 Since 2014 the system of assessing referrals into Mersey Care NHS Trust has changed significantly, although the central and single point of referral remains in place. This team now conducts a face-to-face assessment with the service user and does not rely purely on written information provided to it. This means that the inadvertent loss of information that occurred in 2014 between HMP Manchester and Mersey Care NHS Trust, or any other organisation and team, would not happen again.

Term 1.6

Were single and multi-agency policies and procedures adhered to and effective in the management of this case?

6.1.66 As is clearly highlighted in section 1.5, there was a lapse in the complete compliance with Section 117 aftercare requirements and the requirements of a Care Programme Approach for Dean. This lack of completeness adversely impacted on the subsequent management plan for Dean once he was under the care and management of Mersey Care NHS Trust and also influenced staff's perspectives about his needs. Specifically, he was not placed on a Care Programme Approach. Although Dean's case was showing on Epex³² as 'open', there was nothing to indicate that he ought to have been subject to the Care Programme Approach, which he met the criteria for.

6.1.67 In particular, the incomplete handover of Dean's care (for which both Manchester Mental Health and Social Care NHS Trust (HMP Manchester) and Mersey Care NHS Trust have responsibility) impacted on:

- The assertiveness with which Dean was followed up when he did not attend for his outpatient's appointments;
- The opinion formed at the time Dean was assessed under the Mental Health Act in November 2014;

³¹ See footnote 29

³² If a person is registered on Epex and an episode is 'open', this indicates that the case is 'live' and the person is in receipt of a service or services. This does not automatically indicate that they are required to receive those services under CPA, as the criteria for meeting CPA is statutorily defined. In other words, there are service users who are open on Epex and 'live' and in receipt of a service, but the nature of their needs means that they do not require CPA.

- The perspective the Criminal Justice and Liaison Team had in terms of Dean suffering from any mental health disorder in December 2014, and the urgency of follow-up requested for him in February 2015;
- The information made available to the various prisons when Dean was again given a custodial sentence in December 2014 (it is important to note however that all salient information about Dean was held on SystmOne, which was available to the prison services at all times).

Multi-Agency Public Protection Arrangements

- 6.1.68 Dean was the subject of three MAPPA meetings. While the panel has not seen the minutes of the meetings, the Merseyside MAPPA Coordinator provided a report that drew its information from the MAPPA minutes and a MAPPA review of Dean's case initiated in June 2015. The Coordinator shared the review.
- 6.1.69 The initial MAPPA meeting [the registration meeting] in March 2014 was in preparation for Dean's release on 2 July 2014. It decided his risks needed managing through a multi-agency forum at MAPPA Level 2 management. He was designated a Category 3 offender³³. That referral complied with the MAPPA policy.
- 6.1.70 The meeting knew that Dean had a diagnosis of paranoid schizophrenia and that while cannabis use did not cause his mental illness, its further use would accelerate his mental health deterioration. It was noted that Dean would be released at Sentence Expiry Date with no probation intervention and very limited family support. It was unclear at this time where he would be living. The meeting recognised that further information on how to manage his risks would be beneficial for police and mental health staff.
- 6.1.71 The meeting identified that Dean presented a high risk of causing serious harm to members of the public, people in authority and other prisoners and posed a very high risk to staff. Had Dean's family been assessed as being at risk from him, they would have been specified as 'known adults' in the risk assessment. The prison offender supervisor told the meeting that Dean's behaviour had deteriorated in custody, with increasing incidents of aggression, especially towards staff, and he was presenting as very anxious. He had been returned to prison from the Spinney because of unacceptable violent behaviour to staff. The probation officer who referred Dean's case to MAPPA stated the importance of ensuring Dean maintained links with mental health services and took his medication as well as addressing lifestyle and substance misuse.
- 6.1.72 Dean's static and enduring risk factors were listed as:
- Continued drug misuse and cannabis use and previous Class A drug use;
 - Links to organised crime gangs;
 - Mental health issues and failure to take medication or access support on release [given lack of compliance on statutory licence];
 - Mental health diagnosis;
 - Lifestyle and associates [given criminal behaviour and previous convictions];
 - Thinking and attitudes, i.e. use of aggression;
 - Potential accommodation location or being of no fixed abode on release from custody;

³³ Category 3 Offenders are: Other Dangerous Offenders: Section 6.10 MAPPA Guidance 2012 v4.

- History of getting his own way, few boundaries established when growing up, therefore resistance against anyone trying to set boundaries.

6.1.73 The minutes helpfully noted that early warning signs of an increase in risk included:

- Drug misuse;
- Failure to engage mental health services;
- Presents as agitated/shouting especially when behaviour challenged;
- Failure to occupy time positively;
- Associates and lifestyle linked to drug misuse;
- Failure to secure accommodation.

6.1.74 The MAPPA Coordinator clarified what the risk management plan was for Dean by saying: 'The MAPPA risk management plan should also be reflected in the lead agency risk management plan [in this case Offender Assessment system]. In terms of the MAPPA risk management plan, it is listed under the 4 Pillars heading.

Supervision [offender engagement and motivation, accommodation plans]

Monitoring and control [control measures required]

Interventions and treatments [i.e. programmes required/completed, mental health treatment]

Victim Safety [who can assist in protecting current potential victims]

A general summary of actions from that meeting are as follows –

Probation actions

Link mental health services and support.

Provide background information to Sefton Local Authority representative.

Refer Dean to Multi-Agency Response to Guns and Gangs/Compass prior to release.

To liaise with prison offender supervisor about why Dean should not be returned to HMP Liverpool.

Establish if possible is Dean registered with a GP.

Liaise with HMP regarding his mental health / medication, potential release address.

Police actions

Contact GMP and Spinney to update why assault charges not proceeded with.

Sefton Local Authority representative

Consider housing options and also locate where mum is following her eviction.

Alcohol/Drug services

Consider archive records.'

6.1.75 The second MAPPA meeting [a review meeting] took place in June 2014 while Dean was still in prison and its focus was on managing his risk on release. The risks were

the same, and again the danger of Dean not taking medication for his mental disorder was identified as a key issue. The prison offender supervisor reported that Dean had started to engage with them, which was positive; however, his behaviour remained of concern, with several outstanding adjudications. Dean provided his aunt's address in Leeds as his release address, and the planning – for example, liaison between Merseyside Police and West Yorkshire Police – took place on that basis.

- 6.1.76 The prison offender supervisor stated that Dean was hearing voices telling him to harm another prisoner and that it was essential to ensure a mental health referral was made to the Leeds area. The meeting acknowledged the difficulties of managing Dean given it needed his voluntary compliance with mental health services. He had failed to comply when on parole licence. His mental health diagnosis remained the same. The meeting concluded that the case was to remain Level 2 management, and following Dean's release from custody, Merseyside Police would be the lead agency.
- 6.1.77 As is now known, Dean did not move to Leeds on his release, and the normal arrangements for him to access mental health services in Merseyside broke down. As the National Probation Service had statutory responsibilities for the case until his release at sentence expiry, their terminating Offender Assessment System Risk Management Plan [which should also have coincided with his release from custody] formed the risk management plan.
- 6.1.78 The last MAPPA meeting was held on 27 August 2014, some eight weeks after his release. Merseyside Police was identified as the lead agency. Dean's mental health concerns remained the same. The meeting was unsure whether he had been referred to the trust's community mental health team or if he was registered with a GP. Actions were raised to check on both points and if necessary to make a referral to mental health asking them to give Dean an appointment. The police visited his mother's address on several occasions following his release, but he was never seen, although his mother confirmed he lived there. (See paragraph 5.2.5.)
- 6.1.79 Several actions were set under the 4 Pillars headings as part of the August MAPPA risk management plan. These included checking/making a referral to the community mental health team, circulating a further briefing sheet to neighbourhood officers and staff and ensuring that Dean remained on the Police National Computer as a Priority and Prolific Offender and that he was also recorded as part of Compass³⁴.
- 6.1.80 The August MAPPA meeting decided that Dean's case should be discharged from MAPPA Level 2 multi-agency management and could safely be managed by Merseyside Police outside of the MAPPA framework.³⁵ The conclusion section of the minutes record: 'No agencies are dealing with or have had dealings with Dean since his release. He is to be removed from the MAPPA process pending any new info/Intel.' The acknowledgement that no agencies had dealt, or were dealing, with him should have raised significant concerns, as it meant he was not engaged with mental health services, which was the key to managing his risk.

³⁴ Compass is the process for integrated offender management within Merseyside. Nominal is short hand for someone recorded on a system.

³⁵ Dean was referred and managed in MAPPA as a Category 3 case and will have been deregistered from MAPPA, as Category 3 cases cannot be managed as Level 1.

- 6.1.81 While ordinary agency management requires one agency to manage the risk and does not require multi-agency meetings, it does not mean 'other agencies will not be involved' [MAPPA Guidance paragraph 7.2].
- 6.1.82 The National Probation Service IMR says the decision to move Dean's case from Level 2 to Level 1 was not one they agreed with. The MAPPA Coordinator, in her report to the DHR/II, remarks: 'There is no record from the minutes that there was disagreement in regard of de-registration from MAPPA. This is not to say that discussion did not happen, it just hasn't been captured/reflected in the minutes. As it was not recorded in the minutes this did not form part of the MAPPA review in June 2015.' The DHR/II panel is not able to reach a conclusion as to whether there was a disagreement. Had there been a disagreement, the expectation of the DHR/II panel is that it should have been minuted and, if necessary, escalated to management if consensus could not be reached. The MAPPA Coordinator reports that such matters are covered in the training of MAPPA Chairs and minute-takers. There is no evidence in this case that the disagreement was escalated to management. The DHR/II panel felt any disagreement should have been escalated.
- 6.1.83 The DHR/II panel felt there were a number of points to consider arising from Dean's MAPPA case. Merseyside Police knew that Dean was living at his mother's address. This was sheltered housing containing vulnerable members of the public over fifty-five years of age. It is known that Dean presented a high risk of harm to members of the public, but there is no evidence that Merseyside Police considered whether he posed a risk to residents of the sheltered housing scheme and what control measures they put in place to protect residents.
- 6.1.84 The central feature of Dean's risk was his mental health. In short, if he was not taking his medication and was smoking cannabis, his risks were greater. The minutes of the August MAPPA deregistration meeting as reported by the MAPPA Coordinator say: 'No agencies are dealing with or have had dealings with Dean since his release.' That is clear evidence that the principal risk factor was recognised, and yet the MAPPA meeting decided to deregister him without an effective plan on how to manage that risk. The DHR/II thought that was a wrong decision.
- 6.1.85 The MAPPA Guidance at paragraphs 7.7 to 7.10 says:
- '7.7 The three different levels [of management] enable resources to be deployed to manage identified risk in the most efficient and effective manner. Although there is a correlation between the level of risk and the level of MAPPA management, the levels of risk do not equate directly to the levels of MAPPA management. This means that not all high-risk cases will need to be managed at level 2 or 3. Although MAPPA management does not equate directly to the risk of serious harm the offender has been assessed at, this will always be central to the reasons for increased oversight and management.
- 7.8 The complexities of managing a low or medium risk case might, in exceptional circumstances, justify it being managed at level 2 or 3, especially where the offender is notorious.
- 7.9 The central question in determining the correct MAPPA level is:

“What is the lowest level of case management that provides a defensible Risk Management Plan?”

7.10 As risk can and will change, so the means of managing risk can and will change with it. MAPPAs provide the framework within which changes can be effectively and consistently managed. The overriding principle is that cases should be managed at the lowest appropriate level, determined by defensible decision-making.’

6.1.86 The DHR/II panel understood the difficulties in managing someone who was under no compulsion, such as a parole licence, to comply with taking medication. One route would be to consider whether his mental health had deteriorated to such an extent that it warranted Dean’s assessment under the Mental Health Act. The DHR/II panel would have expected this to be recorded in the minutes under ‘Contingency Planning’. The MAPPAs Coordinator explains:

‘The heading Contingency Planning is included in the MAPPAs template. This is to contingency plan around any areas that have not already been addressed under the 4 Pillars plan and actions.

