Domestic Homicide Review C15

Arising from the death of

“Tigre” – January 2018

Safer Devon Partnership

on behalf of Exeter Community Safety Partnership

Overview Report

FINAL (following Home Office Quality Assurance).

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Introduction

Purpose

1. This report of a domestic homicide review examines agency responses prior to the murder of Tigre, a resident of Exeter, by Canada, who regarded her as his girlfriend, in January 2018. (These are pseudonyms which were chosen by their families.) As they were in an intimate relationship, this was a domestic homicide under the terms of the Domestic Violence, Crime and Victims Act (2004). By taking a holistic approach the review seeks to identify appropriate solutions to make the future safer.

2. At the time her death Tigre was aged 32 and Canada was 36. Both were of White British ethnicity, living separately in supported accommodation, and receiving community mental health treatment. Both had a long history of contact with public agencies. The Review gave attention to various time periods between 2001 and the homicide, proportionate to the scope to learn lessons for improving the response to domestic abuse today. This is explained in #10 below. The Review Panel recognises the grief and loss experienced by the families of both Tigre and Canada and offers its condolences.

3. The key purpose for undertaking domestic homicide reviews is to enable lessons to be learned from homicides where a person is killed as a result of domestic violence and abuse. In order for these lessons to be learned as widely and thoroughly as possible, professionals need to be able to understand fully what happened in each homicide, and most importantly, what needs to change in order to reduce the risk of such tragedies happening in the future.

4. This Overview Report aims to draw out key themes and lessons from a complex story. Thirteen agencies involved in supporting Tigre and / or Canada have contributed to this review. The report is structured as follows:

   a) Introduction – to the Review and its terms of reference;

   b) Approach – how the Review worked;

   c) What happened – an account of key events;

   d) Analysis – of how agencies acted;

   e) Conclusions – key learning points and recommendations.

Confidentiality

5. The findings of each review are confidential. Information is available only to participating officers/professionals and their line managers. Pseudonyms are used in this report to protect the identity of the people involved.

Timescales

6. This review began in July 2018, following the criminal trial, and was concluded in October 2019. National guidance says that the overview report should be completed, where possible, within six months of the commencement of the review. This was not possible as Devon Partnership Trust did not release to the Panel its own external reports on the death until November 2018.

Dissemination

7. As a draft, this version of the Overview Report is for distribution only as indicated on the front sheet and covering message. The final version will be disseminated to multi-agency partnerships responsible for reducing domestic abuse, individual agencies and family as described in Appendix A.

Terms of Reference

8. The agreed terms of reference reflect Home Office guidance on domestic homicide reviews and set the purposes of the review as to:

   a) establish what lessons are to be learned from the death regarding the way in which professionals and organisations in Devon work individually and together to safeguard victims;

   b) apply these lessons to service responses including changes to inform national and local policies and procedures as appropriate;

   c) identify clearly how and within what timescales any recommendations will be acted on, and what is expected to change as a result;

   d) prevent domestic violence and homicide and improve service responses for all domestic violence and abuse victims and their children by developing a co-ordinated multi-agency approach to ensure that domestic abuse is identified and responded to effectively at the earliest opportunity;

   e) contribute to a better understanding of the nature of domestic violence and abuse; and

   f) highlight good practice.

9. The Panel agreed, in the light of the initial information available, that the Review should focus on the following questions:

   a) What elements of Tigre's and Canada's situation when they met, and of their past histories, influenced the risk of domestic abuse in their relationship?

   b) What is now known about the nature and development of the relationship and any domestic abuse prior to the homicide?

c) Did agencies, singly and together, take sufficient account of the relationship and associated risks in their care planning and other interactions with each of the couple?

d) How well did agencies work with each other and with relatives, particularly over the two years before the homicide? What helped or hindered this?

10. The Panel identified relevant time periods to focus on as follows:

a) The period between the couple meeting in July 2017 and the homicide, covering what is known about the course of their relationship and how agencies interacted with each of them, including recognition of and response to the relationship.

b) For each of them, what is known about their life and their interaction with agencies over the period between the previous change of accommodation and the start of the relationship. For Tigre this was March 2015 when she started living at Address C, managed by Caraston Hall[1]. For Canada this was August 2016 when he left Langdon Hospital (Devon Partnership Trust's forensic inpatient unit) to live in a Hollywell Housing Trust property, Address A, with care provided by Home Group.

c) For Canada, all earlier interactions with the criminal justice system, including reported assaults where no further action was taken, the MAPPA (Multi Agency Public Protection Arrangements) process and any detentions under the Mental Health Act.

11. For each of them, other key life events and interactions with agencies in Devon were considered only insofar as they provide relevant context for understanding the later events or insights into the nature of domestic abuse.

Approach

Decision to undertake a review

12. In Devon an Executive Group accountable to Safer Devon Partnership oversees the response to deaths potentially requiring a domestic homicide review. Through a locally agreed protocol the Community Safety Partnerships in Devon meet the statutory requirements for such reviews through Safer Devon Partnership. Membership of the Executive Group is listed in Appendix A.

13. Devon & Cornwall Police referred the death of Tigre to Safer Devon Partnership as a potential domestic homicide in January 2018. In line with the protocol, the Domestic Homicide Review Co-ordinator for Safer Devon Partnership then asked

[1] Caraston Hall is a private provider of supported living services to people with mental health problems or learning disabilities.

agencies to check records of their contacts with Tigre and Canada. In the light of the initial information available, the Executive Group agreed at their meeting on 5th February to initiate a Domestic Homicide Review, and appointed Christine Harbottle as Independent Chair.

Evidence considered

14. The following agencies provided detailed information for the Review, such as a chronology. Eight of these agencies were also asked to prepare either an Internal Management Review, which is an internal report whose author was not involved in the events, or an equivalent by an external reviewer. Two others provided copies of internal investigations undertaken for their own Boards. Further information about these sources is given in Table 1 and Appendix B. Domestic abuse agencies in Devon confirmed that they had received no contact from or about Tigre.

Table 1: Agencies contributing evidence

Key to Info column: C – chronology or records only; E – external review; I - Internal Management Review; O – other form of internal investigation report.

Agency	Services provided	Info
Caraston Hall	Supported accommodation for Tigre	O
Devon & Cornwall Police (D&C Police)	Response to calls relating to Tigre being in vulnerable situation and to noise complaint.	I[2]
Devon County Council	Children's Services arranged safeguarding and adoption of Tigre's children. Adult Social Care received and triaged safeguarding concerns about Tigre.	I
Devon Doctors	Out of hours primary care to Tigre. (No incidents relevant to this Review.)	C
Devon Partnership Trust (DPT)	Mental health care for both, in both community settings and inpatient units.	E
Exeter City Council	Housing advice for both. Action on behalf of neighbours complaining about noise.	I
Hollywell Housing Trust	Charity providing a housing and tenancy management service for people with learning disabilities, including Canada at Address A	I

[2] The Police included within their chronology and Internal Management Review records from Multi Agency Public Protection Arrangements (MAPPA) meetings concerning Canada.

Home Group	Housing Association providing care and support to Canada at Address A	I
Rethink Mental Illness	Charity providing supported accommodation to Canada at Address B	O
Royal Devon & Exeter NHS Foundation Trust	Pregnancy care for Tigre; paediatric treatment for Canada; Emergency Department responses to both	I
South Western Ambulance Services NHS Trust	Paramedic treatment of Tigre at Caraston Hall	C
Together Devon Drug & Alcohol Services	(Previous service provider RISE) had referrals for drug treatment for both.	E

15. Additional sources of evidence were as follows.

    a) The insights of people who had known Tigre and Canada were sought as discussed below.

    b) The Independent Chair interviewed a senior staff member from each of Hollywell, Home Group and Caraston Hall.

    c) A half day shared learning meeting was held in January 2019 bringing together staff from Devon Partnership Trust, Hollywell, Home Group and Rethink. The Panel members from Splitz and the Trust helped facilitate this event.

    d) The National Probation Service panel member provided a summary of relevant policy on Multi Agency Public Protection Arrangements.

    e) Splitz Support Service briefed the Panel on how domestic abuse agencies can advise other agencies on managing vulnerable adult clients seen as at risk of domestic abuse.

    f) Regulatory reports on key agencies were reviewed.

Involvement of family, friends and wider support networks

16. Safer Devon Partnership recognises that the quality and accuracy of domestic homicide reviews can be significantly enhanced by family, friends and wider community involvement, and that victims' families should be given the opportunity to be integral to reviews. Such participation is voluntary for those involved, and Safer Devon Partnership seeks to provide appropriate support and a choice of means of contact.

17. Tigre and Canada had both left their family homes in early adulthood, and neither had subsequently married or formed a stable long-term relationship. Both remained in contact to varying degrees with their parents (divorced in each case)

and siblings (see Table 2), sometimes living with them for short periods. Some of these relationships were, at times, troubled.

Table 2: Family context during the relationship

Tigre	Canada
Father (living in Exeter)	Father (living in south east)
Mother (living in Somerset)	Mother (living in Exeter)
Full, half & step siblings (various locations)	Older sister (living in midlands)
Father's partner (living with him from 2015 on).	Paternal grandmother (living in Exeter)
2 children (adopted, no contact)	1 child (adopted, no contact)

18. The Panel made initial contact with Tigre's family through the police Family Liaison Officer during the trial to explain that the Review would follow, provide contact details and signpost an advocacy service. Initial contact with Canada's family, to let them know of the Review was made via the Devon Partnership Trust Serious Incident Review. During the Review the Independent Chair held meetings with Tigre's father, accompanied by his partner, and with Canada's mother and sister, to ask about their observations and concerns. Canada's father took up the option to contribute at the draft report stage.

19. Comments on the draft report from Tigre's father and his partner, and from Canada's sister, mother and father have been taken into account. Further details of these contacts are given in Appendix C. Information from the families, both from their contributions to this review and from their earlier contacts with agencies, is included in this report. The Panel appreciates their help.

20. Neither Tigre nor Canada was engaged in employment, education or volunteering in the three years prior to the homicide. They each had a range of friends and contacts who shared their supported accommodation or socialised in central Exeter. The Panel, taking account of the vulnerability[3] of these friends, sought direct contact with only one, a woman friend of Tigre. Information from another friend of Tigre who had given evidence during the criminal investigation was summarised in the Police Internal Management Review, as was information from two men who had shared accommodation with Canada and one with Tigre.

21. The Panel values the contribution of relatives and friends to the Review. Where references are made to the views of family and friends in this report they draw from these sources, but do not claim to be the views of all friends or family members.

[3] As reported by agencies already in contact with them

Review Panel

22. The Domestic Homicide Review Panel members were as shown in Table 2. The Panel held eight face to face meetings between 23rd July 2018 and 4th April 2019 and conferred by electronic means and sub-group meetings to clarify evidence, share family comments on the draft, and finalise details of the report.

Table 3: membership of the Review Panel

Agency	Panel member	Job title
Devon & Cornwall Police	Philip Hale	Detective Sergeant, Serious Case Review Team
Devon County Council	Geraldine Benson	Principal Social Worker – Commissioning
	Gill Unstead	Public health (substance misuse)
Devon Partnership NHS Trust	Penny Rogers	Managing Partner – Safeguarding & Public Protection
Exeter City Council	Melinda Pogue-Jackson	Policy Officer - Environmental Health and Licensing
Hollywell Housing Trust	Simon Bowkett (to April 2019)	Trustee[4]
National Probation Service	Simon Davis	Senior Probation Officer
NEW Devon Clinical Commissioning Group[5]	Derek O'Toole	Commissioning manager (mental health)
Splitz Support Services	Sara Williams	Training and Development Team Manager

23. No members of the Panel had any prior direct involvement with the events or decisions covered by the review, or management responsibility for any staff whose actions are described. The Review Panel operates collaboratively to reach agreed conclusions. This report and recommendations were agreed by the whole Panel and signed off by the Chairs of Safer Devon Partnership and Exeter Community Safety Partnership. A draft report was sent to the Home Office for Quality Assurance in February 2020 and the response received in June 2020.

[4] Voluntary role May 2017 to April 2019. When appointed to the Panel Simon Bowkett was Chief Executive of CoLab Exeter (formerly Exeter Council for Voluntary Services) and also contributed from this wider perspective.
[5] From April 2019, following reorganisation, Devon Clinical Commissioning Group.

24. The Independent Chair, who was also the author of the report, has never been employed by any of the agencies concerned with this review, and has no personal connection to any of the people involved in the case. Further details of her relevant experience are given in Appendix D. The Panel had administrative support from the Safer Devon Partnership Co-ordinator for Domestic Homicide Reviews, based at Devon County Council.

Parallel Reviews

25. The Panel has drawn on internal reviews carried out by agencies under their own processes, either directly or through their Internal Management Reviews (Appendix B). These included two complementary Serious Incident Reviews commissioned by Devon Partnership Trust from a specialist external consultancy, Enable East, which ran in parallel with the initial stages of this Review[6]. The scope of these was to review the services offered by the Trust:

    a) to Tigre from January 2017 to January 2018

    b) to Canada from his first contact with community services in October 2016 to the date of the homicide[7].

26. The Trust asked the independent investigators to consider whether there were any gaps or deficiencies in the care and treatment offered to Canada and if any failings had contributed to the death of Tigre. It also asked for identification of areas of best practice, opportunities for learning and areas where improvements to services might be required which could help prevent similar incidents from occurring.

Equality and diversity

27. The Panel has considered the relevance of the nine protected characteristics under the Equality Act 2010 in setting the terms of reference and conducting the Review. The sex of the victim was relevant given the prevalence of violence against women and girls. The only other characteristic specifically relevant to their situation was disability. Both had long term mental ill health, entitling them to disability benefits. Canada had a mild learning difficulty. The report comments on how these factors may have affected their access to or experience of services.

28. Tigre had a diagnosis of hebephrenia (disorganised schizophrenia). She was intelligent, and bilingual, but found it hard to concentrate for long. Canada had a

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[6] These reviews were not started until after the trial, at the request of police.

[7] The start point for the Serious Incident Review of Canada is his first appointment with a community mental health team psychiatrist. He started as a tenant at Address A in August, while still at Langdon Hospital, spending increasing time there during the transition period, with contact continuing with the inpatient forensic team. He first met the care coordinator from the community mental health team in September 2016.

primary diagnosis of paranoid schizophrenia and also “mild mental retardation” and dissocial personality disorder. He had difficulty reading and writing, and in listening to complex information. He was provided with a court intermediary during his trial, due to limitations in his communication skills. A Home Group support worker, writing in September 2017, commented “Most of Canada’s support needs centre around his comprehension. Unfortunately, he has learnt to cover his lack of understanding well and often appears to understand but does not.”

What happened

29. This section starts by summarising the facts of the homicide and outcome of the trial. It then traces key elements of the history of both Tigre and Canada, covering the following periods:

- Background context for each
- Agency contacts with Tigre while at Address C before meeting Canada
- Response to violence by Canada prior to his move to Address A
- Agency contacts with Canada while at Address A before meeting Tigre
- Agency contacts with both, in the following time blocks:
    - Mid July 2017 (the start of the relationship) to September 2017 - includes Home Group’s withdrawal of care from Address A
    - October - November 2017- includes Canada’s eviction from Address A
    - December 2017 until the homicide - includes Canada’s admission to Address B.

The perspectives of the families, as expressed to agencies during contact from 2016 on, and in their contributions to the Review, are then summarised.

30. These accounts combine evidence from the contributing agencies and draw on a detailed chronology held in spreadsheet form as a working document for the Panel. People and places are introduced with code names: a reference list of these is at the end of the report (before the appendices). An overview at the end of the section sums up this descriptive account and provides a timeline of key events, leading into the Analysis section which follows.

The homicide

31. The homicide took place in Tigre's room at Address C, a multi-occupancy home run by Caraston Hall in Exeter, at around 5.30am[8] on Day H[9] in January 2018. The couple had spent most of the previous afternoon and night together. This was initially in Canada's room at Address B, another multi-occupancy home in Exeter, run by Rethink Mental Illness, where both smoked cannabis, and around the city centre. Just after midnight they made the short journey to Address C on Canada's motorcycle, via a cashpoint and shop. The shop assistant recalled them arguing about what food to buy.

32. The resident at Address C in the room adjacent to Tigre's reported, after the death was discovered, that he had heard them arguing at around 5.30am. He described Tigre as really screaming "Get out of my house". She sounded angry. He then heard Canada saying "No but I love you" and heard thumps. He said Tigre sounded angry and upset and Canada sounded panicky.

33. Canada admitted killing Tigre, by holding her neck, then leaving without calling an ambulance or alerting staff. A post mortem later confirmed death by strangulation. Canada had minor injuries, consistent with Tigre attempting to fend him off.

34. Canada was charged with murder and pleaded self-defence. Some weeks after his arrest, when his mental state was assessed, it was determined that he was mentally well and should be subject to criminal proceedings. The trial at the Crown Court focused on whether he intended to kill Tigre. He was found guilty of murder and sentenced in July 2018 to life imprisonment with a minimum term of 15 years.

Background context for Tigre

35. Tigre, British through her father, was born in another part of Europe where she spent her early childhood. She first came to England with her father during a temporary separation of her parents, shortly after she started school. She was bilingual, did well at athletics and loved music. Tigre's family described her as having a "lovely, big-hearted, gentle nature", but subject to sudden mood swings. Since early childhood she had appeared restless, with a short attention span and unwilling to stick to plans. Tigre was described by a friend as having "a sense of freeness to her…. open to things". While at times she was low in mood she was "very good at talking … hours and hours of talking putting world to right". She

[8] This time, admitted by Canada, was consistent with evidence of their movements from CCTV and the testimony of the occupant of the neighbouring room,

[9] To assist anonymisation of this report, the date of the homicide is referred to as Day H, and other dates in January 2018 in terms of the number of days before or after this.

enjoyed being creative, for example cooking, dressing up and karaoke. Although she did not engage in religious practice, her friend recalled her visiting open churches to enjoy the quiet space and speaking about Jesus and God as helpers.

36. Around the time she moved to secondary school her parents' relationship ended. Tigre, with one of her brothers, moved with her father and a new stepmother, with whom she had a fraught relationship, to a remote part of her birth country. This was an emotionally difficult period for Tigre and in her early teens she started smoking cannabis. The level and strength of her cannabis use increased when the family, now including step-siblings, settled in Devon when she was in her mid-teens. On two occasions when she was 14 incidents within the family came to the attention of police or social services. Her father recalled her behaviour becoming more volatile and she started to play truant from school. With hindsight he realised that drug use among her then group of friends was more serious than he knew at the time. She did not obtain any regular employment after leaving school.

37. Tigre was first admitted as a mental health inpatient in 2005 (aged 20) and had regular contact with mental health services for the remainder of her life. Between 2006 and 2014 she had eight further inpatient admissions in Devon and one at a specialist mother and baby unit in London for the birth of her second child. Between these episodes she attended outpatient clinics and received community services. In 2013 and 2014 she was subject to Community Treatment Orders under the Mental Health Act. (See Appendix E for explanatory note.)

38. Tigre was noted by Devon Partnership Trust as having a history of poor compliance with treatment, for example times of not taking medication, or going missing from wards. At times she was low in mood. She was recognised by agencies in contact with her to be vulnerable to self-neglect and exploitation, including seeking out drugs and taking risks in her sexual contacts. A female friend described her attitude to sex as transactional, often exchanged for drugs. "It was something that happened, she was expected to do it but she wasn't that sexualised." There were occasional incidents in which Tigre was physically aggressive to family or staff, but she did not have a criminal record.

39. Tigre lived in a succession of supported housing placements, and sometimes for short periods with family members. These placements often broke down. For example, in 2009 she was evicted from a previous stay at Caraston Hall after a fire in her room caused by leaving hair straighteners on. She came to Caraston Hall in 2015 following a few months living with her father after discharge from an inpatient unit, but they agreed she needed residential support. Her father remains concerned that elements of community mental health treatment agreed as part of her discharge plan had not been not provided.

40. Tigre had some awareness of domestic abuse and potential support. In 2007 police attended a domestic abuse incident involving her ex-partner. While there

was no evidence or complaint of a crime, she was assessed as at medium risk of domestic abuse. However, she declined further contact from police or domestic abuse support services. A female friend who had experienced domestic abuse and discussed it with her (prior to meeting Canada) said she showed insight into the issue, including awareness that it could include financial exploitation as well as violence. “She could recognise safe and abusive relationships in other people but not herself.”

41. Tigre had two children, born in 2011 and 2013, with different fathers. There was multi-agency working, including police, to support her and safeguard the children on each occasion once she had disclosed pregnancy. Both children were adopted soon after birth as she was judged unable to care for them due to her mental health problems and substance misuse. Friends and family saw that the loss of the children continued to be a source of grief to her.

Background context for Canada

42. Canada’s parents separated when he was aged 5. His earlier life had involved some moving around as part of an armed services family. He then lived mainly with his mother, who herself had a difficult childhood. He grew up with a love of animals and enjoyed racing pigeons as a hobby. After leaving school he worked for a while with animals at a Devon visitor attraction. His sister observed that while he would shout and protect his space, he was easily influenced and wanted to be everyone’s friend.

43. Canada had a long history of mental health problems, drug use and violence. His condition at the time of the homicide was summarised in Devon Partnership Trust’s Serious Incident Review as “a primary diagnosis of paranoid schizophrenia and also mental health and behaviour disorder due to harmful use of cannabinoids, mild mental retardation and dissocial personality disorder.” He had his first contact with mental health services at the age of nine when he was referred to a child psychiatrist after causing a head injury to another pupil at school. His school attendance was intermittent.

44. Canada also had a number of contacts with the Royal Devon and Exeter Hospital as a child and adolescent. He was referred to the Paediatric Department by his GP in 1987, aged five, following concerns about home circumstances and behaviour at school. Between the ages of 12 and 17 he had contact about abdominal pain related to anxiety, head injuries and cannabis use. Doctors, concerned about his situation, referred him to the Child Guidance Service in 1994 (aged 12). This was the relevant service available at the time.

45. As an adult Canada had 12 attendances at the Royal Devon and Exeter Hospital between 1999 and 2017 (but none after he met Tigre). Several, as a young adult, resulted from minor injuries in fights or accidents, in which police recorded him as

a victim. Others were for physical conditions, but he had no long term physical illness. Between 2002 and 2016 he had several admissions to Devon Partnership Trust's inpatient services under sections 2 and 3 of the Mental Health Act. He had also been detained by court order under section 37 of the Act (a "hospital order"[10]). For some of the periods in which he was not in hospital he was subject to Community Treatment Orders. He lacked insight into this condition, often telling clinical staff that he did not think he had a mental illness or required medication.

Response to violence by Canada prior to 2016

46. As summarised in the Devon Partnership Trust Serious Incident Review "Between 2004 and 2016 Canada's clinical records indicate that there were numerous occasions when he threatened staff at his residential placements or community and inpatient Trust staff. There are reports that he was also violent towards his family, staff in residential accommodation and the police."

47. In 2001 Canada pushed his mother's neck, causing her minor injuries. Police recorded this assault as domestic abuse. He was charged and Exeter Magistrates Court, on the recommendation of the Crown Prosecution Service, gave a bind over. Later in the year he was fined, and given a further bind over, for breaching the first order. (Records are unclear on what led to this.)

48. In 2002 police recorded a crime of common assault when Canada visited his mother and became aggressive, grabbing her around the face. Canada was arrested for assault and for criminal damage to a door. His mother was unwilling to provide a statement or support a prosecution, as she did not believe this would help him and hoped for a mental health outcome. She said she had previously been a victim of similar behaviour but had not reported it, and her aim in reporting now was to get help for Canada. Mental health services, when contacted by police, considered that Canada did not meet the criteria for detention under the Mental Health Act. Canada was released with no further criminal justice action.

49. In March 2004 police were called by Canada's mother following an argument with Canada (who was then living with her pending alternative housing being found for him). She had left the house in fear. Police took a carpet knife from Canada and he agreed to stay away in the short term. (As he was at home, possession of the knife was not an offence.) They contacted Devon County Council's out of hours social services, who at that point held no information about Canada. Police recorded risk to his mother from Canada as an alert for future incidents in their

[10] This can be given by a court, following an offence which could lead to a prison sentence, to an offender medically certified to have a mental disorder suitable for treatment in hospital. The term "hospital order" is used in this report.

intelligence records and completed a domestic violence referral form. (Records of any subsequent contact from police domestic violence officers are no longer available.) Later in 2004 Canada was admitted to a mental health inpatient unit for a period.

50. There were further (non-crime) incidents at Canada's mother's home in November 2004. In December 2004 Canada was arrested and charged regarding threats to kill her. The charge was withdrawn at court, for reasons which are no longer on record. Contact between social services, mental health workers and police then led to Canada's case being considered, for the first time, at a MAPPA meeting on 12th January 2005. (A fuller explanation of MAPPA is given in Appendix E.)

51. Information shared at the MAPPA meeting included threats by Canada, previously unreported to police, to his estranged partner, who had given birth to his child in December 2004. The child (subsequently adopted) was under a care order and Canada was not allowed contact. Canada was assessed as MAPPA level 2 (ie requiring active multi-agency management). The assessment identified continued drug use and homelessness as elements increasing his risk. His GP was informed.

52. On 17th January 2005 Canada was arrested and charged with criminal damage after breaking into his mother's home, so a MAPPA meeting on 2nd February continued his level 2 status. This offence led to a conditional discharge, but in March 2005 he went to prison (serving 2 months) for other offences including harassment of his mother. The sentence included a protection from harassment restraining order running until March 2006. Canada breached the order by going to his mother's home in August 2005 and was returned to prison. A domestic abuse risk assessment, using the newly introduced Domestic Abuse Stalking and Harassment (DASH) form was completed for his mother and she was determined as at "very high risk".

53. A third MAPPA meeting in September 2005 considered preparation for Canada's release from prison in October. A recent psychiatric assessment in prison had reported "no mental health problems". He was considered as making himself intentionally homeless due to his own poor behaviour. Actions agreed were to discuss housing options with Canada and disclosures to family members about his release and contact if future circumstances changed. Level 2 status continued.

54. In December 2005 Canada, returning to Exeter homeless after staying with relatives outside the area, was arrested for breach of the harassment order when sitting on his mother's doorstep. (She had not been aware he was there.) This led to a 6 month prison sentence. Further MAPPA meetings in March and April 2006 recorded that Canada had coped well in the structured environment of

prison and that his aggression might be an expression of his inability to cope without support.

55. In May 2006 Canada broke into his mother's house while she was on holiday. A relative found him there and called police. He described himself as being homeless, desperate and hungry. He admitted burglary. A MAPPA meeting in July 2006, while he was on bail for this offence discussed the need for the presentence report to gain a forensic psychiatric view. In December 2006 he was sentenced to a hospital order.

56. Further MAPPA meetings in January 2007, June and September 2008 monitored Canada's progress. At the September meeting, while he was detained at Langdon Hospital, Canada was described as not posing an immediate risk of harm so it was agreed he would no longer be managed at MAPPA level 2.

57. In January 2011 Canada was re-referred into MAPPA by a forensic social worker. At that point he was still in Langdon Hospital, with options for supported living in the Exeter area being considered through Exeter City Council and Devon Partnership Trust, and a Community Treatment Order being considered by the psychiatrists treating him. The MAPPA meeting decided that the current risks were insufficient to require MAPPA management. An action was created for the forensic social worker to make a future referral if concerns are identified.

58. In December 2011 Canada was living in supported housing at Address B and was in a relationship another service user there, Resident 1. She called police to report an assault by him. A Domestic Abuse Stalking and Harassment risk assessment was completed. In this Resident 1 said that Canada strangled her often and that he was very controlling. It also identified her vulnerability due to mental health issues. She was assessed as at "standard" risk from him. The assault and a further one she reported in February 2012 were investigated by police. Resident 1, although rehoused, actively tried to continue the relationship, and was unwilling to support a prosecution. The Crown Prosecution Service judged the evidence insufficient for a prosecution without her support.

59. Resident 1 died from natural causes before the homicide. Evidence from the police investigation into the 2011/12 events was admitted at the homicide trial. Canada's family told this Review that they knew Resident 1 at the time and remained in touch during her final illness, when she told them her allegations against him had been exaggerated. They are included in this account, not to judge what actually happened then or how agencies responded to Resident 1, but because the reports and investigations which followed were on the records of agencies working with Canada during his relationship with Tigre, so relevant to their assessment of risks.

60. In addition to the police investigation a safeguarding alert was raised and there was a multi-agency strategy meeting including Devon Partnership Trust. Rethink

undertook an internal serious incident review. The following details of this episode are particularly relevant to this Domestic Homicide Review:

a) Resident 1 told police Canada had hit her and attempted to strangle her. This had been going on for 2 months when disclosed, but she had previously denied it to protect him. She was unwilling to provide a formal statement as she thought Canada needed help with mental health problems.

b) Although both used drugs and alcohol she did not think these were a trigger for the violence. Rather it was something she said about her past sexual activity which offended him. She said "since then at random times he wants to kill me". "One minute he is fine and the next minute he wants to kill me".

c) Canada told Rethink staff he "lashed out" because he did not know how to handle the disturbing thing she had said.

d) The strategy meeting described both as "predatory, but also vulnerable" and "able to exploit but also be exploited".

e) Police, Rethink and Devon Partnership Trust worked together to try to safeguard both Resident 1 and Canada but struggled to find an appropriate course of action which respected their mental capacity and tenancy rights.

61. In April 2012 Canada was reported to have assaulted a male resident of Address B, Resident 2, by grabbing him round the throat. Canada denied the offence and the police investigation was closed as "no further action" due to insufficient evidence. Canada was recalled to inpatient mental health treatment, for breach of his Community Treatment Order, in the light of this incident and other concerns including threatening behaviour towards a Devon Partnership Trust community staff member. He continued to be detained under the Mental Health Act until August 2016.

62. Resident 2, interviewed by police during the homicide investigation, stated Canada had attacked him in 2012 without provocation and for no reason, grabbing him with two hands around the neck and pushing him backwards into a wall. He recalled other incidents of bullying by Canada, using verbal aggression to control him and others eg by getting them to make him food. He had witnessed Canada kicking Resident 1 but had been too scared to report this. He said Resident 1 loved Canada and would tell staff her injuries were from falls. He described Canada as unpredictable, changeable, pacing around getting angry about nothing.

63. On two occasions in March 2013 Canada, while an inpatient at Devon Partnership Trust's inpatient service at The Cedars, assaulted male members of staff, once by punching and once by head butting. He was arrested, charged, and given an absolute discharge at the court. (This is a confirmation of guilt, but no further sentence was given as he was already detained under the Mental Health Act.) Following this incident, a safeguarding alert was made to Devon County

Council and a warning was placed on their Care First client information system for Canada. “Risk to Staff - Not to be seen alone - has mental health issues and could be a risk to others.”

64. In July 2013, when Canada was an inpatient in Langdon Hospital, police recorded an actual bodily harm assault against a female support worker. She reported that Canada had run at her, the grabbing her by the neck, picking her up and throwing her to the floor. With no witnesses there was insufficient evidence to prosecute.

65. A number of other incidents of threatening behaviour and physical violence to Devon Partnership Trust staff and to fellow patients were recorded by Devon Partnership Trust. Home Group, in internal correspondence in April 2016 when preparing to provide care for Canada, cited this comment from a consultant psychiatrist. “The nature of Canada's mental disorder is that of a chronic, difficult to treat schizophrenic illness that has led to repeated admissions to hospital under section for long periods of time. He has lacked insight and repeatedly returned to substance misuse when not in hospital care. His relationship with psychiatric services has often been acrimonious and there have been repeated episodes of poor treatment compliance, absconding from hospital and supervision failure. His mental disorder has led to significant harm to others both in the community and in hospital.”

Engagement with Tigre March 2015 to June 2017

66. During this period Tigre was resident at Address C, run by Caraston Hall, a private provider of supported living services which offers social support, care and housing to people with mental health problems or learning disabilities[11]. The individual service user agreement started at 14 hours of one to one support per week plus overnight support. In November 2016 one to one support hours were increased to 22.5 per week and continued at this level until her death.

67. Needs which Caraston Hall identified Tigre as having during her residence with them included[12]:

    - Personal care – direct support in taking medication, prompting on hygiene and taking regular meals.
    - Support managing finances – “does not budget her money and can spend her income within days of receiving it”.

[11] The landlord and support services are separate in the company structure, but for simplicity this distinction is not made in this report.
[12] Parts of this section are taken from the Caraston Hall documents dated October 2017, discussed further below, but probably apply across her residence there.

- Help finding opportunities for meaningful activity such as volunteering, training or exercise.
- Prompting to remember appointments and to have physical health checks, including dental care.
- Ongoing emotional support. “She needs to feel understood and needs in-depth conversation to find meaning in emotion.”

68. Tigre had no issues with mobility, being “very active and walks everywhere” although reluctant to use public transport. She went out daily from Caraston Hall. “Tigre is very social and often goes out in the community to meet friends unsupported and would like to continue to do this independently.” “Tigre builds strong relationships with others and is well liked. She has strong bonds with her family and regularly speaks to and meets with her father”.

69. The Caraston Hall assessment also warned that Tigre might try to find her two adopted children. In January 2016 a police community support officer who engaged Tigre in conversation on the street identified her as vulnerable and noted that she was having problems coming to terms with having her children removed from her care. Tigre disclosed that she self-medicated with “a little bit of cannabis”.

70. In March 2016 Tigre attended the Royal Devon and Exeter Emergency Department with neck pain following an alleged attack in her room at Address C. No physical cause or evidence of an attack was found. Tigre felt paranoid and said she had been raped in her sleep and was frightened of a male resident. Medical staff found a lack of physical evidence to support her claim of an attack and referred her to Devon Partnership Trust Psychiatric Liaison Team, who considered it due to paranoia. The allegation was not reported to police but the rationale for this is not clearly recorded in the hospital notes.

71. Caraston Hall raised safeguarding alerts with Devon County Council in October and November 2016, with concerns about Tigre’s vulnerability, risk associated with her relationships with men and the effect of the use of illicit substances on her mood. Consent for the referrals had not been obtained from Tigre and she was unaware of them. The first referral cited repeated contact with unknown men arriving at Address C looking for her. Staff had frequently asked them to leave, as they were under the influence of drugs and alcohol. A male resident of a nearby Caraston Hall property, with whom Tigre was thought to be in relationship, was also cited as having shouted angrily at her. The second referral reported that Tigre had been coercing two other tenants at Caraston Hall into giving her money and purchasing alcohol for her.

72. Both referrals were triaged by Devon County Council’s Safeguarding Team, who obtained additional information from Caraston Hall staff. Neither progressed to a Safeguarding Adult Enquiry. The manager reviewing the October 2016 referral

summarised the Safeguarding Concern form as follows. "In summary this client has a range of complex needs and is seemingly not engaging fully in the support that is on offer to her. No evidence of actual abuse although professional concerns remain regarding the males that the client is associating with. Client is not aware of any safeguarding concern being raised and no outcomes in relation to safeguarding have been discussed with her. Agree with recommendation that the concern is closed to safeguarding with no further action."

73. The summary continued: "Recommend that a risk enablement meeting may be a more useful way forward in considering the risks presented to this client, ascertaining her views of the risk and what support she might like or engage with. Ensure the meeting is attended by multi-agency including representatives from the Police, G.P, housing etc. To identify the risks, rag rate the risks and determine what action each agency could undertake to reduce risk. If a further safeguarding concern is identified it is imperative (unless there is a question over capacity) that such concerns are discussed with the client, to ascertain whether they wish to pursue the issue through a safeguarding framework and what outcomes they would like from a safeguarding enquiry." However there is no record that this recommendation was shared with Devon Partnership Trust, and no such meeting was called.

74. On 1st December 2016 Tigre was referred to RISE, which at that time provided drug and alcohol support services in Exeter, by a support worker from Caraston Hall[13]. Her presenting substance misuse issue was reported as cannabis and alcohol, but the volumes were not provided by the referrer. Tigre's motivation for using cannabis was said to be to mitigate side effects of her medication, and her motivation for contact with RISE "to get clean and get off substance abuse". There is no mention of her children in the referral.

75. A RISE Team Leader reviewed the referral document on 14th December 2016 and assessed Tigre as having "moderate" substance misuse needs. She was allocated to a RISE triage worker for telephone interventions and signposting until an ongoing one-to-one worker became available. The record states: "Triage = Amber. Smoking cannabis most days and living in mental health supported accommodation. Need more information regarding alcohol use. RR1 (a RISE Recovery Worker) to ring to give advice and gather further information."

76. For most of 2017 the community support from Devon Partnership Trust to Tigre was provided by the Trust's Active Review Team. This team provides regular but less frequent contact with clients who have long standing mental health problems and are currently stable. Tigre was on the caseload of VCC1, a full-time nurse. On 16th January 2017 VCC1 noted "Tigre requested a medical review. Has been

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[13] The RISE record implies the referrer was from Devon Partnership Trust, but this was not the case.

served notice on her accommodation at Caraston Hall. Evidence of substance misuse but denied by Tigre. Support workers identify compliance with medication 'hit and miss'."

77. On 17th January 2017 RR1 from RISE tried to contact Tigre, but as she was not available, spoke instead to the support worker who had made the referral. He provided information about the volume and frequency of Tigre's use: she smoked cannabis heavily for four days every two weeks. RR1 asked him to support Tigre to attend substance misuse mutual aid meetings. Tigre's motivation to change was identified as fluctuating but overall her substance misuse needs appeared lower than indicated by the initial referral. When RR1 reported this conversation to her line manager RISE reclassified Tigre as having low rather than moderate needs. This meant that brief intervention and signposting would be sufficient, without being on a waiting list for a one-to-one worker.

78. On 24th January 2017 RR1 spoke by phone with Tigre, who said she was happy with her progress in reducing her cannabis and alcohol use and that she no longer required support from RISE. On 30th January 2017 RISE closed the case, recording the outcome as "Incomplete – treatment declined by client". Tigre was told she could re-refer into RISE as needed. No further action was planned, and it is not clear whether the Caraston Hall support worker was informed. There is no indication that RISE had direct contact with Devon Partnership Trust during this process.

79. Caraston Hall gave Tigre formal notice of eviction on 27th January 2017, telling Devon Partnership Trust's housing officer, at a meeting on 2nd February, that to stay she needed to engage and comply with medication. VCC1 arranged for Tigre to be assessed by a Senior Mental Health Practitioner, SMHP1, from Devon Partnership Trust's Crisis Team, on 2nd February, and for an outpatient appointment with her consultant psychiatrist, CP1, on 8th February. After CP1 adjusted Tigre's medication, her mood and behaviour improved and Caraston Hall withdrew the eviction notice.

80. By July 2017 a move to a supported placement in a flat in Torbay was being considered, with the aim of a fresh start away from her drug-using associates. A visit to this had been arranged, but Tigre lost interest in this as soon as she met Canada.

Engagement with Canada August 2016 to mid-July 2017

Transition from hospital to community

81. Over the period August to October 2016 Canada moved from Langdon Hospital to accommodation provided by Hollywell Housing Trust, with enabling support from Home Group. This was commissioned by Devon Partnership Trust's Individual Patient Placement service under the umbrella of the Enhanced

Community Recovery Service. (See Appendix E.) There was a 10 week transition plan, gradually building up the time spent in the community.

82. Contact with Home Group to arrange support for Canada in Hollywell accommodation had started in January 2016, but it took until August to agree the package. Correspondence from this period reveals concerns among Home Group managers about delays and lack of information provided by Devon Partnership Trust, and about Canada's history of violence and the degree of help they could expect from statutory services in managing him. During this period letters to Canada's father, entitled to information as the Nearest Relative under Mental Health Act, were wrongly sent to his ex-wife's address, which he had never shared.

83. The final referral for Canada to Hollywell was sent by Devon Partnership Trust on 8th August 2016. The form said Canada needed a "structured and supportive placement" and that, "…he can live with other people and does interact well on a social level. There have been concerns in the past around developing relationships with other patients and using them to his advantage, but it is still believed he could live in a shared accommodation."

84. The referral explained that Canada had a diagnosis of paranoid schizophrenia; was to be released from Langdon Hospital on a Community Treatment Order; and would be under the supervision and care of the Devon Partnership Trust's Community Mental Health Team (Exeter Psychosis and Recovery Team) and subject to MAPPA (multi agency public protection arrangements). The risk assessment accompanying the referral disclosed that Canada had a "history of assaultative behaviour" towards police, family members, and care professionals; and that this risk was best managed through ensuring that his mental health and substance misuse are monitored and managed.

85. On 11 August 2016 Canada's tenancy with Hollywell Housing began. This was at Address A, a 4 bedroom semi-detached house in Exeter shared with another tenant, Resident 3. Both had enabling support provided by Home Group, including a sleep-in worker overnight. Over the next two months Canada completed the transition from living at Langdon Hospital to supported living at Address A. The support package was initially for 6 hours per day one to one support, in addition to the sleep-in worker.

86. On 20th September 2016 Canada was discussed at a MAPPA meeting for the last time. This identified that he had successfully completed stays in the community including overnight stays with his mother. There was acknowledgement that strained relationships with friends, family or partners could increase risk. It was recorded that he was willing to have drug tests as part of his Community Treatment Order as use of drugs, alcohol and caffeine could trigger poor mental health. Devon Partnership Trust (Langdon Hospital) was identified as the lead

agency for responsibility for Canada. An assurance was given that should any issues come up Canada would be reviewed by a consultant psychiatrist and could be returned to Langdon Hospital. It was noted that his care coordinator could refer incidents to police and make referral to MAPPA if required. There is no evidence in his clinical record that Canada understood the MAPPA arrangements.

87. The minutes of this meeting highlight that Canada had not been violent since July 2014 when he started receiving his medication through a fortnightly depot[14] injection. Elements to reduce risk were listed as support from mental health services; prescribed medication; choosing not to use drugs, alcohol and caffeine and participating in any treatment or support required for this; engaging in positive daily activities (eg his interests in pigeons and motorbikes) and finally being offered space to talk one to one at times of stress.

88. The MAPPA panel agreed that Canada was compliant and that his Community Treatment Order, care coordinator input and response to poor behaviour would enable either psychiatric assessment, police intervention or referral to MAPPA. A police intelligence entry was made to highlight potential risks that Canada might pose. This describes the likely behaviours he would display if mentally unwell. His future MAPPA status was noted as level 1 managed by Devon Partnership Trust.

89. Devon Partnership Trust involved Canada's mother in plans for his transition to the community, with the forensic social worker, FSW1, and assigned Care Co-ordinator, PCC1, making several contacts with her between 29th September and 14th October 2016. This included discussion of risks to her and how she could raise concerns. At that point she felt he was managing well and had appropriate support in place.

90. On 11th October 2016 a multi-disciplinary Care Review meeting was arranged by Devon Partnership Trust's forensic service to hand over the clinical care of Canada to community services and agree recommendations. This included health and social care representation from within the Trust, but no Home Group or Hollywell staff were included. Canada did not attend as he was on leave at his placement at Address A.

91. The Community Treatment Order for Canada started on 20th October 2016, following a formal assessment by two doctors on 19th October. Justification for the order included that he "suffers from paranoid schizophrenia which has been characterised by delusional beliefs, passivity phenomenon, auditory hallucinations, and thought disorder. It has been associated with serious violence. Since starting depot medication his mental state has remained stable

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[14] This delivers a slow-release, slow-acting form of medication by injection into a large muscle, and must be done by a health professional.

and there have been no violent episodes. However, [he] does not believe he is mentally ill and will not comply with treatment unless compelled to. A CTO is necessary to ensure compliance with medication in the interests of his health and for the protection of other persons."

92. Notification of the Community Treatment Order was sent to Canada's Care Co-ordinator, PCC1. The conditions of the Community Treatment Order were:

    - (Discretionary) to reside at Address A.
    - To comply with medication.
    - To attend appointments with mental health professionals.
    - Not to consume drugs and comply with urine drug screening.
    - Only to consume alcohol in agreed quantities.

93. At this point, as an action arising from the MAPPA meeting, FSW1 met with the secretary of the pigeon club that Canada attended, to ensure that he was aware how to contact services and raise an alert if he notes any deterioration in Canada's mental health.

Initial months at Address A

94. Ensuring that Canada complied with the conditions of his Community Treatment Order proved problematic. In December 2016 there were suspicions that he had used amphetamines and he often expressed the view that he did not require his anti-psychotic medication. From as early as December 2016 he demonstrated a pattern of failing to attend planned appointments for depot injections and for out-patient review appointments. Devon Partnership Trust community staff, and Home Group staff worked tenaciously to maintain his community placement by re-arranging appointments and reminding him to attend, and for the most part he did attend re-arranged appointments when reminded to do so. Although he did break the terms of the order he would re-engage as required and stayed very close to what was required.

95. The role of Hollywell Trust staff was to oversee Canada and Resident 3 on tenancy matters. Over the initial months of the tenancy, housing workers checked-in regularly with both tenants, and the only issues were very minor. Home Group records show Canada engaging in purposeful activities such as pigeon racing and riding a BMX bike, cooking meals and visiting his mother, but also regular pushing at boundaries eg returning from evenings in bars beyond the agreed curfew.

96. By January 2017 there were signs that Canada was beginning to disengage with support and was regularly asleep and unprepared for housing support visits. The

Chief Executive of Hollywell wrote to him to remind him of his obligations. Hollywell's concerns about both tenants' behaviour continued to grow in the first half of 2017. These included smoking in the house (which was against the rules of the tenancy), levels of drinking, noise, and suggestions of drug use.

97. From January 2017 on Home Group got agreement from the Individual Patient Placement Directorate for increased funding to cover a waking rather than sleep-in member of staff at night. This was due to noise at night regularly disturbing sleep, and to increase their ability to check for drug use. In February a Home Group worker offered to refer Canada to RISE, during a conversation about his drug use and its impact on his mental wellbeing, but he did not agree to this.

98. Resident 3, in his statement to police after the homicide, described living with Canada and doing "things that people their age would do like taking drugs, drinking alcohol, watching movies and listening to music". He described Canada as a common, simple bloke with a fight or flight attitude. Although Resident 3 was larger than Canada he would not have wanted confrontation with Canada as he was "a hard man who could fight".

99. Changes in Devon Partnership Trust's community service staffing during 2017 affected the continuity of care for Canada. His first community consultant psychiatrist moved to another post within the Trust and the post was covered by locum consultant psychiatrists. A Community Treatment Order review in April 2017 was undertaken by second psychiatrist. In addition to changes in consultant psychiatrists his first care coordinator, PCC1, was replaced by PCC2 in May 2017.

100. Early in June 2017 Canada travelled with his mother to stay with his sister for a few days. His sister, looking back, said he appeared well at this point. However, on 27th June 2017 Canada attended the Emergency Department at the Royal Devon and Exeter Hospital with a swollen right hand, weak arm and poor appetite. This turned out to be his last attendance at the hospital.

Developments in early July 2017

101. By this point Canada's behaviour had deteriorated further. Home Group expressed serious concerns to Devon Partnership Trust about both tenants' mental health, alcohol and drug use. In an email to PCC2 on 29th June 2017 a Home Group support co-ordinator summed up their increasing concerns as follows: "We are becoming increasingly concerned about Canada's mental health. As you are aware he has been frequently using illegal substances (amphetamines and cannabis) and we believe that this is contributing factor in his decline of his mental wellbeing. From Canada's history he has a number of trigger points that indicate this decline.

- He is frequently complaining of physical ailments and is even going to the hospital to get these looked at.
- He is sleeping for most of the day and being awake at night.
- He is stating that it's his medication that is making him ill.
- He is not engaging well with staff and can become confrontational or just walks off.
- He has not been to see his pigeons in nearly 2 weeks.

We have received a phone call from his mother who is also concerned as she states that he has lost a lot of weight and this can also be a trigger for his mental decline. We would appreciate your input on how to manage this decline and the best way to move forward."

102. On 7th July Home Group called police to Address A after seeing a gun in his room. This turned out to be an air weapon (so not illegal) but officers removed it as a precaution. Canada accepted this, though reluctantly. Home Group staff became increasingly concerned for their safety and the safety of others. An email from Home Group's Clinical Lead (HGCL) to PCC2, on 11th July said "Moving forward there is now a very real concern from all involved in providing/paying for this placement that it is now at a point of total breakdown and there is clear risk at this time." The Individual Patient Placement Directorate agreed a temporary increase in funding so that Home Group could have two staff present at Address A.

103. On 12th July 2017 a risk meeting was held with Devon Partnership Trust and Home Group staff present. This included PCC1, PCC2, HGCL and a Home Group support worker, but no psychiatrist. HGCL's update to Home Group staff following this noted that the discussion included

a) "concerns around the current placement, current mental health presentation, risk around this and potential increase in risk within the context of previous incidents of physical violence;

- current on-going use of drugs and the potential negative impact this is having on current mental health/risk;
- Canada driving his motorcycle potentially under the influence of drugs/alcohol;
- the Community Treatment Order in broad terms and the fact that there is no current psychiatrist with the team although there is a locum starting next week."

104. The plan from the meeting included getting the locum psychiatrist to see Canada as soon as possible and consideration within Devon Partnership Trust of whether he could be recalled to hospital under the Community Treatment Order.

Meanwhile Home Group staff at Address A would continue to work in pairs. PCC2 was to contact the Driver and Vehicle Licensing Authority for advice, though it was noted that the risk of Canada being violent to staff would increase if their action led to withdrawal of his licence.

105. Concluding his message to staff, HCCL wrote "I think it is fair to say that we feel that Canada would currently benefit from a recall and this will also allow time for all concerned including IPP/medication staff and ourselves to all meet up and look to support Canada in moving forward. His placement at this time is clearly on the very edge of collapse and there is a clear need for further joint risk/strategy meetings as we move forward." On 14th July Home Group notified Hollywell Housing that they had increased staffing at Address A due to the risk.

106. Devon Partnership Trust arranged for Canada to see a new locum consultant psychiatrist, CP2, at an outpatient clinic on 13th July. Additional medication which Canada could take orally to calm his mood was prescribed at that appointment. Home Group remained concerned. One of their support co-ordinators emailed PCC2 on 16th July giving details of Canada's behaviour, and summarising "I have concerns about his mental health presentation and that it keeps changing even throughout one conversation. I feel that even with having his depot this week it hasn't improved his mental wellbeing and Canada's mental health is still declining. (Home Group) Plan: Staff to continue to monitor Canada's mental wellbeing and record and report as necessary. Staff to continue to monitor the level of risk Canada may present to staff, himself and the public and record and report as necessary." PCC2 responded promptly that he would discuss this with the Community Mental Health Team on 17th July.

107. Following the Community Mental Health Team meeting the community consultant psychiatrist, CP2, summarised advice for the "housing team[15]" as to be aware of risks; community mental health team and crisis team available for any discussion support; any emergencies - call police. A detailed note from CP2 to PCC2, also dated 17th July, includes "On paper, this chap is VERY risky when unwell. I think the recent upheavals are secondary to illicit drugs, which he has been open about. My understanding is that he remains compliant with CTO conditions (are there any other stipulations other than meds and engagement?). ... Though there was some evidence of ongoing symptoms …. on the whole he kept it together. … I would say he is also quite risky even when well (anger issues) … We need to separate the housing team's concerns about his tenancy … that's their decision to make?"

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[15] This does not distinguish the roles of Home Group and Hollywell Housing Trust.

108. The Hollywell housing support officer challenged both tenants of Address A about drinking and drug use at a routine meeting on 17th July, noting that Canada became annoyed.

109. CP2 had, in his note of 17th July, raised the possibility of a multi-disciplinary team meeting to discuss Canada, and on 20th July he saw Canada again at an outpatient clinic. PCC2 then wrote to colleagues and to Home Group "We need an urgent mdt[16] to discuss the housing issues for Address A and the risk and contingency for Canada." PCC2 explained that he would be on leave until 14th August but thought the matter could not wait and his manager should attend. Home Group briefed Hollywell on this on 21st July, also telling them that they were considering withdrawing their support and advising that Canada be given notice to end the tenancy.

110. PCC2 explained the concerns as that Canada "is not presenting as mentally unwell in the two outpatients to the extent to need hospital admission, but is angry and struggling to control himself around the house. He is sticking with the main CTO requirements … However there is a risk his placement will be withdrawn because of his drug use and lack of engagement with staff … possible aggression… need to staff this 24hr supported house with 2 staff present. Home Group are aware he has capacity and is responsible for his actions. CMHT[17] will continue to monitor. There is no contingency in terms of alternative housing if he is served notice. And there is a real risk of violence in response if he is given notice. … Questions are around is there an alternative placement? Can the current placement be adjusted to manage the risk?"

111. In a response to this, dated 21st July, a colleague from the Trust's Individual Patient Placement team, along with giving diary availability, commented. "With regards to other placements being suitable and available. The main issue with Enhanced Community Recovery Service will be that as he has been using illicit substances for some time now and with his presentation within [Address A] being problematic and risk to others has increased, no other Enhanced Community Recovery Service provider will consider him. The reality is, that if his placement has failed with Home Group, it is highly unlikely that it will succeed with any other provider."

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[16] Shorthand for multi-disciplinary team (meeting). The note anticipated Home Group being invited to this.
[17] Shorthand for community mental health team

Engagement with both – mid July to September 2017

Start of the relationship and initial agency responses

112. It was at this point of instability, somewhere around **20th July** 2017, that Canada and Tigre met, probably through Resident 3. They soon began a sexual relationship. The agencies caring for them quickly became aware of this. Home Group noted on **21st July** "Canada has appeared in a very good mood this evening. He appears to be texting a lady. He has been polite & humorous with staff." His behaviour for the following week improved, and he spent time with his mother and other relatives and talked to support workers about future plans.

113. Home Group staff first met Tigre on **27th July** when she spent most of the day at Address A visiting both tenants. She stayed in Canada's room overnight and Home Group staff noted that "There was a strong smell emanating from his bedroom, which staff believed to be cannabis." On **28th July** Tigre had a scheduled meeting with VCC1 but did not attend the appointment. Later that day Tigre was reported to police as missing by Caraston Hall staff. Home Group staff had contacted Caraston Hall on learning from Resident 3 that Tigre was resident there. At Caraston Hall's request police went to Address A and spoke to Tigre, who stated she had lost track of time. She was not intoxicated and said she had not come to harm nor been involved in crime as either a victim or offender. Police recorded Canada as an associate of hers, not boyfriend or partner, and did not identify any risk. Caraston staff were informed and content for her to stay out. She returned to Address C late on **29th July**.

114. On **28th July** HGCL phoned the Community Mental Health Team concerned that no date had been set for a risk meeting about Canada, which he thought urgent as "we are as close as we can be from feeling that we need to pull the support out of the house ASAP". He spoke to a colleague covering for PCC2, reporting that after a few calm and stable days drug misuse had resumed, and there had been several visitors to Address A, including Tigre staying overnight. He pointed out that risk to staff would increase when Canada given notice that they were leaving and "potential risk to Resident 3 should we pull staff out. We have also talked about us contacting the police should we have concerns about people in the house using drugs etc. I have advised that if we feel the need to do this then I would immediately instruct our staff to leave the house and not return as the risk would be too great should Canada then return to the house after being involved with the police."

115. Although PCC2's colleague undertook to pass these concerns on to the Community Mental Health Team Manager and ask her to respond urgently to HGCL, there was no response that day. On **29th July 2017** Home Group made the decision to withdraw support from Address A immediately. A staff meeting on the evening of **28th July** had identified increased risk due to the expectation that

police would call there that evening. (Resident 3 was visiting relatives for the weekend.)

116. On **28th July** Canada's mother phoned the Home Group support co-ordinator. She voiced her concern after speaking to Canada on the phone, learning that Tigre had stayed overnight and "is now his girlfriend and will be staying at Address A now". She was concerned about him "spending time with Tigre who is a mental health patient" and worried that Canada would start taking drugs again. She made a point of asking for this phone call to be kept private from Canada because she was scared of his reaction.

117. Home Group notified Devon Partnership Trust of their withdrawal from Address A on **31st July**. They also informed Caraston Hall of the lack of cover and encouraged them to make a safeguarding referral for Tigre. A Home Group support co-ordinator noted "Phoned Devon Safeguarding to inform them of the potential risk to Tigre due to Canada's history of violence. They informed me that as no incident has occurred there is nothing they can do and they cannot raise a safeguarding concern at present." The call was not noted in Council records.

118. On **31st July** various email exchanges and phone calls took place between Home Group, Hollywell and Devon Partnership Trust staff (including CP2 and the Trust's accommodation and support services team - PCC2 was still on holiday). The Chief Executive of Hollywell wrote "It is now untenable for Canada to remain at Address A. I have heard nothing back about a risk meeting that was being proposed … and as such feel that given Canada's violent and unpredictable history the risk to the property … staff and the surrounding neighbours is unacceptable. I understand that Canada is now in the property without any support or supervision at all and this is incredibly worrying." She explained that Hollywell had taken legal advice on a way of giving Canada just 10 days' notice to leave. "We will not be providing alternative accommodation for obvious reasons … the mental health team will then need to source him alternative accommodation. It's a shame that we have not been able to have a stakeholder meeting about this and I'm confused as to why this doesn't appear to be getting more urgent attention given Canada's background?"