As part of the contingency plan there are set headings and an opportunity to add additional headings depending on the nominal.

The headings are:

- accommodation breakdown
- offender going missing
- contact with the victim
- failure to comply

At the initial MAPPAs meeting there is no completed contingency as Dean was in custody.

At meeting two [review] accommodation breakdown was highlighted as an issue and the local authority to assist i.e. homelessness. Under failure to comply this was interpreted about compliance with statutory supervision which was coming to an end therefore noted there would be no specific restrictions.

At meeting three [review] contingency plan mirrored that which was recorded in the previous meeting.’

The DHR/II panel felt the contingency plan was weak in that it recognised when risk might arise, but did not specify what the contingent action was. However, it has to be recognised that Dean was never assessed as posing a risk to his mother or sister.

6.1.87 The DHR/II panel felt that until the facts about Dean’s medication were established, he should have remained under MAPPAs Level 2 management. However, the panel did not find a link between deregistration and the deaths of Nina and Jenny.

6.1.88 The DHR/II panel wondered what the arrangements were for checking that actions from a MAPPAs deregistration meeting had been completed. The MAPPAs Coordinator said that following their review of this case, the MAPPAs Minute template has been

amended and a process established that requires feedback on actions to be sent to a nominated person.

- 6.1.89 No mental health professionals attended the three MAPPA meetings despite invitations being sent out. This presented a significant gap in the expertise available to the MAPPA meeting, thereby denying the members access to specialist advice. The Criminal Justice Mental Health Liaison Team told the MAPPA Coordinator they were unable to attend the meeting because of other demands that day.
- 6.1.90 The DHR/II panel understands that unexpected operational matters can, and do, prevent attendance at meetings. The DHR/II panel would have expected the Chair of the MAPPA meetings to challenge the non-attendance and record it as an action in the minutes.³⁶ The MAPPA Coordinator said: 'The expectation is if there is a failure to attend that the Chair will follow this up after the meeting. There is no evidence from the notes that this has happened.' The DHR/II panel felt the lack of challenge by the MAPPA Chair/s was a breach of expected practice.
- 6.1.91 Dean went back to prison on 11 December 2014 and was released on 27 February 2015. There is no evidence that he was re-referred to MAPPA³⁷. Also, there is no evidence that he was considered for re-referral to MAPPA following the incident on the crane or when he was perpetrating domestic violence on Female One. All these matters presented missed opportunities to return him to MAPPA Level 2 management, where greater focus would have been applied to his risk and control measures.
- 6.1.92 However, that is not to suggest that, had he been returned to Level 2 MAPPA management, he would not have killed his mother and sister; there are simply too many variables. The MAPPA Coordinator observes the difficulties faced by agencies when a case is not under statutory supervision and that it needs raising again via the police MAPPA governance process for consideration and learning.

6.2 Term 2

What knowledge did your agency have about domestic abuse between the principals? What risk assessments were undertaken and what actions were taken to ensure the safety of those at risk?

- 6.2.1 No reports were made by Nina or Jenny during the period of the review, or by third parties on their behalf, to indicate they were victims of domestic abuse by Dean. Merseyside Police hold information outside the timescale of this Domestic Homicide Review showing one incident with Nina as the victim and Dean as the perpetrator and one incident with Female One as the victim and Dean as the perpetrator. On one occasion, Dean was also the perpetrator against his sister. Following Nina's

³⁶ Merseyside MAPPA is piloting a core panel approach to MAPPA in one Local Authority area in Merseyside. Mental health agencies are core panel members and will attend all MAPPA meetings in that Local Authority area regardless of direct involvement with the case. This pilot will conclude in June 2016 and if deemed successful will be considered for roll-out around the other Merseyside Local Authority areas.

³⁷ Setting the MAPPA level of management is not the responsibility of the prison service. The lead agency will provide the prison service with information about the level of management. The process for setting the MAPPA level of management should take place at least six months before a person is released from prison. Paragraph 15.8 and 15.9 MAPPA Guidance 2012 V 4.

death, Merseyside Police found evidence from friends that she had been subjected to abuse by Dean. Friends said Nina suffered a broken collar bone. The fact that he offended against two female members of his family suggested to the panel his disregard and disrespect for them.

- 6.2.2 The Domestic Homicide Review panel looked for evidence of that injury within agency records. They found that Nina had visited Aintree Hospital A&E on 28 October 2014 with an injury to her shoulder. There was also evidence from the GP records on 7 January 2015 that she presented with a fracture of the right clavicle. The panel felt it was reasonable to assume this was the injury referred to by friends. However, they could find no evidence from the records that connected this injury to domestic abuse by Dean or anyone else.
- 6.2.3 The panel considered whether health professionals who treated Nina should have probed the reason for the injury and asked direct questions about domestic abuse. Domestic abuse is not always perpetrated by intimate partners (see Appendix B). The panel felt that professionals may therefore not have considered asking questions about the relationship between Nina and her son Dean. In relation to the attendance at Aintree Hospital on 28 October 2014, the IMR author states that safeguarding was not considered despite changes in the history given. This is a gap, and a specific recommendation is made concerning this.
- 6.2.4 In relation to the visit Nina made to the GP on 7 January 2015, the Halton CCG representative personally re-interviewed the GP who dealt with Nina as to their knowledge of this consultation and the possibility the injury was not accidental.
- 6.2.5 The GP could not specifically remember that consultation, although they were able to refer to notes. The GP said Nina attended complaining of pain in her right clavicle. The GP asked her what happened and she said she couldn't remember how the injury occurred. It was approximately eight weeks after the incident had happened that she attended this consultation. The GP asked Nina if she could have fallen again or suffered some further trauma as she was complaining of pain and this was the reason for her attending. Nina denied any further fall.
- 6.2.6 The GP says Nina was not very forthcoming and the letter from the hospital was confusing, referring to her falling out of bed and also to being run over. The GP did not suspect anything suspicious. There was nothing that made the GP think this injury was non-accidental. Nina never mentioned Dean; it was always her daughter she referred to as being worried about her due to her problems. The GP was not aware of any other specific injuries that would have raised an alarm. The GP says that if they'd had concerns, they would have contacted Social Services and made a referral. The panel is therefore satisfied the actions of the GP in seeking an explanation were of an appropriate level.
- 6.2.7 Nina is reported to have been supportive of her son, saying that he was 'misunderstood' and that he was a 'good boy'. It is the perspective of the panel that her defence of him may have meant that professionals did not consider domestic abuse as a factor of their relationship.
- 6.2.8 Dean's use of address 1, and the fact that Nina had to stay in someone else's flat on some occasions when he stayed, indicates she may have been under duress from Dean. Based upon what Your Housing Group knew about Dean and the responses Nina had given to them, they had no grounds for suspecting Dean was abusive towards his mother. While other residents raised concerns that Dean

engaged in criminal activity and about his behaviour at the site, those concerns did not extend to domestic abuse. It seems Your Housing Group therefore had no grounds for sharing residents' concerns with Merseyside Police and that their decision to manage the complaints about Dean as a tenancy issue was a reasonable step to take. However, as the Your Housing Group IMR author acknowledges, the failure to fully complete the risk assessment during the tenancy discussions was a lost opportunity to discuss and explore domestic abuse. Whether Nina would have disclosed something will never be known. The quality and impact of domestic abuse training for Your Housing Group was discussed with their staff as part of interviews, and it was recognised widely that training could be improved. Your Housing Group have an up-to-date Domestic Abuse Policy (October 2014). However, it was recognised there were gaps in the policy regarding referral pathways, risk assessment, routine enquiry and training requirements. In addition, Your Housing Group's Safeguarding Policy did not make adequate reference to domestic abuse, domestic abuse referral pathways or risk assessment. Remedial actions have been implemented within Your Housing Group to address the above.

- 6.2.9 Other than the single incident recorded by Merseyside Police outside the timescale of the Domestic Homicide Review, there was no evidence that Dean had been abusive towards Jenny before he killed her. Unlike Nina, no one has since come forward to state that abuse from Dean had taken place. The Domestic Homicide Review panel also looked to see what agencies knew about the relationship between Dean and Jenny and to see whether there were any traces of domestic abuse that agencies should have been aware of. Other than the single incident referred to above, they found none.
- 6.2.10 Again the panel considered whether agencies should have asked direct questions of Jenny about domestic abuse. There were opportunities to do this. Jenny presented regularly at hospitals and her GP surgery. While many of these were in connection with unrelated matters, she did present on at least three occasions with physical injuries. These included on 3 May 2013, when she said she had been assaulted and injured her arm. On 5 and 18 June 2013 she again presented with pain in her arm and shoulder. On 5 June 2013 she again blamed this on an assault although later changed her explanation, saying it was a chronic problem. There was no indication that Jenny was asked direct questions by her GP or health professionals in A&E about whether the injury might have been the result of domestic abuse.
- 6.2.11 While they gave consideration to these issues, the panel came to a view that there were no missed opportunities to assess that Jenny was at risk from Dean. Other than the single incident of domestic abuse recorded by Merseyside Police, which is outside the timescale of the Domestic Homicide Review, no information came to light then, or has come to light since, that Jenny had been assaulted by Dean. It is known that Dean was in custody when Jenny presented with injuries in June 2013. Consequently, there was nothing to be missed in respect of him. However, good practice³⁸ suggests that health professionals should have probed Jenny further and asked direct questions about domestic abuse.
- 6.2.12 Female One was at risk from Dean. There was one record of previous domestic abuse recorded by Merseyside Police outside the timescale of the Domestic Homicide Review and three relevant events during it (events 11, 12 and 13, Appendix C). In view of the information that Dean might have access to a firearm, appropriate tactics were employed and extensive searches undertaken. Unlike event

³⁸ NICE guidance Domestic Violence and Abuse: multi-agency working 2014.

13, Dean was circulated as wanted. Dean was also referred into a Multi-Agency Risk Assessment Conference, although by the time they met he was in custody.

- 6.2.13 Despite the high risk assessment to Female One, Dean was still in a position to be able to assault Female One when he accosted her four days later in the shopping precinct. Dean had been recorded as a dangerous offender (Multi-Agency Public Protection Arrangements Category 3) and managed at Multi-Agency Public Protection Arrangements level 2 by the National Probation Service. He was therefore among a small cohort of offenders capable of causing serious harm and thus presented a higher risk than many others.
- 6.2.14 The key matter highlighted during this review in relation to domestic abuse and risk relates to events on 31 March 2015 (Breach of Restraining Order). The panel gave careful consideration to this and to whether Dean would have been able to kill Nina and Jenny if he had been in custody. The kernel of the issue is that had Dean been circulated as a wanted person following event 13 (Breach of Restraining Order, 31 March 2015), it is highly likely he would have been arrested when he was stopped and given a warning for possessing cannabis on 5 April 2015.
- 6.2.15 Because of his previous history of failing to appear before courts, the high risk he posed to Female One and the fact he was of no fixed abode, there was a possibility that he may have been remanded in custody. However, this was by no means certain. If he had been remanded, he would not have been in a position to kill Nina and Jenny on the date he perpetrated the acts. Had he been released, for example after serving a sentence, he might still have gone on to kill them³⁹.
- 6.2.16 The reasons why Dean was not circulated as wanted are complex and relate to the way in which crimes were allocated at the time this homicide occurred. The IMR author for Merseyside Police has undertaken a rigorous review of these events, including in-depth interviews with the police officers involved so as to understand not just what happened, but why it happened. The panel has carefully considered the author's analysis, in particular the knowledge officers had about domestic abuse, the risk assessments undertaken and the actions taken to ensure the safety of Female One. The following paragraphs summarise the key issues.
- 6.2.17 The officer who initially attended the Breach of Restraining Order report (event 13) took a statement from Female One and made attempts to trace Dean, which were unsuccessful. A Vulnerable Person Referral Form was completed (VPRF1). The matter was recorded as a crime on the Niche system used by Merseyside Police. The officer carried out a risk assessment and their judgement was that Female One was a 'bronze' victim. Although there was sufficient evidence to arrest Dean, the officer attending event 13 did not consider formally circulating him at that stage.
- 6.2.18 That officer accepts they should have recorded event 13 as a 'domestic incident' on Niche. Even though the matter was not recorded as a domestic incident on Niche, the Storm log did contain information that event 13 was a domestic incident. Had

³⁹ The Merseyside Panel member sought clarification from the Crown Prosecution Service. If a restraining order is breached very close to the making and/or involves another offence, particularly violence or threats of violence, then a custodial sentence is far more likely. If the breach is, for example, being in the street without the victim's knowledge, or being in contact but with some consent, then custody would not have been inevitable. Having reviewed the statement made regarding the breach of the restraining order, the panel member confirms that no violence was threatened or used and the order had been granted over a month prior to the breach. As such, it was not by any means certain that Dean would have been taken into custody as a result of the incident.

officers involved in the subsequent allocation and investigation of the crime read the Storm log, it would have alerted them to this fact. The following is an extract from that log:

'Treat all calls as urgent, occupant (Female One) was the victim of domestic abuse and is therefore at high risk of future harm from (Dean). Children reside at address. Please ensure domestic incidents are correctly identified and VPRF 1 is e mailed. Positive action⁴⁰ must be taken if offences are disclosed.'