119. In reply the Trust's accommodation office noted that "If Individual Patient Placement are unable to source an alternative placement by the time the client is evicted he will need to be advised to present as homeless to the local council. Our Mental Health Accommodation Officer can offer support by contacting the council to give them notice that he will be presenting and if the client wants it, give him phone advice re his rights/options. As he is presenting as volatile I would not think it is safe for her to advise him face to face at this time." CP2 regretted the delay in setting up a meeting, and offered to see Canada again, but pointed out that "these behaviours are not in our opinion cued by a relapse in his mental illness. He remains compliant with the terms of his community treatment

order as regards his engagement and cooperation with us. You are however very right to be concerned about risks…… We had asked that you let us know when you were serving notice before you serve it – as indeed risks will escalate. These escalated risks could take the form of violence or deterioration in mental health. We had also understood that Canada would have 2 months' notice to give us all time to explore alternatives." (This email referred to HGCL "of your team", conflating the roles of Home Group and Hollywell.)

120. An entry in Canada's records for **31st July** shows that CP2 intended to record the current risk through Devon Partnership Trust's Risk Management System. However this system, which would have alerted the Trust's Safeguarding Team, was not used then or for any subsequent developments in this case. The summary care note from CP2 was "Seen twice in last few weeks - has decision making capacity - mentally stable - compliant with CTO conditions (meds and opas[18]) - not recallable at that time being served notice identified as potential trigger to future risk (violence) - though could also impact mental health (+/- via illicit drug use)."

121. From then on, Tigre frequently stayed with Canada at Address A and he on some occasions stayed at Caraston Hall with her. In this they both breached the rules of their accommodation. Resident 3 recalled that Canada and Tigre spent most days together at Address A as Canada was not allowed at Address C. He never saw any violence between them, and only one example of verbal aggression from Canada to Tigre.

122. Canada's mother recalled first meeting Tigre when Canada brought her to visit on his motorbike. This shocked her as he only had a provisional licence and knew he should not take passengers. He told her that Tigre had insisted. Canada had seen his mother most days until meeting Tigre, but this became less frequent and she found it harder to get hold of him by phone. Canada's family observed that he and Tigre were having a bad effect on each other. He started to neglect personal care, although previously he had been very clean. He lost interest in visiting his pigeons (which were kept at a friend's house).

123. Home Group continued to offer daily telephone support to Canada throughout August, for example to remind him of appointments and help him apply for alternative housing. They also received and responded to calls from his mother, who remained concerned about him, but were not able to pass on information without his consent. On **3rd August** Canada had a further outpatient appointment with CP2, and he continued to have contact with the Community Mental Health Team and attend Trust wellbeing clinics for injections.

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[18] Abbreviation for medication and outpatient appointments

124. On **2nd August 2017** VCC1 recorded (probably on notification by Caraston Hall) that Tigre was in a relationship with Canada, who was known to Devon Partnership Trust and considered to be of significant risk of violence. She arranged to see Tigre on **4th August** with SM1, the service manager at Caraston Hall, and a support worker at Caraston Hall. They explained to Tigre that she may be at risk of violence and harm from Canada. This was in general terms, without citing his past assaults.

125. VCC1 recorded that they had discussed the risks posed by Canada and that these risks had also been previously discussed with Tigre by SM1. Tigre acknowledged their concern that "we are not safe". The discussion included the risk of harm from Canada as he had been violent in the past, the risk of self-neglect and poor diet and the risk of exposure to illicit substances. Tigre was advised to contact staff if she felt threatened in any way. During this meeting Tigre reported that she had not been in contact with her father since an altercation with his partner. (This had happened a few weeks earlier.) VCC1 recorded that no thought disorder was identified, that Tigre's speech was normal, and that she "currently has capacity and acknowledged the risk". Canada's mother recalled that Tigre later mentioned the warning to her, appearing to have understood it but decided to take no notice.

126. The Serious Incident Review commented that from this point on clinical notes show that Tigre became more difficult to engage. This was confirmed through the external reviewer's interviews with Devon Partnership Trust staff.

127. On **7th August** 2017 SM1 contacted Devon County Council's Safeguarding Team to raise a safeguarding concern about the relationship between Tigre and Canada. The Care First note is that "Tigre has not resided at her own address for approaching two weeks. She is residing with Canada who has a history of abuse. Tigre is assessed as having capacity and can make value based decisions. It is felt by SM1 Tigre is making a series of poor choices. SM1 says she visited Canada's address this morning in attempt to see Tigre. The pair were spotted outside of the address. SM1 confirmed Tigre appeared well. She asked her to come to her own address to discuss and take medications however Tigre and her friend were off for a breakfast. SM1 will be discussing how the mental health team can best proceed with their concerns. SM1 agreed that at this time there is no evidence of abuse and or neglect, Tigre makes choices of her own free will and appeared well. I advised I would not be raising a Safeguarding Concern based on the information provided or without consent and agreement from Tigre."

Responses to the changed situation

128. The legal process of Hollywell seeking to evict Canada started with a notice delivered by hand on **31st July** with an initial leaving date of **14th August**. Proceedings continued through August and September, as he was advised by

Devon Partnership Trust and Exeter City Council not to leave without a court order. Hollywell reported that these agencies did not engage directly with them to discuss alternative options. An amended notice delivered to Canada on **9th August** set an initial date for eviction of **10th October**.

129. On **10th August** a professionals' meeting involving Devon Partnership Trust staff, including the care co-ordinator responsible for Canada during PCC2's holiday, Home Group and Hollywell staff, considered his housing situation. No medical staff or Trust managers were present, and Home Group expressed concern about this at the meeting. CP2 was no longer in post. Despite requests, the Trust did not produce minutes of the meeting. Key points noted by Home Group at the time were that:

- At this point Canada had been encouraged to bid for social housing through the Home Choice scheme, with phone support from Home Group, but appeared to be having trouble understanding how to do this. Enhanced Community Recovery Service placements were not being considered, due to Canada's lack of willingness to engage and refusal to live outside Exeter.

- There are risk concerns about neighbours, who did not know about the supported accommodation having people with violence risk and might go round to complain about noise. Neighbours were families, elderly people and young female students.

- Police had been informed about Canada but were not willing to get involved due to it being a mental health issue.[19]

- The meeting noted that "Canada has a girlfriend who is a vulnerable female who is staying in other supported accommodation. She is at risk of losing her accommodation, by staying and also at risk from Canada due to his history of violence towards girlfriends."

- When HGCL expressed concern that the Community Treatment Order had not been used to recall Canada to hospital, the manager of the Trust's Approved Mental Health Practitioner team joined part of the meeting to discuss this. Key points were that only the Responsible Clinician (a consultant psychiatrist) can recall; there was currently no Responsible Clinician; there must be a bed available before the order is enforced; some terms such as substance misuse are not enforceable,

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[19] Police were not present, so this is an indirect reflection of their view of their role in this case. Overall, police are involved in many mental health related incidents.

and that a Community Treatment Order cannot be used to minimise risk, it must be due to mental health.

130. On **14th August** 2017 Canada's mother contacted Exeter City Council to say that her son was being evicted from Address A the following day and could not stay with her due to risk issues. A Council Housing Options Officer contacted PCC2, who visited the Council with Canada the following day (**15th August**), bringing Hollywell's notices to quit.[20] Canada was advised about the length of time before he could legally be removed. It was hoped that this extra time would enable the PCC2 to find him somewhere suitable and avoid the need to place him into temporary accommodation. At this point the Housing Options Team were made aware that Canada was a risk to others but this information was given in general terms and based on historic behaviour. The Housing Options Officer was not made aware that Canada was a specific and current risk to women.

131. On **17th August** 2017 Devon Partnership Trust convened a Risk Strategy meeting to discuss how to monitor and maintain contact with Tigre and Canada and concerns about their relationship. Their increasing reluctance to engage with health services was a concern as was the fact that that Tigre was spending more time at the house of Canada. The meeting was chaired by Devon Partnership Trust's Community Service Manager and included PCC2, VCC1, Home Group and Caraston Hall. A request for police presence was sent through the central 101 system, which would have been passed to a neighbourhood team, but no officer was available. Police domestic abuse officers would only have attended if the meeting had been identified as concerning domestic abuse.

132. The meeting identified the risks inherent in the situation and these were recorded in a detailed note in the Devon Partnership Trust clinical records. However, no written record was sent to any other agency. The summary note in Tigre's records following this meeting included:

a) Background "History of using substances – Canada is a drug user. Concerns around unplanned pregnancy. Concerns around violence toward Tigre from Canada due to history of violence towards previous girlfriend. Violence towards staff on the ward. Canada had demonstrated poor insight around his risks and his behaviour." Issues around Resident 3 were also noted.

b) Assessment: Tigre … is now staying most nights at Address A. Staff there "have been removed because of risk towards the staff by Canada and the use of drugs". Canada has been seen as an outpatient by CP2, not felt suitable for recall …. no significant concerns as accepting medication. Tigre compliance with medication is very poor as she is not living in Caraston Hall: increase in

[20] There were two notices under "Section 8" and "Section 21" powers.

self-neglect; increased risk of pregnancy; poor compliance with medication will possibly result in return of psychosis. Fire risk due to cigarettes. Planned moved to (location in Torbay) – this could increase risk to Tigre from Canada.

c) Recommendations: Both Canada and Resident 3 have been served notice and will have to move. Community Mental Health Team has a role to provide additional support to all three. Look for alternative accommodation for Canada and the risk for this will be Tigre will simply follow him. Assessment of Tigre via outpatient appointment. Joint meeting with Canada and Tigre around the concerns raised. Fast track move to Torbay. Security staff overnight[21].

133. The Serious Incident Review reported that the meeting discussed at length issues of confidentiality in informing Tigre about Canada's violent history and decided that she should be informed of concerns. PCC2 and VCC1 were very clear that Canada and Tigre wished to be together. They discussed at length grounds for Mental Health Act detention but did not believe this was an option. Canada was considered by Devon Partnership Trust to be mentally well at this time. Capacity was also discussed but viewed as not being an issue, even if those present at the meeting considered Tigre's choice as unwise. Caraston Hall reported that the response to their referral to Devon County Council's Safeguarding Team was that it did not meet the criteria and that it "was a choice she was making". No reference to MAPPA arrangements at the meeting is recorded, nor any reference to the Trust Risk Management System.

134. On **1st September** 2017 VCC1 discussed with the community mental health team the possibility of a referral for Tigre to that service. From then until her death there are multiple entries in Tigre's clinical record demonstrating increasing concern for her health and her safety and failed attempts to engage with her. For example, on **4th September** clinical records for Tigre note that staff remained concerned about the threat posed by Canada to her and to staff if they tried to visit her at Address A. They were aware that Tigre was not collecting her medication. A further entry by VCC1 stated that Tigre had refused to return to Caraston Hall, had disengaged from all services and was not attending appointments. Caraston Hall served notice to quit on Tigre on **30th August** 2017. This was withdrawn after she returned to staying there more often in September, prompted by a visit from one of the Caraston Hall staff to warn that she could lose her room there.

135. On **4th September** PCC2 contacted Home Group to ask their views on the level of housing support Canada would need in a new placement. His suggestion was that "he can manage independent housing with low level of floating support".

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[21] It is not clear which property was intended. The notes of a later meeting (16th Nov) imply this may have been a suggestion that security staff were employed to keep Tigre out of Address A.

In response the support co-ordinator reminded him of the risk assessment that had led to their withdrawal and commented. “I believe that Canada was previously in a position where he would be able to manage a tenancy with minimal floating support in relation to comprehension of postal correspondence and benefit support. However, his substance use rose to an unmanageable level and this would also be unacceptable within any community setting. I do not believe that he will be able to manage the financial responsibilities his own tenancy would bring without the assistance of an appointee.” She suggested he would need a support package to include help in maintaining healthy relationships, managing finances and meaningful use of time.

136. Tigre’s father and his partner only saw her once, briefly, after she met Canada, on a visit Tigre initiated around this time. Although thinking the couple mismatched, they noticed Tigre appeared to have “a spring in her step”.

Noise problems and substance misuse referral

137. On **6th September**, Canada self-referred into treatment with RISE. He had been encouraged by PCC2 to do this to increase his chances of being accepted by housing providers. He said he was experiencing difficulty with his cannabis use and was smoking between 2 and 6 times per week but did not disclose the volumes, or his use of other substances. On **15th September** PCC2 contacted RISE to ask when Canada would be assessed and was told that they were waiting for a one to one worker to become available.

138. On **11th September** Tigre attended an Outpatient Clinic appointment with CP1 and VCC1. Her support worker from Caraston Hall was also present. Her medication was reviewed and continued. It was noted that “She is now back at Caraston, for a week following about 4 weeks of instability, with her spending the nights and days at her boyfriend’s accommodation. … She described her new relationship as distracting, acknowledging that she became ill during that period of about 4 weeks as she was no longer taking her medications regularly, smoking cannabis and almost lost her tenancy….. She reports feeling better since her return to Caraston, taking her medications regularly as prescribed, and has stopped smoking cannabis. She reports auditory hallucinations of God telling her nice things and giving her advice…… She is currently not speaking to her father after falling out with his partner, but she plans to re- establish contact with him.” The follow up planned was for CP1 to continue to provide support and monitor her mental health, and Caraston Hall to continue to provide community support and encourage engagement in beneficial social activities.

139. On **16th September** 2017 Caraston Hall staff again reported Tigre to police as missing. There was a mention in the initial missing person report of their concerns that she could be at risk of domestic violence from Canada, now referred to as boyfriend. Tigre was again found at Address A and told officers she

was fine and there had been no issues. They noted she appeared well and uninjured.

140. Resident 3, after the homicide, recalled the relationship between Canada and Tigre as an unusual mixture as she was “an intellectual hippy, happy go lucky type” with a laid back attitude to the relationship. He described Canada as more possessive and working harder in the relationship. He thought he was seeking to take things quicker and further than Tigre, who was happy to see how things developed.

141. Canada’s mother took him shopping for food several times a week. He told her that he was waiting for benefits, but looking back she realised that he had spent his own money on drugs. Tigre accompanied him on these shopping trips, and Canada expected his mother to buy food for her too, saying “well she’s staying with me all the time now”.

142. On **19th September** a neighbour called Exeter City Council to complain about loud music coming from Address A. Following the usual procedure, on **20th Septembe**r an Environmental Health Technician, Tech1, visited the complainants to confirm that the council would be dealing with the matter and explain the process and how they should record any further disturbance. Tech1 knocked at Address A, with no answer although music was still audible. She delivered a standard notification letter, and on realising it might be a hostel of some kind, contacted police to find out if they had relevant information.

143. In September 2017 Canada’s care transferred to a newly appointed but experienced consultant psychiatrist, CP3. This was his fourth consultant within the first twelve months since leaving Langdon Hospital. On **25th September**, he was assessed by CP3 as part of his Community Treatment Order. Also present were PCC2 and an Approved Mental Health Practitioner AMHP1. Canada presented as calm with no evidence of psychotic symptoms and it was submitted that his cannabis use was being misinterpreted as a mental health problem. It was further noted that his existing support workers were no longer working with him due to concerns about his aggression.

144. On **26th September** PCC2 again rang RISE requesting the date of the full assessment for drug treatment. The administrator said it would be within a week. Later that day RISE tried to contact Canada by telephone to check his welfare, but found his phone consistently engaged. Canada attended court for an eviction hearing that day, supported by PCC2.

145. On **28th September** a Police Community Support Officer, PCSO1, contacted Tech1 to inform her that Canada had issues with women in authority and presented a possible risk to women. He advised officers to visit in pairs. He gave a copy of details held on a police database including Canada’s medical history, relationship with drugs, ability to understand proceedings and possibility of

becoming violent if unwell due to not taking his medication. The information came from the Home Group carer, with whom PCSO1 had contact due to earlier complaints from neighbouring student accommodation about the noise from Address A. He had given the students words of advice on dealing with the issue safely.

146. Tech1 discussed the warning with colleagues including her Principal Officer, although no formal risk assessment was carried out and Canada was not included on the Employee Protection Register. The register is an Exeter City Council database of people who are considered to be a risk to council workers. There is a strict protocol for adding a name to ensure that it is not used unnecessarily. All council staff have access to the register and its use is trackable.

147. Tech1 advised the neighbours not to approach the residents at Address A but did not give specific information about why as she did not want to frighten them. She also advised that if there was a particularly bad noise episode out of hours they could call 101 or email PCSO1. The complainants informed the Tech1 that a woman was also living at Address A and that when they had complained to the tenant he had said it was his girlfriend who was playing the music. Tech1 gave this information to PCSO1 on **28th September**. On that date a police intelligence record was made stating Canada and Resident 3 were becoming increasingly dangerous to approach and had a particular dislike of women and this behaviour had led to the carers leaving the building. PCSO1 was aware that Canada had been under MAPPA but could see it was not a current case and so did not contact any department in regard of this.

148. On **29th September** the RISE assessment team tried to contact Canada to schedule and complete an assessment. There was no response. As RISE workers had tried to make contact twice with no success, they then sent a letter to Canada giving him 7 days to make contact or his current treatment journey would be closed.

Engagement with both – October and November 2017

Increasing disengagement with services

149. In early October Tigre failed to attend a planned meeting with VCC1 at Caraston Hall at which responsibility for her support was passed from the Active Review Team to VCC2, a care coordinator in the Community Mental Health Team. VCC2 arranged to meet Tigre at Caraston Hall on **5th** and then **10th October**, but Tigre failed to attend. Staff at Caraston Hall reported that Tigre was taking her medication 'sometimes' but they had 'no concerns about her presentation.' VCC2 asked them to get Tigre to complete a pregnancy test the next time she returned.

150. During October and November there are multiple entries in the clinical record describing attempts by VCC2 to see Tigre. These were not successful. Concern for her wellbeing was regularly discussed at the Devon Partnership Trust multi-disciplinary team's morning meeting.

151. On **4th October** Canada failed to attend the Devon Partnership Trust clinic at which he had his regular depot injection. While he had often been late, this was the first time he had missed it. Clinic staff asked his mother to contact him. She did so and said he did not intend to come that day. The clinic staff emailed CP3 and PCC2 to report their concerns, commenting in the notes that "Despite all efforts to avoid this probably do need to recall Canada to hospital as risk potentially increasing". The notes also include "Mother - does not want Canada to be recalled to hospital but is concerned for him. She reports that he is very twitchy and thinks that he may have used. She is also very aware that due to the court[22] business Canada is very stressed."

152. On **6th October** Canada's father called police and Devon Partnership Trust saying that his son could not be contacted over the last three days, despite attempts by several family members. He was located safe at Address A later that day and had phone contact with Home Group, sounding well, over the next couple of days. Also on **6th October**, RISE closed Canada's case as he had not made contact. There is no evidence that this was communicated to Devon Partnership Trust.

153. On **11th October** 2017, Hollywell submitted a request for accelerated possession of Address A to the courts, and in the next two weeks made several unsuccessful attempts to engage with Devon Partnership Trust in contingency planning ahead of the eviction.

154. Canada had the delayed depot injection on **11th October**, having missed another appointment on 10th. The clinic undertook a drugs test, which was positive for cannabis and amphetamines. At this visit the Community Treatment Order was renewed by CP3 and Canada's rights and obligations explained to him. The Community Treatment Order conditions were revised, leaving only two actions of compliance:

- to accept prescribed depot medication
- to attend appointments with the mental health team.

155. On the **14th October** a police intelligence record for Canada was added that he and his flat-mate were taking amphetamine, could be dealing drugs[23] and that excessive noise was coming from Address A. An update to this notes that the

[22] This refers to his recent eviction hearing
[23] The record contains no detail of why it was suspected they were dealing drugs.

neighbourhood policing team were aware and would gather more information. The detail in the initial information was insufficient to obtain a warrant from a magistrate to enter the address.

156. On **17th October** PCC2 and the Devon Partnership Trust accommodation officer met Exeter City Council's Housing Options Officer. (Canada had been invited but did not attend.) They shared fuller details of his diagnosis and said that the Trust would end its duty to arrange accommodation under Section 117 of the Mental Health Act due to his lack of engagement. The Housing Options Officer was concerned that this made it likely that he would become street homeless and reported this to her manager. On the same day VCC2 wrote to Tigre offering an appointment on 24th October but saying that if this was missed mental health support might be withdrawn.

157. On the **18th October** Exeter City Council assigned the noise nuisance case to another Environmental Health Technician, Tech2, as Tech1 had changed role. Tech2 made contact with Hollywell who provided information on current issues with the two tenants, reaffirming Canada's risk to women. Tech2 informed them that the council now had sufficient evidence to issue a noise abatement notice. Hollywell explained that they were already going through eviction proceedings with Canada because of his previous behaviour, but thought the notice might help the eviction process with the courts. Further complaints of noise were received, so a noise monitor was installed. This picked up loud music but no evidence of domestic violence such as shouting or arguing. Tech2 had continued contact with Hollywell about the progress of the eviction.

158. Canada's mother recalled some of her visits to Address A, finding the house a mess with drink bottles and underwear on the floor and lipstick drawings on the television she had given him. On one occasion she saw Tigre, soaked in urine, asleep, and Canada apparently afraid to wake her up.

159. During their involvement with Canada, Exeter City Council's Housing Options team also had contact with his mother as she often came to hand in paperwork for him or to talk to staff about the situation. Although his mother never said she feared Canada, the Housing Options Officer had the impression that she was afraid of her son although also wanting to help him. She expressed the wish to move accommodation herself, although she did not make a formal request, and the officer was aware that she was getting into financial difficulties because of her son. Home Group notes also refer to concerns about Canada borrowing money from family members.

Tigre's situation at this time

160. At the time of the homicide Tigre was funded for support by Caraston Hall under Section 117 of the Mental Health Act, for 22 hours of enabling support plus

a sleep-in member of staff on the premises. Caraston Hall provided four documents completed in October 2017 about her needs and support.

- Assessment of Current Needs (internal document)
- Client Risk Management Plan – a form for staff use only, rating level of concern for the standard list of risks.
- Provider Report to the commissioner dated **19th October**, on standard template set by Devon Partnership Trust and Devon County Council.
- Support Plan, dated **28th October** 2017, developed with Tigre.

161. While there are some inconsistencies between these documents, and the Caraston Hall internal review notes they are "not accurately dated", they indicate the nature of Tigre's needs and support as given by Caraston Hall at the time.

a) Tigre was often away from Address C for days at a time "to be with her boyfriend" and was then non-compliant with medication.

b) While generally mentally well and stable "she can have ups and downs which may be linked to her drug use." While she needed reminding of appointments and made poor choices of associates the documents state there were no mental capacity issues.

c) Tigre was reported to require overnight support when she is unwell and to ensure that she is not bringing males into her room overnight.

162. The documents focus on the support that Tigre needed to maintain hygiene, manage finances, take medication and attend appointments. The main risk cited in the Assessment is of self-neglect, eg not washing, or forgetting to eat. The Risk Plan identifies high concern risks of not taking care of her body, paranoia / delusions and misuse of alcohol or drugs; and medium concern risks of financial exploitation, self-harm, verbal or emotional hostility to others, damage to property (accidental fire), depression, hallucinations. It does not mention either the absences or visitors, or identify any risk of abuse from Canada.

163. Tigre had a long talk with a female friend at about this time, after a casual meeting in the city centre. While she "mentioned she was seeing someone" she spoke more about the father of her elder child (who had long since left the area). She also described a new "desperation" to get her children back, with the idea that "they would save her … then she'd be OK". The friend, who had met her half a dozen times in the previous year, did not meet Canada but had heard of him from others. "He was not a nice person around women, he didn't like women, didn't want them around him. That was the word on street. If Tigre was aware of that, she didn't say." The friend's impression was that Tigre did not regard Canada as a partner or boyfriend at this point.

164. Another female friend interviewed by police said that Tigre had told her that Canada, described as her boyfriend, had asked her to move upcountry where a relative had offered him a job, but she was a bit unsure about going[24]. Tigre told the friend she wasn't sure about her feelings for Canada, but "never had a bad word to say about him other than he was like her shadow". This friend had a positive view of Canada, saying he showed affection to Tigre, always holding her hand and touching her affectionately and buying her new clothes and wigs. She thought he showed signs of being genuinely caring. However, she found him unnerving sometimes when he was on drugs as he would "twitch and stare".

165. Around this time Canada's sister met Tigre for the only time, at a family event in Exeter. She was shocked by her poor personal hygiene, and her brother's physical deterioration since June that year, although he appeared happy. She found it difficult to have a coherent conversation with either her brother or Tigre as they had used drugs.

Final weeks at Address A

166. On **13th November**, following increasing complaints from neighbours, two Environmental Health Technicians visited Address A with the police and spoke to Canada about the situation. Tigre was present and although the technicians mainly addressed Canada they also checked that Tigre understood what was being said. There was nothing in this meeting that gave the Environmental Health Technicians cause for concern. Following normal procedure, they informed Hollywell of Tigre's presence as she was not a tenant of the property but appeared to be staying there. On the **14th November** VCC2 became aware, during a telephone call to Caraston Hall, that Tigre was there but staff reported that she was asleep. They said there were no issues with her presentation, but she was not taking her medication. VCC2, who worked part-time, was not able to take the opportunity to visit her on this day.

167. On **14th November** the Housing Options Officer phoned PCC2 to get an update on whether he had been able to find accommodation for Canada. This was prompted by a phone call from Canada's mother saying he was being evicted on 16th November. PCC2 said no alternative supported accommodation had been found. He mentioned that Caraston Hall had been asked but had refused in order to protect Tigre. ("There were DV issues in 2011 with another partner but nothing since but landlords still refused"). He said supported housing in North Devon was being considered but as Canada did not want to leave Exeter the best option was bed and breakfast and then privately rented. On the **15th November**, unable to contact PCC2, the Housing Options Officer contacted the accommodation officer at Devon Partnership NHS Trust, who agreed that a multi-

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[24] Date uncertain – probably towards the end of the year.

agency meeting should be arranged as soon as possible. However, no meeting involving Exeter City Council happened.

168. In the morning of **16th November** 2017 Devon Partnership Trust held a further Risk Strategy meeting. This included CP1, PCC2 and VCC2. Caraston Hall was represented through SM1, but Hollywell was not invited. (Home Group were no longer involved at this point.) Relevant points from the background and history were noted. PCC2 reported that he was in touch with Canada's mother who was supporting her son on aspects of the eviction process, and who thought Tigre a bad influence on him, and with his father who had taken the couple for a meal on a recent visit to Exeter and thought Canada should be recalled to hospital.

169. Key points from the meeting note include the following.

a) Purpose: Tigre has only been at Caraston Hall 2-3 times a week - she is living with Canada and "there are concerns of domestic abuse". Risk around losing accommodation and mental health deteriorating due to not taking the medication. Using cannabis regularly. Concern about behaviour when she is at Caraston Hall.

b) Tigre was at risk of losing housing benefit, since she was not spending at least 4 nights per week at Caraston Hall. She was often under the influence of cannabis and "just eats and changes her clothes and leaves again", sometimes arriving early in the morning, perhaps to give the impression of having been there all night, and not engaging with staff. Her reported view was "Why can she not be left alone and people get off her back?".

c) Caraston Hall reported observing Canada as "quite controlling", accompanying her visits but staying outside. "Tigre came back after they had fallen out but he turned up and they went off together." They felt they had no evidence of abuse from Canada to Tigre. "No one has seen any harm to Tigre only him being controlling and only little evidence of this."

d) Tigre was not engaging with mental health support. VCC2 had not yet managed to meet her. She had just received a message from Tigre asking her to make contact but suspected this was just to avoid being discharged and losing housing.

e) Tigre seemed to be taking about half her medication – "enough just to keep herself from having an episode". There was no impact yet on her mental state. "Not sure of the level of capacity but when she does she is making bad decisions."

f) PCC2 recapped Canada's history and outlined current issues at Address A, where Canada's eviction was in progress: there had been noise nuisance and aggression to staff and no care staff were present. "The first few months were ok and then there was cannabis use and the staff struggled to manage the

drug use." Canada admitted use of cannabis. Resident 3 had already moved out of the house[25]. Canada had resumed visiting his pigeons, which had stopped when he met Tigre. Home Group's concerns about the risk of him riding his motorbike while under the influence were noted but "he says he doesn't and the police have not stopped him".

g) Canada attended his depot injections but did not keep appointments with PCC2. He was due to visit potential accommodation in North Devon the following week but wanted to stay in Exeter. He had an outpatient appointment due the following week with CP3.

h) PCC2 had seen Canada and Tigre together twice, once at Address A and once at a clinic. Canada had shown no signs of abusive language towards her. PCC2 had hoped to see them together and "have an open dialogue" but as Tigre did not keep appointments this had not been possible. PCC2 thought Tigre was influencing Canada's decisions in the relationship, and that the couple were being unrealistic, with Canada expecting to be allowed to stay at Address A have Tigre join him there.

i) The agreed actions were for VCC2 to accompany PCC2 on a visit he had planned to Address A that afternoon, to try to see Tigre, and for Caraston Hall to continue to support Tigre.

170. Also on 16th November Canada's mother telephoned the Housing Options Officer to say that PCC2 had asked her to accommodate Canada and she had refused because of the risks to herself. She understood that Canada was now looking at a place in North Devon and she would let the Housing Options Officer know when she had further information.

171. That afternoon (**16th November**) VCC2 attempted to visit Tigre at Address A, but found she was not there. When VCC2 telephoned her, Tigre reported that she had broken up with Canada and that she had no concerns. VCC2 arranged to visit Tigre on **21st November** at Caraston Hall. There is no record that she alerted any of the other agencies involved to the reported "break up" or offered advice about raised risk of domestic abuse during separation. Tigre was not at Caraston Hall to meet VCC1 on **21st November.** Staff there reported that she was still in a relationship with Canada, typically returning to Caraston Hall several times per week. They continued to be concerned about her lack of engagement, absences and vulnerability.

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[25] On 14th October 2017.

Engagement with both from December 2017

Eviction and temporary accommodation

172. On **4th December**, PCC2 contacted Hollywell to confirm that emergency bed and breakfast accommodation had been found at Address D, a guest house in central Exeter, and that Canada would vacate the property that day. Initially Canada failed to turn up at Address D so the Housing Options Officer advised him via PCC2 that if he did not make contact the offer of temporary accommodation could be withdrawn. PCC2 told her that Canada had assaulted his mother that afternoon but she had not reported it to the police. PCC2 had encountered Canada's mother in a distressed state, saying that Canada had pushed her in the face so that she banged her head. He provided safety advice and encouraged her to report to the police. He later discussed the incident with the police 101 helpline and passed their advice on to Canada's mother.

173. The Housing Options Officer did not discuss whether the assault should be reported and was unaware that there had been such assaults in the past. She did open a case file for Canada's mother and work with Sanctuary Floating Support to get her support to deal with her financial situation and potentially help her to move.

174. CP3, learning on **5th December** about Canada's assault on his mother noted "PCC2 had seen Canada only shortly before the incident, and did not observe any signs of psychosis. Discussed how this should be considered a criminal act therefore – PCC2 did liaise with the police. The relationship between Canada and his mother is complicated (problematic at times, whilst also supportive). I have not recalled Canada's Community Treatment Order because I am not being alerted to signs of relapse in psychosis, he has been having his depot and seeing PCC2".

175. On **5th December** bailiffs attended Address A, together with a housing officer from Hollywell and (by prior request from Hollywell) police. They found the property vacant and changed the locks. On **7th December** staff at Caraston Hall reported to Devon Partnership Trust that Tigre had tried to gain entry to Caraston Hall for Canada, but that staff had refused him entry. Tigre had stayed at Caraston Hall and Canada had left but staff were concerned that he would return.

176. On **8th December** the landlord of Address D contacted Housing Options to tell them that Canada was "smoking weed" at the property and allowing his girlfriend to stay, both of which are against the terms of the tenancy. A further report was made on **14th December**. The Housing Options Officer contacted Canada to advise him that this breached the terms of the tenancy, so Exeter City Council would cease its duty to accommodate. Canada agreed that Tigre had been staying but denied smoking. The Housing Options Officer then called the

community mental health team duty worker (as PCC2 was not available) and explained the situation. She did not identify any potential risk to the girlfriend.

177. On **14th December** SM1 informed VCC2 that Tigre had been given 28 days' notice to leave Caraston Hall, as she was not compliant with the rules at the home.

178. On **14th December** Hollywell contacted police after hearing from Canada's sister that he planned to break into Address A to get bedding. Police attended and a found a rear window open. Hollywell contacted Exeter City Council's Assertive Homelessness Outreach Team to alert them that Canada might be sleeping rough.

179. Also on **14th December**, Canada's father reported to police his concerns that Canada had been evicted again, was homeless and his whereabouts unknown. He said Canada was mentally ill and suggested he needed to be sectioned but said he had been told by Devon Partnership Trust that they could not act until the police were involved. Canada then called his father from his grandmother's address. Police gathered mental health information from the Street Triage worker who informed them that Canada had been evicted for cannabis use and having his girlfriend to stay. It was confirmed Canada was on a Community Treatment Order and that his mother, father and sister had all reported that he was mentally unwell. Police visited his grandmother's address and were assured she was happy and capable of having Canada there. They saw Canada who left the house saying he was going out to see his girlfriend. No concerns were identified by the officers.

New placement for Canada at Address B

180. On **18th December** the provider in North Devon which had been considering Canada's application for supported housing rejected it. Canada, with PCC2, made an informal visit to Address B, run by Rethink Mental Illness in Exeter, to which a referral had been made on **15th December**. Rethink noted that Canada seemed both motivated and clear about what was expected of him. The Service Manager, RM1, was assured that Canada was doing well and determined to make the placement a success. (However, the referral paperwork noted that he had missed two appointments with the Community Mental Health Team since leaving Address A.) On that day PCC2 saw Canada and Tigre together and thought "both presented well".

181. The service provided by Rethink Mental Illness at Address B is medium and high level supported housing accommodation offering housing related support to people with medium to high support needs, leaving hospital or a residential setting. At the time it was staffed from 9am to 8pm and with security staff overnight. The funding panel application identified a need for Canada to receive 21 hours of support per week to re-establish a period of stability. There was an

understanding at the informal meeting on **18th December** that due to the Christmas period initial support would be less regular than normal.

182. The application identified the following outcomes for Canada:

- stable housing
- prompts to attend fortnightly depot
- support to move to independent housing
- access to training and employment
- support to avoid drug use
- support to attend appointments with the Mental Health Team.

183. On **19th December** Canada moved into Address B on an assured short-hold tenancy. PCC2 was also hopeful that he would be able to move on within a few weeks to a bedsit in Exeter. VCC2 called Caraston Hall ahead of a planned appointment with Tigre and was told by staff that she was not at the property "having left following incident last night in which she was caught smuggling her boyfriend into the property. He then became aggressive towards staff when asked to leave."

Looking forwards

184. Devon Partnership Trust held a third Risk Strategy Meeting that day **(19th December)**, chaired by the clinical team leader CT1. The focus was on Tigre's future beyond eviction from Caraston Hall. The meeting included Tigre's consultant CP1, care coordinators VCC2 and PCC2 and SM1 from Caraston Hall. Rethink were not involved. Caraston Hall reported that Canada's mother had been calling them "very concerned that Tigre is not in Canada best interest and is very anxious". They had explained that they were not allowed to discuss things with her.

185. Key concerns discussed included:

a) Tigre's lack of engagement. On receiving notice she "was initially upset and then stated 'I don't care'…. and gave a 'whatever attitude'". She was "not quite at the point of being sectioned but is not in a good place mentally. … she has come a long way in the last few years … if not taking medication and still smoking a lot of cannabis she could get worse."

b) Risks to Tigre of pregnancy, of being a passenger on [26]Canada's motorbike without a helmet. Concern that having previously had a reasonable level of contact with both parents she had "cut the parents out of her life since she

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[26] He had a provisional license which does not allow passengers to be carried.

has been with Canada", and that her personal hygiene and dental health had become very poor.

c) Signs of control by Canada, including of financial exploitation as Canada always accompanied her to the bank. Caraston Hall reported that "Canada is very controlling and wants to be there when she does stuff and won't let her go to meetings, he has a lot of control. If she does not see him, he will come on his motorbike and collect her."

d) Reasons for Tigre not being able to stay at Caraston Hall including Canada's aggression to staff, her disruptive effect on the house ("she trashes the place and they are unable to manage her") and signs of becoming involved with a new male resident there.

e) Canada's housing position was explained, and his mental state summarised as "He is getting a depot every fortnight and his psychotic illness is treated quite well and we have not seen any paranoid or psychotic behaviour."

186. There was extensive discussion of the relationship and whether it was desirable or feasible to place them as a couple in accommodation in future. Points raised included:

a) PCC2 considered "They are definitely a couple and they both seem to have capacity".

b) CP1 is noted as saying that he "has not heard any professionals saying they cannot be a couple, they just both have issue with the boundaries".

c) They are both vulnerable to using cannabis. "Their behaviour is not good when they are together." "Both are immature and they are drinking and taking drugs and not engaging with recovery and restructuring their life."

d) Under the rules at Address B, Canada could book Tigre in as a guest for 2 nights per week. Rethink's views on her potential regular presence were unknown. If she were also placed there the night time security could help prevent drug use and "put the boundaries in place for both of them".

e) "Canada will sabotage any conversation with Tigre getting any accommodation so maybe getting Tigre at the same place they would then be together. If not they will both sabotage each other's accommodation. … If she gets a placement she will not stay there so it may be better to get them somewhere together."

187. It was agreed that CT1 would try to contact Tigre the next day if she attended Canada's clinic appointment with him, and that VCC2 would seek new accommodation for Tigre to move to before her eviction date of 15th January

2018.[27] The summary of the note also included "VCC2 to do a DASH[28] form", but this does not appear in the action plan and does not appear to have been done by the time of the homicide. It also included a proposal "To look at getting a housing placement together and offer the support." No options for such a placement had been explored by the time of the homicide.

188. On **20th December** Canada attended the clinic and was observed to be "bright in mood" and showing "no evidence of any psychosis and no hostility or aggression". CT1 met Tigre at the clinic. This was in the presence of Canada and there is no evidence he was asked to leave. CT1 noted that Tigre appeared "under influence[29]; difficult to concentrate; not sad to leave Caraston as needs bigger room". CT1 suggested that they should all meet in early January to consider a joint solution to their housing difficulties. Tigre and Canada agreed to this. Canada's mother recalls both of them subsequently sounding enthusiastic about the idea.

189. On **20th December** the Housing Options Officer called the accommodation officer at Devon Partnership Trust to find out what was happening with Canada's accommodation and was informed that PCC2 had found supported accommodation with Rethink at Address B.

Continuing challenges in new placement

190. Rethink allocated MHRW1, a Mental Health Recovery Worker, as Canada's keyworker, and she completed initial paperwork with him on **22nd December**. This included a Rethink Mental Illness Anti-Social Behaviour Contract, which he was asked to sign due the service staff having already identified problems around cannabis use, playing loud music and letting visitors into the property. Canada did not engage with active support from Rethink after 22nd December. He and Tigre spent part of the Christmas period with his family. A friend stated to police that both Canada and Tigre had told her this went well. On **28th December** a male Mental Health Recovery Worker, MHRW2, accompanied Canada and Tigre, noted as his girlfriend, to the shops.

191. On **28th December** 2017 MHRW1 and MHRW2 completed a Safety Assessment on Canada, who was not present. This identified "high" likelihood and severity on four risk areas – i.e. all except financial exploitation:

- exploitation or harm to someone else
- verbally hostile towards someone else

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[27] Had this date been reached, TIGRE would not have been turned out immediately. Caraston Hall say they would have continued to try to engage her while following the subsequent legal process.
[28] Domestic Abuse Stalking and Harassment – a tool used across agencies for risk assessment.
[29] This is ambiguous, but probably means of drugs not of Canada.

- physically hostile towards someone else
- mood swings.

192. The Safety Assessment provides some further detail as to the nature of these risks, triggers, and what preventative measures could be put in place to reduce the concern. In relation to the risk of verbal or emotional hostility towards others, it states "most recently he was found in the building where his partner lives, refused to leave but was escorted out, then caused a nuisance outside ringing the doorbell (it was late at night), verbal aggression towards staff who reported that his partner, Tigre, was holding him back from staff. Police called and he was escorted off the premises, no charges were brought, but banned from property." This information had been provided by email to RM1 by Devon Partnership Trust on **21st December** but did not include the date of the incident.

193. On **27th December** there was a formal hearing of a Mental Health Act panel of three hospital managers about the renewal of Canada's Community Treatment Order (s20A renewal). This followed the standard timetable for reviews and was not a response to recent events. Canada asked for the order to be revoked. The panel received a social circumstances report prepared by PCC2 on 24th November and presented by a colleague and a report from CP3, the Approved Clinician.

194. The social circumstances report detailed Canada's history of aggression between 2002 and 2014; briefly summarised the break-down of the arrangement with Home Group "they felt intimidated and threatened from Canada when he was confronted on use of drugs" and noted that he was subject to Section 117 aftercare but "the plan for supported housing failed and is under review". Explanation of the housing position included "Indeed Canada has said he did not want staff to be around. The current assessment of his housing needs is that he would do best 'with his own front door', but we have also approached supported housing providers in the area because of the difficulty in sourcing independent housing."

195. The only reference to Tigre in the written social circumstances report was that although "a passionate pigeon-fancier … [Canada] has had a relationship in recent months and he has been less involved with pigeons, occasionally dropping in". The answer to the question on the form "Whether the patient, if discharged from the CTO, would be likely to act in a manner dangerous to themselves or others?" was "I feel that if Canada is taken off his CTO he will quickly disengage with mental health service and stop taking his anti-psychotic medication. To "whether, and if so how, any risks could be managed effectively in the community?" it was "The experience of recent months is that there is a strong correlation between having the depot and stable mental health. Drug use seems to destabilise. He seems to function well without staff around but needs prompts to manage medication and will need support to maintain a tenancy." The report

noted that he was “currently managed at MAPPA Category 2 Level 1” but named a member of staff at Langdon Hospital as the lead contact. In recommending continuation of the Order CC2 wrote “I feel that the combination of Canada’s lack of insight, use of illicit substances and lack of compliance with medication would led to Canada’s relapse and increased risk to members of the public, health care professionals and family members.”

196. At the hearing Canada presented as calm and non-psychotic and did not appear to be under the influence of alcohol or substances. He stated his use of substances and alcohol had significantly reduced and that he had not used amphetamines for three weeks. The hearing concluded that Canada met the criteria for continued placement on a Community Treatment Order as he had an established mental disorder of a nature (paranoid schizophrenia) but not of a degree, that required continued treatment and monitoring under the order. It was agreed that there was a risk that there would be a relapse in his mental health if discharged from the order so it was renewed with the conditions remaining (as set on 24th October) to accept prescribed medication and attend appointments with the mental health team.

197. On **30th December** staff recorded a strong smell of cannabis coming from Canada’s flat, reported by another resident, in their incident database. On **1st January** 2018, Tigre visited Address B, and MHRW1 let her in and accompanied her to Canada’s flat. On **2nd January** staff at Address B contacted Devon Partnership Trust to explain that over the Christmas period Canada had been an ‘absolute nightmare’ and he once again faced eviction.

Tigre’s final days

198. Tigre’s pattern of non-engagement continued into January. She did not attend an appointment with VCC2, who discussed the position with the consultant psychiatrist CP1, who suggested contacting the Crisis Team. They said they could not accept Tigre as she was unable to give consent. The Serious Incident Review commented that it is not clear from the record whether this “unable to give consent” was a judgement on her capacity to consent, a refusal to consent or that she had not been asked to provide consent, although previous entries to clinical records suggested that her capacity to make decisions had been considered and was not compromised.

199. Interviewed by police after the homicide, Tigre’s neighbour at Address C said he had thought they were quite a good couple together. They had their quarrels but went out on the bike together and she seemed happy. However, towards the end (the week before her death) she told the neighbour that she wanted to split up with Canada: she had had enough. Another male resident of Address C, again interviewed after the homicide, said that Canada had told him that he was “under the thumb” with Tigre and loved her. The resident thought, from things Tigre had

said to him, that she did not like this. “She was very independent”. Both these witnesses were aware that Canada was not allowed on the premises.

200. On **Day H-6 January** 2018 Caraston Hall staff asked VCC2 to contact Tigre’s father to ask if he would collect her possessions when she was evicted, as she was refusing to get them and Tigre had withdrawn consent for them to contact her father. However a Caraston Hall support worker had told Tigre’s father a few days earlier that she had said (though not written) that she was now willing for them to share information with him. VCC2 said that she, too, did not have Tigre’s consent to contact her father. Tigre did not attend her appointment with VCC2 that day. VCC2 discussed the situation with consultant CP1 and he suggested contacting the Crisis Team to ask them to assist with encouraging Tigre to engage.

201. VCC2 contacted the Crisis Team the same day, explaining that Tigre was not engaging with either Caraston Hall or the Trust. She reported that Tigre had missed planned appointments both at clinics and when VCC2 had gone to Caraston Hall. She was spending her time with Canada and dishevelled in appearance. VCC2 was concerned as she needed to plan for Tigre’s imminent eviction and review her mental state. The Crisis Team advised if VCC2 could get Tigre’s consent for an assessment then they would support her in a joint review the following week. The clinical note includes “[VCC2] debating whether MHAA[30] may be indicated. I advised she could have a conversation with the AMHP[31]'s but advised again we will support a joint review if she can get consent.” The clinical records demonstrate that in the first week in January VCC2 contacted several other services within the Trust to secure support but was unsuccessful, although a community nurse advised that she would be willing to assess Tigre the following week if she agreed.

202. Meanwhile, on **Day H-6,** Canada attended clinic for his scheduled depot injection and review with PCC2. Tigre was not with him. He owned to having recently used amphetamines. His behaviour was appropriate during the appointment and showed no evidence of any psychotic symptoms, hostility or aggression. His next appointment was due on Day H+7 January.

203. Also on **Day H-6** Canada, with PCC2, met RM1 to reinforce rules which would allow him to stay in Address B with the possibility of improved accommodation, also supported by Rethink, in the near future. At the meeting RM1 raised concerns around non-engagement and anti-social behaviour. Canada was issued a verbal warning during the meeting for non-engagement, playing loud music and

[30] Mental Health Act Assessment
[31] Approved Mental Health Professionals – who would carry out a Mental Health Act Assessment

cannabis use. After another incident with loud music over the weekend, Rethink then gave him a written warning on **Day H-2**.

204. On **Day H-1**, the day before the murder, at 10:15am VCC2 discussed with the Approved Mental Health Professionals team the possibility of a formal Mental Health Act assessment on the grounds that "I have been unable to make significant contact with Tigre in the time that I have been working with her and she is not engaging with the staff at her supported accommodation; she is being evicted soon and will be street homeless; as far as I am aware she is not taking her medication; it has been reported that her current partner whom she appears to be spending the majority of her time with is controlling towards her; the referral to the Crisis Team was not accepted. The clinical note concludes "It was agreed that there was not sufficient evidence to warrant this taking place". The Serious Incident Review commented that "A more detailed explanation in the clinical note as to the evidence presented would have been helpful." At 11am VCC2 rang Caraston Hall and established that Tigre was there but was advised that she would not come to the telephone to speak to her.

205. Also on **Day H-1**, Canada missed pre-arranged support with another Rethink Mental Health Recovery Worker. When she knocked on this door he appeared to be out.

206. Police were called to Address B on the night of **Day H-1** for an incident of criminal damage (not linked to either Canada or Tigre). They spent a couple of hours there around midnight. Officers recalled seeing Canada talking to Tigre in the hallway but did not know or have reason to ask their names. One officer asked in conversation "Is everything okay?", and both replied "Yes we are fine". That was Tigre's last contact with any public agency. Shortly afterwards the couple left for Address C, where the homicide occurred as described earlier.

Family perspectives

207. Information about contact from family members, and their recollection of particular events, has been included within the timeline above. This section covers broader points made in contact with the families during the Review. It also summarises complaints made by Canada's sister to various agencies in November 2017 and their response.

208. A point made strongly by both families was that drug misuse had not been taken seriously or related to mental wellbeing. They understood that cannabis use in adolescence, probably involving more potent varieties and sometimes other illicit drugs, was thought to have contributed to the development of mental illness for both Tigre and Canada. They argued that using cannabis and amphetamines while in supported housing receiving mental health treatment must undermine its effectiveness. Yet they felt services treated it as a minor

problem, with Devon Partnership Trust saying it was a choice adults could make, and Caraston Hall being ineffective in preventing residents from inviting in drug pushers. Neither family thought their relative had been offered any real help to reduce their drug misuse.

Tigre’s family

209. Tigre’s father felt that services had been reactive rather than proactive in working with her, and active intervention not offered until she was in crisis. Mental health services had failed her in that her first child was conceived during a spell in an inpatient unit. He said social workers had not communicated effectively with Tigre and her family about the reasons for her children being adopted, and this had affected her confidence in services in general. He understood that cognitive behavioural therapy had been suggested (around 2015) after her last period of inpatient treatment but that it had not been delivered.

210. Tigre’s father expressed concern about the apparent ease of access non-residents had to Caraston Hall while Tigre was there. His perception was that local drug dealers were able to get residents to let them in, with sleep-in staff unaware and CCTV ineffective as a deterrent. He had hoped that a move on placement from Caraston Hall would have been found, preferably somewhere rural to disrupt contact with city drug users and engage her in constructive activities.

211. Tigre’s father had not been aware of her disengagement from services in the second half of 2017, nor of the risks posed by her relationship with Canada. This is a matter of deep regret to him, as he had successfully maintained contact with his daughter over many years, even when she was most unwell. He recognised Tigre’s right to withdraw consent for information to be shared with him. This had happened from time to time in the past, but she would normally soon change her mind. He thought she used the threat of withdrawing consent if she did not get what she wanted (eg money), as the only form of control available to her.

212. Tigre’s father did regularly phone Caraston Hall to ask about Tigre’s welfare and was confident that he could have positively influenced her to maintain contact with the service and protect her from Canada. He thought there should be a way in which services could give him a headline view of her welfare or risks she faced, even when permission to disclose clinical information had been withheld. He was also concerned that Tigre orally renewing permission to a Caraston Hall worker was not sufficient for them to update him on the situation she then faced, and that her capacity to make decisions was often referred to but never formally explored.

213. Tigre’s father stressed the importance of making her fully aware of Canada’s recorded history of assaults early in the relationship, rather than a general warning that he could be violent. He thought this might have persuaded her,

particularly if he himself had also been informed and able to influence her. While he had not had the opportunity to observe the relationship at the time, information gained through the trial about Canada's attitude and past behaviour made him aware of the risk to Tigre of pulling apart from him.

Canada's family

214. In mid-November 2017 Canada's sister, who had been in telephone contact with him and their parents, cited Hollywell and Devon Partnership Trust in social media posts saying he was being made homeless. There was subsequent email contact with her by both organisations as described below. Tigre is not mentioned in any of the correspondence.

215. The Chief Executive of Hollywell emailed on **23rd November** to explain the issues and the charity's actions to Canada's sister. This included the following points:

a) "This is definitely not a case of Hollywell evicting Canada simply because we want the house back. I completely understand why you feel Canada has been let down by mental health and his support team."

b) "Canada moved into [Address A] on the understanding that he would have 24-hour care from Home Group, which was the case until July ... We wrote to Canada and his housemate a number of times between January and July as well as attending house meetings to explain that their behaviour on terms of smoking inside the house, allegedly taking drugs and finding an imitation firearm … was putting their tenancy at risk. Unfortunately, these breaches continued…"

c) "We have tried very hard to work with Devon Partnership Trust to find a solution and get Canada housed in more suitable supported accommodation as we are simply not able to provide housing to someone with his needs without external support from a care provider. … I cannot see that they have made any progress .... We have tried very hard to allow adequate time for alternative accommodation to be found … I don't understand why we are now 13 days from eviction and nothing has been done. We can't delay it any longer as the owner[32] will not allow us to."

d) "This has put us in an incredibly difficult position as it's clear ... that Canada needs support from mental health to continue to be able to live independently. … We are getting daily complaints about the noise coming from the property… Making the decision to evict someone is not something we take lightly and is an extremely rare occurrence …. We have reached a point where we can do

[32] Of Address A – a privately owned house which Hollywell rented.

no more, hence instructing the bailiffs which is the standard process for a court eviction where a tenant has not left the property when they have been asked to. I have tried numerous times to get a clear answer from mental health over the last 5 months.”

e) “I can … understand why ... you are so angry with the situation and those who are meant to be supporting Canada …. I’m afraid that we cannot change the fact that Canada will be evicted on 5th December – the focus now needs to be on ensuring that Devon Partnership Trust and the local authority housing team ensure that Canada is found alternative accommodation before this date.”

216. In acknowledging this the same day, Canada’s sister expressed concern that she had received no response from Devon Partnership Trust beyond a tweet from their Chief Executive on 20th November, and that PCC2 was not responding to her messages. She thought that her brother should not have been taken to court for breach of tenancy as his agreed support had been withdrawn. She commented “If the Home Group staff wouldn't support Canada due to fear for their own safety why is he allowed to live in the general population? The whole situation with court proceedings along with the possibility of become homeless is additional stress that is really affecting Canada's well-being and state of mind making him very vulnerable at the moment.”

217. Canada’s sister had emailed Devon Partnership Trust on **19th November 2017** via its Patient Advice and Liaison Service. The message started “… whomever receives this … I trust that you will forward to the people named … and anyone you think will address this promptly. After speaking to my very distressed brother and parents over the weekend. … I am appalled that your service is letting my brother down once again.” She expressed serious concerns that PCC2 was not supporting Canada to find new accommodation or communicating with the family. “My parents have told me he isn't doing anything.” She was aware that a visit to a potential placement in North Devon was planned but argued that this would be unsuitable as “he will be a long way from his friends and family and he needs them for support”. She warned that “Canada is very stressed and depressed at the moment and rapidly going down hill in his mental health.”

218. The Patient Advice and Liaison Service responded on **21st November** saying that they had contacted PCC2 about concerns and that he had assured them he had been in touch and had given her his email address for direct contact. “We felt … you would be able to discuss these issues directly with PCC2”.

219. On **26th November** Canada’s sister emailed the Trust again, this time including Home Group’s Complaints Panel, with a formal complaint against both the Trust and Home Group, copying in external parties including the Care Quality Commission. She included the correspondence with the Patient Advice and

Liaison Service and parts of her correspondence with Hollywell. Points she made included:

a) "My concern is that since Home Group withdrew the 24hr care for Canada in July and he has received no support and DPT have failed to find alternative care or accommodation giving Hollywell House no choice but to evict Canada."

b) She had spoken to PCC2 on **24th November** but thought what had been done was "very little" and "way too late". She asked why support from voluntary sector befriending and advice services had not been arranged for Canada.

c) "Since the summer I have seen Canada rapidly go down hill and I fear it will not be long before he goes back to his old ways or does something silly. ... Canada is very low and vulnerable at the moment and he is only days away from being homeless and hearing how depressed he is very distressing".

220. On **27th November** 2017 a Complaints Investigation Officer from the Trust's Patient Advice and Liaison Service responded, sending a Complaints Resolution Plan which restated the complaint for her to check, and explaining that consent from Canada would be needed to share any clinical information. It recorded the desired outcomes as "You would like to know why replacement accommodation was not provided before an eviction notice was served. You would like accommodation to be found close to your brother's friends and family." It did not pick up the point about the gap in support at the accommodation. A response signed by the Trust Chief Executive was promised by 27th January 2018. On **28th November** HGCL spoke to Canada's sister to clarify her concerns. As a result of this no complaint was logged on Home Group's system but HGCL offered to liaise with the Trust's Complaints Investigation Officer.

221. The complaint made by Canada's sister was investigated by the Trust through a review of records and interview with PCC2. The investigator obtained Canada's permission to share clinical information. On **Day H-2** the Trust Chief Executive signed the letter setting out the results. This gave assurance that the investigator had found evidence that PCC2 had tried to prevent the eviction, despite Canada's "traits of aggression". "Your brother was deemed to have capacity to understand the actions and decisions he was taking at the time." The investigator had seen documentation showing PCC2 "had maintained frequent communication" with Canada and his family offering advice and support and that PCC2 and other Trust staff had contacted other accommodation providers for Canada. "Many providers refused to accept your brother due to him having a history of not respecting house rules, continuing his illicit drug use and potential risk to other tenants." "Unfortunately, the ideal accommodation could not be found and is still being sought."