- 6.2.19 Because there was no record on Niche that event 13 was a domestic incident, it was allocated to a uniform patrol supervisor. The crime should have been allocated to the Family Crime Investigation Unit. The officer who allocated the crime to the uniform supervisor did not read the Storm log and therefore did not take the issues it contained into account when allocating the crime. The officer told the IMR author there was no requirement for them to take cognisance of Storm logs when deciding whom a crime should be allocated to. While the Merseyside Police IMR author confirms it was not a requirement to read the Storm command and control log, they believe this should have been done as a matter of professional judgement.
- 6.2.20 The author believes the officers who dealt with these incidents lacked the knowledge and experience of an investigator (i.e. make sure that you are aware of all of the facts before you begin an investigation, and to do that, undertake basic checks of all available systems). The IMR author says they did not have that knowledge and that recommendations 1 and 2 within the Merseyside Police Recommendations (Appendix F) are intended to address this issue in the future.
- 6.2.21 Even though the crime was not allocated to the Family Crime Investigation Unit to investigate, a copy of the VPRF1 log was passed to that unit, and two days later they reviewed the risk assessment. That resulted in Female One being assessed as a 'gold' victim. Referrals were made to ICS Careline, Adult Social Services and an Independent Domestic Violence Advocate. She was not referred to a Multi-Agency Risk Assessment Conference, as Female One did not fall into the Coordinated Action Against Domestic Abuse repeat referral criteria. Even though the crime was not allocated to the Family Crime Investigation Unit, that unit were aware of the full history of Female One and Dean and the risks he posed to her. The only action they took was to arrange for a domestic violence liaison officer to make contact with Female One (see below).
- 6.2.22 The policy within Merseyside Police at that time for allocating these crimes was that Family Crime Investigation Unit staff should investigate them. The officer in charge of the Family Crime Investigation Unit told the IMR author that because of the volume of incidents, that policy was not sustainable. The decision as to who dealt with what was therefore not clear and was determined by a number of factors, such as how many prisoners were in custody and how serious the crime was. The panel was advised that because there has been a raising of awareness through training, this has resulted in a significant increase in the number of victims recorded as 'gold', which means there are not sufficient resources for a specialist unit such as the Family Crime Investigation Unit to deal with all gold victims.

⁴⁰ In the context of domestic abuse, 'positive action' is an expression used within many police forces that means taking some affirmative action if offences are disclosed – for example, arresting the offender if they are present at the scene.

- 6.2.23 Two days after event 13, the uniform supervisor allocated the crime to a uniformed patrol police constable to investigate. An investigation plan was formulated, although it was based only on the Niche crime report and the witness statement of Female One. Neither of these recorded that the matter was domestic abuse⁴¹. No background enquiries were undertaken, such as reading the command and control log or conducting intelligence checks. The reasons those background enquiries were not carried out is that the officer did not realise Female One was recorded as a 'gold' victim, as they only read what was on the crime report and her witness statement. Consequently, there was no appreciation of the urgency in circulating Dean as wanted.
- 6.2.24 The IMR author believes that because Female One was a 'gold' domestic abuse victim, and because Dean lived in another area to that in which the investigating officer worked, a Police National Computer circulation should have been completed at the earliest opportunity. This had been the case at the time of the original offence (harassment of Female One, event 11). Because Dean was not circulated, any police officers who came across him at another incident or carried out a stop check would have been unaware he was wanted. This is exactly what happened when Dean was stopped and checked on 5 April 2015.
- 6.2.25 The IMR author found there were different ways in which work was allocated by Family Crime Investigation Units within Merseyside Police. Some staff were not fully conversant with their roles, including their responsibilities, as they changed to adapt to different situations. The system was overwhelmed, and not all crimes involving gold victims were being investigated by Family Crime Investigation Units. This presented a situation where staff did not identify the bigger picture. Consequently, crimes such as the breach of the restraining order were dealt with as relatively minor, isolated occurrences. Ultimately this is what led to the delay in the investigation of the breach and the non-arrest of Dean. The Domestic Homicide Review panel member from Merseyside Police advised the panel that a significant rise in the number of 'gold' victims has increased resource pressures in Merseyside Police and has created a situation where aspirations to deal with these matters as a special case have not always been achieved.
- 6.2.26 The Domestic Homicide Review panel also considered the way in which both Multi-Agency Risk Assessment Conference and Multi-Agency Public Protection Arrangements processes were able to identify and mitigate the risks of domestic abuse posed by Dean. In relation to Female One, her case was discussed by a Multi-Agency Risk Assessment Conference following event 11. However, no actions were raised to ensure Female One was safeguarded. The reason for this was that when the Multi-Agency Risk Assessment Conference met on 13 January 2015, Dean was in custody.
- 6.2.27 However, Dean was not sentenced until 30 January 2015, and while he was remanded in custody, the Multi-Agency Risk Assessment Conference could not have predicted with certainty that he would receive a custodial sentence. A number of things could have happened before, or on, that date, which would have changed the risk Female One faced. For example, Dean could have received a non-custodial sentence or could have been granted bail while a report was prepared. No

⁴¹ In her witness statement Female One denied she had been in an intimate relationship with Dean. Therefore, strictly interpreted, this meant the incident did not fall within the definition of domestic abuse in Appendix A. The officer allocated the investigation had read this statement and was of the opinion the matter was not domestic abuse.

contingency actions were put in place by the Multi-Agency Risk Assessment Conference to protect Female One should events not follow the course expected. While a restraining order was successfully obtained when Dean was eventually released from custody, the need for this was not driven by the Multi-Agency Risk Assessment Conference. The panel believes the Multi-Agency Risk Assessment Conference should have considered and made some plans for such contingencies.

- 6.2.28 The DHR/II panel also discussed the way in which Multi-Agency Risk Assessment Conferences in Liverpool make a record of their meetings, allocate actions and ensure agencies complete them and report back (see paragraph 5.4.6). In particular, the DHR/II panel was concerned that some agencies believed there was a restriction upon them recording information from and actions raised by a Multi-Agency Risk Assessment Conference on their own systems.
- 6.2.29 David Hunter spoke with the manager responsible for the Liverpool Multi-Agency Risk Assessment Conference. She confirmed that meetings are not recorded and minutes are not produced. Action points are recorded and each agency is expected to record these on an appropriate database so they can help manage the risk. The manager says there is no restriction on agencies recording actions on their databases. The DHR/II panel feels it is very important there is clarity as to how actions are recorded and allocated and agencies are held to account for their delivery. They have made a recommendation concerning this (see recommendation 7).
- 6.2.30 Dean's case was discussed at the Prolific and Priority Offender monthly meetings and these were attended by police, probation and the substance misuse provider CRI⁴². However, undertaking meaningful work with Dean in relation to his substance misuse was difficult. The Independent Author understands that Dean was not motivated to address his substance misuse, and the amount of time he spent in custody also presented a barrier to engaging him in relevant activity to address it. However, CRI was able to test Dean for illicit substances twice weekly.

What has changed since the deaths of Nina and Jenny?

- 6.2.31 Since the homicides of Nina and Jenny, information from VPRF1s and PROtect logs is now inputted directly onto the Niche system. This means that the history of domestic abuse is more readily available to patrols dealing with incidents. Persons wanted in domestic abuse cases are now circulated within twenty-four hours if not arrested. Other recommendations for changes in the way in which Merseyside Police deals with domestic abuse are identified within the agency recommendations in Appendix F.
- 6.2.32 The DHR/II panel was informed that significant changes have also been made since March 2015 in the way Multi-Agency Risk Assessment Conferences operate. Meetings in Liverpool now focus more on the perpetrator and not just victims, and each case has specific actions allocated against it. Because of the volume of cases at the time of these events, there was only likely to have been a brief discussion on a case such as this. There is also academic research underway to establish whether the MeRIT risk assessment scoring is correct to deal with contemporary levels of violence. This in turn may impact upon the number of cases that are then referred to MARAC.

⁴² CRI (Now CGL – Change Grow Live) is a social care and health charity that works with individuals who want to change their lives. In some areas it provides substance misuse services as a commissioned service.

6.3 Term 3

What knowledge did the victim's family and friends have about domestic abuse within the family and what did they do with it?

- 6.3.1 Friends and family of Nina knew that Dean had assaulted her. However, this information was not provided to agencies until Merseyside Police undertook the homicide enquiry. Other than the single incident recorded by Merseyside Police outside the timescale of the Domestic Homicide Review, there is no evidence that Jenny had been subjected to domestic abuse by Dean or that family and friends had any relevant knowledge.

6.4 Term 4

If there were lapses (failures) in service provision to any of the principals, were there issues in relation to capacity or resources in your agency that impacted the ability to provide services to the principals and to work effectively with other agencies?

In relation to the non-arrest of Dean, resource issues were not the underlying issue.

6.5 Term 5

Establish what lessons are to be learned regarding the way in which professionals and organisations work individually and together to safeguard future victims.

- 6.5.1 The lessons learned in this case are set out at Section 7 below.

6.6 Term 6

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.

- 6.6.1 The lessons learned in this case are set out at Section 7 below, and the recommendations arising from them are set out at Section 9.

6.7 Term 7

Were equality and diversity issues – including ethnicity, culture, language, age, faith and disability – considered?

- 6.7.1 Section 4 of the Equality Act 2010 refers to 'Protected Characteristics', one of which is 'Disability'.

Section 6 defines 'disability' as:

- (1) A person (P) has a disability if—
- (a) P has a physical or mental impairment, and
 - (b) the impairment has a substantial and long-term adverse effect on P's ability to carry out normal day-to-day activities.

Therefore, Dean had a disability under the Act and it was recognised as such by agencies.

6.8 Term 8

Were issues with respect to safeguarding (adults) adequately assessed and acted upon?