222. The letter concluded by noting that Canada was now in mental health supported accommodation with Rethink, and that there was a plan to move him

to a bedsit at the end of the month. It was postmarked on **Day H+2** and reached Canada's sister on **Day H+3** – the day he was charged with murder. Understandably, this only added to his family's distress.

223. In their contributions to this Review, Canada's family expressed deep frustration that services had not listened to them. "It will keep happening until people closest to them are listened to." Both his mother, seeing him frequently, and his father on more occasional visits, said that they had seen his mental and physical condition deteriorate during his relationship with Tigre, but staff did not accept this as a symptom of mental illness.

224. Canada's family think he should have been recalled under the Community Treatment Order as he was using drugs and had admitted this to Trust staff, and it was clearly harming him. They said that, while he did not like being told what to do, he should have been given clear rules and made to stick to them. They felt that both Home Group and Devon Partnership Trust tolerated his substance misuse. They were also disappointed that he had not been given more support to engage in positive activities in the community, for example to improve his reading.

225. Canada's family recognised his relationship with Tigre as bad for both of them but described him as genuinely loving her and wanting to get married, live together and have a family. He had sometimes believed her to be pregnant and welcomed this. They were distressed by Tigre's lack of care for herself and the example this set him. His mother, who saw the couple together more often than most other observers, regarded Tigre has the one who was more controlling. She said Canada had once asked her "What do you do when someone keeps hitting you and poking you?" but could not accept her answer of "walk away".

Overview of what happened

226. This section summarises the events described above. Selected dates are shown for reference in Tables 3 and 4.

Table 4: Key events before Tigre and Canada met

	Tigre		Canada
1994			Referred to Child Guidance Service
2001			First assault on his mother reported to police
2004			Assaults on mother leading to court action.
2005	First of many mental health inpatient admissions		First discussed at MAPPA. 2 spells in prison.
2006			Detained under hospital order.
2007	Police identify as victim of domestic abuse		

2011	Child born and adopted		Left hospital for supported living at Address B. Assaulted girlfriend also living there.
2012			Assaulted male fellow resident, recalled to hospital for breach of Community Treatment Order.
2013	Child born and adopted		Convicted of assaults on hospital staff.
2014	Last episode of inpatient mental health treatment		
2015	Placed in supported accommodation at Caraston Hall		
2016	Caraston Hall raised safeguarding alerts and referred her to RISE		Moved from Langdon Hospital to Address A, under CTO. MAPPA level reduced to 1.
Jan 2017	RISE closed case.		
Early Jul 2017	Offered placement in Torbay		Risk Meeting (DPT & Home Group). Staff at Address A increased. Review with psychiatrist.

227. Tigre and Canada met in late July 2017, when they were living in separate supported housing projects with housing benefit paid through Exeter City Council. Both had long term mental health problems for which they were receiving community treatment from Devon Partnership Trust, having had several periods of inpatient treatment in the past. Both were receiving additional support at their accommodation commissioned by the Trust and had some supportive contact with family members living in the area.

228. Tigre's history of relationships with men included one recorded incident of domestic abuse and a pattern of transitory relationships often associated with drug use. Her two children had been adopted at birth, which continued to distress her. Since 2015 she had lived at Address C, run by Caraston Hall, where staff support focussed on getting her to take her medication, look after her physical health, and avoid misuse of drugs. At the time she met Canada plans were being made for her to move to Torbay for a fresh start away from drug using contacts.

229. Canada had a history of aggression towards women, including his mother, past partners, and health staff. This often involved attacks to the neck or head. His most recent inpatient stay (2012-2016) was under a hospital order following such assaults. His discharge to community treatment was under Multi Agency Public Protection Arrangements (Level 1) and a Community Treatment Order, both overseen by Devon Partnership Trust.

230. In July 2017 Canada lived at Address A, a house run by Hollywell Housing Trust, who provided housing support, which he had moved to in 2016 on leaving

Langdon Hospital. He and the other tenant received additional support from live in Home Group staff. While this initially went well, in the first half of 2017 his behaviour became increasingly challenging, affected by drug use. Due to staffing changes at Devon Partnership Trust, his care co-ordinator changed in May 2017. At the point where Canada met Tigre, Home Group had told Devon Partnership Trust that they had serious concerns about risk to their own staff, and Hollywell was considering giving Canada notice.

231. Over the last weekend in July 2017 Tigre went missing from Address C, staying at Address A. Agencies quickly identified that she and Canada were in a relationship and that this put her at increased risk, but an initial police visit to Address A found her safe. Home Group decided they could not leave their staff at Address A but continued to offer telephone support to Canada through August and September. Devon Partnership Trust warned Tigre that Canada had a history of violence. Caraston Hall contacted Devon County Council's safeguarding team who decided there was no basis for intervention. Hollywell started eviction procedures, concerned about the risk to their staff and neighbours without the Home Group presence. Devon Partnership Trust arranged various meetings to review the situation during August, although none which brought all these agencies together.

232. Tigre spent most of her time at Address A from August to November, returning to Address C a few times a week. Caraston Hall staff attempted to engage with her when they could, in particular to provide her medication. Both Tigre and Canada often took drugs (cannabis and amphetamines) during this period. Devon Partnership Trust, backed by Home Group until October, ensured Canada got to clinics for his fortnightly depot injections, apart from one in early October. Tigre had broken off contact with her father, but Canada's family remained in contact and expressed increasing concerns about the situation. A review by a Consultant Psychiatrist on 11th October renewed Canada's Community Treatment Order. Due to staffing changes, she was the fourth consultant community psychiatrist responsible for Canada in the previous year.

233. The legal process for eviction took some time, and in September student neighbours of Address A complained about noise levels. Exeter City Council took enforcement action, and the neighbourhood police team, aware of Canada's record, provided safety advice to them and the neighbours. The Council's Housing Options Team also became involved in seeking alternative accommodation for Canada.

234. In October Devon Partnership Trust transferred Tigre from their Active Review Team to the Community Mental Health Team to allow for more frequent contact. However, she did not attend any appointments offered by her new care co-ordinator. Her last meeting with Trust staff responsible for her was on 11th September with her consultant psychiatrist and previous care co-ordinator.

However, she was observed accompanying Canada to some of his appointments after that.

235. In November Devon Partnership Trust and Caraston Hall held a risk strategy meeting to discuss concerns about the relationship. Points raised included Canada's controlling influence on Tigre, although with no indication of physical violence; problems finding alternative accommodation for Canada; and the risk of Tigre losing entitlement to housing benefit for Address C through frequent absence.

236. Shortly after this Canada's sister, reflecting the family's concerns that he was "going downhill" and could become homeless, made a formal complaint to Devon Partnership Trust about lack of support and of alternative accommodation. The official response to this, dated just before the homicide, reached her after it.

237. On completion of the eviction process by Hollywell in early December, Exeter City Council made an emergency placement of Canada in a city centre guest house. He lost this due to drug use and Tigre staying, then was homeless or with relatives for a few days before Devon Partnership Trust commissioned a further supported housing placement at Address B, run by Rethink. Meanwhile Caraston Hall had given notice to Tigre who was increasingly disengaged.

238. On 19th December Canada moved into Address B, and Devon Partnership Trust held a further risk strategy meeting about the relationship and where both Canada and Tigre might live in future. (Rethink were not included in this.) This led to a proposal made to both, when Canada attended for his depot injection the following day, of a meeting in January for both of them and their care co-ordinators.

239. Canada's challenging behaviour continued at Address B, including noise, drug use and allowing Tigre in without permission. His care coordinator and the Rethink service manager met him on **Day H-6**, after his depot injection, to agree a behaviour contract. Meanwhile Tigre's care co-ordinator, increasingly concerned about risk, unsuccessfully sought help from other Trust services to engage her.

240. On 9th January, Tigre went from Address C to Address B and spent the remainder of the day with Canada there or nearby. Both had rejected scheduled contact with their key workers earlier in the day. Shortly after midnight they went together to Address C, where she let him in. In the course of an early morning argument he strangled her.

Table 5: Selected dates of events during the relationship

Date	Tigre	Canada
20/7/17	(Probable) first meeting	
27/7/17	Tigre stayed at Address A with Canada	
29/7/17		Home Group withdrew staff from Address A due to risk to them.
31/7/17		First eviction notice served
7/8/17	Caraston Hall safeguarding referral to Devon County Council	
10/8/17		Professionals meeting held.
17/8/17	Risk Strategy meeting for both	
6/9/17		Referred to RISE
11/9/17	Saw consultant psychiatrist and care-coordinator at outpatient appointment	
19/9/17		First noise complaint to Exeter City Council re Address A.
4/10/17		Missed depot injection.
5/10/17	Did not attend first appointment with new care co-ordinator.	
6/10/17		RISE closed case due to lack of contact.
11/10/17		Depot injection (1 week late), CTO reviewed and renewed.
17/10/17		Meeting with Housing Options
16/11/17	Risk Strategy Meeting for both	
26/11/17		Complaint from sister re lack of planning & support and impact on mental health.
4/12/17		Left Address A for emergency accommodation at Address D. Assault on mother.
14/12/17	Given 28 days notice to leave Caraston Hall for non-compliance	Lost Address D for drugs & Tigre staying. Burgled Address A for bedding.
18/12/17	Aggression from Canada to Caraston Hall staff stopping him entering with Tigre	
19/12/17		Moved into Address B (Rethink)
19/12/17	Risk Strategy Meeting	
20/12/17	Spoken to together when Canada attended for depot injection	
27/12/17		CTO renewed at MHA Panel
	January 2018 dates (part-redacted)	
Day H-6		Depot injection & meetings
Day H-2		Written warning from Rethink
Day H-1	Each refused contact from key worker. Most of day together at Address B.	
Day H	Went together to Address C about 1am. He killed her there 5.30am.	

Analysis

241. This section analyses the events described above, considering why they occurred and whether different decisions or actions may have altered the course of events. It reviews in turn:

- agency involvement prior to the start of the relationship as relevant to the nature of the risk to Tigre from Canada or agency preparedness to address it;
- the risk to Tigre from Canada over the course of the relationship;
- how and when agencies recognised and recorded that risk;
- how agencies, individually and together, responded to the risk;
- what alternative responses might have been considered; and
- system issues affecting the ability to respond well.

Setting the context for the relationship

242. Prior to the start of the relationship there had been some effective single and inter-agency actions which improved Tigre's safety or reduced the risk of Canada harming others, but also some missed opportunities.

243. Canada's past assaults had resulted in a short prison sentence and a hospital order. There had been insufficient evidence to prosecute him for the 2011 assault reported by his former girlfriend Resident 1. Through the MAPPA process and police and Devon Partnership Trust records, information on his history of violence was available to some decision makers. However, his record on the Devon County Council Care First system did not mention violence towards women.

244. The Devon Partnership Trust Serious Incident Review found correct application and recording of Mental Health Act interventions. It judged that the Trust had a comprehensive care plan in place for Tigre with evidence of regular and appropriate care and support from health teams. The specified contact interval at this point was monthly but she was seen more regularly than this when her needs increased, for example in February 2017 when action by the clinical staff resulted in an identified improvement.

245. Tigre and Canada both benefited from supported accommodation funded as aftercare under Section 117 of the Mental Health Act. Such aftercare, for as long as needed, is a statutory right following certain types of detention under the Act. Tigre was placed at Caraston Hall, where staff co-operated effectively with Trust clinicians and her family to help her sustain her tenancy and treatment and look

forward. While Caraston Hall staff were aware of Tigre's needs and working to engage her, the company's internal review found gaps in how they recorded their work with her. This included absence of key information, little evidence of clinical reasoning behind decisions and a general lack of coherence in the overall record system for Tigre.

246. Two referrals from Caraston Hall to Devon County Council's Safeguarding Team about Tigre in 2016 were dismissed at the triage stage. This helped set an expectation that this service would be unlikely to help in the event of future concerns about relationships which Caraston Hall staff regarded as unwise.

247. Caraston Hall referred Tigre to RISE for help with substance misuse in December 2016, but RISE did not get full information about her situation, saw it as a low priority and closed the case when Tigre declined help after one phone conversation, in which she said she was happy with her progress. Her use of cannabis and alcohol did not in fact reduce and her motivation to change fluctuated. This was a missed opportunity for her mental health and support teams to draw on substance misuse expertise in planning how to make the most of the times when she was open to change.

248. Canada had a planned and managed transition from Langdon Hospital to Address A in 2016. This included consideration at MAPPA meetings and communication with his mother. Risks were discussed both with Hollywell, which provided accommodation with tenancy support, and Home Group offering more intensive enabling support. The arrangement was under the Devon Enhanced Community Recovery Service which commissions support for people with severe and enduring mental health issues in their own homes.

249. While some consideration had been given to deterring drug misuse, of which Canada had a long history prior to his hospital admission, the arrangements were ineffective. His Community Treatment Order included a condition on testing for drug misuse, and that he must only consume alcohol in (unspecified) agreed quantities. Home Group were expected to manage and monitor substance misuse, but this relied on staff influence, as there were no sanctions available to them. They did not manage to establish the clear rules and routine which his family felt he needed.

250. Neither at the start of the community placement, nor when it became clear that substance misuse was a partial cause of difficulties managing Canada in the first half of 2017, was there any referral to RISE. This could have been made by any of the agencies with his consent, which could have been sought at the start of the Order. While Canada did not meet the threshold on substance misuse for "dual diagnosis", a request for consultancy support on managing him could have been made to RISE at this stage. Success in helping him avoid substance

misuse on his return to the community would have supported efforts by Home Group to engage him in constructive activities.

251. Ensuring that Canada complied with the conditions of his Community Treatment Order was problematic, despite tenacious efforts of staff from both Devon Partnership Trust and Home Group to get him to appointments. The Trust's Serious Incident Review commented that "Although he did break the terms of his CTO he would re-engage as required and stayed very close to what was required. The culture and bias for community clinical staff is to maintain clients in successful community placements. This may have influenced the decisions [not to] revoke his CTO, supporting his often expressed wish that he did not want to return to hospital."

252. There is limited expertise in forensic provision amongst Trust community teams and the forensic service (which includes Langdon) was not expected to provide support to clients after their discharge from this specialist service. In Canada's case it would have been helpful if staff from the forensic service had been able to provide community support following discharge or at least participate in reviews of his Community Treatment Order.

253. Devon Partnership Trust's response to the concerns raised by Home Group and Hollywell about Canada's deteriorating behaviour in the first half of 2017 was inadequate to address risks which had escalated since the initial placement. Home Group had expected a three monthly review, including a medication review from clinical staff at the Trust, but this did not always happen. Hollywell reported that some messages expressing concerns were unanswered or received a dismissive response.

254. Some positive steps were taken in June and early July, including agreement of funding for Home Group to have waking night staff at Address A, and arrangement of an extra outpatient consultant appointment. However, this was with a locum new to the case. The Care Co-ordinator, himself fairly new to the case and about to go on holiday, urged colleagues to set up a multi-agency meeting during his absence, but this did not happen for three weeks, by which time Tigre had joined the scene. The relevance of Canada's status as MAPPA Level 1 with the Trust as lead agency was not discussed. The Trust focus was his mental disorder, and they were successful in sustaining community treatment for this. However, his landlord, carers and family thought they had been assured he could be recalled to hospital if the community placement was not working. When this did not happen, the other agencies felt risk had been transferred to them which they could only handle by withdrawing services. When seeking guidance and support, it would have been helpful had mental health professionals recognised that housing workers were struggling to manage behaviours that were increasingly outside of their expertise and risk frameworks.

255. Home Group informed the Individual Patient Placement Directorate of Devon Partnership Trust, their commissioners, of concerns via phone calls and emails. This is their normal practice. However, Home Group pointed out that it would be useful to have a protocol on ways to escalate concerns with more senior managers.

256. Those involved with Canada at this point (mid July) could not have known that he was about to meet Tigre. With hindsight, action could have been taken then which would, unwittingly, have protected her. At this point the case for recalling Canada to hospital under the Community Treatment Order was judged by the Devon Partnership Trust Serious Incident Review to be “a considered but ‘fine line’ decision… within the boundaries of a reasonable clinical decision”. However, it is not clear that information from Home Group staff and his family about signs of mental ill health as well as anti-social behaviour was fully taken into account.

Risk to Tigre from Canada

257. Tigre was at risk of domestic abuse by Canada from the start of their relationship due to his history of violence, hers of risk taking, and both being vulnerable due to their mental health problems. Canada had used violence, on a number of past occasions when frustrated at his situation. This was usually against women who were close to him, including his mother and former partners, and often directed at the neck or head of his victims. Some staff and other clients in previous placements, including men, found him intimidating. Home Group were concerned about the safety of staff caring for him at Address A. Tigre had a history of transitory relationships with men, sometimes associated with cannabis supply. Those responsible for her care thought her choices unwise. She was also inattentive to aspects of personal safety, for example dental health and fire risk. Both showed volatile behaviour and reluctance to comply with rules.

258. When the two met in July 2017 there were some protective factors in place. Both had a recent history of some positive responses to mental health treatment and support. They were each in supported housing, with staff presence, some distance from each other. Canada had not been seen to use violence since starting medication via depot injections in 2014. Tigre had recovered from a period of instability earlier in the year, after adjustment of her medication, and was hopeful about a proposed move to Torbay. Both were in touch with relatives who took an active interest in their welfare.

259. As the relationship progressed, the risk of harm to Tigre grew. Her drug use increased, adding amphetamines to cannabis. (Living with Canada, and availability of his money, enabled this, but it is not possible to know how they influenced each other in drug purchase and use.) She spent much of her time away from Caraston Hall, so had less contact with staff who could support her and ensure she took medication, including contraceptives. Missed doses and

illegal drugs reduced the effectiveness of her treatment, affecting her mental health. Following the withdrawal of Home Group staff from Address A, Tigre and Canada spent most of their days and nights out of touch with services. Tigre ceased contact with her father and did not renew her consent for services to keep him informed. From October 2017 she kept no appointments with Devon Partnership Trust. Canada's mother found him less easy to contact and was concerned about Tigre's influence on his lifestyle. Canada continued his mental health treatment but used illegal drugs alongside it. The level of anti-social behaviour, for example excessive noise at Address A, increased.

260. Canada appears to have seen the relationship as long term, talking of his hopes to set up home with Tigre, get married and have children, and describing himself as in love with her. Tigre's views and hopes for herself cannot be easily ascertained. While she missed her children and had hopes of a future in which she could get them back or establish a new family, she gave no indication that she saw Canada as the route to this.

261. It seems likely, from the evidence available, that the course of the relationship from Tigre's perspective was as follows.

- She was initially attracted to Canada and freely chose to spend time with him, both at Address A, where they had the freedom of a house with no staff reminding her to stay clean and tidy, and going out together to socialise in the city centre.
- From the start Canada was present with her most of the time except when she returned to her room at Caraston Hall. A friend observed him as being "her shadow". He discouraged her from attending appointments unless he could accompany her. An early outcome of this was her turning down the offer to view the proposed placement in Torbay. Another was that he lost interest in his pigeons.
- As the relationship continued her independence from Canada was weakened by increased substance misuse, which he possibly funded, and increasing absence from support and treatment. He followed her into Address C when he could, but staff there recognised that she valued it as a space where she could be apart from him.
- Tigre accepted the situation and neither friends nor those staff who saw them together witnessed arguments or violence between them before the homicide. However, she appeared less lively than before, and both of them became increasingly unkempt.
- Towards the end of 2017 Tigre was contemplating ending the relationship, though she still spent most of her time with Canada even after his eviction from Address A. She talked about resuming contact with her father. Canada

threatened staff to try to get into Caraston Hall on occasions when she returned there. She may have broken with him for a few days in November and had a brief relationship with another Caraston Hall resident in December.

- Tigre was under notice to leave Caraston Hall and knew that Canada wanted agencies to place them together but had not engaged sufficiently to ask about her options or make a choice.

262. The homicide occurred when the risk had been further raised by this instability in the relationship. The protective factor of the couple living separately in staffed accommodation had been restored. However, this did not prevent them being together at night in Tigre's third floor room, with staff unaware of a quarrel loud enough to wake residents of neighbouring rooms.

Recognition of the risk

263. Multi Agency Public Protection Arrangements (MAPPA) had been used effectively in managing Canada prior to his discharge from Langdon Hospital in 2016. After that his MAPPA status was ambiguous. The September 2016 MAPPA Panel put him at Level 1, so having single agency management in the community. However, his convictions were not for the violent offences which qualify for Category 2, so he was Category 3[33], which is either managed on a multi-agency basis at Level 2 or 3 or removed from the arrangements. This position was an unintended outcome of the way mental health and criminal justice processes had interacted over the period 2004 to 2012. Although several assaults by Canada against women were recorded, his prison sentence was for related crimes (harassment and burglary) which were easier to prove without victim co-operation. Assaults against staff while he was in hospital had not led to a further sentence as he was already detained under a hospital order.

264. Canada's MAPPA status had little practical effect on the recognition and management of risk after October 2016. The ambiguity had the benefit that MAPPA was mentioned on some of the referrals to support agencies, and was in police records, signalling that there was a risk of violence. A September 2016 police intelligence entry describes the behaviours indicating Canada is in need of mental health support. "When unwell he will show aggression, shout, be over active, display paranoia ..". However, Devon Partnership Trust did not set out what the MAPPA status meant for their management of Canada, nor consider referring him back to MAPPA as a potential Level 2 when concerns increased.

[33] Some of the previous MAPPA minutes list Canada as a category 2 offender and others as a category 3. See Appendix E for an outline of the framework..

265. The start of the relationship raised concerns at both supported housing placements, and they appropriately alerted other agencies. Caraston Hall's concern arose not only from Tigre's absence overnight but because the Chief Executive, in a previous job, had contact with Canada including knowledge of the 2011 incident with Resident 1. Home Group, already having difficulties at Address A, were concerned at Tigre's overnight presence and drug use there. Home Group staff rightly contacted Caraston Hall on learning (from Resident 3, who already knew her) that she lived there.

266. Police made welfare checks on request from other agencies, which included checking for signs of domestic abuse. They were first involved on 28th July when Tigre was reported vulnerable and missing and visited her at Address A to check she was safe. They visited again on 16th September following a second report from Caraston Hall that she was missing. Officers were content there was no indication of domestic abuse on those occasions, and that Tigre demonstrated awareness of her situation and had a plan for her immediate future actions. As concerns had been raised that she may be at risk of domestic abuse from Canada it would have been good practice to create a link between the two names on the police UNIFI system. This was not done but is unlikely to have affected subsequent events.

267. Although the start of the relationship coincided with, and may have contributed to, Home Group's withdrawal of staff from Address A, other risks obscured focus on Tigre in that decision and the reaction to it. While Home Group had given repeated warning to Devon Partnership Trust that they might have to remove staff, the risk of a hostile reaction from Canada to the 28th July police visit was a factor the timing. The intensive contact over the following week between Home Group, Hollywell and Devon Partnership Trust largely concerned the overall increased risk at Address A with Home Group staff off site, and Hollywell consequently starting eviction proceedings. Hollywell identified a risk to staff and neighbours due to Canada's violent and unpredictable history but did not learn of Tigre's presence at Address A until later.

268. Home Group did recognise the risk to Tigre and shared their concerns with Caraston Hall. Both support agencies, appropriately, contacted Devon County Council's Safeguarding Team to report potential risk to Tigre due to Canada's history of violence. In neither case was this recorded as a safeguarding concern. The Home Group caller, a frontline worker, was, incorrectly, given the impression nothing could be done until an incident occurred, and the Council did not make any record of the call. Caraston Hall, where the call was from a senior member of staff, were able to have a fuller discussion, but were informed at the end that it would not be recorded as a Safeguarding Concern. There was therefore no formal triage as to whether to open a Safeguarding Enquiry (see Appendix E). In making this decision the Council did not use all the information available or ask

relevant questions. Tigre's personal circumstances, support need, care plan and risk assessment were not fully explored in the context of the concerns raised.

269. In deciding not to record a Safeguarding Concern on 7th August the Council's Safeguarding Team did not take account of information easily available to them. Their Care First system recorded alerts for Tigre in 2013 and 2016, (not taken beyond triage), indicating a risk profile of non-prescribed drug use, noncompliance of prescribed medication, risk arising from relationships with men, alleged domestic abuse, coercion and unstable mental health. As in 2016, a key factor in the Council's response was the judgement that Tigre had mental capacity and was therefore free to make unwise choices. (See Appendix E for an outline of the law on mental capacity.) This is an important tension which a Safeguarding Enquiry would have had to consider, but the criterion for opening an Enquiry (see Appendix E) is not mental capacity as such, but ability to protect oneself. Given Canada's volatility and record of assaults, the withdrawal of his support staff and Tigre's absence from her support and history of self-neglect, that could not be assumed.

270. The Safeguarding Team also had access to the Care First records on Canada, which included a warning that staff should not see him alone. They had recently (May 2017) been granted access to Devon Partnership Trust's records, which outlined his history of violence to women and action already taken by Trust staff to warn Tigre about him. There is no indication that these were used, nor that any consultation beyond the caller was done. The Care First record uses only the ambiguous phrase "his history of abuse", which does not show whether he was the perpetrator or victim. The Safeguarding Team need a valid reason to look at records of an individual other than the subject of the concern. There is no written record of the information provided by or to Caraston Hall other than the Care First note. However, it is very likely that the caller did say that Canada was thought to have a history of violence against women and certain that she would have explained this if asked.

271. A further factor in the decision not to record a Safeguarding Concern, and central to the feedback given to Caraston Hall, was that Tigre had not been informed of or consented to the referral. While keeping the subject informed rightly forms part of safeguarding guidance, there is no requirement for the person reporting a concern to obtain consent in advance. This response ignored the point Caraston Hall staff had made, that they had tried to speak to Tigre without Canada present but had been unable to do so.

272. Whether or not accepting a Safeguarding Concern and potentially opening an Enquiry would have changed the immediate course of events, acknowledging the situation as an adult safeguarding risk would have provided a framework for a more effective multi-agency response. The perceived dismissal of concerns affected other agencies' recognition of the risk. Staff interviewed for the Devon

Partnership Trust Serious Incident Review said learning that both support providers had contacted the County Council Safeguarding Team without result had discouraged them from looking to internal safeguarding arrangements for help.

273. Devon Partnership Trust recognised that the risk of violence from Canada might escalate without support but did not use their own risk management system to record it. They did advise that due to his volatility their (female) accommodation officer should not meet him in person. They did not regard this as a mental health problem since he remained compliant with treatment. Although clinical notes acknowledged the risk should be recorded in the Trust's Risk Management System, this was never done. The Trust's Safeguarding Team (whose role is outlined in Appendix E) were therefore unaware of the situation. This failure to follow procedure undermined the Trust's process for oversight of risks including domestic abuse, and meant clinical staff were not offered the in-house advice available.

274. The Trust ensured that Tigre acknowledged the risk from the relationship and was seen to have capacity to make choices. She was encouraged to contact staff if she had any concerns. She was not given information about domestic abuse agencies, but it is unlikely that she would have made use of leaflets or self-referral. Staff are often faced with the dilemma of wanting to protect mental health clients from making what are perceived to be poor choices but recognizing that they must work within the law. Tigre's clinical notes contain structured risk assessments which were regularly reviewed. Her risk rating was judged to be high due to self-neglect and vulnerability. It is not clear that the risk to her was prominent in Canada's clinical records, so it may not have been considered in all the decisions made about his care.

275. Multi-agency meetings to discuss the risk from the relationship were held in August 2017 but were not based on an understanding of domestic abuse. The professionals' meeting on 10th August, mainly concerned with Canada's future, noted that he now had a girlfriend who was also vulnerable and was at risk of violence due to his history. The first full consideration of the risks arising from the relationship came in the Risk Strategy Meeting on 17th August, which explored the issue in depth. This involved Devon Partnership Trust staff familiar with each of the couple, and staff from Caraston Hall and Home Group. The relevance of Tigre's history of choices which put her at risk, and of Canada's violence to women were recognised. However, this was not put into context as a relationship with potential domestic abuse, and the focus was on possible future violence rather than coercion or control. Few of those present had received training in recognising and responding to domestic abuse. The meeting discussed confidentiality and agreed Tigre should know of concerns about Canada's violent history, but there was no consideration of involving police through the Domestic Violence Disclosure Scheme (outlined in Appendix E). Tigre's clinical records

include detailed notes of the Risk Strategy Meeting, but no minutes were produced for the other agencies involved, so there was no agreed record of the way forward.

276. Caraston Hall's internal review identified shortcomings in their records of risk and mitigating action. Their latest Risk Plan and needs assessment (dated October 2017) focused on self-neglect. Her financial and sexual vulnerability were cited, and a history of allowing male visitors to stay at Caraston overnight without permission, but there was no reference to specific risks from her relationship with Canada, such his past violence and her frequent absences. The review found that staff were concerned about Tigre and aware of the risks. However up to date records are important to ensure that all staff understand current risks and plans to mitigate them.

277. Subsequent Risk Strategy Meetings convened by Devon Partnership Trust to discuss the relationship had even less multi-agency involvement, so limiting the knowledge available. The only external agency invited was Caraston Hall, although Hollywell were still involved in November and Rethink had just taken on Canada in December. Exeter City Council had asked, the day before the November meeting, for a multi-agency meeting about Canada's accommodation, and had been dealing, separately, with the noise complaint. Despite increasing concerns about the risk, and urgent messages from Canada's family about their worries for him, no advice from the Trust safeguarding team, police or domestic abuse agencies was sought. Completion of a DASH form was noted as an action at the December meeting, but this had not been done by the time of the homicide 3 weeks later. These were missed opportunities to have the benefits of a multi-agency agreement of the level of risk and how this should be shared and mitigated.

278. Devon Partnership Trust missed opportunities to engage with Tigre. When she accompanied Canada to his fortnightly clinics, Trust staff recorded her presence, but with no reference to the behaviours displayed or their interaction with each other. Given concerns about the risks to her both from Canada and her failure to respond to contact from her own clinical team, these were chances to monitor and engage her.

279. The risks arising from Canada's substance misuse were not shared with RISE. Canada's care co-ordinator encouraged him to self-refer in September 2017, and later chased RISE to contact him, but did not brief them about any aspect of the relationship with Tigre or how his drug misuse increased risk to her. Indeed, as Canada gave only partial disclosure of the range and level of his drug use to RISE, they saw him as only low priority, so closed the case after two unanswered phone calls.

280. The neighbourhood police team covering Address A recognised the risk of violence from Canada when Exeter City Council sensibly checked before visiting to deal with the noise complaint. PCSO1 learned from police systems that Canada was on a level 1 MAPPA, and, appropriately, contacted Home Group and added to the police intelligence system their view that Canada posed a risk to women "trying to be authoritative". He warned the Environmental Health technician not to visit alone and advised the female students who had made the noise complaint not to call at Address A[34]. This approach was effective in mitigating the risk to public safety.

281. Exeter City Council Environmental Health staff took account of risks from Canada in their contacts. However, the technicians did not carry out a formal risk assessment or share the information about risk with anyone outside their team. While Environmental Health work is inherently based on risk assessment, the Council did not at the time have a set procedure for assessing risk in these circumstances but did hold an Employee Protection Register which could have logged a warning. Although the early information about the noise complaint said that Canada blamed his "girlfriend", neither the police nor Environmental Health identified a risk involving Tigre. She was present with Canada on the joint visit on 13th November. Nothing to cause concern about her was seen and following standard procedure the Council informed Hollywell as landlord that she appeared to be living there. However, under a more holistic multi-agency approach, this visit could have been an opportunity to check on her welfare.

282. Little attention was given to the risks to Tigre when Canada moved from Address A. An attempt was made to place him in North Devon, which could have ended the relationship, but this was unsuccessful, and there appears to have been no discussion of how to help Tigre adjust had it succeeded. When the eviction process finally concluded Canada left Address A on 4th December for a temporary bed and breakfast placement at Address D. While Devon Partnership Trust and Exeter City Council rightly focused on preventing him becoming street homeless, there was no recognition of the increased risk to either Tigre or his mother (who was in fact the target of his frustration that day). This was a missed opportunity to reach out to Tigre, who had lost her unofficial base, and to plan better control of Canada's access to her at Address C and to help her consider her own future. Predictably, the temporary placement quickly failed as Canada used drugs and allowed Tigre to stay at Address D. In the increasingly urgent task of finding him alternative accommodation, the risk to Tigre got little attention. There is only a passing reference to her in the social circumstances report written for the December Mental Health Act Panel, and no indication that she was vulnerable or at risk from him.

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[34] The warnings also took into account information about Resident 3.

283. In commissioning support from Rethink at Address B, Devon Partnership Trust made no mention of risk to Tigre. The key risk identified in the referral was relapse if he became homeless. Current risk of harm to others was rated as low, with the history of harm to others being described as prior to hospital admission in 2011 and problems with authority in hospital. The application for funding to the Individual Patient Placement team referred to the breakdown of Canada's placement with Home Group as being triggered by recreational drug use which their staff were unable to manage due to his challenging behaviour. The desired outcomes of Rethink work specified in the funding application made no mention of Tigre or of any other relationship. This understated the level of concern about Canada's challenging behaviour and risk to women.

284. Despite the history of the couple staying with each other in breach of their tenancies, no arrangements were made for Rethink and Caraston Hall to share information on risk. An email about Canada's attempt to enter Address C the night before he moved to Rethink, was sent to Rethink by Devon Partnership Trust two days after the event (21st December). The next day Canada completed standard Rethink documentation including a data consent form and authority to process and disclose information. However, there was no direct contact between Rethink and Caraston Hall, nor, due to data protection concerns, was Caraston Hall officially told where Canada was living. Rethink therefore had limited awareness of the nature of the relationship and of Tigre's vulnerability.

285. Rethink recognised that Canada posed more serious risks than they had expected but did not explore them fully. Rethink's internal Safety Assessment was completed on 28th December 2017 so took account of their initial experience of Canada. It rated 4 of 5 risk areas as 'high', including risk of harm to others and mood swings. However, the risks were not recorded on Rethink's client information system nor Safety Management Plans. Rethink did not contact either Home Group or Devon Partnership Trust to seek fuller information about the difficulties Home Group had in managing Canada. The Safety Assessment noted "Canada states he is not using [drugs] anymore", but there was no evidence confirming this (unlikely) change of behaviour.

286. Rethink's internal review identified gaps in their recording of information, including the decisions on Canada's verbal and written warnings for anti-social behaviour in January 2018. The link to Canada's 2011 stay at Address B when he attacked Resident 1 was not made at the time. The overall effect of the gaps in information provided, sought and recorded was that Rethink had taken on a client who, with hindsight, they judged to be on the borderline of acceptable risk for the service, without full information. While they rightly recognised that Canada posed high risks, they were not alert to the particular risks to Tigre.

Response to the risk

Overall approach

287. The concern and compassion of most staff, their commitment to seeking an appropriate response and tenacious efforts to engage Tigre and / or Canada were noted in individual agency reviews, particularly from Devon Partnership Trust, Caraston Hall, Home Group and Hollywell. The multi-agency focus group confirmed this picture, and the Review Panel commends it. The analysis that follows looks at what helped or hindered the effectiveness of those individual efforts do deal with a situation which, was, as a family member put it, “a recipe for disaster”.

Within the relationship

288. The agencies involved with both Tigre and Canada made some response to the recognised risk of domestic abuse, sometimes based on consultation with another agency. However, at no point was there a multi-agency approach to mitigating that risk involving all the relevant agencies. After the relationship had continued for a few weeks with no incidents of violence, inter-agency discussion mainly concerned the impact of Tigre’s overnight stays with Canada on both of them maintaining access to supported housing. At no point was the agreed inter-agency tool for domestic abuse risk assessment, the DASH form, used.

289. There was a proactive approach to warning Tigre that she was at risk, but it did not draw on available powers for fuller disclosure which might have had more impact on her. VCC1, on being made aware of the relationship, discussed the risk with Caraston Hall and took action with them to warn Tigre. They let her know that Canada posed a risk of violence or harm and reminded her of the risk of self-neglect. This would have been an appropriate point to invoke the Domestic Violence Disclosure Scheme thus involving the police in briefing Tigre on Canada’s past offending. The scheme allows for a complete and thoughtful disclosure appropriate to the circumstances while ensuring all data protection requirements are met. While prompt action to contact Tigre was appropriate, guidance from the Trust’s Safeguarding Team was not accessed, nor was the risk to Tigre ever logged on the Trust’s Risk Management System. These internal systems could have prompted consideration of use of the scheme.

290. Individual agency plans tended to focus on other significant risks, for example of aggression from Canada towards staff, or of Tigre’s self-neglect harming her physical health. Devon Partnership Trust concentrated on the impact on the mental health of each of them – for example Tigre missing her medication. They did not consider the wider implications of Canada’s level of risk, Tigre’s vulnerability, their mutual reinforcement of harmful habits or the increasing

squalor in which they lived. Multi agency solutions providing comprehensive support to both were not sought.

291. In the three risk strategy meetings held by the Trust the focus was directed at mental health interventions only and not the wider implications of risk management and Tigre's vulnerability, including potential domestic abuse. While meeting notes were recorded in Trust clinical records, no minutes or action plans were sent to other agencies. Thus the meetings did not result in any form of plan being agreed by and available to all the agencies involved. Although the social circumstances report prepared for the December Mental Health Act Panel had standard questions about risk to others, the answers given made no mention of domestic abuse or of risks arising to either from the relationship, so the Panel did not address this when renewing the Community Treatment Order conditions.

292. In considering responses, agencies rightly took into account the Mental Capacity Act and the right of adult service users to make potentially unwise choices. Tigre's capacity was explicitly considered in contacts with her between July and September, but a formal assessment was not undertaken. However, after that, although Caraston Hall was the only agency with direct contact with her, there was no formal reconsideration of whether she retained capacity to make decisions concerning Canada. There was reason to think her capacity to consent might fluctuate, as she was observed to be neglecting her health, to be with him under the influence of drugs and alcohol; and concerns had been raised about Canada having a controlling effect on her.

293. At the time of the homicide Devon Partnership Trust staff were considering identifying shared accommodation. This was not an appropriate solution given the level of concern and risk presented by Canada and the fact the clinical record reflects that Tigre appeared less committed to her relationship with Canada. This option was prompted by the reality that both ignored rules about overnight visitors in separate accommodation. However it bypassed the task of supporting Tigre in making an informed decision about her future which would have allowed her to safely end the relationship. Moreover, neither had been offered any help targeted at helping them understand what healthy relationships involve.

In care for Tigre

294. The response to Tigre focused on trying to re-engage her with services both at Caraston Hall and Devon Partnership Trust. VCC1 was tenacious in her attempts to engage with and support Tigre even though the size of the caseload for staff within the Active Review Team was significant. Caraston Hall staff took appropriate actions when she turned up, for example offering pregnancy tests, helping her with hygiene, offering assurance and sometimes turning Canada away. They also made efforts to reach her at Address A when she disappeared

for longer periods. However, their documented plans for her did not name Canada or include proposals for reducing the risk of domestic abuse.

295. Indeed, the Caraston Hall internal review found a number of failings in internal record keeping and led to a further review of paperwork and new operating practices and procedures. Key meetings with Devon Partnership Trust staff were generally only indicated in the Caraston Hall clinical record by the date of occurrence, it not being usual practice to record the content or outcomes. There was no evidence that these meetings led to amended or re-prioritised planning. The support plan and risk management plan for Tigre were incomplete and inadequate. This could have prevented support staff delivering the agreed interventions consistently in line with agreed support goals.

296. Devon Partnership Trust's transfer of Tigre from the Active Review Team to the Community Mental Health Team in October was well intended but counterproductive. While it increased the staff time available to engage her Tigre's new Care Co-ordinator never met her, despite making repeated attempts using different methods of contact and seeking advice from colleagues for more intensive support as her needs increased. These attempts were hampered by two factors. For her own safety VCC2 rightly avoided visiting Address A alone to find Tigre, but was thus limited to inviting her to Caraston Hall or clinics, or accompanying PCC2 when he went to Address A. As she worked part time, she had limited scope to seize opportunities to engage a client as unpredictable as Tigre. The net effect was that the connection VCC1 had made with Tigre and with other agencies was lost, and VCC2 had no personal knowledge of Tigre to draw on in discussing the way forward. The Trust's Serious Incident Review noted a wider issue of fragmentation within its community services, pointing out that the transfer of clients between teams presents problems with continuity of care and the development of positive and therapeutic relationships with clients. As a result of this the Trust made policy and practice adjustments which aim to ensure patient need is at the forefront of decision making.

297. During 2017 clinical staff considered detaining Tigre under the Mental Health Act for Tigre and judged that it was not appropriate. The Devon Partnership Trust Serious Incident Review judged that these were clinical decisions made by senior and experienced clinicians and appropriately recorded. The Mental Health Act requires the 'least restrictive option' and the associated code of practice is clear that if a patient can be safely and lawfully treated without detention they should not be detained.

298. There was no contingency planning as to how to help Tigre should she want to end the relationship, although separation is known to raise the risk of domestic abuse. (It is identified as a risk factor in the DASH form, but that was never completed for her, and as discussed below some staff had not been trained in its use). The recommendation that an alternative placement for Tigre be sought

remained in the Caraston Hall support plan, but no action on this was taken during the relationship. In a rare phone contact with her Care Co-ordinator in November she said the relationship was over. This was an indicator of increased risk, which was not recognised, and also a brief opportunity to engage her and explore her wishes which could have been seized had agencies been alert to its importance. While the separation lasted only a few days, information gained from fellow residents after the homicide indicates Tigre was getting tired of Canada. Moreover, within 3 weeks he was due to leave Address A, disrupting their pattern of life. The only planning for her future, had Caraston Hall proceeded with the eviction, was for her to live with Canada. Had the homicide not happened, this would have made it harder for either of them to end the relationship.

299. From mid 2017 on Tigre had withdrawn consent for both Caraston Hall and Devon Partnership Trust to give her father information about her. As she was an adult, staff were obliged, under most circumstances, to respect her confidentiality and her instructions on sharing personal information. However, they could have maintained more contact with him than they did under the principles set out in the Trust's 2018 Carers Strategy (written after this tragedy) which allow "general" information still to be shared. General information would not, however, include informing Tigre's father than she was in a relationship with Canada, nor that he had a history of posing a risk to women.

300. Given Tigre's long history with mental health services and tendency to withdraw and renew consent for contact, it would have been helpful if the Trust had invited her, in a more stable phase, to make an Advance Statement to enable relatives to be contacted in particular circumstances, although this would have been over-ridden by her subsequent insistence that no information was shared with her father. Late in December 2017 Tigre agreed orally that information could, once again, be shared, but as this was unwritten it was not acted on. It is unlikely that someone whose lifestyle is chaotic would take time to write their instruction.

In care for Canada

301. Devon Partnership Trust focused on managing Canada's mental health through ensuring he took his medication and was seen at clinics. Although they understood the level of risk they judged that Canada was mentally well and that efforts should continue to support him in the community despite lapses in compliance with the terms of his Community Treatment Order. Clinicians challenged him regarding his behaviour, but his recorded responses followed a pattern of claiming he was now compliant. The lack of continuity in medical staff overseeing the Order may have contributed to tolerance of Canada's behaviour. Senior experienced clinical staff made judgements not to revoke the Order even when there had been clear breaches of conditions and he could have been

recalled to hospital. These clinical decisions are well documented, recording that there was no evidence of a deterioration in his mental health.

302. In Trust contacts with Canada, consideration was given to his mental state and to the level of risk, but not to addressing his criminal behaviour. Trust staff suspected that Canada continued to take illicit drugs during the course of his care and had been told this by Home Group and his family, but there are no entries in his clinical records made about any actions taken to address this, other than random urine testing. The Devon Partnership Trust Serious Incident Review is clear that this use of illicit drugs was in breach of Community Treatment Order requirements and could have resulted in his recall to inpatient care. This could have benefitted him, by interrupting access to drugs, and have disrupted the relationship to protect Tigre.

303. In focusing on whether Canada's mental health had deteriorated, Devon Partnership Trust did not address the impact on him or others of the withdrawal of the Home Group service they had commissioned. His mental health was no better, and his behaviour worse, than in October 2016 when he was assessed as needing daily on-site support to live in the community. His ability to understand forms and systems remained limited. Although it was clear that finding new accommodation would take months, there was no referral for alternative floating support. The Trust's Serious Incident Review found no suggestion that financial constraints directly affected the level of care offered.

304. For nearly five months Canada received a far lower level of contact than agreed and funded. His family repeatedly expressed their concern about this, the effect on his health, and the impact on them. His Care Co-ordinator undertook some tasks support staff would have done, eg accompanying him to court and reminding him about clinics. Exeter City Council liaised with the Care Co-ordinator to provide the housing advice due to a vulnerable adult, also providing advice for Canada's mother, who was helping him buy food and worried that she might be expected to take him in. However, these inputs could not replace the support package commissioned to accompany the Community Treatment Order.

305. There were only limited attempts to address the behaviour which had caused Home Group's withdrawal. Devon Partnership Trust recognised that Canada's known drug misuse would make him unacceptable to many local providers and got him to self-refer to RISE. The referral was seen by RISE as low priority, based on the limited information Canada had disclosed, despite chasing by the Care Co-ordinator. They closed the case after two unanswered phone calls, without reporting back to the Trust. There was no impact on the substance misuse.

306. The October 2017 renewal of the Community Treatment Order weakened the position further by removing the conditions relating to substance misuse and

residence. This endorsed what had become the position in practice: that Canada could be confident of avoiding a recall to hospital provided he attended for his depot injections and presented well at appointments with Trust staff. This reflected the Trust's focus on his mental health, and the position that only the conditions directly relating to mental health treatment could be enforced.

307. No progress had been made by October in finding alternative supported accommodation for Canada, who was reluctant to engage with the process. Caraston Hall were even asked to consider taking him, but rightly refused given the risk to Tigre (and other female residents). The Trust's Accommodation Officer pointed out that Canada would need to consider placements out of area, but only one (in North Devon) was visited. The focus on finding an Exeter placement was understandable given the wishes of Canada and his family, and the risk of further discontinuity in his clinical care. However, this delayed finding a provider able to cope with him. Given the difficulty in finding a local solution, a wider search for providers able to take on his risks should have been considered.

308. Exeter City Council's Housing Options and Environmental Health teams did not contact each other about Canada although they were working with him at the same time. Housing Options were aware that anti-social behaviour was the reason behind Canada's eviction and Environmental Health knew that Housing Options potentially had a role to play in terms of finding Canada further accommodation. Both teams recognise that it would have been useful to have a fuller picture of Canada's circumstances to enable them to respond. Their contacts were not a missed opportunity to identify domestic abuse, as the officers concerned knew other agencies including police were already involved and did not themselves witness situations of concern.

309. Despite more than four months warning, Canada's eviction from Address A left Tigre, the public and his family at risk. When he moved to emergency accommodation arranged by the City Council at a guest house (Address D) there was still no support arrangement in place, and he soon lost the room through breaking rules. Before a placement was agreed with Rethink, Canada broke into Address A to find bedding.

310. The failure to find an alternative before the eviction shows a misalignment to need of either the process for assessment, or the local provider market, or both. While it was appropriate for Devon Partnership Trust and the City Council to help Canada understand his legal right to challenge the eviction, his hope to be able to stay in Address A and invite Tigre to move in was never realistic. Home Group offered insights into Canada's support needs from their experience. However, there was no full multi-agency assessment of the type of support package Canada needed, or explicit consideration of how options for him would affect risk to Tigre. Communication with his family did not adequately address their anxiety about him. This may have influenced the Trust's underestimate, in information

given to providers, of the risk he continued to pose. Their view, eg in the December 2017 social circumstances report, that he could live in privately rented accommodation provided he took his medication and had some tenancy support ignored the history of nuisance to neighbours and threats to women in authority.

311. Rethink's internal review recognised that their record keeping and planning for Canada did not meet the standards detailed within their Integrated Support and Safety Planning Policy. While Rethink undertook their own risk assessment and identified risks they had not been briefed on, the only goal recorded in their client information system for Canada was to have day to day contact with staff. No Safety Management Plans were included, despite preventative action having been identified in their Safety Assessment. This meant their staff response to Tigre's visits to Address B was not well informed.

312. The 27th December formal review of the Community Treatment Order by a mental health panel did not take full account of Canada's situation. They heard assurances from Canada about his substance misuse, but these were not tested for credibility against other evidence. The Trust's investigation of the complaint by Canada's sister, written within a few working days of this, blamed his "continuing illicit drug use" for the delay in finding accommodation. The panel did not hear about problems Canada was causing at Rethink, or about the continuing risks to Tigre. The panel did, however, continue the Order, against Canada's expressed wish to end it.

313. Devon Partnership Trust's communication with Canada's family over the period of his relationship with Tigre was below the expected standard, although consent from Canada was in place. In the light of his mother's frequent contact with him, including assisting him with shopping and housing applications, she was acting as a carer in the terms recognised by the strategy adopted by the Trust in 2018. She and other family members felt their concerns and questions were not addressed and calls not returned. Through an administrative error the Trust had addressed correspondence to Canada's father, who was the Nearest Relative recognised by the Mental Health Act, to his mother's address. His father was therefore unaware for several months that Canada had left Langdon Hospital.

314. The Trust's PALS service did not recognise that Canada's sister's mid-November email expressed a frustration which required more than a reminder that she could contact the care co-ordinator. Her more formal complaint the following week was recognised as such and an investigation started, but the urgency of the concerns the family were raising about Canada's condition was not recognised. Rather, they received an explanation of the Trust's actions to house him (but not of the gap in support staff) in a letter approved by the Chief Executive before the homicide but posted after. The administrative failure to recognise the name and recall the letter reinforced the family's perception that

no-one was listening. A separate error by Enable East in giving their phone number for contact during the Serious Incident Review compounded this.

Alternative responses

315. All agencies, with hindsight, recognised that an agreed inter-agency approach to the whole situation was essential. While the analysis above has identified points at which communication, consultation and record keeping could have been better, it is unlikely that these alone would have affected the outcome. This section considers some of the frameworks that might have been used to design, plan and deliver a more holistic approach, drawing in expertise which was not used, particularly on domestic abuse.

316. Maintaining Canada and Tigre safely in community placements was challenging given his lack of insight into his condition, her tendency to accept risks in relationships and the legal limitations on restricting their choices or ensuring compliance with agreements on behaviour. In analysing alternative courses of action agencies could have taken, the Review recognises that there is no assurance that these would have prevented this homicide or another adverse outcome.

Involving substance misuse specialists

317. Drug misuse was a key factor in this tragedy, but only token efforts were made to address it. For both Tigre and Canada it disrupted their engagement with health and housing services, and it seems likely that once together they mutually reinforced their substance misuse. It may have led to fluctuating capacity to recognise risks and exercise choice. There was no indication that either was dealing in significant quantities or was being exploited by a criminal network.

318. Although the initial form of the Community Treatment Order had conditions that Canada should not use drugs or excess alcohol, he was given no specialist help to address these habits in the community. Home Group and Devon Partnership Trust staff encouraged him to desist, but it was not until nearly a year after leaving Langdon that he was put in touch with the treatment service, RISE. Had a proactive referral been made, or information about the positive drug tests been shared, the treatment service would have reprioritised him into structured treatment, rather than having to accept his assertion that cannabis was the main drug of choice and not at a problematic level.

319. An even more effective approach would have been communication between Devon Partnership Trust and RISE prior to discharge from hospital. This might have resulted in Canada and his support workers having a trusted contact in the treatment service from the start of his placement at Address A. It might have helped him accept that drug screening tests conducted under the Community

Treatment Order were for his benefit. There are arrangements for such pre-release contact for offenders leaving Devon's three prisons.

320. There was little opportunity for police to use their powers to tackle Canada's use of illicit drugs, although their intelligence records did note suspected drug use at Address A. The only drug offences on his criminal record were for possession of cannabis in 2005 and earlier. Magistrates do not grant a warrant for police to enter properties unless offences are substantial and have wider public interest. Police could have seized drugs and charged Canada with possession if they had seen them when visiting for other purposes, or if shown drugs found by Home Group or Hollywell staff. Without good reason to think Canada was carrying a substantial amount of drugs a stop and search under the Misuse of Drugs Act would not have been justified. Testing for riding his motorbike under the influence of drugs would have been justified had that information been passed to police. Without specific information such a vehicle stop would have been a general policing response if the motorbike was seen mobile. Neither this nor possession would have been likely to bring a custodial sentence.

Involving domestic abuse specialists

321. Professional advice on domestic abuse should have been sought. The risk that Canada would harm Tigre was identified almost as soon as the relationship started. However, while the term "domestic abuse" was used in some discussions within agencies and in inter-agency meetings, the problem was not framed as this. As discussed below, many of the staff involved had not had an appropriate level of training in safeguarding at the time. Advice was available, both within Devon Partnership Trust through its Safeguarding Team, and to staff of any agency through the commissioned provider of domestic abuse services in Devon, Splitz. This could have been given despite Tigre herself being unlikely to seek or accept direct help from Splitz. Devon County Council Safeguarding Team should also have been able to signpost advice on domestic abuse to any agency, regardless of whether they recorded a safeguarding concern.

322. Advice to the professionals involved from a domestic abuse specialist would have been of value both when the risk was first recognised and at key decision points thereafter. In particular, this would have challenged the proposal from the December risk strategy meeting that the couple might share accommodation, and that a meeting with both present was the right way to ascertain their wishes. However, any approach to help Tigre choose a safer way forward would have been reliant on her engagement.

323. Splitz operates a single point of access helpdesk. This function takes referrals and assesses the risk and needs of victims of domestic abuse, but also provides advice and information to professionals, members of the community and family members. Due to the number of calls into the helpdesk, early in 2017 a

specific professionals' line was set up to fast track their enquiries. Splitz also offers training and workforce development, and staff frequently attend team meetings and forums to brief other professionals on identifying domestic abuse and making referrals.

Using formal multi-agency frameworks

324. The Devon Partnership Trust Serious Incident Review concluded that a fundamental reason for the tragic death was the absence of a robust multi-agency approach to the complex needs of both parties, and staff having too narrow a focus on their mental health status. Canada presented a challenge to many agencies but did not easily match the requirements of their systems and processes to allow a positive response. The Risk Strategy Meetings convened by the Trust invited one or two external agencies, but, in effect, took their views into the Trust's own planning, rather than producing agreed multi-agency plans.

325. Several multi-agency frameworks could have been used, each with established working procedures: a Safeguarding Enquiry, re-referral to MAPPA or referral to the Multi Agency Risk Assessment Conference (MARAC) which looks at high risk domestic abuse cases. While these differ in their remit, and to some extent in membership (see Appendix E), they would basically have brought the same agencies to the table. None of the frameworks gives any additional resources or powers to act. However, any of them would have brought recognition that management of the risks required multi-agency collaboration; clarity on seeking consent to share information, or to justify sharing it without consent; assessment of the level of risk based on more informed input on domestic abuse, substance misuse and offending; and a shared record of what had been agreed. Of the three, MARAC was probably the most relevant to preventing the homicide. Any of the agencies could have made a referral to MARAC based on professional judgement.

326. Several factors contributed to the frameworks not being used. The only one attempted – referral to Safeguarding through Devon County Council – had not been accepted, influencing expectations all round. The non-statutory agencies were not clear that they could refer direct to MARAC or MAPPA and expected Devon Partnership Trust to be the agency that would do this if required. This was reasonable, as, unlike them, the Trust had access to information about both parties. However most of the Trust staff involved had not, at the time, completed the safeguarding training that covered domestic abuse risks assessment and referral to MARAC, and did not alert their own Safeguarding Team via the internal risk management system. While Home Group had significant concerns about the potential risk from Canada, they knew very little about Tigre, could not have used the DASH form, which is victim focused, as a way in to MARAC.

327. As discussed earlier, Canada's MAPPA status was ambiguous and forgotten. Whilst the police receiving the information about Canada's anti-social behaviour in 2017 did not identify a particular risk at the time, the officer was aware of the MAPPA unit where advice could have been sought. Other agencies should also have a point of contact with knowledge of MAPPA who can advise those with concerns about the process and whether a referral is appropriate. This would assist them to flag up concerns based on the actions of a potential perpetrator rather than knowledge of the victim.

Empowering problem solving at the front line

328. While formal frameworks are useful, a key factor in working with people with complex needs whom services find difficult to support is collaboration at the front line, both for individuals and, where appropriate, couples. A culture that supports this is important. There were examples of staff reaching out across agencies to protect Tigre, for example when Caraston Hall and Home Group responded to the start of the relationship, in the two Devon Partnership Trust clinical teams discussing the risks and police supporting environmental health. However, the default position was that each agency focused on its own remit and priorities, so staff did not benefit from a shared picture or goals. There was limited progress in engaging either Tigre or Canada in positive activities prior to their meeting, and none after it, with the focus mainly on the basics of daily living and avoiding harm. Incomplete records also left some support staff reliant on oral briefings on risks and plans.