- 6.8.1 The Care Act 2014 (which came into force in April 2015) places responsibilities on local authorities in relation to the protection of adults with care and support needs due to abuse or neglect. If a local authority believes an adult is subject to, or at risk of, abuse or neglect, an enquiry should establish whether any action needs to be taken to stop or prevent abuse or neglect and, if so, by whom. The Act places responsibilities on all agencies.
- 6.8.2 Dean's presence in the accommodation provided by Your Housing Group meant there were significant safeguarding risks to other people living in that accommodation. However, Dean was a visitor and not a tenant, and Your Housing Group did not know anything about him, except what Nina told them: that he was her son. Nina did not disclose any concerns about Dean; rather, she described him as 'my little baby, my little boy', 'misunderstood' and 'a lovely boy'.
- 6.8.3 Merseyside Police, who were the lead agency responsible for managing Dean at MAPPAs, knew that he lived with Nina because police officers visited her several times and she told them this (see paragraph 6.1.78). However, no agency approached Your Housing Group to share information with them or to seek information from them about Dean until 14 April 2015. On this date a police officer visited the accommodation looking for Dean. No information was shared by the police officer with the management of Your Housing Group beyond the fact that Dean was wanted and the police should be informed if he was seen.
- 6.8.4 The DHR/II panel felt that because Dean was assessed as presenting a high risk of harm to the public, the Multi-Agency Public Protection Arrangements meeting on 12 August 2014 should have given consideration as to whether information should be shared with agencies or groups in respect of the risk to the public. Your Housing Group would have fallen into this category, as the sheltered accommodation they provided was accessed by a number of people who were also vulnerable. There is a section within the MAPPAs minutes that prompts consideration of this risk and whether to share information. While the panel has not seen the MAPPAs minutes, the Merseyside MAPPAs Coordinator provided a comprehensive report about their content. The MAPPAs Coordinator informed the panel that the minutes from this meeting record that the local authority housing representative was invited to the meeting and did not attend. A decision was made in the meeting not to disclose information to the registered housing provider. However, there was no discussion recorded in the minutes as to who the registered provider for that address was or of the need to invite the registered housing provider (Your Housing Group) to review meetings. The DHR/II panel has made a recommendation (see recommendation 5c).
- 6.8.5 While Nina lived in accommodation provided by Your Housing Group for persons aged over fifty-five years, there was nothing to suggest she had other care and support needs. The risks of abuse she faced were from Dean, and these have been considered fully at section 6.2.
- 6.8.6 Jenny was capable of independent living and did not appear to be in need of care and support. There was no information to suggest to the local authority or any other agency that she was at risk of abuse or neglect from Dean or anyone else.

- 6.8.7 Female One had no known risks of abuse or neglect other than domestic abuse from Dean. These risks were considered, and she was identified as a 'gold' victim and measures put in place to protect her. These are fully considered at section 6.2.
- 6.8.8 Dean had a long history of mental health issues that stretched back to his childhood. The mental health care treatment he received from the NHS and other agencies is covered fully at section 6.1.
- 6.8.9 The DHR/II panel felt there was insufficient consideration of safeguarding issues in relation to the supported housing tenancy.

6.9 Term 9

Determine through reasoned argument the extent to which the deaths of Nina and Jenny were either predictable or preventable, providing detailed rationale for the judgement.

- 6.9.1 The DHR/II panel concluded there were two important issues to consider in respect of predictability and preventability. The first of these relates to the management of Dean's mental health. The second relates to the missed opportunities to arrest Dean after his breach of the restraining order on 31 March 2015.
- 6.9.2 With regard to the mental health lapses, the ones of greatest significance were:
- Dean was not managed on a Care Programme Approach from July 2014 until the homicides of Nina and Jenny;
 - The recommendation to stop his medication.
- 6.9.3 However, managing Dean on a Care Programme Approach per se would not have made him engage with mental health services. The impact of this would more likely than not have been:
- More assertive and sustained efforts to follow him up when he did not attend for his scheduled outpatient appointments. But successful contact with Dean may not have been achieved even if this had happened. The panel considers that the chances of success here were low.
 - Greater attention to Dean's needs by the Criminal Justice Liaison Team in December 2014 and February 2015. Dean was displaying no signs that would have prompted an assessment under the Mental Health Act. This means that he was free to engage or disengage with mental health services. He was offered an outpatient appointment prior to the death of his mother and sister – an appointment he did not attend. The panel believes that but for the Mental Health Act assessment of November 2014, the Criminal Justice Liaison Team would have possibly been more attentive in December 2014. However, the panel believes it would not have made any difference to the subsequent course of events. In February 2014, the Criminal Justice Liaison Team practitioner did more than they were required to do. The only thing that may have changed was the urgency for CMHT follow-up. Again, the panel believes it is unlikely this would have made much difference. Dean still would not have attended his outpatient appointment.
- 6.9.4 With regard to his medication, the panel is unsure what difference this would have made. He was already non-compliant with his medication in November 2014 by his own admission. Had subsequent medication prescriptions been made, there is no

guarantee that he would have collected them. In any event, there was no compulsion on him to take them.

- 6.9.5 What we do know is that when he was given a custodial sentence on 10 December 2014, he was within the prison population until February 2015. His behaviours were not sufficiently concerning or notable to prompt a request for assessment by a consultant psychiatrist, as happened in 2013 prior to him being transferred to the Spinney. He was also managed in the community from the end of his sentence to the time of Nina and Jenny's deaths without drawing undue attention, with the exception of events 11, 12 and 13, which related to Female One.
- 6.9.6 The panel therefore concluded that in respect of mental health issues, the opportunity for a different approach was removed. However, even had everything been done correctly, there is no measure of confidence that the sequencing of events would have been any different. Dean's removal from MAPPA management in August 2014 was an inappropriate decision, but the DHR/II panel does not believe there is a causal effect to the homicides. Had Dean been registered for MAPPA management prior to his release in early 2015, a risk management plan would have been developed, including an action for agencies to alert the MAPPA lead agency of any change in Dean's mental health or other issues impacting on the risk he posed. The panel believes that in respect of the way Dean's mental health was addressed, it was not predictable that he would kill Nina and Jenny and therefore not preventable.
- 6.9.7 As a result of the homicide investigation, it is now known from friends and family that Nina was the victim of domestic abuse by Dean. The panel cannot discount the possibility that when Nina attended Accident and Emergency on 28 October 2014, it was as a consequence of domestic abuse. That information was not known to Merseyside Police, nor could they have reasonably ascertained it. While they correctly identified that Female One was at high risk from Dean, they did not know, and could not have known, he presented a risk to Nina or Jenny. Consequently, their homicides could not have been predicted.
- 6.9.8 In relation to the way in which Merseyside Police sought to arrest Dean following the incident on 31 March 2015, there were missed opportunities. Dean was not circulated as wanted, and therefore if police officers encountered him at another incident or carried out a stop check, they would not know this fact. This is what happened on 5 April 2015, when a police patrol stopped him in the street and issued him with a caution for possessing cannabis, and an opportunity to arrest him was lost. The Merseyside Police IMR author is clear that had Dean been arrested, then he would have been kept in custody to appear before the courts. It is possible that the court would have remanded Dean to prison due to his previous history of failing to appear, having no fixed abode and the high-risk domestic violence threat he posed to the victim. However, that cannot be known for certain given the lack of any violence or threats of violence when the restraining order was breached.
- 6.9.9 Had Dean been arrested, on 5 April 2015 or at any time thereafter, for breaching the restraining order on Female One, and then been remanded in custody, the homicides of Nina and Jenny might have been prevented on the day they occurred, although this would have provided no guarantee that they could have been avoided completely.

7. LESSONS IDENTIFIED

- 7.1 The IMR agencies' lessons are not detailed here because they appear as actions in the Action Plan at Appendix E.
- 7.2 The lessons identified by this Domestic Homicide Review are listed below. Each lesson is preceded by a narrative.
- 7.3 Lessons are identified as arising either from the panel's analysis of the case or from broader discussion.

Lessons arising from the panel's analysis of the case

Lesson 1 (Recommendation 1 applies)

Narrative

There was an incomplete handover of Dean's care, for which both Manchester Mental Health and Social Care Trust (HMP Manchester) and Mersey Care NHS Trust had responsibility. Face-to-face meetings did not take place and there was not a full and complete exchange of information, including care plans. An example of why this did not happen is that Mersey Care only received part of a fax from HMP Manchester that included clinical summaries made by the visiting psychiatrists who attended to assess Dean and prescribed the management plan for him.

Lesson

Although the situation that arose between Mersey Care NHS Trust and Manchester Mental Health and Social Care Trust could not now happen, the incomplete information transfer in this case highlights the importance of information providers having a safety step in their processes so that they can ensure that all information provided has in fact been received.

Lesson 2 (Recommendation 2 applies)

Narrative

While in prison custody prior to being admitted to the Spinney in July 2013, and then again following a custodial sentence in December 2014, Dean appeared to be arbitrarily moved around the prison system, thus denying him the level of mental health supervision, assessment and treatment he required.

Lesson

Prisoners who enter the prison system with mental health issues are at increased risk of vulnerability. For those prisoners who require mental health assessments, moving them routinely around the prison estate is not a good plan, as it interrupts the process of assessment. Therefore, an approach needs to be developed within the prison system that enables the continuity of mental health care for those prisoners who may need to be moved.

Lesson 3 (Recommendation 3 applies)

Narrative

There were some missed opportunities to identify that Nina may have been at risk of domestic abuse. For example, when Nina sought accommodation in April 2014, a risk assessment was undertaken. The section concerning domestic abuse was left blank. In December 2014 a routine older person assessment was undertaken. Nina was not asked direct questions about domestic abuse. Nina had contact with Aintree Hospital in October 2014 in relation to a fracture of the right clavicle. Safeguarding was not considered at the hospital presentation.

Lesson

Professionals should be empowered to make routine enquiries of patients or victims to establish if they can provide information that indicates they are at risk of domestic abuse or have been subjected to domestic abuse. Professionals need to be provided with clear pathways so they understand what should be done with any information they discover.

Lesson 4 (Recommendation 3 applies)

Narrative

Nina resided in a sheltered housing scheme for people over fifty-five. Dean was able to enter the scheme freely and access Nina's flat even when she was not there. This included the day Dean killed Nina. On occasions Dean stayed over in Nina's flat, which meant she had to sleep in other residents' flats. The family believe Dean was highly manipulative and felt he should not have been staying with Nina. The housing provider knew little about Dean's background and felt he was shy and polite.

Lesson

Providers of housing occupied by residents who are elderly, infirm or suffer from mental health issues need to understand that these residents may be vulnerable to persons such as Dean who can exercise coercive behaviour towards them. Providers need to be alert to these dangers, be inquisitive about visitors and what they do, and take steps to protect their residents from the risks of controlling individuals such as Dean.

Lesson 5 (Recommendation 4 applies)

Narrative

The family says Nina was frightened of Dean. He would telephone and demand her return and could be heard screaming down the telephone at her. The family say Dean would take advantage of his mother's kind nature by taking money from her. Friends believe Dean was responsible for fracturing Nina's shoulder.

Lesson

Families and friends of victims sometimes have valuable knowledge about the domestic abuse a victim has suffered or the way that a perpetrator has behaved that they do not repeat to others or report to agencies for many different reasons⁴³. Information needs to be made available to friends and family so that they know how best to support victims, which may include sharing the information with agencies, but at all times recognising the safety of the victim is paramount. This will empower families to have the courage to say something and to know where they can share information safely. Sometimes families stay quiet because they believe they will make it worse for the abused if they speak out.

Lesson 6 (Recommendation 5 applies)

Narrative

In the opinion of the DHR/II panel, it was inappropriate to remove Dean's case from MAPPA management as the plan to manage his risk was underdeveloped. For example, it was not known whether he was engaged with mental health services, thereby meaning his single biggest risk factor was uncontrolled. On his release from prison in February 2015, no one considered whether he should be re-registered with MAPPA. This was a missed opportunity to identify and manage his risks, including the consideration of disclosing his risk profile to Your Housing Group for the protection of its residents.

Lesson

Poor MAPPA management and adherence to its policies and procedures leads to risks being uncontrolled and potential victims unprotected.

⁴³ The reasons victims gave for not reporting domestic abuse to the police were identified in a survey as: fear of retaliation (45 percent); embarrassment or shame (40 percent); lack of trust or confidence in the police (30 percent); and the effect on children (30 percent). Her Majesties Inspector of Constabulary: Everyone's Business Improving the Police Response to Domestic Abuse 2014 ISBN: 978-1-78246-381-8

Lesson 7 (Recommendation 6 applies)

Narrative

The key issue highlighted during this review in relation to police actions is that Dean was not circulated as wanted for the breach of the restraining order committed on 31 March 2015. There were a variety of reasons why this did not happen. This included a failure to record/recognise the matter as a domestic incident, a lack of clarity as to who should deal with such matters, not allocating the crime to a specialist to investigate, officers not reading all the information that was available and held on the police systems, not carrying out background checks, and not appreciating the urgency in circulating Dean as wanted.