329. To ensure they engage effectively with the unique circumstances of each individual, including their relationships, staff need to understand how their own contribution to progress and safety fits in with that of others. All also need to be aware of triggers that could escalate dangerous behaviour, and how to respond. A culture which encouraged front line staff to recognise and solve problems through collaboration, seeking permissions as needed, might have found better ways to monitor both Tigre and Canada during the second half of 2017. For example, the environmental health officers could have been encouraged prior to their visit to look out for Tigre, seeing her as a potential victim as well as an accomplice to anti-social behaviour. Devon Partnership Trust could have offered contact to Tigre at Canada's scheduled clinics (where he had to stay for 2 hours monitoring after each injection). Caraston Hall and Rethink could have prepared a joint plan for responding to attempted overnight stays, either seeking their clients' consent to share relevant information, or justifying it on the basis of the risk to Tigre (and to others at Address B given her history of accidentally starting fires).

330. Devon Partnership Trust does have experience of enabling such frontline collaboration. The Care Quality Commission report (discussed below) "found good examples of staff working closely with local teams such as the police and

the local housing services. Staff had worked with them and attended meetings in order to share risks and to build relationships for the benefit of services users."

Revoking the Community Treatment Order

331. Devon Partnership Trust could have recalled Canada to their secure hospital in July 2017, and possibly later on, for not complying with the terms of his Community Treatment Order. This was what Home Group and (later) his family wanted and thought justified, based on their observations – reported to the Trust - of his behaviour and health and the risk to others. However, the threshold for recall under a Community Treatment Order is relatively high. The criteria are that recall to hospital is needed for treatment of the mental disorder and that there would be a risk of harm to the patient's health or safety or to others if not recalled.

332. As discussed earlier, these were clinically marginal decisions, and fuller attention should have been paid to the views of those in frequent contact with Canada. The Community Treatment Order had been made on handover from the forensic hospital, but the community mental health clinicians reviewing it had not (through staff turnover) been involved then. Canada was sufficiently skilled in his presentation to mental health professionals to make them doubt they could argue successfully for recall, particularly in a system where there is considerable pressure on resources, especially beds. Availability of forensic hospital beds was a background pressure: Langdon Hospital occupancy in 2017 was 100%, as has been the case for several years.

333. While such a recall would, with hindsight, have protected Tigre, at least from Canada, it would only have postponed the question of how to enable him to live safely in the community. One purpose of Community Treatment Orders is public safety, but they are not intended to result in someone being returned to hospital whenever their behaviour is problematic. Canada might have successfully challenged further detention through a Mental Health Act tribunal. However, in the time that took Tigre might have re-engaged with her own support.

334. The recent Independent Review of the Mental Health Act[35] is in general terms critical of Community Treatment Orders and calls for numbers to be halved. It agrees there is a role for them, giving people who have been on a hospital order as an example, but sees better support in the community as preferable. The real issue for public services is how that can be provided safely. Home Group and Hollywell understood the Community Treatment Order to be an assurance that mental health services would keep Canada compliant with its conditions including those on substance misuse. This was to overestimate its powers.

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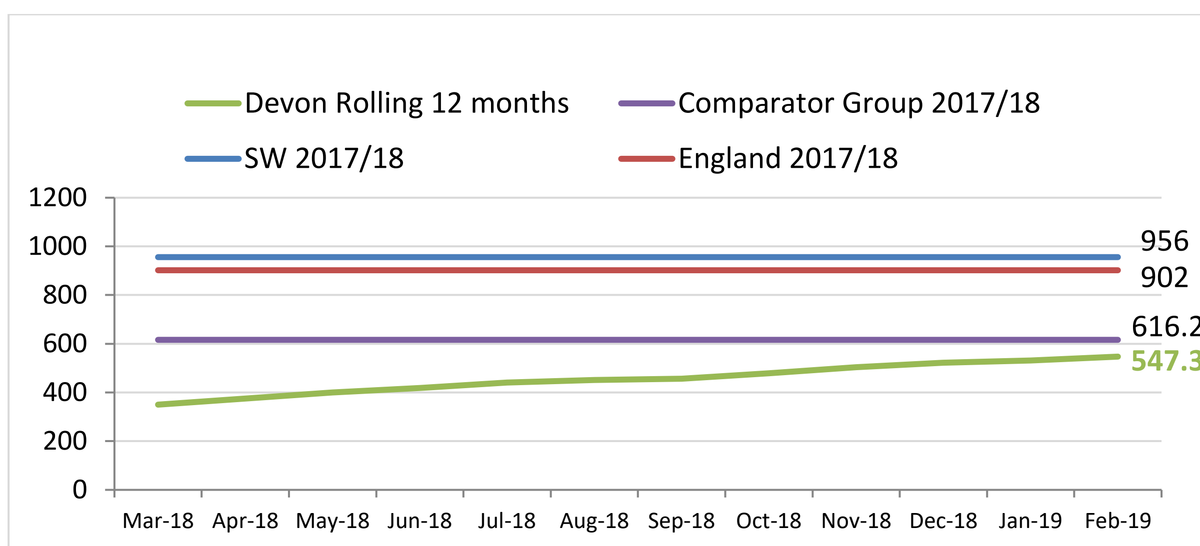
[35] Modernising the Mental Health Act Increasing Choice, Reducing Compulsion Dec 2018

System issues

Safeguarding

335. Devon County Council's Safeguarding Team decided the situation did not meet the criteria for their involvement despite two housing providers attempting to raise a concern. This response was not unusual for the Council at the time. National data first published in 2018 demonstrates that in 2017/18 Devon recorded a low level of "safeguarding concerns" compared to other authorities, taking account of population size. As illustrated in Figure 1, the rate increased in the year following the homicide, as the Council changed its practice, so the gap probably reflected the Council's response more than how many people were at risk or how many people contacted the Council with a possible concern.

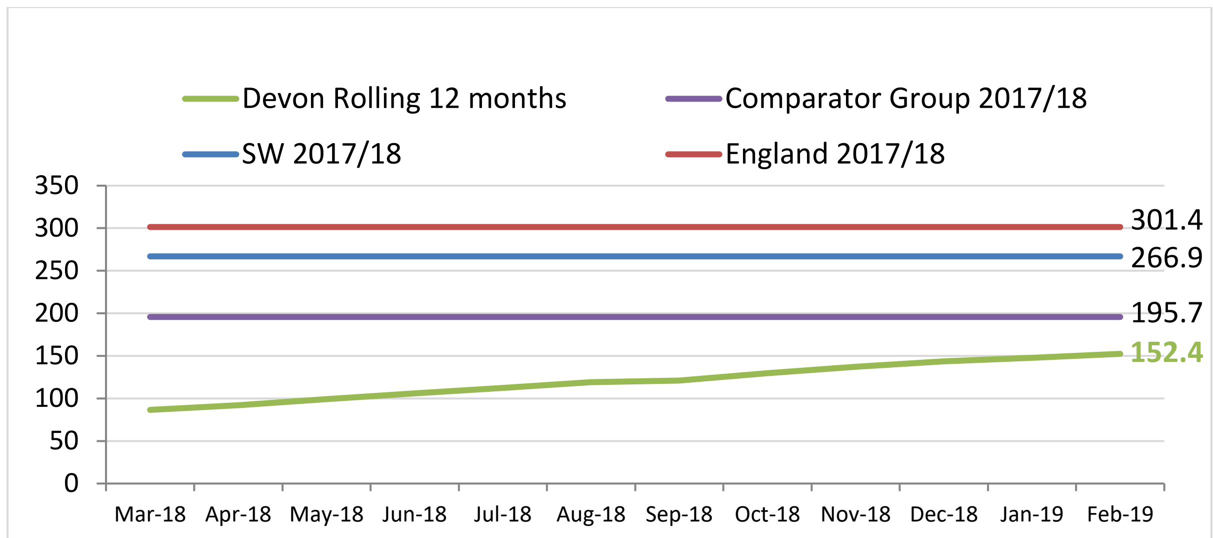
Figure 1: Safeguarding concerns per 100,000 population[36]



336. In 2017/18 of the concerns recorded within DCC only 25% were converted to an enquiry. The rate for England was 38%, but this is an experimental statistic[37], so differences in terminology and recording practice may contribute. Again, the gap reduced during 2018, following a "deep dive" analysis of local practice prompted by the national figures (Figure 2).

Figure 2: Safeguarding enquiries per 100,000 population

[36] Comparator group refers to a group of councils with a similar context.
[37] Experimental Statistics are official statistics published to involve users and stakeholders in their development and to build in quality at an early stage. Limitations may apply to the interpretation of these data.



Accommodation and support

337. The challenge of finding new accommodation and support for Canada was in the context of increasing need and stretched services. Both at Panel meetings and at the Learning Event there was a clear view that his situation was not exceptional. This is a local reflection of a national situation. For example, Clinks, the umbrella organisation for voluntary agencies working with people in the criminal justice system, reported[38] that “The number of service users continues to rise with 55% of organisations telling us the number of people they are working with increased…. This year, again, the overwhelming majority of organisations report that the needs of their service users have become more complex (80%) and urgent (73%). .. This ongoing trend will be having a cumulative impact on voluntary sector services, their staff and volunteers. It is likely to be putting them under increasing pressure as they work to address and meet the needs of their clients. Further, this finding also indicates that service users are likely to be experiencing sustained levels of complex and urgent needs.”

338. These pressures damage trust between agencies, which can lead to defensive rather than co-operative action. Exeter City Council Housing Options staff recognised that if Canada were discharged from mental health support due to non-engagement, which PCC2 raised during the 15th August 2017 meeting with them, a risk arose as they still had a duty to house him. The City Council has found that this is a regular occurrence but that there is no mechanism for responding to such concerns. Hollywell concluded in their contribution to this Review that they needed to “to review our … risk appetite ..and .. better interrogate partners’ commitments to support and supervision ...Without greater

[38] Clinks: The state of the sector 2018 / Key trends for voluntary sector organisations working in the criminal justice system.

assurances and support from statutory partners Hollywell is less likely to take on tenants with greater levels of complexity."

339. Arrangements for national oversight of this provision, beyond general provisions of company law, health and safety etc, are patchy. Charities and housing associations are accountable to national regulators whose main remit is finance and governance rather than quality. The Care Quality Commission only has a role where clinical services or personal care are provided.[39] There is no generally applicable user feedback or peer review system. Services may have multiple commissioners. The Chair of the Charity Commission recently drew attention to the "problem in the supported housing sector … that there is no shared understanding – between providers and beneficiaries - of what 'supported' accommodation means and how much individual support people residing in such settings can expect, and there is no framework of oversight, ensuring that support provided to individuals is sufficient."[40]

340. Given this context, clear agreement between commissioners and providers on the scope and standards of services is vital. Devon County Council contracts Devon Partnership Trust to manage the provision of identified accommodation needs for individual clients of mental health services. Funding for each placement is approved through application by the client's care co-ordinator to a Trust panel which includes clinicians and managers. There is a contract, for each client, between the Trust and housing provider, which specifies the level of support required from the provider and the value of the contract. However, it does not detail the level of clinical support to the client that the housing provider can expect from Trust staff or from other agencies. This causes tensions between housing providers and the Trust about what should be expected from their services. Concerns were raised by Home Group, to this Review and in the Trust's Serious Incident Review, that clinical staff did not understand what their staff could, and could not, offer. Concerns about commissioners' matching of clients and services have also been raised in recent Safeguarding Adults Reviews in Devon.

341. Although not a requirement of their agreement with Devon County Council, Devon Partnership Trust does monitor the accommodation and related support commissioned. There is no national system for inspection of the quality of such services unless they carry out one of the activities regulated by the Care Quality Commission. However, the Trust has a system to ensure contractual requirements are met by accommodation providers, with a checklist of points to review on regular visits, including looking at the property and reviewing a sample

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[39] This did not apply to Caraston Hall, Hollywell, or the services provided by Home Group at Address A or Rethink at Address B .

[40] Speech by Baroness Stowell, Charity Commission Annual Public Meeting, 3rd Oct 2019.

of care plans. Under this scheme Caraston Hall had bi-monthly visits from the Trust's social care contract and review manager. Home Group reported a good working relationship with the Devon Partnership Trust Individual Patient Placements team and believe they are well supported by this team.

342. It is the responsibility of the Board of a private or voluntary sector agency providing housing or support to ensure policies and procedures are set in line with any relevant legislation or national standards and that there are arrangements to ensure compliance. Home Group and Rethink, providers with national scope, use internal quality assurance systems. However, Rethink found risks from Canada identified by their staff had not been recorded properly on their main internal systems. Caraston Hall's internal review found that there appeared, at the time of the homicide, to be no standard operating procedures in relation to support planning, review and recording with which to cross reference support plans.

Skills and training

343. In a system under pressure, effective working with other agencies is key to making the best use of available resources to support vulnerable people. This case has illustrated how skills in this are important at all levels. Devon Partnership Trust's Serious Incident Review said that staff would benefit from regular clinical supervision and / or action learning to develop skills and explore thinking around the management of complex cases, and to share learning and good practice. Development of such skills is likely to be of increasing value to all agencies.

344. Many of the Devon Partnership Trust staff involved in the provision of care, and in risk management meetings convened to consider the risks posed by Canada to Tigre were not up to date with mandatory training requirements. Policy in 2017 required the clinical staff concerned to be trained to Level 3 safeguarding which is designed to improve awareness and knowledge relating to safeguarding of vulnerable adults at risk. A new approach to Safeguarding Training introduced by the Trust that year increased compliance with this level from 10% in June 2016 to 48% (600 staff) in January 2018. However, several key staff involved with Canada or Tigre, including PCC2 and VCC2, had not undertaken the training by the time of the homicide. In the Community Mental Health Team as a whole, while 98% had undertaken basic Safeguarding Training by July 2017, only 17% of those required to had undertaken the Level 3 training.

345. Completion of the training would have provided a better understanding of domestic abuse, and of the systems in place within the Trust, which could have supported the efforts of Trust staff to identify and address the risks. The mandatory training includes comprehensive information on domestic abuse, use of DASH risk assessment, the Domestic Violence Disclosure Scheme and Multi

Agency Risk Assessment Conferences (MARAC). It reminds clinicians of the mandatory questions on domestic abuse which should be included in all assessments and routinely reviewed. In addition, it includes information on how to refer and on escalation processes, where clinicians have concerns that a referral has not been triaged as meeting the criteria for a safeguarding enquiry. The Trust also offers optional stand-alone training on domestic abuse through e-learning and face to face. Training is supported by use of workbooks, leaflets and self-help guides and web-based information available to both staff and patients.

346. Devon Partnership Trust's contracts with accommodation and support providers do not specify the level of training required for staff. Caraston Hall's Safeguarding Adults from Abuse Policy for 2017-18 covered domestic abuse and included provision for all staff to undertake the Devon County Council Safeguarding Adults Alerter's course, and Service Managers to complete Level 3 Practitioner training. All staff have to complete mandatory safeguarding training every 2 years and safeguarding is part of staff supervision sessions, provided every 6 weeks. Rethink expected all staff to complete a mandatory safeguarding adults e-learning package, which includes domestic abuse, as part of their 12 week induction. Managers are responsible for ensuring that training undertaken by staff is discussed in supervision so understanding of safeguarding is clearly established and further support identified if required. This can be delivered by individual safeguarding briefing sessions developed by the charity and available to all managers. At the end of 2017 74% of staff at Rethink's Devon Supported Housing Service had completed safeguarding training. currently 100% of staff have completed safeguarding training.

347. Exeter City Council identified through its Internal Management Review that their housing and environmental health staff who were in contact with Canada would have benefited from training on domestic abuse, to enable them to recognise situations of concern, know how to refer to the appropriate agency, and challenge other agencies if they do not feel risk is being appropriately addressed.

Recognising the risk of violence

348. Strangulation is known to be a common method used by male perpetrators of domestic homicides on female victims. The DASH form takes account of this risk in the question: "Has [name] ever attempted to strangle/choke/suffocate/drown you?", and practice notes to the form say that any attempt at closing down the victim's airway should be considered high risk. Strangulation may often not produce visible injuries but may cause injuries internally. It is recognised in guidance to police and paramedics on "red flag criteria" requiring hospital assessment.

349. Canada's recorded criminal history did not highlight his past use of partial strangulation. (His father noted that this was a technique he had adopted for self-

defence when younger.) Due to the lack of visible injuries strangulation is often recorded by police as a common assault, which does not reflect the potential for serious or fatal injury. Domestic violence is itself considered an aggravating factor, so a strangulation in a domestic abuse context should be recorded as a more serious offence. The Crown Prosecution Service Charging Standards allow for a wider view. “The degree of harm caused will in many cases be more than just the level of injuries sustained. There will be cases where, although the level of injury may be quite minor, the circumstances in which the assault took place e.g. repeated threats or assaults on the same complainant or significant violence (e.g. by strangulation), make a charge of Actual Bodily Harm appropriate rather than one of Common Assault. There should be an assessment of the overall harm caused when deciding on charge and awareness that the level of injury is simply a part of the overall harm.”

Pressures on community mental health services.

350. The Care Quality Commission’s unannounced inspection of Devon Partnership Trust in November 2017[41] found that overall the Trust provides a Good service, as had the previous inspection (December 2016). The rating for Forensic Inpatient / Secure Services (covering Langdon Hospital) improved to Excellent, and the Trust’s regional leadership on forensic care was commended. However, the rating for Community-based Mental Health Services for Adults of Working Age (previously inspected in 2015) went down from Good to Requires Improvement.

351. A significant factor in this was staffing capacity. Long term sickness and vacancies within teams had impacted assessment times and the size of staff caseloads. Staff shortages also impacted on the ability to safely deliver the duty phone services where patients could phone in to access support. Staff felt that they were not always provided with the resources to deliver the services effectively: for, example, cover for sickness and vacancies. In July 2017 the Community Mental Health Team had a vacancy rate of 11% overall, 17% for qualified nurses.

352. The Trust’s Serious Incident Review reported that:

- There are a number of community based clinical teams within Devon Partnership Trust, with differing responsibilities resulting in unclear pathways. In addition to unclear pathways, levels of vacancies and changes in personnel inhibit the development of therapeutic long term relationships with clients. Changes in both medical and non-medical staff

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[41] Visit 27th – 29th November, report published May 2018.

supporting Canada had an impact on relationships and partnership working.

- "In interviews with many Trust staff and staff working in partner agencies there was a level of concern expressed about the deterioration of partnership working due to increasing pressures faced by community services, and increasing fragmentation of this service."
- "Home Group expressed concern that the care coordination service is severely stretched. They reported the crisis service to be unresponsive and unhelpful, reluctant to see people in their own home and overly restrictive in terms of accepting referrals."

Conclusions

353. This tragedy illustrates a system failure to prevent the killing of a woman, vulnerable through mental health and drug misuse, by a man who shared these vulnerabilities and had a history of aggression to women. This occurred despite both having support allocated from publicly funded services, though that support was hampered by their lack of engagement. The risk was recognised, but the attempts to mitigate it were ineffective and did not draw on available frameworks for addressing domestic abuse.

354. This section sets out the lessons learned from this Review along with progress already made on some of the issues. The Recommendations which follow show how the lessons will be applied.

Lessons to be Learned

Inter-agency response to people with complex needs

355. Agencies need work together to help clients with significant and complex needs. A focus solely on their own core responsibilities, such as making decisions based only on mental health, is insufficient to mitigate risk and promote wellbeing. To quote recent national research, to which Devon agencies contributed: "People are complex: everyone's life is different, everyone's strengths and needs are different. The issues we care about are complex: issues – like homelessness – are tangled and interdependent. The systems that respond to these issues are complex: the range of people and organisations involved in creating 'outcomes' in the world are beyond the management control of any

person or organisation…. [so agencies should work together in] a way that is human, prioritises learning and takes a systems approach."[42]

356. Devon Partnership Trust's Serious Incident Review rightly concluded that the Trust needs to develop more robust arrangements for the management of complex cases. "Complex" should not just mean individuals recognised by several agencies to have high needs. It should include people who are difficult to support due to multiple factors which may not meet individual service thresholds. It should take account of their relationships with others who are vulnerable and be sensitive to the potential effects of past trauma. Where two clients are in a relationship where domestic abuse is considered a risk, services working with them should look at their situation as a whole. While mental health services may often be involved, the principle applies more widely.

357. Agency culture and expectations, and staff skills in working in a multi-agency context, are as important to this as formal process. A participant in the Review commented "Had we all been able to work together without the constraints around risk of blame, then both information sharing and joint working could have significantly reduced the risk of this incident occurring. There needs to be more of an understanding that these stakeholder/multi agency meetings and conversations should be a 'safe space' to enable organisations to share honestly and ask for help from one another."

358. This tragedy has illustrated some factors which could enable a co-ordinated response:

- shared understanding of roles, responsibilities and risks;
- information on the risk of harm, including MAPPA status and known triggers for escalation, available to all services;
- shared plans, with client consent, as the norm;
- commitment to joint action in the event of escalating risk or deteriorating mental health or behaviour;
- the expectation of effective and timely communication between agencies and, where appropriate, with relatives;
- arrangements by which any agency can escalate through senior management if seriously concerned that the response by another agency is inadequate.

359. There has been some progress in this direction. Devon is developing a multi-agency complex cases forum, learning from a similar scheme in Plymouth. Devon

[42] "Exploring the new world: Practical insights for funding, commissioning and managing in complexity" Collaborate for Social Change 2019

Partnership Trust now has an internal forum for discussion of complex cases. Home Group, prompted by this tragedy, now request earlier meetings with Devon Partnership Trust's Individual Patient Placement Directorate regarding risk concerns with other clients. The Trust has tightened the Enhanced Community Recovery Service Contract guidance, to promote NHS support for contract providers when dealing with risk.

360. Substance misuse can be a significant barrier to the effectiveness of support plans. This should lead to early involvement of specialist substance services in multi-agency planning to ensure appropriate risk assessment and treatment where necessary. It is important that partner agencies understand how to refer proactively into drug and alcohol treatment provision, as self referrals may not work in the same way: individuals are not always honest about the level, impact and type of drug use until trust is developed with the service. Police powers, while understandably targeted at more serious drug related crime, could occasionally be used to disrupt illicit drug use within an overall multi-agency plan for a vulnerable person.

361. The involvement of relatives adds further complexity, but it is important that they, too, understand the multi-agency approach. Devon Partnership Trust's staff guidelines on working with carers (2018) summarise "Some would argue that serious mental health problems present the greatest challenge in trying to maintain positive understanding and communication between those who care as partners, friends or relatives, the staff from all services, statutory, voluntary and independent, and the service users themselves." Multi-agency working needs clarity for clients and their families on how queries, comments and complaints about their overall support may be made. The Trust's strategy for carers would form a useful basis for a protocol which other agencies working with them on complex cases could share.

Safeguarding

362. The overarching arrangements for responding to the risk of serious harm to vulnerable adults are through the inter-agency Devon Safeguarding Adults Board. Devon County Council holds the statutory duty for triaging concerns and carrying out Safeguarding Enquiries and so influences what staff of all agencies see as a "safeguarding" risk which might justify intervention. Over the period relevant to this case, Devon was less likely than comparable authorities to record issues reported to them as safeguarding concerns. Those it did record were less likely than in comparable authorities to lead to a full enquiry after the initial triage. Such variation risks confusion as many services likely to raise concerns work across local authority boundaries, and all have staff or clients with experience of other parts of the country.

363. The Council has made progress in closing this gap since the homicide, working with other south west authorities on a regional review of practice, reminding its own staff of correct process and improving information on its website. Improvements to the organisation of some internal NHS safeguarding teams, including Devon Partnership Trust, have helped in gaining appropriate referrals. Relationships with care providers and partner agencies have developed, resulting in advice being sought prior to a concern being raised. A referral form for health and social care professionals who work directly with adults has been updated to prompt provision of a full picture about the person's situation and evidence of high risks. Outcome letters have been developed to help the safeguarding team consistently provide written feedback on the outcome of a safeguarding referral with a clear rationale as to why the decision has been reached. Further improvement work is under way, including further visits to community teams from the Safeguarding Practice Lead, and a Peer Review of adult safeguarding due within the next 12 months.

Supported accommodation

364. Accommodation has long been recognised as a key component of health and wellbeing and in the rehabilitation of offenders. Section 117 of the Mental Health Act mandates the offer of supported accommodation after detention under the Act. Enabling support from staff with the time to treat clients as individuals is often a key factor in recovery. Such accommodation and support comes from a mixed market of non-statutory agencies, including housing associations, charities and the private sector, some with a specialist focus and some offering a range of provision. The Devon mental health accommodation providers' network includes twelve organisations, of which six qualify for Enhanced Community Recovery Service placements. There are no overall arrangements for predicting demand, planning the level of resources, or identifying gaps either by geography or type of support. The Individual Patient Placement Directorate pays for out of area placements as required, but has not drawn from this work to identify whether increased local provision of the right sort could reduce that spending.

365. Wider social trends and pressures on public finances are likely to mean the demand for suitable supported accommodation increases both overall and in the level of individual client need. This needs to be addressed at a strategic level in the county, with the aim of having capacity in the system to find a more suitable placement quickly if one breaks down or a client agrees to move away from unhelpful influences.

366. Devon Partnership Trust, acting on a recommendation from the Serious Incident Review, has improved its approach to contracting with housing providers, aiming to ensure robust arrangements are in place for safeguarding, information sharing and management of risk. This includes new standards and monitoring arrangements for both regulated and non-regulated providers.

Training and skills development

367. The histories of Tigre and Canada illustrate the wide range of agencies and staff roles in contact with them, all with a need to collaborate with each other and with the potential to identify domestic abuse. This underlines the importance of training on domestic abuse and, more broadly, developing skills in collaboration across agencies. Direct contact with professionals from other agencies, for example through joint training events, shadowing or joint projects, aids mutual understanding. While the Trust has improved its own compliance with safeguarding training, some of the smaller partners it relies on have less expertise in this. Rethink, one of the larger providers, identified learning from this tragedy about increasing awareness of awareness of domestic abuse within their training, whether supporting the victim or the alleged perpetrator. As identified by Exeter City Council, staff in a range of public facing roles may encounter examples of domestic abuse and would benefit from training on how to respond.

368. When staff face a difficult situation in a multi-agency context they need to know about the existing frameworks which may be relevant. Where domestic abuse is a risk, these include MARAC, the Domestic Violence Disclosure Scheme and MAPPA. In addition to coverage in mandatory safeguarding training, staff also need to be able to access advice on whether these are relevant to a particular case. Agencies of all sizes need to ensure staff know who to turn to.

369. Training coverage and content has improved since the homicide:

a) The external reviewers undertaking Devon Partnership Trust's Serious Incident Review, from July 2018, found "notable improvements to safeguarding systems" within the Trust, with new and improved safeguarding training and an improvement to levels of staff compliance with safeguarding training. In May 2019 90% of all registered clinical staff were compliant with Level 3 training.

b) The staff team of Rethink's Devon Supported Housing Service undertook an externally accredited course on risk management in June 2018. All staff at the had completed safeguarding training had completed safeguarding training as at April 2019. Within the charity as a whole, all lessons learnt from safeguarding issues are discussed within teams and changes in practice are embedded, where appropriate. Key organisation learning from safeguarding events is provided to operational services in the form of scenario based briefings. All staff receive briefings on local authority and Rethink Mental Illness Safeguarding Adults Policies in line with any updates and changes.

c) Splitz has obtained government funding for 2019/20 to provide training and support to Housing Associations, specialist housing providers, and housing support agencies across Devon to assist people with complex need to protect their tenancies and ensure these providers have good awareness of domestic abuse.

d) Caraston Hall has implemented a more systematic approach to staff training, particularly on support planning, record keeping and working with dual diagnosis clients. It has also run bespoke sessions for management development and on managing challenging clients.

Agency internal arrangements

370. Frequent changes in clinical staff at Devon Partnership Trust have impeded the development of positive therapeutic relationships and interfered with the ability of clinical staff to develop an understanding of the clients. A factor in this is the national shortage of many clinical grades in mental health services, leading to difficulties in recruiting experienced and senior staff. This makes arrangements which facilitate continuity of care all the more important. These include careful handover including briefing incoming staff on the role of other agencies involved with their clients, and any urgent issues raised by partner agencies.