Lesson

Police systems need to provide clarity at all times as to who owns an investigation; the actions that need to be taken in cases of domestic abuse; and who has responsibility for actions, together with realistic deadlines for these actions to be completed and monitored that balances urgency against the prevailing demand on, and availability of, resources.

8. CONCLUSIONS

- 8.1 From a young age it was known that Dean's behaviour was challenging. Education services reveal a history of disruptive behaviour and poor school attendance, with frequent and positive resistance by his family towards educationalists' advice, and unwillingness to accept their guidance. His extended family also thought his behaviour was disruptive.
- 8.2 Dean drifted into the culture of gangs and crime and does not appear to have been in paid employment. He abused illegal drugs and soon began accumulating convictions and periods of imprisonment.
- 8.3 It was during one of his incarcerations that it became apparent that he had mental health needs, and he was transferred to a secure mental health hospital. In January 2014 he was diagnosed as a paranoid schizophrenic with personality disorder and returned to prison. During his time in the hospital he was disruptive and racially abusive, assaulted staff, and cunningly obtained, concealed and used mobile telephony before being returned to prison. It was of particular note that Dean was moved around the prison estate because of his disruptive behaviour. As a consequence of this, there was a lack of continuity in his mental health care.
- 8.4 The risk assessments completed on Dean by the National Probation Service showed he was a very high risk to staff and a high risk to the public. He was not assessed as being a risk to his family.
- 8.5 Failures in the discharge procedures between prison mental health services and community mental health services meant that he was not recognised as having an entitlement to Section 117 planning and to a Care Pathway Approach. Therefore, when Dean left prison in July 2014, he was without any mental health support. This was known to the MAPPA meetings, who took no effective steps to manage his risk and in fact deregistered him in August 2014 without ever having a mental health professional at any of its three meetings. Dean's high risk of causing serious harm to the public was largely uncontrolled.
- 8.6 A mental health assessment was undertaken in December 2014 following an incident where he climbed a crane. While the trainee psychiatrist dealt appropriately with Dean's presentation, he did not know his existing diagnosis and gave Dean inappropriate advice that he did not need to take medication.
- 8.7 Around the same time, he was assessed by Merseyside Police as posing a high risk of causing harm to a woman he described as his partner, a status she denied. He was dealt with for the issues and sentenced to another term of imprisonment before being released in February 2015, when he went to live with his mother in her sheltered housing scheme. He should have been considered for MAPPA management prior to release, but no one thought to do it.
- 8.8 Apart from one incident in 2006 where he was involved in a domestic incident with his sister and assessed as posing a low risk to her, no other reports of him abusing his family were made. However, subsequent to the homicides, evidence has been uncovered that he assaulted his mother, probably linked to financial abuse. She did not reveal her victimisation and always spoke up for, and protected, her son, a position understood by the DHR/II panel.
- 8.9 The panel considered whether there was evidence of controlling and coercive behaviour and financial abuse by Dean against his mother and sister. There were reports by neighbours to Your Housing Group staff that Nina had to sleep elsewhere when Dean stayed at her flat. That was explored at the time by Your

Housing Group and no evidence was found to support the reports. There is no evidence that Dean was financially exploiting his mother or sister. That is different from saying those things did not happen. There is no doubt that Dean exerted significant influence over his mother for all his life. She could see no bad in him and was always ready to defend him. It is very likely that over his lifetime that Dean was receiving money from his mother and whether she gave it freely cannot be ascertained. It is known that he assaulted her and therefore the panel felt it was reasonable to conclude that he did exert controlling and coercive behaviour over his mother and because of his nature probably his sister; he assaulted her at least once. Whether his mother recognised his behaviour as controlling and coercive is a different question that cannot be answered with confidence.

- 8.10 Within less than eight weeks of his February 2015 release from prison, he killed his mother and sister, following which he was detained under Section 3 of the Mental Health Act 1983.

9. RECOMMENDATIONS

- 9.1 The individual agencies' recommendations appear in the Action Plan at Appendix E and are not repeated here.
- 9.2 The Domestic Homicide Review panel and Mental Health NHS Independent Investigation recommendations appear below and also in the Action Plan.

Domestic Homicide Review panel recommendations

- 9.3 The Domestic Homicide Review panel recommends:
1. That Manchester Mental Health and Social Care Trust (HMP Manchester) and Mersey Care NHS Trust confirm in writing to Sefton Safer Communities Partnership what actions have been taken to remedy the identified weaknesses when releasing prisoners who are entitled to Section 117 services.
 2. (a) That in cases in which prison mental health services have identified that a mental health assessment is needed, the National Offender Management Service ensures that when decisions are taken to move offenders between prisons, the assessment is completed prior to that move. If the prisoner is to be released before the assessment is completed, the National Offender Management Service should ensure there is a process in place to highlight the incomplete assessment to the offender's current or last known GP, and request the GP to refer the offender to the nearest secondary mental health provider to the area in which they are released.
 - 2 (b) Furthermore, that where a prisoner is already being assessed by specialist mental health services, the National Offender Management Service is asked to determine the risks to that individual, and of the individual reoffending, if a complete mental health assessment cannot be achieved as a direct consequence of the prisoner being moved or released.
 3. That Your Housing Group reports in writing to Sefton Safer Communities Partnership what action it has taken to ensure that it minimises the risks of domestic abuse to its tenants. This must include commentary on how it ensures that the risk of domestic abuse is assessed for all new tenants, and how its staff are trained to respond to information that raises a domestic abuse concern.
 4. That Sefton Safer Communities Partnership undertakes research within its local communities about barriers to reporting domestic abuse and how the community can be empowered to 'speak out'. Furthermore, Sefton Safer Communities Partnership is asked to develop, publish and publicise advice for family and friends on what to do [or not to do] when they receive disclosures of domestic abuse and to ensure that this information is always available in places frequented by the public.
 - 5 (a). That Merseyside MAPPAs Strategic Management Board reports in writing to Sefton Safer Communities Partnership what action it has taken to ensure that Section 6.15 of the MAPPAs Guidance 2012 [Identifying MAPPAs offenders] is adhered to.

- 5 (b) That MAPPA-managed offenders are managed at the appropriate level and that any substantial disagreement between agencies on which level a person should be managed at has a resolution pathway.
- 5 (c) That disclosure is always considered when there is a risk to others. Disclosure to a third party (Your Housing Group) was considered but not felt necessary when Dean was assessed as presenting a risk to the public at the MAPPA meeting on 12 August 2014. While full disclosure to all residents was unlikely, this should have been discussed and clarified in the minutes, as should discussion and clarification of disclosure to Your Housing Group. The learning from this event is that disclosure should always be considered when there is a risk to others. This learning should be fed back to those who chair MAPPA meetings.
6. That Merseyside Police reports in writing to Sefton Safer Communities Partnership what action it has taken to ensure that its policies and practices for circulating wanted people are appropriate and followed.
7. That the pan-Merseyside MARAC steering group considers the way in which the recording of MARAC meetings can be improved, how actions are recorded and allocated, and how agencies are held to account for their delivery. The steering group should consider whether meetings should be voice recorded.

Mental Health NHS Independent Investigation recommendations, improvements made and recommendations outstanding

- 9.4 At relevant stages throughout the previous pages, changes that have been made have been highlighted. The outstanding issues for mental health are set out here.
- 9.5 The only change that occurred as a consequence of this case review and other inquest comments is the new requirement in Lancashire Care Foundation Trust for their staff to review SystemOne for relevant information about newly processed inmates.
- 9.6 Mersey Care NHS Trust has made a number of changes⁴⁴ to its centralised approach to the referral and assessment process. While these have not been made as a direct consequence of this case, they do address features of the mental health omissions in this case.
- 9.6.1 Manchester Mental Health (HMP Manchester) have also made their changes for good practice reasons rather than as a consequence of this case. It is not thought they constitute 'lessons learned' as a consequence of the Dean case. However, this case has highlighted yet again the central importance of:
- Uncompromising adherence to safe practice procedures such as Section 117 aftercare and Care Programme Approach discharge, as they are designed to ensure effective transfer of critical information about a service user.

⁴⁴ All referrals are received by the newly arranged access team. The patient is physically assessed as part of the triage and then allocated to the appropriate part of the service.

- The need for relevant agencies to have access to complete information about a service user. This case has highlighted the importance of SystemOne prison records to Hospital Psychiatric Liaison Teams, Criminal Justice Liaison Teams and, I would argue, Crisis Intervention Teams.

Mersey Care NHS Trust's internal assessment and referral processes

9.7 An outstanding action for Mersey Care Trust is to establish the reliability with which its staff ensure they have read and assimilated all the information provided about a new patient at the point of referral and acceptance. This did not happen in this case. There are a number of ways the trust could achieve this:

- Via survey method
- Via simulation method, in conjunction with safety tools such as Failure Modes and Effects Analysis
- Via observation and interview methods

The trust is required to set out its action plan for achieving assurance and to share this with Sefton Safer Communities Partnership.

9.8 Mersey Care NHS Trust has revised how it assesses new referrals, and a face-to-face meeting with its own team now occurs as normal practice. However, what happens 'as a norm' when a service user is allocated to a community mental health team needs to be established.

- How do community mental health teams ensure that they are appropriately knowledgeable about a service user?
- To what extent is the information known about a service user reviewed and assimilated by a community mental health team?

One way to test this would be to simulate Dean's referral and acceptance into Mersey Care NHS Trust as it occurred in June 2014 and to test its newly revised systems to determine what, if anything, would be different. Alternatively, the revised process could be visually mapped and a selection of staff working in and across the new system brought together to apply the principles of Failure Modes and Effects Analysis to identify any weak points in the system that reasonably could lead to the information loss that occurred in this case.

SystemOne records

9.9 Most mental health prison in-reach is provided by NHS trusts. However, the clinical data is documented on a clinical information system known as 'SystemOne', which a mental health trust would not have access to outside of the prison setting. The purpose of SystemOne is to enable all prison health teams to have access to relevant records regardless of what prison a prisoner resides in at any given point in time. For SystemOne to be delivered nationally, access also needs to be available to:

- The Criminal Justice Liaison Service on a national basis
- Section 12 Approved Doctors and Approved Mental Health Professionals (AMHP) when they are conducting an assessment under the Mental Health Act

Had the SystemOne records been accessible by these two groups of professionals in this case, the clinical knowledge about Dean would have been enhanced, and staff strongly believe that they would have acted differently to how they did in respect of:

- The management plan post-Mental Health Act assessment in November 2014.
- The two Criminal Justice Liaison Team contacts: one in January 2015, and the other in February 2015. The key difference here would have been the urgency of request regarding subsequent assessment of Dean.

Finally, the discharge letter from prison health to Dean's GP was not clear in respect of his diagnosis at the time of discharge. The formulation of discharge letters needs to ensure that the receiving health professional can quickly see what the current diagnosis and treatment needs are.

- Categories of risk – Merseyside Police categorises risk to victims of domestic abuse as 'gold', 'silver' or 'bronze'; each of these categories has a list of interventions to be considered
- Corvus – Merseyside Police briefing and information system
- Niche – Merseyside Police record management system for crime, custody and intelligence records
- Police National Computer (PNC) – relates to criminal records
- Police National Database (PND) – relates to national records
- PROtect – Merseyside Police Family Crime Investigation Unit (FCIU) system on which all incidents of domestic abuse are recorded
- Storm – Merseyside Police command and control system

DEFINITIONS

Domestic violence and abuse

1. The definition of domestic violence and abuse as amended by Home Office Circular 003/2013 came into force on 14 February 2013 and 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.'

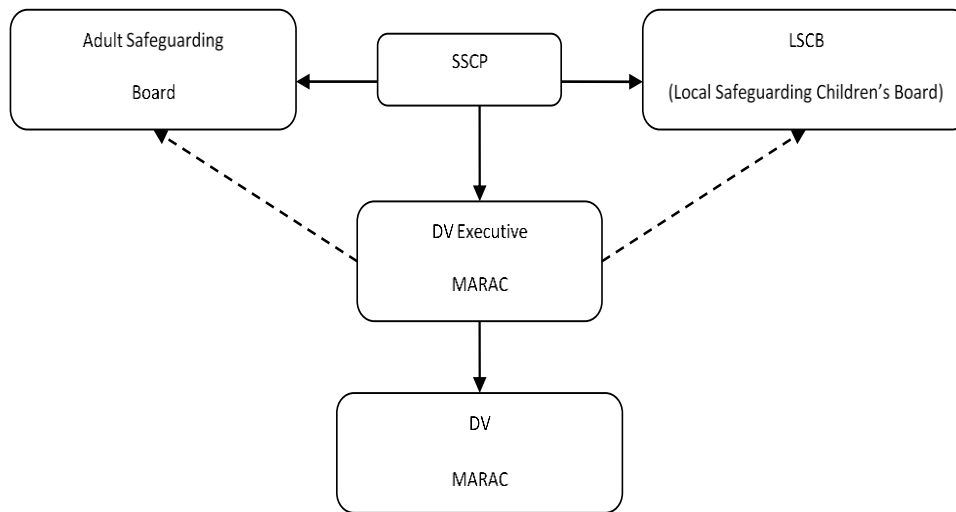
Risk assessment terms

Merseyside Risk Identification Toolkit (MeRIT)

2. MeRIT is the risk assessment model currently used by Merseyside Police and partner agencies. MeRIT 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.
3. Police officers who attend domestic abuse incidents use the MeRIT tool to identify the level of risk faced by the victim. Information gathered, together with any additional comments by the officer, is submitted to the Family Crime Investigation Unit (FCIU) using a Vulnerable Person Referral Form 1.
4. A trained assessor in the FCIU reviews and categorises the risk to the victim of abuse. The FCIU risk-assesses victims of domestic abuse and categorises them as gold, silver or bronze. Gold victims suffer the highest risk of further abuse that could amount to serious harm.
5. The FCIU uses the information contained in the VPRF 1 document to populate a database entitled 'PROtect' where all incidents of domestic abuse are held. During the risk assessment process, the FCIU identifies actions designed to reduce known risks to the victims, and this can include referrals to other agencies or a Multi-Agency Risk Assessment Conference.
6. Multi-Agency Risk Assessment Conferences are meetings where information about high-risk domestic abuse victims is shared between local agencies. By bringing all

agencies together at a Multi-Agency Risk Assessment Conference, a risk-focused, coordinated safety plan can be drawn up to support the victim.

Governance arrangements in Sefton



7. Sefton Safer Communities Partnership (SSCP) and the Local Safeguarding Children’s Board (LSCB) have identified domestic violence as a core priority, recognising the significant impact upon communities.
8. SSCP has responsibility for all crime and community safety issues in Sefton. The Community Safety Partnership (CSP) is chaired by the Cabinet Member for Safer Communities and Neighbourhoods.
9. DV Exec is a specific group established to look in detail at the top-level repeat cases and identify specific Multi-Agency Risk Assessment Conference actions to address what is causing the repeats.
10. DV Multi-Agency Risk Assessment Conferences are meetings where information about high-risk domestic abuse victims is shared between local agencies and appropriate actions are defined.
11. LSCB is the key statutory mechanism for agreeing how organisations will cooperate to safeguard and promote the welfare of children and young people.

Support to victims

12. Currently those individuals experiencing domestic violence have access to a range of support services provided through the Council and voluntary sector. These include the following.
13. The Vulnerable Victim Advocate Team (VVAT) supports high-risk domestic violence victims, all high-risk sexual violence victims and all Multi-Agency Risk Assessment Conference cases; provides crisis interventions; undertakes full needs and risk assessments and sanctuary assessments; assists with safety and support plans; and acts as an advocate on behalf of the victim in dealing with other agencies. VVAT also provides support to male victims of domestic abuse at any risk level.
14. Sefton Women’s and Children’s Aid (SWACA) offers long-term specialist support for women who experience domestic abuse, refuge accommodation, and a children’s

service for children and young people who have experienced or lived with domestic violence.

15. Venus Women's organisation offers information and support (on issues such as housing, benefits, etc.), volunteering, day trips, and residential accommodation.
16. Voice4Change is an independent support and counselling service for male and female victims of domestic violence.
17. RASA (Rape and Sexual Abuse) Sefton provides essential crisis and therapeutic support to survivors of sexual violence by offering support and counselling. RASA works with all individuals who have been victims of sexual violence at any time in their lives.
18. Aspire (Sefton) helps female offenders to access supervision appointments within SWACA. Packages of support are developed by offender managers and SWAN centre.
19. Probation perpetrator programmes. For male offenders who are convicted of any offence related to violence against their partner or ex-partner.
20. No Xcuses: an approximately 30-week voluntary perpetrator programme facilitated by Sefton Family Support Workers. Referrals made by Social Workers. Partner support offered by SWACA. Currently a pilot programme. VVAT can also provide partner support for the No Xcuses programme.
21. InPACT, a Knowsley-based organisation, is also delivering a pilot programme in Sefton. Funded by the Police and Crime Commissioner via the Sefton Safer Communities Partnership, it focuses on targeting perpetrators not eligible for the No Xcuses programme. InPACT is a programme for men aged 18 or over who want to stop being violent or abusive, or look at changing their past behaviour. 26-week (or more) group programme and individual assessments.

Review of domestic abuse

22. A sub-group of the LSCB agreed a review of domestic violence should be carried out to provide an up-to-date picture of the key issues facing Sefton. From this a Domestic and Sexual Abuse Strategy for the next three years has been developed and has now been approved by Sefton Safer Communities Partnership. A Domestic Violence Executive Group is being established to take this forward, develop the action plan and oversee the lessons learned from Domestic Homicide Reviews on an ongoing basis.

Multi-Agency Public Protection Panels and their relationship with mental health services

(Extract from Multi-Agency Public Protection Arrangements Guidance 2012. This is an open source document which can be found on the web)

23. The duty to co-operate applies to a range of Health Trusts and Authorities, meaning that a range of health practitioners and administrators may be involved in Multi-Agency Public Protection Arrangements. General Practitioners and Accident & Emergency departments, for example, are often amongst the first to witness the effects of the sort of behaviour which Multi-Agency Public Protection Arrangements is established to prevent, and it is important that the Chief Executives of all Trusts and Authorities are engaged in the drafting of the memorandum. Usually, it is

Mental Health Trusts with whom the Responsible Authority is likely to deal most frequently because many Multi-Agency Public Protection Arrangements cases will involve offenders with a history of mental disorder.

24. Indeed, given the incidence of mental disorder amongst offenders, there are numerous mutual benefits of co-operation in Multi-Agency Public Protection Arrangements for both responsible clinicians and Responsible Authority (and other) agencies, including:
 - The facility to exchange data securely to inform risk assessments of offenders/patients.
 - An insight into available criminal and clinical interventions, and
 - A framework for referral between agencies about high-risk cases.
25. Relevant sexual and violent offenders who receive hospital or guardianship orders qualify automatically for Multi-Agency Public Protection Arrangements under Categories 1 or 2 for as long as the hospital order or the sexual offender notification requirement lasts. Hospital orders expire on discharge from hospital, unless the discharge is conditional, in which case the Secretary of State has the power to recall to hospital for treatment. Conditions will only apply where there is also a restriction order. Conditions may also be added under a community treatment order, which gives the responsible clinician the power to recall to hospital for treatment (see chapter 26 on Mentally Disordered Offenders for details).
26. Relevant sexual offenders who receive unrestricted hospital orders will be subject to the notification requirements of Part 2 of the Sexual Offences Act 2003, i.e. will be on the 'sexual offenders' register', for 7 years, or life if the order is restricted.
27. Offenders who receive prison sentences, but are subsequently transferred to hospital for treatment for mental disorder and who remain there beyond the custodial element of their sentence, are treated as if subject to unrestricted hospital orders. The same applies to offenders who were given hospital directions by the sentencing court. These offenders are commonly known as 'notional 37s' and, during the currency of their licence, they will be subject to statutory supervision by probation. It is also important to note that the Offender Manager's sentence planning responsibilities continue, even where the prisoner happens to be in hospital. The Offender Manager should maintain his or her involvement in the Care Programme Approach process throughout the licence period.
28. Mental Health Trusts (together with Social Services) have a statutory supervisory/care role in relation to certain Multi-Agency Public Protection Arrangements offenders. Under section 117 of the Mental Health Act 1983, there is a requirement on the relevant Health and Social Services authorities to provide after-care services to offenders subject to section 37 hospital orders who are discharged from hospital, for as long as they require them. What the care consists of will naturally vary but in many cases it will be co-ordinated by community mental health teams.
29. After-care under section 117 will generally be established and managed via the CPA, which is intended to provide a systematic assessment of health and social care need; an agreed care plan; the allocation of a key worker (care co-ordinator); and a regular review for mentally ill patients who are considered for discharge or accepted by specialist Mental Health Services. The after-care requirement applies in

relation to both restricted and unrestricted patients. When the former are discharged, this will generally be subject to conditions, and a Social and Clinical Supervisor reporting to the Secretary of State will be appointed to monitor the patient's progress in the community. (See chapter 26 on Mentally Disordered Offenders for more details).

30. Care Programme Approach involves a multi-disciplinary approach to care, and Responsible Authority agencies may be involved. This co-operation at level 1 should continue with referral to Multi-Agency Public Protection Arrangements level 2 or 3 only once it is clear that the Care Programme Approach is not equipped to deal with the risks identified. It is likely that most offenders subject to hospital orders will be managed within Care Programme Approach without recourse to Multi-Agency Public Protection Arrangements levels 2 and 3. The offender will have received a hospital order because the court decided that that was the appropriate way to proceed and, while the care teams may wish to consult Responsible Authority agencies (and will often benefit from doing so), it is likely that the interventions available under Care Programme Approach or via the supervisory regime for restricted patients will be the most appropriate.
31. However, experience shows that this cannot be taken for granted. Without appropriate planning and communication, the Responsible Authority might find itself suddenly dealing with a dangerous offender who has historically been dealt with by a health disposal but who for a variety of reasons is now considered unsuitable for such an approach. In addition, leave decisions may benefit from information-sharing. The Responsible Authority will often hold key information about the offender and the victim which may not otherwise be available to the Trust.
32. It is essential therefore that the memorandum includes clear standing agreements about these offenders. In addition to other requirements, for example including Responsible Authority contacts to help Trusts with Care Programme Approach-managed cases, the memorandum should require Trusts to identify all offenders who fall within Multi-Agency Public Protection Arrangements (both those in hospital and those in the community) so that:
 - The details can be notified to the Multi-Agency Public Protection Arrangements Co-ordinator on the form Multi-Agency Public Protection Arrangements I.
 - They are well-placed to consult other Multi-Agency Public Protection Arrangements agencies and refer to Multi-Agency Public Protection Arrangements level 2 and 3 as required.
 - They can contribute to the area statistical returns and monitoring.