371. In a positive step for clients such as Canada, Devon Partnership Trust was one of three sites awarded contracts by NHS England in May 2018 to become pilot sites for new community forensic teams. The main aim of the two-year pilot, which will be closely monitored and evaluated by NHS England, is to reduce length of stay for patients in secure care through the provision of specialist community forensic teams who will work alongside inpatient teams to help facilitate transition to the community and provide more robust community treatment and support. The multi-disciplinary team will be relying upon a relational model to help understand and support the patients they are working with, following on from the relational discovery approach of inpatient services at Langdon Hospital.

372. As well as providing more specialist and robust direct patient care in the community, the team plans to work very closely with supportive accommodation providers to give them extra training, consultation and supervision to help ensure that the placements themselves are better equipped to support the patients in the community and help them engage in more meaningful activity. A fuller description of the service is given in Appendix E.

373. Correct use of internal systems was an issue at some level for most of the agencies involved. Devon Partnership Trust staff failed to use their risk management system and made mistakes in communication with relatives. Hollywell and Rethink concluded they needed to be more thorough at the referral stage. Caraston Hall identified inconsistencies within its recording systems which it has addressed through implementing standard operating procedures for client assessment, support planning, incident reporting and risk management processes. In addition, the company has introduced a new system for recording communication with external agencies and a regular audit of client support files.

374. The need for an updated process for employee protection has already been recognised within Exeter City Council. The Principal Health and Safety Officer is now leading a Safety of Employees Review Group which now meets monthly to review assault incidents that have been added to AssessNet (the health and safety case management system). The group decides whether to add the perpetrator to the Employee Protection Register and whether sanctions are needed beyond any emergency measures already in place. The group also looks at individuals on the Register whose cases are up for review to check whether they still need to be included or can be removed because they no longer pose a risk. An email then goes out to all staff to alert them that new entries have been included on the Register and advising them to check it.

Recommendations

375. These recommendations are developed in more detail in the separate action plan and are cross-referenced here to the supporting paragraph in this report.

R1 Improve arrangements for the co-ordination across agencies of services for clients with complex needs, including those who, overall, have a high level of need or risk but may not meet individual service thresholds. (#355-#359, #361)

R2 Improve communication and joint working arrangements between Devon Partnership NHS Trust and local drug and alcohol treatment providers for mental health patients with substance misuse problems. (#360)

R3 Review the nature and level of public agency commissioning of accommodation and associated support services for vulnerable adults in Devon to ensure appropriate facilities are available to meet needs safely at a choice of locations. (#364-#365)

R4 Improve the handling of adult safeguarding referrals where there are difficulties obtaining consent to refer or where the referrer has serious concerns about the response. (#362-#363)

R5 Ensure that staff working directly with clients in all agencies providing or commissioning care or support for vulnerable people receive training, appropriate to their role and in line with the 2018 Inter Collegiate Guidance, on adult safeguarding including domestic and sexual violence and abuse. (#367-#369)

R6 In managing structural and personnel changes, seek minimal effect on continuity of care for mental health clients, including liaison with other agencies involved with them. (#370)

R7 Review the way in which Devon and Cornwall Police record, investigate and present evidence to the Crown Prosecution Service regarding assaults involving strangulation. (#348-#349)

R8 In evaluating the Devon Partnership NHS Trust pilot of a community forensic team, take account of the views of partner agencies on how the team collaborates with their services. (#371-#372)

R9 Ensure there are arrangements by which staff at any level in agencies working with individuals who pose risks are alert to the potential use of multi-agency frameworks for managing them and can access information and advice on their use. (#368)

Key to name codes

Note that staff roles were those held at the time relevant to the action described.

Code	Meaning	Organisation
Address A	Where Canada lived until early Dec 2017	Hollywell Housing Trust
Address B	Where Canada lived at time of homicide	Rethink Mental Illness
Address C	Where Tigre lived at time of homicide	Caraston Hall
AMHP1	Approved Mental Health Practitioner	Devon Partnership Trust
CP1	Consultant Psychiatrist for Tigre	Devon Partnership Trust
CP2	Consultant Psychiatrist for Canada (summer 2017)	Devon Partnership Trust
CP3	Consultant Psychiatrist for Canada (autumn 2017)	Devon Partnership Trust
CT1	Clinical Team Leader	Devon Partnership Trust
FSW1	Forensic Social Worker	Devon Partnership Trust
HGCL	Clinical Lead	Home Group
MHRW1	Mental Health Recovery Worker	Rethink
MHRW2	Mental Health Recovery Worker	Rethink
PCC1	Care Co-ordinator for Canada to May 2017	Devon Partnership Trust
PCC2	Care Co-ordinator for Canada from May 2017	Devon Partnership Trust
PCSO1	Police Community Support Officer from neighbourhood team covering Address A	Devon & Cornwall Police
Resident 1	Girlfriend of Canada in 2011 when both lived at Address B.	
Resident 2	Male resident of Address B in 2012	
Resident 3	Co-tenant of Address A with Canada	
RM1	Service Manager for Address B	Rethink Mental Illness
RR1	Recovery Worker (substance misuse)	RISE
SM1	Service Manager	Caraston Hall
SMHP1	Senior Mental Health Practitioner	Devon Partnership Trust
Tech 1	Environmental Health Technician	Exeter City Council
Tech 2	Environmental Health Technician	Exeter City Council
VCC1	Community psychiatric nurse (Active Review Team) for Tigre to Oct 2017.	Devon Partnership Trust
VCC2	Care Coordinator for Tigre from October 2017	Devon Partnership Trust

Appendix A: Safer Devon Partnership oversight of Domestic Homicide Reviews

The Safer Devon Partnership provides the strategic leadership for addressing community safety matters across Devon, aiming to work together to enable the people of Devon to feel and be safe in their homes and communities. Partners include the four Community Safety Partnerships in the county, the Police, the Fire and Rescue service, the Clinical Commissioning Groups, Public Health Devon, the Office of the Police and Crime Commissioner, the National Probation Service, the Community Rehabilitation Company and the County Council.

One of Safer Devon Partnership's responsibilities is to provide (on behalf of the Community Safety Partnerships) the governance for domestic homicide reviews as they are required in the county. Under the protocol agreed, this is delegated to an Executive Group. At the time of this review the Executive Group was led by the Chair of the Safer Devon Partnership Board, and included representatives of:

- Devon County Council
  - Chief Officer for Communities, Public Health, Environment and Prosperity
  - Elected Member with responsibility for Community Safety
  - Principal Communities and Commissioning Manager (with responsibility for Domestic and Sexual Violence and Abuse)
  - Safer Devon Partnership Manager
  - Principal Social Worker, Adult Services

- Devon & Cornwall Police
  - Detective Chief Inspector for Local Investigations (Devon) and SODAIT
  - Detective Sergeant from Serious Case Review Team

- Devon Clinical Commissioning Group
  - Lead Nurse, Safeguarding Adults

- Devon Partnership Trust
  - Managing Partner, Safeguarding

The final version of this Overview report will initially be distributed to:

- Tigre's father (and other family members on request).
- Canada's mother, father and sister.
- Members of Exeter Community Safety Partnership via its Chair.

- Chief Executive and officer with responsibility for domestic homicide reviews (in this case the Director – Communities, Health, Wellbeing, Sport and Leisure) of Exeter City Council
- Members of the Safer Devon Partnership Board
- Safer Devon Partnership's domestic homicide review Executive Group
- Safer Devon Partnership Manager
- Chair of the Devon Safeguarding Adults Board
- Chair of the Devon Safeguarding Adults Review Group
- Chair of the Devon Children and Families Partnership (Devon's Local Safeguarding Children's Board) and the Chair of its Serious Case Review Subgroup.
- Police and Crime Commissioner for Devon, Cornwall and the Isles of Scilly
- All organisations named in Table 1.

Appendix B: Agency reviews

The Panel drew on the reviews by individual agencies shown in the table below. Most were Internal Management Reviews prepared for the Domestic Homicide Review following Home Office Guidance. The Panel agreed to accept the independent external reviews commissioned by Devon Partnership Trust from Enable East as part of the NHS Serious Incident Review process following the homicide as fulfilling the role of an Internal Management Review. Two of the not for profit agencies providing services had undertaken internal reviews through their own governance processes before the Domestic Homicide Review started, and the Panel agreed to use these.

An Internal Management Review (reported to the agency concerned and the Domestic Homicide Review Panel only) is carried out by an agency officer not involved in the case, typically one with a quality assurance role. They review the agency's records and policies, interview staff involved (where appropriate and still contactable) and report on:

- the chronology of relevant interaction with the victim and / or perpetrator;
- what was done or agreed;
- whether internal procedures were followed; and
- conclusions and recommendations from the agency's point of view.

Agency & report writer	Independence statement	Sources
Caraston Hall Non-executive Board Member	The author of report has no personal connection or direct line management responsibilities for this case	Internal documents including notes, referrals, meeting minutes, assessments, support plans, correspondence, email, policies.
Devon & Cornwall Police Detective Sergeant Serious Case Review Team	The author of the report confirms that they have no personal connection or line management responsibility for this case.	Force information systems including UNIFI, Storm, Compact and Sharepoint. Police National Computer. Selected evidence used by the criminal investigation. Interview with PCSO1.
Devon County Council Team Manager Specialist Placement Team	The author of this report has no personal connection or line management responsibility for this case.	Care First
Devon Partnership Trust Independent Review (in two separate reports)	Undertaken by Linda Glasby & Tracey Greatrex, Enable East, who reported they were given full access to	Trust clinical records and other documents. Interviews with Trust staff involved in the care and treatment of both Canada and Tigre. Interviews with managers of

of services offered by the Trust to Canada and to Tigre.	clinical notes and Trust documents, and were confident that staff interviewed were open in their discussions.	Home Group and Caraston Hall. Interviews offered to families (see Appendix C).
Exeter City Council Policy Officer and Corporate Safeguarding Lead, Environmental Health & Licensing.	The author of the report confirms that they have no personal connection or line management responsibility for this case	Environmental Health, Housing Options and Benefits case management systems. Clarifications from staff involved in the case and discussion with their managers.
Hollywell Housing Trust Trustee	The author of this report confirms that he has no personal connection or line management responsibility for this case.	Information from all the Hollywell staff involved who had contact with Canada. Discussion with the Chief Executive Electronic records and logs of incidents, development and subsequent actions Records of tenancy review meetings.
Home Group Registered Manager covering area (appointed in 2018)	The author of the report confirms that they have no personal connection or line management responsibility for this case.	Review of records.
Rethink Mental Illness Head of Community Services (South) and Head of Quality Assurance.	Terms of reference set by, and reported to, the charity's Integrated Governance Overview Group	Service user database and incident and accident management database. The Human Resources system to re the experience and shift patterns of staff. Interviews with Service Manager, RM1
Royal Devon and Exeter NHS Hospitals Trust Senior Safeguarding Nurse	The authors of the report confirm that they have no personal connection or line management responsibility for this case.	Electronic records of Emergency Department and other hospital systems. Hospital notes It was not possible to speak to staff involved as they have left the Trust or retired.
Together Drug & Alcohol Services Panel member from Public Health substance misuse commissioning	Author is commissioner not provider.	Archived records from RISE (previous service provider). Discussion with current service provider.

Appendix C: Involvement of family, friends and support networks

Initial contact with Tigre’s family (father, mother and brothers) was through the Police Family Liaison Officer, who explained that a Domestic Homicide Review would follow after the trial. In co-operation with the Safer Devon Partnership Domestic Homicide Review Co-ordinator, the officer arranged for the family to receive the explanatory leaflet from the Home Office, details of an advocacy organisation, and the Co-ordinator’s contact details. On the day the Independent Chair observed part of the trial the officer introduced her to Tigre’s parents, and this provided the opportunity for discussion of what the Review aimed to achieve.

Following the trial, the Co-ordinator sent further messages for Tigre’s father, mother and elder brother which included an offer to facilitate contact with an advocacy organisation and to discuss the draft terms of reference of the Review. The family preferred not to contribute at this point. However, Tigre’s father and his partner did meet the Enable East Reviewer, who reflected their views in the Devon Partnership Trust Serious Incident Report.

The Co-ordinator let the family know that the invitation for them to offer views remained open, and in March 2019 Tigre’s father and partner met the Independent Chair and the Public Health member of the Panel and provided helpful insights into Tigre’s situation and family concerns and discussed potential recommendations. The meeting was recorded by consent. Her mother did not accept the offer of contact.

For reasons explained in the report, the Panel sought contact with only one of Tigre’s friends. She is a survivor of domestic abuse whose comments to the media had been reported after the trial and was known to one of the Panel members. She met the Independent Chair and the Co-ordinator at an early stage of the Review and shared her memories of Tigre and insights into her situation.

The initial stages of this Review ran in parallel with the Enable East reviews commissioned by Devon Partnership Trust, and it was agreed that the Trust’s representative on the Panel would facilitate co-ordination of contact with relatives, and that the Domestic Homicide Review would not directly contact Canada’s family until the Serious Incident Review relating to him was complete.

The Enable East review invited contributions from Canada’s father and mother. However, the invitation gave an incorrect telephone number, so his mother, who does not use email, did not make contact at that point. Ill health and distance prevented his father’s participation. When the Serious Incident Review was complete the reviewer met Canada’s mother and sister to explain the findings and passed on an invitation to contact the Domestic Homicide Review Co-ordinator. It was at this

point that Canada's sister made the reviewer aware of her November 2016 complaint to Devon Partnership Trust.

Canada's mother and sister both took up the offer of contact with the Domestic Homicide Review. In March 2019 his sister emailed copies of the complaint and related correspondence and social media activity, and then had a telephone conference with the Independent Chair which covered these and broader background. Canada's mother met the Independent Chair and the Exeter City Council panel member to talk about Canada, the services he received and his relationship with Tigre. She was accompanied by a woman friend to support her. The friend had known Canada so also contributed to the discussion. Understandably, Canada's mother expressed frustration at not being listened to in the past. In this and related telephone contact with the Co-ordinator assurance was given that her contribution was valued. Regrettably, due to technical problems, neither of these meetings was recorded, but participants were given the written notes to check afterwards.

Tigre's father received a copy of a draft report in August 2019, and, after an agreed period to study it, he and his partner met the Independent Chair and Splitz panel member to discuss it. The draft report was amended to take account of their comments, which were recorded by consent.

The Independent Chair, with the police panel member, then met Canada's mother and her friend to discuss the draft report (in September 2019). Canada's sister did not take up the offer of further contact at that point. Attempts to contact Canada's father had initially been unsuccessful, but he was able to meet with the Independent Chair and Safer Devon Partnership panel member in October 2019 to discuss the draft report and contributed information by email in advance of this. These meetings were recorded by consent. The report was further amended to take account of comments made at these meetings,

The Panel appreciates the contributions and insights of both families, and their desire to see the lessons from this review applied.

Appendix D Independent Chair / Report Author

Christine Harbottle was the Independent Chair of this domestic homicide review, and the report author, steering the work of the Review Panel and drafting this report which reflects their agreed conclusions. Responsibility for the final report and publication following quality assurance by the Home Office rests with Safer Devon Partnership.

Christine has undertaken this role for some of the other domestic homicide reviews undertaken by Safer Devon Partnership. Other than this she has no connection with Safer Devon Partnership or Exeter Community Safety Partnership and has not worked for any of the agencies named in this review.

The main part of her career was with the Audit Commission, an external regulator of public bodies including councils, police forces and NHS Trusts. The role involved evidence based independent reports on these public services, taking account of the views of service users. She had a regional lead role on community safety, and contributed to national reports on drug misuse, mental health and partnership working. Following the reduction in the Audit Commission's remit she left in 2011 and now works freelance.

From 2008 to 2017 Christine was a Trustee of Langley House Trust, a national charity and housing association working with offenders. None of the Trust's services were involved in this case.

Appendix E: Explanatory notes

Community Forensic Team – pilot

In a pilot scheme started in May 2018 Devon Partnership Trust has a Community Forensic Team (CFT), a small multidisciplinary team working (Monday to Friday) as part of the wider community forensic services (CFS) that also includes Pathfinder, FIND and Offender Personality Disorder Services. The team will work from Easby House as a base and form their own Community Forensic Services Local Delivery Unit, under a Service Manager.

The CFT have a whole-time Consultant Psychiatrist, an 8c Psychologist, three Occupational Therapists and three Community Psychiatric Nurses, a Social Worker and a Peer Support Worker. The team will offer full care coordination for the patients that they have assessed and who meet the team's eligibility criteria. The main criteria for referrals to the team are:

- The patient is currently in a secure setting
- The patient is from, or will be willing to be discharged to the Devon area
- There are significant risks of harm to others
- The CFT could shorten or improve the patient's transition to the community.

Community Treatment Orders

A Community Treatment Order, under Section 17A of the Mental Health Act, provides a framework for the management of patient care in the community and gives the Responsible Clinician the power to recall the patient to hospital for treatment if necessary. The framework includes regular review and means of appeal.

A Community Treatment Order may be made if the certain criteria are met, including:

- The patient is suffering from a mental disorder of a nature or degree which makes it appropriate for them to receive medical treatment;
- It is necessary for the patient's health or safety, or for the protection of other persons, that they should receive such treatment;
- Subject to the patient being liable to be recalled, such treatment can be provided without their continuing to be detained in hospital;

Conditions set depend upon the patient's individual situation. The purpose of these is to:

- Ensure the patient receives treatment for their mental disorder; and
- Prevent risk of harm to the patient's health or safety or to protect others.

This might cover for example:

- Stipulating where and when the patient is to receive treatment;
- Stipulating where the patient is to live; or
- Requiring avoidance of known risk factors or situations relevant to the patient's mental disorder.

Domestic Violence Disclosure Scheme

The Domestic Violence Disclosure Scheme, commonly known as Clare's Law, allows people to request information from the police about their partner's previous offending history in relation to domestic violence, the "right to know". Further the police have a "right to tell" those identified as being at risk from domestic abuse by a partner. It is not in fact a law but a process that suggests a multiagency agreement is normally required to confirm the risk and the need to share the information. Information sharing is still governed the Data Protection Act. The process allows for third party concerns whereby a friend, relative or agency may raise the concern to the police and trigger consideration of a disclosure to the potential victim.

Any agency can trigger this process by contacting police and asking for the process be considered for a particular couple. Information will normally only be shared with the individual at risk unless for some reason they cannot protect themselves effectively when a carer may also receive a disclosure.

In Exeter considerations for disclosure under the scheme are discussed at the fortnightly MARAC meeting to provide the multiagency consideration the process requires to authorise the action. Police may assess applications at an early stage and decide that there is nothing to disclose and provide a letter outlining that fact but being mindful that the police record does not hold all information about people. The scheme provides certainty for professionals from all agencies and allows for considered discussion of what and how disclosures should be made. It may be decided that someone other than the police deliver the information.

Individual Patient Placement (IPP)

IPP is a Devon Partnership Trust service with responsibility for specialist individual patient placements which are commissioned to meet an individual's complex needs which cannot be met in Devon. These placements are usually out of area.

The IPP Directorate is a commissioning and contracting function which makes it different to other Directorates within the Trust. It commissions and approves funding and placements in a range of contexts which include:

- High Dependency Inpatient Rehabilitation (HDIR) (Open) - Out of Area and Langdon Hospital
- Enhanced Community Recovery Service (ECRS)
- Psychiatric Intensive Care Unit (PICU).

Tasks undertaken by the IPP team include:

- Facilitate a safe repatriation back to Devon to the least restrictive environment
- Reviewing out of area placements and treatment (attending CPA's, Mental Health Act Tribunals, Multi-Agency Public Protection Arrangement, strategy meetings, safeguarding, etc.)
- Provide advice using their expert knowledge to recommend appropriate placements, treatments and care pathways
- Advise on appropriate funding streams
- Well established links to Secure Services – attending Langdon referral and discharge meeting
- Advise and recommendation for appropriate step down placements
- Key stakeholders on IPP funding and review panels
- Authorise and validate invoices
- Key member and link to Social Care panels

MAPPA: Multi-Agency Public Protection Arrangements

Multi-Agency Public Protection Arrangements (MAPPA) are multi-disciplinary meetings held on those individuals most at risk of causing harm and are designed to protect the public from serious harm. They require the local criminal justice agencies and other bodies dealing with offenders to work together in partnership in dealing with these offenders. Typically a MAPPA panel might consist of the Police, Probation Service, Prison Service, accommodation providers, drug and alcohol service providers and Social Services. Local arrangements for MAPPA meetings vary. Those for Exeter (and Torbay) they are held weekly, hosted by Probation and are represented by regular attendees, and chaired by either a probation manager or senior police officer. Each agency considers what they can provide to enhance the risk management plan within their own sphere of professional responsibility. Individuals are referred mainly, but not only, by police and probation. Referrals are

considered by a screening panel who decide whether a case meets the criteria for a panel meeting to be convened.

Individuals subject to MAPPA arrangements are placed at one of three levels and in one of three categories. The Levels are from 1 to 3 where Level 1 is a single agency managing the individual and Level 3 applies to a small number of offenders requiring exceptional resources eg for cross-border working. At an initial MAPPA meeting the Level and Category of the person is determined. The Level can be escalated at subsequent meetings if the situation warrants it. The Categories are 1 (sexual), 2 (violent) and 3 (other dangerous offender). There is a specific list of offences and sentences associated with Category 2. To qualify for Category 3 there must be a conviction or caution for an offence which indicates that the offender is capable of causing serious harm and the requirement for and possibility of active multiagency management. Category 3 cases are therefore only managed at Levels 2 or 3

Within MAPPA meetings all agencies scrutinise the risk management plan, compiled by the responsible Probation Officer, and make suggestions as to the management and monitoring of the individual or for any further specific actions to be taken (like referrals to other agencies/services, drug screening, home visits etc). MAPPA meetings are only held on people as long as their risk is assessed as requiring it. When the assessed level of risk falls and the risk is thought to be manageable, the individual is moved down a level, held at MAPPA Level 1 by a single agency (usually Police or Probation), without panel meetings, or discharged from MAPPA altogether. MAPPA does not give supervising agencies any additional powers: it is a system for assessing and managing risk.

Agencies make their own arrangements for recording the MAPPA status of their clients. The Devon and Cornwall Police UNIFI system person record displays a warning showing the MAPPA level. When individuals are actively managed by the MAPPA panel (ie at Level 2 or 3) the system links the person record linked to an interested parties marker which notifies a specific officer or team when a crime or piece of intelligence is linked to that person. Interested person markers allow those with specific responsibility to assess and react to any such updates. Once a MAPPA subject is no longer managed under the process the UNIFI marker is removed, though any intelligence submitted during that period remains on the record to be seen by officers dealing with them in the future.

MAPPA status can be disclosed to a third party. Disclosure must comply with the law, be necessary for public protection, and be proportionate. Police can disclose where others may be at risk e.g. in supported accommodation.

MARAC: Multi Agency Risk Assessment Conference

This is a regular meeting where information is shared on the highest risk domestic abuse cases between representatives of local police, probation, health, child

protection, housing practitioners, Independent Domestic Violence Advisors and other specialists from the statutory and voluntary sectors. After sharing all relevant information about a victim, representatives discuss options for increasing safety for the victim and turn these options into a co-ordinated action plan. At the heart of a MARAC is the working assumption that no single agency or individual can see the complete picture of the life of a victim, but all may have insights that are crucial to their safety

Mental Capacity

Adults have a legal right to make their own decisions, even when they are unwise, as long as they have the capacity to make that decision and are free from coercion or undue influence. In addition, the decision needs to be informed by the possession of all relevant information.

The Mental Capacity Act recognises the following principles:

- A person must be assumed to have capacity unless it is established that he lacks capacity.
- A person is not to be treated as unable to make a decision unless all practicable steps to help him to do so have been taken without success.
- A person is not to be treated as unable to make a decision merely because he makes an unwise decision.
- An act done, or decision made, under this Act for or on behalf of a person who lacks capacity must be done, or made, in his best interests.
- Before the act is done, or the decision is made, regard must be had to whether the purpose for which it is needed can be as effectively achieved in a way that is less restrictive of the person's rights and freedom of action.

Devon Safeguarding Adults Board Guidance states: "People generally have the right to take risks and to live their life as they choose. These rights, including the right to privacy will be respected and weighed up when considering safeguarding duties and responsibilities. They will not normally be overridden other than where there they would be likely to suffer serious harm, or where they lack the capacity to make relevant decisions in an informed way or where there may be risks to other adults with care or support needs. Information may need to be shared and gathered in order to assess the level of risk that someone faces."

Risk management policy (Devon Partnership Trust)[43]

Risk management is a core component of mental health care. Practitioners make decisions every day about how to help clients manage their potential self-harm or neglect. Good risk assessment should be structured, evidence-based and as consistent as possible across different settings or different service providers.

Devon Partnership Trust's Risk Management Strategy recognises risk management should aim to improve a person's quality of life and their plans for recovery, whilst being mindful of the safety needs of the person, those in their immediate social network and the wider population. The Trust endorses positive risk management and will support any risk-related decision if it is:

- Considered – carefully, collaboratively, based upon the best information available and conforming with relevant guidelines/best evidence.
- Recorded – in accordance with the tool/structured prompt and record system in place and that identified risks are reflected in overall treatment/care/risk management plans.
- Communicated – the relevant people are involved/informed in a timely way.

The Trust has in place a risk management strategy and a set of policies and procedures relating to the management of risk. The assessment and management of risk is the responsibility of all staff key actions include:

- It is essential to raise any queries or concerns in relation to risk through your managerial and/or professional line manager.
- Ensure your decisions and responses to risk assessment and management are considered carefully, collaboratively and based on best information available conforming with guidelines and best evidence.
- Record your risk assessment on a person's notes in accordance with standing operating procedures for the system used and complete incident form if required.
- Ensure you communicate information to the relevant people in a timely way
- Ensure Recovery principles are at the heart of risk management care planning.

[43] These paragraphs taken from the Devon Partnership Trust Serious Incident Reviews

Safeguarding at Devon Partnership Trust

Devon Partnership Trust has a central safeguarding team which operates a duty system to allow clinicians to contact them, during working hours, for urgent advice. In addition, safeguarding supervision clinics are held across the Trust every week where any staff may consult with a member of the team. Safeguarding referrals can be made via the Trust's Risk Management System, introduced in May 2017, which allows a single front door for all incident reporting and safeguarding referrals. All safeguarding adults concerns are triaged by the safeguarding team within 24 hours, Advice is provided to clinicians reporting concerns and where appropriate the referral is forwarded to the relevant local authority. The system enables corporate oversight of safeguarding concerns.

Safeguarding Adult Enquiries

[Extract from Devon Safeguarding Adults Self-Neglect Directory, 2018]

A Safeguarding Adult Enquiry can be used to enable multi agency information sharing, risk assessment and protection planning, or contingency planning in the following situations.

• An adult at risk has been identified as having a pattern of behaviour of serious self-neglect resulting in, or likely to result in, serious harm.

• They have capacity to make relevant decisions but have refused essential services, without which their health and safety needs cannot be met.

and

• the health and social care process that the person is eligible for, such as adult social care, mental health or substance misuse service, have been provided but have not been able to mitigate the risk of serious self-neglect that could result in significant harm.

In these cases, Safeguarding Adults processes can be used to enable multi-agency risk assessment and protection planning to take place. While it may not always be possible to safeguard someone from self-neglect if they fail to engage with services or a protection plan, the Safeguarding Adults process can help ensure that all those involved are aware of the following;

• All information available on level of risk

• Who to share any further risk information with

• What support can be offered, and by whom

• What protection or contingency planning can be made

[Extracts from Devon Safeguarding Adults guidance: "Deciding when and how to carry out a Safeguarding Adults Enquiry".]

When a concern that an adult is at risk of abuse has been reported to Devon County Council it is recorded as a Safeguarding Adults Concern. Information is gathered and recorded to help decide whether a Safeguarding Adults Enquiry is needed or whether other actions should be taken.

The criteria for the Local Authority to make (or cause to be made) whatever enquiries it thinks necessary to enable it to decide whether any action should be taken, is that an adult:

(a) has needs for care and support (whether or not the authority is meeting any of those needs),

(b) is experiencing, or is at risk of, abuse or neglect, and

(c) as a result of those needs is unable to protect him/herself against the abuse or neglect, or the risk of it.

Objectives of a Safeguarding Adults Enquiry:

• Establish facts

• Ascertain the adult’s views and wishes

• Assess the need for protection, support and redress

• Protection from abuse, in accordance with the adults wishes

• Make decisions on follow up action needed and who will take it

• Enable the adult to achieve resolution and recovery.