Table 1. Events involving Dean

Event	Date	Nature of Event	Outcome	Recorded as Domestic Incident	Health Assessment Conducted
1	27/4/10	Stop check of Dean in street in possession of cannabis.	Formal warning issued. Drugs seized.	No	No
2	30/4/10	Stop check of Dean in street in possession of cannabis.	Fixed penalty notice £80 issued. Drugs seized.	No	No
3	3/5/10	Arrested and charged with burglary and damage.	Remanded in custody then granted bail. Breached bail and re-arrested 4/6/10. Attempted to escape. Later found NG.	No	No
4	4/6/10	While on remand for event 3 he spat in face of court officer.	Summoned. Three months' imprisonment, suspended and tagged.	No	No
5	29/9/10	While on remand for event 3 he was interviewed for an assault on another prisoner.	NFA.	No	No
6	26/1/11	Arrested for burglary.	Medically assessed regarding previous warning signals, and admissions to custody staff that he takes medication for a diagnosed paranoid schizophrenic condition. Thirty-five months' imprisonment.	No	Yes
7	17/2/11	Assaulted prison officer, breaking two of his bones.	He received four months' imprisonment.	No	Yes
8	21/5/13	Damaged property at a bail	Recall to prison to serve remainder of sentence.	No	No

Event	Date	Nature of Event	Outcome	Recorded as Domestic Incident	Health Assessment Conducted
		hostel.			
9	4/6/13	Assault on health care assistant in prison.	Interviewed three months later as he was in hospital under Mental Health Act. Prior to interview, Dean's condition was reviewed by hospital staff, and he was deemed fit to be interviewed and able to understand the prosecution process. Conditional discharge for twelve months and £100 compensation.	No	Yes
10	23/11/14	After leaving hospital climbed onto a crane and threatened to jump off. Caused damage to crane and to the windscreen of a police vehicle.	Taken back into hospital for assessment, discharged into police custody and arrested. While in custody, a care plan was introduced. It was not deemed necessary for any further assessment, due to his recent discharge from hospital with no mental health issues. Charged with criminal damage of £4,078. Given conditional bail. Pleaded 'guilty' to these offences and sentenced to eight weeks' imprisonment.	No	Yes
11	6/12/14	Female One states Dean is harassing her and her family, causing damage to her property and threatening to burn the house down. There was a suggestion he was in possession of a firearm.	Circulated as wanted and extensive enquiries made to trace and arrest him (see event 12 below).	Yes	No
12	10/12/14	Female One assaulted in street by Dean, who punches her to side of head.	Arrested at scene for this offence, and event 11. While in custody was assessed by the Criminal Justice Mental Health Team. Dean stated he had no mental health issues, as had been confirmed by the hospital on 24/11/14. Care plan put in place while in custody. Interviewed, charged with assaulting Female One and remanded in custody.	Yes	Yes

Event	Date	Nature of Event	Outcome	Recorded as Domestic Incident	Health Assessment Conducted
			Sentenced to twenty-two weeks' imprisonment. Restraining order re Female One applied for when Dean was released from custody on 7/2/15.		
13	31/3/15	Female One states Dean outside her house in breach of restraining order.	Dean was not circulated as wanted for this offence and therefore not arrested when he was stop checked and received a street caution for possession of cannabis on 5/4/15.	Yes	No
14	20/4/15	Arrested for murders of Nina and Jenny.	Unfit to interview and detained in hospital under the Mental Health Act.	Yes	Yes

Table 2: Prisons where Dean was held

From	To	Prison
04/06/2010	28/01/2011	HMP Liverpool
28/01/2011	09/03/2011	Not in prison custody
09/03/2011	20/05/2011	HMP Hull
20/05/2011	12/07/2011	HMP Forest Bank
12/07/2011	07/10/2011	HMP Altcourse
07/10/2011	16/12/2011	HMP Hull
16/12/2011	19/12/2011	HMP Liverpool
19/12/2011	27/02/2012	HMP Preston
27/02/2012	25/04/2012	HMP Durham
25/04/2012	23/10/2012	HMP Everthorpe
23/10/2012	09/01/2013	HMP Liverpool
09/01/2013	22/05/2013	HMP Oakwood
22/05/2013	20/01/2014	HMP Liverpool
20/01/2014	02/07/2014	HMP Manchester
02/07/2014	11/12/2014	Out
11/12/2014	05/01/2015	HMP Liverpool
05/01/2015	27/01/2015	HMP Holme House
27/01/2015	27/02/2015	HMP Preston

Action Plans

Panel Recommendations						
No.	Recommendation	Key Actions	Evidence	Key Outcomes	Lead Officer	Date
1	That Manchester Mental Health and Social Care Trust (HMP Manchester) and Mersey Care NHS Trust report in writing to Sefton Safer Communities Partnership what actions have been taken to remedy the identified weaknesses when releasing prisoners who are entitled to Section 117 services.	SSCP to write to Manchester Mental Health and Social Care Trust (HMP Manchester) and Mersey Care NHS Trust to request an update report	Report	Improved processes for accessing Section 117 services Prisoners receive the appropriate support they are entitled to on release	SSCP	June 2017
2 (a)	That in cases in which prison mental health services have identified that a mental health assessment is needed, the National Offender Management Service ensures that when decisions are taken to move offenders between prisons, the assessment is completed prior to that move. If the prisoner is to be released before the assessment is	SSCP to write to National Offender Management Service to request a report outlining the procedures for mental health assessments for prisoners, particularly in relation to prison moves and release. This report should include any changes to processes since the time of this DHR and any lessons learned that have been implemented as a result.	Report	Clarity and reassurance for the SSCP that appropriate procedures are in place for assessing the mental health of prisoners, particularly if they move or are due for release.	National Offender Management Service	June 2017

	completed, the National Offender Management Service should ensure there is a process in place to highlight the incomplete assessment to the offender's current or last known GP, and request the GP to refer the offender to the nearest secondary mental health provider to the area in which they are released.					
2 (b)	Furthermore, that where a prisoner is already being assessed by specialist mental health services, the National Offender Management Service is asked to determine the risks to that individual, and of the individual reoffending, if a complete mental health assessment cannot be achieved as a direct consequence of the prisoner being moved or released.	As above	Report	Clarity and reassurance for the SSCP that the risks of prisoners are appropriately considered.	National Offender Management Service	June 2017
3	That Your Housing Group reports in writing to Sefton Safer Communities Partnership what action it has taken to ensure that its tenants are protected from	SSCP to write to Your Housing Group requesting an update report	Report	Reassurance that organisational polices and procedures are appropriate and are being	Your Housing Group	June 2017

	domestic abuse, including the need to fully complete its initial assessment.			followed. That policies and procedures have been updated as required and training for staff is included in this.		
4	That Sefton Safer Communities Partnership develops, publishes and publicises advice for family and friends on what to do [or not to do] when they receive disclosures of domestic abuse.	Information for friends and family is available on Sefton Council's website at www.sefton.gov.uk/behindcloseddoors Sefton also supported the public health led 'Lover not a fighter' domestic abuse campaign. The development of further public awareness campaigns, including further information for friends and family, is being looked at as part of Sefton's Domestic Abuse Strategy .	Information on website Development of further promotional materials	Awareness of domestic abuse amongst the general public is raised. Information for friends and family is readily available	SSCP	Completed September 2017
5 (a)	That Merseyside MAPPA Strategic Management Board reports in writing to Sefton Safer Communities Partnership what action it has taken to ensure that Section 6.15 of the MAPPA Guidance 2012 [Identifying MAPPA offenders] is adhered to.	This case was formally raised at Merseyside SMB and MAPPA Chairs briefings. A report has been provided by the Merseyside MAPPA Strategic Board to update the SSCP outlining the changes in practice and processes that have taken place since this case was managed. .	Report	SSCP is reassured learning from this DHR has been taken on board and practices have already been updated to ensure MAPPA guidance is followed.	Merseyside MAPPA Strategic Management Board	Completed

5 (b)	That MAPPA-managed offenders are being managed at the appropriate level and that any substantial disagreement between agencies on which level a person should be managed at has a resolution pathway.	<p>Report provided</p> <p>Escalation process into SMB formalised and issued to all MAPPA Chairs Feb 2016. This is the formal process whereby disagreements, agency non attendance can be raised, discussed and resolved at SMB.</p> <p>MAPPA Chair continuous improvement events (2/3 times per year)</p> <p>MAPPA SMB case Audits – 2 / 3 times per year, 2016 / 17 cycle considered Adult safeguarding, mental health, risk management plans, ARMS themes. 2017/ 2018 case audits to ensure that exit strategy is one of the areas considered and addressed. Learning to be provided to Chairs.</p>	Report	<p>SSCP is reassured learning from this DHR has been taken on board and procedures updated.</p> <p>Appropriate escalation policy is in place.</p>	Merseyside MAPPA Strategic Management Board	Completed
5 (c)	That disclosure is always considered when there is a risk to others. Disclosure to a third party (Your Housing Group) was not made when Dean was assessed as presenting a risk to the public at the MAPPA meeting on 12 August 2014. It is not clear from the minutes whether or not residents at Your Housing Group were	<p>There is a National MAPPA Key Performance Indicator: Disclosure to be considered and decision recorded in minutes at 100% of Level 2 and Level 3 meetings. Disclosure consideration must be recorded in every case.</p> <p>MAPPA Administrators collate quarterly KPI information and MAPPA Co-ordinator checks for any failures and feedback provided to relevant</p>	Report	SSCP is reassured learning from this DHR has been taken on board and procedures updated.	Merseyside MAPPA Strategic Management Board	Completed

	<p>specifically considered to be at risk from Dean. The learning from this event is that disclosure should always be considered when there is a risk to others. This learning should be fed back to those who chair MAPPA meetings.</p>	<p>Chair</p> <p>MAPPA Chair training includes briefings slides in regard of 3rd party disclosure, to ensure Chairs are aware of the importance and new legislation i.e. Child Sex offender disclosure scheme, domestic violence disclosure scheme.</p> <p>National MAPPA Audit template (issued Jan 2017)</p> <p>The role out of MAPPA Core Panels across Merseyside (Sefton implementing April 2017) will ensure a Local Authority Housing representative at all Level 2 meetings who can provide support and provide advise in regards of contact with registered providers.</p>				
6	<p>That Merseyside Police reports in writing to Sefton Safer Communities Partnership what action it has taken to ensure that its policies and practices for circulating wanted people are appropriate and followed.</p>	<p>SSCP to write to Merseyside Police to request an update report</p>	Report	<p>Reassurance for partners that Police policies and procedures are appropriate and being followed.</p> <p>That risks associated with wanted people are managed</p>	Merseyside Police	<p>June 2017</p>

				appropriately.		
7	That the pan-Merseyside MARAC steering group considers the way in which the recording of MARAC meetings can be improved, how actions are recorded and allocated, and how agencies are held to account for their delivery. The steering group should consider whether meetings should be voice recorded.	Sefton MARAC Coordinator to raise this as an agenda item at the next Merseyside MARAC meeting To also be considered with the review of Sefton's MARAC currently being conducted	Minutes of meeting Sefton MARAC Review report	Improved recording of MARAC discussion, actions and outcomes. Clear evidence of how agencies are held to account for their delivery	Pan-Merseyside MARAC steering group	June 2017

Agency Recommendations: Merseyside Police						
No.	Recommendation	Key Actions	Evidence	Key Outcomes	Lead Officer	Date
1	When a crime is recorded, officers responsible for allocation should research the incident Storm log and use it to assist in determining to whom it should be allocated.	Merseyside Police is about to adopt an Investigation Allocation Model (IAM) that will require a full review of all available information before cases are allocated for investigation on the basis of seriousness, complexity and risk. Information will be more readily available to the officers applying the IAM because of an IT solution (electronic version of the VPRF) that makes researching the background of the parties involved easier.	Copy of IAM training material	Relevant information is researched and taken into account prior to allocation of a crime for investigation	DCI Rooney	01/10/16 Complete
2	When a crime is allocated to an individual, the fundamental standard of investigation should commence with research of the Storm log, and	Merseyside Police is about to adopt an Investigation Allocation Model (IAM) that will require a full review of all available information before cases are allocated for investigation on the basis of seriousness, complexity and risk.	Copy of IAM training material	Relevant information is researched and taken into account prior to allocation of a crime for investigation	DCI Rooney	01/12/16 Complete

	basic intelligence checks on the subjects and addresses.	Information will be more readily available to the officers applying the IAM because of an IT solution (electronic version of the VPRF) that makes researching the background of the parties involved easier.				
3	Any investigations involving a 'gold' victim should be dealt with by FCIU investigators. Every effort should be made to ensure that crimes against individual 'gold' victims are dealt with by the same investigator to ensure continuity, safeguarding and reassurance.	The IAM has been designed to ensure that crimes against 'gold' victims of domestic abuse are investigated by the most relevant person/department.	Copy of IAM training material	Crimes against 'gold' victims of domestic abuse are investigated by the most appropriate person/department	DCI Rooney	01/12/16 Complete
4	The force should produce a documented 'work allocation' and 'personal responsibility' procedure in relation to each role	The roles and responsibilities of every officer/member of staff dealing with domestic abuse have been documented within the force's Domestic Abuse Policy.	Merseyside Police Domestic Abuse Policy	Police officers and members of police staff are aware of their responsibilities in relation to reports of domestic abuse	DCI Middleton	01/09/16 Complete

	<p>within an FCIU. This should be published and appended to the force's Domestic Abuse Policy and Procedure as a clear reference point, to avoid ambiguity. The same procedures should apply in every FCIU within the force.</p>					
5	<p>When a victim is discussed at a MARAC meeting and the perpetrator is currently in custody, a documented safeguarding action plan must be completed to ensure the safety of the victim upon the perpetrator's release. This should include details of whom the actions are allocated to, and timescales for</p>	<p>This issue was raised at the pan-Merseyside MARAC Steering Group and leads from the five Local Authority Community Safety Partnerships agreed to implement action plans relating to perpetrators who are leaving custody.</p>	<p>MARAC minutes</p>	<p>Safeguarding action plans have been developed for victims by the time that perpetrators are released from prison</p>	<p>DCI Middleton</p>	<p>01/09/16 Complete</p>

	completion.					
6	When there is sufficient evidence to arrest a 'domestic abuse' suspect following an allegation of crime involving a victim risk-assessed as 'gold', then that individual should be circulated as wanted on the PNC at the earliest opportunity and no later than twenty-four hours after the time of the allegation.	The Assistant Chief Constable with responsibility for domestic abuse has circulated an 'In Touch' document to all officers, ordering that suspects linked to matters involving 'gold' victims of domestic abuse are circulated as wanted within twenty-four hours if they have not been arrested immediately. Compliance to this process will be tested via the monthly Senior Responsible Officer (SRO) meeting.	'In Touch' document and slides from the SRO meeting	Suspects linked to matters involving 'gold' victims of domestic abuse are circulated as wanted within twenty-four hours if not arrested immediately	DCI Middleton	01/11/16 Complete

Agency Recommendations: MerseyCare NHS Foundation Trust

No.	Recommendation	Key Actions	Evidence	Key	Lead Officer	Progress
-----	----------------	-------------	----------	-----	--------------	----------

				Outcomes/Updates		
9.7	<p>An outstanding action for Mersey Care Trust is to establish the reliability with which its' staff ensure they have read and assimilated all the information provided about a new patient at the point of referral and acceptance. This did not happen in this case. There are a number of ways the Trust could achieve this:</p> <ul style="list-style-type: none"> • Via survey method • Via simulation method, in conjunction with safety tools such as Failure Modes and Effects Analysis • Via observation and interview methods <p>The Trust is required to set out its action plan for achieving assurance and to share this with Sefton Safer Communities Partnership.</p>	<p>1. A learning event (Oxford Model Event) to be arranged to invite key people to apply the principles of the Failure Modes and Effects analysis to identify any weak points in the system that reasonably could lead to the information loss that occurred in this case.</p>	<ul style="list-style-type: none"> • Action plan from the day • Power point presentations from the day 	<p>To identify any weak points in updated system and identify any other key actions that needs to be taken to improve this.</p> <p>OME took place on 16th February 2017. This was well attended and positive feedback was received.</p>	<p>Denis Cullen</p> <p>Maria Dineen</p> <p>Suzi Lloyd-Ellington</p>	

		<p>A further OME is being arranged specifically around Risk management related to another SUI that will include reflection/discussion how we keep risk live.</p>	<ul style="list-style-type: none"> Action plan developed from the event. Power point presentations from the day Outcome to develop a Task and finish group. 	<p>Further actions and key learning was noted and will be actioned</p> <p>Oxford Model Event took place in November 2016 and task and finish group has been developed.</p>	<p>Steve Morgan</p> <p>Chris Fisher</p> <p>Richard Whitehead</p>	
9.8	<p>Mersey Care NHS Trust has revised how it assesses new referrals and a face to face meeting with its own team now occurs as normal practice. However, what happens 'as a norm' when a service user is allocated to a community mental health team needs to be established.</p> <ul style="list-style-type: none"> How do community mental health teams ensure that they are appropriately knowledgeable about a service user; To what extent is the information known about a 	<p>Development of a triage tool for assessment.</p> <p>Develop Implementation plan for the role out of triage tool</p> <p>DNA policy to be reviewed</p>	<p>Triage Tool</p> <p>Implementation plan</p> <p>Copy of updated policy</p>	<p>Completed</p> <p>Following OME further actions agreed</p> <p>Completed. There is on-going work around more robust implementation plan</p>	<p>Chris Jackson</p> <p>Alex Henderson</p> <p>Jimmy Cousineau/Kieran Daley</p>	

	service user reviewed and assimilated by a community mental health team	<p>Audit of DNAs to be completed</p> <p>Develop standards for MDT meetings</p> <p>Audit of compliance of MDT</p>	<p>Quarterly Audit results</p> <p>Audit Outcome</p> <p>Standards document</p>	<p>and further training is to be given to PAC staff. The introduction of SMS text reminder service will commence on the 1.3.17 and this will be audited quarterly to see the impact of this on DNA rates</p> <p>Audit completed in 2016/2017 audit cycle. Further audit to take place in 2017/2018</p> <p>Completed</p> <p>Audit in 2017/2018 programme</p>	<p>Jimmy Cousineau/Kieran Daly</p> <p>Alex Henderson</p> <p>Joanne Bull/Audit Lead for Local Services</p> <p>Tony Ryan</p>	
--	---	--	---	--	---	--

		standards.	Audit Outcome			
		Review of assessment/Stepped up care services	Review paper and recommendations Meeting Minutes	<ul style="list-style-type: none"> • The Draft report was presented by Tony Ryan at the Local Services Division Senior Managers on 7th March 2017. • Senior Manager comments to be forwarded to the Divisional Strategic Operations Manager by 16th March 2017. • Divisional Strategic Operations Manager to forward local division response to Tony Ryan by 20th March • Presentation to Commissioners by Tony Ryan on 8th 		

		<p>To implement transformation programme for community services</p>		<p>March.</p> <ul style="list-style-type: none"> • Commissioners comments to be sent to Tony Ryan by 29th March • Final report will be received by the end of March • Transformation plans are currently being reviewed. Over the last 12 months there has been on going caseload review for Community Mental Health Team focusing on criteria for clusters to ensure appropriate service users are being seen. 		
--	--	---	--	---	--	--

Agency Recommendations: Royal Liverpool and Broadgreen University Hospitals NHS Trust						
No.	Recommendation	Key Actions	Evidence	Key Outcomes	Lead Officer	Date
1	Illegible signatures: Documentation of ED Triage Nurse identity via a printed name accompanying a signature is not consistent. This could cause problems in identifying staff involved and hamper the investigation of any incident.	Continuing education in safeguarding training emphasising the importance of documentation including identities Documentation audits focusing on quality, including identifiable names/signatures, with results fed back to staff	Training records Documentation Audit results	ED records will clearly document staff signatures to allow for staff members involved in any investigation to be easily identified	Safeguarding Nurse for Children Practice Development Nurse	Complete Action plan will be monitored at Strategic Safeguarding Group
2	ED staff will consider and document their enquiries regarding any possible or suspected case of domestic abuse	Emphasis included in the ongoing Safeguarding training programmes for frontline staff to increase awareness that victims of domestic abuse may present in different ways or be reluctant to disclose domestic abuse	Training records	Ensure that domestic violence cases are better assessed and identified	Safeguarding Lead for Adults	Complete Action plan will be monitored at Strategic Safeguarding Group

Agency Recommendations: Aintree University Hospital Trust						
No.	Recommendation	Key Actions	Evidence	Key Outcomes	Lead Officer	Date
1	Safeguarding assessment completed on the emergency care health records	<p>Audit emergency care health records – completed July 2015</p> <p>Results of records audit presented to Safeguarding Group – August 2015</p> <p>Results of records audit escalated to senior nursing staff at Safeguarding Group – August 2015</p> <p>Results of records audit presented to senior Accident and Emergency staff – October 2015</p> <p>Staff training on</p>	<p>Audit results presentation and date delivered to senior Accident and Emergency staff</p> <p>List of staff who attend the audit results presentation</p> <p>Training material to complete the safeguarding assessment</p>	<p>Consistent safeguarding assessment on admission to Accident and Emergency</p> <p>Demonstrate improvements through audit – January 2016</p> <p>Increased multi-agency referrals for early intervention and safeguarding services</p>	Angela Derbyshire, Safeguarding Nurse	Complete

		<p>completion of the safeguarding assessment – October 2015</p> <p>Re-audit of emergency care health records – January 2016</p>				
--	--	---	--	--	--	--

Agency Recommendations: Your Housing Group						
No.	Recommendation	Key Actions	Evidence	Key Outcomes	Lead Officer	Date
1	Your Housing Group to review the YHG Domestic Abuse Policy and Safeguarding Policy and ensure that both policies adequately reflect the importance	<p>Review and update of YHG Domestic Abuse Policy</p> <p>Review and update of</p>	<p>Revised policies</p> <p>Policy audit to demonstrate implementation of risk</p>	<p>Quality of risk assessment regarding domestic abuse</p> <p>Safer assessment of</p>	Lead Director, Director of Compliance	Complete

	<p>of comprehensive and routine risk assessment of all tenants within YHG Supported Living Schemes regarding domestic abuse to include coercive control. A referral pathway for domestic abuse to be included within YHG Domestic Abuse Policy with clear links to YHG Safeguarding Policy. This recommendation to be considered as a high priority for YHG and to be completed by December 2015.</p>	<p>YHG Safeguarding Policy</p> <p>Ensure that documentation used is representative of revised policy document e.g. Older Persons Assessment Documents</p> <p>Formal launch of new policy</p> <p>Ensure that training programmes include messages from new policy</p>	<p>assessment, quality of referrals and outcome from referral</p>	<p>service users</p> <p>Improved training and awareness</p>		
2	<p>Your Housing Group to include domestic abuse training for relevant staff within their training strategy and training plan. Training must be competency based and include training in risk assessment and routine enquiry. YHG to</p>	<p>Development of competency framework for YHG staff with particular focus on routine enquiry and risk assessment</p> <p>Develop training needs analysis</p>	<p>Training strategy</p> <p>Training needs analysis</p> <p>Training plan</p> <p>Training programme</p>	<p>Quality of risk assessment regarding domestic abuse</p> <p>Safer assessment of service users and quality of referral</p>	<p>Lead Director, Director of Compliance</p> <p>YHG Training Department</p>	<p>Complete</p>

	consider this as a high priority and implement by March 2016.	<p>Develop training plan</p> <p>Develop training programme to include case examples and learning from Domestic Homicide Review</p> <p>Ensure that training programmes include messages from new policy</p> <p>Develop evaluation tool</p>	and evaluations	Improved training and awareness		
3	YHG Housing Officers and Scheme Managers to ensure that the risk assessment component of the tenancy application form for older persons is completed in full for every housing application and to ensure that each older	<p>Amend procedure documents and relevant documentation</p> <p>Hold debrief and lessons-identified events for personnel, but ensure confidentiality regarding</p>	<p>Amended procedure and relevant documentation</p> <p>Minutes of debrief sessions</p> <p>Audit tool and spot-</p>	<p>Quality of risk assessment regarding domestic abuse</p> <p>Safer assessment of service users and quality of referral</p>	YHG Director of Supported Living	Complete

	persons assessment and review includes a full risk assessment and routine enquiry regarding domestic abuse. This is to be managed as a priority and implemented with immediate effect.	the DHR is maintained Develop audit tool and 'spot check' framework	check framework	Learning from critical incident		
4	All YHG staff to be in receipt of an update regarding the importance of effective documentation to include data protection principles.	Briefing paper/team brief Check data protection policy and training Develop records audit tool to ensure effectiveness	Briefing paper/team brief Records audit tool Results of audit and audit plan	Improved documentation and record keeping Tenants' sensitive data protected	Director of Compliance Governance Team	Complete

End PF Report for QA Panel V0.14